



Legislative Assembly of Alberta

The 31st Legislature  
Second Session

Standing Committee  
on  
Families and Communities

Ministry of Mental Health and Addiction  
Consideration of Main Estimates

Tuesday, March 10, 2026  
7 p.m.

Transcript No. 31-2-3

**Legislative Assembly of Alberta  
The 31st Legislature  
Second 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),\*Acting Deputy Chair

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\* substitution for Nicole Goehring  
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**Also in Attendance**

Eremenko, Janet, Calgary-Currie (NDP)  
Metz, Luanne, Calgary-Varsity (NDP)  
Shepherd, David, Edmonton-City Centre (NDP)  
Sinclair, Scott, Lesser Slave Lake (Ind)

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## **Standing Committee on Families and Communities**

### **Participants**

Ministry of Mental Health and Addiction

Hon. Rick Wilson, Minister

Coreen Everington, Assistant Deputy Minister, Policy and Programs

Rachel Melynychuk, Assistant Deputy Minister, System Overview and Strategic Services

Ashley Robertson, Assistant Deputy Minister and Senior Financial Officer, Financial Services

Evan Romanow, Deputy Minister



7 p.m.

Tuesday, March 10, 2026

[Ms Lovely in the chair]

### Ministry of Mental Health and Addiction Consideration of Main Estimates

**The Chair:** All right. Well, welcome 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, 2027. I'd ask that we go around the table and have members introduce themselves for the record. Minister, please introduce the officials that you have with you at the table when it comes to your turn.

I'm Jackie Lovely, the MLA for the Camrose constituency and the chair of the committee. We'll start to my right.

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

**Mr. Getson:** Shane Getson, the MLA for Lac Ste. Anne-Parkland, better known as God's country.

**Mrs. Sawyer:** Tara Sawyer, MLA for the outstanding constituency of Olds-Didsbury-Three Hills.

**Mr. Lundy:** I'd qualify my riding, but we have a limited amount of time here. Brandon Lundy, MLA for Leduc-Beaumont.

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

**Mr. Wilson:** Good evening. Rick Wilson, Minister of Mental Health and Addiction. Tonight I've got with me my deputy minister Evan Romanow, my assistant deputy financial officer Ashley Robertson, the amazing deputy minister of policy and programs Coreen Everington, and assistant deputy minister, and a person in her own right, Rachel Melnychuk.

**Mr. Sinclair:** Good evening, everybody. I'm Scott Sinclair, the MLA for Lesser Slave Lake.

**Member Eremenko:** Janet Eremenko. I'm the MLA for Calgary-Currie and the shadow minister for Mental Health and Addiction.

**Mr. Shepherd:** David Shepherd, Edmonton-City Centre.

**The Chair:** All right. Now we do have someone participating remotely. Please go ahead and introduce yourself, Member.

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

**The Chair:** I'd like to note the following substitutions for the record. Member Batten will be substituting for Ms Goehring as deputy chair. Mr. Cyr is substituting for Ms Johnson from 7 p.m. to 8 p.m.

A few housekeeping items to address before we turn to the business at hand. 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 meetings can be accessed via the Legislative Assembly website. Members participating remotely are encouraged to turn your camera on while speaking and mute your microphone when not speaking. Remote participants who wish to be placed on a speakers list are asked to e-mail or message the committee clerk, and members in the room should signal to the

Chair. 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 should be considered for three hours. Standing order 59.01 sets out the process for consideration of main estimates and 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 both the minister and the member speaking agree. If debate is exhausted prior to the three hours, the ministry 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 to the committee clerk about the process.

With the concurrence of the committee, I'll call a five-minute break near the midpoint of the meeting. However, the three-hour clock will continue to run. Does anyone oppose having a break today? All right, we'll have a 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 the microphone in the gallery area, and are asked to please introduce themselves for the record prior to commenting. 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 members may sit at the table to assist their members; however, members have priority to sit 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 materials 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. Debate flows through the Chair at all times please, members, including instances when speaking time is shared between a member and the minister.

I would now invite the Minister of Mental Health and Addiction to begin with your opening remarks. Minister, you have 10 minutes.

**Mr. Wilson:** Thank you, Madam Chair. In the 2026 budget for Mental Health and Addiction, we're continuing to build on our strong commitment to support Albertans in their wellness and help those facing mental health or addiction challenges to pursue recovery. We are carrying on with our strategic work to build the Alberta recovery model, which includes investing in the infrastructure, programs, and services that are going to give Albertans access to the key supports that they need, when and where they need them, and to live hopeful, fulfilling lives. The decisions we have made in this budget reflect a clear belief that with the right care and supports, recovery is possible for anyone.

Today I'll speak to the foundation and success of the Alberta recovery model, the role of Recovery Alberta and the Canadian Centre of Recovery Excellence, known as CORE, and how Budget 2026 will provide Albertans an even stronger continuum of recovery-oriented supports and services through Alberta's largest investment to date for Mental Health and Addiction.

Since 2019 the Alberta recovery model has represented a shift from simply managing symptoms in isolation to connecting people with the supports and services needed to pursue long-term recovery.

The model is built around five key focus areas: increasing access to treatment, removing barriers to care, building new facilities, making treatment immediately available, and building better futures. This is also what Budget 2026 is focused on. The investments we are making through this lens will have life-changing and life-saving impacts for many Albertans. As I mentioned earlier, this is the largest budget for Mental Health and Addiction to date, reflecting an increase in wages for front-line health care professionals, addressing pressures in acute care systems, and preparing for the implementation of compassionate intervention in 2027.

Before I expand on what Budget 2026 will provide for Albertans, I'll take a moment to walk you through an overview of how funding has been allocated. Mental Health and Addictions' total operating expense is budgeted at \$2 billion in '26-27. Now, this includes \$1.7 billion for operating services provided by Recovery Alberta, \$283 million for department programs and services, and \$8.7 million for CORE.

A little over a year and a half ago we established Recovery Alberta as the provincial health agency responsible for the delivery of publicly funded mental health, addiction, and correctional health services. This marked a monumental shift forward in prioritizing these services within the health care system. Recovery Alberta's \$1.7 billion operating budget will provide more than \$206 million to operate 936 psychiatric beds at five stand-alone sites and \$121 million to operate more than 1,470 addiction detox and treatment beds. Recovery Alberta's operating budget also includes \$60.2 million for health care and transitional services in provincial correctional facilities.

We are also continuing to strengthen research and data around recovery-oriented care. Budget 2026 includes \$8.7 million to support CORE, and this funding will support CORE in a variety of applied research initiatives, including the evaluation of outcomes for people who access opioid agonist treatment, addiction services in correctional settings, recovery communities, and evidence-based prevention programs for children and youth. Now, this work ensures we build a recovery-oriented system of care based on evidence. We also know there is still a significant need to expand capacity within the mental health and addiction system. Budget 2026 includes more than \$421 million in capital investment and grants to ensure the necessary infrastructure to support those in need of mental health and addiction care.

A central part to this work is the development of compassionate intervention centres. Budget 2026 commits \$291 million over three years to build two 150-bed compassionate intervention centres in Edmonton and Calgary. These facilities will provide secure, specialized care for people experiencing the most severe forms of addiction and who are at risk of harming themselves or others. Compassionate intervention is a key part of my ministry mandate. While these new centres are under development, \$11 million is being invested to renovate existing facilities so compassionate intervention programming can begin saving the lives of those most severely impacted by addiction sooner, starting in 2027. This allows us to balance the urgency of getting compassionate care implemented, while also building for the long-term needs of the mental health and addiction system.

This year's capital plan also continues to build capacity to support youth. An investment of \$20.2 million will complete renovations and establish the 105-bed northern Alberta youth recovery centre, providing live-in treatment support for young Albertans experiencing addiction.

Additionally, \$20 million in one-time capital grants will build CASA houses for youth with complex mental health needs. The capital plan included in Budget 2026 will see Alberta has the

infrastructure needed not just for today's pressures but for years ahead. This year's budget also includes \$26 million for 30 psychiatric and 60 critically needed community-based beds within the mental health and addiction system. These are for those who no longer need in-patient care in hospitals, which will help address a priority for our government to reduce pressures across the acute-care system.

7:10

Now, for many Albertans the first step toward recovery is not easy, and often it cannot wait. When somebody is ready for help or when their life is at risk, timing matters and access matters, and the right kind of support at the right moment can change everything. That is why Budget 2026 continues to invest in supports to ensure Albertans have the opportunities to pursue recovery no matter where they live or what challenges they are facing. This year's budget includes \$173.9 million to support more than 1,750 addiction treatment beds across the province, including beds operated or contracted by Recovery Alberta and beds in recovery communities. This also includes \$29.6 million to open 375 new beds in five Indigenous-led recovery communities this year, bringing no-cost, culturally safe, live-in addiction treatment to communities disproportionately impacted by addiction.

As mentioned, addiction is one of the most challenging forces someone can face in their lifetime, and access to immediate treatment is critical. Budget 2026 includes \$13.3 million to continue providing barrier-free, same-day addiction medicine through the virtual opioid dependency program and virtual rapid access addiction medicine program. Through these services Albertans can connect with addiction medicine physicians and begin treatment the same day without needing to travel or deal with barriers preventing them from pursuing recovery. This is especially important for people living in rural and remote communities.

We also recognize the importance of working with police services and within correctional settings to help those experiencing addiction access care. Budget 2026 continues to invest in partnerships with police services and provides funding for therapeutic living units and transitional services in provincial correctional and remand centres. For many Albertans, support for their well-being starts with a conversation, a call, a text, or a message sent at a moment when they are not sure where else to turn. That is why community-based mental wellness supports remain a core part of our budget in 2026.

We are continuing to invest in partnerships with 211 Alberta and Counselling Alberta to ensure support is not limited by location, income, or circumstance. As I mentioned earlier, Budget 2026 also reflects our commitment to supporting the mental well-being of young people in Alberta. Prevention and early intervention support for children and youth are critical in building resiliency and strong futures. Budget 2026 continues to invest in school-based mental health programs, youth mental health hubs, and counselling options. These programs enable students to receive the support they need without leaving their classrooms, help families navigate challenges earlier, and reduce the likelihood of challenges escalating later in life.

In closing, I would like to reinforce that the unprecedented scope of Budget 2026 for Mental Health and Addiction shows how committed our government is to mental health and addiction care in Alberta. It builds on the strong foundation of the Alberta recovery model, strengthens service delivery through Recovery Alberta, makes targeted investments to expand access and increase capacity, and it will improve outcomes for Albertans. Most importantly, it ensures Albertans are supported no matter where they are along their path to recovery. These investments reflect careful use of

public dollars grounded in evidence and driven by the belief that recovery is possible.

Thank you.

**The Chair:** All right. Thank you, Minister. I'm just going to give another reminder, Minister and members, that conversation must flow through the chair. Looking forward to having time to hear some very thoughtful questions and some very thoughtful answers this evening. So 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 both the committee room and on Microsoft Teams. Now, members, do you prefer blocked or shared time?

**Member Eremenko:** Thank you, Madam Chair. The minister and I discussed, and I think we are willing to share time.

**The Chair:** All right. Minister, you're in agreement?

**Mr. Wilson:** Yes.

**The Chair:** All right. Let's proceed.

**Member Eremenko:** Thank you so much. Thank you, everybody, for being here. Thank you to the staff for putting in some very long hours to put together some significant documents here. I'm looking forward to diving in. Thank you, Minister, as well for sharing time.

My questions are largely sequential, but we'll kind of see how it goes and we may change some of the order of some of these pieces. Starting right at the top with the business plan on page 119, key objective 1.2 is the compassionate intervention for individuals due to their substance use or addiction.

I suppose, through the chair, my first question to the minister is just a note of language. Now, Bill 53, the Compassionate Intervention Act, talks about severe substance use or addiction issues. I'm very mindful that throughout all of the Budget 2026 documents that word "severe" does not precede substance use. Something as significant as compassionate intervention: we need to be incredibly mindful that there is not mission creep when it comes to the people that are actually meant to be subject to the compassionate intervention. Was that just a typo, or does it still in fact qualify severe substance use or addiction issues? Please.

**Mr. Wilson:** It's in the legislation on compassionate intervention. It's for people that are going to do harm to themselves or others. It's meant for the people that are in severe trouble.

**Member Eremenko:** Severe substance use or addiction. Okay. Thanks.

Through the chair, on what data did the department rely to decide that 300 beds in compassionate intervention facilities would be adequate? Has the department made any progress on knowing the rate of alcohol abuse, prescription opioid abuse, polysubstance use, methamphetamine abuse? Does the department know how many Albertans have a severe substance use or addiction issue that may be eligible for involuntary treatment?

**Mr. Wilson:** Thanks for the question. This is just kind of an example. In 2024 Alberta's health care system incurred over \$370 million in costs to substance use related emergency visits and hospitalizations; \$58 million from emergency department visits. In 2024 more than 36,000 people visited an emergency room for substance use issues, with 839 of those individuals visiting 10 or more times; \$321 million from hospitalizations, with \$64 million

tied to a small group with five or more admissions. I don't have it broke out per type of drugs they were using.

**Member Eremenko:** No. Thank you very much. That certainly is helpful, I think, just to get our heads wrapped around the significance of the challenge.

So 300 beds then: was that a relatively arbitrary number? Why did we land on 300?

**Mr. Wilson:** Do you want to jump in?

**Mr. Romanow:** Sure.

Chair, I know the department did undertake some assessment looking at optimal sizes for facilities, looking at budgetary opportunities for the development of new facilities. There was certainly an identified need in both Edmonton and Calgary for additional capacity and working through the Ministry of Infrastructure. We looked at what a potential size could look like. Certainly, as we're seeing with pressures for treatment spaces, psychiatric facilities, we know there is significant need, but this is a next immediate investment for capacity to add to the broader continuum of care that's in place across the province.

**Member Eremenko:** In the minister's opening remarks, Madam Chair, we talked about \$11 million to renovate existing facilities as a bit of a stopgap measure. It's the interim step before the compassionate intervention facilities are open in 2029, I believe. I'd like some more details about what these facilities are. Where are they located? What are the number of spaces? The initial announcement from the department was 50 beds in the north and 50 beds in the south that would be, I don't know, commandeered. I would really be concerned if the 50 beds or even a portion thereof was kind of a net loss to other psychiatric or recovery beds. Can the minister tell us a bit more about where those beds are located, what the renovations entail, and if there was any net loss to psychiatric acute-care beds, for example?

**Mr. Wilson:** That's a great question. I've been pressuring the department pretty hard to get this up and running. That was kind of their stopgap to find me some beds that weren't going to impact anything, yet we could get up and running sooner than – because when we start building, you know, it's going to take a couple of years to get them actually built. I want to get this up and running quicker, so they found me some spots and I'll let them describe where.

**Mr. Romanow:** Yeah. Thank you, Minister. Thank you, Chair. Certainly, the compassionate intervention facilities are enabled to provide tailored assessment, medical withdrawal management, and intensive treatment for concurrent disorders. Importantly, these sites are leveraging existing Recovery Alberta capacity. It really is the compassionate intervention framework, the legislative ability and enabling, but really it's leveraging secure sites that are in place and making modifications as referenced by the member in the budget, where some enhancements are needed for security and other purposes.

Also important to mention: it's related to upgrades of capacity with PCHAD, the protection of children abusing drugs, facilities which are in place across the province. As is noted in our business plan and in the legislation, PCHAD as legislation will be repealed, and compassionate intervention will be able to oversee that framework to offer supports for children and youth. So those dollars also go towards youth facilities that are existing across the province but need to provide that longer term treatment.

7:20

**Member Eremenko:** Of those 100 interim beds some of them are going to be identified for youth, or will those be in addition to?

**Mr. Romanow:** It is in addition to. We do have it – and these details are listed on our website on the government of Alberta platforms – where initial spaces are being identified with Recovery Alberta. I can list a couple of the specific sites.

**Member Eremenko:** No. That's okay if they're listed there. Thank you.

**Mr. Romanow:** Sure. Yes.

**Member Eremenko:** Okay. Thank you, Madam Chair.

I'll move on, still on page 119, to key objective 1.3 of the business plan, which is to continue to build and support an engaged, skilled mental health and addiction workforce, see also objective 1.5 about access to effective, high-quality mental health and addiction services. How is this objective going to be impacted by Bill 13? Will there be any professions from within Recovery Alberta that will be required to take cultural competency training because it is so intrinsic to their work?

We know that there was an exception made within Bill 13 that, despite making cultural competency training illegal, where it is absolutely fundamental to a profession, it would be not just permitted but also required. Given the prevalence of Indigenous populations, for example, particularly in the area of addictions and corrections, will the department be advocating for any professional associations who must have cultural competency training because it is absolutely inherent to their work?

**Mr. Wilson:** I'll jump in, and then they can kind of follow up.

As you know, we're putting, like, four on First Nations and one on a Métis community up at the Métis Nation of Alberta, just north of Edmonton there, so there'll be five recovery communities for Indigenous people, and it's going to be mostly cultural content.

I found working with Indigenous people that the best way to heal is to use their culture, their language, their sweats, the smudging, that type of thing. There's going to be elders involved. The first thing I did when I got into the ministry was look around the room, and I thought: oh, for an Indigenous lens we actually need some Indigenous people. So I've set up an Indigenous wisdom council, and that's people from all across the province that work in this field. There's some amazing people out there. I set up this council. We've met three times already. We just met up in Bigstone here a couple of weeks ago during the big snowstorm. We survived the trip up there.

It was really interesting to get the input, to get the Indigenous feel of what's happening, because there are concerns around compassionate intervention. What does that mean? Like, how does this impact? We got some really good input as to how we can set them up and make sure that when people go in that we're doing it very carefully. Like, I don't want my wife to be able to just lock me up. We want to have some good controls in there. There's going to be, first you go through – you can explain it better than me. Maybe just explain the whole phase as they go.

**Member Eremenko:** No. Actually, I'd like to avoid doing that. I mean, your joke that, you know, we don't want somebody to just lock us up: this is inherently the challenge with compassionate intervention, especially when they don't stand before a commission for up to 72 hours, isn't it? I hear you loud and clear on the recovery communities, but I'm not just speaking to the recovery communities

and certainly not just to the five recovery communities on First Nations.

Schedule 22 in the table section of the fiscal plan has a breakdown of full-time equivalents. The Mental Health and Addiction department increased from 186 to 216. Recovery Alberta, Madam Chair, grew from 8,190 last year to 9,284 FTEs. That's the estimate for 2026, and then CORE had an increase from 40 to 50. So when we're talking about cultural competency, certainly at bare minimum I would expect that recovery communities on First Nations would have some degree of cultural competency. But we are talking about nearly 10,000 full-time employees here that are dealing with a high, moderate, light level, all of it, 9,284 FTEs who are certainly going to be interfacing with a very diverse clientele. What about the cultural competency for them, and will you be advocating to the Minister of Justice around Bill 13 or within the Health Professions Act to talk about how we can make sure that cultural competency is provided and permitted?

**Mr. Wilson:** You're going to like this. All Recovery Alberta and department staff receive Indigenous awareness and sensitivity training. All of them.

**Member Eremenko:** Okay. What does that entail?

**Mr. Wilson:** There's a whole program. We work with the department. Actually, I used to be Indigenous Relations. There was a great group of people that work in there. A good friend of mine passed. Gilman Cardinal.

**Member Eremenko:** Sorry for your loss.

**Mr. Wilson:** You know, he actually adopted me as his grandson because I'd lost my family. He said: you can't be a lone minister. It was a huge loss. But there's still good people in there working and training people and making sure that there is that Indigenous awareness with all our staff.

**Member Eremenko:** So no advocacy specifically around including or in, like, permitting cultural competency within the professional sphere, but it is happening with all Recovery Alberta employees. Does that include the 216 Mental Health and Addiction employees as well?

**Mr. Wilson:** On the front delivery it's all Recovery Alberta, and those staff all go through the training. Yeah.

**Member Eremenko:** Back to the workforce question. This came up during Public Accounts, and then I noted as well that there are some areas around the workforce development piece, and of course it wouldn't be budget estimates if I didn't ask about the status of work that's happening with counselling therapists. Now, given all of your work around taking some time to look at the broader system to ensure alignment with the current and future health care workforce and refocused health care system, the department said that they'd be bringing the College of Alberta Psychologists and the Association of Counselling Therapy of Alberta to discuss a focused approach. This work started nearly 10 years ago. Three years ago the former Minister of Mental Health and Addiction announced that counselling therapists would be regulated under the College of Alberta Psychologists, and we have seen very, very little progress. Have the meetings between CAP and ACTA taken place over the winter, and can the department provide an update, please?

**Mr. Wilson:** Thanks. Alberta deserves access to professional and consistent mental health and addiction services across all health professions and the recovery model that I have formed with the

Mental Health and Addiction Recovery Workforce Advisory Committee. Before we undertake any regulatory work, we are going to make sure that the broader system ensures steps by government are aligned with the current and future health workforce and refocused health care systems and the recovery model. Our government remains committed to regulating the counselling profession and working collaboratively with the Association of Counselling Therapy of Alberta on a clear and effective path forward to make sure that does happen.

**Member Eremenko:** Under what line item in the estimates – if there's a cost associated with that, where is that going to fit under my operating expenses in government estimates?

**Mr. Wilson:** Do you know which line you're looking for there?

**Member Eremenko:** No. I'm asking where I would find it under any of these. Is it ministry support services? It's my understanding that the process to regulate counselling therapists does come at a cost, and I'm curious.

**Mr. Wilson:** We'll have to get back to you on that. They're not sure exactly where to look for that. This is a thick binder, so we'll get back to you.

**Member Eremenko:** Yeah. Please. If you can tell me where I can find that number and what is the current estimate in terms of how costly this endeavour is going to be to bring counselling therapists under CAP.

**Mr. Wilson:** Yeah. We'll get back to you on that.

**Member Eremenko:** Great. Thank you.

Through the chair, are addiction counsellors included in the department's goal to support an engaged, skilled mental health and addiction workforce? What is the plan to see them regulated given that a group of professionals who can have someone apprehended under the Compassionate Intervention Act really should have some degree of professional oversight and minimum public assurances?

**Mr. Wilson:** Under the recovery model with the Mental Health and Addiction Recovery Workforce Advisory Committee, like we said before, before we undertake any regulatory work, we are going to make sure that the broader system to ensure steps taken by government are aligned with the current and future health workforce model. I have just met with NorQuest, who is actually developing a course on addictions and mental health. Our staff is going to reach out to them to make sure that what they are going to be putting into their course is very much in line with what we want them to be working at with the people. There's a lot of stuff happening behind the scenes that is just still in the development stage.

**Member Eremenko:** Through the chair, can the department say whether or not in that planning stage addiction counsellors will be regulated? That was a line item that was specifically removed from existing legislation, that addiction counsellors would not be regulated.

7:30

**Mr. Wilson:** Can you say which line that was?

**Member Eremenko:** In the legislation? I'd have to actually pull up the Health Professions Act. The department very explicitly removed addiction counsellors from being on the path to regulation, so I'm curious if the department has plans to bring addiction

counsellors back into the fold when it comes to the conversation about regulating mental health professionals.

**Mr. Wilson:** I'm going to let Evan jump in on that one there.

**Mr. Romanow:** I think, to clarify, there certainly is, as the minister said, under this new Mental Health and Addiction Recovery Workforce Advisory Committee as a new ministry with Recovery Alberta, looking at the scope of the workforce needs, including with Indigenous service providers. We're looking at what system-wide approach is needed for the workforce, where we've got specific needs, what the regulatory and professional association environments look like across the mental health and addiction system, including working with ACTA. We've just had meetings in the last couple of weeks with them. They're very pleased with the process based on feedback from their leadership.

And there is commitment, as the minister said, to look at what oversight and professional designations are needed to protect Albertans in a safe, secure way. We are taking a bit of time as this system and the sector is being built out. We have committed by the fall to have advice coming back to the minister to work with this committee, to look at the needs, including related to counselling therapists and other aspects of the workforce.

**Member Eremenko:** Okay. Thank you to the department for the timeline on that front.

Another significant chunk of professions that have started to hold a far greater kind of presence in the workforce are recovery coaches. Madam Chair, I have a couple of questions about recovery coaches. Does the department know how many recovery coaches are currently employed by Recovery Alberta? How many are currently employed by organizations funded by Recovery Alberta or the department? And can the department tell us what the average salary of a recovery coach is?

**Mr. Wilson:** We continue to implement strategies to build and support an engaged, highly skilled mental health and addiction workforce in the ministry and in community services delivery organizations. Building the workforce capacity is essential for delivering a co-ordinated, effective, and sustainable recovery-oriented system of care.

In 2026-27 almost \$1 million is allocated to support operation of the Recovery Training Institute of Alberta, that provides specialized training sessions for those employed in recovery communities, therapeutic living units, and other addiction treatment organizations to enhance their skills in providing effective care. Also in '26-27, \$1.7 million is allocated to the Recovery Coach Academy of Canada, which launched in April 2024 and has provided training to more than 750 recovery coaches across Alberta.

Recovery coaches are an integral part of many publicly funded addiction treatment programs, including recovery communities and navigation centres in Edmonton and Calgary. Some clients in recovery communities and TLUs have gone on to complete the recovery coach course and certification so they can pursue opportunities to join the mental health and addiction workforce upon their return to the community.

**Member Eremenko:** Thank you, Minister. I think my question . . .

**Mr. Wilson:** I don't have a breakout of what everybody is making individually.

**Member Eremenko:** Do you even have an average?

**The Chair:** Sorry. Members, pardon me. The conversation is not flowing through the chair. I've given two reminders. Both Minister and members, please, the conversation needs to flow through the chair throughout our entire discussion today.

**Member Eremenko:** Thank you. Can the department tell – I'd be curious if there is even just an average hourly rate for recovery coaches. Of course, if we're talking about hundreds of recovery coaches that are employed, it will certainly have a relevance to the budget if it is minimum wage or if it's \$30 an hour. Just an average number would be great and, again, the number of recovery coaches that are actually employed.

Further, what is the dollar value of the current contract with Bowline Health? Bowline Health is the employment agency that hires recovery coaches perhaps on behalf of Recovery Alberta. Perhaps the department can clarify that for me. I heard \$1.7 million for the Recovery Coach Academy, but it's my understanding that the Recovery Training Institute is far greater than \$1 million a year. So, please, if the department can clarify the current contract with Bowline Health, the value of the contract for Recovery Training Institute of Alberta and the Recovery Coach Academy of Canada, as well as just a ballpark hourly rate, hourly wage for recovery coaches and a ballpark number of the number of recovery coaches that are employed.

**Mr. Wilson:** We're just digging up Bowline's numbers.

The average wage I can't give you. They're employed by several different groups out there. The employment is going to vary. I can't give you a number on that. Sorry.

**Member Eremenko:** Can the department provide the number of recovery coaches that are working in Recovery Alberta?

**Mr. Wilson:** Yeah. Go ahead.

**Mr. Romanow:** Chair, through this mental health and addiction workforce advisory committee that is one of the starting pieces for all of the employers across the system. We've done a survey – it's just been released a couple of weeks ago to all the employers that are contracted – to get a sense of the exact types of positions. We certainly know, through the grant agreements with different operators, the general types of programming. To get a real sense of the workforce: that's type of information we'll have coming back. As the minister noted, it is up to different employers across the broader system, including AHS, Recovery Alberta, who would employ different employees in those spaces. We'll have a better sense, through that workforce survey, about what the exact numbers will look like and get a better sense of what the salaries would relate for those positions as well.

**Member Eremenko:** Can the department clarify the value of the contract for Recovery Training Institute for '26-27, please?

**Mr. Wilson:** You'll just have to give us a second to look that up.

**Member Eremenko:** Sure. Would you like me to keep going?

**Mr. Wilson:** Recovery Coach Academy of Canada: that is \$1.7 million.

**Member Eremenko:** Through the chair, I asked about the Recovery Training Institute of Alberta, not the Recovery Coach Academy.

**Mr. Wilson:** Yeah. Chair, on the Recovery Training Institute of Alberta, that provides specialized training sessions for those

employed in recovery communities, that's just around \$1 million for that one.

**Member Eremenko:** All right. Thank you.

Page 119 of the business plan says that \$42.5 million is allocated to implement an operationalized compassionate intervention legislation while in the fiscal plan, pages 77 to 78, the department reports \$33 million for compassionate intervention. There were a lot of numbers in the minister's opening comments, and I just want to revisit a couple of those. Can the department please confirm how much is operating cost and how much of this is capital? Perhaps the \$33 million is a part of the \$42.5 million. If they can clarify, please, that would be helpful. How precisely will that be spent in the year ahead?

What is the cost of the Compassionate Intervention Commission, and what is the status of the recruitment to that list? I see that a commissioner has been hired, but there are no current board opportunities listed. Is this just waiting for the regulations to be completed?

**Mr. Wilson:** To start from the back, Chair, it is waiting for the regulations to be completed for the board members.

The numbers are – okay – \$318 million for capital and \$42.5 million in operating. The department is \$9.7 million, and Recovery Alberta is \$32.9 million.

**Member Eremenko:** Sorry. Through the chair, \$42.5 million is the operating . . .

**Mr. Wilson:** That's split between the department and Recovery Alberta.

**Member Eremenko:** Okay. So \$33 million is Recovery Alberta while another \$2.9 million is the department.

Now, this is an ongoing challenge, I think, and perhaps . . .

**Mr. Wilson:** It's \$9.7 million for the department.

**Member Eremenko:** Nine point seven. My apologies.

**Mr. Wilson:** And \$32.9 million for Recovery Alberta.

**Member Eremenko:** Okay.

Through the chair, are there third parties identified to support the implementation and operationalization of compassionate intervention? What work, directly or by way of partnerships, has been done to build the capacity of law enforcement and health care systems to fulfill the mandate of involuntary treatment? What, if any, lessons have been learned in the operationalization of the Mental Health Act that might inform how the department proceeds with involuntary treatment?

**Mr. Wilson:** Evan is going to jump on that for the first part.

**Mr. Romanow:** Thank you. Recovery Alberta is leading all the secure compassionate intervention facilities, supporting with the conveyance and being able to work for the patient assessments and patient care. Other contracted providers, addiction treatment providers could have a role in some of the treatment programs beyond where Recovery Alberta is offering that stabilization and their sites.

Additionally, community partners for the aftercare could play a role, looking at housing environments, supportive living, disability-related sorts. All of that different programming could be through other partners. They would be identified through compassionate intervention and designated as being parties as part of compassionate

intervention. But Recovery Alberta is leading the secure sites exclusively.

7:40

**Member Eremenko:** I just want to double-check that I heard the deputy minister correctly there, that it will also be Recovery Alberta responsible for conveyance – that is, the transportation of individuals to the appropriate facilities – if I’ve got that right. Please correct me if I’m wrong.

As far as capacity building at the front end of this entire endeavour – apprehension, detention, possible acute medical care that’s required before conveyance to the compassionate intervention facility – what kind of capacity-building supports or funding transfer might there be to ensure that all of these other departments are in fact complementing and aligned with the system at hand so that it works relatively seamlessly? I mean, it really does need to be smooth.

**Mr. Romanow:** Chair, to respond, certainly, police, and there is a requirement for apprehensions for police to play a role. AHS Protective Services and Recovery Alberta staff, including nursing, psychiatric nurses, and others, could have a role to support with the medical aspects, with police playing a role just for that apprehension component. But this is a health response. This is not a police response, and there is a very narrow role. We’re working with police through a working group across the province to make sure the right protocols and procedures are in place. That’s certainly through Minister Ellis’s department, Public Safety and Emergency Services, to make sure there’s very strong and robust co-ordination.

But it is a health response, and Recovery Alberta and AHS Protective Services, who are health professionals who secure sites all across the province each and every day, are playing that role within those secure settings to make sure that the high quality of care they are currently providing continues to be provided in compassionate intervention related facilities.

**Member Eremenko:** Yeah. I mean, the Mental Health Act, through the chair, is also a health response, but it is heavily reliant on the role of law enforcement to do their job, to do a very, very challenging job. The rules around respecting private property, where a person can be apprehended, can they go into private property to apprehend a person: the demands on law enforcement to actually hold up those initial 24, 48 hours of this entire process are significant. Will there be funding transfers from the Ministry of Mental Health and Addiction to Public Safety and Emergency Services to provide them with the capacity and the expertise – the very unique expertise – that those individuals require to actually detain and apprehend somebody within the time frame that the legislation requires?

**Mr. Wilson:** The simple answer is yes.

**Member Eremenko:** There will be a funding transfer from Mental Health and Addiction to Public Safety and Emergency Services?

**Mr. Wilson:** If it’s appropriate, yeah.

**Member Eremenko:** Okay. Thank you.

Oh, gosh. Okay. What comes next here? Let’s get into some of the performance metrics if I may. Speaking of the Mental Health Act, page 120 of the business plan, performance metric 1(b), has the percentage of individuals admitted three or more times to hospital under the Mental Health Act. I believe that the goal here is that we reduce the number of people who have been admitted three or more times to a hospital under the Mental Health Act. Just some

very logistical questions that can clarify the data for me: over what period of time and for how long does the three admissions apply? Page 120, at the top.

**Mr. Wilson:** It’s over the course of a year. I’ve had some extreme cases. I just had one over 220 times in one year if you can imagine.

**Member Eremenko:** Okay.

**Mr. Wilson:** I mean, these people are in extreme trauma.

**Member Eremenko:** To what extent are appropriate discharges then considered in that example that the minister provided, Madam Chair, if an individual has been admitted under the Mental Health Act 220 times?

**Mr. Wilson:** They weren’t admitted under the Mental Health Act.

**Member Eremenko:** Oh, I’m sorry. What was . . .

**Mr. Wilson:** That’s just people that have come from a shelter probably, have been taken to the emergency room because they’ve overdosed.

**Member Eremenko:** Okay. Through the chair, the performance metric is the percentage of individuals admitted three or more times to a hospital under the Mental Health Act. We’ve established that that is three or more times in the period of a year. We’re looking to have this number go down. This is a percentage of some larger group. The metric for 2024-25 was 8.6 per cent for re-admissions. So it’s 8.6 per cent, Madam Chair, of what larger group? Is it 8.6 per cent of everybody that has been admitted at some point in that year under the Mental Health Act? Is it total admissions in a hospital? Eight point six per cent of what?

**Mr. Wilson:** I’m going to have to clarify. We’re not quite sure what you’re shooting for here.

**Member Eremenko:** Okay. I’ll just maybe read this verbatim.

**Mr. Romanow:** Are you on page 120?

**Member Eremenko:** I am on page 120, performance indicator 1(b), “percentage of individuals admitted three or more times to a hospital under the Mental Health Act.” In ’24-25 we have 8.6 per cent of people who were admitted three or more times; 8.6 per cent of what?

**Mr. Wilson:** It looks like it’s the total admissions for mental health.

**Member Eremenko:** Total admissions for mental health. Okay. So not total admissions to the hospital. It’s anybody that was admitted.

**Mr. Wilson:** With a mental health indication.

**Member Eremenko:** Under the Mental Health Act, through the chair?

**Mr. Wilson:** No.

**Member Eremenko:** Okay. So just anybody admitted.

**Mr. Wilson:** With a mental health indication.

**Member Eremenko:** Right. Presenting with a primary mental health.

**Mr. Wilson:** Yes.

**Member Eremenko:** Does the ministry collect data on the number of people presenting for in-patient treatment, either voluntarily

through the emergency department or primary care provider versus those who are seeking an intervention through the Mental Health Act? How many people actually got admitted in the last fiscal year for a primarily mental health issue?

**Mr. Wilson:** To the chair, what page are you on now?

**Member Eremenko:** This is just digging into performance indicator 1(b) once again. If we're trying to get a good sense of what . . .

**The Chair:** I'm just going to make a comment. We are here this evening for the purpose of budget estimates, so those are the questions that you need to focus on. It would be helpful if you gave a page number so the minister can go through and answer the questions.

**Member Eremenko:** Same performance indicator. Page 120 of the business plan, performance indicator 1(b).

**Mr. Romanow:** I think, if we're understanding the question, Madam Chair, admission is coded Mental Health Act and then gives that total, and then out of those it's how many are three-plus, and yes, that data is collected throughout the entire health system.

**Member Eremenko:** Through the chair, can the department tell us why there are no targets beyond '24-25 for this particular metric?

**Mr. Romanow:** Thank you, Chair. That's a performance indicator rather than a performance measure, so that is providing the snapshot, as indicators provide. It's indicating the current state in a given year, as is outlined in the business plan.

**Member Eremenko:** Okay. Thank you.

Back to page 119 of the business plan. Of \$1.7 billion, \$60.2 million supports mental health and addiction service delivery in correctional settings. Page 119 once more on the business plan. What percentage of the \$60.2 million is used to operate the 200 therapeutic living units, and what data is currently publicly available concerning the effectiveness of this intervention?

7:50

**Mr. Wilson:** Chair, the TLUs, the therapeutic living units, are \$6 million.

**Member Eremenko:** Six million? Just to clarify that I've heard that correctly.

**Mr. Wilson:** Yeah.

**Member Eremenko:** Okay. Can I then assume that the remaining \$54 million is used for all correctional health services?

**Mr. Wilson:** The \$54 million is separate, so the \$6 million is separate from this. The TLUs are \$6 million on their own.

**Member Eremenko:** Correct. So if we're looking at \$60.2 million in supports for mental health and addiction service delivery, what does the other \$54 million entail?

**Ms Everington:** It includes health services provided in correctional facilities.

**Member Eremenko:** Okay. Through the chair, that was my initial question: does the remaining \$54 million cover all of correctional health services? For those listening at home, Recovery Alberta is the health agency that is responsible for delivering all health services across 10 correctional facilities in Alberta. What I'm

basically looking for is: what is the expense for '26-27 to deliver correctional health services to all inmates in correctional settings?

**Mr. Wilson:** It is \$60.2 total.

**Member Eremenko:** Right. Then less the TLUs, so \$54 million is what remains to cover the remainder of all correctional health services.

**Mr. Wilson:** Correctional health services, \$54.8 million; TLU operations, \$6 million; transition services, \$1.7 million.

**Member Eremenko:** Thank you.

Through the chair, can the department provide this committee with some information about the health of inmates and the nature of those services being provided for \$54 million? How many and what type of public health interventions are provided? I mean, I've got a number of questions here about the ways that Recovery Alberta, uniquely situated to provide mental health and addiction support, is in fact providing a whole range of health services to a population of 3,500 adults and youth across 10 correctional services. Chronic disease management, prescriptions, preventative health care, vaccinations, X-rays: Recovery Alberta is doing this for all inmates across correctional facilities. Maybe rather than asking here, where can the public find the information regarding the ways that that \$54 million is allocated to support inmates in correctional facilities for health purposes?

**Mr. Wilson:** If you went through Recovery Alberta's business plan report, it would be reported in there. The correctional health services across the province include primary care, public health, dentistry, mental health and addiction services, and that's to serve about 20,000 clients.

**Member Eremenko:** Oh. I suppose 20,000 clients over the course of a year as a result of people being admitted and discharged.

**Mr. Wilson:** Incarcerated.

**Member Eremenko:** Incarcerated. That's the word I was looking for. Thank you.

No specific data in terms of the demand on the type of service? I've seen highlighted just very generally vaccinations, dentistry, pharmaceuticals, but nothing specifically about the actual areas of what the allocation is specific to the different treatments.

**Mr. Wilson:** I'd have to take it away and have Recovery Alberta dig deeper. This is like a high-level overview. How many people actually got fillings: no, I don't have that.

**Member Eremenko:** Even just the budget line item for what dentistry costs.

On page 119, speaking of performance metrics, we've got the percentage of individuals primarily admitted for more than 30 days to hospital in-patient care for a mental health issue. Concerning the targets, once again, 17 per cent of individuals admitted for mental health reasons stayed longer than 30 days. Is that 17 per cent of all admitted patients? On the last sentence on page 119, through the chair, the department has, "In 2024-25, the percentage of individuals admitted to inpatient care for more than 30 days was 17.0 per cent." That's 17 per cent of what total group?

**Ms Everington:** It would be 17 per cent of those admitted for mental health reasons, similar to the other metric that we spoke about.

**Member Eremenko:** Okay. Through the chair, for those who stayed longer than 30 days, what's the average length of stay?

**Mr. Wilson:** I wouldn't have that information here. We'd have to get back to you on that.

**Member Eremenko:** Yes, please. If I can get that in writing, what the average length of stay is for an individual in hospital in-patient care for a mental health issue.

Through the chair again, I mean, we've got individuals who are admitted in the hospital oftentimes for deeply complex and concurrent physical and mental health issues that can be incredibly challenging to support out in the community. My concern, just so that the department kind of understands the thrust of my question here, is that in the rush to clear up beds, to clear the ALC category of individuals, we end up discharging people out of hospital either before they're ready or they are discharged into a facility that is not prepared to deal with the kind of complexity and concurrence of issues that an individual may have. So I just have a couple of questions about that.

For these patients that are staying in hospital in-patient care longer than 30 days, at what point are they assigned an ALC status, in that they can't be discharged to the public but rather are waiting for a continuing care or long-term care bed? Where there are high medical complexities, are these patients included in the metric? Does it mean where the mental health issue is the primary reason for hospitalization, and for this particular metric, is it the exclusive reason?

**Mr. Wilson:** What line are we on again?

**Member Eremenko:** Page 119, performance metric 1(a). We're talking about the percentage of individuals primarily admitted for more than 30 days to hospital in-patient care for a mental health issue. Do we have a sense of how many of those individuals also have concurrent physical health issues?

**Mr. Wilson:** We wouldn't have that metric yet. We're working with the other ministries to nail that stuff down right now, but I wouldn't have that right now.

**Member Eremenko:** Do we have a sense of how many ALC status patients are currently waiting for a long-term care or continuing care bed?

**Mr. Wilson:** Chair, as of March 10, 2026, there were 203 mental health patients classified as ALC, acute, subacute, and forensic – in acute-care hospitals and stand-alone psychiatric facilities including 114 patients – for more than 100 days.

**Member Eremenko:** Through the chair, that's 114 of the 203?

**Mr. Wilson:** That would include that, yeah. Including 114.

**Member Eremenko:** Thank you.

Through the chair, if I may, I'll continue on. On page 121 performance indicator 2(a) has a change in recovery capital scores of Albertans accessing publicly funded addiction treatment. Now, of course, recovery capital score is meant to be a person's kind of point system on how well they are doing on their path to recovery. I may use up the last 15 minutes here with the minister to discuss this particular recovery capital score because in many ways it is the strongest indicator we've got about how effective programs and services and interventions are within Mental Health and Addiction and Recovery Alberta, but it has come at a very rocky start.

**8:00**

The recovery capital score was collected using an app called My Recovery Plan. The My Recovery Plan app was purchased from a private residential facility in B.C. I'm hoping that the department can start by just giving me some clarity. Maybe I won't need the full 15 minutes to talk about recovery capital score. Is the department continuing with My Recovery Plan or not? Has it been abandoned or, perhaps, are there plans to abandon My Recovery Plan? What is the pathway to do that? How can we collect recovery capital score without the tool that people can engage with?

**Mr. Wilson:** Madam Chair, we have used My Recovery Plan platform to track changes in recovery capital, and that platform is being transitioned to a new application as part of the broader evolution of the Alberta recovery model. MRP continues to be used until the new tool is ready, and outcomes will be reported annually in the minister's annual report.

Performance indicator 2(a), like you're talking about, in the 2026-29 business plan speaks to change in recovery capital scores for Albertans accessing publicly funded treatment. At this time the score is obtained when an individual completes a questionnaire upon admission to treatment and then again usually upon discharge. The decrease in the percentage change reflects that the number of participants in the scoring tripled between the two points, which is a great indicator of how many Albertans are accessing the services.

Basically, building recovery capital is a pillar to our government's approach to mental health and addiction recovery, ensuring individuals have the personal, social, and community resources that they need to pursue and sustain a life of purpose, connection, and wellness. Improving and maintaining recovery capital is a key factor in service planning. For example, planning and co-ordinating community-based services, supports for compassionate intervention clients who are discharged to help maintain the recovery and improvement in overall health.

There's going to be ongoing work to enhance treatment programs to provide Albertans with safe, quality services and ensure community-based pathways to build recovery capital. This includes inviting family members and friends to be part of someone's treatment, skills training and transition planning, and to engage the individual with housing, health care, and other supports to help them in maintaining their recovery once their treatment is completed.

**Member Eremenko:** Through the chair: does the department have a timeline on when the new tool will become available?

**Mr. Wilson:** They're developing right now. Over the course of the year you'll see it as it evolves.

**Member Eremenko:** Will it be introduced in a phased-in approach, or are we waiting for it to be fully baked before operators can begin using it?

**Mr. Wilson:** The original one that we're using now, that My Recovery Plan one, that's not being abandoned at this point. It was an innovative tool that supported our work to refocus addiction care and treatment on a recovery-oriented approach. As recovery-oriented systems mature through research and evaluation, the digital solutions that support the clinical environment will evolve and catch up. So, it's being developed as we speak.

**Member Eremenko:** I'm sorry. I don't understand. From the department: are we building off My Recovery Plan and so still using the foundation that that created, or are we, in fact, building a brand new plan?

**Mr. Wilson:** It's a new platform. It will be phased in as it goes along, but it's a new platform.

**Member Eremenko:** Ultimately, My Recovery Plan will be abandoned once we have a new tool in place.

**Mr. Wilson:** Yes.

**Member Eremenko:** But the new tool will be fully operational in a year.

**Mr. Wilson:** Hopefully less than a year.

**Member Eremenko:** Less than a year.

**Mr. Wilson:** This year.

**Member Eremenko:** Before the end of calendar year 2026 MRP will have been fully abandoned and replaced.

**Mr. Wilson:** That is the goal.

**Member Eremenko:** That is the goal.

I note on the estimates document under Recovery Alberta, line 2.6, that information technology has quite a significant budget of \$43.6 million for '26-27. Is that where this work to create a new recovery capital score capture tool is going to be found? What is the cost of developing the new tool, through the chair?

**Mr. Wilson:** I guess we haven't set the total up yet, Madam Chair. They're doing the licensing on the platform.

**Member Eremenko:** Can the department remind us what the cost of the My Recovery Plan app was? What I'm hoping to do here is performance metrics.

**Mr. Wilson:** Well, we have a huge book, so you can't just throw numbers at us and expect us to find it right away. You're going to have to ask a specific question.

**Member Eremenko:** I was hoping for the numbers to be thrown my way.

**Mr. Wilson:** Well, you have to ask me about a specific page; otherwise I can't find it.

**Member Eremenko:** We've got performance metric 2(a) that speaks to the recovery capital score. We don't have a sense of what the new tool is going to cost to establish precisely what we need so that we can actually identify whether we're moving the needle on recovery capital score, the only tool that we actually have within the Ministry of Mental Health and Addiction to know if we are making a difference in people's lives. If we don't have a sense of what the new tool is going to cost to develop, at minimum let's be clear on the value of the tool that we are going to be abandoning by the end of the year so that we know if we're getting, you know, value for taxpayer dollars. When it comes to creating a new tool, how much money will have been spent on a tool that will no longer be operational come the end of the year?

**Mr. Wilson:** Thanks, Madam Chair. We came up with the cost here. MHA is working with Technology and Innovation right now to have funding assigned to develop the replacement for MRP, and it's going to be an approximate cost of \$2.6 million over the next two fiscal years. That's as close as I can nail it down for you.

**Member Eremenko:** Okay. No. Thank you. Thank you very much to the minister. What lessons were learned from My Recovery Plan,

that will be abandoned at the end of this year, that will make sure that the new tool is in fact going to be able to capture the recovery capital score in the business plan? Lessons learned.

**Mr. Romanow:** I think what's really important, as the member asked in the question, Madam Chair: My Recovery Plan has provided significant learnings and it is generating currently, right now, a recovery capital assessment to generate the recovery capital index. Again, that's for consenting clients at admission. The success of this indicator is not just about the scores; it's about the broader number of participants, which is increasingly scaling up, as noted in the scores adjustment in the last reporting, but I think these learnings – and certainly there's an interest to look at the measurable approaches. We've had some learnings about the length of the questions.

For example, wanting to make sure that it's being able to be done in a judicious and streamlined way as individuals are entering more facilities across the broader system. Some of the learnings looking at the initial indicators, looking at the usability for operators, and the consistency, the length, and, again, making sure that we've got a tool that's not only useful for a broader system measurement but useful for individuals to identify the recovery capital domains, identify where are the specific areas in their lives, their individual experiences with their treatment operators and providers of services, wherever they may be in the broader system, to again help them articulate their goals and help them plan on their path to recovery.

So, many learnings. It's why it's a tool that's continuing to be used, but the scope and space that recovery and the system that we're currently operating in, inclusive of Recovery Alberta, has changed tremendously since MRP was developed. It was a smaller space that served its time very well, but again lots of learnings to expand and scale as we move forward.

**8:10**

**Member Eremenko:** Okay. Thank you. In the last four and a half minutes here, maybe I'll finish with the business plan. Page 122 has performance measure 3(b), which is the number of operational and newly created mental health and addiction facilities per 100,000 population.

I find, through the chair, one of the challenges working on this file is that we talk about mental health and addiction interchangeably. They're right there in the title, and we often talk about them kind of synonymously, but they certainly are not. I think the nature of the facility and the nature of the care required and the nature of the professional skill set required is very different. What I'm hoping for page 122 performance metric 3(b), that the department would like to see an increase in the number of operational and newly created mental health and addiction facilities per 100,000 population: can the minister distinguish the mental health facilities from addiction facilities, please?

The business plan up until this point, as I mentioned, has been quite tilted toward addiction, but if what I hear in my office is any indication the need for mental health supports, the need for residential mental health support, whether it be simply for purposes of stabilizing or for the longer term, is incredibly high. Can you, to the extent that the department is able to, please parse out mental health facilities from addiction facilities, and what are those ratios per 100,000?

**Mr. Wilson:** Madam Chair, there are three types of addiction. The recovery communities: we've got 274 beds to provide longer term treatment with supports using a four-phase model that includes community reintegration. Then we talked about the five Indigenous-

led recovery communities, and Recovery Alberta has 2,851 beds that provide addiction and mental health services in the community: 1,373 beds are for community mental health and supported living in transitional care and 1,478 beds provide addiction services. Then, of course, starting in 2027 we'll have the compassion intervention beds as well. Then for children we're developing the CASA program. You're familiar with that?

**Member Eremenko:** Yes, thank you very much. Through the chair, my question was in regards to facilities, not beds.

**Mr. Wilson:** Well, if I can go back to CASA House, that's for mental health for kids, so that's facilities. We're actually having four CASA houses across the province, and that's beyond what the CASA classrooms are. That's a full facility where kids will stay. We've got one in Sherwood Park right now. If you get a chance, it's an amazing facility with kids in there. I've been through it. The kids that would normally be really struggling and not be able to even participate in classrooms: all of a sudden, when they're in this type of a situation, they're not only participating but they're excelling beyond what an average kid would do. They're doing a really good job there. It's an amazing facility, and there will be three more built across the province.

**Member Eremenko:** Through the chair, can we just clarify what we mean then by facilities? I'm assuming that mental health classrooms do not qualify as mental health facilities. These are actual CASA houses?

**Mr. Wilson:** Yes.

**Member Eremenko:** Okay. I'm sorry if I missed it: how many youth can actually be accommodated across the four CASA houses, please?

**Mr. Wilson:** Twenty per house.

**Member Eremenko:** Through the chair, will the CASA houses be used for the purposes of the new compassionate intervention legislation for youth?

**Mr. Wilson:** No. This is for kids that have been diagnosed with serious mental health issues. This isn't addiction; these are kids that are struggling with various problems.

**Member Eremenko:** What is the expected duration of the average stay, through the chair, at CASA House?

**Mr. Wilson:** I think it's three months. Three to four months would be the average, kind of, stay.

**Member Eremenko:** Thank you very much. I see the clock running down. Perhaps before I start another question, I'll cede the rest of my time.

**The Chair:** Thank you so much, members. We're going to take our five-minute break, and when we return, we will go to the private member, Scott Sinclair, for his questions. Thanks, everyone.

[The committee adjourned from 8:15 p.m. to 8:20 p.m.]

**The Chair:** All right. Well, thank you, everyone. Let us resume. Let's now go to our private member. Would you prefer to have blocked or shared time with the minister?

**Mr. Sinclair:** I'll do shared time, if it pleases the chair and the minister.

**Mr. Wilson:** That's fine.

**The Chair:** Please proceed.

**Mr. Sinclair:** Thank you, Madam Chair. Thank you, Minister and your team. I'll just get right into it. For many families in our rural, northern, and Indigenous communities, one of the hardest parts of watching a loved one struggle with addiction is seeing them lose the ability to keep themselves safe. In small communities where everyone knows each other and support systems are already stretched pretty thin, turning our backs on people who are at serious risk of harming themselves or others isn't really compassionate; it's abandonment.

I am encouraged to see the ministry business plan include a \$42.5 million investment to implement compassionate intervention legislation, which I believe for reference is on page 119. For many of our communities, having a tool that can save lives while still respecting the rights and dignity of Albertans is incredibly important. I know it's a delicate balance, for sure. The mandated intervention is never something to take lightly; it's a last resort. I believe the intention is to protect people when every other option has failed. I remember the line, meeting with Minister Williams when he had your file, and I think it was already mentioned here today that the threshold should be and is extremely high: a danger to themselves and others. I think that's important, and this process is handled with care, cultural understanding, and strong oversight.

My question, through the chair, is: could the minister speak more about this investment? And what specific supports or services will it help fund, especially for rural, northern, and Indigenous communities, where access to care is often limited? Selfishly, because that's the area that I represent, so I see it first-hand.

**Mr. Wilson:** Thanks for the question. Madam Chair, the investment for compassionate intervention includes funding for several components of the process, and this includes the commission, the office of the statutory director, and for Recovery Alberta to provide services and secure facilities. Once a person is no longer meeting the criteria for compassionate intervention, they would be discharged from compassionate intervention. But that doesn't mean that support is going to stop. All clients will receive a thorough discharge planning and be connected with community supports and services. Depending on the individual's needs this might include continuing treatment in a recovery community, day programming, or ongoing work with a recovery coach, and the funding for compassionate intervention is just one component of supporting these individuals and their communities in their long-term recovery journey.

We are intentionally not rushing implementation of the compassionate intervention so that we can ensure that additional voluntary treatment, such as recovery communities, housing, and recovery supports are going to be in place. Building out these supports is all part of the recovery model. For Indigenous clients this includes connections to Indigenous-led programs in the community, access to elders, traditional healing practices to help them return to their home communities, and we're engaging with Indigenous partners, including through the wisdom council that I talked about earlier that we set up to discuss what resources will best meet community needs. I just had a group in today from Bigstone that are working on a program to do that aftercare, so there are a lot of things that are getting in place right now.

**Mr. Sinclair:** Thank you, Minister, and thank you, Madam Chair. Just a special thank you, Minister, to you and your team for making the trip to Wabasca in the Bigstone area for one of those big wisdom council meetings. I was grateful enough to be able to attend it, so I

could say that forming the council is one thing but having those meetings in our areas in northern Alberta, thankfully everyone arrived safe. Being able to experience the roads is incredibly important to me and the area I represent because it gives a real snapshot of the idea of the struggles of the transportation aspect of getting people to treatment in our area.

I think it was even mentioned in the meeting that a lot of the people from the facility we've seen were being transported to Fort McMurray or even High Prairie. On a map it doesn't look that bad, but on days like that when the weather is so terrible, getting somebody three and a half hours by truck is difficult. Thank you for making that trip, and thank you for forming that council.

My secondary question is I believe from page 118 of the business plan. It specifically mentions the Compassionate Intervention Commission. I know it was touched upon earlier by Member Eremenko, but could the minister explain how this body will ensure the legislation is applied appropriately and respectfully, particularly in Indigenous and remote communities? I know it's a concern that I get asked about.

You and I have spoken one on one about this, about the delicate balance between understanding that we are in a crisis and that it does affect disproportionately Indigenous people but trying to find the line between, you know, you're in a new frontier, and it's a crisis, and we need something done quick, but you're also – I don't want to say fighting – trying to balance that with Indigenous inclusion, with an emphasis on lived experience for workforce development but also cultural inputs. You know, we had that mutual friend who gave us an example of just referring to them as nieces or nephews or uncles and cousins instead of clients. It seems so silly or small to people who don't understand, but it's just a very important thing that makes people feel welcome.

Thank you.

**Mr. Wilson:** Thanks for that question, Madam Chair. Around the rez they call me Uncle Ricky, so I understand that, you know, the family tie is very important. I've been so blessed to have been welcomed into many communities and start to understand all the complex issues that are out there.

The Compassionate Intervention Commission is going to be led by a commissioner, and then the decision-making panels will be comprised of lawyer members, physician members, and public members. During hearings the lawyer members will be the chair of the panel responsible for ensuring that orders align with the legislation, including harm criteria, time frames, reporting, and more. The physician member will be able to assess the health perspective and needs of compassionate intervention orders, while the public member will provide a layperson's perspective to the situation. Recruitment strategies for commission members will encourage diversity, including representation from Indigenous peoples and rural and remote communities. I think that's going to be the key part of making this thing work, that we make sure that we have Indigenous people on the panel when there is an Indigenous person being looked at.

In addition to having their independent legal advice, being chaired by a lawyer member and being well informed of the legislation, commission decisions are subject to internal appeals, and decisions resulting from internal appeals are subject to judicial review of the Court of King's Bench. As you heard when we had our wisdom council meeting, one of the ideas brought forward is that if it's an Indigenous person, there should be an elder there so that they can have that connection back to the community. It's definitely something that we'll be looking at.

**Mr. Sinclair:** Thank you. I appreciate the answer. Through the chair, just to follow up, Minister, are there other partners – you mentioned the wisdom council already – Indigenous leadership, local health providers, or community organizations and nonprofits who will be involved in Alberta's compassionate intervention process to make sure it reflects the realities of not just Indigenous people but maybe specifically rural and northern life?

**Mr. Wilson:** Thank you. Through the chair, that's a great question. We just talked about the wisdom council and how it's important to get that Indigenous lens on things. Like, I've always been told: nothing about us without us. I've learned that lesson well.

As compassionate intervention implementation advances the department is going to engage with multiple stakeholders, including the service providers for the Indigenous recovery communities and others who can help inform the department's approach to compassionate intervention. The department continues to engage with police services, including self-administered Indigenous police services. We have the Blood Tribe Police Service, Tsuut'ina police service, and up north we've got the Lakeshore Regional Police Service to support an approach to apprehension and conveyance that is going to be very well informed.

8:30

The Compassionate Intervention Act also has a unique provision permitting First Nations and Métis to enter into agreements with the minister to integrate their unique practices and traditions into the compassionate intervention process. I think that's an important part that hasn't really been talked about much. There is going to be that direct input into it. We're going to continue to talk to the communities about how this provision can be levered for their communities specifically.

**Mr. Sinclair:** Okay. Thank you. I just wrote down a question earlier; I missed it when you went over the details. You mentioned a 105-bed youth treatment centre earlier. Would you be able to tell me where that's located?

**Mr. Wilson:** Yes. Through the chair, that's going to be in Edmonton.

**Mr. Sinclair:** Okay. Thank you.

**Mr. Wilson:** It's well under construction. That'll be late fall or early next year. Yeah.

**Mr. Sinclair:** Okay. Thank you. I appreciate that.

Madam Chair, the recovery community model has become one of the most important parts of this government's approach to mental health and addiction care. On page 77 of the fiscal plan recovery communities are highlighted as a major pillar of our mental health and addiction priorities in government. I haven't yet had the chance to visit one of these facilities myself, although I'm definitely going to as soon as I get the chance. I've heard incredible stories from people who have. It's clear that these recovery communities are offering something that's, you know, impactful in a pretty dark and heavy area. We have the opportunity to save people's lives.

In the north we understand that staffing and other challenges make it difficult to build and operate facilities of this scale in our own communities. It's not going to stop every single one of them from asking for one. I do understand the realities of the process and the recruitment and retention challenges we'll have. It doesn't mean that northern residents should miss out on the same supports. If these facilities can't be built in the north or in as many communities as they'd like, can we bring northern Albertans to the facilities, whether through transportation supports or other solutions that

ensure equitable access? This was something, again, that we made reference to briefly in the wisdom council that I attended just because of the obvious drive and the challenges there. My question, through the chair, to the Minister is: for rural and northern Albertans who may not live near one of these facilities, what work has been done to explore transportation supports or other solutions to ensure they can still access this level of care?

**Mr. Wilson:** Through the chair, thank you. That's a great question. I've travelled the province and I've been to every First Nation out there. Transportation is such a huge issue, especially for some of the remote communities there.

We are looking at a recovery community for Grande Prairie. That's going to provide up to 75 beds to deliver promised addiction treatment and recovery beds in that region. We're aiming to establish these services in fiscal year '27-28.

I recognize the transportation barrier that exists for rural and remote communities. While we explore transportation options, particularly as Indigenous-led recovery communities are operationalized, we encourage people to contact the recovery community directly to determine whether the service provider is able to support with transportation or connect the person with transportation options. Recovery community operators may be able to facilitate transportation for individuals, for example those leaving therapeutic living in a correctional facility or those completing detox at a facility relatively close by.

If you ever get a chance, I would love to take you to one of the recovery communities, especially the therapeutic living units in the prisons. If you don't come out of there crying, you don't have a heart. I've got to tell you that. It's pretty amazing what's happening in there.

One of the really cool things: I was in I think it was Lethbridge, and there was a young fellow that I knew there from Maskwacis. He was offered parole, and he turned it down to stay in our program. He wants to become a recovery coach and go back to his community and help. That's the kind of success that we're having in these things. It's pretty amazing.

**Mr. Sinclair:** Thank you, Minister. I appreciate the answer.

Madam Chair, to the minister. Many northern rural communities have unique cultural traditions, community dynamics, and ways of supporting one another. What work is being done inside of these recovery communities specifically, if you know, even if they're located outside the north? Would you be able to get maybe some more of the details on how they'll reflect and respect cultural and community needs for the people who travel to them? I mentioned the language earlier and how much those small details matter to Indigenous communities. If you could provide any details on what that would look like, I know I get asked about this quite often.

**Mr. Wilson:** Through the chair, I'm sure you do, and thank you. We are looking at culturally and socially that all recovery community sites are going to have embedded Indigenous healing practices and community participation. Smudging, of course, and hopefully some of them will implement sweat lodges with it as well. Recovery communities are encouraged to tailor their approach to each individual's needs, recognizing that of course no two communities or clients are exactly alike. We are definitely trying to get that cultural aspect into all of them.

**Mr. Sinclair:** Thank you. I appreciate that.

Through the chair to the minister: once rural and northern residents complete their stay at a recovery community, what supports do we have in place to help them transition back home

successfully so they can maintain their recovery while reintegrating into their own communities? I know when I speak with not just people from my riding but specifically Indigenous and First Nations people, there are lots of concerns, and there's no simple answer here. I think it's probably four or five different things at the same time.

I made mention of the trade winds program right here in Edmonton that I know you know about. Minister Sawhney, when she was in Advanced Education: I was thankful to watch her support that program. I think something along those lines in northern Alberta would be a fantastic idea. I know we have the whole job core infrastructure we discussed. Any other programs that, I would say, are investments in preventative ideas specifically for youth, I think, which is a huge issue in remote areas specifically; they just flat out don't have anywhere to go after school sometimes. I don't know if that's too long worded of a question, but if you could just speak on that.

**Mr. Wilson:** That's a great question, Madam Chair. The continuity of care that's going to happen after discharge: that planning has to include appropriate information-sharing and warm hand-offs. By warm hand-offs, if we have to take and drive somebody to the next facility, that's what we have to do. Recovery communities are skilled in supporting these transitions. For example, 94 per cent of people transitioning in recovery were discharged into safe housing. Additionally, transition support is where support from a recovery coach can be helpful as they work alongside individuals and care providers. The broader recovery-oriented system provides peer-based support and referrals for smoother transitions.

Like you say, the programs like trade winds where we can start giving people back that hope and the training they need to get back into society and start earning a living and feeling good about themselves, I think that's such an important piece of the puzzle. We have to really focus on that, and I'm glad that you brought that up because that's a great idea.

**Mr. Sinclair:** Thank you, Minister. Thanks again to your staff. I think a few of them came with you up to northern Alberta, too, and we appreciate seeing you guys there.

Madam Chair, I will cede the rest of my time, if that's okay, unless the minister has some closing remarks.

**The Chair:** Thank you so much, Member. It's nice to have you join us this evening. Glad to hear your questions and the thoughtful answers from the minister.

We are going to move over to the government side. Would you prefer blocked or shared time, Member?

**Mrs. Sawyer:** Should it please the minister, hopefully we'll share. After you shared with everyone else.

**Mr. Wilson:** I'll share with you.

**Mrs. Sawyer:** My feelings might be hurt if you said no to me now, to be honest.

Through the chair, I do want to start by thanking the minister and his department for the work that they're doing for compassionate recovery. I hazard a guess that, sadly, there's probably no one in this room who hasn't been in touch with knowing someone with mental health or addiction issues. It's challenging. I know why I'm getting emotional; I just didn't expect to. Sorry. I don't mean to bring my personal things in here. I do want to thank you for what you are doing, and I especially want to thank the people who are on the front lines giving that compassionate recovery care to the people.

8:40

Budget 2026 has a strong commitment to mental health and addiction supports. On page 19 of the strategic plan under priority 2, objective 2, there is a list of investments to various initiatives to help Albertans recovering from mental health and addiction challenges. Through the chair to the minister: how does Budget 2026 support the Ministry of Mental Health and Addiction mandate, and how will this budget work to improve mental health and addiction care in Alberta?

**Mr. Wilson:** Thanks for the question, through the Chair. You're going to get me going here. I don't think I've gone anywhere where there hasn't been someone like you that's come up to me after we're done and said: "I need help. There's someone in my family." There's a son, a daughter, a sister, a brother. This is impacting everybody. There's no stigma here. My heart is with you. Sorry.

**Mrs. Sawyer:** That's okay.

**Mr. Wilson:** I'm very pleased that our budget in 2026 continues to invest in expanding the Albertan recovery model and focuses on what matters most: ensuring that anyone struggling with mental health or addiction challenges has access to supports required to pursue recovery. Like I said earlier, our budget is \$2 billion, an increase of \$167 million or 8.9 per cent from '25-26.

Now, this includes operating expenses, the \$2 billion, \$20 million in capital grants and \$19 million for inventory consumption, mainly for drug costs. This is Mental Health and Addiction's largest budget to date, reflecting an increase in wages for front-line health care professionals and the work we are doing to address pressures in the acute-care system and prepare for the implementation of compassionate intervention. This budget will continue to provide Albertans with a continuum of recovery-oriented supports and services with a priority on front-line addiction treatment and psychiatric care. Budget 2026 capital funding will also continue to increase capacity in the mental health and addiction system by building critically needed infrastructure, including building the remaining recovery communities, compassionate intervention centres, and facilities for youth struggling with complex mental health challenges.

**Mrs. Sawyer:** Actually, I was going to go on to recovery communities next. Staying on page 19 of the strategic plan, there are investments being made to build and operate recovery community facilities across Alberta, including five led-by-Indigenous communities. To my understanding the facilities work with people facing addiction to recover from their addiction while learning to rebuild their lives. If I could ask a few questions, through the Chair, on some details on the recovery communities. Would the minister please outline how in Budget 2026 it's working to build and operate the recovery communities as well as how investments in recovery communities through Budget 2026 work to expand the mental health and addiction system?

**Mr. Wilson:** Through the Chair, thank you so much for the question. This year's budget, as we talked about, demonstrates our priority by providing the highest quality addiction treatment to as many Albertans as possible. Recovery communities are part of our public health care system and like all our publicly funded residential addiction treatment services, this holistic and world-class treatment is free – free – for all Albertans. Budget 2026 allocates \$21.3 million in capital funding and \$52.8 million in operational funding. That is going to build us and operationalize 11 recovery communities across the province. The funding includes \$29.6

million for operating five Indigenous-led recovery communities, and they are all well under way and they're going to open this year, which aligns with the approximate per-year average operating cost of a recovery community at \$5 million to \$6 million. This includes staff salaries, general supplies, food, and vehicles.

**Mrs. Sawyer:** Thanks. I'd like to touch on compassionate intervention. It's something that as far back as during my by-election I had constituents who were very happy to see this coming, and they had lots of questions about it.

On page 119 of the business plan key objective 1.2 is about implementing compassionate intervention in collaboration with community, government, and Indigenous partners. The recovery communities are a voluntary treatment facility. We understand that, but compassionate intervention is for individuals who are likely to cause substantial harm to themselves or others due to their substance use or addiction. With that in mind, through Madam Chair I'd like to ask with respect to the compassionate intervention centres: how is funding in Budget 2026 going to support compassionate intervention legislation, and what's the timeline for compassionate intervention rollout as the two main compassionate intervention facilities are being built?

**Mr. Wilson:** Thank you again for the question, Madam Chair. First off, the Compassionate Intervention Act is about helping the most vulnerable Albertans get the life-saving support they need to begin their recovery journey. It's meant to be a last resort when other treatment and recovery efforts have been unsuccessful. Budget 2026 is investing \$318.6 million over three years, up to 2026 through 2029, and that is going to renovate existing facilities and build two 150-bed compassionate intervention centres, one in Edmonton and one in Calgary, and the construction is expected to begin this year.

These facilities are essential for delivering safe, secure, and individualized care in a medically supervised environment. That's \$291 million for the two compassionate intervention centres, \$20.2 million for renovations to establish the northern Alberta youth recovery centre, \$7.5 million for early compassionate intervention beds, and \$42.5 million for early implementation operating costs. It's kind of two-phased because I wanted to get going quicker than it's going to take to build them. That's why we're investing some money this year with existing facilities, to get the program started sooner.

**Mrs. Sawyer:** Thank you to the minister for that one.

Talking about correctional and remand facilities, I'm staying on page 119. This one's key objective 1.4 of the business plan. It involves providing quality mental health and addiction services in police and correctional facilities. The minister has spoken about therapeutic living units before, and I do want to get some more information on what I think is a very important program. Would the minister please highlight how Budget 2026 is investing into supporting therapeutic living units and transitional services in provincial correctional and remand facilities across the province? As well, when we are voting on allocating taxpayer dollars into programs, we do have to make good decisions, so what proof is there that TLUs and transitional services are worth the investment being made?

**Mr. Wilson:** Thanks again for the question, through the chair. We're continuing to collaborate with the Ministry of Public Safety and Emergency Services to operate the therapeutic living units, or TLUs I'll call them, and transitional services in provincial correctional facilities and remand centres. The TLUs are specialized live-in units within correctional facilities that allow

individuals serving sentences to access recovery-oriented addiction treatment. In 2026-27 Mental Health and Addiction will allocate \$7.6 million to operate TLUs in four correctional centres: one in Red Deer, one in Lethbridge, one in Fort Saskatchewan, and one in Calgary. Now, these are provincial prisons. That's two years less a day.

Transitional services, which are available in select remand facilities, provide release planning and connect individuals to mental health and addiction treatment, housing, and other supports to ensure continuity of care during their transition from custody to community. This support can include connecting individuals in custody with recovery coaches who help motivate positive behaviour change related to their addiction, and these coaches also provide referrals and support warm hand-offs to other recovery-focused services within communities.

The Canadian Centre of Recovery Excellence is conducting a system-level evaluation of TLUs – that's the CORE – to understand early outcomes and program impact and has some excellent findings. Although research on these types of programs is still limited, evidence shows positive effects such as reduced reincarceration, relapse, and rearrests, with program completers experiencing an 18 per cent decrease of reoffending within one year.

In 2024-25 29 per cent of programs completed transition to recovery communities while 71 per cent moved to other community supports and returned to families. Roughly one-third of clients completely recovered capital assessments, and 92 per cent of those showed measurable gains in recovery capital. Economic analysis suggests potential annual cost avoidance of about \$360,000 from reduced reoffences and rising to more than \$1.8 million if reoffending results in a year of incarceration, with further savings expected if we look at the broader system. They are very cost-effective. They are already in prison. We're already feeding them. They've already got beds. We just put them out of general population into these therapeutic living units.

8:50

To be in one of those is amazing. The guards, the big guys with no necks: they're high-fiving the prisoners and playing basketball with them. To go from general population into one of these: that's where they want to be, and they have to sign off. There is a whole sheet that they have to sign off. I said a swear word in there once. I got in big trouble. You can't swear in there even, and they keep the place spotless. It's pretty amazing.

One young guy has been in prison, in and out, most of his life. He's got the ants tattooed on his neck going up into his ear, and I got to meet him in one of the prisons. A couple of months later I met him in a recovery community, and he came up and gave me a big hug. I think it was Evan who was with me, and he says: how do you know him? I said: well, we met in prison. It's pretty amazing, and I'd really like to, if you get a chance, take you to one of them and just see what an amazing transformation it is. It's very cost-effective.

**Mrs. Sawyer:** Thanks for sharing that. Sorry; through the chair, thank you, Minister.

If I could, I'd like to cede the rest of my time to my colleague MLA Lundy.

**Mr. Lundy:** Well, thank you very much, and thank you, Madam Chair. Through you to the minister, I always appreciate your grounded approach and your ability to always draw out the human side in what we're trying to achieve as legislators. I certainly appreciate that. If I had anything that was more caring,

compassionate, or graceful than my colleague from Olds-Didsbury-Three Hills, I would say it, but I actually don't think I do. Thank you so much for sharing your experiences as well.

Minister, through the chair, I know you touched on CASA House earlier, and I certainly look forward to getting a chance to, you know, go up to Sherwood Park. Being someone who's in the region and close, I look forward to that. There can't be anything more important than the health of our children, and that includes mental health, of course. Madam Chair, we're on page 121 here of the business plan, and that does reference this \$46 million budget allocation, including \$33 million to operate CASA House facilities in partnership with CASA Mental Health. To the minister. I'd love to give you a chance to expand on some of your preliminary comments on this. How will this funding from Budget 2026 work to add beds to the mental health and addiction system? Maybe, if you wouldn't mind, through the chair, how will this investment enable the aims of outcome 3; namely, that Alberta's communities are engaged and have the capacity and resources to support families and help individuals lead satisfying, hopeful, and contributing lives?

**Mr. Wilson:** Thank you for the question, through the chair. The expansion of our specialized services like CASA House: this can be a critical step in improving access to youth mental health care within the mental health and addiction system. Youth who benefit from CASA House programming are experiencing mental health challenges that are complex but do not require treatment in an acute-care setting or a psychiatric hospital. The goal is to support kids closer to home, reducing the need for hospital stays, and including parents and caregivers also in the program.

CASA House facilities are planned for Fort McMurray, Calgary, and Medicine Hat, with the aim of Fort McMurray and Calgary opening in 2027 and Medicine Hat by 2029. The existing CASA House in the Sherwood Park area is going to be updated by 2029 as well. Each CASA House is going to have 19 treatment beds. Once completed, we expect to quadruple provincial capacity to serve more than 300 youth each year.

On the second part of your question, the key objectives and related investments under outcome 3 are intended to empower communities and families to support individuals in their recovery journey. We are working with our partners to provide a range of programs, services, and resources in more communities across the province to foster resilience and well-being and help Albertans facilitate and sustain recovery. Investments are focused on long-term treatment infrastructure such as recovery communities, targeted programming to provide culturally appropriate services, and community-based prevention and intervention initiatives and mental health supports for children and youth. Combined, these investments cover the full continuum of the Alberta recovery model, from prevention and intervention to treatment and recovery, and promote and achieve better health and wellness for individuals and for their families and, hopefully, for our communities.

**Mr. Lundy:** Thank you so much, Minister, through the chair. I appreciate that information and especially the information on those new sites.

I know we've talked a little bit about a recovery-orientated system of care, but I think it's important that we give the minister a chance to expand on some of that information. We know here in Alberta that the government has made major investments into this recovery-orientated system of care. We see the provision of a continuum of services to Albertans, including prevention, intervention, treatment, and recovery supports. Madam Chair, I'm actually on key objective 2.1 on page 120 of the business plan, and

this is about continuing to provide co-ordinated supports for individuals to help build recovery capital and sustain long-term recovery. Through the chair to the minister: how will investments through Budget 2026 work to provide these co-ordinated supports, what will these supports involve, and how will Budget 2026 improve recovery capital for individual recovery outcomes?

**Mr. Wilson:** Thanks again for the question, through the chair. The work under outcome 2 demonstrates the government's commitment to ensuring every Albertan has access when and where they need it to a co-ordinated continuum of care and thus can provide prevention, intervention, treatment, and recovery options that align with their individual needs. Services under this objective cover a range of needs to support well-being and recovery, and they can include, among other things, community family caregiver supports that have a meaningful impact on addressing challenges before they become more serious, access to recovery coaches for those waiting for a bed in a recovery community, and the recovery on campus programs at 26 publicly funded postsecondary institutions that provide peer support, recovery coaching, education, and research opportunities. Collaboration is ongoing with our partners to remove barriers, expand care pathways, and to build capacity to ensure people living in Alberta are supported in building their recovery capital and their resiliency.

**Mr. Lundy:** Thank you, Minister. Again, important information. Thank you for sharing.

I actually want to chat about virtual supports. You know, these are supports that are important to certain segments of our population, whether they may be perhaps rural or underserved communities or even just the aging demographic. I think it's important, and I would, through the chair, like to ask the minister specifically in relation to key objective 2.2, which is about enhancing access to and promoting virtual, phone, and in-person mental health and addiction supports and services to improve health outcomes for more Albertans, including underserved communities and rural and remote populations. Through the chair: Minister, what sort of services will be funded through Budget 2026 to accomplish the aims of this key objective 2.2? How does the funding through Budget 2026 go to improve outcomes, especially for Albertans in underserved communities in rural and remote populations?

**Mr. Wilson:** Thanks again for the question, through the chair. Access to assistance: that's going to be essential for improving our health outcomes for Albertans, especially, like you said, in our underserved and our rural and remote populations. That's why we're funding, co-ordinating, and consolidating helplines that provide information, navigation services, and referrals to Mental Health and Addiction services. That's where you've got your Kids Help Phone and access lines for clinical interventions. We're also looking at supporting system navigation for Albertans who have mental health needs or who are concerned about their substance use but may not be aware of how they can get help.

Starting April 1, 211 – that's going to be such an important number to remember, 211 – will become the single front door for multiple Mental Health and Addiction services and support with fully integrated navigation; warm transfers and standardized pathways; and depending on the caller's needs such as information on Recovery Alberta walk-in, virtual clinics, warm transfers to Recovery Alberta's clinics, warm transfers to Health Link.

**The Chair:** All right. Thanks, everyone. That concludes the government members' first block of questions.

Now we move to the second round of questions and responses. The caucus rotation going forward will be the same as in the first

round, starting with the Official Opposition, followed by members of any other party or independent members, and members of the government caucus. However, the speaking times are now reduced to five minutes for the duration of the meeting. We'll begin this rotation with a member of the Official Opposition, who will have up to five minutes for questions and comments, followed by a response from the minister, who may speak for up to five minutes. After both individuals have had an opportunity to speak once, we will then move on to the next caucus in the rotation.

If the member and the minister agree to share time, we will proceed with the 10-minute segment, during which neither the member nor the minister may speak for more than five minutes at a time. Members are reminded that they may not share any unused portion of their five minutes with another member. That's very important, members. You cannot cede your time to another member.

Member and Minister, do you wish to share your time or have blocked? Share?

**9:00**

**Mr. Wilson:** We'll share.

**The Chair:** Okay. Please proceed.

**Member Eremenko:** Just to clarify, Madam Chair, it's still just five minutes?

**The Chair:** It's 10 minutes, but you can only speak for a maximum of five.

**Member Eremenko:** Right. Okay. So that will be monitored?

**The Chair:** Yes.

**Member Eremenko:** Okay. Thank you.

Through the chair, the minister kind of pinged something for me around the benefit of 211. I know that the department has been working quite a bit on trying to work on, like, systems navigation, systems alignment, actually trying to create consistent pathways for people to be able to access mental health and addiction services. Part of the challenge is that users of that system, people who have substance use issues who want to finally kind of step through those doors and address their addiction, oftentimes are really left to their own devices.

I wonder. With 211 has there been any conversation with the department about creating some kind of a centralized list so that an individual doesn't just have to essentially google: where is the nearest detox facility, what recovery centre, what facility, whether it be a recovery community or any of the other dozens of private, for-profit and not-for-profit recovery facilities that exist in Alberta? Is there some attempt within the ministry, under 211 and some of the services that they fund with that call centre, to actually provide a centralized wait-list of sorts so that people can have a more expedited path to service?

**Mr. Wilson:** Through the chair, that is a great question. Thank you so much. Centralizing that 211 is going to improve co-ordination across crisis response, clinical programs, and community supports. It's going to be continuity and efficiency of care such as consistent navigation and scheduling across Alberta, ease of access for callers, and caller experience. People get what they need without restarting their search.

Starting April 1, callers to 211 Alberta are going to be routed through several pathways, depending on their needs. You dial 211, you say, "I want information on Recovery Alberta, walk-in and virtual clinics," and away you go: warm transfer to Recovery

Alberta's clinical access line, warm transfer to Health Link 811 for health needs, and direct intake for Counselling Alberta and connection to crisis supports. That 211 number, I think, is going to be probably one of the better things that we've really got going this year for people. Like you say, if you're in crisis, what do you do? Who do you call? So this is going to be really important. You can hit that 211, and it's going to take you. I can tell you, from my own daughter's experience, it works.

Okay. We have a little supplement here. A dashboard is being developed to provide real-time bed availability and contact information for publicly funded withdrawal management, treatment, and recovery beds across the province. So you phone in, you're from southern Alberta: where can I go?

**Member Eremenko:** Through the chair, just a point of clarification. Is that a dashboard that's available to those on the call centre end, or is it also then posted publicly for individuals to see?

**Mr. Wilson:** It's going to be publicly available, but 211 can help guide you through it.

**Member Eremenko:** Great.

**Mr. Wilson:** The dashboard is being tested right now. We've got a select a group of providers and feedback collected during this time, and it will be used to refine the tool prior to implementing it through the mental health and addiction system.

Having a centralized source of addiction treatment bed availability strengthens collaboration across the continuum of care and supports a more co-ordinated, recovery-oriented system. This tool is being designed right now to improve co-ordination and reduce the administrative burden for both service providers who are working to place a client and for programs seeking an appropriate bed.

The dashboard is going to use only operational, nonidentifying aggregate data, and it does not include mental health beds at this time – psychiatric beds, in-patient units, emergency department capacity, or any acute-care mental health services – but eventually we want to.

**Member Eremenko:** Thank you.

Through the chair, perhaps I'll stay on the note of data and go back to the online tool that the department is working on to replace My Recovery Plan. I don't think I heard from you in the estimates under which line item that is going to – the \$2.6 million for the new online tool. I don't think I heard where that's going to reside in the expense document.

**Mr. Wilson:** Apparently, it's under Tech and Innovation's budget.

**Member Eremenko:** Tech and Innovation.

**Mr. Wilson:** Yeah. Under Minister Glubish's department.

**Member Eremenko:** Oh, I see. So this is not a Mental Health and Addiction expense, through the chair.

**Mr. Wilson:** That's right.

**Member Eremenko:** Okay. Thank you.

I do have a question. I thought of something as the minister had mentioned that the tool is not going to be available within Recovery Alberta. It will only be available for those service providers outside of Recovery Alberta. Have I got that right?

**Mr. Wilson:** It's inclusive of Recovery Alberta.

**Member Eremenko:** It is inclusive of Recovery Alberta. What is the extent of the interface with Connect Care in that case?

**Ms Melnychuk:** Thank you for the question, through the chair. There's been conversation with the digital health side of PPHS to ensure that any connectivity that would be needed in the future would be there with Connect Care. But at this time it's bed availability, so that's not something that is counted through Connect Care. It's counted through Recovery Alberta's contracted service providers as they do head counts, and they report that in to Recovery Alberta, who reports it in to the ministry to provide the data into the dashboard that we're testing.

**Member Eremenko:** Oh, I see, through the chair. So that is in regard to the dashboard that both Albertans and the call centre folks are going to have eyes on. I was speaking to the recovery capital score and the new tool that's going to be utilized for the recovery capital score that will replace My Recovery Plan. But thank you. That's valuable information about the bed count.

**Mr. Wilson:** What's your question on My Recovery Plan, then?

**Member Eremenko:** The \$2.6 million tool that is going to replace My Recovery Plan: will that be a tool that has an interface with Connect Care? Will it be used within Recovery Alberta and also within the community facilities for users?

**Mr. Wilson:** I'll let Evan speak to that.

**Mr. Romanow:** Thank you, Madam Chair. There certainly is an interest across the broader system and inclusive of Recovery Alberta sites to leverage Connect Care, the very strong capacity that it provides. We're looking at different options, working to identify which platforms – there are software, different platforms that are readily available, and an important piece is looking at where that can tie in and connect with Connect Care, I think, still determining what that path looks like and the approach. But it very much is intended to be interconnected with the broader system of treatment providers in community as well as Recovery Alberta. Connect Care, obviously, is a platform within the health space broadly where that information is held.

**Member Eremenko:** I would assume also, then, in that case, Madam Chair, that where there is an interface with Connect Care – I mean, Alberta has some of the most stringent privacy regulations, particularly around health data. Can the department assure Albertans and everybody in the committee that where there is that interface with Connect Care yet a facility outside of the health agency is still being able to participate in that questionnaire, there are safeguards put in place so that they are not then privy to everybody's personal health information outside of the mental health and addiction supports that they're accessing in the facility?

**Mr. Wilson:** Through the chair, Recovery Alberta owns all of My Recovery Plan data for their operated and contracted service providers, and the recovery communities own their respective data, which is managed under the Health Information Act and other privacy legislation. The new application being developed will continue to have rigorous privacy protections with compliance to the Health Information Act, the Protection of Privacy Act, and the Access to Information Act.

**Member Eremenko:** Thank you very much to the minister.

Just as a point of clarification, the ADM – thank you – on the end had specified that Minister Glubish would be overseeing the development of the tool for the dashboard. But what about the replacement of My Recovery Plan – I’m sorry, Madam Chair; I don’t have a name for the thing. It might help a little bit. The tool that is going to be replacing My Recovery Plan until it gets maybe a jazzier name: is that \$2.6 million going to be an expense of the Mental Health and Addiction ministry?

9:10

**Ms Melnychuk:** Thank you for the question. Through the chair, the \$2.6 million is being asked for through Tech and Innovation for the replacement to My Recovery Plan. The dashboard around bed availability is being developed from within Mental Health and Addiction with some funding that is already in existence for a digital team.

**Member Eremenko:** Thank you very much.

I might get this in very quickly. In that case, what does the information technology line item, 2.6, under Recovery Alberta include?

**The Chair:** All right. Over to the government side.

**Mr. Getson:** Thank you, Madam Chair. To the minister: are you good with sharing, or do you want block?

**Mr. Wilson:** We’ll share.

**Mr. Getson:** Excellent. Appreciate it.

Minister, just to get you prepped over there, the first question I’m going to ask you is going to be on page 117 and page 119 of the business plan for Recovery Alberta. Mental health and addiction challenges continue to impact many Albertans and their families, obviously, and ensuring timely access to those supports, especially in rural, is going to remain a key priority for everybody. Strong, co-ordinated service delivery is very much required. In our area we have – I call it God’s country nonstop. We also have the Gunn centre out there. We got to see the difference of how the old model worked versus now. Again, really good work being done there.

Many Albertans rely on mental health and addiction services, and it’s that delivery arm of the ministry that really is important to us here. It’s a provincial health agency, as folks may know, and it’s front-line health care workers and physicians and the contracted community support providers and volunteers.

In Budget ’26 it looks like it allocates \$1.7 billion – and that’s with a capital “b” – to those services across the province. With that, Minister, through the chair, what priorities will this funding go towards in ’26-27? Can the minister speak on how the ministry is measuring effectiveness of Alberta’s recovery plan, including the outcomes for those Albertans, whether it’s KPI or some other method? Can you tell us what that is?

**Mr. Wilson:** Thank you for the question, through the chair. As a provincial health agency Recovery Alberta has an important system leadership role along with the Department of Mental Health and Addiction in ensuring that Albertans have access to a full continuum of high-quality mental health and addiction services. The \$1.7 billion allocation in ’26-27 for Recovery Alberta is to deliver in-patient psychiatric care, outpatient care that includes walk-in clinics and virtual supports and community mental health and addiction bed-based treatment.

Recovery Alberta also provides all health services within provincial correctional settings. Recovery Alberta priorities for ’26-27 include implementing compassionate intervention, ensuring

patients and families have access to co-ordinated, integrated, innovative, and recovery-oriented programs and services, and building support and engaging with a highly skilled workforce. It’s a huge continuum of care that’s happening out there.

**Mr. Getson:** I appreciate that, Minister. Again, I know there was a bit of a pivot there a while back to get this, and I appreciate you and your team doing this. Just a gentle observation, through the chair, to the minister and his team. Again, you wear your hearts and your sleeves. It gives me a lot of confidence that you’re doing it for the right reasons here, too. Thank you for doing that.

Looking at page 19 in the strategic plan, \$121.1 million is allocated for delivering medical withdrawal management and bed-based addiction treatment services and then enhancing the quality of programming to support the Albertans pursuing recovery from substance use issues. We all want to see people thrive and break that cycle and then get back into a meaningful life, obviously, as part of the community. A couple of items there for you, Minister, through the chair. Would the minister explain what sort of treatment and programming will be provided through this investment? How will the funding work to enhance that quality of programming?

**Mr. Wilson:** Well, thank you for the question, through the chair. Budget 2026 is continuing to invest in life-saving treatment and supports to help those experiencing addiction access the care they need to pursue recovery. Since 2019 we have increased publicly funded addiction treatment bed capacity by 55 per cent by providing standardized funding and contracts for about 800 new detox treatment and recovery beds. Alberta now has approximately 1,752 publicly funded addiction treatment beds offering medical withdrawal management, pretreatment and posttreatment services; 1,478 publicly funded beds are operated by, contracted by, Recovery Alberta, and 274 publicly funded beds are operated in recovery communities, with another 375 beds anticipated to come online this year when the five Indigenous-led recovery communities are in operation. Have you been to the Gunn? I’m assuming that you have been out.

**Mr. Getson:** Absolutely.

**Mr. Wilson:** Amazing. I don’t know if I can say this, but they just won a huge award. Through Accreditation Canada they got 100 per cent. You can’t get higher than that.

**Mr. Getson:** Give it 110 per cent. Now we’re going to brag up my area. I literally have constituents texting me right now saying: the minister had better say about how we did out there. Like, they’re pretty darn proud of this.

**Mr. Wilson:** They’ve been so accepted into your community there. Like, the guys go out when it snows. They’re shovelling sidewalks. They keep the grounds like a golf course. I was so impressed when I was there. The accreditation: people said it’s the best one they’ve seen in North America. In North America. That’s pretty amazing, so you’ve got something to really be proud of there.

**Mr. Getson:** No, it is. Through the chair to the minister, again, my understanding is when we’re setting it up and doing that, there’s also performance metrics that are shared between the different groups, so it’s a continuum of learning on that as well. There’s a little bit of credence, I believe, of having a little competition between those groups. When you have key performance metrics and the outcome is the competition is better, people quicker back in their communities, that’s something you definitely want to celebrate.

The other one, Minister: again, children's mental health and addiction issues are pretty tough. I had a constituent in that just broke my heart telling me about the story, Madam Chair, through you to the minister, of how she lost him to addiction. They literally approached me at an event in Onoway, and she came on a little podcast so we could share that story. This is going to be around that, respecting that family as well as how this impacts us directly.

Anyway, with that I'm going to be looking at 120 in the business plan, and there's \$93.4 million if you want to flip to that. Again, these kids are facing lots of challenges and, you know, we see it all the time, different social factors and otherwise in school and, heck, we just went through COVID and everything else. This stuff comes up, and it's real for everybody. Nothing worse than something happening to a kid. That \$93.4 million: it's allocated for community-based mental health services for children and youth to address those issues. With that, Minister, I want to make sure we're getting some bang for our buck there and where this is going. The first part is: what are some of the examples of services being made available, and how do we know that they'll improve the mental health and wellness for the children and the youth? Then the second part of that is: how are these services being expanded or enhanced through 2026, the budget.

**Mr. Wilson:** Thank you for that question, through the chair. This is probably going to be where I focus a lot of my attention this year is with the youth. If we don't help these kids, we're in a lot of trouble.

Supporting young people is another vital part of our Alberta recovery model, ensuring children and youth receive the mental health and treatment care they need to live full healthy lives. Prevention and early intervention programs for children and youth start early with school-based supports with mental health capacity building. We've got integrated school support programs, Kickstand youth mental health hubs, Kids Help Phone, education and training for professionals. You've probably seen me on TV starting to open up some of these Kickstand programs. This is such an amazing program. I don't like to brag up the federal government, but I actually invited her out to one of our openings at Calgary and she showed up with her chequebook. So it was pretty amazing. It's great to be able to work with the federal government to get these programs up and running.

**Mr. Getson:** I'm okay with them bringing our tax dollars back to us.

**Mr. Wilson:** Exactly. I figured you'd like that.

Recovery Alberta services include programs and treatment options for children and youth such as therapeutic services through community mental health clinics and specialized and hospital-based services. The department also provides funding for more intensive and specialized supports for youth mental illness. You heard me talk earlier about the CASA classrooms and the live-in treatment through CASA House, where there's a personalized community care program, treatment for eating disorders, and day hospital services at the summit. That ties in with what we are working with the school board and the Premier's cabinet committee for complex classrooms. We are going to be a big part of that, helping out in that area too.

We're working closely with CASA Mental Health to scale up and expand mental health classrooms to schools across the province, including rural Alberta and remote communities and to build and operate three additional CASA House facilities. So \$30 million in Budget 2026 is going to support and expand access to school-based

mental health supports through CASA classrooms, from 28 to 40 by the end of the fiscal year.

**9:20**

Budget 2026 also continues funding to build and operate three new CASA houses, like I said earlier, in Medicine Hat, Fort McMurray, and Calgary. Construction on the Fort McMurray house is going to start earlier this year here. This budget also provides \$6.4 million to operate and develop 11 of the Kickstand youth mental health hubs, of which 10 are funded by the province and one is funded through philanthropy. An additional five new mental health hubs are at different stages of readiness, including some led by First Nations. I'm really excited that everybody is seeing that this is a problem and they're getting behind it, so it's an exciting time to be in this line of work.

**Mr. Getson:** Perfect. Well, there's not much time, and I don't think I can ram through a question as quick as I did, but I just want to take the time, Chair, through to the minister and his team, again to thank you, especially for the work on the youth. You know, a penny of prevention is worth a pound of cure here, so thank you.

**The Chair:** All right. Thank you, government members.

We'll be going back over to the Official Opposition.

**Member Eremenko:** Thank you, Madam Chair. I will give the department a chance to answer my question from my last block. Can they just very briefly tell us about what the information technology line item is on the estimates, please?

**Mr. Wilson:** I'll have to get back to you on that one. We'll get you a good layout on that.

**Member Eremenko:** Sure. Thank you so much.

Okay. I'm going to shift, maybe continuing on the theme of speaking about youth and the care that they are receiving. On page 121 of the business plan there is a recommendation or, I'm sorry, perhaps a performance – let's see. I don't want to get it wrong. One of the key objectives here is to respond to addiction and mental-health related recommendations of the OCYA, the office of the Child and Youth Advocate. Can the department please tell us which performance indicators or targets in the 2026 budget or business plan will track progress on implementing the OCYA recommendations related to mental health and addiction? These include, per the recommendations from the office, service access, wait-list reduction, and youth outcomes. Furthermore, how will baseline data and target metrics be reported publicly?

**Mr. Wilson:** Yeah. Thank you for the question, through the chair. There are six OCYA recommendations relevant to MHA, and two of them from 2021-22 are ongoing and have seen significant progress and are being addressed. The first issued in June '21 relates to the development of a youth opioid substance use strategy and supporting a comprehensive, co-ordinated range of services for youth. The second was issued in March of 2022 and relates to co-ordinated service delivery for youth with complex mental health needs and would ensure continuity of care for young people and their families regardless of ministerial responsibility. For the two ongoing recommendations, 2021 and 2022, the OCYA's March 2025 evaluation indicated an intention to formally close these items once implementation is fully embedded in 2027.

On November 20, 2024, four new recommendations were issued as part of the calling for change and consolidated public report, and three recommendations are crossministry and focus on improving

accessibility and co-ordination of child and youth services across the province.

I'll just carry on, if it's okay, on the performance measurement. OCYA tracks and publicly reports on ministry responses to recommendations through its consolidated reports and follow-up evaluations. This includes assessments of progress, and MHA provides regular updates to the OCYA and meets with the advocate on a bimonthly basis to discuss progress, clarify expectations, and identify any emerging issues. It also participates in a crossministry community of practice to co-ordinate responses to shared recommendations.

For the two ongoing recommendations from '21 and 2022 the OCYA's March 2025 evaluation in order to continue the expansion of services and recognize province wide implementation: that takes time. The evaluation also emphasized the importance of sustaining this progress to ensure equitable access for youth across Alberta. That evaluation of both recommendations were assessed as having made significant progress, and the advocate has indicated an intention to formally close these items once implementation is fully embedded.

**Member Eremenko:** Thank you so much. Okay. Several of the recommendations, I would say, require a high level of co-ordination between various departments: Mental Health and Addiction, certainly, but then education and children's services are absolutely critical to fulfilling those recommendations as well. How does Budget 2026 fund collaborative programs or shared outcomes that respond to these recommendations? What specific actions has the minister taken to advance those recommendations in the collaboration with other ministries?

**Mr. Wilson:** Thank you, and through the chair, everything that we do is in collaboration, so I can't break out a specific number. We work with all the ministries across the board.

**Member Eremenko:** Nothing specific in terms of partnership or particular projects that are being worked on with education or children's services or others? Health?

**Mr. Wilson:** Yeah. There's a lot of stuff. I'll let Coreen jump in.

**Ms Everington:** Yeah. If I may, through the chair, I can give a couple of examples. One example is the work that we're doing with Children and Family Services on the personalized community care homes. There are two homes: one in Calgary, one in Edmonton. They were designed for very specific youth with very complex needs, those youth in mind. Some of them have kind of graduated out of that program now, but those programs still exist. It's funded partially through children's services, partially through Mental Health and Addiction. Recovery Alberta also provides services in those facilities.

We also work with children's services on the youth virtual opioid dependency program. There's partial funding from Mental Health and Addiction as well as children's services. That program was initially designed for youth in group care homes so that they could have access to those services.

**Member Eremenko:** Yeah. Thank you very much for the answer. I was immediately going to go to the risks, of course, of providing care virtually to a child and what levels of safeguards are actually being provided by a guardian in those cases, but knowing that this is actually happening in a group home setting, then there is some further caution taken.

Speaking of touring really exceptional sites across this province, one of the places that I got to tour in my early days as shadow

minister was The Summit. The Summit is just a really exceptional facility in Calgary's inner city that provides complete, wrap-around, very robust mental health care supports for youth. Fortunately and unfortunately, Madam Chair, The Summit is funded by the Alberta Children's Hospital Foundation. It opened with philanthropic dollars, not public spending dollars. I wonder if the department is familiar with The Summit. Have they considered creating similar kinds of facilities across the province? The impact has been monumental.

I can't imagine how incredibly scary it must be for a youth to have to go and talk about and access mental health supports in an emergency department in a very busy hospital. The Summit is designed, it is made for, it is absolutely uniquely created to meet the needs of youth struggling with their mental health. Have there been considerations by the department to replicate the model in other jurisdictions in the province and perhaps to fund future ones? Thank goodness for hospital foundations that really do step up to the plate when government is unable or unwilling to do so. Please, just commentary from the department on whether or not models such as that are on the table.

**Mr. Wilson:** Thanks for the question, through the chair. We do cover the operating on that. The expansion of specialized services like CASA and The Summit is a critical step in improving access to youth mental health care. The full impact of investments on wait times across the system is still being evaluated. CASA has seen wait times improve from 56 per cent in median wait times for some of their specialized programs, including meeting a 60-day access target.

For programs where wait-list data is not available, such as The Summit, day hospital access and outcomes are measured through service volumes. From April to December '25 The Summit recorded more than 9,400 appointments at walk-in intensive community treatment services and day hospitals combined. Without community-based services such as The Summit some of these youth would require more intensive services through emergency departments and in-patient stays. So they are doing a great job there.

**Member Eremenko:** Through the chair, can the minister define what is the operating budget, in that case, for Mental Health and Addiction to fund The Summit? Is it a more effective spend when we're talking about 9,400 unique individuals? Perhaps the minister can clarify if it's unique individuals or 9,400 visits, and perhaps that was a single person making multiples. Yeah. What is the operating budget for The Summit for '26-27, and how does it compare to the operating budget for, let's say, the emergency department at the Alberta Children's hospital? Because then we are talking about a similar population and a similar demographic.

9:30

**Mr. Wilson:** Through the chair, thanks for the question. Recovery Alberta funds \$3 million for '26-27 for The Summit, and they may not all be unique, but it's appointments, so some could be the same.

**Member Eremenko:** Appointments. Through the chair, would the department be able to provide the committee with unique individuals in the last fiscal?

**Mr. Wilson:** I wouldn't have it right now. We could look into it and see if we could find it. Yeah.

**Member Eremenko:** Thank you. Back to my question, then, about how that operating funding – I know it's hard when we're not just talking about mental health – in the emergency department at the

children's or at the Stollery compares, having that kind of specialized space versus the emergency department at hospitals as far as the value for dollar?

**Mr. Wilson:** I don't think I'd be able to break that out for you right now, but, like, the children's hospital in Calgary . . .

**The Chair:** Thank you so much, members.

We'll move back over to the government side. Please proceed, Member.

**Mr. Singh:** Thank you, Madam Chair. I'll take it as shared time, Minister?

**Mr. Wilson:** Okay.

**Mr. Singh:** Also, I would like to thank the Premier and minister and all the staff for coming to Calgary's constituency for the grand opening of a recovery centre in Calgary-East. It has 70 beds there, and we chatted with the staff, the new patients, and, definitely, we really got good feedback from that place. Thank you, Minister, again, for coming.

Through you, Madam Chair. My question is on treatment and referral pathways. We see the impacts of addictions in our cities and on our streets. Key objective 1.4 on page 119 of the business plan entails "[Advancing] treatment referral pathways and appropriate supports to help people who interact with the justice system initiate recovery and provide access to quality mental health and addiction services in police and correctional facilities." We have discussed the TLUs and transitional services in provincial correctional facilities, so my question is around the relationship between the police and the treatment.

Firstly, there may be some concerns around police involvement when it comes to helping a person with addiction. What does this partnership entail and, through the chair, how is Budget 2026 going to advance key objective 1.4? What services and partnerships with police will be supported through Budget 2026?

Thank you, Minister.

**Mr. Wilson:** Thank you so much for the question, through the chair. Local police services and the Department of Public Safety and Emergency Services are important partners in Alberta's recovery-oriented system of care. Now, as first responders, police are often the first contact for vulnerable Albertans who are experiencing addiction or mental health crises.

Police and crisis teams are specialized units that pair police officers with mental health professionals to respond to police calls for service involving individuals in mental health crisis, offering de-escalation assessment, short-term, follow-up, and connection to appropriate care. We also support the human-centred engagement and liaison partnership, or HELP teams, that pair police officers with social navigators and mental health therapists to provide outreach services to people struggling with addiction and mental health and connect them with essential community resources and supports by providing referrals, follow-ups, and case management plans.

In Calgary last year the data from Alpha House Beltline HELP team showed tremendous impact from more than 9,000 interactions with individuals experiencing homelessness and intoxication. They want me to go on a ride-along with them, so that's going to be an interesting day. These interactions resulted in over 11,000 referrals, including about 6,400 transports to safe locations and services such as shelters or acute-care, and more than 1,000 welfare checks resulting in 11 drug overdose reversals. The team also identified seven encampments, four of which were resolved in collaboration

with partners, and diverted 198 calls from 911, reducing pressure on emergency services for nonemergent situations.

To talk about the advancement for key objective 1.4: Budget 2026 continues to invest in police partnerships and services and supports for individuals in custody, with the goal of helping underserved Albertans access essential health and recovery services. Recovery Alberta's correctional health services is allocated \$60.2 million to provide primary care, public health, dentistry, mental health and addiction services to incarcerated individuals in provincial correctional facilities and provide transition services for when they return to community.

This budget also allocates \$10 million to support continued work with police services across the province to provide integrated health and police community outreach services and to enhance support for individuals facing a mental health and/or addiction crisis who have been detained by police for their own safety or the safety of others. This includes offering someone who has been arrested immediate access to addiction treatment through partnerships with police services in Edmonton, Calgary, Lethbridge, and more than 110 RCMP detachments, pairing police officers with social navigators and mental health therapists to respond to situations where mental health or addiction is a factor, and the HealthIM digital tool that helps police respond to mental health emergencies.

**Mr. Singh:** Thank you, Minister, for such a detailed answer.

My next set of questions is on front-line workers. Through you, Madam Chair, we have heard a lot about capital investment in programs when it comes to advancing mental health and addiction care in Alberta. We also know that the front-line workers are the key to providing these services and support.

I see that key objective 1.3 involves continuing "to build and support an engaged, skilled mental health and addiction workforce." It seems to me that this is an incredibly important part of the success of the mental health and addiction system across the province. Through the chair to the minister, how does Budget 2026 deliver on key objective 1.3?

The second part of key objective 1.3 involves improving knowledge, expertise, and capacity as it relates to delivering care. How will funding through Budget 2026 accomplish this aim, and what will that look like in 2026 and 2027?

**Mr. Wilson:** Well, thank you for the great question. Through the chair, Albertans deserve access to professional and consistent mental health and addiction services across all the health professions. A range of opportunities are helping to ensure that consistent, high-quality services are available in communities across the province while preparing a new generation of addiction and mental health professionals to meet emerging needs.

To advise on current and future workforce needs of the Alberta recovery model, I have formed the Mental Health and Addiction Recovery Workforce Advisory Committee. It is to support provincial workforce planning and implementation for mental health and addiction services. We are also actively working to ensure Recovery Alberta has the clinical workforce and corporate supports it needs to deliver high-quality services both through supports embedded in Recovery Alberta and via Health Shared Services. Collective bargaining increases are also included in our '26-27 estimates.

On the second part of your question, in '26-27 almost \$1 million is allocated to support the operation of the Recovery Training Institute of Alberta, and that provides specialized training and sessions for those employed in recovery communities, therapeutic living units, and other addiction treatment organizations to enhance their skills in providing effective care.

Also in '26-27, \$1.7 million is allocated to the Recovery Coach Academy of Canada, and that has provided training to more than 750 recovery coaches across Alberta. Recovery coaches ease the burden on clinical services by supporting people on wait-lists and preventing escalation of more serious addiction by intervening early to prevent or mitigate the effects of relapse.

We are working on service delivery planning, recruitment and training programs to support compassionate intervention implementation. We collaborated with Advanced Education to add 761 new seats by investing \$10 million over three years for more mental health care professionals in postsecondary programs.

On the recovery coaches, what I am finding is that the people that have come through the system and who were addicts take the training and then they go back and they want to help. A lot of the people that are recovery coaches are people that have lived experience and are now working in the system. It is pretty rewarding to see that happen.

9:40

**Mr. Singh:** Thank you, Minister, for the answer.

My next set of questions, through you, Madam Chair. As legislators, Committee of Supply meetings are an excellent way to get caught up on what ministries like Mental Health and Addiction are planning to accomplish in the year ahead. It is a chance to learn more about proposed policies, review spending, and discuss future planning. With that in mind, I would like to touch on key objective 1.5 on page 119 of the business plan. It involves strengthening policy and legislation and continuing to monitor and enforce compliance. Through the chair, will the minister outline what is being done to strengthen policy and legislation through Budget 2026, in 25 seconds?

**Mr. Wilson:** Well, thank you for that question. Through the chair, I'll talk quickly. We're working hard to provide the best mental health and addiction care by continuously reviewing and updating policy and legislation to meet the evolving needs of Alberta. Last year the Compassionate Intervention Act was introduced and later passed, in May, and the work is under way involving service delivery, planning, and preparation for the launch of compassionate intervention in 2027.

**The Chair:** All right. Back over to the Official Opposition.

**Member Eremenko:** Thank you so much. Okay. This might be my last go, so let's see if I can get it all in. Madam Chair, may I ask the department for a written response to a question? I'd like to get this in just right away, that on page 122 performance measure 3(c) is the number of funded mental health and addiction beds per 100,000 population. I've already made a request to parse that out a little bit, identify and distinguish mental health from addiction beds. The OECD recommends that the ideal ratio of mental health beds to 100,000 is 60, with 30 being the minimum. Could the department please follow up in writing with what Alberta's current ratio is of mental health beds to 100,000 population, please?

**Mr. Wilson:** Absolutely.

**Member Eremenko:** Thank you.

Moving on to compassionate intervention, when can the department expect the regulations to be finalized and made public?

**Mr. Wilson:** We're working on it. It should be ready for this fall in advance of 2027.

**Member Eremenko:** Okay. Thank you very much. Can the minister then explain how the \$33 million in operating expenses is

going to be spent in '26-27? Again, that was the \$33 million under Recovery Alberta and then a \$9.7 million allocation under the department. Really, \$42.5 million to operationalize a program whose regulations won't even be finalized until the fall. Can the department explain how those operating dollars are going to be deployed?

**Mr. Wilson:** Basically, we have to hire staff and get them trained and ready to go and get the facilities ready to go.

**Member Eremenko:** Can the department tell us how many employees are going to be hired for this initial year of compassionate intervention?

**Mr. Wilson:** The details are still being finalized with Recovery Alberta.

**Member Eremenko:** In that case, the capital spend of \$11 million to renovate the facilities that are going to be providing 50 beds in the north and 50 beds in the south: will those two be operational come the fall?

**Mr. Wilson:** Maybe late fall if I'm lucky, but probably not until early 2027. I'm hoping sooner.

**Member Eremenko:** Okay. That's very robust training. Very robust training.

Okay. A couple of questions on the capital plan details, page 112 of the fiscal plan. Let me pull that up as well for reference. One of the items I'd like to know about: a project that has been a long, long time coming. When was the bridgeland riverside continuing care centre originally announced and, through the chair, when is it now slated to be complete?

**Mr. Wilson:** That would be Minister Nixon's department, probably.

**Member Eremenko:** Oh, I see. Because it is focused exclusively on complex mental health care patients, does this department have any participation in the bridgeland riverside continuing care centre?

**Mr. Wilson:** I guess we've participated in the planning, but the funding will be through the ALSS committee.

**Member Eremenko:** For capital. Does Mental Health and Addiction provide any operating funding to this type of continuing care facility?

**Mr. Wilson:** They'll be doing the operating as well.

**Ms Everington:** If I may, Chair, I understand that this is a PDD facility, so the operating funding would also come from ALSS.

**Member Eremenko:** Okay. That addresses some of my other questions, then. That's good.

I have my next question. What level of collaboration does the minister have with his counterpart? I would expect at minimum, however, Madam Chair, that there would be some conversation about how we partner between Assisted Living and Social Services and Recovery Alberta facilities, whether a person is coming from a treatment centre to a continuing care facility. Maybe this is demonstrative of a bigger challenge or a bigger question around co-ordinating care that unfortunately the health care refocus has, frankly, exacerbated and made more difficult. When it comes to discharge planning, for example, what is the level of interface between Mental Health and Addiction from a recovery community to a continuing care facility? How do we know that there's space? Will there be a door-to-door hand-off? How do we know that the

continuing care facility is equipped with the kind of psychiatric and mental health and – I don't know – opioid agonist therapy expertise that it might require to support that person having left a treatment facility?

**Mr. Wilson:** I'll let Coreen jump in. There's a lot of word salad there.

**Ms Everington:** Sure. If I may.

**Member Eremenko:** It's complicated.

**Ms Everington:** Yeah.

Thank you for the question, through the chair. In terms of that particular facility Mental Health and Addiction was involved with ALSS in the planning of that facility, and Recovery Alberta is involved in working with ALSS on developing the overall service model, so we anticipate Recovery Alberta will be providing in-reach clinical services to the facility. In terms of that coordination effort between that facility or really any ALSS-funded facility and our Mental Health and Addiction treatment system, if you will, we have several joint tables that we are always collaborating with our partners – ALSS, Child and Family Services, education, others – in discussing how we can ensure that there are those transitions of support, particularly for quite complex clients. One example is that recovery communities have ability to provide transportation and can pick people up and transport them back.

**Member Eremenko:** Not a word salad at all. Thank you so much, Madam Chair, for that.

Can the ADM clarify: is that happening at the ADM level?

**Ms Everington:** All the working levels.

**Mr. Wilson:** We meet, all the ministers – myself, Minister Nixon, Minister LaGrange – literally weekly to go through, to sort out, to make sure that we're all leaning into our specific areas and working together to make sure that it's all integrated throughout the whole.

**Member Eremenko:** Thank you.

A few more questions on the capital plan, if I may, through the chair. The ministry budgeted \$85 million for recovery communities last fiscal year, but they blew way past that; now forecasting \$102 million for '25-26. Can the minister confirm for the committee how many recovery communities were open as of March 31, 2026, and what was the reason for almost \$20 million overspend when it comes to the capital plan for recovery communities?

**Mr. Wilson:** We'll have to verify the date, but I think there were five open as of that date. Cash flow and readiness to buildings, so it's a moving target. We're trying to move them all and get open as quick as we can. They're all moving along fairly rapidly. We're going to open five more this year, like within the next two to three months.

**Member Eremenko:** Through the chair, if last year's budget exceeded the capital plan by \$20 million to build recovery communities, does that indicate that we're ahead of schedule in terms of opening the doors?

**Mr. Wilson:** We're actually on schedule, I guess. Yeah.

**Ms Robertson:** Thank you for the question. Through the chair, it's really a timing of payments. We wanted to make sure that we followed accounting standards and did the proper accruals, that the recovery communities met all the requirements before the funding

went out the door. The funding did all go out the door this fiscal year versus last. It's a matter of, like, March payment versus April and May. So there really weren't any delays there.

**9:50**

**Member Eremenko:** Okay.

Have the service providers been identified and selected for the recovery communities on First Nations?

**Ms Everington:** Through the chair, the operating model for the Indigenous recovery communities is determined by the communities. In some cases they are choosing to operate those recovery communities themselves. In other cases they are choosing to contract with service providers, but it is up to the Indigenous community to determine how that happens and what the operating model looks like.

**Member Eremenko:** Where they have chosen to be the operator, has the department discussed funding of those activities? Will they be funding those activities?

**Mr. Wilson:** Yes.

**Member Eremenko:** Okay. Thank you.

Very last question here. The capital plan has and what we've heard from the minister, through the chair, is that Budget 2026 has allocated \$291 million to build new facilities. Why the increase from the original \$180 million quoted from the former minister when compassionate intervention facilities were announced?

**The Chair:** All right. We're going to go back over to the government side. Please proceed.

**Mrs. Johnson:** First, thank you to the minister and your staff for joining us here on this very late evening. It's difficult to be the last one to be asking questions on a very late night and especially after such very thoughtful questions have been asked in the evening. Of all the questions I've had, I've had to kind of siphon through and filter them a little bit because you've been doing a wonderful job of covering all this information.

I also want to thank the minister and his staff – boy, you get around everywhere – for coming to my area and for coming to the centennial centre with some of your staff and iRecover and Rising Sun Clubhouse as well. I would give a shout-out to them, too. I've not been to the summit, but I would say that Rising Sun for sure is top quality and is being so efficient and effective in the community and worth every penny and changing lives forever, so shout-out to them for sure.

We haven't got much time here, so I'll try to get in just a few tidbits at the end. We've spoken at length today about recovery. Outcome 2 on page 120 of the business plan highlights that Albertans should have timely, appropriate, and consistent access to a continuum of high-quality, person-centred mental health and addiction supports to meet their unique needs. Everyone has a different story when it comes to facing addiction challenges, and everyone has their own recovery journey. As it relates to key objective 2.1 on page 120, what does long-term recovery look like in 2026-27?

**Mr. Wilson:** Thanks for the question. It's always great coming to your area. I appreciate you showing me around.

Recovery in Alberta looks different for each person. It's often not a linear journey or a continuous progression. In general recovery is a continued state of well-being where a person manages their mental health or substance use condition in a stable, healthy way over the long run. Years of research and evidence tell us there is a

reduced risk of relapse when a person has strong personal and social connections, housing and financial stability, and access to supports such as counselling, peer support, case management, or medical care. That's why the Alberta recovery model, with my ministry's work with our partners, helps ensure anyone pursuing recovery has easily accessible opportunities, co-ordinated supports, and various types of care available to achieve whole-life improvement that can sustain a person's recovery.

**Mrs. Johnson:** I wish that for every single one in this province, as I know you do, too, Minister, through the chair.

I'll go quickly here on to the next one because I want to save the best for last. Looking at page 118 of the business plan I see the Compassionate Intervention Commission, which we've talked a little bit about here this evening. It's an independent, quasi-judicial body led by a commissioner. Members have legal authority under the Compassionate Intervention Act for conducting assessment and treatment order hearings, issuing orders, dismissing applications, discharging individuals, and hearing client reviews. As a result of Budget '26, what is the expected timeline of this commission being set up? What role does this commission play as it relates to implementing the compassionate intervention legislation?

**Mr. Wilson:** Thanks for the question. The timing is really important here, how we put this whole puzzle together. A key part of implementing compassionate intervention: Alberta's government appointed Jonathan Carlzon last August. He is our commissioner of the Compassionate Intervention Commission, and that was for a three-year term. So he's been busy. He's been setting up its operation. He's been recruiting staff. He's been developing processes and policies. Commissioner Carlzon has also provided input into the regulations that are required to set out the specific authorities in the Compassionate Intervention Act. The commissioner's leadership is going to be crucial in ensuring that compassionate intervention process and policies will safeguard the rights of Albertans receiving this care. When we do this, we want to make sure it's done right, and that's why it's taking a little longer than what I would like, but we want to make sure it's done right when we do it.

**Mrs. Johnson:** Well, through you, Chair, thank you to the minister for that and for the thoughtful answer.

There are four minutes left, and I'm going to give you the whole time to talk about a couple of little things here. I can't imagine a better minister than you to take these two questions. We've heard a lot of numbers this evening and discussed a lot of different programs and initiatives. I'd like to think we've all emerged from this process much more informed about what Alberta's government is planning to do to help individuals facing mental health or addiction challenges in 2026-27. Given we are at the end of the evening and there's not much time left, I'd like to direct this last question to you, through the chair to the minister. What is your biggest concern for 2026-27? Second, what are you most looking forward to in this coming year?

**Mr. Wilson:** Thanks for the question, through the chair. One of my biggest concerns is the people struggling with mental health and

addiction challenges, especially our young people. I've been out there, like you say. I've been across the province, and I've been looking at different facilities, and this is going to make me cry, but it's brutal. I knew the problem was bad, but I didn't know it was as bad as it was. There are so many young people that are struggling right now, and we really need to get a handle on that.

Our team has been just great. I said: let's see what we can do for our kids out there. That's why you're seeing all this work around CASA houses and CASA classrooms and youth mental health and there are pilot projects going on. There's just a ton of stuff that we've been doing to try to get these kids the help they need. It's been a real team effort. Other ministries are leaning in on this. I can see that we're making a difference, and when we start getting some of our projects completed, like our 105-bed facility we're building for compassionate care for kids in Edmonton, you're going to see us start making some real serious differences there.

I think we all have to lean in where we can and help families because it's a difficult time for everybody right now, especially in the province with what's going on. People are worried about what's happening. You know, reach out, talk to your neighbours, help them where you can.

It's going to be a big year for us. We're going to be opening up our recovery communities on the First Nations. I'm so excited about that. This is going to make a real difference in lives, like ARC down in Calgary. You've probably heard of them, the adolescent recovery community. Their slogan is: wake up, save lives, repeat. What better job can you have?

I've seen the difference we're making. I've been into these recovery communities. The one fellow I can think of: I almost thought he was maybe a lost cause, and we've got him through recovery, and now he's going to be a recovery coach. Here's somebody that probably wouldn't have made it, even out on the streets. We've taken him through recovery, and now he's giving back. That's what I really find so rewarding with this. People who have gone through the system want to give back, and it's just amazing to see how you can actually touch people and make a difference in their lives. It's been really rewarding.

The Premier has been so good to me and just kind of turned me loose. She said: I'll give you enough rope to hang yourself. So we're out there and we're making a difference in people's lives, and that's so rewarding, to see that you can actually, you know, work in government, get a lot of good things done. We've got so many good people. I hope that the opposition comes with me, too, and we can go through some of the facilities and see what's happening out there. It's pretty amazing.

**The Chair:** Well, thank you so much, Minister. We're all teared up.

I want to 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 are scheduled to meet tomorrow, which is March 11, at 9 a.m. to consider the estimates of the Ministry of Education and Childcare.

This meeting is adjourned. Have a good night, everyone.

[The committee adjourned at 10 p.m.]







