Legislative Assembly of Alberta

The 28th Legislature
First Session

Standing Committee
on
Families and Communities

Mental Health Services in Alberta
Stakeholder Presentations

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First Session

Standing Committee on Families and Communities

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Standing Committee on Families and Communities

Participants

1 p.m. Wednesday, February 6, 2013

[Ms Pastoor in the chair]

The Chair: Good afternoon, everyone. I'd like to call this meeting of the Standing Committee on Families and Communities to order.

I'm Bridget Pastoor, the committee chair and MLA for Lethbridge-East. I'd certainly like to welcome everyone and thank you for your attendance at the meeting this afternoon. We'll start by going around the table to introduce ourselves. Before I do that, I would like to say that David Swann, Shayne Saskiw, Ken Lemke, and Heather Forsyth have phoned in and will be doing this by teleconference.

I can just start at my right. Mrs. Fritz, if you would start, please.

Mrs. Fritz: Thank you. Good afternoon, everyone. Yvonne Fritz, Calgary-Cross.

Mr. McDonald: Everett McDonald, Grande Prairie-Smoky, sitting in for Maureen Kubinec.

Mr. Pedersen: Good afternoon. Blake Pedersen, MLA for Medicine Hat.

Mr. Wilson: Jeff Wilson, Calgary-Shaw.

Ms L. Johnson: Linda Johnson, Calgary-Glenmore.

Mr. Fraser: Rick Fraser, Calgary-South East.

Mr. Fox: Rod Fox from the wonderful constituency of Lacombe-Ponoka.

Ms DeLong: Alana DeLong, Calgary-Bow.

Ms Jansen: Sandra Jansen, Calgary-North West.

Mrs. Sarich: Good afternoon. Janice Sarich, Edmonton-Decore.

Mrs. Leskiw: Good afternoon. Genia Leskiw from God's given country, Bonnyville-Cold Lake.

Dr. Massolin: Good afternoon. Philip Massolin, manager, research services.

Ms Rempel: Jody Rempel, committee clerk, Legislative Assembly Office.

The Chair: Thank you.

Bruce McAllister has just joined by teleconference as well. Thank you.

Just to confirm that Everett McDonald is the official substitute for Maureen Kubinec.

Also, a reminder that the microphones are operated by *Hansard*. The audio of the committee proceedings is streamlined live on the Internet and recorded by *Alberta Hansard*. Audio access and meeting transcripts are obtained through the Legislative Assembly website. Again I would remind you to keep your cellphones off the table as it does interfere with the *Hansard* recording.

I would like you all to take a look at the agenda. Could I have someone approve that agenda? Thank you, Janice Sarich. All in favour? Yes. Thank you. I didn't see many hands, but I assume that's in favour. Thank you.

Approval of the minutes. Would anyone like to approve them for me, and are there any amendments? Seeing no amendments, Ms Jansen, thank you for approval of the minutes. All in favour? Any opposed? We have a few abstainers.

This afternoon we have five presentations on the topic of mental health in Alberta. The first two presentations are from Alberta Health and Alberta Health Services. Each of these presentations is scheduled for one hour, including a 30- to 40-minute presentation followed by questions from committee members. After these presentations we will take a quick health break and then reconvene for the last three presentations: Alberta Human Services, Alberta Justice and Solicitor General, and Alberta Education. These three presentations are scheduled for half an hour: a 15-minute presentation and time for questions following. Clearly, we have a pretty full afternoon ahead of us, so I would ask that committee members hold their questions until the end of the presentations.

I think we can start now. I would invite our first guests from Alberta Health to join us, please. Thank you, ladies. If I could ask you to introduce yourselves, please.

Ms Williams: My name is Susan Williams, and I'm the chief strategy officer for Alberta Health.

Ms Vajushi: I'm Silvia Vajushi, and I'm the executive director for the addiction and mental health branch of Alberta Health.

The Chair: Thank you very much.

Who just joined on the teleconference? Jason Luan. Thank you very much. Welcome to you all in the teleconference.

Ladies, the floor is yours.

Department of Health

Ms Williams: Okay. Basically, we circulated around to everybody – so, I guess, apologies to people on the phone – the highlights document for the addiction and mental health strategy called Creating Connections so that you have that at your fingertips. I'll be going through the presentation and then open for questions.

The Chair: I don't think we've had that passed around.

Ms Williams: There are a few copies that we brought. I thought they were handed out. I guess they will be handed out.

The Chair: They're coming now.

Ms Williams: I'll be going through a high level of what the strategy is, what it's all about, and where we're at in our implementation of the strategy called Creating Connections.

The strategy was released in the fall of 2011. This is sort of the order of the presentation that I'm going to go through: why did we do this strategy, who was involved with the strategy, and the implementation. I'll do a high level of what is in the strategy on the five strategic directions and that. I'll talk a bit about some of the initiatives that we're working on under the five strategic directions on the implementation plan and next steps of where we're at.

Why was the strategy necessary? Why did we start this work back in 2010? Basically, it's a very important issue, and I think there was a very sort of urgent paradigm to look at this issue. We've provided you with some statistics in the PowerPoint about why. One in 5 people will experience a mental illness in their lifetime, and the remaining four will be affected by someone that they know – families, friends, and colleagues – so it touches everyone. An additional 1 in 10 people over the age of 15 may become dependent on alcohol or drugs at any given time in their life.

I want to stop there. I know that your interest is in mental health, but from our perspective of what we're going to be talking about this afternoon, it is around addiction and mental health because there is a significant sort of relationship and codependency between the two conditions.

This slide says that it's estimated that at least 50 per cent of the people who have mental illness also have an issue of an addiction with drugs or alcohol. You're going to hear from Alberta Health Services a slightly different number of around 30 per cent. I think the issue is basically that it's a significant portion of people who have a codependency between addictions with drugs and alcohol and mental illness. I think the statistics relate to whether you're talking about Alberta or Canada.

Why was the strategy necessary? We looked at, basically, that the health system has been historically underfunded in this area. There was a recognition that there needed to be enhanced co-ordination and integration of services, both between addiction and mental health and also between addiction and mental health services with the rest of the health system and other services that are being provided.

This condition has a significant economic burden when you look at the ability of people to be productive members of society, to work. You look at absenteeism and other issues and the significant monetary value of that from society. So we need to create programs and services that can prevent the development of mental health and addiction problems, and we need to help people get earlier access to services and improve the health and quality of life of Albertans. Part of the focus is on techniques and strategies that we can use to be able to become more aware of issues before they happen. I know that in early childhood development, part of that is working with families to be able to do that.

So we're looking at reducing the burden of mental illness and addiction. It can also generate cost savings such as less productivity losses in the workplace, as I said, absenteeism and turnover of staff, keeping people out of hospital or the criminal justice system, and reducing the use of social supports.

1:10

Who was involved in the actual development of the strategy? The strategy implementation is being led by both Alberta Health and Alberta Health Services, but it also has involved a lot of other ministries and a lot of other partners. Right now there are eight other partners besides Alberta Health that are involved in this initiative with us. It involves not only Alberta Health Services but Education, Enterprise and Advanced Education, Executive Council, Human Services, the Mental Health Patient Advocate, Municipal Affairs, and Justice and Solicitor General. You'll be hearing from a number of them this afternoon as they present to you and talk about what their piece is and what they're doing in this strategy.

The strategy is broken into five strategic directions. It's a five-year strategy, so it would be sort of, you know, from 2011 or '12 through to '17. It has a total of 25 different initiatives that we're working on, and I'll be going through each strategic direction and talking about some of the initiatives that we're involved in implementing right now. We've had each ministry and Alberta Health Services agree to be an executive champion for each strategic direction and help us move forward with this, to take accountability and champion the activities and work on the integration of some of the work that we're doing.

In the strategy in the document the vision is around healthy communities, promoting mental well-being enabled by comprehensive, co-ordinated, and compassionate addiction and mental health services. The purpose of the strategy is to transform the addiction and mental health system in Alberta by developing a comprehensive and co-ordinated system that provides people with a range of addiction and mental health services and supports that they need. We want to enhance health promotion and prevention activities. We want to provide timely access to high-quality assessment so that we know what we're doing and treatment and supportive services, if they are needed, are available. The goals that we have are to reduce the prevalence of addiction and mental illness and to provide quality assessment, treatment, and supportive services.

As we were developing this strategy, we looked at a number of other key initiatives that were under way across government, particularly the SafeCom initiative, the children's mental health plan, the 10-year plan to end homelessness, the fetal alcohol syndrome disorder, FASD, 10-year plan that we're working on, and the prevention of family violence and bullying strategy. So we looked at all of that to see how much we could basically leverage some of the work that's being done under those strategies to help achieve the purposes and vision that are under this strategy.

The restructuring of health care service in 2008-09 with Alberta Health Services created one provincial health authority which actually was an enabler and an opportunity for us to provide a provincial addiction and mental health strategy and to create one provincial system for the delivery of addiction and mental health services.

As I said, this strategy was developed by Alberta Health and Alberta Health Services. It's had a number of partners around the table. It sets the direction and agenda for what we're trying to do, from the delivery, policy, legislation, and standards perspectives for the whole field of addiction and mental health for the next five years. We are coming to the end of year 1 of implementation of that five-year plan. The strategy is intended to guide our actions to improve the health and mental well-being of Albertans across all areas of the province.

This chart which is on slide 8 has a continuum on it, and it comes actually from the strategy. The continuum looks at, from the left side of the chart, tier 1, which is the least intensive service and would be providing more prevention and services to individuals in the community, all the way through to the right side of the chart to tier 5, which would talk about the more intense service, which would be sort of a specialized facility treatment for complex needs and would be, for example, things like Alberta Hospital and the types of services that are offered there.

This is a picture to talk about the services that are being offered across a continuum of what both individuals' needs might be and the types of services that would be required as the intensity and complexity of the needs of individuals increase and how we might look at that from both community housing and wraparound services.

Alberta Health Services, when they come up to present, will be going through this slide in more detail and will be giving you sort of more concrete examples about the types of services and probably where in the province you will be able to see things under the various levels and tiers.

The strategy also has seven enablers, so not just the five strategic directions but enablers about how we're going to do some of the work, that are also key and important, being essential to build capacity and infrastructure to do this work. You can see them up on the slide there.

- Policy direction and alignment
- Individuals with lived experience and family engagement

We actually have a bit of a family counsellor group that provides information and advice.

- Funding and compensation framework

so that the funding and compensation that we do are actually enablers and not disincentives for what we're trying to achieve.

- Workforce development

That is significant, that we have the right people to be able to support the work that we're doing.

- Research, evaluation and knowledge transfer

so that this work is being informed by research, that we are able to evaluate the effectiveness of programs and services, and that we are able to transfer knowledge about what works.

- Leverage technology and information sharing

That is important. More and more work in health care is enabled by technology, whether that's IT or other types of technology and evidence-based practices.

- Cultural safety, awareness and competency

Safety for individuals but also safety for the workforce and people who are providing services to the individuals.

Part of the strategy was also looking at it from a lens of First Nations, Métis, and Inuit perspectives. There was a fair amount of discussion when the strategy was being developed about whether to have a particular strategic direction on this or how to incorporate it in the strategy. The result at the end was to look at the strategy holistically from the perspective of First Nations, Métis, and Inuit and not build in a separate section to deal with them. That was basically done through the teams that developed it and by using a First Nations, Métis, and Inuit checklist that was developed in partnerships with both Aboriginal Relations and our aboriginal partners. This checklist ensured that the work and the strategies that we were coming up with and the initiatives under it actually maintained the lens from their perspective, were inclusive of their perspective and their health needs, and were actually addressing what some of their needs were.

The services will be and should be culturally respective and customized to meet the needs of the FNMI people and communities. For example, they need to address the diversity within different FNMI populations. We recognize there are differences between First Nations, Métis, and Inuit perspectives, incorporating traditional concepts of history, spirituality, and relations. The FNMI organizations have been and will continue to be involved in the development of addiction and mental health programs and services.

Now I'll go into a little bit more detail on the strategic directions and the actual initiatives. This is a bit of a busy slide. With the colour it's sort of hard to read, but it's there for your reference, and I'll take you through each one individually.

The strategy has five strategic directions. The first one is to build healthy and resilient communities. The second one is to foster the development of healthy children, youth, and families. The third is to enhance community-based services, capacities, and supports. The fourth is to address complex needs. The fifth is to enhance assurance.

1:20

There are 25 initiatives under these five strategic directions. You see them numbered. I'll be going through each one, and I'll explain in a little bit of detail what is incorporated within each of the 25 initiatives that we're working on now. But we're not doing this alone within Alberta Health. Again, I'll emphasize that this is work that is being done with Alberta Health Services and with the other partnering ministries, so while I'm giving the broad overview and will talk at a very high level about each of the 25, when the other ministries come up, they'll go into more detail about what, actually, they are doing and delivering under these activities and how it is meeting the various needs of the populations. Some of them are more specific or unique populations that they may be dealing with in their ministry.

The first one is building healthy and resilient communities. This strategic direction was looking at both healthy and resilient families, but it was also in the community, so the fabric of Alberta and the communities. There were actually building blocks and services in that to promote mental well-being and to basically mitigate the negative effects of addictions and mental health. This strategic direction was meant to deal with everything from prevention to wellness, tools that people and families and communities need to be able to achieve the outcomes of what the direction is trying to do.

Of the six initiatives under that that we're working on, one is promoting and distributing low-risk drinking guidelines that have been developed nationally in support of the Alberta alcohol strategy.

The second one is reducing the prevalence of youth tobacco use by engaging youth in tobacco reduction strategies. Minister Horne actually did release a new 10-year strategy for tobacco reduction in November. That would be fitting under not only addiction and mental health but also the tobacco reduction strategy.

The third one under this is that addiction and mental health services have been identified in the minimum panel of services to be offered by family care clinics. Again, Minister Horne has been quite strong on this point, that part of the services that we are looking at enhancing in primary health care is access to addictions and mental health. In the application kit that is out for consultation, it is part of the comprehensive services and the sort of minimum services that would be offered at family care clinics. That would include things like early identification and treatment of addiction and mental health problems, including screening and diagnostic interviews to be able to do that, assistance to individuals and their families in navigating the system to ensure access to addiction and mental health services if they're required, and encouraging individuals and families to maintain healthy lifestyle choices that will contribute to maintaining good mental health.

The fourth one is about supporting postsecondary psychological services. Again, a couple of weeks ago there was an announcement made about funding that is going to the University of Alberta, the University of Calgary, the University of Lethbridge, and the Alberta Students' Executive Council for the colleges and technical institutes for them to be able to provide enhanced services for addictions and mental health. We were quite concerned about the rates of mental health and suicide that we had received from a national report about what was happening in postsecondary education. This money will help develop student mental health services, including the hiring of professional staff and developing models of care that can be used on campuses.

The fifth one is to support school communities to enhance health and well-being of school-aged children and youth within school communities. This funding addresses things like healthy eating, active living, positive social environments, and it includes a focus on emotional well-being of students, fostering a sense of belonging and connectedness within schools, and working with families and communities to be able to do that.

The last one in this area was a number of positions that were funded by us to Alberta Health Services to collaborate with the school communities to promote physical activity, healthy eating, and positive school environments. These last two initiatives are initiatives that I think are falling under our general sort of Alberta wellness approach and our Alberta wellness strategy.

The second strategic direction was fostering the development of healthy children, youth, and families, so this is a focus on children and youth. Again, it's looking at having a good, strong foundation

in a child's early years, which increases the probability of positive outcomes later in life, and looking at some of the supports both with families through early childhood and into the school system on how we can do that and increase that strong foundation.

This strategic direction recognized the importance of identifying mental health concerns early on amongst children and youth in support of effective development and growth and requires comprehensive services being offered to families as a whole to help them be able to basically address the issue and seek support. The initiatives under this are building capacity in schools and communities for students at risk, so being able to identify which students potentially could be at risk and are at risk and offering services and supports for those individuals; developing a comprehensive, co-ordinated, and integrated referral access strategy for local, regional, and provincial addictions and mental health services to do this; enhancing services and advocacy supports to families who have a family member requiring support due to addictions and mental illness. This would be through the Mental Health Patient Advocate role that we have in the province, so Fay Orr's role. The postpartum depression screening would be implementing standardized screening across the province on recognition of postpartum depression and access to services around that. We are looking at a consensus conference that is being held to determine more specific guidelines for clinicians and that on recognizing postpartum depression and then what to do.

On the provincial acute, tertiary, and rehabilitation plan for children's mental health Alberta Health Services is developing a provincial bed plan for children's mental health beds, including not only acute but residential and community-based treatment homes and group homes. This is work that we're doing on understanding where the beds are within the province based on needs.

Triple-P parenting/PAX Good Behavior Game, a pilot and comparative study: it's a particular, I think, pilot project that we're working on, examining good behaviour to determine which mental health outcomes are impacted by these programs.

The third strategic direction is really looking at the community-based services, capacities, and supports at the community level. This is focusing on community-based programs and services and supports required, so again not just about what screening can we do but what services are available for people once issues are identified and what is available in your community. This strategic direction is designed to improve the quality of life for individuals by enhancing capacity in the community and improving navigation of those services.

Some of the initiatives under this strategic direction are looking at defining and delivering a fundamental service basket on addictions and mental health – Alberta Health Services is doing that; they will be discussing that in more detail, about the work that they're doing on defining what the services are and then what is actually available in each community within Alberta – enhancing telehealth services; looking at increasing clinical services to Albertans through standardized processes; leveraging technology to access rural and remote communities; providing resources and training to support clinicians. Again, Alberta Health Services will talk about the work that they're doing on that particular one and where they're at.

1:30

We've been looking at development and finalization of a housing framework that outlines treatment and care options, provider roles, and funding accountabilities through the identification and elimination of major housing and service gaps. The reason why we have a housing framework is that there is recognition that a lot of people who have addictions and mental health issues are often also housing fragile, as I would call it, or homeless. So part of this is looking at the housing continuum of what type of supports for people we need to be able to support them on their treatment plans.

We were also looking at a gap analysis of addictions and mental health programs, and I'll talk about that on the next slide as to what that work is. We've been providing some funding to enhance sexual assault services to victims in a number of regions, including Edmonton, in the northeast and northwest areas of the city. We've provided some money through Human Services to some of the homelessness foundations to be able to do some of the addictions and mental health wraparound services for individuals in Calgary, Edmonton, and Lethbridge. Human Services will speak to that in their presentation.

I referred to the fact that we have been doing a significant gap analysis. We have hired Dr. Cam Wild, a professor and associate dean with the School of Public Health, to do this work for us. He is looking at sort of what currently exists for publicly funded addiction and mental health programs across the province, in our various programs that we're offering through the ministries and across the province and what funding is attached to them. This inventory of services is being developed to give us a better picture of the addictions and mental health system so that we can get a better sense about where the gaps are and where we need to look. We're anticipating that we will use that as part of the formulation for the activities and the initiatives for year 2 and forward that we should be using as priorities.

This work is expected to be completed by June or this summer of 2013. Some of the guiding questions that this work, this analysis is doing or that we've asked Dr. Wild to look at are: what programs and services are currently funded by provincial dollars and delivered to Albertans? What are the provincial financial resources that are currently being expended on the identified programs and services? Are there gaps or overlaps in the addiction and mental health services in the province? As I said, we're going to look at this to see and get a better idea about what actually is available in urban and rural communities, where there may be gaps, and how that will inform us about where we need to set priorities for the future.

The fourth area is addressing complex needs. People with complex needs require extraordinary services and often extraordinary help to be successful. These are people that are often provided with services across multiple government ministries and various service sectors and stakeholders. They often require services as they may have complex health needs and severe behavioural problems in addition to addictions and mental health. They often have a number of comorbidities of health issues. They could have issues with housing and a number of other issues. They may have been in and out of the justice system. These are complex individuals coming to a number of us for various programs and services, and part of this is to look at how we can serve them better and how we can integrate some of our service delivery in doing that.

Some of the initiatives under this are: providing funding for four specialized mental health in-patient units, for a total of 80 beds, at Alberta Hospital Edmonton. Areas of enhancement are concurrent disorders; community crisis, short stay; rapid assessment and discharge, subacute care; and community transition units, so people would stay there for a short period of time and then transition into the community.

We're identifying the support needs of persons with developmental disabilities, so PDDs and complex needs clients, and looking at what their supports are and being able to support them in the community and to have a co-ordinated and integrated service plan for them. We're creating a framework on the range of

specialized care for addictions and mental health, people who have complex needs.

Alberta Health Services and Justice will speak to this because this is an area that we have done a significant amount of work on under the SafeCom initiative. We'll also be speaking to some of the work and some of the initiatives that they have been doing, that they are funding on projects around the integrated justice service project in enhancing services and corrections for these individuals.

The last area is enhancing assurance. This is around the quality of the services that we have. Patient/client safety is fundamental as building blocks of this. In order to achieve it, part of this is about metrics; part of this is looking at the workforce that we use to be able to do this service.

We have a number of initiatives under this one, including developing and implementing a plan to ensure addictions and mental health services are delivered by confident and capable service providers; building a comprehensive performance framework to monitor, evaluate, and report on addictions and mental health outcomes, programs, and services – we don't have a comprehensive performance framework, so this is the work that we are doing under this area and then collecting the data so that we have better knowledge about the effectiveness of services and programs – enhancing the level of knowledge and understanding about addictions and mental health for staff and individuals in the system, so broad awareness and understanding about this area and in that; applying this knowledge to inform policy, service planning, delivery, and for staff development; also, providing Albertans with information and resources to help them make informed decisions when choosing an addictions treatment facility and helping them to receive appropriate treatment that matches their needs in a safe and supportive environment. This is an area where people and services and treatment facilities may not be licensed, so providing more information to them about the services and what the services are that people are providing and what the quality is of the services that are being provided at those centres.

We're also working with the Canadian Centre on Substance Abuse to develop a strategy to address prescription drug misuse in communities. There has been a significant amount of work done both in the province and nationally on prescription drug misuse.

The last one is on mental health first aid. This is around providing mental health first aid training in partnership with the Mental Health Commission of Canada to front-line delivery staff both within Alberta Health and within other GOA delivery partners so that they know what services are available in recognition of mental health issues.

Into implementation, as I said before, this strategy is a five-year strategy. We're coming to the close of the first year of implementation. I walked through at a very high level the 25 initiatives that were chosen that we're working on for the first year. We know we still have more to do. Part of the gap analysis that we're doing is to have a better informed position to basically assess the priorities for the next number of years that we need to do for the remainder of the five-year strategy.

Implementation will continue to take a crossministry approach and to work collaboratively with all of our partners, including Alberta Health Services. We will be examining programs and initiatives across the government of Alberta and Alberta Health Services that we can leverage from so that we are going with an eye to reducing duplication and allowing us to implement effectively and look at what we can co-ordinate together. Stakeholder engagement is key to this and having people around the table that are informed in the work that they're doing and have an ability to provide input into it. Alberta Health Services has, actually, an advisory committee on addiction and mental health that can receive advice from stakeholders. This is aligned, as I said, with a number of crossministry initiatives that we are working on. There are a number of them on the slide here, from social policy framework to the 10-year plan to end homelessness, prevention. I'll not read them all. You have them.

1:40

We are doing this work in a governance structure that has an executive steering committee that's composed of the partners that I talked about: Alberta Health, Alberta Health Services, and the ministries that are responsible for implementing the actions. I'm the chair of the executive steering committee. We have various work teams that are doing this work, and it is supported by a secretariat of staff, both from Alberta Health and Alberta Health Services, to support this work, and we have an advisory committee that is composed of not only the main key partners that are doing it but broader stakeholders that are involved in this work; for example, the Alberta Alliance on Mental Illness and Mental Health; the Canadian Centre on Substance Abuse; the Alberta Medical Association; CARNA, the College and Association of Registered Nurses. There's a primary care physician, and there are even individuals, patients or families, who have lived experience with addiction and mental health. So this is the structure of sort of how we're doing this work.

Next steps. We're going to continue to do our work. We're going to continue to press forward with the 25 initiatives, in getting them up and running and assessing how they're doing. We will receive the work that Dr. Wild is doing, and we will be looking at that to make assessments in setting priorities for the next few years under the strategy.

Thank you very much. These are the key people from crossministry and the champions for each of the five strategic directions, including myself, and some of them will be coming up here to present for their ministry on what they're doing from their ministry's perspective.

Thank you.

The Chair: Thank you very much.

At this point I'd like to recognize Mrs. Mary Anne Jablonski and Ms Rachel Notley as having joined us. Thank you.

I believe there is a speaking list here. We'll start with Janice Sarich.

Mrs. Sarich: Thank you very much, Madam Chair. Also, thank you very much for your presentation this afternoon. I truly realize that a tremendous amount of work and progress has been made on this particular file since the establishment of the addiction and mental health strategy and implementation ideas, but I do have a number of questions.

I am actually quite surprised and puzzled to learn just exactly where you are today. Maybe I can frame it this way. I look to the report of the Auditor General in 2008, and, yes, the configuration for mental health was much different during that time. This is a new chapter because Alberta Health Services was established. Regional health authorities were nine, and all merged into one in 2008. Having said that, that this framework was established and rolled out in 2011, September to be exact, I appreciate the governance model. I guess I'd like to have a greater sense of: what is the budget? What is the funding distribution? What are you working on?

I was quite curious in your statements about the gap analysis. You're going to be taking a look at what's available, what is invested. If I look back to some of the key advice of the Auditor

General in 2008, that was exactly what the problem was at that time under a different model, and here we are today. So if you had to give a report card over this past year of the dollars invested, the progress made, priorities, what would that report card say?

I'm asking the question because we're at a critical juncture in this province. Our economic situation has changed, a lot of the programs and services that people count on in this very important area, and it touches many specific aspects of mental health and addictions, across many ministries, across many stakeholders in the province of Alberta.

I'm really afraid that you don't have enough data to support the longevity and the intent of a framework. If you don't have some concrete evidence about effectiveness at this point, then how are you providing advice for moving forward even to the minister, for that matter, or Alberta Health Services? I'm wondering if you could comment.

Ms Vajushi: I will make a few opening comments. One is to say that we very seriously reviewed the Auditor General's report, and the Auditor General has signed off on Alberta Health meeting the commitments of the recommendations of the report. The addiction and mental health strategy was a step towards that. In developing the strategy, we relied on not only our internal knowledge but national and international experts who vetted the strategy as well as a literature review, so we did have the best evidence available to move forward.

We also appreciated what the Auditor General required around a gap analysis and agreed that in order to be accountable, in order to make sure we have the right services in the right place, we need to do that work. But we couldn't afford to wait for that work to be finished when we did have good information and evidence that allowed us to continue the work and work parallel while the gap analysis is being developed, which is an analysis of all the services that are offered through any public funding, be it Health, Human Services, et cetera. It is a large piece of work that will be delivered in June, and we were able to start with other pieces of the strategy while this piece is being developed.

Mrs. Sarich: I guess, Madam Chair, I'll close with this. You also mentioned a comprehensive performance framework being developed. It seems to me that if you're setting priorities and if that setting of priorities took place in 2011, at the same time you would be giving serious consideration to a performance framework. Either it did start at that time or you're just starting now, but I guess I'm still not clear on the dollars being invested. What is it? How does it break out? And if you were asked to give a report card today, are we getting good value for the dollars invested? Are you anticipating that something may have to change, given our different economic realities in the province? If so, what might that be, and what would be your strategy going forward to prepare for some other methods of delivery or considerations of programs and services to be able to appropriately respond? I welcome your comment.

Ms Williams: On the financial question, our money for addictions and mental health, we have a small budget within Alberta Health of about $25 million with which we are doing some grants to nonprofit agencies to do some of the initiatives that I talked about. Just about all of the money from Alberta Health to addictions and mental health is part of the global funding that goes to Alberta Health Services. When Alberta Health Services is up here, they will describe what their global funding amount is and where their money is going to, and each of the other ministries that come up will talk about their programs and their funding towards addictions and mental health and some of the clients that they're delivering to. I don't feel it's appropriate for me to talk here to you about a budget and what is going to happen in the budget or its impact on programs.

Ms Vajushi: However, if I could add to that, when you ask about a good investment, compared to every other province across Canada, what we hear is that we are all aligned. We are providing services in very similar ways, so we are investing in an appropriate way. We need to invest more and invest better, and I think that's the work that's still ahead, but I think what we do have, I'm confident in saying that we are investing well.

1:50

The Chair: Thank you very much.

I would ask Mrs. Leskiw next. Perhaps because I have a list here and we have a short time frame, I'd ask you to keep your questions short. Any questions that would go around budget are probably better asked after March 7.

Mrs. Leskiw: Okay. Thank you. I'm going to ask from a different approach, being a rural MLA, where mental health education and services are very, very important. First of all, I want to thank you for doing a gap analysis because I think one of the problems in rural Alberta – well, I'm going to just talk about mine. That way I won't get into difficulties. In my constituency there are too many duplications of services, and we could spread out our money a lot better if we knew exactly what was out there and who was doing what.

The other thing is that I do want to thank you on the violence and sexual assault. They're doing some wonderful work up in the Bonnyville-Cold Lake area, and the funding that was just recently given for a three-year project was definitely appreciated and long overdue. Thank you for that.

My question is about the First Nations, Métis, and Inuit initiatives. When we talk about First Nations initiatives, we are talking about off-reserve aboriginals, correct?

Ms Vajushi: We're mostly talking about off reserve although I would defer a larger answer to Alberta Health Services because my understanding is that they do work off and on reserve. They actually could answer that more fully.

Mrs. Leskiw: The reason I asked is that when I was doing consultations on PDD across the province, one of the things that we heard from our aboriginal people on reserves is that when their people needed help, if they wanted to get help from the province, they had to leave their home on the reserve in order to get the PDD funding, in order to get any of the other. If they stayed on the reserve, the funding from the provincial government wasn't there. That was a concern.

Also, rural programming and the budget ramifications. What I find in our area specifically is that half of our problem in getting help out into the rural areas is spending money on transportation. To get the health expertise, we end up spending all our money on just getting them there. We get the same amount, allotment, as somebody in an urban area; therefore, our money isn't spread out, getting down to actually helping the patients, because we're spending that money. Are the rural initiatives being addressed when it comes to mental health hospital beds like the ones in St. Paul? That's where my constituents go for mental health.

Ms Vajushi: We're looking at it in concert with the other ministries and Alberta Health Services and, in fact, met yesterday with the zone executive directors of Alberta Health Services as well as

the provincial health services team and the Alberta Health Services team. Many of the same issues that you're bringing up today were brought up, and they are issues that we have to look at for the second year of priorities, absolutely.

Mrs. Leskiw: I think co-ordinating with Education, Health, Alberta Health Services is definitely the way to stretch our money the greatest amount so that more people can benefit. For that, thank you very much.

The Chair: Thank you.

Alana DeLong, please. If we could keep our questions really pointed.

Ms DeLong: Okay. I just wanted to support Janice Sarich in her comments. I'm still frustrated how in government we can come forward with all these programs, but we never think about measuring them until later. Unless we come forward with the two at the same time, essentially we're going blind. You know, everybody's always got a wonderful idea as to all these wonderful things that we can do, and there will always be 10 more than we can pay for.

Ms Williams: I don't want to leave the impression that we have no measurement and we have no data. It's one thing to be able to have data for certain programs, and it's another thing to have a comprehensive performance measurement system for the strategy that basically has common definition about how the data is captured and being able to report it across all of the strategic directions, to do that. We have data. We have performance metrics from Alberta Health Services. But I think what we're looking at doing is taking it to another level of a very comprehensive, rigorous performance metric system on the evaluation of the effectiveness of the programs and services that we're doing across the landscape of the ministries.

Ms Delong: I guess the other comment that I have is that there are an awful lot of things here, and there are certain priorities, I think, that are out there, which is whether or not the community services are actually getting to the people and whether or not there are enough community services. I mean, that's what I've been hearing for 10 years. I think that we need to have our eye on what's really important and make sure that the money is being spent on what's really important.

I know you can't talk about budget, but Janice did have a good point, that all programs are going to be looked at through a very critical eye. Whether or not something is actually performing is really key. So you really do need that.

The Chair: Thank you.

Ms Notley.

Ms Notley: Thank you. It's going to be hard. I have so many questions, and of course it's hard to get them all in. Just a clarification. The Auditor General's report talked about the fact that in 2011 you were doing a bed inventory. Is that what the mapping is?

Ms Vajushi: The gap analysis?

Ms Notley: Yes.

Ms Vajushi: The gap analysis is looking at publicly funded services, including beds. There's also a bed inventory that Alberta Health Services is doing, that they can respond to.

Ms Notley: Okay. So you don't know if that's complete yet. That was the one that they told the Auditor General about.

Ms Williams: They're going to be talking about it today.

Ms Notley: Okay. So two different things.

You mentioned you had $25 million in the Ministry of Health to work with under mental health. Is it possible to get a much more broken down explanation of what that money does? It doesn't appear in the budget documents right now in a way that's remotely helpful.

Ms Williams: In the budget documents is a figure of, I think, $100 million for primary health care. That's composed of $25 million for addictions and mental health and $75 million for furthering primary health care on family care clinics.

Ms Notley: Right. What this committee would be looking for is a breakdown of that $25 million. We want to see.

Ms Vajushi: There was a press release on that $25 million, I guess in the fall, that spoke about it being broken into four categories: Alberta Hospital Edmonton, children, counselling services, and housing. Those are the four areas that are being funded through that $25 million.

Ms Williams: We could provide details to the chair.

Ms Notley: Did the press release have a line-by-line on some of the grant recipients so we have an understanding of the type of services that are being funded through the ministry as opposed to AHS? We're going to be looking for that across the board with every ministry that reports, so we really want a more detailed one there.

The final thing that I would just like to ask. One of your priorities in terms of your strategies is workforce development. I think it's called enhancing assurance. As you know, I'm sure, there was a time back in '08-09 when the government was aware of the incredible wage gap that existed amongst a number of people in the nonprofit sector, including people who work in PDD as well as some other sectors that impact on mental health.

When our caucus did our health care tour in 2010, we had one person talk to us about how, you know, she was paid $15 an hour to work at a transition house, or women's shelter, and what was happening was that the acute care mental health centre at Grande Prairie hospital was phoning the director of their women's shelter asking them to do community transition services for acutely mentally ill women. Of course, none of the staff were trained for that or paid for that or anything.

I'm wondering where you guys are at given that that plan to supplement that gap in terms of those folks who are working in the nonprofit sector appears to have gone up in smoke a couple of years ago. Where is that now, and what evaluations do you have to offer at this point?

2:00

Ms Vajushi: I can't answer that. That plan was before my time. I have never seen a plan for the nonprofit sector in health.

Ms Notley: Well, okay. I think a lot of people here could tell you that there was a plan. Oh, I guess Mary Anne is not here. The PDD staff were supposed to be receiving money, and it ended up being an annual, yearly amount as opposed to actually permanently increasing their salaries, but it would also . . .

Ms Vajushi: Right. Yes. I remember. I wasn't involved with it, but now I remember what you're talking about.

Ms Notley: It also impacted the nonprofits like, for instance, in our rural centres, who are dealing with mental health even though

they are not even marginally qualified to be doing that service. But they're doing it in many centres in the rural areas.

Ms Williams: I would say that the workforce development plan would not be at the compensation level but would look at the competencies and training and what the workforce needs are of what we need, so that sort of supply and demand, more modelling and training and competencies that are needed in that. I think we're also going to look at what is sort of regulatory for some of the professions in this area.

Ms Notley: Right. Well, I think you'll find that in terms of community counselling and community support, it's a complete dog's breakfast, and if you don't look at that issue, you're going to completely miss the quality of community care issue.

The Chair: Thank you very much. That was three, Rachel.

Ms Notley: Yeah, I know. Thank you for your patience.

The Chair: I have five more people. I'd like to also suggest, to make sure that I can get all five in, that some of the answers could come back in writing. So, ladies, if you feel that you could answer some of them in writing, then I would appreciate that.

Next is Linda Johnson. Again, please keep your questions very pointed.

Ms L. Johnson: Okay. Thank you, Madam Chair. Thank you for your in-depth presentation. My question relates to the Department of Education initiative on the early child development mapping project. Are you able to use some of that information to build where you deliver your programs?

Ms Williams: Can you ask that question to Education when they're up?

Ms L. Johnson: Okay.

The Chair: Thank you. Yes. They are presenting this afternoon.

Okay. Rod Fox.

Mr. Fox: Thank you. I have a couple of questions here for you just on how the strategy was developed. I'd like to know if you'd be willing to provide a list or table a list of who your key stakeholders were when you developed this. I'm hoping that you can do that fairly shortly. I'd also like to know which studies you used, if you could table those, in creating this strategy. I think it's important that we find out exactly where and who you were consulting with to create this.

The last question I have for you is on the implementation of this through family care clinics. Right now I think there are only two or three in the province. We're working with a primary care network right now. My question is: how is this going to be implemented through the primary care networks that we have in the province today?

Ms Williams: We're having discussions with primary care networks right now about some of the characteristics that are in the application kit for family care centres. So what are some of the sort of key characteristics of what a family care centre would look like or could look like? And we're having discussions with them on where the program is going to evolve or go to.

The minister has talked about taking a standards-based approach to primary care networks, and the Primary Care Alliance has been asked to look at some of the standards that are being proposed for family care clinics and to get back to him by the beginning of April on which of them they would be interested and willing to adopt for primary care networks because that program is also going to change and evolve as they move and change. So that could look at the provision of mental health and addictions. They are quite interested in that, and they are quite interested in how they get better access to mental heath and addiction support for their clients. Some of them are already doing it through primary care networks, and some of them are looking at enhancing that.

Again, Alberta Health Services and Dr. Megran could talk about that a bit more when they're up.

Mr. Fox: Thank you. When could we expect the tablings on the key stakeholders and the studies used to develop the strategy?

Ms Williams: I think the stakeholders could be pretty easy. We'll have to go back and see what information is still available from the files as to what the studies were that people looked at. We'll do that and talk to Minister Horne about it.

Mr. Fox: Thank you.

The Chair: Thank you.

Matt Jeneroux.

Mr. Jeneroux: Right. Thank you, Susan. Maybe I should wait until Alberta Health Services, but I'm going to throw it out there anyway, and maybe Alberta Health Services, if they're in the room, can kind of comment if need be. I'm looking at strategic direction 2, fostering development of healthy children, youth, and families.

Again, we talk about postpartum depression, and at this point we're kind of lumping it in with anxiety as well. I guess I'm worried and a bit nervous that we're going to lose the scope of including males in this perspective as well and not just females. That goes with the depression and anxiety that kind of comes along with birth. I just want maybe some comments on that as there is increasing evidence that that's available.

I'm just quickly scanning through the Alberta Health Services' presentation. They mention a consensus in conference planning around this. If you could just explain maybe a bit of what that means to you, I guess.

Ms Vajushi: I think Alberta Health Services is in a better position to give an elaborate answer, but I can say that we are working together through strategic clinical networks and through other work that Alberta Health Services is doing and through our maternal and infant health strategy to look at clinical pathways for depression which include men and women. They can elaborate more on what that looks like.

The Chair: Thank you very much.

Dr. David Swann, on the telephone. You're up.

Dr. Swann: Thank you very much. The big issues in our health care system are quality and access. I haven't really heard you talk about quality measurements and access measurements, so I'd be interested to hear a bit about that and, in addition, what role patients and families will play in measuring the quality of the services and the access to services, how long they have to wait.

Ms Vajushi: Again, I think Alberta Health Services can give a more complete answer. We do have access targets for children's mental health that they can expand on, and we're moving towards access targets for adults as well. Quality treatment is one of the major goals of the strategy, so different areas are certainly being looked at. I can't give you a complete answer to that. I would want Alberta Health Services to weigh in on programs.

Dr. Swann: Okay. Thank you.

The Chair: Thank you.
The last one is Blake Pedersen.

Mr. Pedersen: Thank you. I just wanted to back up some of the other colleagues' comments. It's always great to see these strategies put out, but to not see any numbers or measurables tied to it – I don't know how we as a committee can even sit here and think that we can offer anything of importance that's going to change the direction or the focus. To think that we don't need that information I don't think is accurate because in one comment you're saying that you're seeing good results and you'd like more money. I think everybody would like to say that.

Then, too, also to back up to another comment, I'm also disappointed that there's nothing in here about the PCNs that are already in place. There's talk about the FCCs, which are something that is being developed. I think that we already have PCNs in this province that are working with mental health right now, and to not see them, you know, specifically in here as being contributors to making positive steps towards how mental health is treated and dealt with – I think we've missed something there. That's just something that I've noticed. Again, hopefully, it's going to be something that you guys have a look at because we don't know where the FCCs are going to go, the numbers, the services they're going to provide, where they're going to be provided at. We do have PCNs out there already. That's known. To be dealing with two unknowns at the same time, that's juggling too much. We're putting too much at stake here.

That's all I have to say, I guess.

Ms Williams: There are 40 PCNs in existence in the province. They are expected to provide comprehensive health services, and a part of comprehensive health services is access to addictions and mental health services. So that's already part of what they're supposed to be doing.

2:10

The Chair: Thank you very much. Ladies, thank you very much. Susan and Silvia, most appreciated. That was a very good presentation. Thank you.

Well, it looks like I don't have to invite you up. You know that you're next up, so thank you very much, Alberta Health Services.

Dr. Megran: Good afternoon. We'll maybe start with introductions. We're waiting for our fourth chair here. I'm Dr. David Megran. I'm the executive vice-president and chief medical officer for clinical operations at Alberta Health Services along with my dyad partner, Chris Mazurkewich, who, many of you know, is the chief operating officer. The two of us at an executive level are accountable for all of clinical operations within AHS.

I'll ask the other three individuals who have joined me here today to introduce themselves, and then I'll make a few opening remarks.

Mr. O'Brien: Good day. My name is David O'Brien. I'm the senior vice-president for primary and community care with Alberta Health Services.

Ms Beverley: Hello. I'm Laurie Beverley. I'm the executive director with the primary and community care department for addiction and mental health.

Dr. Trew: I'm Dr. Michael Trew. I'm the senior medical director for addiction and mental health for AHS, and I'm a psychiatrist practising in Calgary.

The Chair: Thank you very much, gentlemen. I will turn it over to you completely.

Alberta Health Services

Dr. Megran: Thank you. Just a few opening remarks before I have Dave O'Brien go through the presentation. Thank you for the opportunity. We've already made a few jottings of some of the questions that were posed to Alberta Health that might be answered by us in a complementary or perhaps more detailed fashion. We'll try to touch on those through the presentation or come back to them right at the end of the presentation. Thank you for that.

I just want to stress a couple of things. One is that the three people here with me today work within a new department, a relatively new portfolio in AHS called primary and community care. We brought this portfolio together maybe about eight or nine months ago. The components were in the organization already, but we brought them together. There are three main components, one being primary care, the second being addiction and mental health, and the third being seniors. I think the message, obviously, in bringing those together is the amount of overlap and the importance that each has for the other, particularly when thinking about the people who are most affected in those three areas.

The primary care piece has already been touched on here by your questions and is exceedingly important regardless of how many specialists one might have like Dr. Trew, psychiatrist, or mental health nurses or other workers. The bulk of mental health care and mental health promotion really needs to be carried out and is carried out by our primary care providers in our primary care system. Again, we thought it was very important that our new portfolio brought these three partners together to work closely.

Dave O'Brien, to my left, is the leader, the senior vice-president, along with the senior medical director, Dr. Lewanczuk. They're the leaders of that portfolio. As you heard, Ms Beverley works within it. Dr. Trew, as well, is the medical lead for the strategic clinical network in addictions and mental health. We may have an opportunity to touch on the importance of the strategic clinical networks in bringing innovation and care pathways and consistency and equitable care in our province.

With that, I'll just say that we did receive the questions from your prior meeting. We, Alberta Health Services, were not present. We've tried to incorporate those questions or concepts behind those questions in the presentation, and if not we'll kind of speak to them as we go along or thereafter.

Dave, I'd ask you to go through the presentation for us.

Mr. O'Brien: Certainly. Thank you very much for the opportunity to present here today. I think you will find a fair bit of overlap with Alberta Health's presentation. Our work is highly co-ordinated with Alberta Health. We do meet regularly.

In the area of primary and community care, that I am the lead of along with Dr. Lewanczuk, our primary responsibility is in developing mid- to long-term strategies around how best to integrate community services; that is, primary care, addictions and mental health, seniors' health, and continuing care along with chronic disease management and rural service planning.

Again, we're really all about ensuring there is good alignment across the health care continuum within Alberta Health Services but, importantly, also link very closely with the ministries and with other agencies who also have funding or jurisdiction and provide services, so we're very, very tightly linked and co-ordinated. It is a work in progress, but we are seeing some very, very positive improvements in terms of our ability to co-ordinate work. Again, I

apologize for the overlap with Alberta Health's presentation. Nonetheless, it is the very same topic matter.

The outlying page. Again, this is structured to complement the other presentations that you have heard from Alberta Health as well as the ones upcoming from the other ministries and hopefully not be too repetitive. Nonetheless, it's also structured to answer specifically questions that were raised out of the minutes of the last standing committee. Hopefully, it will address some of those questions, and I recognize that it may generate more questions today. Happy to hear those.

This is somewhat repetitive of Alberta Health's slide, that there really is a strong case for change. Short facts. According to the World Health Organization the prevalence of mental disorders across seven survey countries, including Canada, ranged from 12 to nearly 50 per cent. As Susan mentioned, these numbers are highly variable because in a lot of cases they are self-reported statistics. The estimated lifetime prevalence for Canadians is 38 per cent. One in 5 will experience mental illness in their lifetime, and as also mentioned, the other four will be impacted by mental illness in one way, shape, or form. As many as 10 per cent of people over 15 may be dependent on alcohol or drugs, and a large percentage of those individuals also have concurrent mental disorders. The consequences of addictions and mental health are far reaching. It speaks even more to the need to co-ordinate with other ministries around community and social supports. The economic burden, which I would argue is underestimated, constitutes more than 15 per cent of the burden of disease in Canada.

Just in terms of roles and responsibilities – I think that in your questions you touched on it, and in Alberta Health's presentation they touched on it – it is complex. There are many service providers, and there are different funding agencies. It's obviously a large job to be co-ordinated, and we are working very hard at this in terms of trying to be more co-ordinated.

Much of the publicly funded addiction and mental health services are provided through AHS and funded through Alberta Health. However, there are other ministries who do fund addiction and mental health services, and many of them are here today to present, so I'll leave it to them. There is a wide range of other providers as well. Private providers, nongovernmental organizations, community and consumer groups provide direct addiction and mental health services to Albertans as well.

Ultimately, delivering services as close as possible to home and to where the consumers and families live is the objective. Again, you've hear it spoken of already, but the gap map work that Dr. Cam Wild is doing is going to be of critical importance for us in terms of trying to plan effectively where gaps currently exist within the system, where the needs are, and cross-referencing that with the available services so that we get a fuller understanding of how to make improvements in the system.

2:20

Again, Alberta Health covered a version of this slide. It is essentially a diagram that depicts the integrated addiction and mental health service model that is currently in place in Alberta. This is based on the national treatment model for addictions. A very important aspect is that health promotion is embedded across the continuum, as is reflected by the white arrow. As mentioned, the range of services goes from least intensive and expensive on the far left to more expensive and intensive treatments and interventions through to tier 5. Tiers 4 and 5 really are specialized programming that we've talked about for complex needs clients, who have severe, persistent, and chronic addiction and mental health issues.

There are broad categories of services that are provided by Alberta Health Services – I think you have the slide in front of you, so I won't go through it in detail – either on our own through our own staff or through our very strong links to contracted service providers or through our primary care networks, with whom we work very closely, or through our family care clinics, who are up and coming: essentially, health promotion and prevention services through to screening, early detection, support, and intervention; more intensive clinical intervention and support and relapse management through to the higher levels of treatment and associated supports for clients with complex needs and specialized treatment; rehabilitation and associated supports, which includes acute care services in some cases as well.

This slide – it's probably too small for you to read – shows you the location and breadth of community addiction and mental health services that are available across the province. Hopefully, it's large enough on the slides that you have for you to get a good sense of it. There are approximately 80 community mental health clinics across the province. This number includes mobile and satellite services as well. There are about 30 Alberta Health Services rural and semi-urban addiction service locations across the province, and in many communities addiction and mental health services are integrated and based on a best practice service model.

The locations shown represent services that are available. They're not necessarily inclusive of the full range of services across the continuum. The strategies, goals, and the work that we're doing now is intended to improve access, improve the co-ordination of services, and really deliver services where they're needed at the right level of intensity. Clients, residents of Alberta who are unable to receive the right services at the right time invariably will default at some point to a higher level of care. Delivering the services at the right time and place is critical for us to ensure sustainability of the system.

This is a brief slide that shows you the current addiction and mental health beds that are owned or operated by Alberta Health Services or are contracted by Alberta Health Services. There are very few contracted; nonetheless, there are some that are included. What we have done is broken them down for you by the type of service provided and by zone as well so that it gives you somewhat of a decent overall picture. In the column that says Provincial Psychiatric, in brackets are the standalone facilities, so the 100 in Calgary, the 330 in the central zone. The 100 is Claresholm, and the 330 is Ponoka. The 305 is Alberta Hospital Edmonton. The balance of the Edmonton number is Villa Caritas. That gives you a sense of the overall structure of the beds within the province.

Within Alberta Health Services approximately $540 million is spent on the provision of addiction and mental health services. This excludes anything that is grant funded, which I'll give you a bit more detail of in a minute. It also excludes anything that is part of our prevention and promotion programs. This is approximately 6 per cent of our annual budget.

As I mentioned before, there are numerous services that are provided outside of Alberta Health Services' budget and jurisdiction. Those may be funded by Education, Human Services, Justice, et cetera. They may be private practitioners. They may be not-for-profit organizations such as the Canadian Mental Health Association, the Schizophrenia Society of Alberta, et cetera.

Addiction and mental health is actively involved in results-based budgeting for Alberta. Again, with respect to the gap analysis I think we're very much looking forward to the information that will give us a good sense of what's going on in the publicly funded world. I think we've spoken many times in the

past while that stage 2 of that may need to be a better understanding of what is privately funded as well to get a fuller picture of the situation.

The next two slides just give you a sense of some of our grants. These are restricted grants that we have that are not from Alberta Health. We have funding from the Ministry of Enterprise and Advanced Education around research chairs in addiction and mental health, intended to increase our academic and practice-based research capacity within Alberta and strengthen our connections between practice and research and really start to drive evidence-based improvements to the system.

The second is funding from Health Canada. This is intended to provide mentorship and training to the front lines in primary care delivery around high-risk youth and young adults and understanding and treating drug addictions.

The final one is funding we've received through Human Services, again trying to understand and better link with continuing-care services addiction and mental health issues that are in the seniors population.

The next slide is a summary of Alberta Health funded grants within our system. These amount to approximately $40 million a year in annual funding. There are a number of these grants that we're currently working with. Many of these have gone on for a number of years and/or continue into the future for years.

The first is around the children's mental health plan, focusing on strategies to improve services to infants, children, youth, and their families and addressing the needs of children and youth who are at risk, linked with safe communities.

Clinical pathways for child and adolescent depression. Again, this was mentioned earlier. There is work that is specifically grant funded around that. We also are undertaking, through our strategic clinical network under Dr. Trew's leadership, the development of pathways for adults as well, men and women.

We have community treatment orders and special mental health initiatives funding. This work has been under way for some time now and is delivering excellent results.

The mental health capacity building for children and families. That project has been under way for some time but is also exceedingly well received and has some very strong support.

The safe communities grants around community mental health and addiction initiatives, continued support for additional mental health and addiction beds as well as enhancing addiction and mental health services and supports within correctional facilities: three of them are mentioned below.

2:30

Just to give you a bit of a sense, we do have about 400 contracted service providers that Alberta Health Services contracts with to provide addiction and mental health services, with the annual value around 78 and a half million dollars. These are legacy contracts. Most of them existed in the former regions and/or with the Alberta Mental Health Board or with AADAC. Again, we continue many of those.

The service contracts: a number of them are sort of a flow through on a government grant, so I just wanted to be sure you understood that the funding comes from a variety of operating and/or grant funds. Again, a great deal of our work at AHS is around taking advantage of the scale of our provincial organization and working to ensure consistency and equity in terms of the services that are delivered and how they're funded. We are really working hard at rolling out consistent contracts with strict accountabilities and quality improvement monitoring and reporting processes and, again, making sure we're driving that equitable funding and ensuring that wherever the services are provided in Alberta, we're consistent in terms of how we fund them and how we treat them.

The next slide is just to give you an overall summary of the contracts that we have by type. They align under treatment, prevention, support, or other specialized contracts. The revenue contracts we have are just where we might provide services to different organizations across the province using Alberta Health Services employees.

Diving a little bit into the strategy itself, these are the specific priorities that Alberta Health Services is leading, and I wanted to give you a bit of a flavour for how that might drill down into actual outcomes and deliverables and what specific initiatives we're intending to undertake there. You know, I think it's important to note a few things. One is, obviously, as mentioned, that it is designed to address the unique needs of the First Nations, Métis, and Inuit populations in communities, that it is intended to take into consideration and to continue to work with those who have lived experience and to engage families in this. As was mentioned, we have struck a public advisory council on addiction and mental health, and this is a council that is represented from the public, by the public, and many of those individuals have lived experience.

We're working on our funding and compensation models to optimize the use of services and the access to services across the province. Some specific examples: for instance, under the primary health care tools and supports we are working to deliver tools – tool kits, education, information – to our primary care networks, to primary care physicians and other front-line primary care providers. That will help to improve access for individuals into the system and will also improve the ability of primary care providers to assess and deal with mental health and addictions issues.

We are, obviously, as mentioned before, integrating our learnings and our multidisciplinary team approaches into primary care networks as well as into the three family care clinics now and the model for future family care clinics. We are working on postpartum depression and anxiety and, again, focusing on standardizing prenatal and at-birth screening and treatment for mothers at risk and undertaking environmental scans for both public health and addiction and mental health services.

As you mentioned, we have consensus conference planning in effect and working groups that are going to address screening and treatment standards with strong linkages to our strategic clinical network. The co-ordinated and consistent access to child and adolescent addiction and mental health services builds on the children's mental health plan for Alberta and the operational policy framework for services for children and youth with special and complex needs. It includes the mental health capacity building in schools initiative, which is on track. It addresses improvement in access and wait times to children's mental health services. Again, we are reporting that on a quarterly basis and noting improvements.

The provincial bed plan for children's mental health is work that has been under way, and we have a crossministerial planning and review committee meeting this month intending to advance that work ahead. We have spoken about Dr. Cam Wild's GAP-MAP services, around identifying and defining a fundamental basket of services that need to be available for Albertans who have addiction and mental health issues. A great deal of work has been undertaken and completed in enhancing our capability for telemental health, which will allow physicians and other primary care providers across the province to access experts in other parts of the province.

The housing and supports framework has been spoken of already and is a critical element in helping us to understand how best to deliver services in the community to individuals who might

otherwise be underserved or who might otherwise be overserved in an acute-care type of environment.

Finally, around the tertiary care framework, again, on developing consensus amongst our professionals in terms of the right level of care that can be provided in the community and how best to provide it and what those physical environments look like and what those care models look like: a great deal of work has gone into that and continues to go into that.

Around the complex needs we have completed an integration management model with the establishment of local and provincial structures. We've worked very, very closely with the ministers of Human Services and Health around how best to co-ordinate our efforts, co-ordinate our services, and address delivering appropriate services to this population. We've devised a memo of understanding, a service level agreement, between Alberta Health Services and PDD so that we understand and then can operate more fluidly between us and share information. We've developed community support teams so that there can be an ongoing flow of information between the organizations, again in an effort to ensure the best seamless services are delivered to that population.

We've talked about workforce development. We are working on plans to ensure that professionals within addiction and mental health services are properly credentialed, are working to their full scope of practice, that we have appropriate pay levels, and that individuals are being asked to do only what's within their scope of services but also that they practise to their full scope.

Around research evaluation and knowledge translation we've established our strategic clinical network. We are working on development of a system performance framework. It's been spoken of already in the Alberta Health presentation. We've completed the third and fourth editions of a system level performance for addiction and mental health in Alberta, and we're currently working on reviewing and refining our addiction and mental health performance monitoring framework, which will guide our system level performance measurement in Alberta. Again, it's going to build on extensive consultations that have been conducted with other jurisdictions with expert reviewers and literature findings.

In addition to those things that we're undertaking under the strategy, there are many other initiatives and, obviously, important things that Alberta Health Services is working on, so I just wanted to quickly mention a few of those. They overlap with and they complement the strategy. But, in addition to that, it's our job to try to weave these together with the work that we're doing with the other ministries: the PCHAD expansion and the work that we're doing around protection of children abusing drugs, the community treatment orders work that's under way, the strategic clinical network priorities around clinical pathway development and giving supports to primary care networks and primary care physicians, a real focus on outcome measurement and quality improvement. Some of these other initiatives that are important: I'll skip over them just to allow some time for questioning.

2:40

Dr. Megran: Perhaps just to round out the presentation, I'd like to focus on a couple of other areas that I think tie in with recurrent themes in the questions we heard for Alberta Health.

Back to the link to primary care, Dave has mentioned the support of primary care networks and family care clinics in terms of education and programs and things of the like. Two other aspects I want to stress there. The first is that the business case that each primary care network develops is done in collaboration with Alberta Health Services, and almost all of those plans certainly have an element directed towards mental health, to addiction and mental health or to mental health itself. Of course, the funding that comes to PCNs from Alberta Health supports many of those activities, and in addition Alberta Health Services provides many in-kind services. We have many mental health workers and other health providers whom we support and pay for who go out and work with PCNs: their patients, their doctors, and other staff.

The family care clinics Susan alluded to. Mental health and looking at the social determinants of health are basically requirements in an FCC and will be very important components and requirements as we take primary care networks and their clinics to the next level, so-called enhanced PCNs, et cetera.

The three FCCs in operation actually reflect that when you look at their location. One is in Slave Lake, chosen in large part because of what happened to that community with the fire and the recognition thereafter that mental health became an even bigger issue for that community in light of that natural disaster. The other two are in east Calgary and east Edmonton and serve populations that have a number of challenges. One might say that they're clearly underserviced populations, but they are populations with a different socioeconomic status, often a higher immigrant status and an unfamiliarity with the health system, and certainly areas where the populations do have significant mental health and addiction problems.

So the three current FCCs, that were launched as pilots, were chosen intentionally for those areas, and mental health, social work, and dealing with the social determinants of health were very intentionally put in as major components and goals of the three FCCS. That will carry on with the others and as we enhance primary care networks and clinics that are already in existence.

The final thing I'd just ask Dr. Trew to comment on is that the strategic clinical network is an important vehicle in terms of looking at innovation, of reassessing practice but also in terms of bringing consistency to care. What are the best practices? How do we bring those in an equitable fashion across the province? How do we bring that information and those tools to the people, as I said in the beginning, who provide most of the mental health care, which are the primary care providers?

I don't know, Mike, if you wanted to say a couple of words about the depression pathway and the work of the SCN. In particular, we heard some comments about, you know: are we focused only on postpartum depression, and where does everyone else fit in with this common problem?

Dr. Trew: As Dr. Megran was saying, depression is one of the targets for the strategic clinical network. We're working very closely with the primary and community care portfolio and have really taken over what they'd started with some work on a care pathway for depression in adults, which was primarily targeted in primary care. We're doing a bit more work on that before we think it's ready for general release across the province, but that's our target. In fact, the target here is really to say that five years from now Alberta will be, if you will, the best place in Canada for prevention, screening, and treatment for depression right across the spectrum. That goes everywhere from some prevention work – and we're looking at some of that – to screening and treatment in primary care, which is where we're starting. We're a little bit earlier, but we're also doing some work on treatment for adolescents, which works with both primary care and the community care treatments because that's where some of the psychosocial treatments are based. Then we plan to work through various levels of intensity to try and bring some co-ordinated approach to that.

Some of the challenges are trying to deliver that in even ways, understanding that when you've got complex care pathways, you need, for instance, electronic health records to support that. In the record system in primary care there are three systems that are

supported. About half the docs in the province have those in their offices. What about the other half? There's the electronic health care record support in AHS as well to work with. We have a few balls in the air, needless to say.

Going back to postpartum or perinatal depression, with all due respect I think the women win on the hormonal sort of part of that. For that particular aspect, we're currently waiting for some key review work that's being done in the United States, and that's really what we plan to bring to this consensus conference in about a year's time with the goal of having, again, some very specific targets and recommendations to work with.

I wanted to just say one other thing, and that's about the whole measurement piece. Over the last two or three years we've been working very hard to do a thing called the HoNOS, and you'll see that it's the health of the nation outcome survey. We have all sorts of administrative data. We have relatively little clinical data that is standardized, that we can measure here and here, and we can say that this is how people have changed over time. Is it better? Is it worse? What does it look like? Or, for that matter, we've got this hundred or thousand people who got this and this hundred or thousand people, and how do you compare those groups? That's precisely what the HoNOS scale has done. We've trained literally thousands of clinicians in Alberta over the last couple of years.

I think we're on the same page as you are in the sense that we really do understand that if you don't measure, it's really hard to do anything other than say: well, this is how much activity we've done. That may have been good enough for five years ago, but it's not good enough now, and it's certainly not good enough for five years from now.

Dr. Megran: We're open to questions.

The Chair: Thank you very much.

The first person I have is Mr. Wilson.

Mr. Wilson: Thank you, Madam Chair. Thank you all for your presentations. My understanding, I guess, of the purpose of today's meeting was to hear from the various ministries involved in administering care for mental health and addictions in the province and to assist our committee in sort of narrowing our scope about what we're going to be focusing on here. It seems apparent that many of you – and I guess we got that from Alberta Health as well – are waiting on this gap map analysis to really direct your own organizations as to how you're going to move forward. Knowing that, what, in your opinion, could this committee study that would add value to Alberta Health Services over the next 12 months?

Mr. O'Brien: That's a good question. I'd have to think on that a little bit.

The Chair: Thank you.

Would you mind getting back to this committee with that answer?

Mr. O'Brien: Not at all.

The Chair: Clearly, that's something we are going to be discussing, and I would certainly appreciate your thoughts on that. Thank you.

Blake Pedersen.

2:50

Mr. Pedersen: Thank you very much, and again thank you for the presentation as well. Just some comments and some questions. Do we know what the cost of the gap map study is going to be? You can respond afterwards.

On the slide where it talks about the addiction and mental health service delivery model, how are the resources allocated? Of course, you have it broken up into five different tiers. As you get from 1 to 5, you would think there would be more requirements for more intensive use of resources once you get closer to 5. I'm just wondering if you have any of that broken down.

In regard to your addiction and mental health bed chart, is there any way to get a specific breakdown by location and your level of care or service? When you say the south, I'm from the south. It's quite a large area, so it would be interesting to get more of a specific on that. I'm sure central and north would also appreciate that.

Dr. Megran: I think we have three questions there. I don't know whether Dave or Susan can comment on the cost related to the gap analysis or had any comment there about the cost or at least an order of magnitude.

Mr. O'Brien: Susan is telling me that it's a half million dollars.

Dr. Megran: I guess we'll find out.

Mr. O'Brien: That's right. It's $500,000 approximately, the cost of the gap map.

I'll just answer your third one first, which is: we'll get you the details.

Mr. Pedersen: Okay. Perfect. Two other little things here. Again, I'm just concerned that PCNs are not formally mentioned in here. I think you did a good job about verbalizing it, but I'm always cautious about what's verbalized versus what's written, so I have concerns about that.

The last one is specific. When we're talking about, you know, mental health or addiction issues, we have a homeless shelter in Medicine Hat that used to be funded for 24-hour service. They've been reduced down to 12-hour funding, and it doesn't work. Right now they're working from 6:30 in the evening until 6:30 in the morning. Wake-up call to these individuals is 5 a.m., and it just doesn't work. The hours that they operate are outside of all the supportive groups that are in Medicine Hat that can help these individuals. There is no overlap. These people have to play catch-up. There is phone messaging going on. It doesn't work.

Even if you can get the funding back to 16 hours, at least they have overlap with the social service networks that are in place, but right now it's not working. You're creating this revolving door that is accepting and kicking out, accepting and kicking out. At least in Medicine Hat that's an issue. I don't what it's like anywhere else, but that's an easy one. I think there's an opportunity there.

Mr. O'Brien: I mean, I can't speak to the hours of the homeless centre, but I know our friends in Human Services are listening, and they will be able to address it. Having said that, it does speak to the fact that we must be co-ordinated across the entire system because problems that occur in one area will download to another area. So that is certainly not at all falling on deaf ears.

Just once again, the area that we work in with Dr. Trew and Dr. Lewanczuk is primary and community care, and we have a very, very strong focus and connection to primary care networks. So I can assure you that although it may not have shown up in the text, it's of critical importance to us.

Mr. Pedersen: Thank you very much.

The Chair: Thank you very much. Well done, Blake. That was five questions.

Ms Notley.

Ms Notley: Thank you. Oh, well, I've got a challenge now.

The first really quick question is with respect to the mapping strategy. When did it start?

Ms Williams: My recollection is that it started in the early fall, so around September or October. This is about a nine-month research project.

Dr. Trew: If I might, some of the planning started before then. It rapidly became clear that it was more complex than Dr. Wild had originally anticipated, so that extended it.

Ms Notley: Okay. That's good. There are so many questions on this. I would like to say to the chair that I'm going to be raising the fact that I'd like us to be able to ask more questions through the chair in writing when this is finished because I have far too many questions than are possible to go over now.

I'd like to look at slide 8 because I'm always trying to go to things that are specific. It's difficult in these presentations to get much in the way of specificity, but that outlines the beds. My first question is if you would be prepared to provide us with some trends on that, tell us the number of beds we've had in 2000, in 2005, in 2010, and now, just so we have a sense of historical context. That would be good. You can send that to us, I'm sure, if you don't have it with you now.

Mr. O'Brien: Certainly.

Ms Notley: The other question. I was looking, as Mrs. Sarich was, at the Auditor General's reports from both '08 and 2011 as well as an internal report that our caucus was in possession of. The clear consensus, of course, through all of this was that we have a dramatic shortage of community beds in Alberta. That was what the Auditor General said. So we have this list of beds for 2012 that are on the slide. I believe it's 535 beds in the province. Is that enough in your view, Mr. O'Brien, or do we need more?

Mr. O'Brien: I think there is a widespread understanding that we have a shortage of community capacity. We're acutely aware of the fact that we have individuals who are underserved in the community and/or perhaps overserved in acute care and that we do need to increase our community capacity in order to provide them the right services in the right spot.

Ms Notley: My final question on this slide. Can you tell us what the actual amount is that is invested for each total column of beds? What's the cost of each column?

Dr. Megran: We can provide a package of more detailed information.

Ms Notley: Thank you.

I'll have more in writing. That's fine.

The Chair: Thank you.

Ms Delong.

Ms DeLong: Thank you very much. Just a general question first of all. I wonder whether you could get us information as to how much of your budget is front-line workers and how much of your budget is administration and management.

I have just a concern around the postpartum depression and anxiety, that that information be held extremely closely, that it not be shared with social workers who might misinterpret the information, and that the services actually be provided to the family and to the parents that actually need it rather than being shared with children's services with possible ramifications, let's just say.

Dr. Megran: We can get you more detailed numbers about the proportion of budget for front-line workers. I can assure you that the vast, vast majority of the budget goes towards front-line workers, but we could certainly come back with numbers.

I don't know if Mike or Laurie could comment on the postpartum depression or on the budget.

Ms Beverley: The postpartum depression screening and assessment that's happening right now is going to be part of some of the work that Dr. Trew described with the strategic clinical network as well. We've done an environmental scan across the province. It is completed, as Dave mentioned, for both public health and addiction and mental health. Many of our current services are, in fact, already implementing this and doing this in emerg, in their community clinics, and so forth. But it has not been standardized, and we want to ensure we're bringing in the very best evidence around what ought to be rolled out provincially.

That is why that consensus conference is being held. There's a lot of new research that's being brought to the forefront internationally around what's changing with that, what screening tools should be put into place, what are the most appropriate ways to treat. That's through the kinds of interventions we would normally do from a psychosocial model but also from a biomedical model. We really want to do this well, and then that will be rolled out. The strategic clinical network would advise on that, too.

I know it sounds like we're not doing anything with it. We're doing a lot, really. It's already happening in a lot of places where we know we have the gap, and we're trying to bring in the very best algorithm for everyone to follow and adhere to so we can in Alberta say that we are actually leaders in this work and we know that we're following the best evidence possible.

3:00

Ms DeLong: Do you have really explicit rules in terms of privacy around that information?

Ms Beverley: Privacy around – I'm sorry if I'm not understanding.

Ms DeLong: In terms of who that information is shared with. In other words, can it be shared with children's services?

Ms Beverley: The clinical pathway development?

Ms DeLong: No. Sorry. Specifically the assessments of the postpartum depression.

Ms Beverley: My committee will speak to that.

Dr. Trew: Yeah. If you're speaking about specific patient information, I think that can only be released or shared if there's consent. That would not be shared unless there's consent by, in this case, say, the mother. There are specific cases where there might be an assessment requested or required, and that's a slightly different set of rules around that, but that sharing of information should be up front.

Ms DeLong: Okay. It's just that I want to really make sure that it's clear that this is for treatment of the parents rather than information that can be shared to have the children taken away.

Dr. Trew: I think that that's very clear as far as front-line health practitioners are concerned. If anything, we run into more trouble with information that is shareable not being shared with family, for instance. We have more trouble with that than we do with sharing too much.

Mr. O'Brien: I just want to make, perhaps, a general comment about that as well. We recognize that there are all kinds of issues and barriers that we either create that don't exist or that do actually exist – and we may need to take them down – that prevent us working in a more co-ordinated fashion across all of the ministries and throughout the agencies as well. There is work that is under way around trying to identify: what are some of those barriers, and how can we address them?

Ms DeLong: It's just that I want to make sure, because social workers are not trained in mental health. They do not have the expertise that would be working, you know, in terms of the assessment and understanding and all of that. They are not trained in that, and a little bit of information can be very damaging.

The Chair: Thank you.

I believe Heather Forsyth is next.

Mrs. Forsyth: Thank you, Chair. I have a comment, and I'd like some information, and it can be sent through the chair. The first one is on page 5, which is slides 9 and 10. It was mentioned by one of the presenters that the grants that you're referring to have gone on for a number of years. I'd like you to table if you can, please, and send us information on the strategic outcomes of the grants.

My next comment – and I'm not sure you can answer this right now. It's very interesting on slide 9 when you talk about being actively involved in results-based budgeting. I wonder how you can have results-based budgeting when you don't have strategic information or strategic outcomes on your funding.

Dr. Megran: On the first issue – sorry – I'll just refresh my memory. I was thinking about your last question.

Mrs. Forsyth: The grants that you said have been going on for a number of years.

Dr. Megran: Right. On the grants. There are some that are actually quite long standing. Most of these grants would come in the form of two to three years, at which point an assessment and evaluation is required, and then a decision is made whether they should become part of everyday care provision by former regions, now Alberta Health Services, whether they continue as part of the program in a more globally funded fashion. These are usually multiyear. Some have gone on for quite some time because of their value and continue to be funded that way, but generally they'd be two to three years, with an assessment at the end and a decision about what their effectiveness was and whether they should be rolled into kind of business as usual.

On the other count, I don't know if Susan wanted to comment at all about that aspect. No? Or we can.

Ms Beverley: I would just add to that, Heather, that we are also reporting the outcomes with our grant funding. We're accountable to government for that work, so we do regular reporting to them on the outcomes of the services we're providing under those grants.

If I can give an example, with safe communities we have some funding for the provincial family violence treatment program. We're funding a lot of community agencies with that work, and it's very much geared to developing provincial standards of care and, broadly, the evaluation of the effectiveness of those services. So we do report on that.

Those are very specific services for individuals who are mandated for assessment and, when appropriate, treatment through the courts as it relates to domestic violence. We have very clear performance measures, evaluation, and outcomes that we're producing and reporting to Alberta Health and Alberta Justice with that work. They're each very different, but we certainly are doing that.

Mrs. Forsyth: We're trying to understand what is working and what isn't working, so if you could provide those results through the chair, I'd appreciate that.

Ms Beverley: We'll do what we can with that one. You bet.

Mrs. Forsyth: And the second question on the results-based budgeting.

The Chair: Go ahead, Heather.

Mrs. Forsyth: I asked the question. I'm waiting for the answer, Madam Chair.

Ms Williams: Results-based budgeting is a process that the government of Alberta is going through. Minister Horner has talked about it. It started in the fall for Alberta Health. They are looking at health benefits programs in primary health care. Addictions and mental health are part of primary health care. That review is going on sort of over the course of the winter, as we speak.

Mrs. Forsyth: I know what results-based budgeting is, Susan, and I appreciate the response. The comment is about strategic planning and outcomes. What I'm asking is: if you don't have an outcome, how can you do results-based budgeting?

Ms Williams: Results-based budgeting is looking at three tests: relevancy, effectiveness, and efficiency. We are looking at a methodological approach on how we're doing all of those three as part of that process in doing the plans and presenting the information to the challenge teams. So it's a bit more complex than just looking at, I guess, outcome indicators. That is the process that results-based budgeting is doing.

Mrs. Forsyth: Thank you, Chair. I'll ask the question further in writing.

The Chair: Thank you very much.

Before I go to the next speaker, I'd like to acknowledge that the MLA for Edmonton-Riverview, Steve Young, has joined us. Thank you.

Now, Janice Sarich.

Mrs. Sarich: Thank you, Madam Chair. Also, thank you this afternoon for the wonderful presentation to provide some additional insight to our committee.

I'd like to go back to the gap-map analysis. I have a couple of questions in this particular area. Again, it was pointed out that some of the parameters of this particular analysis are going to look at what's available, the amount of dollars invested. I'm wondering: because you're looking at the supply side, do you have any sense of what's on the demand side? I'm raising the question because you made a comment that at the community level there's always a question or a knowledge base that there has to be an in-

crease of community capacity. So the demand side of the question is really worth exploring as it relates to providing direct programs and services for children, youth, and adults. What would be the demand, and how does it break down in this analysis that you're doing? That would be one question.

This analysis also has an interrelationship with, perhaps, some recommendations on quality improvement within your system. I'm just wondering because you raised a statement about looking at CQI. Are you using any particular model for quality improvement? If so or if not, I'd like to get a little more information because usually when a health care system talks about quality improvement, there's also a comment about how those improvements have come at a savings to the system and a savings that could be reinvested. If you had any savings through your quality initiative, are there any dollars that would be identified to roll into this very important area that we're addressing, which is addiction and mental health?

3:10

The other thing I was very curious about: the comments about family care clinics and their interrelationships. Since their establishment – because we have information about how these programs and services are structured, you know, on the delivery model. I'm just wondering at this point, as of today: are they fully staffed with doctors and allied health professionals for the delivery of what's really important to the community? This is another very valid composition of services, and it could touch on this very important area that we're addressing today.

I'll just stop there and wait for your response.

Dr. Megran: You've raised questions in, I think, two very important areas. I'll tackle the latter one with respect to FCCs, make a general comment about the first area, and then maybe Dr. Trew could comment a bit more about the quality aspect, et cetera.

The current three FCCs have been operational for about nine months. They are based on multidisciplinary teams. It obviously took some time to staff them to be able to operate them at the hours and to prepare and take on the volumes of patients and the complexity of problems that we want. In fact, they're still evolving and growing in that latter regard.

In general the three clinics each have at the current time a full complement of physicians. Nurse practitioners form an important part of the staff. I'd say that overall, if we lumped the three together, we may be probably at about an 80 per cent staffing level for nurse practitioners for where we want it to be at this point in time. That's putting aside the fact that we want these to continue to grow.

When it comes to other disciplines – it can be anything from physiotherapists to social workers to mental health workers, et cetera – some of those have been a little more difficult to fill because those people are an even greater need and a little harder to find.

The challenges clearly are different for these three FCCs. For Slave Lake, being in the north zone, there have been greater challenges attracting the staff that's needed in the disciplines, including the nurse practitioners, more so than in Calgary and Edmonton. Many of these people are specialized and are hard to find.

The other thing one has to be careful with in recruiting in the other two FCCs, in east Calgary and east Edmonton, is that these are complex populations and they take quite a while to care for. There can be everything from socioeconomic to language issues in the nature of their problems, et cetera. You have to be sure that you bring in staff that have experience dealing with those populations and the different strategies that are required and, quite frankly, that enjoy it and understand that you have to spend more time.

For where we want it be at this point in time, I think we've done fairly well in the staffing of the FCCs. We need to of course continue to ramp up and take on larger volumes of patients and provide a broader level of care, and that will require more staffing. We have a second phase of hiring that we've planned, really, for their second year of existence, so that will continue.

The FCCs were brought in with specific evaluations that needed data to be collected, et cetera. We wanted to get them up and running, so a large part of that evaluation framework was developed after they actually opened. That was done in conjunction with Alberta Health as well as ourselves and the physicians and other care providers in the clinic.

Dr. Trew mentioned before that there can be many challenges in collecting information and having data to compare to, one of which is ease of collection and availability of electronic health records, et cetera. Our clinics, the FCCs, are about eight, nine months in, and we're sort of now getting ourselves to the point where we can actually start easily collecting the kind of data that's required to fulfill the evaluation that was planned and is still planned for them. We would envision over the next six months having much better data in terms of what the clinics are doing and, as Dr. Trew said, not just activity data but outcomes.

There are some early things. For example, we've seen in Slave Lake since the opening of the FCC about a 20 to 22 per cent drop in the number of people presenting to the hospital emergency department. We have simpler measures. Patient satisfaction: significantly good scores and rising scores in terms of satisfaction of people being cared for in the FCCs. The proportion of people who are seeing a health care provider other than a physician in the FCCs grows. That's what we would want and expect in a team model. There are a number of markers like that that are kind of early indicators of success that I think we're doing well in, but we certainly have plans for more elaborate evaluation.

Mike will make a few comments about the quality aspects and the other first component of questions.

Dr. Trew: Right. Quality improvement. I'm sitting here thinking: how would you like me to start? There are multiple levels where quality improvement is addressed in Alberta Health Services in general and addiction and mental health in particular. There are relatively large system quality improvement ventures. You could in fact put the strategic clinical network in that general category in that we're very much committed to evidence-based improvement at a systems level.

There are some other things that are at a large system level. The AHS quality improvement department supports a program called Alberta improvement way, which is a particular brand of a quality improvement mechanism. There are other ones that are available. For instance, many clinics have gone through a process called AIM to improve the effectiveness and efficiency within that particular clinic.

To my knowledge it doesn't mean that we've laid anybody off. We've generally improved the number of people who can be seen and so improved the efficiency, perhaps reduced wait-lists, and so on. There's lots of demand for the supply that we have.

Mrs. Sarich: Sorry. Just on that point it's really important to know, if you're making an investment in a quality improvement system and whichever one you're using within different points within your system, that it's not only efficiency as a driver. There

should be some cost savings as a result of that, and somebody should be calculating that. It is standard practice in CQI systems. I'm wondering if you could report back to the committee if there have been any savings for the various variations that you have in your quality improvement and how you're redirecting those savings, if any, within a $17 billion operation.

Dr. Megran: Absolutely. Good question. I think Dr. Trew alluded to the fact that data and analysis and evaluation in mental health clearly have lagged behind. It would be far easier to provide that kind of data in other areas of care. I think we really have lagged behind in mental health in many ways, and one would be that kind of rigorous evaluation of what's done.

You also touched on the issue of demand. Again, I think over the years, historically, in all jurisdictions we haven't done nearly as good a job of defining demand, the extent of problems, and prevalence of disease in mental health as we have in many other illnesses. I think we could talk for some time about what the factors are, from social stigma to maybe chronic underfunding, et cetera. That era, I think, has changed.

Your interest and your offer in that first question – how can we help you? – kind of took us by surprise. It's a great question, and I think one we need to discuss with the other partners before we answer. I think there are lots of signals that things have changed for mental health. But it has lagged behind in many of those key areas that you've said, and we will endeavour to provide you with answers as best we can.

3:20

Mrs. Sarich: I thank you for that comment.

On the demand side I'll just close with this, Madam Chair. You have 398 service contracts identified in your slide deck on page 6 with an annual value of $78.5 million. Obviously, by that number there is an investment, there is a demand because you've got service contracts there. I appreciate the interest by your organization to take a closer look at the demand. I would just ask you – it would be very helpful for the committee – as you progress in the gap map analysis, that you would take serious consideration in this very important area to understand the demand. If we're looking to give recommendations for policy or changes through the lenses that we have through this committee, it would be very important for us through your assistance to understand what the demand looks like because at the very basic level it could mean an illustration of the demand for wait-lists of services and programs for addictions and mental health by children, youth, and adults. That's very basic.

Thank you.

Dr. Megran: I'd just comment. The number of contracts is perhaps a little bit startling. I think, as Dave commented, these were in some ways inherited by AHS because of arrangements in previous regional entities. That's not to say that there isn't great need or that these contractors don't provide value, but I think you'll see at the end of today, with the interaction and collaboration between ministries, also within AHS, a great endeavour here to say: let's pull all the pieces together, let's have an accurate inventory, let's do a gap analysis, and let's get far more co-ordinated and integrated both within AHS and with our other partners. I think that by the end of today you'll see some examples that people are clearly committed to that and making some inroads.

The Chair: Thank you.

Mr. O'Brien, you had your hand up?

Mr. O'Brien: I was just going to add if I could, just to clarify, that part of getting co-ordinated across all the ministries and with other agencies is Dr. Wild's work, which is why it is taking nine months and costing half a million dollars. It does involve, as well, a better understanding and a deep dive in what are the needs of the population.

The Chair: Thank you very much for that.

Mrs. Leskiw, I have four more speakers.

Mrs. Leskiw: Actually, your comment goes right to my question. This gap analysis is being done by both Alberta Health Services and Alberta Health?

Mr. O'Brien: It is being done by Alberta Health. They've contracted Cam Wild to do it.

Mrs. Leskiw: Okay. Then my next question is to that. When Alberta Health completes their analysis and finds out that there might be duplication in what they're doing and what Alberta Health Services are doing, does Alberta Health Services have to follow the recommendations of what Alberta Health puts out to them? Does it also affect Covenant Health? Covenant Health has to somehow fit into this whole mixture of Alberta Health and Alberta Health Services in the gap analysis.

Dr. Megran: Well, I think, clearly, in AHS we recognize that the role of Alberta Health and government and you folks is to set higher policy and direction, and we respect that relationship. I think in terms of the results and the recommendations out of this review, you know, we would expect that those would be addressed in a collaborative relationship with Alberta Health but have to be consistent with the strategic approach that this government has set for mental health. We clearly look to work together on those.

Mrs. Leskiw: What about Covenant Health? How does that fit into this whole picture?

Dr. Megran: David, did you want to maybe make a comment about the relationship with Covenant Health in mental health?

Mr. O'Brien: Yeah. I mean, Covenant Health is a contracted service provider to Alberta Health Services but one, obviously, that has significant services that they offer. We work very closely with Covenant Health to try to be co-ordinated and act as a single organization wherever we can, and they certainly are included within the gap map study. Again, I believe that as a group we would decide.

Mrs. Leskiw: Thank you.

Dr. Megran: Although, clearly, as Dave has said, Covenant Health is a contracted provider, given their size and their history we certainly operate under a partnership model to a great degree. The other thing is that this is an organization that's shown tremendous commitment in many areas but in particular in mental health, vulnerable populations, seniors' health. There is a deep commitment in that organization, so the relationship has been good.

Mrs. Leskiw: Good.

The Chair: Thank you.

Dr. Swann.

Dr. Swann: Thanks very much. Excellent discussion. In spite of all this discussion about the gap analysis, I'm still not sure what's

in and what's out. Is this gap analysis looking at organizational gaps or service gaps? Is it looking across the spectrum of mental health services from prevention through to rehabilitation for gaps? I guess I want to be realistic about what we can expect from this report and when we would begin to see some results.

Ms Vajushi: We'll see the results by June. I don't want to speak about what we can expect from the results because until we get them, we're not sure what those will look like. However, the work of Dr. Wild is to survey stakeholders as well as professionals around need. It will look at supply and demand, and it will make some recommendations.

They're in the process right now of basically surveying all services whose primary purpose is to provide addiction and/or mental health services to the public, so that includes looking at safe communities, looking at Alberta Health Services, Alberta Health, Alberta Education, and so. It also includes all the contracted agencies because they are contracted through many of the ministries or through Alberta Health Services.

We should have a very complete assessment of what exists, and we should also have a good survey of what the expectations are, of what's lacking, of what there is enough of. We will then work together. Although Alberta Health is the lead in terms of having paid for the services of Dr. Wild, as David O'Brien said, we will work together very closely, as we have in developing the strategy with Alberta Health Services and with the executive team of the addiction and mental health strategy, to come up with solutions that work across the board and are aligned and provide more comprehensive services.

We want to stop providing services in silos and confusing everyone in the public as well as professionals about who does what, so it has to be a very comprehensive look. Hopefully, in June those results will point to what we were able to achieve.

Dr. Swann: Just to reiterate, the doctor is going to look at organizational gaps in mental health services or service gaps?

Ms Vajushi: Service gaps.

Dr. Swann: Not organizational gaps?

Ms Vajushi: As far as I know, not organizational gaps and would not make recommendations on how an organization or system should look but, rather, what the services are that need to be provided.

Dr. Swann: Okay. With respect to the continuum of mental health services is he going to be commenting on the balance between prevention, assessment, early intervention, treatment, rehabilitation, that array? Will he be commenting on each of those parts of the continuum for mental health services?

Ms Vajushi: He will be commenting on some of those parts. I can't say all of those parts. It depends what he discovers, so it's difficult to say at this point. But, yes, we are looking across the continuum, so it depends on what he finds.

Dr. Swann: Was he deliberately asked not to include organizational gaps in his analysis?

Ms Vajushi: No.

Dr. Swann: So he could be assessing organizational gaps?

Ms Vajushi: He wasn't asked to assess organizational gaps or to omit organizational gaps. I would be surprised if he was including them, but he could be including them.

Dr. Swann: I see. Thank you.

The Chair: Thank you.
Ms Johnson.

Ms L. Johnson: Thank you, Madam Chair. I'll just make an observation. You spoke about contracting and that you want to have consistent contracting across the province. I hope you're balancing that with buy-in from local community groups. It's just in terms of a philosophy in how you approach service delivery. I don't need an answer on it. I'm making the observation that I'm sure I'm not alone as a committee member in that one model does not fit all across all our communities across the province. You need to make sure our dollars are taken care of, but the services have to suit the local needs.

Thank you.

3:30

The Chair: Thank you.
Mrs. Jablonski?

Mrs. Jablonski: Thank you very much. Well, one program that I'm very interested in is, of course, the protection of children abusing drugs program. I have four questions – they're pretty straightforward – and if you don't have the answers, maybe you could provide the answers for us. My questions are: how many beds are there in the PCHAD program? What communities have those beds? How many children have been served? Could you provide us with statistics on the outcomes and successful treatment and how you define successful treatment?

Dr. Megran: We'll certainly take away to provide those answers.
Laurie or Dave, do you want to make any general comments about this?

Mr. O'Brien: No. I think we will just give you a more comprehensive answer in a written way.

Mrs. Jablonski: A colleague is trying to ask me something here. Rachel, would you ask the question, please.

Ms Notley: Well, I'm just not sure how much more work this would be, but if we could get an assessment of the number of private beds that perform the same functions, privately funded beds in the province.

Mr. O'Brien: I hate to say that this might be an area where we don't have good information, but we'll endeavour to find that. The private area. Certainly.

Ms Notley: Let us know what you can find.

Mr. O'Brien: Yeah.

Mrs. Jablonski: Thank you very much. I look forward to receiving that information.

The Chair: Thank you very much. That was our last speaker.
Gentlemen and lady, thank you very much for coming. It's been very informative, and if nothing else, you have the homework about the question. Thank you very much.

We will now take a maximum seven-minute health break. We are a bit behind.

[The committee adjourned from 3:32 p.m. to 3:46 p.m.]

The Chair: Thank you, everyone. I'd like to get started again and invite Karen Ferguson, assistant deputy minister, early childhood and community supports division, for her presentation, which will be a half-hour, I believe, 15 minutes for the presentation and the rest of the time for questions.

If I might, I'd like to suggest to the committee members that as they go along, they write their questions and that they could have them a little bit more pointed because, clearly, we're running behind. Thank you.

If everyone is sitting down and we're ready to go, Ms Ferguson, it's yours.

Department of Human Services

Ms Ferguson: Thank you very much. I'm very pleased to be here today. Silvia Vajushi will operate the slides for me.

Addiction and mental health issues, of course, impact the lives of many children, youth, families, and communities. By working together in an integrated way, we can better serve Albertans. I'm going to highlight some of the Human Services programs where those we serve will be positively impacted by the activities identified under the strategy. So I'll keep it pretty high level.

The first is the family support for children with disabilities program. We provide parents with funding to access various supports that strengthen their ability to promote their child's health, growth, and development. We also help them connect with various community supports, including mental health supports in the community. You can see that out of the caseload of 8,500, approximately 1,200 children have a primary mental health diagnosis, so they will definitely benefit from more timely access to services.

Our next slide is on child intervention. Just to talk a little bit about child intervention, this is where we determine whether children have experienced abuse, neglect, or do not have a legal guardian. Our first goal, really, is to support families to care for their own by providing services that are supportive and mitigate the risks that impact a child's well-being and safety. Where safety needs cannot be met in the family or extended family, the child is removed as a last resort. Where appropriate, we then work with the family and their support systems to safely return the child as soon as possible.

Many of the children who come into care require some level of mental health services and supports. They've experienced separation and loss, anxiety, trauma from abuse, just to name a few areas. You can see that approximately 12,000 children come under child intervention; 3,500 of these are served at home, and that's with supports to the family and to the child. We have almost 8,500 children in care. Roughly 67 per cent of those children in care are aboriginal.

Ms Jansen: Sorry. How much?

Ms Ferguson: Sixty-seven per cent.

I just want to talk a little bit about AVIRT, Alberta Vulnerable Infant Response Team. We have this program operating in Calgary and Edmonton. This involves child intervention caseworkers, public health nurses, and police working together, providing intensive guidance and support for at-risk families with infants. With this integrated approach we're able to provide immediate multidisciplinary resources to support the safety and well-being of vulnerable families. Families learn coping skills and gain access to various supports such as addictions counselling and family-violence counselling to help keep their children safe. It started in Calgary; it's been expanded to Edmonton. It's a very successful program at getting early identification of families and children who are at risk.

We work in partnership with multiple disciplines to get the most robust and comprehensive information to assess and base decisions on. Judgment about taking a child into care is based on information from those who are most knowledgeable and most connected, and that includes the families. We're often challenged on the flip side sometimes by families and communities and other interested parties who think that the only way to keep children safe is to apprehend them. It's not as simple as that. Families are first, and it's a mutual responsibility in our communities to make sure we keep children safe.

Early childhood development. We're working very closely with Health and Education on this file. It's very much aligned with the addiction and mental health strategy. Just a couple of areas, and I know Health and Alberta Health Services touched on this. We know that a strong foundation in the early years increases the probability of positive outcomes. It just makes sense. Where there's a weak foundation, that increases the potential for mental health problems and addictions, so we need to make sure we're looking at comprehensive services to families as a whole. One critical area is to make sure we're identifying concerns early and providing follow-up services. In the early years it's very important that we start there and that families have access to these supports.

Our next slide is on parent link centres. We have 46 community-based family resource centres throughout the province that actually reach 160 communities. A few of the risk factors for child maltreatment include parental depression, other mental health problems, addictions problems, parents' poor understanding of child development, and social isolation, just to name a few areas. Parent link centres provide a one-stop shop, basically, for information and referral for parents who are struggling. They won't necessarily provide all the necessary supports, but they're connected in their community to help pave the way for the families.

Two areas that they do focus on are the knowledge of child development and providing training, education for families to learn more about child development. In our last survey we did of the parents who attended parent link centres about 80 per cent agreed that the parent link centre benefited them by increasing their knowledge of positive parenting skills in child development. They also indicated that they were able to make social connections at parent link centres and, therefore, deal with their isolation issues. A lot of these families come from either out of province or out of country, and it's families in the community that say: why don't you go to that parent link centre and make some connections there?

Family and community support services, FCSS, as it's known. This is an 80-20 funding partnership between government, municipalities, and Métis settlements. It's designed to deliver preventive social programs that enhance the well-being among individuals, families, and communities. Now, FCSS does not fund treatment programs as their focus is on prevention, so a preventive focus. But they do fund a variety of short-term programs with a mental health focus such as support groups, stress workshops, mental health first aid – that was mentioned earlier – and mental health awareness. That's where they focus. They, again, are well connected in their communities and know how to refer families to other supports.

3:55

Adolescent depression pathway. This was already talked about. It's a partnership with many ministries and Alberta Health Services. The important thing here is that the results of this pathway

will tell us when it is best to involve professional clinical services as well as how much and for how long. It'll be based on the results of this pilot. This will ultimately help youth who are living with depression; it'll help them receive the appropriate interventions. It also helps families. They then receive the necessary information and knowledge to best support their child. This is one example where we're working very well together.

The next slide is on AISH. Total caseload: over 46,000. Just over 31 per cent of the current caseload have a mental health diagnosis. Again, AISH staff help clients connect with the community outpatient counselling, community clinics, and other community resources. At times AISH also may provide funding for room and board at approved residential addictions treatment programs for eligible clients.

Adults with complex service needs. This was touched on as well, but what I'll focus on here is the PDD clients who are currently residing either at Alberta Hospital Edmonton or Ponoka Centennial Centre and are ready for discharge and are waiting to transition to community-based services. PDD and Alberta Health Services are working collaboratively to find these people places in the community. There are multidisciplinary teams with PDD and Alberta Health Services staff that provide community-based mental health services at the local level. These teams provide invaluable support to individuals, their families, and the agencies supporting them to reduce the need for readmission to an Alberta Health Services facility. I'll leave it at that.

Ten-year plan to end homelessness. From April 2009 to the end of September 2012 over 6,600 Albertans have been provided housing and supports. Of these, 40 per cent self-disclosed mental health issues at program intake. The reality is that there's probably a far greater number of homeless people who have mental health and addictions issues that have yet to be treated and who continue to require outreach and support services in order to get them off the streets. We need to get them into appropriate housing with the appropriate level of wraparound supports.

Outreach and support services initiative. We have $60 million provided. This helps to move clients out of homelessness and into housing with supports. A couple of examples: diversity in Edmonton and Pathways to Housing programs in Calgary. They provide wraparound supports that include medical supports, psychiatric case management, life skills coaching, and addictions counselling. This is in addition to housing first, that keeps these people in a permanent housing situation.

Co-ordinated discharge planning. We're working, again, with Alberta Hospital on that, and it's focusing on preventing client discharge into homelessness when leaving mental health acute-care beds. We're collaborating on that and making great strides in that area.

Just very briefly on youth homelessness, we've had extensive community consultations, and we've identified two overarching goals. One is to prevent the youth from becoming homeless to begin with, and that's making sure that there are family supports available and education. The second one, where there are homeless youth, is to rapidly rehouse these youth by placing them in the care of nurturing adults. We do know that to address youth homelessness, we must address the underlying causes such as addictions and mental health issues.

Addiction and mental health supports for homeless Albertans. I think someone touched on this already. This is $5 million we receive from Health to expand services in this area. You see the breakdown there. Lethbridge: to support outreach programs in the local shelter, focusing on providing addiction and mental health services in a permanent housing setting. This will target up to 24 chronically homeless clients. In Calgary we're again targeting the chronically homeless with mental health and addiction issues who are coming out of a health or corrections system. In Edmonton this money is helping to create 102 permanent supportive housing spaces targeting aboriginal families and individuals and youth with complex addiction and mental health issues.

Housing and supports framework. This was mentioned already as well. We're working with a number of ministries again. By increasing the number of housing and support options and by placing clients into appropriate housing with the right supports, we hope to reduce the reliance and recidivism, actually, back into the justice and emergency health systems, which are very expensive, and mitigate the need for specialized and longer term treatment and rehabilitation.

Supports for sexual assault victims. We provide $1.7 million to nine sexual assault centres throughout the province, and I know the additional funding was mentioned, most recently $350,000 to address service needs in the Bonnyville-Cold Lake area. The centres do report an increase in the number of victims seeking counselling and support who are presenting with multiple complex mental health and addictions issues.

We're working with Health, Alberta Health Services, and other government ministries and communities to address priority areas. We feel that the addiction and mental health strategy will support a further integrated and co-ordinated system.

The Chair: Thank you very much, Ms Ferguson.

Ms Ferguson: You're welcome.

The Chair: I have my speaking list. Sandra Jansen, please.

Ms Jansen: Thank you, Chair. I'm looking at this number that 67 per cent of the 12,000 kids that are in care are aboriginal. I'm just wondering if you might be able to give me a sense, perhaps, the numbers, whether they've gone up or down maybe since 2008, just rough numbers, if you have a sense of whether this problem is a growing problem.

Ms Ferguson: Okay. I'll actually clarify that. I said 67 per cent. I need to correct that. It's 68 per cent of children in care that are aboriginal. That's out of that 8,500.

Ms Jansen: Out of 8,500?

Ms Ferguson: Right. Are aboriginal.

I'm sorry. The next part? Oh, if that's increasing or decreasing. You know what? I don't have an immediate answer on that. I know it's a long-standing issue that we are looking at addressing. I know it has not gone down. That I can tell you.

Ms Jansen: Assuming that number has gone up and we're talking about delivering some kind of service in this arena in terms of aboriginal community support or prevention or, you know, whatever these programs are, do you have any measures designed to reflect the efficacy of your interventions?

Ms Ferguson: Sorry. When you're talking about interventions, are you talking about . . .

Ms Jansen: Whatever these programs are, the community supports, do you have any measures to give you a sense of where you're going, what's working and what's not?

Ms Ferguson: We do in certain areas but not necessarily targeted to specific populations, to say, "Is this working with aboriginals? What's our benchmark on that, or what's our performance indi-

cator?" Not necessarily. That is an area that we're working on as well. When we look at the overall addiction and mental health strategy, the same thing applies. How are we going to know if we are making a difference in any of these?

What I will clarify is that with child intervention specifically we do outcome-based service delivery. This is where we're working with partners, including aboriginal partners, in looking at: what do we need to do differently to make an impact on that? With those groups we are establishing a strategy and how we're going to measure that. I would say that it's not done yet, but that's what we're working towards.

Ms Jansen: So when you say outcome based, we're assuming, then, that you're going to be able at some point to measure it, but you haven't been able to do that as of yet.

4:05

Ms Ferguson: There has been some of that, but not specifically: are fewer aboriginal kids taken into care? But there is some of that already. I don't have the number off the top of my head on how many outcome-based service delivery sites there are. The aboriginal ones have been fairly recent. I can look into that to see what we have already, but ultimately when these are done, we absolutely will have some measures to see what impact we're making.

Ms Jansen: I think that considering we're talking that 68 per cent of the kids in care are aboriginal, perhaps that's something that you could address.

Ms Ferguson: Absolutely. That's why there's – I don't have the name of it; I wish I had the child intervention person here. But we are, as I said, with the aboriginal stakeholders looking specifically at how we address the needs of their children. In the past we've done some outcome-based service delivery. It's just been global. Now we're doing some specific ones with aboriginal kids.

Ms Jansen: How soon might we be able to see what those measurements look like?

Ms Ferguson: I don't know, but I will find out.

Ms Jansen: Thank you.

The Chair: Thank you.

I'm going to allow a question from a questioner who is at the bottom of the list, but it's pertaining to this particular question. Yvonne Fritz.

Mrs. Fritz: Thank you. It's just to this point. Great questions, by the way. I know the aboriginal stakeholders, including First Nations chiefs, would gather at Government House approximately every three months for a full day, and it was based on the number of aboriginal kids in care and within child intervention. I'm uncertain if those meetings have continued, so when you answer the previous question, would you please include that in your answers, if they have continued and if there are still full reports done which are incorporated and captured just as we do with *Hansard*?

Ms Ferguson: Right. Sure.

Mrs. Fritz: Thank you.

The Chair: Thank you very much.

Rod Fox.

Mr. Fox: Thank you, Madam Chair. I have some questions around the parent link centres, specifically the need to keep them in the facilities that they're in. I know in my community there is one that's coming up for contract renewal within an elementary school. With the growth pressures in some of our high-growth constituencies, keeping these centres operating is a bit of a challenge because they get shuffled around a bit. I'm wondering what supports there are going to be from the ministry to make sure that either they stay in the same place or that there's a seamless transition and that there isn't an interruption in service to the clientele coming in.

Ms Ferguson: That is something we are looking into, and we're working very closely with Alberta Education on this. I know they're up next, so I'm assuming Dean is here and can answer that question. But we are looking to see how those can be included because a number of our parent link centres are in schools. They're in these hubs, and it's working well. That was a need that we identified awhile back, so we'll make sure we follow up.

Mr. Fox: What is it that you're going to do to make sure that they stay in these centres?

Ms Ferguson: Well, Dean can speak about the schools. I don't want to give the wrong information, so I'll let him answer that because he's in charge of capital planning there.

Mr. Fox: Okay. Thank you.

The Chair: Alana DeLong.

Ms DeLong: Thank you very much. A couple of questions. First of all, Sonshine Community Services, which works in my constituency with family violence, was appalled at the number of children of previous clients they had who were becoming clients and wanted to stop that intergenerational revolving door, so they are providing treatment to children whose parents were involved in violence. I just wondered whether you're supporting that program or not.

The next is a request for information: the number of children who are injured while their parents are being provided supports by children's services versus the number of children who are injured in foster care.

Ms Ferguson: Okay. I don't have that information here, but we can look into it.

Ms DeLong: If you could, yes. Thank you.

The Chair: Thank you.

Rachel Notley.

Ms Notley: Thanks. I have three sets of questions. The first one. I want to really try and focus on the mental health piece of things here as much as possible. You talk about the fact that there are roughly, I think you said, 8,500 children who are in care. I always think of that as, I mean, this is where we as members of government and as members of society are de facto parents. You know, we've heard lots of talk about how I'm a relatively well-paid MLA. If my child has a mental health issue, I'm ultimately, almost definitely – and this is what friends that I know will do. They'll go and hire a private psychologist because, frankly, that's the only place if you've got issues and you want to get them dealt with. That's what you've got to do. You're not going to get quick service any other way.

That being the case, as the de facto parent what amount of resources is dedicated to providing actual mental health treatment and counselling to the 8,500 children who are in care? Do they get access to what they would if they were my kid or someone else's child who has lots of disposable income? How do we deal with the mental health piece of that?

Ms Ferguson: If they're in care, we are the guardian. You are correct there. We will make sure that they get access to mental health services. Sometimes it will be through Alberta Health Services. Other times it will be through a contract that the child and family services authority will have with a psychologist, as an example. What I will say is that we will do that as the guardian just as we would as the parent. So we do do that.

There is a struggle at times when we can't find the expertise to deal with some of our real high-needs kids. For sure that is an issue, and that's something that we are working with, Alberta Health and Alberta Health Services. We've identified that as a need. We have to come at this as a collective to figure out how we best serve these kids because, yes, these kids are in care, but they're still community kids. We need to make sure that they have access to the best possible services. But we make sure we do follow up on that.

Ms Notley: What I'm curious about is if you could provide the committee with the dollar amount that is dedicated to mental health services for those 8,500 kids that are in care.

Then this might be a little bit more complicated, but I think eventually you're going to need to answer this question: what are some of those other black-and-white indicators that people were asking for more generally of the system in terms of wait times and that kind of thing?

Ms Vajushi: If I can answer that to say that Alberta Health Services does have wait time targets for children's mental health. I can't speak to them specifically, but maybe someone from Alberta Health Services can. There are targets for children for publicly funded mental health clinics.

Having said that, we are also reviewing that because we are hearing across the province that there is a need for more services for children and for more immediacy of care, understanding at the same time, as some of the members have pointed out, that there are very long-term, chronic, intergenerational issues that are being dealt with that are not going to have outcomes within six months. It sometimes takes a generation or two to really see healthy outcomes. What we have to do is work harder and better towards those outcomes. We are meeting collectively to start to address that problem for our year 2 priorities.

Ms Beverley: I could just add from Alberta Health Services that, as Silvia has mentioned, we are collecting and reporting on children's mental health wait times in the community. We're doing that according to their access for scheduled visits, emergent and urgent care. These are according to the Canadian Psychiatric Association guidelines, so standards in the country that have been set with specific targets. I will say that, certainly, our results are showing significant improvement as we are developing and enhancing these services and programs and working more collaboratively across the ministries with AHS. I hope that answers that.

Ms Notley: Fair enough. That's good to know. I think I did see some notations in the documents that were provided about those. I'm just looking for that subset, that 8,500 as well, just to get a sense of that.

The other question I had related again to family enhancement and how that interacts with actual mental health therapy and counselling, not referral, because God knows we can all refer. I refer out of my office. You can put me in your inventory, too, but that doesn't help if I can't refer them to anyone. I'm looking at, again, those family enhancement services, particularly as they relate to these parent link centres. You said you've got 46. I'm wondering: do any of them actually provide mental health services, mental health counselling, or are they simply a referral centre?

4:15

Ms Ferguson: Parent link centres do not provide counselling directly, but they are connected in the communities. When I say referrals, for some families they just want to know where they're supposed to access things. Other families need more support, so they'll do the warm hand-off, as we call it. It's not just: here's the number; go phone. They'll make sure they're connected in the community, and they'll help the family navigate the system if necessary.

Ms Notley: Are your parent link centres able to provide reporting on sort of the percentage of their clients or the percentage of the work that relates to issues around mental health or addictions?

Ms Ferguson: No, I don't believe so. They would have that captured in a number of areas that they address, but not specifically how many for mental health and addictions.

Ms Notley: Okay. The last thing I wanted to ask about relates to a question I had asked previously. You mention that you fund the $1.7 million or something that was sent to the sexual assault centres. The concern that I've heard on the road from different centres in different parts of the province is that these sexual assault centres, their staff, are being expected to provide, effectively, mental health therapy with virtually no training and certainly not the compensation that would be associated with that. What do you guys think that $1.7 million is going towards, and do you think it's enough?

Ms Ferguson: I can't answer that question. What I can say, back to your previous question and along these lines, is that what we formed is this workforce alliance and these collaborative efforts with Human Services and contracted agencies. The focus really is on: how do we attract and retain a skilled community workforce that is able to provide quality services and promote positive outcomes for vulnerable Albertans?

What we are doing is – an example I can give you is with Alberta Health Services and PDD. They're looking at community support teams across the province. On that team will be people from the agencies, from PDD, from Alberta Health Services, and experts from multidisciplinary teams who come together and work with the staff who are dealing with high-needs clients. This started, I believe, in January 2012. I'm not positive about that date, but it's fairly recent. Part of it was designed to address what you are talking about there.

As far as the training for the sexual assault centres, I'd have to follow up on that, but under the workforce alliance they are also involved in that.

Ms Notley: Could we get more information, then, after the fact, just a little bit more about particulars around this workforce alliance, the idea being what kinds of things these people are being trained to do and what kind of skill sets they came to the table with to begin with, so that we have an understanding of the quality of mental health services that are being provided in the

community? This is in no way to undermine the commitment of the many people that do this work because I know the people that do this work are doing it as a labour of love and passion and commitment. But the question becomes: is that the right way for us to be delivering mental health services in the community? If you could provide us more information on how that's working and who it's being done to and what they're being taught or supported with or collaborated with or whatever verb you want to use.

Thank you.

The Chair: Thank you.

Jeff Wilson.

Mr. Wilson: Thank you, Madam Chair. A couple of points of clarification before I ask you the same question I asked the previous presenters. The $2 million for permanent supportive housing programs in Edmonton: you said that's for 102 beds. Now, is that including operating costs, or is that just specifically for the four walls with a bed?

Ms Ferguson: I don't have that information. Again, we can get that.

Mr. Wilson: Okay. Great. Thank you.

Secondly, the 80 PDD-eligible individuals who are going to be moved out into the community from the two hospitals you mentioned. What is going to happen with those beds after they are moved into the communities?

Ms Ferguson: With Alberta Hospital? Alberta Health Services would have to answer that question.

Mr. Wilson: Okay. Great.

Ms Vajushi: They'll be filled.

Mr. Wilson: What's that?

Ms Vajushi: They'll keep turning over.

Mr. Wilson: Right. Okay. That was my question. The way it was presented, it almost sounded like: once we've got these 80 out, we don't have 80 more coming in because all 80 are ready to be moved out into the community.

Ms Vajushi: Sorry. On your housing question, if you're talking about the $2 million provided by Alberta Health to Edmonton, $2 million to Calgary, and $1 million to Lethbridge, that is for addiction and mental health supports provided to community-based operations out of the seven CBOs, or community-based programs across the province. Those three had the more immediate needs at that point, so they're being supported through Health. So it is for operations.

Mr. Wilson: Okay. Thank you.

The Chair: I think Mr. O'Brien would like to augment that answer.

Mr. O'Brien: Just in terms of what our plans are with the capacity, once it is freed up from the individuals who move into a more appropriate community setting, it goes to the previous question from the MLA regarding savings. Obviously, as long as there is an ongoing demand for the services that are provided in those beds, then there will be no cost savings attributed to finding community placement. Some other individual will come and take that spot. If we theoretically build enough capacity within the community that we no longer have a demand for that, then we will have an opportunity to reallocate our resources accordingly.

Mr. Wilson: I appreciate the clarification. Thank you.

One more. With the outcome-based service delivery model versus the traditional model that you referred to, that some locations are using, could you clarify for us either now or with something tabled back to the committee what specific differences are entailed in that?

Ms Ferguson: You bet. Yes. We can do that.

Mr. Wilson: Great. Thank you.

Finally, in your opinion what aspect of mental health and addiction could this committee study that could add value to Human Services?

Ms Ferguson: Oh, where to start.

The Chair: You can get back to us.

Ms Ferguson: Yeah. I'm really not sure. There are a lot. We collectively will come up with some recommendations, for sure.

Mr. Wilson: Perfect. Thank you.

The Chair: That would be great. Thank you.

Ms Vajushi: You didn't ask us, but we'll also provide some.

The Chair: Last, Janice Sarich, please.

Mrs. Sarich: Thank you, Madam Chair. You had indicated through your slides here almost 8,500 children in care, of which 68 per cent are aboriginal. You also made some really excellent points – and I thank you for that – on the long-term chronic problems like the profile of some of these children. These children in care become adults. I'm wondering if you can comment about the trend and where we are with adults. When these children turn 18 and they're in care, where do they go? What do we have in this system? What are some of the considerations that we may want to explore or have knowledge of? For adults with complex service needs you identify 80 as PDD eligible. Surely, when we talk about adults – as they grow from children in care and transition, what do we do? What does the system look like?

Ms Ferguson: One of the areas that has been identified is the whole transition issue, exactly as you said. So for kids who are in care or just kids who have struggles, when they turn 18, where do they get supports? Some of these children or youth will definitely go to PDD for supports. For others there are very limited opportunities, and I would call that unmet needs.

That's an area that we're exploring not just across Human Services but also across government and with our partners in Alberta Health Services as a key area. What happens to these people who need the supports? We don't want them just going to the correctional systems, ending up there, or ending up in the hospital. So that's one of the main areas that we're working on together to make sure we get these supports early enough and plan early enough. There are better options for these youth so that they get better community supports and don't end up in these other places.

4:25

Mrs. Sarich: I'll close with this. It seems that when we talk about children in care, that's a vulnerable portion of our society, and when they become adults, they're still vulnerable. I appreciate your comments and candour around the limited information, and

I'm wondering if you could provide us some sort of summary of what that looks like because it's a definite policy question, and it might help us with a policy discussion about, you know, some focus areas.

Thank you.

The Chair: Thank you.

I misspoke. Mary Anne Jablonski, please.

Mrs. Jablonski: Thank you, Madam Chair. I actually thought you were deliberately forgetting me because you read my mind and you know that I'm going to pick on Lethbridge.

The Chair: I would never do that, even if you do pick on Lethbridge.

Mrs. Jablonski: Thank you. My question stems from the slide on page 6, the bottom slide, addiction and mental health supports for homeless Albertans. It's a $5 million program, and it looks like it's out of proportion to me, so I'd like to ask about that. Lethbridge has approximately 90,000 people, and Edmonton and Calgary both support around a million people each. So Lethbridge gets $1 million, and Calgary and Edmonton both get $2 million. Then I think of places like Medicine Hat, Grande Prairie, Fort Mac, Red Deer. They're not in the program. I'm just wondering why. Do we have no homeless with mental health problems?

Ms Vajushi: Yes, we certainly do. That was a decision that Human Services made in speaking with the seven CBOs across Alberta as a place to start. For Lethbridge specifically there were about 40 homeless people who are also very medically fragile, who needed a place in the day, weren't being well cared for in the shelter, and there wasn't another place for them. So the city of Lethbridge is working with Covenant and Alberta Health Services to look at providing a different level of care for those folks. That's not to say that there isn't a need in other places as well, but it's a need that came forward as needing some immediate attention.

Mrs. Jablonski: Proportionately that's a huge portion, so does that mean that Calgary and Edmonton only have 80 people in that area of need?

Ms Vajushi: I can't speak to how Calgary or Edmonton are spending their resources or what we were augmenting. We'd have to go back to Human Services and ask how that went out, but those were requests from the CBOs.

Mrs. Jablonski: Thank you.

The Chair: Thank you very much.

That wraps up our questions. I'll just take a prerogative as the chair and just say that Mrs. Jablonski and Mrs. Leskiw and myself would point out that there are a whole pile of us in the rural area.

Thank you very much, Ms Ferguson, for your presentation.

Ms Ferguson: Thank you.

The Chair: If we might ask Dr. Margaret Shim and Judith Barlow, executive director, young offenders branch, to come forward for Alberta Justice and Solicitor General. Thank you, ladies. You may begin.

Department of Justice and Solicitor General

Dr. Shim: Good afternoon, ladies and gentlemen. Thank you for inviting us to provide information on the work that we are doing at Alberta Justice and Solicitor General to address this issue. There is a complex relationship between mental health issues and the justice system. Individuals with mental health issues pose unique challenges to the criminal justice system as mental health problems and illnesses have been identified as risk factors in an individual's involvement in crime, and incarceration has been identified as a risk factor for mental health issues.

Over the years the number of individuals with mental health issues who have become involved in the criminal justice system has increased. There is also a high rate of substance abuse amongst these individuals, resulting in a number of people with complex needs.

As noted earlier, individuals with complex needs require extraordinary resources, definitely from more than one ministry and in many cases from a number of sectors and stakeholders. Judith and I are going to share with you some of the work that is being done in Alberta to promote safe and healthy communities.

Here is a quick overview of our presentation. I will start off with some background on safe communities, SafeCom, and also provide information on SCIF, the safe communities innovation fund, and some initiatives to enhance addiction and mental health services.

Ms DeLong: May I just make a comment? Since we're way behind in time right now, is it possible for you just to concentrate on mental health itself instead of safe communities?

Dr. Shim: Okay. Because a lot of these activities actually relate to mental health issues, I'll be focusing on that, and Judith will provide information on the correctional health services. I'll fly through here very quickly. This is going to be fast, okay?

Some background on safe communities. As we know, the Crime Reduction and Safe Communities Task Force was established in March of 2007, and the mandate was to identify ways to reduce crime, improve community safety, and improve public confidence in the criminal justice system. The task force provided a report that included 31 recommendations that ranged from prevention and treatment to enforcement. There were five priority areas. The first one was drug and alcohol addictions. The second was law and the courts; the third, families, children, and youth; then policing; and community action. SafeCom was established to work on these recommendations.

One of the things I really want to talk about is that SafeCom has staff seconded from a number of ministries and is governed by the partnering ministries in an integrated and collaborative manner. Partnering ministries include Justice and Solicitor General, Health, Education, Aboriginal Relations, Human Services, International and Intergovernmental Relations as well as Culture. I am seconded from Health, so that's why I'm talking more about Health.

In keeping with recommendation 31 . . .

Mrs. Sarich: Madam Chair, I'm just asking for a point of clarification. In your slides you indicate that on September 13, 2010, Justice and Solicitor General transferred responsibility for the provision of health services within the 10 provincial correctional centres to Alberta Health Services, so I'm just wondering: is it more appropriate that Alberta Health Services address the issue of mental health and addictions through the lens of, you know, our correctional services since the responsibility was transferred to Alberta Health Services?

Thank you, Madam Chair.

Ms Barlow: I can try to address that. Obviously, the decision to transfer was based on a review. We had significant involvement from Alberta Health, Alberta Health Services, and I was involved

throughout the process. Certainly, I have been asked to speak to the issue because it's a collaborative relationship. Neither one of us can address those deliveries of services without the other. They happen within a confined environment that is our responsibility, but the delivery of care rests with AHS, so it's a very symbiotic relationship.

I'm not sure how you want to proceed. I mean, if you don't think that I'm the appropriate person to address the issues, then I'm certainly willing to defer to someone else.

Mrs. Sarich: No. That wasn't my question. I'm just asking because it's in your slides and I'm not sure. That's why I was asking through the chair for just a clarification. You could be. I don't know. I'm just asking because of what was indicated in your slides. That's all. I understand the working relationship. I guess maybe for the committee if we're asking level of care type of questions, then is it more appropriate for Alberta Health Services to answer those?

Ms Barlow: Well, I think I have colleagues from AHS who are behind me who can certainly address some of those questions as well in greater detail if you'd like. We can also follow them up in a written format so we can ensure that whatever concerns and questions you have are appropriately responded to by the appropriate experts in those respective areas. Would that be okay?

Mrs. Sarich: Okay. Thank you very much for that clarification.

4:35

Dr. Shim: I think one of the things is that the reason why Judith and I are presenting is because these are safe communities initiatives. We have grants with Alberta Health Services as well as nonprofit agencies to promote safe and healthy communities, so that's why we've been asked to provide this from the Justice perspective.

To run through very quickly so that we have more time for questions, the safe communities innovation fund provides funding to policing and community-based organizations to implement evidence-based and promising practices to address crime prevention and reduction. A number of these initiatives respond to the needs of individuals with addiction and mental health problems. I've included the website there, and I would encourage people to go to the website because there's a lot of information on the work that has been done through SCIF.

Going through, a number of these initiatives were already kind of mentioned by Alberta Health Services when they were talking about some of the SafeCom grants earlier on. Just to note, for the additional beds we actually increased 88 residential treatment beds across the province through SafeCom-funded projects, and we continue to plan for additional addiction and mental health beds. We have a life skills training program that is provided for children and youth in a number of First Nation and Métis communities. At this moment an evaluation is being carried out on this, and we are getting good results on that.

We also have the immigrant and refugee youth mental health initiative, which is an excellent initiative that is through a grant with a nonprofit agency. It focuses on building community capacity for mental health promotion and early intervention to support settlement and reduce youth involvement in gangs.

The next bullet. The police and crisis teams have been piloted in Calgary as well as in Grande Prairie. We also have added teams in Edmonton. These teams bring together police and mental health professionals to provide integrated, community-based services to individuals experiencing a mental health crisis.

The next bullet, a quick one, the comprehensive addiction prevention in schools. Again, counsellors have been hired to implement these programs for schools, and the goal is actually to increase the protective factors and reduce risk factors and foster resiliency in Alberta's students. This links with Alberta's crime prevention framework, which talks about the focus on increasing protective factors.

We also provide funding to the family violence treatment program. Laurie talked about it earlier on. What I'd like to say is that there is actually another report, a three-year summary report, that we had for SafeCom that talked about the work that has been done to address the 29 recommendations that were put forth. Numbers are on the increase in the number of people within the family violence treatment program.

The integrated justice services project. Again, we are looking at collaboration. I think one of the things we really want to bring forward is that a lot of the work that we are doing, we are doing collaboratively with various ministries as well as Alberta Health Services, with the police, with the cities as well as with other stakeholders. The integrated justice services project really links with a lot of the initiatives that are currently under way, which includes the 10-year plan to end homelessness as well as Alberta's addiction and mental health strategy.

Just a quick note. It has been implemented in a phased approach. Phase 1, which included the correctional health services transfer, has been completed. We are on phase 2 now, where we are targeting people. When we say people, it's the risk factors of criminality. For this particular type of group we are looking at people considered a high risk to reoffend. We launched the safe communities resource centre in Calgary in February of last year, where we have probation officers, Alberta Health Services staff as well as other service providers working together with these high-risk-to-offend individuals. The clients receive probation supervision, addiction services, counselling as well as employment and skills support.

Phase 4 addresses the needs of the vulnerable Albertans who are multiple users of police, health, and other emergency resources, as identified by police and related partners. Again, the steering committee actually met this afternoon. Their meeting was this afternoon. As a result of that, my ADM could not come; otherwise, he would probably be the one presenting today. He's with the chief of police during this particular meeting.

This particular steering committee has representatives, including the chiefs of police from Calgary and Edmonton. We have the RCMP, we have Alberta Health Services, and we have the various ministries as well as the cities of Edmonton and Calgary that are involved in this. We also have a working group and a communications group that are working with us.

I'm going to pass this over to Judith Barlow and let her move the next one right along.

Ms Barlow: Okay. To try to answer your question a little bit further, mental health and addiction issues are critical in the justice system. In particular, they're critical to us in the correctional system. I don't think that you can really, truly understand mental health and addictions and what's being done in that centre without understanding the context within which it occurs and what corrections is involved with and what the challenges on a daily basis are. Hopefully, you'll let me proceed and talk for a few minutes about the environment that we work in and then talk to you about why it was important for external experts to come in and provide that care.

Essentially, we're part of the Ministry of Justice and Solicitor General. We're responsible for the custody and supervision and

facilitation of rehabilitative services across the province, so we have responsibility for custodial facilities as well as community-based programs like probation. This particular presentation is focused on those who are incarcerated, people who are remanded into remand centres across the province, who are either awaiting bail or trial or serving a sentence of under two years. If they're sentenced to over two years, they wind up in the federal system, and they wind up in a federal penitentiary.

As well, we have youth who are in custody, again either remanded or serving a sentence. We have eight adult facilities and two youth facilities in the province, and on any day we have approximately 3,200 people who are incarcerated. That translates into approximately 32,000 admissions per year.

This is a 24 hours a day, 365 days per year operation, and I think it's important to recognize that these individuals spend a very short period of time with us. They're primarily living within their home communities, and they come into these facilities. On average, if you look at the slide, the adult individuals on remand spend about 16.5 days and 21 days if they're actually sentenced on admission. It's a little bit longer for youth. Remand is 16 days and 85 for the sentenced.

Now, that's critical. Think about what you can actually accomplish in such a short period of time. It's absolutely important that the appropriate connections with the community services are there. So they have a physician in the community. They have other supports in the community before they come in. Then that care is continued, and after release they have to be connected. That's why it's important for that one system.

The system best positioned to do that is Alberta Health Services, which is the public system in the province. They're the ones providing the care for them before they come in. What a perfect opportunity given the fact that they have so many mental health, addiction, and physical health issues to properly assess them, to treat them within the centre as appropriate and then, based on that, to link them with the appropriate services when they're released so that those supports are there in place for them so that they take their medication, they don't relapse and, hopefully as a result of that, don't get into conflict with the law again and don't come back into our centres. We would be very happy, and we aim for the day when these individuals are appropriately treated and never come back into one of our centres.

Now, I think the other thing you need to know about these people is the fact that the people are coming in not just to our centres within this province but right across the country. Mental illness is a huge issue. Thirteen per cent of the men who come into the system, provincial systems and federal systems, have serious mental health illnesses. They're schizophrenic. They suffer major depression. These are not the worried well. Twenty-nine per cent of the women suffer these kinds of illnesses as well, 4 out of 5 inmates talk about having an addiction, and then you look at the individuals who have both a mental illness and an addiction. You know, you need to deal with that as well.

We also have infectious diseases like hepatitis B and C and HIV and TB. These are all critical because they all link. You can't just, you know, separate the mental health component from the physical health component. It's incumbent on us as a society and as a service to address these issues. Again, who better than the physicians and nurses and psychologists from AHS, who are experts at this, to do that? The correctional system has many areas of expertise, but the delivery of health we don't think is one of those.

4:45

Look at the women within the system. They have a history of sexual abuse from a young age. They come to us totally traumatized. They have twice the rate, three times the rate of mental illness, substance abuse, high-risk lifestyles, and that includes intravenous drug use, prostitution.

Look at the aboriginal population that's coming in: again, you know, significant mental health issues, high rates of suicide and attempted suicide, diabetes, and it goes on, lots of chronic diseases, again, well positioned to be . . . Yes? I'm sorry; you're waving.

Ms Notley: Sorry. I was trying to get on the list.

Ms Barlow: Oh, okay.

Recognizing all of these challenges and the fact that they're increasingly severe and that we really were in the best position to be able to do this, we worked together with our partners at Alberta Health and Alberta Health Services – there were regions at the time – and also the Department of Education. We looked at what we can do to best meet these needs. The decision was made to transfer responsibility. As of that date Alberta Health Services is responsible for all care that's delivered within our centres, and that's really unique in the country in that we're the only jurisdiction that actually does that. We have a fully integrated system. We address physical health, we address mental health, and we address addictions. We're leading the country in that area.

What's changed since that time? Well, a number of things. A number of new programs were incorporated and developed and are now being delivered. For example, given the high needs of the female population that I mentioned, we now have a specialized mental health treatment program for women. It's gender responsive, and it's trauma-informed in recognition of what's happened in their past. We have a men's addictions program that is delivered in different components so that if people come in and out, they can still pick up at a different part if they're not with us long enough to complete the entire program. We try to make these programs as short as possible and still address those needs.

Also, we have a really unique, specialized forensic adolescent treatment program in the Calgary young offenders system. Increasingly, we have more and more violent older youths, and they need to have those tendencies addressed and their mental health issues addressed so that we can reduce recidivism, so they don't go back out into the community untreated and reoffend.

We have significantly enhanced services for transition. A whole host of different people across the province – there are six teams – are there to deal with those level 4 and 5 individuals that I think my colleagues mentioned earlier in terms of severity of mental illness, who actually need assistance when they go back out into that community. They follow up with them to ensure that there's housing there, that they're taking their medication, that they're following up with their physician, that they actually show up, and that they're provided those supports so that they have a chance of making it on the outside.

Training. It's critical that we have a better understanding of mental illness and of addictions and how those play out in that kind of an environment. We had training undertaken not just for our AHS staff in the area of corrections but also for our own staff in the area of mental health. That's really important because that way they're better positioned to be able to assess an individual who comes in with what they would consider odd behaviour or in need of assistance. All they have to do is pick up the phone and call health care within our centre, and a nurse can respond. There's a psychologist there. A whole host of people are now on-

site to be able to do that, and the staff feel far more confident in being able to respond to that. That's really important.

Pharmaceutical services have also been strengthened partly because of the formulary as well as the bulk purchasing power of AHS in terms of access to medication. We've evaluated the transition so far, and now we're also looking at different phases of evaluation. The next phase will be with the actual inmate population to see what they think about these services. Are they satisfied with what's being provided to them? Are there other areas that need to be addressed? All of this then will feed into an external accreditation that will be undertaken by Accreditation Canada. Obviously, AHS are the lead in that, but we're supporting the process.

To sum up, we have assessment, treatment, and provision of care provided within our centres, and we have appropriate linkages to community resources for those individuals when they leave us. We think that collaboratively we're much better positioned now than we were ever before in the past to actually help improve the health outcomes for these individuals longer term, to provide continuity of care while they're within our centre.

We no longer have to worry about not being able to access information from the community. AHS can now access lab information, diagnostic information. They can find out what drugs these individuals were on and continue that and assess it and then make sure that they have an appropriate linkage when they go back out and that they can go see their general practitioner, whoever that appropriate individual is. That's allowed AHS to focus on what they know how to do best, which is deliver health services, and us to focus on other components, which is basically to help ensure safe, secure communities for all of us across the province.

The Chair: Thank you very much. That was very interesting. There were many things there that I didn't know, so I appreciate the update on that.

My first questioner will be Rod Fox.

Mr. Fox: Thank you. On page 3 here – I think it's slide 6 – you're talking about increased addiction or mental health treatment and residential beds opened. I'm wondering how many beds you opened in 2012. Since the number one recommendation from the task force on this was to increase the number of beds, how many are you planning to open in 2013 as well?

Dr. Shim: Good question. We have, like I said, 88 beds. What we did is we had that first three years, right? In '08-09 we had 29 beds that were opened. In '09-10 we had 51 beds. In '10-11 we had two more beds. It was a small one. In '11-12 it was six. Altogether we have, like I said, the 88 beds, okay?

Ms Notley: What was in '10-11? I didn't hear that.

Dr. Shim: In '10-11 it was two beds.

Ms Notley: Okay. And '11-12 was what?

Dr. Shim: Six beds.

Ms Notley: Two and six. Okay.

Dr. Shim: When you say '13, we are still in the process of working out a few more details. I'm not sure exactly how many, but at the moment we are planning to add to more beds. I can't give you the exact number at this moment because it depends on the capital and on what happens. Some people are doing some interim measures to open some beds before capital has been built. We are working things out. We meet regularly, every two weeks, with a committee to work on that.

Mr. Fox: So what was the current plan before we started talking about the 2013 budget? In 2011-2012 I imagine there was a plan moving forward to increase the number of beds for 2013. At that point what was that plan?

Dr. Shim: Can I get that to you? We have it in a Gantt chart.

Mr. Fox: Okay. Yeah.

Dr. Shim: Just in case. I don't want to give you the wrong numbers off the top of my head.

Mr. Fox: Okay. Thank you.

Dr. Shim: Thanks.

Ms Jansen: Thank you for that presentation. I always find it fascinating, especially because we have a bit of a family history here. Not of incarceration, but certainly my mom worked at the young offender centre. My brother works for the Solicitor General. Judith, of course, is familiar with the members of my family. It's been in the conversation in my family for a long time. We talk about mental health related to incarceration.

I'm always interested to know. When funds are being handed out – and we know the situation we're in right now, where we just don't have a lot of funds to hand out – you must have a wish list and more than a wish list, a needs list. Are there needs that you can see now that aren't being met, and do they present red flags in your mind, off the top of your head?

Ms Barlow: You're asking me?

Ms Jansen: Yeah.

Ms Barlow: I think the key need that we have is appropriate transition and supports in the community. We go out of our way to ensure that those services are delivered within our institutions, both adult and young offender. If there's a problem, we can pick up the phone. There's care there. But once they leave and they go back into the community, then it's a different issue.

4:55

Ms Jansen: Are we dropping the ball?

Ms Barlow: I'm not sure that you can look at it in that context. I think that we can do what we can within the justice system, and then based on the new strategy, those resources will have to follow accordingly.

Ms Jansen: Do we have the resources in place right now, or are they not there yet?

Ms Barlow: I can't comment on the resources because I'm not familiar with all of them. My area is within corrections, so I can speak to what we have. I think I'd have to defer to that. But one can always do more, regardless of the sector. There's a huge unmet need.

Ms Jansen: But you must hear stories. Are there kids falling through that net? Are their needs being met? Are there people in the community to help them?

Ms Barlow: Well, I think the biggest challenge that we face is that kids are going back – if you want to talk about kids – into the same situations that they left before they came to us.

We clean them up. We make sure they're fed, that they go to school. In both Edmonton and Calgary the school boards provide the education, so teachers from Edmonton public or Calgary public come in and do that. We can do all those things. You know, the colour comes back into their faces, and they sleep regularly. They're getting regular meals. They're looking much better after a while. We can provide psychologists. They can go into various programs, and they can get their credits in school and so forth. I mean, we go out of our way to hold their hand and make sure that we position them for success. But then they go back to mom and dad and whatever that situation was, or they go back into a different situation, and we no longer control that. That's where it's a societal responsibility to make sure that we provide the level of care and the kind of appropriate care and love for these kids that they need. We can only do so much.

Ms Jansen: Thank you.

The Chair: Rachel Notley, please.

Ms Notley: Thanks. Thanks very much there, Rod. You asked a whole schwack of questions that I was going to, so that was very helpful. The only addition that I had on that one, when you send the numbers about what was planned – I'm not sure. Did you give us '12-13?

Dr. Shim: No.

Ms Notley: Okay. So '12-13 and '13-14. Is the breakdown between mental health and addictions, or do you identify a difference between the two?

Another quick question before I go into my third one. SCIF was a three-year program, and I hear from people in the community in some of the organizations that you identified in your slide that they're not sure about what they're getting come April 1. I mean, I know we can't talk about budget, but is it your intention that a lot of these programs will continue, or are they a three-year cycle?

Dr. Shim: When SCIF was funded, they were funded as three-year programs, and they were asked in their proposals to look at sustainability. I think one of the programs that was talked about was the diversity housing program. Actually, some money now is provided from other areas to continue with that program. But when SCIF was started, that was what it was, three years and looking at sustainability. I can't talk about other budgets.

Ms Notley: So what will happen to those beds that you've just identified?

Dr. Shim: Those beds are not SCIF, okay?

Ms Notley: Oh, okay.

Dr. Shim: Sorry. You see, they were separated. The beds are part of the SafeCom grants from Alberta Health Services. So, no, they will not be closed.

Ms Notley: Can you break down for the committee, not right now, the types of programs covered under SCIF, then, just so we have a clear distinction in our minds between SCIF and SafeCom? Thanks.

Dr. Shim: Okay. Sure. What I'll do is I will tick the website because everything is there.

Ms Notley: All right. Thank you. I could probably do that, but I'd appreciate if you did that.

Dr. Shim: Okay. I'll do it.

Ms Notley: I want to just talk a little bit about corrections. Hopefully, I won't take too long, but I really need to. You know, we talk about how we clean them all up, and we put them back out on the street. But I just want to talk a little bit about a really disturbing situation that I had with a constituent. It really identifies why we're here talking about this issue and, indeed, reinforces some of the points that you made.

A young son has schizophrenia. Dad knows it. Son goes into the hospital because he becomes very ill. Son is released from the hospital after about two weeks. Dad knows son is not better, begs the hospital to keep son. Son says no. He's done; he's out. Son goes home with dad that night, takes a weapon, almost kills dad. Dad goes into the hospital for two weeks, and once he's finally out, he discovers son is in the remand centre.

Dad then spends three months and two trips to the court trying to get son access to a psychiatrist and access to medications while he's in the remand centre. Finally, through judicial intervention son gets moved to Alberta Hospital but only after three months in the remand centre with no treatment and no access to pharmaceuticals, and son at this point is really sick. So I'm concerned about the quality of mental health services, at least in our remand centre.

You mentioned, you know, what's changed, and you identified a lot of things, much like our lady from Health did. My question for you is: you talk about new treatment providers, so I'm wondering if you can provide the committee with the number of new treatment providers within the corrections system, people that do mental health support in some fashion, since 2009; also, the number of positions that are focused in the remand centres as opposed to Alberta Hospital or other forensic centres, what we've got there from 2009 to now.

When you talk about increased access to pharmaceuticals, that's good, but to give us a sense of what that really means, can you give us a percentage increase in expenditures on those pharmaceuticals so that we can get a sense of how much it has actually increased in terms of how many people are getting access to the treatment that a doctor, if they saw one, would suggest they need?

Ms Barlow: I think you'd find that the expenditures on pharmaceuticals have actually decreased because of the benefit of bulk buying through AHS, whereas we had to purchase those pharmaceuticals. Do you know what I mean?

Ms Notley: Then perhaps you can provide us with information on the number of prescriptions that are provided. I'd like a measure of the overall amount of pharmaceutical therapy that is being provided to inmates in the corrections system, a snapshot of 2009 and a snapshot now, however you do it. I thought money would be a way to do it.

Ms Barlow: Money is not always the best indicator.

Ms Notley: If money doesn't work, could you find some other way of measuring access to pharmaceutical therapy? Just saying "increase," it could be an increase by .01 per cent; it could be an increase by 60 per cent. I think we need to know on the committee. The same thing as well with the treatment providers generally as well as the treatment providers in the remand centres.

Ms Barlow: All the treatment providers are AHS staff, so I think we're going to chat offline about that.

Ms Notley: Fair enough. Just wherever we can get the information from.

Ms Barlow: I think it's clear to understand that all of them are AHS staff.

Ms Notley: Okay. Well, some of them used to be psych nurses employed by corrections.

Ms Barlow: We no longer have any.

Ms Notley: I understand that, but my point is that I want to see what we had in the remand centre in 2009. I don't care who employed them. I just want to know how many folks we had providing some form of mental health treatment for some very sick people in 2009 versus 2012.

Ms Barlow: Certainly.

The Chair: Ms Beverley, did you want to augment that answer?

Ms Beverley: Yes. Thank you. I just wanted to make a comment to your question regarding the number of pharmaceuticals and what that trend has been over time. The one thing about addiction and mental health that a lot of people don't understand is that it's not all around medication in terms of treatment and care. There are a lot of very effective therapies like cognitive-behavioural approaches, family therapy. There are many, many different kinds of therapies and modalities of care that are provided. I'm not sure, just as a comment to your question, really, whether the number of pharmaceuticals is indicative of good care or not.

Ms Notley: It's one component.

Ms Beverley: Certainly, in our senior population we would hope to see a decrease in pharmaceutical use.

Ms Notley: I'm talking about our violent offenders in corrections. I think it's a measure, and it's certainly something that the federal ombudsman has identified as a problem in our federal system. You're right, of course, that there are lots of other ways to deal with it. But, again, as I said before, your average guy getting out of remand is not walking down the road to see a psychologist and start doing a bunch of healing therapies either. I think we need to look at the whole piece, everything together.

The Chair: Thank you.

Janice Sarich.

Mrs. Sarich: Thank you, Madam Chair. I'd also like to say thanks for the wonderful presentation and, in particular, on what's changed. I learned a lot since my time working at a correctional facility, so thank you very much for that.

I'm interested in the area where we have not-for-profit groups that get grants that help supplement some of the initiatives that are listed here in your slides; for example, the immigrant and refugee youth mental health project. It's delivered by an NGO, a nongovernment group. What I'm hearing is that in these grant situations the profile of the client coming in is very complex and putting additional pressure on the NGO to respond, sometimes beyond what the original intent of the grant has been. I'm very interested in whether or not you assessed this.

5:05

In all fairness to the NGO and some of those pressures out there, what is a valued project or initiative to be done if you're finding that the client on the referral to the NGO is beyond what their capacity is? Sometimes that's not at phase 1. Sometimes that's a bit into the first quarter or a half year into that grant funding. The NGO is trying their very best to respond to the incoming and realizes: hey, there are clear signals here, but we don't want to let anybody down because we're six months into this project. At the end or somewhere on this process line do you evaluate the pressure on the NGOs for some of these projects and initiatives?

The second thing is the comment about community and the thinness of resources. When the person that has been incarcerated makes a choice to go back home – and that's cyclical – they go back into the situation, or home may not have the comprehensive wraparound services that they received initially, when they were remanded into custody. Even in those situations is there a discussion about a further intervention, that maybe going home isn't the best solution because we want to keep you close to these resources? You know, we're very fortunate in a large urban centre. It appears that it could be all here. But if we look at Alberta, we have remote communities. People make decisions to go back home once they've served their time, and the resources are not there. Is there a discussion or any thoughts about trying to have people encouraged to really have those wraparound services that they truly need and then at a later point transition?

These are kind of two areas that have a significant impact. Thank you.

Dr. Shim: I'll answer the one about the immigrant groups first. You mentioned pressure on them. On that one I will say that I have not measured that. However, this grant is now into its fifth year, and we have really good grant reports from them. They actually report to us on a monthly basis, a status report monthly, and they do a semiannual and an annual report. What they have shown to us are some of the outputs that they have in the services that are provided as well as some of the outcomes, like I said, because this is now five years running. As for that question on the pressure on them, I can't answer that, but this is one of the programs that I will say I've been hearing good results about from them and people in the community.

Mrs. Sarich: Yeah. Maybe my mistake was identifying a specific project listed in your slides here. Just, overall, lots has been downloaded to NGOs in the form of grants. It's a really great thing for those that can respond, but we're finding in these areas that link themselves back to health in particular – addictions and mental health would be one of them – that the complexity of the client coming in is such that it sometimes goes past the abilities of an NGO. Even though they're reporting back and having successful outcomes or whatnot, I guess I'm trying to find out if you're doing an extra level of monitoring. Exactly what's being downloaded, and in all fairness to them do they actually have the capacity to deliver the outcome that we're really looking for here? That's one part of it. The other part is the thinness of resources and community comment that you made.

Ms Barlow: Can I just take a stab at that? I think the really positive thing in all of this is that for the first time we're all working together on the same issues across government ministries and with AHS. We've got Alberta Health at the table, AHS at the table, ourselves, and other key providers. It's a perfect opportunity for us to be able to share information, identify where the gaps are, and look at how we can collectively respond to that and all we need to do. I think that's certainly an area that we could follow up on collectively when we leave here. Thank you for raising that.

The Chair: Thank you very much.

That was my last questioner. Ladies, thank you very much. It was much appreciated. I think there was some information that many of us didn't know. Thank you.

I'm sorry. Clearly, we're behind time, and I thank the staff from Alberta Education for being so exceptionally patient. If I could ask you to come forward now, we'd appreciate that.

I think we're going to lose a couple of members because they have to catch a flight back to Calgary, but thank you. I'm sure that they will be following up the rest of the meeting on *Hansard*.

Thank you very much. We have Dean Lindquist, the assistant deputy minister of learning supports and information management; David Woloshyn, executive director, program delivery; and Joyce Clayton, director of inclusive learning supports.

Thank you. You may begin.

Department of Education

Mr. Lindquist: First of all, Madam Chair, I'd like to thank you and the standing committee for inviting us here today to present. I'd like to just take a moment. You've already introduced us, but to my right is David Woloshyn, executive director, program delivery, and to my left, Joyce Clayton, director of inclusive learning supports.

I realize we are short on time, so I'll move forward quickly. The first few slides are intended to provide you with the context of Alberta Education and supporting student learning within the province of Alberta. In addition, Education enjoys collaboration with our partners, including Health and Human Services, on many of the initiatives that we will discuss today.

In 2008 the then Education minister, David Hancock, was mandated to lead an initiative that created a long-term vision for education in Alberta. The process was an extensive conversation with Albertans to determine what education should look like by 2030. Three aims of the initiative were to heighten appreciation of the importance of education in the life of Albertans, an increasing contribution to a prosperous society and economy; develop a clear understanding of what it will mean to be a successful and educated Albertan in 20 years; and create the basis for a broad policy framework describing the overall direction, principles, and long-term goals for education in Alberta.

On the PowerPoint presentation you'll see that we've identified a couple in bold: shared responsibility and accountability, inclusive equitable access, responsible and flexible approach, and sustainable and efficient use of resources. These relate probably most closely to the topic at hand today.

Following our work with Inspiring Education three Es were formulated that lead the transformation of education in Alberta. These are engaged thinker, ethical citizen, and a student with entrepreneurial spirit. Within that context we'll present today.

Responsibilities of school boards. First of all, it's a key responsibility of all school boards to provide all children and students with an educational program that meets their needs. Within that we can identify the individual's unique learning needs, provide a range of supports and services that respond to the needs of the child/student and opportunities to meaningfully engage families in their children's education, and collaborate with municipalities, other school boards, and community-based service agencies to address their needs.

Funding of our programs. First of all, we've just done a couple key points that align back to our work, and that is the expectation that school boards will offer necessary programs or services to meet the needs of children and students. Our new funding model supports inclusive education. School boards have flexibility to use funds to address local needs and, in particular, the local needs of students.

Two key components of our inclusive funding model work around supports and services funding as well as recognizing that within local communities there are differentiated modifiers, including the socioeconomic status of the community, diagnostic issues within each of the communities, and, of course, geographic location within the province.

Greater flexibility for boards to allocate funding from Alberta Education allows them to provide a variety of supports and services. Some have counsellors; others have behaviour specialists, learning coaches, social workers, et cetera, who participate with families and teachers to design program plans to address children's and students' learning needs.

If we look at the budget breakdown – and you'll notice the chart included on the PowerPoint – over 98 per cent of the $6.8 billion Education budget directly supports operations of school authorities. The less than 2 per cent remaining includes ministry support for basic education programs such as the work that we do around provincial achievement tests, as an example. It does not include the money we provide directly to the boards, but it still supports their work. The remaining 98 per cent directly goes to boards to support student learning.

Madam Chair, I'll turn it over at this point in time to my colleague for assessment and counselling.

5:15

Dr. Clayton: Thank you. Two of the areas that are very important within our school system relative to mental health and wellness of our children and students focus on providing assessment services and counselling services. As you can see, school boards do that in a variety of ways. At times they may have people who are employed in their school systems to provide those services, other times they may contract, or it may be a combination of those.

One of the key things we find is that it is really important to coordinate whatever sorts of referrals or assessments or even treatments with our partners from the community. A key focus that we have as we go through this is trying to facilitate and work together with students, with families, with other professionals in order to provide a range of assessment and counselling services. As Dean has mentioned earlier, this is all within the legislative responsibility of our school boards within the province.

One of the ways that we sometimes depict the services that we provide is using this model, referred to as a pyramid of intervention. Basically, this offers an opportunity to provide a full range of school mental health activities and programs. Typically within this we cover things such as prevention, promotion, early intervention at a universal level as well as targeted and specialized interventions.

Now, traditionally within our schools the mental health services are focused on meeting the needs of a selected or a small group of students and children who have really intense needs. The hope is that through the initiatives that we have within the education system and also with our partners, we can focus more on the universal approach so that we hopefully will have fewer children and students who will require targeted and intensive specialized services.

Relative to mental health supports and services one of the things that we do know is that students will benefit from a school and community philosophy that promotes positive mental health and demonstrates positive attitudes about themselves and others. One of the ways that we achieve this is through our health, life skills, and career and life management programs of studies. These programs of studies encourage students to make well-informed,

healthy choices, and to develop behaviours that contribute to the well-being of themselves and others.

A key component of our career and life management program of study is a comprehensive health care section, which really provides an opportunity for students to experience a change process that taps into the knowledge and skills and energy of the home, the school, and the community in leading to improved learning, enhanced well-being, and positive relationships.

In terms of our universal and broad-based supports what we look at here is basically providing access to positive mental health resources for students, their families, school staff, and community partners. Also, by doing this, it does provide more opportunities for success for students and children within their school setting. What is important about our universal and broad-based approach is that it is used to support all learners within a school environment.

Some examples of the universal and broad-based supports that are being provided – and these are also being provided in collaboration with other ministries and community organizations – are initiatives such as the new bullying prevention strategy, which focuses on government and its partners working collaboratively to promote the value of healthy relationships as a means of preventing bullying.

We also have opportunities to provide professional development for educators and school staff, and we often do this in collaboration with the Alberta Teachers' Association. We also in Education have a regional learning consortia, who provide professional development across the province, and we have a digital online resource referred to as the inclusive education planning tool, which has a library that provides information to teachers.

One of the areas in terms of looking at targeted supports and services that are provided – and we'll just highlight two of those which are available within Education. We have a student health initiative, and some of the numbers that we have in relation to this are that through this initiative approximately 46 per cent of our student health regions have reported that they are providing supports and services for children and students in the area of emotional and behavioural supports. Now, it's interesting that this is our largest category of service, followed only by speech language therapy.

As well, we have supports through the student health partnerships amounting to approximately $20.2 million in 2010-2011, which is a considerable investment in terms of looking at the area of emotional and behavioural supports. The allocation of this funding for the student health regions allowed the 17 partnerships to employ 205 full-time equivalent professionals and 15 full-time equivalent paraprofessionals to support children and students within their schools.

Another area in which we place a focus on students and their mental health is through our Alberta high school completion framework. There are a variety of strategies that are used, but two of the core ones that we have found to be effective are looking at increasing opportunities for student engagement and also emphasizing the need for successful transitions.

We also have within Education at the intensive and specialized levels children and youth with complex needs. For the last year that we have statistics, which would be 2010-11, there were a total of 238 children and youth involved through CYCN for support. Of that group 40 per cent had a diagnosis in the emotional-behavioural range. The average age of the children who were involved was 12 years. It was interesting that 70 per cent of the cases in this category involved a male who had a diagnosis of emotional-behavioural difficulties.

We also offer special needs tribunals, and this is somewhat unique to Education. It is a way that we support school boards when they find that they are unable to provide an adequate program to a student who has a variety of needs. How this operates is that a school board determines that it is unable to meet the special needs of a student, they contact the ministry, and the minister sets up a special needs tribunal, which goes out and develops and approves a plan for a student that is consistent with their needs. One of the features of this is that there is a cost-sharing arrangement between the province and the school board to cover the costs of the student's program.

At this point in time there are only four students who have been subject to a special needs tribunal, and of those four students three have emotional or behaviour needs. The ministry also does follow-up on their programs at least every three years and makes decisions around changes that may be required.

5:25

Mr. Woloshyn: We've identified six major trends. Schools are reporting increased incidences of depression and anxiety among students. There's a need to build capacity to respond in culturally appropriate ways to the changing demographics in our province. Families require information, tools, and resources to guide them in the work they need to find supports for their children. There's a recognition of a need for greater attention to universal, broad-based prevention efforts in addition to targeted and specialized interventions. Joyce talked a little about that. Stigma continues to be a challenge; there's a gap in understanding the difference between mental health and mental illness. We also see a trend of an increase in access to early childhood programs, for example full-day kindergarten, as an early intervention strategy. In the province in 2011-12 12.8 per cent of children attended full-day kindergarten programs, and 50 per cent of school jurisdictions offered full-day kindergarten.

The challenges facing the education sector include increased demand for mental health services, which impacts response time, and that speaks to timely access; shortage of qualified mental health service providers in schools, and this is particularly noted in rural and remote areas of the province; providing mental health services to children and youth with cognitive and communication disabilities, so that presents a unique challenge; a need to develop capacity and coherence across schools and school authorities; the need to align mental health prevention and promotion in schools and to increase support to families; the availability of services and service providers for francophone students to access Charter section 23 rights of being able to receive those services in French; the availability of school space to support collaborative wraparound service delivery, and there was a question in an earlier presentation dealing with that.

We have five future directions for our work. The Norlien Foundation is a proactive, private foundation in Alberta working in the areas of child development, addictions, and mental health. One example over the past year is that the adolescent mental health working group has been working to develop a set of pathways for identifying, screening, treating, referring, and following up adolescents with mental health issues. This group recognizes that this requires a cross-disciplinary, crossjurisdictional approach. It is the hope of the working group that implementation of these pathways in Alberta will result in a uniform approach to treatment of adolescent depression, producing improved results for adolescents and improved effectiveness for the health system overall.

The second direction that we're working on is increasing mental health literacy of school staff to support child and student well-

being, to improve identification of mental health needs in self and others, to promote help-seeking, and to reduce the stigma.

Also, another direction is increasing the capacity of school community partnerships to support child, youth, family, and community wellness. We see this as a shared responsibility of not only government but the community and families.

Regional collaborative service delivery model implementation. We're working with Human Services and Health to provide seamless supports and services in the right place at the right time by the right people. Our focus will be on greater collaboration in support of children and youth and families.

Finally, collection of early development indicator data in kindergarten on five developmental areas that include social competency and emotional maturity provides data to inform planning at the community level and provides data to Health and Human Services about some of the programs they're doing to try to get ahead of and be proactive in addressing the needs of kids and families.

Thank you very much. We're ready for questions.

The Chair: Thank you very much.

Mrs. Leskiw: Good afternoon. Thank you for your presentation. A little bit of background. I taught for 37 years in rural Alberta, and a lot of this stuff as a teacher I struggled with. One, teachers aren't trained to deal with a lot of students that are coming into our classrooms with special needs, and neither is the university providing courses for teachers to come in and be able to handle that. Expectations of school boards to offer it, especially in rural Alberta: it costs so much more to get people to come out from Edmonton to provide those services, so most of our money is spent on transportation. The children in rural Alberta get treated almost like second-class citizens to people in urban centres.

I grew up in Edmonton, and I know what I got as a student in Edmonton. Now that I've taught in a rural area, I feel that they're not getting the support. So what is being done?

The same thing with your universal supports. When was the last time you evaluated your K to 12 wellness education in the schools? I taught health, and I'll tell you that it definitely needs to be re-evaluated, considering the type of students we're getting now and the problems we're getting now. It's a lot different today than it was 35 years ago. That needs to be evaluated.

I could go on with this, but definitely in the rural areas we need help. We need the counselling. You might want to ask somebody: what on earth is a counsellor in rural Alberta? Who do you send them to? The capacity just isn't there. If you want the capacity, you need the bucks, and that's not following either.

Those are my comments. Thank you for your presentation. It was well presented.

The Chair: Thank you.

Mike Allen.

Mr. Allen: Thank you, Madam Chair. As well, thank you for your presentation, for spending the entire afternoon here. Dinnertime will be soon.

Joyce, thank you. I'm always fascinated by inclusive education. When I went to school, inclusive meant you got fries with your cheeseburger.

Thirty-five years ago I went to school in rural Alberta. I'm watching all of the emerging trends and things that you're doing. Actually, the question I'm asking is on behalf of my colleague Linda Johnson, who had to catch a flight. You spoke about early childhood programs and increasing access to that and then as well the future direction of collection of early development indicator data. She had a particular fascination with the EC map. Her question, originally to one of the previous presenters, was: how are you using early childhood development mapping to guide your programs and services towards assisting with, I guess, both developmental and mental health supports?

Mr. Woloshyn: What we're doing as part of the mapping project is that we fund and support community coalitions. We have 99 coalitions in 100 communities that are active. In the last one they're still organizing. We're really excited about the work that they're doing.

What we do is provide them a map of the community which gives them information about the children in kindergarten out of the five domains – social competency, emotional maturity, language and cognitive development, communication skills, and general knowledge – a map of how many kids are not meeting appropriate standards or developmental milestones. Then we also do a map of the community, of the assets of the community. Where are the libraries? Where are the playgrounds? Where are all the supports that are in the community? Then the coalitions use that information to analyze their community, look at the needs and say: where are the gaps, and what could we do to respond to that? We're really excited about this initiative.

How we're planning to use that information in the future: we're exploring possibilities of using that data to help inform. What happens if Health starts to try to improve maternal and infant health and they implement programs and services to do that? Are we seeing the outcomes when the children are five years of age, when they enter kindergarten? So there will be an indicator of the outcomes that we're trying to achieve.

Mr. Allen: Is it fair to say, then, that the EC map is part of your future directions as to how you're putting together that developmental piece?

5:35

Mr. Woloshyn: This is the last year of the pilot project, so we'll be evaluating where we go from here. We're in the middle of that process.

Mr. Allen: Okay. Thank you.

Mr. Luan: Madam Chairman, I've been listening patiently. I'm just wondering if I can ask a question related to ECD? I found the presentation this afternoon very, very informative. This question may not be specific only to the Education folks. It may relate to Health, too, because it is around ECD, early childhood development. One of the things I'm very appreciative of hearing this afternoon is that we've been talking about preventive services. We've been talking about focusing on mental health.

Here is my question to you all. I may not get the answer right away, but I'd appreciate some kind of a written response. The issue has been in my head for some time. The ECD work is one of the six priorities that Premier Redford laid out very clearly in our mandate of this government. Before we go to the polls next time, I'm very much interested to know how we progress on that in a measurable way. I'm so glad to hear lots of folks this afternoon talk about outcome-based reporting. I'm also hearing the hesitation and difficulties already alluded to. Now, it is very hard to provide concrete evidence to give a measurable indicator to say: in these areas, what did we do, and how did it contribute to the global sort of outcome?

I think in the profession of outcome-based reporting and the science of measuring preventive social services we are now at a different stage in that we do have the scientific tools to do that.

I'm so glad you mentioned the Norlien Foundation because I'm very aware that they're one of the leading-edge think tanks. They do have the scientific rationale and the tools to help us get there.

I keep hearing that the Premier has that laid out as a top priority. I've yet to hear that any of our departments clearly connect: here is the outcome; here is the yearly progress; here are some indicators; here is how we measure that we're getting there. The ECD map is absolutely one tool that is very close to what I call outcome-based reporting.

The upcoming work, what we call a results-based budgeting exercise, I take it, is essentially the same thing. We want to know, with the resources we put in, what impact we're producing and to what degree it gets changed, and that degree of change has to be measurable. You cannot say that we all intuitively know that by providing a safe environment for children, they will grow healthier, but by providing a healthy environment, there are many indicators.

This is where I'm very interested to have perhaps a written response from a corresponding department. How are we going about it? Right now I'm not getting any specific, concrete picture about that.

The Chair: Thank you, Jason. I'm sure the department will be able to get back to you with a written answer.

Mr. Luan: Thanks.

The Chair: Rod Fox.

Mr. Fox: Thank you, Madam Chair. You got a preview of my first question earlier this afternoon, so I guess we'll start with that one. What's happening with the parent link offices that are right now housed in schools? Like I said earlier, in my constituency there is a lot of pressure. Since it's a high-growth area, there are a lot of new students coming in. What will be happening with those contracts?

Dr. Lindquist: Well, that's a good question. I probably should ask: is this the Raymond situation, or is this a different community? I apologize, Mr. Fox.

Mr. Fox: Lacombe.

Dr. Lindquist: Lacombe. Okay. We have a similar situation that we're dealing with in the Westwind school division as well. We have our director within school capital planning just for the south region working directly with school boards, working directly with our stakeholders. Our minister believes very firmly that our schools need to be connections directly into the communities, and you see that across the province. Whether it's parent link centres or playschools or a variety of others, wherever there's room for additional space, leases exist to bring these groups in.

The situation that you're talking about: I'd have to follow up specifically on the Lacombe issue to see what we're doing in terms of the Wolf Creek school division. Certainly, when we are aware of these situations, we can sit down with groups, take a look at what options we have available, and find resolution. It's critical that we recognize the importance of parent link centres, whether it's in Lacombe, Raymond, Jasper – it doesn't matter where – because they provide valuable connections back into the school in order to support teachers.

Understanding what MLA Leskiw mentioned earlier about rural Alberta, I come from 32 years in rural Alberta, so I understand what you're saying. But at the same time I think that we also recognize that today when we look at scaffolding supports for children, the parent link centres are critical to us and our teachers in terms of supporting and nurturing our students.

Mr. Fox: Will you keep me in the loop on what's going on with those?

Dr. Lindquist: I will follow up and return to you in writing on that particular matter.

Mr. Fox: Thank you. Now, my second question has to do with bullying prevention tools, and that's listed on page 5, on the one slide there. One thing I've heard from parents is a bit of frustration. It's one thing for schools to have a process on paper in dealing with bullying in the school, but it's another thing to actually have that followed up on. I'm wondering exactly what is going to be done to document bullying issues and to make sure that the schools are actually dealing with these and, if they're not, where parents can go for support to make sure that their issues are heard and that the bullying is stopped within the school rather than just kind of shuffling it under the rug and saying: yeah, we have a process; here it is. I don't think that's satisfactory for our parents and our students.

Dr. Lindquist: I think Education would concur. I'll certainly step aside for a second for my colleagues to provide a response as well, MLA Fox.

I'm 18 months removed from being a superintendent of schools, so I understand what you're saying. I think critical to that is ongoing parental communication with the teacher, the principal, the school board, the local trustee, and the superintendent in order to address those issues.

As you know, bullying manifests itself in many different ways and can occur on campus, off campus, online. It manifests itself in so many different ways and is a challenge for parents, for children, and, of course, for schools. Certainly, all school boards are expected under section 45(8) of the current School Act to provide a safe and caring learning environment for all students, and they need to prepare and present programs related to those. I think that that whole bullying issue is integral to our discussion today. How do we ameliorate those issues? I think from that perspective we do see that there are many supports that are becoming available, a number of programs that we have available to us and to our schools in order to provide those supports.

I'm just going to turn it over to Joyce if I may – I think it was Joyce that talked about it earlier – just to talk specifically about the bullying that we look at because that's integral also to our inclusive learning supports. How do we ensure that all of our children are able to coexist safely and enjoy their K to 12 experience and maximize their learning opportunities?

Dr. Clayton: Okay. In terms of the new bullying prevention strategy, really, there are five priorities that we are looking at. Certainly, a key one is looking at: what are the protocols and processes we have in place? It is, certainly, an issue that we hear of that people aren't sure how to respond to. I think the work that we're doing in that area – it's just starting – will be very helpful, and we're certainly involving our partners, parents and community organizations, as part of developing those protocols.

I think one of the shifts that we've made around the bullying prevention strategy is really starting to focus on: how do teachers and students develop healthy interactions and healthy relationships? That seems to be the root cause in many situations. People aren't sure how to get along, they're not sure how to communicate, or they become easily upset, et cetera. Certainly, a large part of our focus is going to be looking at: what are the resources that we need in place to help develop more healthy relationships certainly within our schools as a way of preventing bullying?

5:45

Mr. Woloshyn: The other elements that we have. We have the hotline for kids 24/7. We also have a website with information for kids, a website for parents. In our new Education Act we've clarified responsibilities of school boards to ensure that they have the responsibility to deal with bullying in and out of school. We have engaged students through Speak Out. Our high school completion strategy deals with the acceptance of all kids. We also have initiatives to try to improve the acceptance of all kids in sexual minorities. The real focus is that all kids belong in school, acceptance of all.

Bullying doesn't happen just in school; it happens in the adult world, too. We want to try through that healthy relationship to have conversations about bullying in our society.

Mr. Fox: Thank you. Just one last question on the bullying prevention. How are you going to track the effectiveness of this new strategy?

Dr. Clayton: I think part of what we're doing within the ministry right now is that we are examining and exploring some new data collection possibilities and options. Certainly, since we have this initiative and many others, that will be part of that process. We know that we collect certain pieces of information now. We are examining whether or not they continue to be the ones we need, or are there new ones? So that will be built in.

Dr. Lindquist: A couple of anecdotes that might support that. For example, a number of our schools across the province use programs such as effective behaviour supports, which identifies the behaviour, the location where the behaviour occurred within the school, and then they begin to identify a list of things that could be done in order to help resolve the issue.

The second one which I think connects to this but also to David's remarks around the high school completion framework is that with our pilot schools we're doing a program, Tell Them for Me. It's a survey tool that measures and looks at student engagement, but it also looks at how schools can be improved in order to become better places for students. We see some of those things. We also see that when students are being bullied, there's a disengagement that occurs as well. We need to be cognizant of all of these tools in order to get to the root cause of the issues.

Mr. Fox: Thank you.

The Chair: Alana DeLong, please.

Ms DeLong: Well, thank you very much. Tying in what you're doing with the general strategy, I see certain sort of responsibilities that are on you, and I'm hoping that I'll get some sort of idea. First of all, in terms of teaching mental wellness, are you looking at that, and are you evaluating where you are and where you want to be so that we come forward with some good plans for that? Number two, who should we have in the school? Should it be parent link? Should it be counsellors? Should it be someone from Alberta Health Services? Who is it that is actually going to say, "Hey; there's a problem here"? Who is actually responsible for making sure that that person actually gets the services? The third thing is: once somebody raises the alarm bell, what's the wait time?

I think those are the three that I see as your responsibility from the general strategy, and I just want something clear. I don't need it right today, but I would really like to see your responsibility in there and where you're going with it.

Dr. Lindquist: We can provide somewhat of a response here, and if you require further in terms of written letters, please advise.

I think this is an ancillary response to the question around parent links and not room in the schools. For example, in our current $550 million projects, where we're building a number of new schools and modernizing, capital planning with the support of Infrastructure has incorporated modified design standards in order to ensure that we're able to put the people in the building that we need to in order to provide wraparound services for students. That might be on a part-time basis, a full-time basis. You may have Health people, Human Services people. It could be, you know, pastors. You name it, type of thing. Through that whole modified design standard that's incorporated into the building of new structures, there's a place available in the schools where people can come in and support students.

On who teaches, can I defer to you on that, Joyce, as part of the inclusive learning?

Dr. Clayton: Certainly you can. I think that in this particular area we work very closely with our curriculum developers, and together we sponsor a wide range of professional development opportunities for teachers and administrators, you know, across the province.

In terms of looking at the overall plan it is something that I can provide to you in writing because I would like to consult with them.

Mr. Woloshyn: The two other projects that we work with our partners on in Human Services and Health is mental health first aid – it's a training program for staff in schools – and also the mental health capacity-building projects, funded through Alberta Health Services and Health, that are just doing phenomenal work in school communities, in catalyzing supports in communities to address the needs of kids and families.

Ms DeLong: Okay. Is there anything you're doing in terms of tracking? You know, once you do see a need or if you think a child might be having mental problems, do you really have the resources available to you to be able to refer them on?

Mr. Woloshyn: That's one of our challenges that I spoke to earlier, that access, that school authorities are reporting a greater demand for mental health services. That is growing, and that is impacting access.

The Chair: Thank you.

We may be in danger of losing our quorum here. I wonder if I could ask the two remaining speakers, Rachel Notley and Janice Sarich, to ask your questions and then get the answers in writing. Thank you.

Ms Notley: Yeah. Okay. I'll be fairly quick because, well, I have two quick questions. I found your presentation interesting. I will start with my very firmly held opinion and that which is reported to me by representatives of a variety of school boards and teachers across the province, which is that setting the direction is a very unfortunate thing. One of the outcomes of that change, unfortunately, is going to be increased pressure on these very issues within the system. Yes, more money went into supporting special needs, but effectively all that did was make up for the freeze that had effectively been in place for the three years before that. So we're still at the same place.

Unfortunately, as much as there were genuine faults with the old system, the problem with this system is that there's even less accountability, and there's a huge reliance on the teachers. The single biggest flaw in that system is that the teachers, as Mrs. Leskiw so appropriately pointed out, were not ever given the

opportunity to learn how to become mental health therapists or emotional or behavioural managers for people with cognitive and emotional special needs, so this problem is going to get worse.

That being said, if we can limit it to simple mental health even though the people that tend to be most likely struggling with mental health will also be those kids with emotional and behavioural issues – often there's a high correlation between the special needs, the failure to properly support those special needs in the school, which, I think, is going to grow. Nonetheless, the fact of the matter is that we're just talking about mental health right now.

That being said, I appreciate that you've identified the challenges as honestly as you have, that, in fact, we have an increased demand for these services. I would be curious to know two things. First of all – and I'm not sure if this was just Edmonton based or if it was across the province, so you may or may not know, but maybe you can tell me – roughly two years ago there was a change in staffing of schools by AHS or by the Edmonton zone or by the school board or children's services. I'm not sure which; I'm sorry. There were basically mental health counsellors – I think primarily in the form of community health nurses, but I could be wrong – who were in schools who were pulled out. They were redefined and reallocated. So I'm wondering if we could get some information about that in the past.

Then flowing from that, I'm wondering if you can tell us – I mean, I appreciate that the boards have a big role to play in all this ultimately as the overall funder, and you do as well – how many FTEs we have in our school systems right now with the skill set to provide mental health therapy or support within our school system and whether that's an increase, decrease, or roughly the same?

Those are my two questions and my little editorial.

The Chair: Thank you.

Janice Sarich.

5:55

Mrs. Sarich: Thank you, Madam Chair. Well, thank you very much for the presentation. I could say that it's almost evening. The beginning of the presentation, Inspiring Education, set the context. Our committee is going to be striving to have a comprehensive policy discussion about what our next steps are going to be, with a collection of information from all the presentations and perhaps even a little bit more.

What was missing for me – and maybe it would help set the stage – is taking another look at the setting the direction framework. It came out in June of 2009. It might be helpful for the committee to have a comprehensive update as to what its report card is relative to the activities that have happened within Alberta Education from 2009, the release of the report, to today, so if you had to report on the recommendations. The reason why I'm emphasizing this particular report is because addictions and mental health are one component when we talk about special-needs children. The need is wide, the demand is heavy, and we need to understand from that framework what has been done: the body of work, if anything has been adopted, and where we're going. Maybe it'll add to our policy discussion.

Another thing that may help our committee when we talk about addictions and mental health: the identification of the problem. Students come in with a composite set of issues, so they're identified. How does that happen? A lot of members on this committee may not know how that transpires. When we look at the issue of diagnostic testing as it relates to learning, it is very important to understand where we are on diagnostic testing. Then a number of colleagues on the committee tried to address or were starting to address the issue of: how does that tie to the competencies of who the tester is? Is that the teacher? Is that a specialist? How are we accessing that, what is the demand, and what are the available resources?

We're very fortunate, as I mentioned earlier today, to be in a large urban centre, and it has complexities. When you move away from large urban centres and you look at Alberta as a whole province, those program services, the diagnostic abilities may not be available in remote places within the province of Alberta. I'm asking you this because a great body of work has been done.

I started as parliamentary assistant with Minister Hancock in 2008, and we worked heavily on these frameworks for three and a half years. I think it would really add to the policy discussion about where we are, what our report card is, and help us maybe to be able to explore some key areas that link learning and health. If you don't have healthy children, it really adds to the complexity of learning plans for children from – it doesn't matter – kindergarten all the way to grade 12.

I'll leave it at that because what I've asked you, I know, is a lot of detail. Thank you.

The Chair: Thank you very much. That is the last speaker.

I would like to thank everyone that is in this room and has held on all this time. I really do appreciate it. Thank you to the staff as well.

I also know that we've received a tremendous amount of information. I know that we are over time, but I still would like to express my opinion that although we have had a long afternoon, it's much easier to get this much information that is back to back and actually overlaps rather than trying to get it in bits and pieces of an hour here and an hour there. I'm trying to justify my calling this long meeting, I guess.

One of the other things. I think that at this point we are probably not up for a committee discussion. What I'd like to suggest is that all the information be gathered – we have written answers coming in, and there's a tremendous amount of information still to come in – and we will go over it and discuss it within our working group, which consists of myself, Heather Forsyth, Dr. Swann, and Rachel Notley. The whole purpose, of course, is for us to come up with a specific focus, and I think anyone who has sat here all afternoon will realize that that is a huge task. What part do we take of all this amazing information and try to bring down?

I think one thing that is very apparent to me is the cross-collaboration between all of the ministries. That is very, very clear. I don't think I noticed in years past even if I was sitting on the other side of the table and the information was perhaps a little different. I just don't remember, even when I met with schoolteachers and school boards and that sort of thing, where the collaboration was so apparent across the ministries. I think, in my mind, that's a very, very positive thing, and I realize how hard it is to bring this really complex subject into a very small school of thought.

So if the committee would concur, that's what I would do. We'll get all the information, and we'll turn it over to the working group, and we can work out something. Is that okay? Thank you.

The date of the next meeting, based on what I've just said. I don't know. It's going to take us a while to put that all together. We can get together with the clerk and then come up with a date. Thank you very much.

I would ask someone for an adjournment.

Mr. Allen: So moved.

The Chair: Thank you very much.

[The committee adjourned at 6:02 p.m.]

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