Legislative Assembly of Alberta

The 31st Legislature
First Session

Standing Committee on Families and Communities

Ministry of Mental Health and Addiction
Consideration of Main Estimates

Wednesday, March 20, 2024
7 p.m.

Transcript No. 31-1-12

Legislative Assembly of Alberta
The 31st Legislature
First Session

Standing Committee on Families and Communities

Lovely, Jacqueline, Camrose (UC), Chair
Goehring, Nicole, Edmonton-Castle Downs (NDP), Deputy Chair

Batten, Diana M.B., Calgary-Acadia (NDP)
Boitchenko, Andrew, Drayton Valley-Devon (UC)*
Long, Martin M., West Yellowhead (UC)
Lunty, Brandon G., Leduc-Beaumont (UC)
Metz, Luanne, Calgary-Varsity (NDP)
Petrovic, Chelsae, Livingstone-Macleod (UC)
Singh, Peter, Calgary-East (UC)
Tejada, Lizette, Calgary-Klein (NDP)

* substitution for Martin Long

Also in Attendance

Bouchard, Eric, Calgary-Lougheed (UC)
Cyr, Scott J., Bonnyville-Cold Lake-St. Paul (UC)
Eremenko, Janet, Calgary-Currie (NDP)

Support Staff

Shannon Dean, KC	Clerk
Teri Cherkewich	Law Clerk
Trafton Koenig	Senior Parliamentary Counsel
Philip Massolin	Clerk Assistant and Director of House Services
Nancy Robert	Clerk of *Journals* and Committees
Abdul Bhurgri	Research Officer
Christina Williamson	Research Officer
Warren Huffman	Committee Clerk
Jody Rempel	Committee Clerk
Aaron Roth	Committee Clerk
Rhonda Sorensen	Manager of Corporate Communications
Christina Steenbergen	Supervisor of Communications Services
Shannon Parke	Communications Consultant
Tracey Sales	Communications Consultant
Janet Schwegel	Director of Parliamentary Programs
Amanda LeBlanc	Deputy Editor of *Alberta Hansard*

Transcript produced by *Alberta Hansard*

Standing Committee on Families and Communities

Participants

Ministry of Mental Health and Addiction
Hon. Dan D.A. Williams, Minister
Coreen Everington, Assistant Deputy Minister, Policy and Programs
Evan Romanow, Deputy Minister

7 p.m. Wednesday, March 20, 2024

[Ms Lovely in the chair]

Ministry of Mental Health and Addiction
Consideration of Main Estimates

The Chair: Well, hello, everyone. I'd like to call the meeting to order and welcome everyone in attendance. The committee has under consideration the estimates of the Ministry of Mental Health and Addiction for the fiscal year ending March 31, 2025.

I'd ask that we go around the table and have members introduce themselves for the record. Minister, when we come to you, if you would kindly introduce your colleagues at the table, that would be appreciated. We'll start to my right.

Mr. Boitchenko: My name is Andrew Boitchenko, and I'm the MLA for Drayton Valley-Devon.

Mr. Bouchard: I'm Eric Bouchard, MLA for Calgary-Lougheed.

Mr. Lunty: All right. Good evening. Brandon Lunty, MLA for Leduc-Beaumont.

Mrs. Petrovic: Chelsae Petrovic, MLA for Livingstone-Macleod.

Mr. Cyr: Scott Cyr, MLA for Bonnyville-Cold Lake-St. Paul.

Mr. Singh: Good evening, everyone. Peter Singh, MLA, Calgary-East.

The Chair: Minister.

Mr. Williams: Okay. Thank you. To my left I have my Chads. I have Chad Mitchell, assistant deputy minister, system overview and strategic services division, and then I have Chad Schulz, assistant deputy minister of the financial services division. To my right I have my deputy minister, Evan Romanow, and my assistant deputy minister of the policy and programs division, Coreen Everington. I am Minister Dan Williams, Mental Health and Addiction.

Dr. Metz: Hello. I'm Luanne Metz, MLA for Calgary-Varsity.

Member Batten: Diana Batten, MLA for Calgary-Acadia.

Member Eremenko: Good evening. Janet Eremenko, MLA for Calgary-Currie.

Ms Goehring: Good evening. Nicole Goehring, MLA, Edmonton-Castle Downs, and deputy chair of this committee.

The Chair: My name is Jackie Lovely, and I'm the MLA for the Camrose constituency and the chair of the committee.

Now, I don't think we have any members participating remotely, so I'll just skip to the housekeeping items here. Tonight we have Mr. Boitchenko substituting for Mr. Long. Thank you so much.

Please note that the microphones are operated by *Hansard* staff. Committee proceedings are live streamed on the Internet and broadcast on Alberta Assembly TV. The audio- and videostream and transcripts of the meetings can be accessed via the Legislative Assembly website. Please set your cellphones and other devices to silent for the duration of the meeting.

Hon. members, the main estimates for the Ministry of Mental Health and Addiction shall be considered for three hours. Standing Order 59.01 sets out the process for consideration of the main estimates in legislative policy committees. Suborder 59.01(6) sets out the speaking rotation for this meeting. The speaking rotation chart is available on the committee's internal website, and hard copies have been provided to the ministry officials at the table. For each segment of the meeting, blocks of speaking time will be combined only if the minister and the member agree. If debate is exhausted prior to three hours, the ministry's estimates are deemed to have been considered for the time allotted in the main estimates schedule, and the committee will adjourn. Should members have any questions regarding speaking times or the rotation, please e-mail or message the committee clerk about the process.

With the concurrence of the committee I will call a five-minute break. Does anyone object to having a break this evening? Okay. Midway through we'll have that break.

Ministry officials who are present may, at the direction of the minister, address the committee. Ministry officials seated in the gallery, if called upon, have access to a microphone in the gallery area and are asked to please introduce themselves for the record prior to commencing.

Pages are available to deliver notes or other materials between the gallery and the table. Attendees in the gallery may not approach the table. Space permitting, opposition caucus staff may sit at the table to assist their members; however, members have priority seating at the table at all times.

Points of order will be dealt with as they arise, and individual speaking times will be paused; however, the block of speaking time and the overall three-hour meeting clock will continue to run.

Any written material provided in response to questions raised during the main estimates should be tabled by the minister in the Assembly for the benefit of all members.

Finally, the committee should have the opportunity to hear both the questions and the answers without interruption during estimates debate. Members, please, debate flows through the chair at all times, including instances when speaking time is shared between the member and the minister.

I'd now like to invite the Minister of Mental Health and Addiction to begin with your opening remarks. You have 10 minutes, sir.

Mr. Williams: Well, thank you very much, Chair, and I thank you for your hospitality and having me here today and to all members for engaging in the process. I understand you've had a long day, so hopefully we'll get through this efficiently together.

Before I get things started, I want to introduce again on the record for *Hansard* the officials I have with me. I have my deputy minister, Evan Romanow. I have Chad Schulz, my assistant deputy minister of the financial services division. I have Chad Mitchell as well, my assistant deputy minister, system overview and strategic services division. Then I also have Coreen Everington, assistant deputy minister of the policy and programs division.

In the Mental Health and Addiction budget for 2024-25 our government is laying out a clear commitment to supporting mental health and wellness for Albertans and supporting them in the pursuit of recovery. We have a plan to continue building the Alberta recovery model. As we invest in programming and infrastructure, that will give children, youth, and Albertans of all ages the opportunity to access the service that they need, whether it be in a school setting, a live-in treatment program, or mental health counselling, as examples.

At the same time, we are in the process of placing more focus and oversight on mental health and addiction services delivered within our provincial health care system. This year the Mental Health and Addiction budget, totalling more than $1.55 billion, includes $1.3 billion for services currently delivered within AHS. This funding will have designated oversight from the Ministry of Mental Health and Addiction and will be used to support the continuation of services within the new mental health and addiction agency being

developed as part of Alberta's health care refocusing. As a result, our budget will continue to support treatment and recovery, children and youth services, prevention and intervention, and many other pieces of the Alberta recovery model, and I look forward to diving into these as part of today's meeting and our questions.

When our government was elected five years ago, we made it clear how we would be responding to the addiction and increasing levels of mental health challenges in our province. The fact is that any person suffering from mental health challenges or from the deadly disease of addiction deserves an opportunity at recovery. I'm grateful to have the opportunity to carry that out now as I serve as Alberta's Minister of Mental Health and Addiction.

When discussing topics such as addiction, I think we as policy-makers have to decide which road we are going to take, whether it be the Alberta model or the Vancouver model. As we have been warning for many years, radical programs like so-called safe supply have turned into harm production instead of harm reduction as they feed addiction and flood the streets with opioids more and more powerful than heroin. Instead of taking this road, our government is following the evidence-based approach and the moral approach of treatment and recovery, giving people suffering from addiction hope and a new lease on life.

This is what we are building in Budget '24 with funding for recovery treatment centres, same-day opioid agonist therapy, and the ongoing operation of more than 29,000 treatment spaces, a total capacity increase of over 55 per cent since 2019. This represents 29,000 opportunities to receive services such as detox and residential treatment for Albertans. Funding in this budget will enable us to move forward with real infrastructure like recovery communities and other facilities to support the well-being of Albertans.

I was able to visit the recovery community in Red Deer recently, which houses 75 Albertans seeking to receive addiction treatment at zero charge to themselves. This is significant as historically residential addiction treatment centres in Alberta have cost thousands upon thousands of dollars for an Albertan to attend. Instead of making cost a barrier to someone's recovery and their second lease on life, our government has looked at addiction treatment as a health care service, fully funding it across the province, ensuring someone's financial situation never prevents them from receiving the life-saving treatment they need.

Facilities built in direct relationship with the Blood Tribe, the Siksika Nation, the Tsuut'ina Nation, and the Enoch Cree Nation are examples of how our government is working with Indigenous communities, overcoming the addiction crisis, and filling the void left by the federal government. In all my conversations with chiefs and leaders the message I hear is very clear, and what they want and need is recovery, not the addiction facilitation model of the federal government and the so-called safe supply.

Facilities built in Calgary, Grande Prairie, Edmonton, and Gunn will be making addiction treatment programs more accessible to communities across our province, with one more location yet to be announced. In total, these 11 facilities are adding another 2,000 treatment spaces per year to give Albertans life-saving treatment that will not only help them overcome addiction but also help them become productive members and contributors to our society.

Equally important, we are investing heavily into mental health programs that are supporting Albertans on the daily. We have partnered with organizations like CASA Mental Health, our second-largest provider of mental health services after AHS. With funding from this budget CASA Mental Health is putting in place more mental health supports in schools across the province. CASA is bringing mental health professionals directly into schools, giving students the full-time support they need without interrupting their ability to receive an education.

Also, in partnership with CASA we are building more facilities to provide live-in treatment and day programs for youth with complex mental health needs. In partnership with the Calgary Counselling Centre and Counselling Alberta we are providing same-day access to counselling services anywhere across our province, which is especially beneficial to those who come from remote parts of the province such as myself. These programs could not possibly operate without commitment to mental health, and I believe this budget makes that abundantly clear to Albertans.

7:10

Budget '24 includes $31 million for prevention and intervention, which means giving Albertans faster access to services in their community that help address challenges early for someone who might be struggling with a mental health crisis. Included in this would be $4.9 million for ongoing operations of 211 Alberta to connect thousands of Albertans calling or texting every single month directly with services in their community. More than $5.5 million is supporting our ongoing partnership with police services in both Edmonton and Calgary to partner officers, through HELP and PACT teams, with mental health professionals on the street. When someone is in mental distress, police are often the first on the scene, but not many have the experience or expertise needed to safely and properly de-escalate a crisis situation. Funding for these outreach teams, in partnership with our law enforcement, is connecting people with the services they need and giving police the tools they need to keep our communities safe.

These investments are more than just line items in a budget; they are making a difference in the lives of thousands of people every single day. I've seen this first-hand as I've visited treatment centres and spoken directly to Albertans across the province. Each time I visit a treatment centre, I talk to them about their stories, and I ask them what hope they have in their life for treatment and afterwards and where they'd be without the treatment. Many individuals have been homeless, trying to survive but stuck in addiction with what seemed to be no path out. Many told me about how they want to reconnect with their children, with their family, how they want to be brothers and mothers and family members and community members again, something that they are learning to do through our recovery communities and in recovery. When I ask where they think they would be if they did not get into the zero-barrier treatment facility that we have provided, without missing a single beat, they raise their head and they tell me that they don't believe they'd be alive today.

The truth is that addiction can only end in one of two ways. It can end tragically, in pain and misery, and run its course eventually in death, or it can end in treatment, in recovery, and a hopeful, new lease on life. This budget and our entire Alberta model of care focuses on recovery because we know that given enough time the other option leads down a path we dare not consider: always chasing another high, always seeking a more powerful drug to satisfy the addiction. I believe that as we follow expert advice, as we follow what I believe is the moral path forward for our society, with policies based on evidence, we will continue setting an example not just in Alberta for our family members and our communities and not just across our country and between other provinces but world-wide, the example of what a compassionate solution looks like dealing with the crisis of addiction.

With that, I look forward to your questions today. Hopefully, we can have a good time having a conversation around mental health and addiction and the wonderful opportunities that we're providing for those who need our services.

Thank you, Chair.

The Chair: Thank you, Minister.

We'll now begin the question-and-answer portion of the meeting. For the first 60 minutes members of the Official Opposition and the minister may speak. Hon. members, you will be able to see the timer for the speaking block in the committee room and, if anyone happens to join online later, on Microsoft Teams.

Member, would you like to combine your time with the minister?

Member Eremenko: Combined, please, Chair.

The Chair: Minister, what's your preference?

Mr. Williams: I'll ask for block time, please.

The Chair: We'll go with block time, then.

Member, please proceed. The shared block time is 20 minutes, during which time – well, if you decide to go back and forth later on, you can, but for now it's set for 10. Go ahead.

Member Eremenko: Thank you, Madam Chair. I'm very pleased to be here to ask questions of the minister in regard to this very important file of Mental Health and Addiction. I'll start off, frankly, where the minister landed, around recovery communities. As per page 106 in the fiscal plan, in the capital plan section, $328 million has been allocated to recovery communities. There is a total of roughly $500 million dedicated to building and operating 11 recovery communities.

The first to open was in Red Deer, with a $4.8 million annual operating budget, but we know, as per the granting guidelines soliciting applications for operating agreements, that the ministry would set aside $13.5 million per year for three years to operate the first three recovery communities. Red Deer opened in September 2022. Lethbridge opened in September 2023. Gunn was included in that initial funding call but is many months overdue, and the doors have yet to open there. Further, a recovery community was promised to the Blood reserve nearly four years ago, and they have yet to put a shovel in the ground.

Through the chair to the minister, each of these facilities is meant to have 75 beds. How many unique individuals are actually meant to flow through these facilities in a given year? How long will the average client stay at one of these facilities? How many beds in the current facilities are reserved for women? Further, how many beds in the current facilities are actually operational? Are they all at 100 per cent capacity?

An important thing to note here is that beds are not the same as spaces. Beds are beds while spaces: well, those are the number of individuals who occupy that one bed over the course of a year. The government lauds itself in having funded 10,000 new treatment spaces, but I think it is very critical to note that three-quarters of them, 7,700 of those new 10,000 beds, are short-stay detox spaces. That is roughly – detox tends to be seven to 14 days.

Through the chair, can the minister tell us how much it costs per day to staff a bed? Is there a different cost to operating a detox bed versus a treatment bed versus a recovery bed? I would assume there is given the intensity of support required in the first compared to a much lighter touch after several months of abstinence in a recovery community.

Madam Chair, in 2022, when the first applications were invited, the decision on successful applicants was made in record time. The RFP was public in July 2022, and the decision was communicated with those few lucky applicants not a month later, in August 2022. Red Deer was operational two months later, but the others have been quite a bit longer. People are dying at a rate that we have never seen, and the government's recovery-oriented system of care is meant to save them. But at the rate we're going, which is, by my calculation, one 75-bed recovery community per year, these efforts will barely staunch the flow of death and loss and suffering.

Through the chair to the minister, when will the next granting call take place to prepare for the next batch of recovery communities when they come online? What was the evaluation rubric for applications in 2022, and will the same rubric be applied in future calls? Will the minister predict an equally expedient timeline in the future?

Further, with this incredible emphasis on quite costly – half a billion dollars to open and run these recovery communities. Where is the funding for outpatient programs? As the minister mentioned, Madam Chair, this is meant to be a zero-barrier process, but I can think of a whole lot of barriers – work, child care, rent – that would prevent somebody from being able to put all of that on hold for 40 or 60 days to access an in-patient program. Where has the minister considered the place of outpatient programs?

Furthermore, it's not to say that in-patient rehabilitation programs like recovery communities didn't exist before the adoption of the Alberta recovery model. So, through the chair, is the minister funding brand new recoveries at the expense of existing treatment facilities, some of which have several decades of proven effectiveness and many of which support some of the most complex participants?

I'll move on from the recovery community conversation to page 107 of the business plan 2024-27 and performance metric 3(a), which is in regard to the recovery capital scores and the My Recovery Plan software application. I'm not entirely clear how the minister would like us to refer to that, so I welcome their thoughts. I have a lot of questions in regard to My Recovery Plan, or MRP as it's known for short. The key objective in the business plan, Madam Chair, states that MRP will be used "to support evidence-based decision making" to gauge the success of programs for the individuals who are actually participating in the Alberta recovery model.

People watching at home may not know that the My Recovery Plan app is a proprietary platform owned by a for-profit recovery and treatment service provider in B.C. The government purchased rights to use MRP here in Alberta, but I have some very significant concerns around the speed with which MRP was adopted and the rigour with which the platform had been vetted for the protection of information and privacy that all Albertans, particularly those who are most vulnerable, should be very concerned about.

In regard to MRP and the recovery capital index we'll start first with organizational considerations. Is it mandatory for treatment facilities to use the MRP and RCI platform? Is it mandatory for their clients to use it? What happens when a client, Madam Chair, refuses to use the tool? Does it impact the overall score of that facility? Furthermore, will MRP be used by former AHS, soon-to-be MHA-run programs and departments?

7:20

Through the chair, can the minister share to what extent future granting decisions will be made in consideration of an organization's recovery capital score? Is it possible, then, that a facility might pick and choose who they accept based on their likelihood to have the greatest improvement in their RCI? Is it not, furthermore, fair to say that some people accessing treatment have lower complexity than others and that some treatment centres are better equipped to support high complexity or concurrence than lower acuity clients? Recovery is not a linear process, Madam Chair. People fall down, and they pick themselves back up again time and time and time again. Gamifying that process with a recovery capital index score and basing future funding decisions on that should be of grave concern to Albertans and to all of those people who are struggling in the recovery process.

If every treatment facility or recovery community across the province is using the MRP, that could amount to thousands of people's data and private information being shared, stored, and analyzed. I have some questions around the privacy considerations. Through the chair, what privacy assurances exist, and who holds the data from the thousands of Albertans and dozens of organizations that use the app? Does it reside with the proprietary owners of the platform in B.C.? Has there ever been a breach of people's private accounts and information? Where is data stored, and who has access to it? Who has access to the app itself and to the organizational dashboards that will inform, again, ministerial decision-making? Do the owners of the app hold rights to access Albertans' information contained within MRP?

Lastly, I'd like to ask a question about target 3(a). That specifies that an indication of a positive effect of ministry-supported services is an increase in recovery capital from the first day in treatment or admission to a recovery community to the last day in treatment or discharge. Just to be clear: what's my score going in; what's my score going out? Through the chair, the minister must know that the positive effect of a stay in a residential treatment is not measured by the change from admission to discharge but in the days that follow discharge. What we need to measure is how well a person fares once they leave a facility, once they are back in their community, back with their family or friends, back to work, back to the stressors that will inevitably come. I would argue that the parameters, Madam Chair, of this performance indicator are not helpful in any way.

Further, we are relying on an unproven evaluation tool holding people's lives, their right to privacy, and perhaps the future of long-standing organizations in the balance. I'd like to hear the minister's thoughts on this particular performance indicator, Madam Chair. A lot is being placed in MRP both in terms of individuals' personal and private information. That can be incredibly sensitive. Is it being made available to employers? How is the tool being used? Who has access to it? And how will it inform future decision-making when it comes to funding and future grants for organizations across the province?

Thank you.

The Chair: Thank you so much, hon. member.

We'll now turn it over to the minister for his response.

Mr. Williams: Thank you, Member Eremenko, for that set of questions. I'll do my best to answer them. I tried to take notes, and I know my team did as well, so we'll try and go through it. We started off talking about the capital plan in the budget, that $328 million over a number of years for, largely though not exclusively, the recovery centres that we're producing. I'll first want to give some lay of the land. I'm going to ask my department to go into some detail in terms of what we see as next steps and how we're trying to move forward to make sure that we do deliver these.

I will first thank the member for what seems to be an agreement that recovery is the centre of a solution to someone in addiction. I think that is the centrepiece we have to agree on politically, understanding that there is an urgency from all sides of the aisle and it's beyond political debate that if we don't give people recovery, we are not going to see people getting better. I think recognizing that from the start is a huge win for us as a province because we see other provinces that don't have that same agreement that seem to be going down a drug facilitation argument and pitting that against what is, to be honest, the only proven way to get someone out of addiction other than the tragic end that we all want to avoid, and that's recovery.

The average is 75 beds though some facilities will have more. Gunn is an example of that that will have more; it'll be up to 100, I believe.

You asked about sort of how those beds are allocated, and I think you're right to say that beds and spaces aren't the same. It's important we make that distinction, exactly as you pointed out, that in any given year for a detox facility, which we can't have be the bottle of the process of those 10,000 spaces we added – we needed to make sure that the first step into the door to recovery, detox, isn't a barrier. Having that mass expansion of detox spaces allowed you to have potentially, you know, 30 to 50 individuals in one bed go through; that's 30 to 50 spaces for one bed.

Now, the facilities that we're building, these recovery centres, are high quality. If you were to go look for a private option of the same quality, you're looking at $10,000 to $20,000 a month easily in order to get that, and this is zero cost.

We also don't have a fixed program date for it. People can go through – and the member is exactly right that every recovery journey is going to be different. You'll see people coming back again even after leaving recovery and falling but then getting back up onto it, trying to get into recovery again and live that clean and sober and recovered life. Sometimes there'll be a repeat coming back again. Of course, we accept that that's part of it. We also understand that it can be up to a year. People can leave at different times as they see progress and they get the skills they need going through recovery in that treatment facility. For example, a 100-bed facility might have an average stay of six months; it could be an average stay of nine months; it could be an average stay of three months. We're going to get some of that information as we spend more time collecting that data. I can let my department speak to the preliminary information.

Red Deer and Lethbridge run at a very high capacity rate, the two that we have open. I'm not sure if we have exact numbers, but the beds are in high demand. We try and keep them moving through very effectively and efficiently. The purpose is to have those very sought-after, zero-barrier treatment spaces always in continuous use.

The divide between men and women is approximately two-thirds men, one-third women, but that's not a firm rule. We have an example in Lethbridge where the not-for-profit of Calgary that's running that also had a previous facility right next door that they have now transitioned to be run, effectively, in conjunction, but that one is committed to women in treatment whereas the full facility of 75 beds is men in Lethbridge whereas Red Deer: it's two-third, one-third with separate wings. It can change based on the particular design to meet the needs.

Maybe I'll pause right there and ask my department to give some more updates and details in terms of moving forward. Obviously, partnering with our Indigenous community is very important. I'm hoping we have more discussion on that going forward. You mentioned the Blood Tribe; we're working very closely with them. This is not an imposition but a proposition with our Indigenous partners, so given that we want to work with them, that means making sure we're culturally sensitive in the programming, in the very physical design itself. We think that putting that time forward now in that relationship is going to pay dividends for us as a partner with the Indigenous community. We're very happy with our relationship we have with Blood, and we are certain that because of that strong foundation we are going to have better outcomes going forward.

I'll let my department touch base on some of those details along with the cost per day on detox versus treatment as well.

Mr. Romanow: Perfect. Thank you, Minister. I'll maybe start there, with the costs for different bed rates. At the highest end, of course, the most intense treatment supports that are required and medical supports, detox is $300 a day. Again, it is, as was noted, a shorter stay but really trying to shift the supports and to be quite individualized. Very importantly, the pathways out of that, which generally goes into the next step down, which is into a treatment space: that's $150 a day. Again, that can be for an extended length of stay in a whole variety of treatment providers across the province. Then the next stage is through residential recovery, which is $80 a day.

7:30

To the question that was asked, Chair, about Red Deer, there have been roughly 150 individuals who have completed through the program over the first year. Of course, it did start up and wanted to make sure programs were well in place, but it is running at capacity or consistently very near capacity on an ongoing basis now, and certainly Lethbridge similarly is ramping up to being at full capacity. As the minister mentioned, the ratios are intended to be roughly one-third women to two-thirds men; continuously evaluating that, but it looks like a ratio that seems to be working for the time being.

Mr. Williams: I'll just add as well that it's important to note that the number of folks that have been through Red Deer – it was a staged opening. Largely when it goes through commissioning, it's a class-based progression, and folks will go almost as a cohort through this, and they'll have other individuals that have entered at approximately the same time as a part of their cohort. So we didn't just open it up all at once for a full 75-bed occupancy immediately. With advice from the provider and what we know around recovery, we first started with a smaller class. I can't remember the exact number, but think of a dozen or two dozen, perhaps, and then we introduced more as time went on and they progressed through. So it scaled up in that sense. Thank you, Chair.

I want to now address the MRP, which is My Recovery Plan. I appreciate the questions. It is an incredibly important piece of it. We are looking for evidence-based policy-making. We need to be collecting data, and right now a lot of the data we have in the system are EMS calls and tragic overdoses. That's important data to be collecting, for sure, something we need to be focusing on as an outcome, where we want to see: how are we improving the lives of Albertans, and how are we making this positive difference around the recovery model? But those are all latent indicators around data. We need to be understanding this earlier in the process. What recovery capital is – and I'm very glad the member focused on that – is a sense of, "Are you getting better over time? Are you working towards those goals and plans you have to be in recovery?" which isn't just to say abstinence, which isn't just to say sobriety and not using.

I had a very experienced individual – he's in recovery for about 40 years – that I met this last summer who told me that, for him, being in recovery is being a grandfather. For him, being in recovery is the ability to be a family member again to everyone that he wasn't for so many years of his life. He was a homeless opioid addict on the streets of Vancouver. The idea of recovery is something any government wants to see from a citizen. It means a fully formed citizen. It means a fulfilled life. It means a sense of gift to others and the ability to love and contribute back to the community and the society you come from.

The recovery capital index is this idea of: are you working towards those end recovery goals? For important clarification, it's an evidence-based metric, and it's also, when we look at the software we're using – and I'm going to have my team speak more to the rigorous work that has gone into privacy impact assessments, making sure we're following all the privacy legislation that's relevant, which is very onerous and is very important, so I appreciate the question. I'm happy to have them speak to it. But it's a not-for-profit organization that currently has it, that works in recovery, that we think is a great partner for us because they also see that we need not just those latent indicators but those earlier ones and a sense of: are we progressing?

I know we didn't get through all of your questions. I'm going to probably ask my team to follow up with some of those in our next block. I'm very happy to, and I think so far the questions have been very, very relevant to the work that we're doing on the recovery model.

Chair, back to you.

The Chair: Thank you so much, Minister. If you and your team would kindly direct the conversation directly through me, that would be much appreciated.

We'll move over to the other side for their questions. Over here. Yes. Go ahead.

Member Eremenko: Thank you, Madam Chair. If I may request, could I please, of the minister and his team that the answers further applying to the MRP be provided in writing. I do have a number of other questions to get to, so I want to make sure that we do give some of those some consideration.

My questions around recovery communities are not an endorsement of recovery communities. We are here precisely because we go through budget estimates specifically to avoid making assumptions, so to the minister: I appreciate that the recovery model is, of course, an important and real cornerstone program for this government. My concern is that the recovery model is at the exclusion of a whole other host of very important interventions that we need to be talking about, so let's try not to make assumptions. That's exactly why we're here, to ask clarifying questions and actually get to the heart of what it is that we're doing to support some of our most very vulnerable citizens.

The next batch of questions I'd like to ask is around prevention and early intervention, Madam Chair. Speaking of which, on page 103 of the business plan we talk about:

> This Alberta Recovery Model is focused on keeping communities safe while treating mental health and addiction as health care issues by working with health and community service providers to deliver services that span prevention, intervention, treatment, and recovery.

I'd like to focus on the first two stages listed in that comment right off the top, through the chair to the minister. Prevention and intervention: it currently receives a quarter of the funding that treatment and recovery is allocated in Budget 2024 and received a nominal increase of roughly $500,000 from last year to this. Through the chair, can the minister explain to us what they include in prevention and early intervention, in that particular line item of the estimates?

There is real truth, Madam Chair, to the saying that an ounce of prevention is worth a pound of cure. Recovery communities and the wonderful services CASA provide to youth are important, but they are ultimately reactive. How is this government going to address the wait-list to access AHS-funded counselling services? Indeed, counselling, therapy, well-funded, easily accessible counselling services are absolutely fundamental when it comes to prevention and early intervention to avoid significant mental illness and perhaps that downward spiral that can lead to both chaotic and entrenched drug use. So, as I mentioned, how is this government

approaching AHS-funded counselling services, that will very soon be within the minister's purview?

How is the $5 million for Counselling Alberta going to possibly be enough to support Albertans when for many, many families a deeply subsidized fee model is the only way they can access therapy? Nongroup coverage for clinical psychological services is up to $60 per visit – this is nongroup coverage – up to a maximum of $300 per family each benefit year, yet the Psychologists' Association of Alberta recommends a fee of $220 for a one-hour session. That $60 that Albertans currently cover is wholly insufficient and does not remove barriers to service. So, Madam Chair, what is the government's plan to bring the rate covered in the nongroup coverage plan up to a reasonable level so that people can actually consider that during this affordability crisis?

It leads me to a question that I have raised before with the minister. I know that there has been a recent development on this front and that the College of Alberta Psychologists has been proposed as the regulating body for counselling therapists. Objective 1.5 of the business plan highlights the need to enhance quality standards and legislative requirements guiding regulatory oversight and enforcement. Why has it taken five years to regulate counselling therapists in this province?

And with the sudden CAP announcement will the minister share how the initial concerns, the initial reasons and rationale for why the delay was so prolonged, which is largely around consultation with First Nations groups, Madam Chair – what is it about this new arrangement that suddenly has resolved all of those concerns that were at the heart of what they claim to be was the initial delay? There are 4,000-plus counselling therapists who are looking to be regulated, bring legitimacy to their profession, but as a result of these delays, as a result of not forming a college, we have compromised public safety, we have compromised value for those dollars that are actually being given to counselling therapists. I would like to hear further about how this recent announcement with CAP has actually resolved some of those concerns and what the new timeline will be to actually form a college.

Furthermore, on that particular note, Madam Chair, all public releases from interested parties reference the regulation of counselling therapists only. It doesn't include addictions counsellors. As we're talking about access to service and, certainly, this heavy, heavy emphasis on addictions and treatment, why wouldn't addictions counsellors be included in this regulatory environment? Why wouldn't this be a top priority for this government when we have an example, for example, up in Grande Prairie of a person who is hanging their hat and calling themselves an addictions counsellor after a proven record of having assaulted patients in a former capacity? Without a college there is no oversight over how she proceeds in her practice.

Furthermore, in the latter half of this block that we have here, Madam Chair, it's interesting to me that the minister mentioned that recovery communities are zero barrier. I'd like to ask right off the top: are they also zero tolerance? If a person does have those occasional relapses, do they have to leave the recovery community? How long do they have to wait before they are allowed to be readmitted? This raises some significant questions around equity in the recovery model.

7:40

Per outcome 2 of the business plan, "Alberta's communities and families have the capacity to support individuals pursuing recovery," $229.2 million has been allocated to expand access to high-quality mental health and care. Through the chair, can the minister tell us how the minister is focusing specifically on services for women, not just coed facilities but specifically for women? How will they accommodate women with young children or perinatal women who are about to give birth or who have just given birth? This, Madam Chair, is where we can talk about prevention and intervention. This is where we provide restorative care and where we can break the cycle of trauma.

Furthermore, on the topic of equity, has the minister considered in-patient or outpatient programming specifically for members of the 2SLGBTQIA-plus community? What is the minister doing to ensure safety for this group of people who deserve to access recovery services free of judgment, stigma, or hatred? Regions outside of Calgary and Edmonton are suffering under the weight of mental health and substance abuse in their communities, but there is a dangerous lack of service and supports. How is the GOA specifically addressing communities outside our two major cities?

Further, where are the considerations in the business plan to provide mental health and addiction supports for racialized communities, Madam Chair, many of which are predominantly first or second generation, where there is often prearrival trauma, PTSD, undiagnosed mental illness, and hidden addiction? Why is there no mention of culturally appropriate funding, service delivery, or programming aside from Indigenous communities?

To be clear, that is an incredibly important and terribly underserved community. There is good attention paid to First Nations, Métis, and Inuit communities in this Budget 2024, and for that I'm thankful. But to what end? In 2020 Blood reserve was told that they'd have a recovery community. Madam Chair, they have yet to break ground. To the minister: what specifically is the delay?

Through the chair to the minister, multiple First Nations have declared a state of emergency due to drug-related deaths: all of Treaty 6, Athabasca Tribal Council, Piikani in my home territory of Treaty 7, and Athabasca Chipewyan First Nation. What exactly does that entail by way of an escalation in response from the provincial government? How will the province step up to that call?

Lastly, how did the government select the First Nation communities that would receive one of the 11 recovery communities? I believe there are three, perhaps four, First Nations communities that have been assured that they would have a recovery community on-site, on-reserve, but as far as I know – and I welcome the minister to correct me on this, Madam Chair – it is none of those, not Treaty 6, not Athabasca Tribal Council, Piikani, or Chipewyan First Nation, that have all declared an emergency but have no recovery community on the horizon for them. To what degree did the minister ensure that there was equity and transparency in that selection process?

Furthermore, what is, once again, the timeline? When can people expect for shovels to be put in the ground, for the kind of planning and consultation and rigour that each of these communities independently deserve to ensure that there is a recovery community that is meeting their specific needs? Again, this is one of the big harms with recovery communities, that even though we're talking about 11 across the province, where is the outpatient programming that would be accessible to all corners and all communities of Alberta?

The Chair: Thank you so much.

To the minister for his response.

Mr. Williams: Okay. Well, thank you, Chair, for the opportunity. I want to start by talking a little bit more about MRP, just following up on that outstanding information for you right now, right here. I'm going to ask my deputy minister, because we got to the point where we were going to talk about the very onerous work being done with the department around privacy concerns. I'll turn it over to the department to start there.

Mr. Romanow: Sure. Thank you, Chair. To answer a couple of the many questions that were asked, I think, sequentially, MRP is absolutely a critical tool to let data inform wait-lists, to measure outcomes instead of just the number of people who go through the turnstile and are accessing. Absolutely, there is follow-up capacity with recovery coaches and other service providers once people are leaving the facilities, including alumni programs that start up. The aftercare is a critically important piece as part of that service. The government of Alberta will not be using information through MRP directly or in an identifiable way. It is in aggregate form only to better understand, to support, and improve the services for Albertans and, really importantly, ensuring tax dollars are being targeted to the interventions that are really working to save people's lives.

So, yes, it is helping to inform effectiveness and outcomes. It is not a mandatory barrier for individuals. If they're not willing, they will not be turned away. However, it is something that's being required with operators and gradually in making sure practices are in place so that they are using My Recovery Plan, because it deals with wait-lists. It helps us measure program capacity, the types of outcomes that we're seeing. Over 1,400 people have already used My Recovery Plan, and we are seeing, as is outlined in the business plan, as was noted, the targets and the types of outcomes from the positive benefits for MRP overall.

I think that answers a number of the questions that were asked, Minister, on MRP.

Mr. Williams: Thank you, Deputy Minister.

Understandably and rightfully, Chair, questions were asked surrounding prevention and early intervention. It's a big part of our model moving forward, understanding that it is one of the most difficult things in a mental health and addiction space to get right. Every jurisdiction in the world sees that as the policy Holy Grail, for good reason. So much pain and misery is averted when we can get and reach individuals who are on that precipice of a crisis or are going down the road of a serious addiction. Instead, we find and connect them with the resources needed.

Just some of the work we're doing here: $30 million has been allocated in this budget for initiatives that support appropriate crisis intervention and offer recovery supports where and when needed. The increase in this budget provides funding for initiatives that address the addiction crisis. Police supports enhance access to provincial helplines in the city of Edmonton and the city of Calgary initiatives. I mentioned some of them in my opening statement. That's why we're doing the $30 million in early intervention services this year, including $2.5 million for recovery coaches, who support individuals in the pursuit of recovery, and $10 million in support initiatives to address the opioid crisis. That's $1.8 million in Calgary and $3.7 million in Edmonton; $4.9 million is budgeted support for all 211 capacity assists in Alberta for all ages, access to critical addiction and mental health support services in the communities and connection. Then, in addition, $5.1 million is allocated for the mental health call line and gender-based violence crisis hotline. I'm happy to have more conversations surrounding prevention, because I think it's an important pillar for us moving forward.

When we talk a little bit about counselling, I'll just note that the nongroup coverage is a question for Minister LaGrange in detail, not something directly within my portfolio. But Counselling Alberta is a terrific resource, Chair, that every Albertan has access to, and it's important to note that with Counselling Alberta, when you call 211 or you go to Counselling Alberta directly, it's of zero cost if that's what you request. It's a sliding scale for access to those services. So if you're in a position where you can afford more and you're willing to go down that road, then you're very welcome to that. But the access is meant to reduce barriers as well, understanding we should be responsible for people who can and are willing and interested in trying to support through payment around that.

This is going to speak to some of the questions for access for rural Albertans as well, which I know you asked later on, and I'm happy to go more into those details at the time. It's $4 million in-year funds on a per-year basis to that end.

Through the chair, I think there were a few questions around zero barrier and if there's some connection to zero tolerance. I don't know if there's a misunderstanding. Maybe I'll just clarify the nature of the recovery model for folks who are following along at home to understand what we expect in terms of how this is supposed to work.

We want to reduce the barriers. For example, there's a $1,240 barrier that the previous government, under the NDP, had left in for those suffering from addiction. To get access to that monthly treatment, you had to find over $1,000 a month. Not particularly easy for those who are living in addiction to find those dollars. You can imagine where that often came from. This is meant to be universal health care coverage, and we believe it is life-saving health care, so of course we're going to reduce that. There will always be difficulties in any individual's life who's suffering from addiction, of course. When I say "zero barrier," I'm not saying that life is made easy for everyone all the time. I understand the struggles they go through. When I say "barrier," I'm saying that on the government side why would we throw up barriers we don't need to? That is the policy.

7:50

I'll tell you that in recovery communities it's largely self-enforced when it comes to this idea of being in recovery and abstaining from the use of the drugs. I can tell you my interaction with folks when I've been to Red Deer and Lethbridge and others outside of the ones that we've created. It's going to be tough to try and hide from other users if you're using. They will know, and they are a community. That word "community" is key. It's self-enforced and self-policed. If somebody does fall and end up back into addiction and using again, then it's a community itself that says: this isn't the right place.

It needs to be abundantly clear. This government is meeting Albertans where they're at. If they're in active addiction or if they're in recovery or they're in transition or they're in detox, if they're young, if they're old, no matter what their background is, to those questions that we heard later on, which I'm happy to get to, around minority groups across the province: it does not matter. We want to meet you there and help you on an off-ramp off addiction.

There are numerous Albertans that have been through recovery communities multiple times, and I believe that member has made that comment early on, that they recognize that this will be a repetitive process for some people. That's not prohibitive by any means. We are about recovery, and if any individual wants recovery, any political party wants recovery, any provider wants to provide recovery, then we are partners with you. That is my coalition, and it goes right down to the very individuals soliciting their services all the way to AHS and the biggest partners across the country when it comes to treatment.

I hope that helps you understand the culture of what we're doing.

Now, when it comes to particularly supporting women more broadly than that allocation of two-thirds, one-third, which – we set that allocation up broadly based on the data we understood to be the rate of addiction amongst men and women. But we also know that especially vulnerable women – women with young children are a

good example of this – need to have specialized care, so we have also funded beds to that end and spaces across the province to that end, something that I want to continue to scale up. It's particularly close to my heart as I see the very difficult challenges these young mothers have and all the capacity they have, if they go through recovery, of being terrific family members and mothers and citizens and individuals of our community again.

I'll let my department address some of the work we're doing around supporting women in addiction with children and families.

Mr. Romanow: Great. Thank you, Minister and Chair. A couple of the programs that we could point to for women and children as well as racialized communities I know was part of the question as well. Alberta's government is providing more than 4 and a half million dollars in funding over three years, for example, for immigrant and cultural-serving organizations, really providing some of the specialized mental health and addiction services and very much specifically targeted for children, youth, and families; for example, the Multicultural Health Brokers in Edmonton providing prevention programming and supports to immigrant and refugee children and youth in over 16 ethnocultural communities. As well, Albertans who are more comfortable accessing help in their own language can access and receive support from translators in more than 100 different languages through 211 and connections to mental health lines as well offering supports.

Mr. Williams: I think that that's helpful.

I just want to make sure I address a few other items, the questions surrounding regulation of counsellors and counselling therapists. Incredibly important space. Obviously, we're going to be continuing to do that. The particular questions asked are not relevant within the budget documents, as far as I understand. If you can point to a line item, I'm happy to address that spending.

When it comes to Indigenous communities – unfortunately, the member said, through the chair, that the harm with a recovery community is that we don't track them moving forward. Well, that's not a harm of a recovery community. The recovery community is doing great work, and we do plan on tracking . . .

The Chair: Thank you so much, Minister. We'll have to come back to you for more answers.

At this moment we'll turn to the government side. Please proceed, Member.

Oh, you've got – yeah. Sorry. I'm getting ahead of myself. All I can think about is my bed. Please, members, go ahead.

Member Eremenko: That's okay. That's okay. Thank you. I will move on. Thank you, Madam Chair to the minister, for the answers to some of my questions here.

I'd like to address performance indicator 1(b), really just kind of a clarification in terms. The minister mentions:

> The current focus of this indicator is on four client groups receiving new or expanded services. Involvement in one or more of these client groups, and an increase in program involvement over time, is indicative of a positive, wider system impact.

This has to do with the percentage of Albertans receiving care at an appropriate level. Minister, through the Chair, what are the four client groups? Just a pretty straightforward question that I hope we can get answered this evening.

Moving on to page 105 in the business plan, key objective 1.2 aims to "ensure every Albertan has access to high-quality recovery-oriented care to improve their overall well-being and help sustain recovery," while key objective 3.4 aims to "support initiatives to decrease the number of opioid-related overdoses in the province." Madam Chair, as many in Alberta know, we have experienced the deadliest year on record for fatal drug poisonings. From January 1 to November 30 Alberta lost 1,700 . . .

Mr. Singh: Point of order, Madam Chair.

The Chair: A point of order has been called.

Go ahead, Member.

Mr. Singh: Thank you, Madam Chair. The point of order is under Standing Order 23(b). The member "speaks to matters other than the question under discussion." The committee is convened for the purpose of considering the minister's 2024 budget, including estimates, fiscal plan, and business plan. The matter that has been raised by the member is not within the boundaries of the set topics. The matter that was mentioned by the member regarding the opioid crisis is outside of the topic at hand of the committee today. They are making it a point of order under Standing Order 23(b), warranting the member to be called to order.

Thank you, Madam Chair.

The Chair: Thank you, Member.

Opposition.

Ms Goehring: Thank you very much, Madam Chair. I do not believe that this is a point of order. The member clearly referenced key objectives and was speaking directly out of the business plan where it mentions opioid overdose, so I think this is absolutely within the realm of the discussion. I would argue that this is not a point of order as it directly relates to the words pulled right out of the business plan.

The Chair: All right, members. What I'll say about this is that when it comes to the minister's time to address the group, if he chooses to answer it, then we'll defer to him.

At this moment, please proceed.

Member Eremenko: Thank you. It has been five years under the UCP's drug policies, and we have the second-highest death rate in the country. The minister often compares Alberta to B.C., as he did in his opening comments, who have taken a decidedly different approach. Indeed, their death rate per 100,000 is higher, but there is an important consideration here: their death rate from 2022 to 2023 increased by 7 per cent; over the same time period Alberta's death rate increased by 24 per cent. If that rate continues, we will sadly surpass B.C. Through the chair, what does the minister have to say about Alberta's growing number of deaths and the steep increase in the rate of death from 2022?

To be clear, one of the objectives stated in the business plan is to support initiatives to decrease the number of opioid-related overdoses in the province. At what time will the government pause and ask itself if the Alberta recovery model is adequate? There's no doubt that there are more funds flowing to Mental Health and Addiction than ever before, but to what evidence can the minister refer that demonstrates value for that spend? Namely, does the minister believe that the Alberta recovery model follows best practice, data, and expertise in their investments in order to reduce harm and to stop people from dying?

Per page 165 in the general estimates, line 2.6 in the operating expenses, labelled Initiatives that Reduce Harm: in the description of supply, Madam Chair, this is defined as "funding to support supervised consumption sites, overdose prevention sites, and the provincial Naloxone program." Evidence shows that harm reduction is what saves lives and provides the opportunity for health-seeking behaviour that moves a person toward recovery. The budget has gone up by $5 million this year in comparison to the

fiscal year prior. We know that $5 million did not go to renewing a funding agreement for an Alberta-based mobile drug testing pilot initiative, and I have learned that the government has even constrained access to basic drug testing strips. Perhaps the additional $5 million will be used to make nasal naloxone kits free since people surveyed report they are more inclined to administer in nasal form than by injection, but they currently cost $120 to purchase at a pharmacy. What portion of line item 2.6 in the estimates is allocated to the operation of overdose prevention sites and supervised consumption sites? Through the chair to the minister, these services will be squarely within the purview of the minister following the transfer from AHS.

Through the chair, does the minister intend to close the overdose prevention site in Red Deer in line with the recent vote by Red Deer city council? And, through the chair, can the minister commit to keeping all current OPS and SCS open, the ones that are AHS operated, with adequate operational funding, knowing that we are in the throes of a significant overdose, drug poisoning crisis?

Excuse me; I've lost my other batch of questions.

8:00

The Chair: Take your time, Member. We've got a lot of it.

Member Eremenko: Thank you.

I'll move on to compassionate intervention. On page 114 in the fiscal plan 2024-27 – this is in the capital plan section – there is a line item for compassionate intervention implementation intake and assessment centres, with $5 million allocated in this fiscal year plus another $5 million in 2025-26. Furthermore, per page 105 in the business plan '24-27 key objective 1.3 is to develop strategic approaches, including a compassionate intervention framework, to expand access to timely and appropriate mental health and addiction services across the province to support individuals who are a danger to themselves or others. This capital plan allocation of $10 million over two years to build a compassionate intervention implementation intake and assessment centre is not congruent with the other Budget 2024 documents, which briefly touch on the framework. Budget 2024 is really quite lean when it comes to discussing what either of these investments are actually going to entail, Madam Chair.

As you can imagine, there are many reasons why Albertans should be deeply concerned about involuntary or mandated treatment for people who use drugs or who are addicted. The Premier and the minister have mused frequently about forcing people into treatment for lack of other reasonable solutions, so you can imagine that a capital allocation of $10 million certainly raises the eyebrows of many people who know about the history that leads up to this conversation. Through the chair to the minister, your government has been musing about mandated or involuntary treatment for several years now. What is this capital allocation? What is the $10 million allocation before a framework has even been established, before any legislation or policy or regulation has been introduced?

Though they are imperfect, there is PCHAD for minors, who can be forced into treatment for 14 days, give or take. There is the Mental Health Act; that does include chaotic drug use and addiction when that drug use poses an imminent risk to the person or to others. There are restorative justice practices and drug treatment courts that can mandate treatment. There are employers and child and family services who ostensibly mandate treatment and/or sobriety to maintain employment or custody/visitation. What is it, Madam Speaker – sorry.

The Chair: That's okay. I don't mind the promotion. It's fine.

Member Eremenko: Madam Chair, to the minister: what is it about our current legislation, the current host of programs that I've just referenced, the current policies and regulations that are inadequate to this minister?

Mr. Singh: Point of order, Madam Chair.

The Chair: A point of order has been called.

Please proceed, Member.

Mr. Singh: Thank you, Madam Chair. The point of order is under Standing Order 23(b), the member "speaks to matters other than the question under discussion." The committee has convened for the purpose of considering the ministry's '24 budget, including estimates, fiscal plan, business plan. The matter that has been raised by the member is not within the boundaries. We are not here to talk about the policies of any ministry; we are here to talk about the Budget 2024 estimates.

Thank you, Madam Chair.

The Chair: Thank you, hon. member.

Opposition.

Ms Goehring: Thank you, Madam Chair. I wish the member would listen along because the member was very clear talking about: per page 105, the business plan 2024-27, "Develop strategic approaches, including a Compassionate Intervention Framework." She's asking for clarity on that. I think it is well within the bounds of these estimates, and I do not think that it's a point of order.

Thank you.

The Chair: All right. Thank you so much, hon. member.

For this item again I will say that if the minister chooses to address it when he gives his remarks, we'll leave that there as well.

Please proceed, Member.

Member Eremenko: Thank you. As I mentioned, I'm curious about what both of these items in Budget 2024 are addressing that our current framework doesn't already, Madam Chair. Furthermore, can the minister discuss what a compassionate intervention framework and the capital bricks and mortar considerations are around the capital plan to build intake and assessment centres, what those are providing and whether they are filling a particular gap? And if so, what is that gap?

I'm curious. A conversation that arose previously that certainly is within the business plan for Mental Health and Addiction is around therapeutic living units. Does the compassionate intervention framework rely heavily on therapeutic living units in remand and corrections for implementation and operation? I would expect that if we are going to force a person into treatment against their will, there would need to be a certain amount of confinement or restricted mobility involved.

My last question in regard to compassionate intervention is that if the recovery communities, Madam Chair, are the panacea that this government is positioning them to be, with the same-day admission that people need them to provide, won't people be eager – eager – to voluntarily access detox treatment and then recovery in one of the government's new Alberta recovery-model-branded recovery communities? Won't they be eager to voluntarily access these programs rather than being forced into treatment? If they were everything that they were meant to be, we would not be looking at forced treatment. If they were everything that they were meant to be and truly zero barrier, then people would be, I'd expect, eager and pleased to be able to access the services and programs that are offered within its walls.

The Chair: Thank you so much, hon. member.

We'll move over to the minister for his response.

Mr. Williams: Okay. Well, thank you for the set of questions. Give me one moment here. First off, I want to start off by addressing a question that was asked previously surrounding how we choose which communities we put the four – not three but four – recovery communities that we're building on-reserve in partnership with Indigenous, First Nation communities. It first needs to be highlighted: the fact that we're doing this is noteworthy in an important sense and – I'll be a bit grand here – in a constitutional sense. The federal government has a responsibility on First Nation reserves, and they have absolutely abandoned them, Chair. It is so tragic to see First Nation chiefs right down to individuals that I meet in my constituency, in which I represent a very wide group of First Nations and Métis, or across the province, and you see them saying: "Please, can we have access to recovery? The government that is responsible for helping us in this very difficult state has abandoned us."

They're funding $100 million a year for SUAP grants that go towards so-called safe supply, and they just overlook the destitution that you see on these First Nation communities. If you talk to Chief Crowfoot, for example, in Siksika and you see the tragedy they're going through, they have choice words for a federal government that has, in their minds, obfuscated their responsibility. The provincial government has stepped up.

I'm going to let the department talk a bit about the details and how those particular sites were chosen because I think that's relevant. The member, Chair, is very right in that First Nations are disproportionately affected by addiction in our province. We have to step in where the federal government has abandoned its fiduciary responsibility to its First Nations in the province of Alberta.

Mr. Romanow: Thank you, Minister. Chair, in response to the question specifically with the Blood Tribe: yes, it absolutely has taken a bit of time to work in a very different and unique model on-reserve, in a space where provincial governments don't just go in and build facilities. We're pleased that there are contracts that are in place. The planning is under way. It took a model from a previous recovery community and really worked with the broader community – again, Blood Tribe is the largest First Nation in the country – and worked with the uniqueness of the community needs to establish what that design looks like. Construction is awaiting this season to hastily proceed. But it really was a new process. With the other four recovery communities, they're at varying stages of readiness. They are grants to the First Nation communities to be able to build on-reserve in an expedited way.

8:10

Those are some of the learnings from our earliest work with the Blood Tribe, and shovels will be going into the ground this summer, we know, with those communities. They are based on selection; the size of community, absolutely, starting with Blood Tribe; where we have gaps in any other services, like in southern Alberta; feasibility to have more than 100 staff available to move and work and live in that community, which obviously in very small communities is more problematic; and absolute willingness and support from the communities to have them on-reserve. These were all factors that went into those first selections of sites.

Minister.

Mr. Williams: Thank you.

I'll go on now to address some of the questions you asked surrounding drug poisoning, so called. I want to, Chair, address language used surrounding recovery communities being the panacea to addiction. I think it is very important that we look at: what is the panacea to addiction? Addiction is a disease of loneliness. It's a disease of isolation. It is caused often as a result of trauma and an alienation that comes out of the difficulty of an individual living and not receiving the connection and community they need.

The antidote, the panacea to addiction is not more drugs. The antidote is not facilitating more drug use, and drug consumption sites in every corner will not solve this crisis. It, by definition, cannot solve this crisis. By definition, what solves a crisis of addiction is getting out of addiction, and that, by definition, is recovery. I encourage all members opposite to be very serious and not flippant in the questions they ask surrounding the importance of recovery in this.

I want to go in now and address some of these questions around Alberta's record. Alberta's record, I think, is one of the terrific outcomes when you compare it to, say, British Columbia. As members of this committee have already admitted into the record, British Columbia has a higher rate, continues to have a higher rate, and in all likelihood has no serious plan to try and reverse that in any serious way. If they put drug consumption sites on every corner in Vancouver and they provided safe supply to every single possible user who's suffering from addiction, they would not see a solution. The only way out of it is recovery, and everything about a recovery model is trying to get people off.

Some of the successes that we've seen. Since 2016 deaths from pharmaceutical opioids have been reduced by 80 per cent. Since 2021 deaths from methamphetamines have been reduced by 41 per cent. Since 2021 deaths from cocaine have been reduced by 61 per cent. Since 2020 deaths from alcohol have been reduced by 60 per cent. And since 2017 deaths from benzodiazepine and different benzos have been reduced by 33 per cent. Now, that is a start, but it is not enough.

The truth is that we have to absolutely double down and focus on it. So we will continue to, using evidence-based research; for example, the Stanford-*Lancet* Commission, written by the world's furthest expert on the opioid addiction crisis, Dr. Keith Humphreys, who is the chair of the recovery advisory panel that I inherited, who is a past adviser to Presidents Barack Obama and George Bush and the current adviser in the White House to President Biden and is universally seen to be one of the best if not the single best expert. We are following the evidence put out in his research along with numerous others internationally on the path forward around recovery.

The Chair: Thank you so much, Minister.

We're going to take our five-minute break now, everyone.

[The committee adjourned from 8:14 p.m. to 8:20 p.m.]

The Chair: Well, hello, everyone. That was a very nice break. Let's resume our session here. We had concluded with the minister's remarks, and now we'll go over to the government side.

Please proceed, Member.

Mr. Singh: Thank you, Madam Chair, through you to the minister here. Minister, I will check your preferences. Do you want to go back and forth, or do you want block time?

Mr. Williams: I guess I'll go block time. Whichever works.

Mr. Singh: Thank you, Minister, and thank you for supporting addiction response and recovery-oriented programs that will help Albertans access prevention, intervention, and treatment-focused health care. I applaud your efforts and commitments to such initiatives.

My question is on therapeutic recovery communities. The delineation of outcome 2 within the ministry business plan highlights an aspect of Alberta's vision for supporting individuals in their journey towards recovery from various challenges, including addiction and mental health issues. The outcome underscores the crucial goal of empowering communities and families throughout Alberta to become active participants in fostering an environment conducive to individual recovery. Its areas of focus include building and operationalizing new recovery communities.

The emphasis on building and operationalizing new recovery communities signifies a proactive approach towards addressing the multifaceted needs of individuals seeking support by investing in the establishment of these specialized communities. Relating to that support by investing in the establishment of these specialized communities, can you please tell us about the current progress in building and operationalizing these recovery communities? Could you please elaborate on how these recovery communities will help support individuals pursue recovery? Recognizing that people in addiction require more than just – to achieve full recovery, how will recovery communities impact other areas of a person's life?

Minister, a significant initiative of this government's approach to a comprehensive mental health and addiction system is recovery communities. Recovery communities are a major addition to our province's infrastructure and a key factor in transforming Alberta's health care system. I have had the opportunity to learn about these recovery communities and the innovative role they play in Alberta's recovery-oriented continuum of care. I understand the Red Deer and Lethbridge communities have already opened to a positive reception, with nine more on the way to be opened across the province.

More especially, I see the partnerships with First Nations to build four recovery communities in Enoch, Tsuut'ina, Siksika, and Blood Tribe as an opportunity to make significant investment in these communities and ensure that they are high-quality, land-based, and culturally appropriate services for Indigenous people. In the business plan we see recovery communities as a key contributor to the success of outcome 2, Alberta's communities and families have the capacity to support individuals pursuing recovery: page 106, ministry business plan. Minister, could you provide us with an update on the two communities that have opened so far? Multiple other recovery communities are in development. Could you please provide us with a status update and timelines for these other communities?

I'll focus my question on addiction and mental health systems. Minister, mental health and addiction are very important issues. This government recognizes this fact, and what we see in this year's budget documents reflects this position. Addiction and mental health truly require an entire system with wraparound supports. These are complex issues that are served poorly by a piecemeal approach, and to drill down on that point, that means that individuals suffering from mental health and addiction challenges are poorly served by a disjoined approach as well as those around these individuals.

I'm happy to see this government is prioritizing a holistic approach to these very large challenges. Outcome 1 on page 105 of the business plan demonstrates this with the goal of ensuring that "Alberta has a comprehensive, integrated, and responsive recovery-oriented addiction and mental health system." This is supported by objective 1.1, which is to "develop a new mental health and addiction system, as part of a refocused health system, to better support Albertans experiencing mental health and addiction challenges." Minister, as much as possible to summarize a very large reform, could you please provide a brief overview of your approach to building a new comprehensive mental health and addiction system? Why is now the right time to make this change here? Thank you, Minister.

With that, Madam Chair, I will cede my time to MLA Bouchard.

The Chair: Please proceed, Member.

Mr. Bouchard: Thank you, Madam Chair. Looking at the estimates for the Ministry of Mental Health and Addiction, I think I speak for the members on our side, hopefully from the opposition as well, when I say that we're very impressed. Looking at line item 2.8, we see the $1.13 billion that was not part of the budget last year. The government announced significant changes to the health care system, including how services are delivered for mental health and addiction-related care.

Now, given that this $1.13 billion is now being managed directly by the Minister of Mental Health and Addiction, I believe it reflects a commitment on putting an emphasis on the importance of these services, especially as it was previously a nonspecified area of AHS that did not get the oversight or management from government that it deserved. With that in mind, I have a few questions around health care refocusing as it relates to mental health and addiction services. Why is this an important part of building the Alberta recovery model? How is the government bringing in more accountability to trace outcomes of mental health and addiction services currently provided by AHS? The $1.13 billion is a massive investment. At a high level, how will this investment be used to help Albertans?

And one more. Big change is rarely without criticism. Minister, how would you respond to criticisms of this action to create a new mental health and addiction system or allocating this kind of money to support this new direction?

One more question on this $1.13 billion infusion, still on page 105 of the business plan. It's clearly a major investment and one that I think well warrants our time today. With this type of major investment into the mental health system, it's important that we discuss how we're going to measure success, looking at both timelines and performance metrics. I'm bringing this up because my constituents ask me when these health care changes are going to be implemented and what they're going to look like for us, so I'm always keeping my constituents and their health care service delivery top of mind when looking at the end result of this type of investment.

As with any government investment, it will be critical to continually evaluate and ensure these funds are in fact moving the needle in the right direction on government targets. Looking at pages 105 and 106 of the business plan, we see two performance measures. One performance measure is outlined with specific annual targets which look at mental health and addiction-related emergency department visits; however, the second performance metric is still under development. That's the percentage of Albertans receiving care at an appropriate level. Page 106 of the business plan indicates that baseline data will be collected on this performance indicator in 2024-25.

8:30

The Chair: Thank you so much, hon. member.

We'll go to the minister for his response.

Mr. Williams: Thank you, Chair, and thank you, members, for your questions. I'll do my best to answer the questions. Again, there are a number of them. I am going to start by answering a previous question around the four client groups that are included in the funding, asked by a previous member. Those would include supervised consumption services, virtual opioid dependency program, therapeutic living units, and residential addiction treatment.

Also, I'll just address quickly the question around drug testing, and I'm happy to get into more detail on these questions afterwards. Drug testing and naloxone have been things that have been presented to us as possible policies. I'll let my deputy minister speak to some of the evidence-based information that has informed us and where we've arrived so far.

Mr. Romanow: Sure. With respect to drug testing, Chair, some of the evidence I know that we've been following, including through the Canadian centre on substance abuse, does point to drug testing not actually necessarily changing behaviours in drug use. In fact, looking at fentanyl and others, individuals are still continuing to use after testing and are not being thrown away. So there's problematic behaviour to suggest that that's a concerning place for investments, which has led to a pause.

Additionally, on the naloxone side, questions with nasal naloxone: it's three times the cost. We did do a pilot project supporting that being implemented in Edmonton: three times the cost and oftentimes reporting that it required an injection of naloxone afterwards, so the efficacy was a concern. Between cost efficacy and wanting to make sure that we've got the most kits available in the hands of Albertans, over $10 million a year going towards that. That's where continued attention has been focused on the intravenous side.

Mr. Williams: Okay. Thank you.

I'm going to continue on with some questions I received as well, Chair, if it's all right with you. A lot of the questions I received are surrounding the recovery centres themselves. As members will know, there are 11 recovery communities across the province that we're planning to build. We still have an announcement for one more Indigenous lead in that, but four of those are Indigenous, partnering directly with the First Nation communities, both in the capital piece but also going forward operationally, making sure that we're with them. So stay tuned for more to go. That's $99 million in this year alone just for the Indigenous-led pieces. This kind of investment is really unprecedented, and it's not simple lip service. This is the closest thing to fulfillment of reconcili-action that I have seen in my time in my Ministry of Mental Health and Addiction. I'm incredibly proud of it and the kind of relationships that can be forged because of this kind of putting our money and our actions where our mouth is, and looking to partner and walk with First Nations has just been an incredible experience.

That also has informed our approach around culturally sensitive and culturally appropriate treatment spaces. So much of that sense of making sure it's culturally appropriate comes from the fact that First Nation and Métis Albertans are disproportionately represented in the addiction crisis, rates that are just so hard to see when you look at the human cost of what that is. The treatment centres themselves are focused on how we can partner with them, taking evidence-based medicine and the proven path of treatment via recovery and marrying that thoughtfully with the lead of the First Nation itself. That could be Blackfoot. That could be Cree. That could be any number of others across the province that we partner with.

The question of, really, "What is recovery?" came up as well, and I think that's an important piece. I touched on it early, but I can't overstate how recovery is not simply a question of abstinence. If you look at the nature of what addiction is – and what we're going through is an addiction crisis – the language here is incredibly important. We're not going through what some activists in the media or in certain spaces of the radical activist world say; it's not a toxic drug supply that causes the problems. I'll be honest. All the different supplies of drugs that people use recreationally that lead to addiction are toxic. All of them; it doesn't matter. The idea that somehow there's just some that are toxic and others can be used safely as a lifestyle choice or something is beyond comprehension.

When you talk to people going through recovery, you understand that it's addiction that is the crisis that we're facing, and addiction is a disease of loneliness, of isolation, that leads often and, tragically, through trauma and often, tragically, through intergenerational trauma, to more and more use. So recovery is reparation of relationships. It's repairing and being in reconciliation in the most intimate possible sense with yourself and those around you so that you can have a balanced, fulfilled life again. That's why I often talk about how being a mother or a brother, as examples, is a good idea of what it is to be in recovery, not simply abstinence, not simply sober but being a family member and a community member and a citizen of a beautiful country and province again.

We did talk a little bit about the Red Deer facility as well. Red Deer and Lethbridge both are open, 75- and 50-bed facilities. The First Nation component is incredibly important, with $99 million that is being invested this year. Some of the reason that we chose where we did is that we looked at where there was a high need and a high population of First Nation and, more broadly, Indigenous who are struggling, and we look for willing partners who are talking to us and asking.

Of course, the demand is always growing, and there are more and more requests all the time. I'm working to try and meet those needs as they come up. But I want to do what I can to make sure that we get these 11 facilities built as quickly as we can within the law that we have for infrastructure, which is a giant frustration at times. We have all sorts of checks and balances, appropriately so. But as members of this committee have mentioned, it's life and death for those who can't receive access, and that's why it's so absolutely important that we start doing this and we start doing it right away. We have limited resources in the budget. That's the whole purpose of our exercise here in estimates today and the budget itself and the nature of our very parliamentary system: we have limited resources. How do we prioritize them? This government has been emphatic that we're going to prioritize them with making sure that we have recovery centres.

Mental Health and Addiction was also brought up by a pair of members as well. I want to address that in a broad sense. If we look at five years ago, before the United Conservative government took office, there was no Minister of Mental Health and Addiction, there was no Associate Minister of Mental Health and Addiction. There may have been a director and an assistant deputy minister buried somewhere, but this government has taken a different approach. This government has said that this is a serious policy space, one that Albertans want to focus on, and we went to, first, an associate minister. As we saw the capacity grow within the department and the need for this and the policy space build out around recovery, that's when we expanded, and thankfully the Premier appointed, just over a year ago, a full minister to this and the budget that I inherited. In the previous budget – look up the operational budget in the previous year's document. It was $275 million thereabouts. We're now at $1.55 billion, as the member mentioned. Chair, I can't tell you how absolutely important it is that Albertans see actions to believe what we're doing here. I think that point is incredibly real.

You can see an increase of double digits, no matter how you want to slice this pie, when it comes to the Ministry of Mental Health and Addiction. That doesn't include the $1.33 billion that we're inheriting from previously AHS, and those services are going to go to augment and focus them on recovery in both the mental health space and in addiction space because every single Albertan deserves the right to have access to recovery.

One of the questions asked was surrounding criticisms and how I'll respond to criticisms as we go through this very big change. I appreciate, through the chair, that that is an important question. I appreciate that making important changes will have opponents or at least those who, fairly, want to ask questions for review. That's the nature of our legislative body, and that's the nature of an open and democratic society. But I'll challenge anyone to come to my community or bring me to their community and tell me that the system we inherited in 2019 was working, especially when it comes to mental health and addiction. I would challenge them to come to Manning, where I had a town hall around mental health and addiction in my constituency, and that community was rallied as they saw a tragic suicide in their community. Unfortunately, had we been doing this transformation earlier, we may have been able to prevent some of these tragedies from coming out and destroying communities and families.

So the criticisms, of course, and the scrutiny are important, and I appreciate that question, but we aren't making decisions in a vacuum. We're making these decisions with real options in front of us. It's not that the grass is greener on the other side no matter what. All members need to realize . . .

8:40

The Chair: Thank you so much, Minister.

We'll move over to the Official Opposition for their questions.

Member Batten: Thank you, Madam Chair, and thank you for the opportunity to speak today. I would like to focus on child and youth inside this . . .

The Chair: Is your request to go back and forth or block?

Member Batten: Oh, I'm sorry. Would you like to go back and forth?

Mr. Williams: I'll stick with block time. Thank you.

Member Batten: Okay. Apologies. So block time, then.

Just starting off with the – in the business plan it states on page 103, "The Department is accountable for responding to addiction or mental health-related recommendations from the Office of the Child and Youth Advocate." That will be predominantly what I am focused on, of course, relating it back to the budget.

The last annual report from the OCYA indicated that there were 33 mandatory reviews that they did on tragic young deaths of children who were in care between April 1, 2022, and April 31, 2023. Twenty-two of these youth, so 67 per cent, contained specific mentions of mental health concerns, substance use, or both, and at least 16 of the 33 youth who died were from drug toxicity, 49 per cent.

Young people are dying. Although this fiscal year is not yet done – we have one more month for the advocate to report the deaths from this month, and we do know there have been a handful of them – what we do know is that 2022-23 was the most deadly year on record, with 50 deaths, and we continue to see that same trend.

The Chair: Hon. member, we're here for main estimates, so if you would kindly ask your questions to the minister. Please get back on track.

Member Batten: Perfect. My next line was that page 165 of the budget, line 2.7, shows a cut of $22 million from what was forecast in the last budget. In addition to that, I also noticed there's a $26 million addition in capital grants. Through the chair, can the minister explain the decrease in funding for the front-line interventions? Can the minister provide insight into these grants? And, through the chair again, can the minister explain how shifting resources from the ongoing front-line resources for these young Albertans is smart, to move it over to, well, apparently, it looks like, capital?

Further recommendations. Again, these all do connect to the budget in that these recommendations – as I read before, the business plan does state that they are accountable for responding to these recommendations. Really, a lot of my questions are asking for specific actions that the ministry has taken and where that funding is coming from inside this budget.

Going on to another recommendation that has not yet been completed by the ministry, there was a recommendation – again, reminding everyone that these are recommendations that come from tragic deaths of young people, right? This is very serious, so when these recommendations are made, it would be in all our best interests that they are actually applied. In fact, earlier the minister had mentioned that, you know, we need data; we need something to substantiate what we're doing. This is data, and this is data that's been provided to this government since the advocate was first moved out of the ministry.

Anyhoo, there was a recommendation back in June 2018 – I'm not kidding you; these things have been in there forever – where we are looking for health promotion and age-appropriate substance use education in junior high and high school curriculum. My question is: where is any of that activity happening in the budget? Which budget line would I find it under? Again, the business plan states on page 107, under outcome 3, key objective 3.3, "Evaluate and expand access to mental health supports for youth in schools and in community to promote positive mental health, prevent severe mental health issues from developing, and provide treatment for students with mental illness." Through the chair to the minister: what do these supports look like specifically? Which budget line can I find the funding for these supports?

Further, outcome 3, again in the business plan, page 106, indicates, "Albertans have access to high-quality, person-centred mental health and addiction programs and services." It specifies "Integrated School Support Programs" as a priority for this government. Again, through the chair to the minister: should Albertans expect more professionals in school to offer these services and supports, or is this another that may not be addressed? Again, through the chair to the minister, if the minister is not able to answer these questions in the room, I would happily accept answers in writing, which might provide the minister the opportunity to connect with fellow ministers, like Education, for instance.

Thank you.

The Chair: All right. Minister, we'll move over to you for some answers.

Mr. Williams: Okay. Thank you very much for that. Starting off focusing around children and youth in the budget: I appreciate the prioritization of that, and I'm very happy to speak to it. We have a number of different programming items that move forward when it comes to youth and family, particularly partnering with other ministries but, of course, also within Mental Health and Addiction. For example, an increase of $10 million from last year's budget will support the expansion of youth mental health and additional youth recovery services; for example, $7 million increase in CASA House expansion operations – that's CASA House, not CASA classrooms, which was a separate item – and then $3 million for youth centres of excellence.

Before I pass off to ADM Everington to answer in a bit more detail around this with some of the programming, I also want to address this tragedy where we see families in a cycle of addiction,

and that intergenerational trauma is very real. Addiction is something that is just so toxic in how it can affect family life. So many of these young Albertans who end up in overdose and tragic deaths due to addiction: there are multiple generations involved there. It reinforces, and rightfully so with the question, that we absolutely need to double down on our effort to break that cycle of addiction not just with the children, of course, who are innocent victims in this, but also with the parents, who are Albertans with dignity, who deserve an opportunity at recovery as well. So that is a lot of what I'm planning on doing.

I'm going to go to my ADM to give some more detail on that children and youth piece to make sure that we get into the record a lot of the programming we have.

Ms Everington: Thank you, Minister, and thank you, Chair. You're absolutely right. The Ministry of Mental Health and Addiction receives recommendations from the office of the Child and Youth Advocate. We take those recommendations very seriously.

The Chair: Pardon me. Through the chair, please.

Ms Everington: Oh, sorry. We take those recommendations very seriously and ensure that we are responding. To the member's question about the overdose deaths and recommendations from the OCYA related to those deaths, in response to the OCYA recommendations we have established the virtual opioid dependency program youth team. This is a team that's dedicated to supporting youth receiving child intervention services, with a specific focus on those in group care. This stemmed directly from a recommendation from the OCYA.

Also, just in relation to the question around element 2.7 from the budget and the child and youth programs that the ministry is making available to Albertans, we have the mental health capacity building in schools program, which is offered by Alberta Health Services. This program works to promote positive mental health in children, youth, and families and community members who interact with those children and youth. Each program is locally planned, co-ordinated, and implemented, and supports might include things like mental health promotion and prevention programming for students, referrals to community service providers for specialized services. They'll do classroom and school-based presentations, support events and campaigns targeted to students. So just a number of school-based mental health supports that are happening there. Included in this is supports within 17 schools on First Nations and supporting Métis settlements.

We also have, operated through Alberta Health Services or funded through Alberta Health Services, the honouring life program, which is really a youth life promotion and suicide prevention program developed to support First Nation and Métis communities by building capacity and mental wellness, resiliency, and healthy lifestyle promotion.

The member had questions about CASA classrooms. We have a number of those classrooms opening across the province and certainly an expansion there, which I think the minister spoke to earlier. Then we've also got, to the question directly around the integrated school support program, which is a comprehensive health model that provides children ages five to 15, again, in schools, with prevention and early intervention wraparound supports. There are expansions planned for that as well.

8:50

Mr. Williams: Thank you.

With the time remaining, I just want to clarify line 2.7. It needs to be clear, and I can understand the confusion. Because we front loaded money from our Canada health transfer into forecast '23-24, it may look like there's a decrease, but in fact when you look at it and read it, it's an 11 . . .

The Chair: Through the chair, please, Minister.

Mr. Williams: Yes, of course, Chair.

Chair, if you look at it, you'll of course see it's an increase of $11 million.

The Chair: Thank you so much. That concludes that portion.

We'll move over to the government side for their questions.

Mr. Lunty: Well, thank you, Madam Chair and through you to the minister and his staff for joining us this late into the evening. We're almost hour nine into our nine hours of budget estimates. To underscore some of your comments earlier, this is an incredibly important topic, and I'm happy to . . .

The Chair: Sorry, Member. If you would just kindly clarify if you're going back and forth or if it's going to be block time with the minister. What's your preference?

Mr. Lunty: We'll stick with the block.

The Chair: Does that work for you, Minister?

Mr. Williams: It does, yes. Thank you.

The Chair: Okay. Let's proceed.

Mr. Lunty: Thank you, Madam Chair. Yeah. Just reiterating, you know, what important work is going on in the ministry, and I'm certainly happy to ask some important questions on some specifics. I do have a number of topics I hope to get to here. I'm going to start with the therapeutic living units. This is on page 103 of the business plan. The second bullet mentions providing therapeutic living units and access to discharge planning and transition for clients in Alberta remand centres and correctional facilities.

We know that a significant percentage of Albertans struggling with addiction finds their way into the criminal justice system and oftentimes have completed their sentence without support for their addiction issues and are released only to continue the destructive lifestyle of addiction and crime. As we see the ever-increasing concerns around public safety in our communities, much of it related to addiction issues, it just makes sense that we would look to utilize an option of recovery at the same time as a prison sentence.

We know that access to discharge planning and transitional supports underscores the commitment to continuity of care beyond the confines of the correctional facilities, and it involves comprehensive planning and co-ordination to ensure that those leaving the remand centres or correctional facilities have the necessary resources and supports in place to reintegrate into society.

Of course, as always, through the chair to the minister: how does incarceration look different for Albertans with addiction accessing these therapeutic living units compared to the general prison population, and what opportunities will they have to access support that will help break the cycle of criminality and lower reoffending rates and pursue meaningful recovery?

Through the chair to the minister: can you confirm how many therapeutic living units the province currently operates and how many more we can expect to have by the end of '24-25?

Obviously, it's a very important topic, but I would like to switch topics for the minister as well, through the chair, and talk about crossministerial partnerships when it comes to our recovery-

oriented system of care. For specific reference, this is in the first paragraph of page 104 in the '24-27 Mental Health and Addiction business plan. It states that

> Mental Health and Addiction works closely with health, public safety, justice and social sector ministry partners, all of which have an active role in establishing recovery-oriented services and policies for Albertans experiencing mental health and addiction challenges.

I know I've heard the minister speak on the need for these partnerships, numerous opportunities, and would certainly agree that these are very important partnerships. Through the chair, can the minister please describe which ministries he is partnering with in support of the recovery-oriented system of care and the work that you're doing with those ministries? Also, why is a crossministerial focus necessary to accomplish the mandate of the Ministry of Mental Health and Addiction?

I think that's two. I know it's late, but I'm going to try to squeeze one more topic in here, Madam Chair, and that, of course, is related to police and public safety. This is incredibly important for me, living in the capital region, needing to take public transit sometimes. I have friends and family who work and live downtown who are also on public transit, and oftentimes tell me they don't feel safe. So it's very important that we get a chance to address this issue.

I'd like to reference, through the chair, page 105 of the business plan, outcome 1. Key objective 1.4 states, "Support initiatives to expand police services' access to tools that support Albertans' . . . recovery while keeping communities safe." Through the chair to the minister: what specific strategies might be employed in equipping police services with tools to support individuals in recovery and ensure community safety? What sort of situation would a PACT or HELP team respond to, and what community-based organizations are partnering with police services?

I was able to sneak three topics in there. My block is running out, but I'd just like to close by once again thanking the minister and his team for joining us tonight.

The Chair: Thank you so much. Well timed.

Minister, for your response.

Mr. Williams: Thank you, Chair. I'll do my best to direct my comments through you. Thank you for your diligence on that point.

On the question surrounding therapeutic living units I'm very glad that it was brought up, Chair, because it's something that hasn't yet received as much notoriety and coverage but is such an integral part of our Alberta model. I remember visiting the remand and correction facility in Lethbridge, speaking to the director, the warden effectively, and I asked: what percentage of the folks coming through your doors who are remanded or sentenced are struggling with a serious addiction? And the individual told me that probably 9 out of 10 indicate so on the intake form, and 1 out of 10 aren't exactly telling the truth. If you saw a Venn diagram of those who the minister of public safety and Minister of Justice interact with on the other side of the law and you saw the folks that end up in serious addiction, you would see near perfect overlap. That's not a condemnation; that's just a recognition that we're going to need this crossministry, nonsiloed approach to dealing with addiction.

We have a group of individuals in our correction facilities that are disproportionately affected by addiction, that have had an intervention of sorts in the broadest sense of the word. An arrest from the police and a trial of some kind perhaps and charges being laid against you and perhaps even a sentencing: that is a serious moment in someone's life. If any one of us along with any of our family members ended up in that spot, they would also be in a spot.

The therapeutic living unit is what allows us, for example, in Red Deer to take people out of the general population and let those individuals voluntarily say: I want to start working on recovery, and I want to do it now. I had this wonderful example when I visited there – I have been there a number of times – just earlier this month where the individuals there were transitioning out of the therapeutic living unit into the recovery centre that otherwise wouldn't have been there had we not built it in Red Deer. There was this beautiful sense of continuity of: what is the continuum of care around recovery in the province of Alberta in action?

I want to go and talk more about those in detail, but I want to just touch base about the second question that was asked, through the chair, by the member, and that's surrounding the need for partnership between ministries when it comes to ROSC. I think the best example of this in recent concrete policy-making, which has been a huge success as far as I'm concerned for my ministry: that's the recovery navigation centre established in Red Deer when it came to the encampments. "Encampments" is such a euphemistic term. It is not like camping in Jasper on the weekend. There have been not just reports but verified media reports of rape happening; violent sexual acts from people who are not even in the encampment, who are walking by; lacerations; violent acts; claims of extortion; claims – pardon me. That was in Edmonton, not in Red Deer, the navigation centre. Thank you for the correction. Claims of – I mean, I think that we saw that a *Lord of the Rings* style battle-axe was taken by the Edmonton police at one point. We all saw those horrific images. This is not a safe place to be.

9:00

The navigation centre, the recovery and navigation centre in Edmonton, allowed us to be able to partner with Service Alberta when it came to getting IDs, when it comes to the virtual opioid dependency program in my ministry, when it came to connecting folks with short- and long-term housing options and Minister Nixon. We see a lot of that coming together. There is no way that I'll be able to accomplish my goal in the recovery-oriented system of care in a silo of my own ministry. I'm going to need all of these different tools.

Just because I only have a limited amount of time and they were all very good questions, I want to address briefly this question around public safety. Public safety, Chair, is just such an important, key aspect. Obviously, my ministry is not a criminal justice ministry; I don't want to become one. This is a health care ministry, and we believe, from a health perspective, that being in addiction is devastating. We know the evidence shows that running its course, for example, an opioid addiction will end in death if we don't get someone into recovery. Those two stark, dichotomous options are beyond comprehension if this is your family member in it.

From a question of safety for that individual, the dignity of that individual struggling but also a wider community safety question, that is why we're building the model. I'm happy to address further some of the things we're doing, and of course moving forward with a compassion/prevention future will be a part of this broad set of tools we have.

The Chair: That wraps up the government side.

We'll head over to the Official Opposition.

Member Eremenko: Thank you, Madam Chair. Speaking of health care, that's a good segue to my next set of questions. I assume that we will continue to do block time.

As per page 105 of the business plan, Madam Chair, 500-plus contracts valued at over $1.13 billion will be overseen by the Ministry of Mental Health and Addiction. Those were contracts that

previously fit under the umbrella of Alberta Health Services. The business plan states that they will be with AHS until "spring 2024." Today, believe it or not, is the first actual day of spring. What is the status of this immense undertaking, and will the minister please provide us with a timeline and next steps?

Through the chair to the minister, in the budget highlights the government referenced $1.55 billion in total expense to continue building the Alberta recovery model. What is the breakdown, to the minister through the chair, of that $1.5 billion between Mental Health and Addiction and, further, between child and youth, adult, and senior care? Considering that the Ministry of Mental Health and Addiction will be taking on this massive new mandate as the lead on the new mental health and addiction organization, I trust I may ask some questions regarding AHS service and program delivery, particularly in consideration that that transition will, according to Budget 2024, have begun today.

A study released in *Molecular Psychology* identified the required number of psychiatric in-patient beds to meet the needs of a population. Sixty beds per 100,000 population was considered optimal and 30 beds the minimum in high-income countries. AHS reports in their 2022-23 annual report that there are 703 psychiatric acute beds and that this includes beds for both adults and for children and youth. When we're looking at 703 psychiatric acute beds, that equals 15.8 beds per 100,000. When we take out the beds for children, it equates to 588, which is a rate of 13.2, less than half the minimum recommendation, Madam Chair. The average, by the way, in Canada is 30. Through the chair, what will the minister do to improve those figures when he takes over from AHS, beginning today?

There is a significant and dangerous backlog in psychiatric hospital units that puts staff and patients at risk. Through the chair, how long do people spend on a psychiatric acute-care unit? Please provide mean, median, and 90th percentiles. Happy to take that information in writing if it's not available this evening.

There are five stand-alone psychiatric facilities in Alberta. Through the chair, can the minister tell us the wait times to secure a bed in any one of those facilities, and does the minister plan to increase beds in stand-alone facilities and in community mental health?

Where housing is exceptionally scarce and cost prohibitive, how is the minister advocating for increases to permanent supportive housing for a population that is at risk of harm, exploitation, and violence? Unfortunately, stigma continues to abound, Madam Chair, when it comes to mental illness, particularly with some of the psychosocial disorders such as schizophrenia and bipolar disorder. It is a population that is unjustly stigmatized and judged. They are at significantly greater risk of violence, of being the victim of violence than being a perpetrator. But for all the latest rounds of funding for affordable housing, I see a real lack of permanent supportive housing. I'm curious about how the minister is co-ordinating with some of his colleagues in Seniors, Community and Social Services to discuss how we can better support folks living with a serious mental illness.

Back to the psychiatric acute-care beds: I have a couple more questions on that front. Is there pressure to discharge mental health patients to unsuitable environments to relieve ER wait times? We know, of course, that the strains on the health care system, Madam Chair, are dramatic at the moment. Again, Mental Health and Addiction is taking on a significant new mandate. For a relatively new ministry I hope that we are going to be approaching this new mandate with a great deal of rigour and discipline. How is the minister going to be making sure that people are not falling through the cracks in that transition, where because of those strains and because of the limited resources people are not going to be kicked out into environments and circumstances that are not going to be conducive with their long-term well-being and with the safety of themselves and the community?

Lastly, where is the funding for day programming, outpatient services, community and family supports so that individuals with complex mental illness are not isolated on their own and that their loved ones are not abandoned, navigating a system that they are not familiar with?

The Chair: Thank you so much.

To the minister for the reply.

Mr. Williams: Okay. Thank you, Chair. I'll do my best to get through the questions.

I want to start by talking about a previous question asked by members surrounding compassion intervention. The policy framework is under way. We're working on that. It is something that we do remain committed to.

I want to stress that the language around that the government has mused quote, unquote, about moving forward with compassioned intervention is wrong on two fronts: one, there's no musing; we are moving forward with compassioned intervention; and, secondly, there's nothing amusing about the idea of leaving somebody in minus 40 weather who has a drug-induced psychosis that could be from a speedball – a methamphetamine with an opioid – living on the streets in Edmonton, for example, in the middle of winter. There's nothing amusing about that. That is not the way a compassionate society addresses the most dramatic crisis an individual can face in their life because of the physiological and psychological dependence on that addiction of the opioid. For example, many individuals with an opioid addiction will lose one-fifth or a quarter of their body weight. They won't eat because that desire to consume the opioid is higher than the desire to feed oneself. There's nothing amusing about that, Madam Chair. We are absolutely serious about intervening to help those compassionately and not leaving them on the street. There's nothing more un-Canadian than leaving our fellow Albertans and Canadians and family members and community members there, so we are moving forward.

Of course, as the member has mentioned, Chair, PCHAD and the Mental Health Act do exist, but they are not suitable for someone who is a danger to themself or a community solely because of their drug use. That is what this act is going to be addressing.

I want to particularly in this moment, before I get on, quote Chief Crowfoot, who said this last summer, as we partnered with them in the MOU signing for the building of the recovery community in Siksika, when he was questioned by the CBC, of all organizations: "Our way is to intervene. We are not raised to sit back and let somebody self-destruct. We want to be able to do something before we are going to funerals. We have individuals that are harming themselves and are harming community. Why would you just sit back and say, 'Oh, well, that's Johnny's choice'?" He continued on to say, Madam Chair, that what we're doing in the government isn't as far as he would like to see us go, but we will continue to move forward thoughtfully and in a balanced way to make sure we're intervening compassionately.

I want to also address now some of these questions asked surrounding the questions of beds and the refocusing of Alberta Health. Last year I did direct AHS to undergo a comprehensive expenditure review of services related to mental health and addiction. This was our first step in moving forward to the state we're in today so that we had a better understanding of what programs are available through AHS at that time. This was well timed because as we came out of last fall and the decision was made

by our government to move forward with the refocusing, we had organized, in an organizational sense within AHS and also from a financial perspective in terms of looking at where dollars are being spent, a provincial portfolio of where we were within Alberta Health Services and what was dedicated to mental health and addiction spending. That's where this $1.13 billion came from.

9:10

Exactly how all those details look are things that we're working through with AHS right now in exactly how that breakdown looks. I can tell you that language around taking over is very, very – it's just not accurate to the situation and the tone and tenor of the relationship that my department and my ministry have with AHS. It is collaborative, it is forward thinking, and it is putting a new focus on mental health. So it's a partnership, and we obviously have named our transition lead, Kerry Bales, who was the portfolio lead within AHS before. It's a collaboration. It's one saying that there will be more mental health and addiction services going forward.

To the questions surrounding beds, we want to see more expansion, of course. I'll let my deputy minister, in the short time remaining, answer some of those details as well.

Mr. Romanow: Thanks, Minister and Chair. Yeah, absolutely, the focus with the refocusing work is to drill into that to make sure that we can quantify the dollars that are in the system, as the minister said, on expenditure review, looking at the dollars and the appropriate bed ratios that are needed across the province. CIHI does report that median wait times for community mental health and substance use services is in the range of 17 to 19 days, so that is benchmarked.

The Chair: Thank you so much.

Now back over to the government side.

Mr. Boitchenko: Thank you very much, Madam Chair. I would like to ask the minister if he would like to stick to block time or . . .

Mr. Williams: Let's keep a good thing going.

Mr. Boitchenko: All right. Sounds good.

As a parliamentary secretary to Indigenous Relations my questions will be concentrating more on the Indigenous file as well as treatment and recovery. Here I would like to personally thank you, Minister, and your team for choosing the path of treatment and recovery versus safe injection sites. I have a very, very close family friend who was an addict for many years, and now because of your treatment and recovery program he's fully recovered and is now a compassionate member of our society. According to his own words if he would have chosen safe injection sites, he wouldn't be among us right now. So thank you again from the bottom of my heart for choosing that path, because in my mind it is the only path forward.

I'll start with Indigenous-led recovery communities. Under outcome 2 key objective 2.3 aims to develop a comprehensive continuum of culturally appropriate mental health and addiction services to support Indigenous people in Alberta. Considering the disproportionate impact of addiction on Indigenous communities, it is evident that the province's addiction strategy, as outlined in the business plan, should encompass culturally appropriate support for Indigenous people in Alberta. We know that working collaboratively with Indigenous communities to develop, actually, culturally appropriate mental health and addiction services is essential for promoting inclusivity, addressing historical trauma, and building trust and also to improve overall well-being within these communities.

It is acknowledged that the unique needs of the Indigenous population are contributing to more effective and sustainable mental health support systems. In light of this, I would like to ask some questions about how the key objectives, specifically in 2.3, align with the substantial capacity-building efforts undertaken in the province's initiatives to establish 11 recovery communities across the whole province of Alberta. My questions would be: what impact will these recovery communities, built in partnership with Indigenous communities, have on the overall well-being of our population? What has the response been from the nations where you have committed to building these recovery communities? How else is this government partnering with Indigenous communities to develop culturally appropriate mental health and addiction services? And the last one would be: how will these efforts contribute to the overall well-being and resilience of Indigenous individuals, families, and communities across Alberta?

The next question will be kind of switched towards recovery supports in our communities. The first bullet on page 103 of the MHA ministry business plan reads, "Helping more Albertans pursue recovery from addiction through increased access to medical detox and long-term addiction treatment." With the increased demand and severity of addictions in our communities we need to expand capacity and access to these much-needed addiction supports, shortening wait times and interim services such as pretreatment, and wait-list support that can help Albertans navigate more successfully our recovery continuum. The questions are: how has Alberta expanded access to addiction supports? How many people are served each year by these expanded spaces for detox and treatment in Alberta? Does government believe the spaces already open for treatment and the ones coming online . . .

The Chair: That's your time, Member.

We'll turn to the minister now for his response.

Mr. Williams: Thank you, Chair. I appreciate that. I'll do my best to get through the questions, all thoughtful ones. Thank you, through the chair, for the member's work as a parliamentary secretary and the work he's done. A lot of what I do is only possible when we as the government of Alberta and across the entire team have good relationships with our First Nation partners in the province.

I'll start by addressing the questions surrounding the importance of the culturally sensitive treatment spaces and capacity building, which I think was the item highlighted in 2.3 of the business plan. We need to have capacity in order to meet the needs of the, tragically, growing number of Albertans suffering from addiction. We're looking for more information nationally to understand if safe supply out of B.C. is contributing to that. So far the federal government has not answered our call to put a unique chemical identifier in safe supply. In all likelihood, we hear anecdotal reports of that making its way into Alberta, tragic if so, contributing to the addiction that we have to deal with here in our own communities and our own families.

That capacity piece is not focused exclusively just on the recovery centres – as you mentioned, there are four that are currently announced, with more to come with Indigenous partners – but we also partner, for example, with Oxford House, which is a part of this capacity building, Chair. What we need to do is make sure that if we focus exclusively on the recovery centres – right? – we need to keep them running as effectively and efficiently as possible, as was asked earlier. We need to have the ability, through pretreatment housing with groups like Oxford House, which is an Indigenous-run organization, that focuses on ways to try and create

a flexibility in our system and the entire recovery-oriented system of care.

That is one example of investments that we're doing to make sure that not only are we meeting those $99 million this year in the budget for building those recovery communities on First Nation reserves but also, beyond that, looking in our communities and urban centres where so many of them reside, partnering with Treaty 6 in a big way, as we saw through Minister Nixon, as well to make sure they all funnel into this direction.

I want to also focus a little bit on the question you asked surrounding what we're doing to partner directly in mental health and addiction services. I want to let you know that there are a number of these different relationships we have, that every one of these grants, every one of these positions that we're funding, every one of these relationships are due to work that members such as parliamentary secretaries, other ministries, and our Premier have done to be able to have these collaborative relationships.

9:20

For example, in this budget: $1.4 million to the Blood Tribe to operate transitional beds for community members awaiting addiction treatment or transitioning from treatment back into the community; $1.2 million to support First Nation client liaison positions, with four health centres in the Stoney and Tsuut'ina First Nations – these liaison positions are incredibly important for increasing community recovery capital and partnering with those nations – $535,000 over three years, 2021 to '24, to the Kee Tas Kee Now Tribal Council to provide improved integrated and co-ordinated mental health and addiction services, which includes Whitefish Lake Nation, Peerless Trout First Nation, Loon River First Nation, Lubicon Lake band, and Woodland Cree First Nation; $500,000 over three years to provide Métis settlement mental health and addiction navigators to work with improved access to mental health and addiction services for clients; another almost half a million over three years for the Métis Nation of Alberta association of wellness, the Community Wellness Advocate's program; another almost half a million dollars over three years till 2026 for the addiction and mental health program that focuses on the population of Grande Cache and surrounding Indigenous communities. I could go on with even more.

I think it's important to highlight that every one of those dollars spent, every one of those individually highlighted grants are more than just dollars and cents. It's more than full-time equivalents, FTEs, as we say in government, of individuals helping navigate, connect through recovery coaches into the recovery program. It also signifies a positive relationship with our First Nation communities, Chair, and this is the biggest win, and we can build on that.

It's just so sad to see that the federal government has been absent, not even showing up, not even putting on their jersey when it comes to trying to help address, in this field hospital we need to be as a province, the crisis that so many of our First Nation communities are dealing with.

I think I'm going to answer some of the questions you had surrounding detox and other spaces at a future time. I'm very happy to continue those conversations, and I think that this is an important piece.

The Chair: Thank you so much, Minister.

Now over to the Official Opposition for their block.

Member Eremenko: Thank you, Madam Chair. My next round of questions is going to be in regard to overdose dependency programs. It includes the VODP program as well as narcotic transition services. Now, this is a file, a program that's kind of an interesting one. It does have significant kind of interfacing with the Ministry of Health in regard to the OAT gap coverage, OAT standing for opioid agonist therapy. You know, with this new merger of all of the addiction and mental health departments under the umbrella of Mental Health and Addiction I think the minister will be able to handily respond to my questions here.

The OAT gap coverage program only covers methadone and buprenorphine formulations, which include Suboxone and Sublocade, for 120 days. This means that people who have not benefited from either of these medications or who wish to start on a slow-release oral morphine like Kadian can't access this program. The 120 days seems like a very concerningly short period of time when we know just how fragile recovery and treatment can be; 120 days amounts to about four months. What happens for those individuals who are accessing VODP, a program that this government, Madam Chair, has really lauded in terms of the uptake, and rightfully so? I think it has proven to be quite a successful program but only for 120 days. What happens at 121? What happens to those individuals who have come to rely on this very critical medication to avoid using more dangerous unregulated illegal drugs?

Furthermore, why is it only covering methadone and buprenorphine formulations and not including Kadian? Kadian is recognized in every Canadian opioid use disorder guideline as a form of OAT, but for some reason it is not included. Considering that, really, the OAT gap coverage program, Madam Chair, is really quite a minimal expense in consideration of all that is going to be within the purview of Mental Health and Addiction in just a few short days, could the minister consider extending the period of universal gap coverage to a full year?

This leads me to another set of questions around the kind of weird selectivity that the minister has demonstrated in terms of what drugs are okay and which ones are not. Madam Chair, methadone is an opioid. Hydromorphone is an opioid. Why is methadone included in OAT gap coverage but hydromorphone is not? Why is the virtual ODP program provided in every corner – same-day service: you can make a call in the morning, and you will have a prescription filled by the end of that day for an opioid. Why is it that VODP and ODP clinics are available across the province but the Calgary zone, with over 1.5 million people, has one narcotic transition services program that offers hydromorphone? Why is methadone okay and hydromorphone is not? They are both opioids. This kind of selectivity, in my mind, is costing lives. It is costing livelihoods. It is harming families. I would like to hear, through the chair, why the minister is arbitrarily choosing . . .

Mr. Singh: Point of order.

The Chair: We've had a point of order called.

Go ahead, Member.

Mr. Singh: Thank you, Madam Chair. The point of order relates to 23(h) and (i) of the standing orders. The member "makes allegations against another Member" and "imputes false or unavowed motives to another Member." That is the minister here. The member has made allegations detrimental to the person of the minister. The statement made by the member, though it may relate to the functions of the minister, also relates to a personal matter, and this claim against the minister is unacceptable.

The Chair: Thank you so much.

Opposition.

Ms Goehring: Thank you, Madam Chair. I don't believe – I don't have the benefit of the Blues, but the member has said that the selection of drugs is what's costing lives, not the minister, so at this point I don't believe that it's a point of order.

The Chair: I actually was going to call a point of order myself. I do find this to be a point of order.

Member, if you would kindly get back to the estimates, the reason for the meeting today, that would be sincerely appreciated. Thank you.

Member Eremenko: OAT gap coverage is absolutely a line item in the mental health estimates, as is VODP, but I will not pursue that line of questioning any further. I'd like to know why some drugs are covered and some others are not.

Furthermore, I'm reading a report here that in 2022 the overall cost of substance use in Canada for alcohol use, Madam Chair, was $20 billion. Those are lost costs in health. Those are costs in health care, lost productivity, criminal justice, and others. Opioids are $7.1 billion. In the strategic plan there was conversation about bringing alcohol sales into grocery stores and convenience stores. Alcohol, according to this data, is actually having a much more significant cost to our system than opioids are. I'm curious if the minister can speak to his thoughts on increasing access to alcohol, that can actually have significantly more damage than opioids.

The Chair: Hon. member, could you please get back to the main estimates?

Member Eremenko: It is certainly considered within the budget that . . .

The Chair: Hon. member, please, if you could get back to the main estimates. Please kindly ask some questions of the minister regarding the main estimates. Your tone is reaching a higher pitch. I just need you to bring it down, and let's get back to the main estimates, please.

Member Eremenko: Through the chair, I'd like to hear the minister's considerations around the cost of alcohol abuse, please.

The Chair: Would you kindly just direct your questions back to the main estimates? I've made my ruling, please.

Member Eremenko: I will cede the rest of my time.

The Chair: Okay. Thank you, Member.

We'll hear from the minister now.

Mr. Williams: Okay. Thank you, through the chair, to the member for the questions. I'm happy to address all the questions asked. We started off talking about the virtual opioid dependency program. For reference, it's important to note that that program had approximately 8,000 unique, individual clients that it was treating in 2023. It's a terrific program, and I want to thank, through the chair, the members for being emphatic about the terrific success of same-day access. I have never heard a member of the opposition so full-throatedly support and sell the government's success surrounding a policy like that at estimates. It's wonderful to see. I could not agree more.

It is same-day access. No matter who you are or where you come from, you can get access to the virtual opioid dependency program, which is opioid agonist therapy. It is evidence-based, proven medicine that helps individuals overcome their addiction, and it does it in a number of ways. This will be a good opportunity for me to address the very important difference between what is opioid agonist therapy and why it's successful and the continued use of drugs and addiction, all right?

9:30

NTS speaks to this as well. For those who didn't follow, NTS is the narcotic transition services. Importantly, narcotic transition services is, one, a transitional service. It's not indefinite use, right? It's very small. I believe it's under 200 individuals province-wide that access it, compared to the nearly 8,000 that access the virtual opioid dependency program. The evidence-based medicine that we follow in this is not going to be affected by, Madam Chair, radical activists that would want to push, for example, hydromorphone, as the member mentioned, in safe supply, which is an unwitnessed, mass distributed, incredibly powerful opioid that is five times more powerful than heroin. Zero transition is required in those programs.

It continues to escalate. Diversion is en masse. Even the B.C. chief medical officer of health admitted to her chagrin, I would imagine, publicly in her own report that it is, quote, unquote, commonplace to see now diversion happening of hydromorphone. We will not bring those policies to Alberta. In fact, those policies are illegal in Alberta, and so long as this government remains in power, they will continue to be illegal in Alberta.

Sublocade, for example, the use of Suboxone in the injectable form, is incredibly effective, and it now has the lion's share of the use of the virtual opioid dependency program in the province of Alberta because it has a number of terrific advantages. This tech, this use is just so effective on a number of fronts. First of all, diversion is really not possible in any meaningful way because the nature of the injectable is that it goes in subcutaneously and forms a gel and is released over a period of approximately 30 days. So the idea of diverting that is really not something, once the injection happens, that is commonplace anywhere, and literature internationally backs this up.

It also does a number of things. The molecular affinity for the Suboxone is higher than an opioid, so if somebody were to try and use a high-powered opioid like, say, hydromorphone, in an attempt to get high again, the affinity is actually higher for the molecules of Suboxone, so it prevents in most cases the ability to overdose or even get high. The tech is incredibly helpful. It also manages for that 30-day period withdrawal. So there's lots of good reasoning, and we can refer to experts, including our very own Dr. Day out of Ponoka, our AHS lead on addiction medicine, that backs up why we have made those evidence-based policy-making decisions that are really leading the way. We're seeing other jurisdictions now transition away from methadone and use more commonly Sublocade, Suboxone, or even the film variety of Suboxone as well.

I'm going to defer to my ADM to speak to some more detail around some of the other drugs mentioned, but we are committed to evidence-based policy-making when it comes to our pioneering same-day access, as members mentioned, Chair, virtual opioid dependency program.

Ms Everington: Through the chair, the member asked a question about the 120 days for the OAT gap coverage program. That can be extended; that 120 days can be extended. The idea is that it is enough time for individuals to get onto a supplementary benefits program. It's usually enough time. If it isn't enough time, then it can be extended beyond that 120 days, Chair.

Mr. Williams: Okay. With that, I'll turn the last six seconds over to the chair.

The Chair: Thank you so much.

We'll head back to the government side for their questions.

Mrs. Petrovic: Thank you, Madam Chair and through you to the minister. In the 2024 Mental Health and Addiction business plan line 3.2 states, "Expand access to a range of virtual and in-person recovery-oriented supports to improve mental health and addiction care and support better outcomes for communities in need, including underserved, rural, and remote populations." I'm from one of these rural communities, and unfortunately I grew up with two parents that suffered with addiction. Thankfully, one of those parents was able to receive recovery-orientated supports, and we were able to get one of those parents back growing up. I'm hopeful that through this government's investment into Mental Health and Addiction that will be able to bring the second parent home, back to family, where they belong. So this is extremely exciting for me.

As a nurse I worked at Piikani Nation in my riding as well. It's a community that – in my community we get to see front-lawn libraries, where you can open up and take free books. In Piikani Nation those, instead of filled with books, were filled with free naloxone kits. These naloxone kits were also something that we handed out for free within the emergency department. So rural supports are very near and dear to my heart, and we know that folks living in rural and remote locations can have a different experience when trying to access support for mental health and addiction concerns. Thankfully, in the community I live in, Claresholm, we have one of the largest mental health and addiction centres, and I'm so grateful for that and the supports that are provided there.

With expanding access to mental health and addiction support in rural and remote populations, we can ensure that all citizens have the opportunity to achieve better mental health outcomes. Now, through you, Chair, to the minister: what is described in this year's budget to help rural and remote access to addiction and mental health supports, and which community-based organizations are improving access to support? Myself and the minister, coming from remote parts of the province: we know how important these services are. If you may share with the committee a bit of your version on how a family can access support when they need it regardless of what part of Alberta they call home.

Then moving on to outcome 3 on page 106 of the business plan, I see a lot of reference to addiction and mental health supports being accessible. Of course, a province could have the best designed and administered programs out there, but they don't do residents any good if they're expensive, cumbersome, and take a long time to access. Chair, through you to the minister: could you please speak at a high level to the role that access plays, particularly in the instance of addiction and mental health programs?

Right now we're living in an increasingly digital age, with more demand than ever for virtual programs or virtual program options. Key objective 3.2 on page 107 of the business plan recognizes this, reading: "Expand access to a range of virtual and in-person recovery-oriented supports to improve mental health and addiction care and support better outcomes for communities in need, including underserved, rural, and remote populations." Chair, through you to the minister: at a high level, Minister, could you speak to the role that digital options play in your service delivery? One of the services listed under outcome 3 includes the digital overdose response system app. I'm hoping you could speak more about this app in particular.

Once again, as we see in the business plan under outcome 3, "Albertans have access to high-quality, person-centred mental health and addiction programs and services." We can especially relate this to the needs of rural and remote communities, which can be undersupported when trying to access affordable mental health care. As the demand for timely counselling support is essential for healthy families, we can see that access to in-community care can be difficult. The reference continues: "Expand access to a range of virtual and in-person recovery-oriented supports to improve mental health and addiction care and support better outcomes for communities in need, including underserved, rural, and remote populations." Chair, through you to the minister: can you please describe what the delivery of virtual mental health supports can mean to Albertans everywhere, in every corner of the province? What is the rate of funding, and how many people have been supported so far across the province?

With that, Madam Chair, I'll cede my time. Thank you.

The Chair: Thank you so much, hon. member.

Let's move to the minister for his response.

Mr. Williams: Okay. Thank you for those questions. Chair, I'm happy to address them. Before I was in the role of Mental Health and Addiction minister, my interaction was probably similar to most Albertans in that I had family members that were affected by mental health crises, had family members and friends that were in active addiction, that were in recovery. Families had been devastated by it, and I understand how deeply personal it is. So I will say to the committee, through the chair, that I appreciate that everyone wants to bring forward their questions because they, from all sides, want to see a successful Alberta when it comes to addressing mental health and addiction. Whatever differences we have, I think that we have in common, and I appreciate very much the questions asked surrounding that. Rural is particularly close to my heart. I hear stories from my constituents not different from members across this committee of tragedies, and access is such a big part of that in rural Alberta.

9:40

We know we have a big task in front of us, and we have the start of a recovery-oriented system of care in this Alberta model, and we have a lot more work to do to make sure everywhere in the province gets to benefit from it. Counselling Alberta is one that we doubled the funding for. It is meant to be an intermediary. If somebody is in crisis – it could be someone considering suicide. It could be not even depression but feeling depressed. It could be anxiety. It could be walking from those difficult situations towards addiction. Whatever it is, you can get access anywhere in the province, Madam Chair. If you call 211, for example, or go to counsellingalberta.com, you can get that access immediately in Alberta, and we're looking to continue to expand that. This budget is an important part of it.

When it comes to addiction itself, we just spent some time talking about the virtual opioid dependency program, same-day access, evidence-based treatment, not about enabling addiction but about facilitating and moving towards recovery. Paired with treatment, opioid agonist therapy is incredibly effective. Any one on its own is less so. So we need to start with that, wherever you are, with that virtual opioid dependency, Madam Chair, and we need to move towards those in-person capacities that we have. The majority of our recovery centres across the province are not in urban centres; the majority are in rural Alberta. We're going to continue down this trend, especially as we focus on those disproportionately affected in rural Alberta, disproportionately Indigenous, who come from rural parts of our province. That is going to continue.

It was asked for the virtual opioid dependency program and DORS to be talked about at a high level. When we talk about DORS, the digital overdose response system, it's an app that can be downloaded on any phone if someone is an opioid user. It's important to note that some people, in trying to create these firm lines, call this harm reduction. Some people say that it's a part of the recovery-oriented system of care. I, for one – anyone who wants to get someone out of addiction is someone I want to partner with.

We will, not in an ideological sense but in a practical, human, dignified sense, Madam Chair, support any policy that brings us to that end. That's why we oppose so-called safe supply. But we will do all sorts of other items that some people across different parts of the aisle will describe as harm reduction.

The digital overdose response system allows a user of an opioid, for example, to have that on their phone, and if they are not continuing to keep it live and interact with it, then automatically called to that location would be an emergency response, where they could administer naloxone and give that person immediate treatment to bring them back from that edge of cerebral hypoxia and, tragically, possibly death. So we're very happy to continue those kinds of programs in the province, knowing that this is the kind of support that is absolutely essential.

We talked about digital options, and it's not just a question of rural and urban when we talk about digital options, Madam Chair. It's a question of people in all different states of life, no matter where they're coming from. It could be that it's a physical location. You could live in the community of La Crête or High Level or Manning or Peace River, in my neck of the woods, seven hours from Edmonton, five hours from Grande Prairie, or it could be that you're in the downtown heart of Edmonton and you, for a different reason, have an obstacle in front of you from physically getting access to it, which is why, when we look at those digital options – the virtual opioid dependency program, vodp.ca; 211, connected to any phone, 24/7 availability; and HealthIM, for example – they are all different programs that we have that can give access, whether the obstacle is geographic or any other variety, because every single Albertan deserves that opportunity at recovery.

The Chair: Thank you so much, Minister.

Sorry. We just finished your questions.

We're now moving over to the Official Opposition. Go ahead.

Member Eremenko: Thank you, Madam Chair. I've got a bit of a grab bag here of various questions, appreciating that this may be my last opportunity.

Thank you, through the chair, to the minister, for kind of pinballing with me over the various documents. I did want to revisit a couple of questions that I think are incredibly integral to have answered this evening. One, going back to an original question, this is per line item 2.6 of the estimates, programs that reduce harm. I'd asked a question of the minister, Madam Chair, around the services that are currently offered and run by AHS in regard to overdose prevention sites and supervised consumption sites. Through the chair, I'll ask the question once more. Does the minister intend to close the overdose prevention site in Red Deer in line with the recent vote by Red Deer city council?

The Chair: Excuse me. Hon. member, we are on main estimates.

Member Eremenko: And I referenced the estimate line item two point – I'm sorry. Maybe I shouldn't answer that. I believe I am as well. Line item 2.6 is initiatives that reduce harm, Madam Chair. That certainly does include OPS and SCS. There was a decision put forward by Red Deer city council that this would be looking at possible closure, and I'm curious if in the 2024-2025 estimate it does include the further operation of OPS and if the minister intends to maintain that program, that service.

I would like to extend that question to all OPS and supervised consumption sites as well, Madam Chair. Will they remain open for the foreseeable future now that they will no longer be operated by AHS but, rather, operated by Mental Health and Addiction?

I'd like to continue on to a question that I did not get a clear answer on in regard to compassionate intervention as per page 114 in the fiscal plan. That's the capital plan section, where there's a line item for compassionate intervention implementation intake and assessment centres, with $5 million allocated in this fiscal year plus another $5 million in the following year. What is a compassionate intervention implementation intake and assessment centre? How is the $10 million going to be allocated, and is there a complementary operational budget line to support that endeavour?

A couple of other questions here. One is that there's a $5 million line item in estimates, line item 2.9, for the centre of recovery excellence. This is an operating expense in Budget 2024 for $5 million for a centre of recovery excellence. In the preamble in the business plan, the preamble states that "a centre of recovery excellence will improve the quality of mental health and addiction service delivery in Alberta." I'm not clear what a centre of recovery excellence is. How will it achieve its target, and will Mental Health and Addiction be the intended operator?

My last question, Madam Chair, to the minister, is as per key objective 3.3 of the business plan. I'll just recite that here. The objective is to "evaluate and expand access to mental health supports . . . to promote positive mental health [and] prevent severe mental health issues from developing . . . for students with mental illness. Through the chair to the minister, this government has made school, home, and community potentially and explicitly less safe with policies on transgender youth. How does the minister square that with the stated business plan objective?

At that point I think I will cede the rest of my time. Thank you.

The Chair: We'll go right to the minister.

Mr. Williams: Thank you for the opportunity to respond. I'm happy to address these questions. First off, when it comes to the drug consumption site in Red Deer, we take very seriously – and this is a broad statement across all municipalities – feedback that we received from municipalities. The municipal council in Red Deer considered its options in front of it, had a very lengthy set of conversations publicly and privately as a council. They engaged me after their vote and asked if we could have a meeting. I happily did so, and my plan is to respect the general direction of Red Deer. But what exactly that looks like is going to be a question of some conversation that we have going forward. I'm happy to keep the wider public and Red Deer up to date as we go forward with that. We need to do some looking and have conversations with Red Deer municipal council and look at what options we have, going forward, to best respect the general direction. I said this many times before, that we take very seriously input from municipalities. That will of course be there going forward.

When it comes to the drug consumption sites operated province-wide by AHS, they will continue to be operated by the new mental health and addiction organization in the province of Alberta when that transition happens. I'll just note from an earlier comment, Chair, that was made: when the business plan refers to spring, we're not referring to the spring equinox date but the season of spring. I think that is an appropriate way to understand that in the text, just for clarity's sake.

9:50

When it comes to CORE, line item 2.9, I'm happy to address it. It's going to be a body that will require parallel legislation, and stay tuned for more information as we move forward. That is going to look at evaluating and assessing our system's effectiveness and efficiency when it comes to mental health and addiction, providing a lot of advice for us at an important evidence-based and -driven level. That $5 million to establish CORE is identified within our budget of 2024-25. It's also an opportunity for us to showcase how

Alberta is doing what it's doing and be able to have a body that can give us public policy advice and be able to look in real time at what is happening in our system.

Albertans are very keen to see us take mental health and addiction seriously. It needs to be evidence-based and evidence-driven policy-making. We take that very seriously. We take that seriously by evidence of this ministry's existence and this budget and these estimates that we're going through today, from the massive expansion, I think, to the seventh-largest ministry in the government and dollar spend operationally.

We know it's important for us. We want to make sure that we have the appropriate backing and advice and information and making sure we're looking at what the system is doing and that we're responsive to it as we roll out programming and policies.

Now, when it comes to the question around compassionate intervention, as I said, we're working on that policy framework now, and we're looking at what it's going to look like in the long-term recovery model, making sure that we're integrated all the way through in the recovery-oriented system of care throughout the entire continuum. We need to make sure that we have the facility and the supports we need. The dollars are going towards making sure that we have that capacity there when the time comes. Of course, as I said earlier, we're going to be working very closely with stakeholders. We are very serious about moving forward, we are committed to moving forward on compassionate intervention legislation.

I think I'm going to address a couple more questions. When it comes to vulnerable Albertans, those who are in minority groups, no matter what the reason, if you are somebody who needs mental health support or addiction support, it doesn't matter who you are. We have an obligation, and we are absolutely committed to supporting that. Good examples of this are access to Counselling Alberta. There's no criteria you have to meet in order to be able to access it. As long as you can get yourself to a working phone or computer, you're there. The province has built the system to have as low a barrier as possible. That is the first step as a fallback resource, to make sure that everyone has access to what can be potentially life-saving support through counselling.

It's incredibly impressive, the work that's done. You'll note that after a number of sessions with Counselling Alberta, at potentially no charge if that's where the individual fits in the sliding scale, the goal is to . . .

The Chair: Thank you so much, Minister. That's your time.

Back over to the government side.

Mr. Cyr: Thank you, Madam Chair. We're in the last leg here. It looks like I'll probably be the last to ask questions here. Thank you for your time tonight, Minister, and all of your staff. I know that, for myself, I feel as if you've done a great job answering our questions. We've actually had the NDP cede their time in the last block here before this, showing that they had all of their questions answered.

Minister, I'd like to thank you for really moving forward with this recovery program, sir. As soon as you announced that you were going down this direction in your ministry, I know that, for myself, I could see promise in this. I really wanted to get an idea of where my constituency sat, and really they were very supportive of you, to the point where they actually went to Edmonton and you met with them, sir, to hear some of their concerns about mental health up in our area. I'm very thankful for that because it shows how proactive you are. You're trying to deal with this.

One of the questions that kind of comes up with this is that when I'm talking with my First Nations and my municipal partners, it doesn't seem like any of them are asking for safe supply. They're looking for recovery centres. It seems strange that this is something that the NDP would be advocating for, the safe supply, when it appears that almost every municipality in Alberta is having issues with this narrative that's coming forward.

Now, getting back to this, I'd like to focus on line 2.6, sir, page 165 of the estimates. This specific line highlights the allocation for initiatives that reduce harm, encompassing funding support for "supervised consumption sites, overdose prevention sites, and the provincial Naloxone program." Noteworthy is the projected increase in funding for the programs in the 2024-2025 fiscal year. The estimate indicates a substantial rise of $5 million, from $30 million to almost $36 million, sir. The question that I have is: since this line encapsulates what are commonly referred to as harm reduction or harm production programs, could you please indicate whether or not the flagship initiative of harm production, also known as safe supply, is included in this funding stream, sir?

I will cede my time for the rest of the evening to you, sir.

The Chair: Okay. Go ahead, Minister.

Mr. Williams: Thank you for the question. I'll be abundantly clear, through the chair: Alberta has made safe supply illegal. It will not happen. It's a failed policy in every single jurisdiction. Canada currently, under the Trudeau Liberals, is the only jurisdiction offering en masse the most radical policy in the globe. There is no good evidence to show that it helps, and you don't need to only look at the data to see that. You can look at the streets and understand the human cost of what this policy is.

I'm not going to speak for members opposite here. I will say that if you continue to advocate and use language like "a toxic drug supply," anyone that does that is making an argument that a safe drug supply is a solution. As anybody in the province can see, if you continue to advocate for drug consumption sites on every corner, with no dollars invested into recovery in any serious way, and you look to, say, examples like B.C. for how we ought to be organizing our addiction response, then you will not help anyone get out of addiction. You will condemn individuals to this tragic, tragic existence of facilitating addiction to the point where either they find their own way out through no help of the government – God willing, that's the case – or instead, Madam Chair, sadly, it leads to death. Recognizing that tragic reality is exactly why this government has made it absolutely impossible.

The Alberta response to addiction is about a recovery-oriented system of care, the Alberta model. That model is trying to capture all the different resources we have. Of course, we're going to prohibit safe supply, but it doesn't work if you don't have hope as well, the personal hope one has, the possibility of overcoming an addiction. If the government is sending a message out in every advertising corner they find, every program that they fund, and if everything you hear from every politician's mouth is, "Just go find more drugs; you'll be fine," then it kills hope inside an individual.

Instead, if there is a positive message that says, "You are an individual with dignity as an Albertan, as a Canadian; we care for you; we want to see you succeed in life; we want you to be a brother and a mother again; we want you to connect with your family, your children; we want you to have a job; we want you to be a community volunteer again," then that tells them that they have dignity and value.

The words we use in government, like "toxic drug supply," can be condemning to an individual when they're struggling with an

addiction, or words like “recovery” can be uplifting and providing a hope that is unparalleled when you’re in the lowest doldrums of what feels like an enslavement to the drug, where there are shackles around your arms and legs and you’re compelled to continue.

That difference starts in committees like this, in Legislatures like the one we all belong to. That difference isn’t just policy. That difference is a cultural shift from the last 30 years of abject failure from the western world surrounding addiction. Alberta is leading the way, and I couldn’t be more proud of that.

The Chair: Thanks so much, Minister.

I must advise the committee that the time allotted for consideration of the ministry’s estimates has concluded. I’d like to remind committee members that we’re scheduled to meet tomorrow, March 21, 2024, at 9 a.m. to consider the estimates of the Ministry of Children and Family Services.

Thank you, everyone. The meeting is adjourned.

[The committee adjourned at 10 p.m.]

Published under the Authority of the Speaker
of the Legislative Assembly of Alberta