



STANDING COMMITTEE ON HUMAN SERVICES

Hansard Verbatim Report

No. 51 — April 29, 2019



Legislative Assembly of Saskatchewan

Twenty-Eighth Legislature

STANDING COMMITTEE ON HUMAN SERVICES

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Cannington

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Saskatoon Riversdale

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Mr. Muhammad Fiaz
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Mr. Todd Goudy
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Mr. Warren Steinley
Regina Walsh Acres

Hon. Nadine Wilson
Saskatchewan Rivers

[The committee met at 15:01.]

The Chair: — Well thank you, everyone, for attending the Human Services Committee meeting for April 29th, 2019. My name is Dan D'Autremont. I am the Chair of the Human Services Committee and the MLA [Member of the Legislative Assembly] for Cannington. With us today we also have MLA Danielle Chartier, MLA Larry Doke, MLA Muhammad Fiaz, MLA Todd Goudy, MLA Warren Steinley, and the Hon. Nadine Wilson.

I will table the following document: HUS 48-28, Ministry of Advanced Education: Responses to questions raised at the April 16, 2019 meeting.

**General Revenue Fund
Health
Vote 32**

Subvote (HE01)

The Chair: — Today we will be considering the estimates and supplementary estimates — no. 2 for the Ministry of Health. We will begin with vote 32, Health, subvote (HE01), central management and services.

Minister Reiter and Minister Ottenbreit are here with their officials. I would ask that the officials please introduce themselves before speaking to the microphones. Ministers, please introduce your officials and make your opening comments.

Hon. Mr. Reiter: — Thank you, Mr. Chair. Since we're doing this over two days, I think I'll have an opportunity for some brief comments on Wednesday. So for today I'll ask Minister Ottenbreit to introduce the officials and read some brief comments into the record.

Hon. Mr. Ottenbreit: — Thank you, Mr. Chair. It's a pleasure to be here to speak about the Ministry of Health's budget for 2019-2020, specifically around our investments into mental health and addictions supports and seniors' care.

A number of ministry senior leaders are with us today. Of course the deputy minister, Max Hendricks, is with us at the front table. Assistant Deputy Minister Kimberly Kratzig is at the table behind, along with Billie-Jo Morrisette, another assistant deputy minister. And we'll ask other officials as they come to the table, as you requested, to introduce themselves as they come forward to answer any questions that would be requested.

We look forward to answering questions from the committee about the ministry's '19-20 budget investments for mental health and addictions supports and seniors' care. The '19-20 health budget strikes the right balance between sound fiscal management and providing quality health services for Saskatchewan people.

This year's budget invests a record \$5.55 billion in health care programs and services. This includes significant investments to support in mental health and addictions and harm reduction, community-based comprehensive team-based care, and planning for future facilities in Prince Albert, Weyburn, and Meadow

Lake.

The Government of Saskatchewan is committed to improving access for services for people with mental health challenges. The 2019-20 budget includes record funding of almost \$402 million for mental health and addictions services, which is up nearly \$30 million from last year's budget. More than \$16 million will go towards improved care and access to services, 13.7 million will support the new Saskatchewan Hospital North Battleford, and 8.39 million will be invested to fund more than 140 new beds to treat individuals with mental health and addictions challenges.

Seventy-five new residential support beds will be created for people with intensive mental health needs who are transitioning from the hospital back into the community. It will also create approximately 50 new pre- and post-addiction treatment beds for people transitioning between detox and in-patient treatment or back to the community. This more than doubles pre- and post-addiction treatment bed capacity in our province.

This funding also adds 10 new in-patient addiction treatment beds in Pine Lodge, a community-based organization in Indian Head; six new in-patient addiction treatment beds in Calder Centre, an addictions treatment facility in Saskatoon; and six new in-patient addiction beds for youth under 18 in southern Saskatchewan.

We are also committing to new funding to hire more mental health professionals in our province: 1.1 million will be used to hire up to 12 new full-time staff to better serve children and youth with mental health issues; \$685,000 will be used to hire up to seven primary care counsellors to work in primary health centres; 515,000 will be used to hire pediatric nurses and social workers to provide enhanced mental health services to children in the Jim Pattison Children's Hospital emergency department; 375,000 will be used to increase the number of nurses available to provide mental health support in the Regina General Hospital emergency department; 300,000 will help provide 24-7 nursing supports at the La Ronge detox centre; 1.4 million in federal funding through the Emergency Treatment Fund will be used to recruit and train more health care professionals to treat crystal meth and opioid addictions.

In the 2019-2020 budget we also have 1.6 million to provide support to launch the three rapid access to addiction medicine, or RAAM clinics in Regina, Saskatoon, and Prince Albert. The RAAM clinics provide immediate access to addictions treatment by multidisciplinary teams. In other Canadian jurisdictions, these clinics have reduced emergency department visits, shortened wait times, and improved outcomes for patients.

We have also committed 1.5 million in new funding to enable the temporary mental health assessment unit in Saskatoon to become a permanent mental health short-stay unit. This seven-bed unit will give people with acute mental health care needs a place to stay for up to seven days. This will better serve patients who need mental health services and ease pressure on the emergency departments and on the Irene and Leslie Dubé mental health centre.

In the '19-20 budget we are also investing 1.4 million to help individuals struggling with opioid addiction and their families

and caregivers. The funding comes from the federal Emergency Treatment Fund announced in November under which Saskatchewan receives \$5 million over five years. It would also help us recruit and train more health care professionals to prescribe opioid substitution therapy, increase the availability of services through the use of remote trip presence technology, and train providers in innovative evidence-based treatment options.

We've also committed to funding for a number of community-based organizations that provide critical mental health and addictions services in communities across Saskatchewan: 1.2 million will launch 18 new mental health walk-in counselling clinics across Saskatchewan through Family Service Saskatchewan; 420,000 will increase the availability of vocational programming for individuals with mental illnesses, provided through the Canadian Mental Health Association in Saskatchewan; 200,000 will be divided between Autism Resource Centre in Regina and Autism Services of Saskatoon, allowing each organization to hire a mental health professional to provide enhanced treatment for autism spectrum mental health disorders; 250,000 will expand the Mental Health Commission of Canada's Roots of Hope suicide prevention initiative in Buffalo Narrows.

In partnership with the Ministry of Social Services, 600,000 in funding is being annualized to support Sanctum 1.5, a 10-bed unit that provides harm-reduction care to pregnant women living with HIV [human immunodeficiency virus] and substance abuse issues. The '19-20 budget will also increase funding for harm reduction of over a million dollars annually, nearly tripling what has been provided in 2007 and '08. This funding will support provincially funded harm-reduction programs which can reduce blood-borne infections.

In the '19-20 budget, federal home and community funding under the Canada-Saskatchewan bilateral agreement will total \$20.6 million, an increase of 1.6 million from '18-19. This investment will support targeted initiatives to help people safely stay in their home as long as possible. 12.6 million will be spent improving the delivery of team-based home and primary health care tailored to meet the needs in communities; 3.8 million will be used to improve access to palliative care in communities across Saskatchewan, including operating funding for the new 15-bed palliative care hospice in Saskatoon; 1.2 million is committed for enhancements to the home care program to improve access for residences across our province; and 2.95 million will be allocated to further enhance team-based care in the community.

This next budget will also have capital, including 12 million to begin the construction of the new long-term care facility in Meadow Lake. This project will substantially improve long-term care in the community and will increase the capacity from 55 to 72 beds. The budget will also include \$5 million in funding to prepare for the Weyburn hospital replacement project and the Prince Albert Victoria Hospital redevelopment project to enter the final stages of approval.

In conclusion, I thank the committee for giving us the opportunity to outline some of the most significant investments of our '19-20 Ministry of Health budget. We are confident this investment will meet better the mental health needs of Saskatchewan residents, and we are now open to taking

questions.

The Chair: — Thank you, Mr. Minister. Are there any questions? I recognize Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair, and thank you to the ministers and all the respective officials here today. It's always a good opportunity to ask, to dig a little bit deeper into the budget document. I'm just going to start actually with what Minister Ottenbreit was just chatting about. That was the newser. Just digging in a little bit deeper on some of the things that this new budget or this year's budget includes.

So when we talk about the 8.39 million in funding to create 75 new residential support beds, are those . . . Last year we had a conversation about the 120 beds that had been in planning for several years now, tied in to complement the Saskatchewan Hospital, people leaving the hospital. So is that what those 75 new residential support beds are?

[15:15]

Hon. Mr. Ottenbreit: — Mr. Chair, just to be clear, the \$8.39 million is allocated to provide all of the following residential programs: the 75 residential support beds for individuals with mental health needs coming out of SHNB [Saskatchewan Hospital North Battleford] . . .

Ms. Chartier: — Mr. Ottenbreit, sorry. Sorry to interrupt. I've got that list and I'm going to ask you questions about every piece. So I was just asking about the 75. Sorry to interrupt.

Hon. Mr. Ottenbreit: — The \$8.39 million is for all of that, of course.

Ms. Chartier: — I'm wondering if those 75 residential beds . . . So we've had this discussion here a few years and, Mr. Hendricks, last year in estimates I asked you about the 120 beds that were to complement the building of the Saskatchewan Hospital North Battleford. And so just the discussion we had last year, Mr. Hendricks, you said, "So maybe I'll start by saying that . . . And I know what you're referring to. There was a discussion at the time that SHNB was built of 120 community residential supported beds."

And then you just went on to explain that times have changed and that was maybe an opportunity to refresh the number. So I'm just wondering if those 75 residential beds are of this 120 that were to be complementing that build.

Hon. Mr. Ottenbreit: — Yes, so tying into that, Ms. Chartier, is the 75 beds are part of that initial 120 that was discussed earlier. Also as Deputy Minister Hendricks did touch on last year, some of those other community supports that have been put in place are alleviating some of those needs. So those are tied in to those supports along with those 75. And we're always looking at seeing what's needed in the future, if there's a need to put additional beds.

Ms. Chartier: — So at this point now that that 120 number has been scaled, is it fair to say that that . . . From the conversation we had last year, I had understood that there would likely be less than 120 beds. I just want to clarify then that that 120 has been

scaled down to 75. Like we're not expecting 25 next year and 20 the year after.

Hon. Mr. Ottenbreit: — That doesn't preclude adding additional beds. For now the 75, and then we'll keep assessing it to see what's needed once all these community supports are in place.

Ms. Chartier: — But what was needed, several years ago it was determined 120, like in a very detailed study about the need for step-down housing. So we knew a few years ago, and it was a joint report between your ministry and that health region, that 120 step-down beds were needed. So at this point in time we don't think we need 120 step-down beds anymore?

Hon. Mr. Ottenbreit: — At this point, with the CRTs [community recovery team] and the other supports that are in place, we're going to just measure what's going to be needed once the 75 are in place and see if there's a need to add more.

Ms. Chartier: — Okay. Moving on to the next point of that 8.39, and I'll get back to the CRTs here in a little bit, but I just am going to do this rather methodically.

So the next point is about the approximately 50 new pre- and post-addiction treatment beds for individuals who are transitioning between detox and in-patient treatment or back to the community. Can you explain what a pre-treatment bed would be? So we already have brief detox and social detox. Could you explain to me what a pre-treatment bed would be?

Mr. Havervold: — Hi. Brad Havervold, executive director of community care branch. So the pre-treatment beds would be for people who have been to detox, been discharged through detox, but they may be pending admission to an in-patient treatment bed. So they would need some sort of support in the community for that bridging period between the time they're discharged from detox to the time they're admitted to in-patient treatment.

Ms. Chartier: — So is it a bed somewhere? Like is it a . . .

Mr. Havervold: — Yes.

Ms. Chartier: — Physical space?

Mr. Havervold: — It could be, mmm hmm. Or better support in the community. But we're looking at beds.

Ms. Chartier: — So I guess my question to the minister then: if you're creating a pre-treatment bed, why would you not just create more addictions treatment beds to bridge that gap between detox . . . I mean, what I hear from everybody all the time is you move from detox and then have to wait up to eight weeks to get a treatment bed. And I know you're adding some treatment beds, but if you need to create actual pre-treatment beds, why wouldn't you just create treatment beds?

Mr. Havervold: — Thanks. So in many situations, the individual who is through detox may have not yet chosen to decide to go to treatment, but yet they need some support in the meantime while they work through that. They may have a specific place where they're looking to go for treatment. So while they're making their family arrangements or whatever they need to do to get into

treatment, they may need some support in the community to bridge in that period. I think it's also that, of these beds, the majority I suspect will be for post-addictions treatment of those people that are discharged from treatment that really need the supports to continue on their journey before they're feeling comfortable and ready to move back into the community.

Ms. Chartier: — So of the 50 that you envision creating, how many will be post-addiction?

Hon. Mr. Reiter: — It's not determined yet. The officials are still working on where we'll go with that, but they anticipate that the majority of them will be post-treatment.

Ms. Chartier: — Okay. And do we have a sense of what that will look like in terms of length of time? So are we envisioning a sober-living community then? Like what are you envisioning in terms of the post-addiction treatment beds?

Mr. Havervold: — So the amount of time that a person will likely stay in bed, of course, will vary depending on the client and their personal situation. But what I'm advised is the research that's out there suggests that between three and six months per individual is the time that is required for them to stabilize post-treatment, build the community supports around them that allows them to gradually transition home.

Ms. Chartier: — Thank you. I appreciate hearing that, though, as I think, that's a big piece that is missing in our continuum of care when you think about recovery-based support. Where are we envisioning those post-addiction treatment beds will be?

Hon. Mr. Reiter: — The ministry officials are working with the SHA [Saskatchewan Health Authority] officials on this right now. They're working on drafting the RFP [request for proposal] because much of this will be hopefully done with CBOs [community-based organization]. So I can't give you locations yet. It'll depend on what ministry officials and SHA officials come up with.

Ms. Chartier: — And when do you expect the RFP to go out?

Hon. Mr. Reiter: — We don't have an exact time yet. I can certainly follow up with you as soon as we know, but obviously we'd like it to be as . . . We want it to be done right but we want to it to be as quickly as we can as well.

Ms. Chartier: — Okay. I just would like a little bit more information around the pre-treatment beds because I really am having a bit of a hard time wrapping my head around like physical space. Like I get just between detox and a treatment, like I get additional support in community if there's not a bed available, but so I just need a little bit more information around what — although it's not going to be the majority of those 50 beds — what those could look like.

Hon. Mr. Reiter: — So just to clarify sort of what services are provided, what physically it would be like. That sort of thing?

Ms. Chartier: — Like what kind of . . . Will it be a CBO providing those pre-treatment beds? Like where, how, what?

Ms. Willerth: — Hi, it's Kathy Willerth. So I just wanted to

answer the question about the component of that investment that's pre-treatment beds. So what we're wanting to do is ensure that there is a place for people to go that is, it may well be in the same physical environment and the same building or operation as the post-treatment.

So some people come out of detox; they aren't sure if they want to go on to treatment. We want to ensure that they are able to maintain some of the gains that they've made while they're in detox centres to help them, you know, make those next changes or supports. Certainly some people are able to continue on that recovery journey without going into an in-patient. They may engage in out-patient treatment. There's a lot of choice in what next steps people take.

[15:30]

So we certainly don't want to limit it to you have to be done treatment in order to access this resource, but rather, you know, on your journey somewhere, if your home environment is not going to be conducive to being able to not use drugs and alcohol, then especially for that first period of time where people are most vulnerable and most likely to relapse, then having those supports available.

So I don't think we're necessarily saying this separate building will be offered or this separate CBO will offer pre-treatment and this one will offer post-treatment, but rather to ensure that we don't lose people in between those steps while they're making their own choices and while we're offering possible next steps to them on their recovery journey.

Ms. Chartier: — Do we find that most people . . . Do we quantify statistically at all, those who finish detox who want to go? In my experience from chatting with folks — and this is anecdotal of course — most people do. If you have gone through detox, the hard work of detox, people want to go straight into treatment. So what I'm hearing you say is there are people who detox who aren't ready or sure that they want to go into treatment yet.

Ms. Willerth: — There are people who go to detox and aren't committing, at the time that they're ready to discharge, to go on to in-patient treatment services. There are also people who go to detox and they choose to use out-patient treatment as their next step. They may also want to return to some kind of employment quicker than an in-patient treatment centre would allow them to. So they may want to do, you know, just out-patient counselling, return to their employment, but don't have stable living conditions. So I think ensuring that we have the supports available for that variety of situations is what we're wanting to do.

Ms. Chartier: — Okay. So just to clarify it then. So pre-treatment might be someone who chooses to . . . Sorry, I thought my phone was on; it's someone else's thankfully. So the pre-treatment then could be someone who has detoxed and then wants supported living for a period of time to access community treatment for example. Is that what we're saying pre-treatment is?

Ms. Willerth: — It can be.

Ms. Chartier: — It can be. Or it can be someone waiting for a bed somewhere as well?

Ms. Willerth: — It could be. Right, yes.

Ms. Chartier: — Okay. And you're envisioning that pre- and post-treatment could possibly be in the same facility.

Ms. Willerth: — Those are decisions that have not been made. But we've not restricted them to being a separate setting.

Ms. Chartier: — Is there a model? I know it's always good to look at best practices elsewhere. Is there a model that we're looking at of jurisdictions that do this with respect to pre-treatment?

Ms. Willerth: — In terms of models, one of the things that I have been able to do as a Co-Chair of a provincial-territorial committee is have opportunities to talk to people in my position in other provinces and territories. There isn't a particular model that we have said Saskatchewan is going to endorse and use, but rather have had some good discussions about how other jurisdictions who are also either meeting this need or struggling to meet this need, and what kinds of innovative investments they've made and solutions. So we've benefited from that.

Ms. Chartier: — Okay. So it's come out of conversations. And that's often how really good ideas do come to fruition, is talking to what other folks are doing or where there's gaps elsewhere. Is anybody else doing something similar or it really was like, oh this is a place where we could all fill in a need? Or is there anybody doing something similar?

Ms. Willerth: — In regards to the other jurisdictions, I can certainly reflect on discussions that I've had with colleagues from BC [British Columbia] who have been making investments in this area and looking at how to ensure that people, post-treatment in particular . . . Pre-treatment I certainly recall having discussions. It is, as we say, a smaller need but not wanting it to be ignored.

Nova Scotia as well. I've had conversations with colleagues there who have looked at that whole step between detox and other treatment and have talked to them about what kinds of innovative things they're doing, including supporting people sometimes through a residence as they move between those two scenarios, which are often detox and in-patient treatment but not always in-patient treatment.

Ms. Chartier: — Okay, thank you for that. With respect to the 16 new in-patient treatment beds — so 10 at Pine Lodge and six at Calder — how did you decide where you were going to put them?

Hon. Mr. Ottenbreit: — So one of the first things we looked at was who had the longest waits, or waits that were a little bit longer than we'd like. And then we looked at who would have the quickest turnaround or best capacity to add those beds in a short amount of time as well as their track record and their service to this sector, and that's where we determined that Calder would be a good place to place those six beds and Pine Lodge would be a good place to do those 10.

Ms. Chartier: — Do both spaces have, like is there major or extensive renovation that has to happen to either space to make it happen quickly?

Hon. Mr. Ottenbreit: — That was a big part of the considerations was capacity and the ability to ramp up and add those beds as quickly as possible. And both of those were deemed to be able to respond quickly along with addressing those long wait times in both facilities, and again they're long term in the business.

Ms. Chartier: — When are we anticipating these 16 new beds will open?

Hon. Mr. Reiter: — Officials are saying that they expect Indian Head to likely be within the next couple of months. Calder, hopefully shortly after that.

Ms. Chartier: — Did you take a look at any other . . . I know that you had an opportunity to chat with Prairie Sky Recovery. Was there any consideration of them as a possible place?

Hon. Mr. Reiter: — Calder and Indian Head, I would say it's because of sort of, they have a long-established practice there. They're both highly regarded and we could — for the reasons that Minister Ottenbreit said — you know, we could react quickly.

Once CBOs and private providers such as that you're talking about, we think there's definitely going to be opportunities for them. It just made more sense to react quickly with the two — Calder and Indian Head — but then to give the others an opportunity through the RFP process.

Ms. Chartier: — The RFP for the pre- and post-treatment beds, when you say through the RFP process, is that what you're referring to?

[15:45]

Hon. Mr. Reiter: — Sorry for the delay. We're just trying to clarify. There's also some in-patient addictions beds for youth that would be on your list for southern Saskatchewan. I was saying, I was trying to clarify.

Predominantly this year it would probably be the organization you're talking about. It would probably be predominantly the pre and post. But you know, we're very optimistic how this process is going to work this year. And as you and I have discussed in the past, this is, you know, a big year for improvement to mental health and addictions. We also anticipate more services coming. You know, I don't want to pre-empt the budget a year in advance, but we expect this to be expanded as well. We think there'll be those sorts of opportunities next year and in the out years as well.

Ms. Chartier: — Okay. So on to those in-patient addiction beds for youth under 18 in southern Saskatchewan, where are we . . . or you'll have an RFP for those beds? Or do you already have a sense of where they're going to be?

Ms. Willerth: — So in response to your question about what communities will be for the six youth in-patient treatments beds, so first I'd like to say that we have 15 youth treatment beds in

Prince Albert. We also have youth treatment beds in Calder as well as stabilization beds in Calder . . . in Saskatoon, sorry, I should say. And in Regina we have the detox beds. So we are talking about southern Saskatchewan. We don't have wait times or waits for either the beds in Saskatoon or Prince Albert. It's really about having a service closer to where young people live and having . . . so we've talked about southern Saskatchewan for those beds.

Ms. Chartier: — But when we say southern Saskatchewan do we have, will there be an RFP or what are we expecting for those? Like, do we know where they will be?

Hon. Mr. Reiter: — We don't know yet but it will be an RFP. So it'll depend what sort of response we get.

Ms. Chartier: — Okay. And when will the RFP be going out?

Hon. Mr. Reiter: — Again, you know, our ministry officials will be working with SHA officials to try to get that out. You know, as I mentioned earlier, obviously we want to get as many of these services running as quickly as we can, but we want to make sure it's done appropriately as well too. So they're working with officials, and we hope in . . . Sorry, I apologize. I don't want to . . . I'm not being coy about it. I just don't want to put a timeline on when we haven't really determined one yet, but hopefully as soon as possible.

Ms. Chartier: — Okay. Just with respect to these new beds and the existing beds as well, does the SHA and does the ministry have a policy around opioid-assisted therapies or medically assisted therapies like naltrexone, Suboxone, methadone in terms of entry into our publicly funded treatment facilities? Is there a policy that exists around that?

Hon. Mr. Reiter: — There's a policy in terms of different types of treatment. You mean for, depending on the addiction?

Ms. Chartier: — Obviously addiction or substance-use disorder is a chronic medical condition and sometimes can be treated with a variety of medications. And I'm just wanting to clarify or make sure that any of the organizations that provide treatment . . . Does everybody allow medical assistance in their treatment programs?

Ms. Willerth: — It is an expectation that the addictions treatment centres that are publicly funded through either directly through the Ministry of Health or through the Saskatchewan Health Authority, incorporate individuals who are on opioid-substitution therapy or any other medications to assist their recovery journey.

Ms. Chartier: — So is there a written policy, or has it ever been flagged for you that there's ever any location that doesn't allow that, or has the expectation of abstinence and considers abstinence the exclusion of opioid-assisted therapies?

Ms. Willerth: — I'm just confirming that we do have expectations that people who are on medication for a variety of things, including to support their recovery journey and opioid-substitution therapy, are included in patient addictions treatment. We have standards for detox and guidelines for alcohol and drug services. I don't have them with me here.

We certainly include, you know, meeting patients where they are. And you know, if we're not aware of a treatment centre that we're involved in that doesn't include people who are on opioid substitution and therapy in particular but certainly on any kind of medication that's being prescribed by a physician or a health practitioner.

Ms. Chartier: — Okay. Thank you for that. I'm going to digress here a little bit from my list and actually talk a little bit about opioid-assisted therapies. So in Regina we have a bit of an issue here where we've got two physicians who the College of Physicians and Surgeons is revoking their licences as of April 1st and May 1st. And so I'm wondering if we know what their caseload in terms of patients is.

[16:00]

Ms. Kratzig: — Hi. I'm Kimberly Kratzig, assistant deputy minister. So your first question was the caseload of the Regina physicians. It looks like it is in the range of about 700 patients were serviced by those two physicians.

Ms. Chartier: — I guess my question then, to the minister, is how are we going to fill this gap? This is a bit of a crisis level.

Ms. Kratzig: — So the Saskatchewan Health Authority has been able to hire a physician who will be providing services to these individuals, working in partnership with their harm-reduction clinic in Regina, so actually providing a bit of a broader level of service to the individuals as well. We also know that the Saskatchewan pharmacists' association has received an exemption from Health Canada because of this situation, where they also are able to prescribe in a very limited circumstance for these clients as well. So their needs are being met. The Saskatchewan Health Authority and the pharmacists' association have worked together and the needs of these individuals are being met.

Ms. Chartier: — The 700 patients are going to be covered by the one . . . I've heard and I don't know if this is the case so perhaps you can clarify, but the physician who the SHA has hired has a maximum caseload. Is that correct?

Ms. Kratzig: — In terms of the Regina provider that you're talking about that was hired by the Saskatchewan Health Authority, she will be working to help manage the care of the various clients that are involved in the program. She is also overseeing and working to recruit additional providers who will be able to work in this regard. As I mentioned, the pharmacists' association has received the exemption so they will be part of the solution as well.

Also just was flagged for me that there's two types of prescribers for opioid substitution therapy. There's prescribers of maintenance and prescribers of initiation. And there are more of the prescribers of maintenance who are able to sort of help manage a stable clientele.

I also want to flag that the province, as you may recall, recently signed a bilateral agreement with the federal government in the Emergency Treatment Fund. And the funding for this year, and it will flow over the next four years, there is a special focus on recruitment and retention . . . recruitment, I guess, of more opioid

substitution therapy prescribers. And also just want to flag that you may be aware that the nurse practitioners' association also have recently passed bylaws and policies so that they are also able to start prescribing.

So we recognize the need is there. And I think in terms of the Regina situation, the SHA, together with the pharmacy associations, have managed that issue I think in a positive way. And certainly we're looking at this issue more broadly in terms of the need. We know there is a need in Saskatchewan.

Ms. Chartier: — More broadly is great, but I know I'm talking to people in community in the short term who are feeling in a bit of crisis here. And I guess, so filling that gap of 700 patients who normally . . . those would be maintenance patients. If you've got a caseload of 700 right now, those would be maintenance patients.

So I just want to again flag that I'm hearing people who are really panicky in community and don't feel like the measures will, in the short term . . . I mean it's great to recruit and use the federal opioid and crystal meth action fund to try to recruit and retain opioid therapy prescribers, but I just need to understand a little bit more. I've been told in community — and this may or may not be correct — but I've been told that the caseload or what this physician can probably manage is about 200 of these 700. So I just want to clarify if that's the case or not.

Ms. Kratzig: — We aren't aware of this specific doctor only being able to take 200 of the 700 on her caseload. Again recognizing that one of the areas . . . She does have a specialty in addictions medicine, and one of the priorities for her as well is going to be recruiting individuals to help in this regard.

We certainly understand the stress that this would be for clients who are, you know, maybe feeling that they don't know exactly where to go, and the Saskatchewan Health Authority has given us every assurance that this is a priority for them. That's why they've hired the new doctor. That's why they're linking it in with their harm reduction clinic to look at sort of how they can have a robust plan to meet the needs of these individuals. Because clearly this is a, you know, this is a situation that needs to be managed very carefully for these clients.

Ms. Chartier: — Can you tell me in terms of the pharmacists' association exemption, how that is going to work? Is it a short-term exemption? And how many pharmacists do we expect to take up that practice?

[16:15]

Ms. Kratzig: — From the information that we have from the pharmacists, it looks like the exemption is valid until September 30th or until further, sort of, communication if it's still needed. It's not only for one pharmacist or a group of pharmacists in the Regina area; it's for all pharmacists. And what it essentially allows them to do is extend a prescription for a patient who is in a stable situation. So it will allow them to get their methadone or Suboxone.

I just want to clarify. You know, we've had a discussion about the one physician and whether the caseload can manage it. Just to be clear that the SHA . . . There is one physician with an

addictions medicine specialty that is working on this issue. She, though, is recruiting others to help pick up the caseload as well, so I guess there's no sense that she will be the only person working on this issue. She's recruiting others to prescribe as well.

Ms. Chartier: — But in the short term, I guess that's the sense of panic in the community. That 700 people who, if they don't have someone supporting them — I mean a doctor — the challenge is, starting to use opioids again rather than their medication and all that can lead to.

So yes, in the short term, people are very panicky here. I'm just conveying that loud and clearly to you that from . . . Folks in the community don't believe that the measures that have been taken will fill that gap right now. I mean it's great that those federal dollars are going to be specifically for that, but 700 patients is a lot of people in community who could possibly be struggling, a percentage of them.

Like, in the short term do you believe that this is the measure that needs to be . . . Like, is there anything else that could be happening that could help fill in that gap?

Hon. Mr. Reiter: — I think the short answer is simply, you know, our officials, SHA officials are very aware how serious this situation is. Obviously what happened with the two doctors wasn't anticipated, so they're trying to react as quickly as they can. They feel like they're taking the appropriate approach with, you know, with the doctor doing the recruitment. And the situation with the pharmacists, as Kimberly explained, I think will help in the short term because you're right, there's sort of two points here. There's sort of the immediate short term, what do we do, and then more long term, and also obviously recruit as quickly as possible.

I've asked officials just now. They'll share with the SHA, you know, your comments today. And if there's something else they think we can do to help alleviate that, we certainly will.

Ms. Chartier: — The addictions physician doing the recruiting and serving patients, how many other addictions physicians is she recruiting?

Ms. Kratzig: — I think it really will depend on what percentage of doctors' time is spent working in this area. I can tell you though that the expectation is that the needs will continue to be met. And so whatever that requires, our expectation is that we understand that this physician is already working and training and starting to recruit individuals to ensure that the need is met. So from the Saskatchewan Health Authority, from the Ministry of Health perspective, the expectation is the needs of the community are met.

I think we've had earlier conversations. We know that there is a need for more OST [opioid-substitution therapy] prescribers in Saskatchewan. Again the nurse practitioners are moving into this space which I think will provide a real service, not necessarily to deal with this particular issue in Regina, but more broadly. So in terms of a number of doctors being recruited, it really will depend — if I'm a doctor and I'm giving 10 per cent of my time to this or someone's who is giving 50 per cent — it will just depend on . . . It's more the amount of clinic days and the amount of time that they'll be providing as opposed to the number of doctors.

But the expectation is clearly from our perspective and the SHA's that the needs will be met.

Ms. Chartier: — Just again I just want to convey sort of the urgency from community about this issue and what it means just, not only to those patients, but to the broader community as well.

With respect to the federal dollars and from the opioid and the crystal meth emergency action fund — I think that's what it's called — that money that is going to be used especially for recruiting addictions physicians or training them up. Can you tell me a little bit about what that is going to look like? And is this, I guess just tying in, is this particular physician being supported through that fund as well or . . . I just want to know what that looks like for 2019-20 fiscal year.

Ms. Kratzig: — Your first question around the Regina physician and the actions in Regina to deal with the situation that we've been talking about, that is not coming out of the emergency treatment fund funding, just to clarify.

So with the emergency treatment fund there is \$250,000 a year allocated each year — '19-20, '20-21, and '21-22 — that will go to the regulatory agencies, 150,000 of it to the College of Physicians and Surgeons. The remaining might go to the SRNA [Saskatchewan Registered Nurses' Association] or others. This is around supporting the recruitment and training of these providers, so this isn't actually paying for the service. It's actually allowing people to go out and do the recruitment, do the training. So this will allow a three-year surge of activity in this critical area for us to ensure that we can have more prescribers, physicians, nurse practitioners in both areas.

[16:30]

I also should just flag that this money is in addition to what we have in our annualized Ministry of Health budget, which is \$80,620 that goes annually to the College of Physicians and Surgeons as part of ongoing funding around training and recruitment of prescribers.

Ms. Chartier: — Last year, I know I think my colleague asked some written questions about prescribers, and I know that nurse practitioners hadn't come on board yet, so I'm wondering if we have any nurse practitioners yet who are prescribers.

Ms. Kratzig: — We are unaware of any nurse practitioners that currently are prescribing. It was just only within the past month or two that their council approved all of the policies that would allow them to do that. So we expect it to be happening, but we're not aware of any right now.

Ms. Chartier: — Okay, thank you. Just jumping backwards here. Just around Pine Lodge, and this is anecdotal, but I've heard it from both addictions counsellors and from patients who've been to Pine Lodge. So just my question about whether or not folks could be admitted without . . . or with a prescription like methadone. And I've been told that there have been people that "no" is the answer.

So I just want to flag that as a concern that that shouldn't be the case, I don't believe. But yes, so it might be worth following up with Pine Lodge just even around the drug naltrexone which is

often used for alcohol-use disorders, and is on our formulary and is used in some of our other centres, but again with Suboxone and methadone.

So that raises a bit of a concern for me that there's new beds going there and they may not be adhering to expectation of the SHA. So you might want to check with them.

Hon. Mr. Reiter: — I think it's fair to say that's the first we've heard about this, but I'll ask officials to check into that. Thanks.

Ms. Chartier: — I've heard from both addictions counsellors and from a few patients, so I just want to raise that with you.

So moving on here, I'd like to actually talk a little bit about the mental health assessment units, the \$1.5 million that is being added to the budgets for the seven-bed unit that will become a short-stay unit. What does that \$1.5 million cover?

Ms. Kratzig: — The \$1.55 million investment in '19-20 for the short-stay unit, it will provide, as we announced, up to a seven-day stay at that unit, which will really support improved patient flow in the emergency department, reduce some occupancy pressures at Dubé. Specifically the 1.55 million will fund a total of 16.62 FTEs [full-time equivalent] including just over 11 nursing positions.

Ms. Chartier: — So 11 nursing positions. So at any given time, what is our expectation of staffing ratios during a day and during the night then? So 11 nursing positions, but obviously when you create a nursing position, you have to also make sure you've got the back . . . when people have holidays, all those kinds of things. So I just want to know what the staffing complement during the day and the evening will be.

Ms. Kratzig: — We will have to follow up and get you that information. We'll have to contact the SHA and find out exactly how the staffing mix will be when it's all operating.

Ms. Chartier: — Okay. So it obviously is currently operating, and it was about 1.2 million was their ask originally when it was just getting off the ground. And that was, I think, two full-time nurses 24 hours a day I believe. So I'm just wondering, and I could be wrong about that, but just in reviewing estimates and notes from conversations I've had with folks. So the money's going up this year, but I'm wondering if that covers security. Does housekeeping . . . like those kinds of things. Will that be included or will that be expected to be pulled from other departments?

I know I chatted with someone who spent four days in there last summer, and you're on your own for food because it's the emergency room. So I'm just wondering what that unit will look like when it's operational. So right now it's sort of an overflow for the Dubé. It's a much nicer facility than it was before, but just wondering what the staffing complement will look like.

Ms. Kratzig: — Again I don't think we have the staffing complement. I think your questions are also a bit deeper in terms of how will it differ from the mental health assessment unit in terms of how it's operating as well. So we'll see if we can get some of that information.

Ms. Chartier: — That's exactly my question, yes.

Mr. Havervold: — Hi, it's Brad Havervold again. So the difference between an assessment unit, which really is an outpatient unit as you've described where people are like being in an emergency department. The difference in a short-stay unit is you will be admitted to a bed. So you will be admitted as a patient of the hospital, and with that comes all, of course, all of the other supports that comes with admission — food and medication, that sort of thing — as an in-patient. So these additional seven beds really allows for a buffer of capacity at the Dubé Centre, right? So you know, people can stay in here for up to seven days, rather than having had in the past been admitted to Dubé.

As Kimberly mentioned, we'll have to get the exact staffing ratios of what that staffing model looks like. But we do know that when the emergency department from the current University Hospital moves over to the children's hospital, just by it losing its approximation to the existing emergency department there may need to be adjustments to staff, because you weren't able to necessarily rely on the, you know, the capacity of nurses and others within the emergency department if you need it. So we'll have to get those specific details, but just by virtue of its losing its vicinity to, adjacency to the emergency room, you may need to have some additional staff there for that purpose.

Ms. Chartier: — And just to clarify here too. I know we've had this discussion, like back with the former minister too and the deputy minister, around the third-door option, or having . . . I think what people have really envisioned is not just a . . . When we talk about assessment and short stay, I mean, people are thinking about the psychiatric emergency care centres in Australia and where you get assessed and stabilized right there and can return into community.

So it's about making sure people have access to those services to help stabilize them. And so it's not just a waiting place for admission into the Dubé. It really is about . . . I know the folks with whom I've spoken would really like to see a more robust approach. I mean, they're happy with it; it's a nice facility. But I know folks are hoping for a little bit more than that. And I don't think in the 1.55 million that that quite covers what people had anticipated or hoped this might be. So I'm wondering what we envision this mental health assessment unit, a short-stay unit, to do.

Mr. Havervold: — So I was actually fortunate to have gone up for a quick tour of the mental health assessment unit and the new emergency room of the children's hospital because I was really interested and wanting to understand the flow of patients and how both pediatric and adult patients will flow in a new world of short-stay.

And the thing that struck me is that in the existing emergency department for adults — and it will move to the new one but additionally for children now — is the position of a psychiatric liaison nurse, which I think is describing a bit of what you're getting to, which is, that person is to be the glue that pulls together, in a client-focused way, how do we make sure that we can build the supports in the community so that people can be managed either from the emergency department directly home or for a short-stay period and then home.

[16:45]

So I think it's safe to say the SHA staff that I spoke to spoke very highly of the role of the psychiatric liaison nurse in being that bridge between community and the acute side of the house.

Ms. Chartier: — And that liaison nurse will be working with both adults and children?

Mr. Havervold: — There is a team that works with the adults and there is a separate psychiatric liaison nurse that works with the pediatric population.

Ms. Chartier: — So just again though in terms of access to services, so it will be a unit of the hospital. So at this point in time it's more of a waiting space. Will there be therapeutic services obviously to help . . . So there's psychiatric nurses. Will there be access to . . . I guess my question too is if you can find out what services will be provided in that space, like that 1.55 million.

I'm also assuming that there will be security, because there will be folks who probably will be admitted on mental health warrants possibly. So I just am wondering what . . . And so I know that we are meeting again on Wednesday or even at 7 o'clock tonight. That might be pressing it here. But it would be great to have a little bit more sense of what that'll look like for staffing there.

Mr. Havervold: — We'll get that.

Ms. Chartier: — In terms of that additional space, I know I've advocated at this committee that the decanted space at RUH [Royal University Hospital], you've already got the mental health assessment short-stay unit there. We're getting close to the children's hospital opening. I'm wondering if there's been any talk about what is going to be in that decanted space, and has there been any focus or talk about it being around improved mental health services?

Hon. Mr. Reiter: — So the SHA is setting up a space planning committee, if you will — the ministry will be on there as well — with the idea of making those sorts of recommendations on what that space could be used for. And I think the short answer to your question about whether mental health would be part of the consideration is yes, it would, along with a number of other things as well.

Ms. Chartier: — I know there's lots of different therapies and folks jockeying for that space, but it seems like the time would be right. You've got this seven-bed assessment unit for which we haven't paid the capital costs, which is always nice. So again, I think that would be a really nice complement. But so when will this committee be doing its work?

Hon. Mr. Reiter: — I think they'll be starting shortly. Obviously the focus right now has been with getting, you know, the new hospital open and running, but I would think . . . I know they've had some discussions already so I would think you will see that committee appointed before long.

Ms. Chartier: — That sounds good. Moving on here. We're going to 5, is that right? And then coming back at 7, I think. We go till 5 today and then come back at 7?

The Chair: — Yes.

Ms. Chartier: — Thank you. The rapid access medicine clinics which you've announced in this budget, can you tell me a little bit about what they're going to look like? So obviously the three clinics are just getting over \$500,000 each, so I want to know how these . . . I'm familiar with the model in Manitoba, and so I'm just I'm wondering what these will look like.

Hon. Mr. Reiter: — So I'm just going to briefly start off and then I'm going to get Kathy to give you some detail. But you had mentioned that you're familiar with the Manitoba option; that's probably the one I'm most familiar with as well. I know other jurisdictions use this or something similar, but some time ago I had had a conversation with the Manitoba minister who spoke glowingly about how well these were working and thought they were very beneficial. So anyway sort of that's the intent.

Again other jurisdictions seem to have had great success with them, so in this case we want to copy best practices as much as we possibly can. So Kathy will give you more detail on sort of specific things that they provide.

Ms. Willerth: — Thanks. And I'll also maybe add that we're looking at having these clinics in Prince Albert, Saskatoon, and Regina, so three across the province.

So RAAM clinics are designed to provide quick access for patients in urgent need of an assessment by a medical professional and require an evidence-based medical treatment for a substance-use disorder which, as you had indicated, is typically either an opioid addiction or an alcohol addiction, both of which have often a prescribing function in part of their treatment.

The overall goal of a RAAM model is to stabilize patients in the short term and link them to community providers for the ongoing care, monitoring support, and continuing on their recovery journey. So typically at a RAAM clinic what we're looking at is having the clinical team do a thorough assessment to prescribe the appropriate medication, to make referrals, as I said, maybe connect them to withdrawal management — which we typically refer to as detox services here in Saskatchewan — other addictions or mental health services, and other social services as necessary. And that might be housing or, you know, food security, things like that.

Again the length of treatment can vary, but it isn't an ongoing treatment. It's in order to link them to . . . long enough to link them to other community services. I know that both Ontario and Manitoba have experienced three to six months as part of the engagement time, so we'll look at what happens here in Saskatchewan for a length of time. And also talked a lot about the real importance of being able to refer to a primary care physician, a nurse practitioner for ongoing support and care in their home communities.

Ms. Chartier: — Thank you for that. I think one of the challenges like that link to community providers is really, really important and will be an important component of this for sure. So I guess that leads into another set of questions here on access to addictions counsellors.

I actually have some questions. I think I've got some written

questions in. But I know in Saskatoon, the caseload there's, I think, four addictions counsellors for about 1,200 patients. So some have caseloads of 400 and others . . . They're not all evenly spread out, but it's about four counsellors for 1,200 patients. So as great of an idea as the rapid access addictions clinics will be, if you don't have those community services, it's a huge problem. So I'm wondering what the plan is to improve the caseload ratios for access to addictions counsellors.

The Chair: — Before we proceed, we are now at 5 o'clock so we will recess and the minister can keep his answer and we will be back here at 7 o'clock. So the committee is now recessed till 7 p.m.

[The committee recessed from 17:00 until 19:00.]

The Chair: — It now being 7 o'clock, the Human Services Committee will reconvene. Ms. Chartier had asked a question and the minister hopefully is ready with an answer now.

Ms. Willerth: — So we were talking about the supports to people in RAAM clinics and on opioid substitution therapy and the importance of the addiction counsellor role in that. And we are certainly working closely with the Saskatchewan Health Authority. We recognize and they recognize the importance of having appropriate supports on that whole continuum of care. Certainly part of the goals of the clinic is to ensure that there is flow-through and so they will want to examine, I think, that whole continuum of care. And although the task will be to introduce the RAAM clinics, thinking about that whole continuum of care will be an important part of that introduction as well.

The clinics will want to ensure that there are supports available and there are addictions staff as part of the funding model. So they will be new positions there but their ability to link clients as they move on to other community-based services is essential.

Ms. Chartier: — Thank you very much for that. I mean in terms of those numbers, I think I had pointed out that in the SHA in Saskatoon anyway, there are four addictions workers for about 1,200 clients. I'm just wondering if you could confirm that that is in fact the number, first of all, and then we'll talk about some of the other major centres as well.

Hon. Mr. Reiter: — The officials are trying to verify the number, but I don't want to hold you up for that so if you'd like they'll try to find it or if they don't have it here, they'll have to verify with SHA and we can get back to you. But in the meantime while they're checking, we can do more questions if you like, I guess what I'm saying rather than just hold you up.

Ms. Chartier: — Sure. I don't want to lose sight of that and I know sometimes that happens. This is a pretty big and a pretty important piece of support for those with substance-use disorders, is the support in community. And I know talking to folks at Westside Community Clinic, I think the caseload was one addictions counsellor for more than 400 patients. I don't have the exact number in front of me. At Mayfair I think it was one to 300. And I think there's two other sites. They're slipping my mind here anyway. So the caseloads . . . And then I was at a community meeting a couple weeks ago regarding increased acts of violence in my constituency, and some folks around that table

had confirmed that and said there were four additions counsellors for about 1,200 clients. So yes, and that's in Saskatoon. So I'm wondering about in other centres as well, like Regina, Prince Albert, Moose Jaw, North Battleford, just in terms of access to SHA addictions counsellors for clients. But I know, like Saskatoon, that is a really challenging number for folks. How do you provide care to folks when you have a caseload like that? So yes, I'll just try to make a note to come back to that if we don't come back to it a little bit later today.

When we talk about . . . Oh, you know what? Staying on substance use here, we talked about some of the new beds that were being created. Obviously crystal meth is a real issue here in Saskatchewan and opioids, I'll talk a little about that as well. But 28-day treatment doesn't even touch crystal meth. I mean it takes several months to detox from what I understand looking at some of the literature. So I'm wondering, not only are we creating new beds, but are we looking at how we are in fact supporting and treating people with methamphetamine disorders? Yes.

Ms. Willerth: — So when we talk to folks who are operating our in-patient treatment centres, they have already been telling us about the need to have people stay longer in in-patient, and they've been adapting to that need.

Certainly we're seeing longer lengths of stay in detox centres as a result of people, primarily as a result of people who are using crystal meth being the change that we're seeing in detox centres and in-patient treatment centres. So those centres are already trying to adapt to the changing needs.

So some people stay longer than 28 days now, and we have always I think recognized the need to have treatment match people's needs. So if you don't need to stay 28 days, we also should help you move back to the community support based on what your needs are.

And if you need to stay longer . . . We had recently met with CADTH [Canadian Agency for Drugs and Technologies in Health] and had talked to them about, was there any new research, having followed what does longer term treatment look like? What does the research say about that? And was there anything new and different? So I think the research continues to talk about 90 days being sort of the benchmark of longer term treatment, and it continues to talk about engagement over that 90 days.

So it isn't necessarily that you're in one treatment bed for 90 days, but rather as a system that we help you move as your needs change, you know, through detox to often in-patient treatment. And now, you know, post-treatment beds would be a likely resource for this population as well, and that we don't have those opportunities for relapse as you move through that.

So we want a much more seamless experience for clients who have those conditions that are typical for people who need longer term treatment, which isn't everybody but it is a group of people, and how do we adapt our system to do that? So I think we've done a little bit of a lot of things to be able to better meet that need.

We have people longer in treatment. Sometimes people come in, of course, through brief treatment, stay, brief detox, stay, move

over to the social detox, stay there longer than we had maybe experienced in years past when we didn't have as many people using crystal meth and describing it as a destructive force on their life. And then moving on to treatment, you know, certainly they need to feel like they're ready for treatment. When you have a crystal meth addiction and then now having post-treatment beds, being able to have that therapeutic value extend to that next treatment section I think and having opportunities to ensure that they safely and seamlessly move from one service to another.

Ms. Chartier: — Are you supporting organizations providing rehab services in those best practices around crystal meth? Alcohol is a very different beast compared to what we have. So many of those centres were established initially around things like alcohol-use disorder. So some of the concerns that have been flagged for me is, yes you can stay longer than 28 days, but you just flip back and start the program all over again. So it's not unique and tailored to . . . or I mean folks try to tailor the best that they can, but really you're repeating; it's not tailored to your particular substance-use disorder.

[19:15]

Ms. Willerth: — We've done a number of things to help all of the service providers adapt to being able to treat individuals who have a crystal meth addiction. I will mention that alcohol addiction is still a real and present concern and is a needed skill and a necessary part of our addictions treatment systems as well.

So over the last few years there's been a fair bit of training and sharing knowledge and building, you know, a small community of practice where people have shared what's working for them, tried to engage and build resources, engage each other, and build resources to better meet the needs of clients that they see coming in to their centres.

As a part of the Emergency Treatment Fund that we spoke about earlier, we'll have resources. The Saskatchewan Health Authority will have a dedicated position to be able to develop crystal meth specific resources and training, and the funds will also support — in addition to developing that knowledge, to having that translation and dissemination, so sort of from knowledge to practice — being able to support addiction treatment providers in wherever they are in the continuum, in ensuring that they are using best practices, that they're aware of them, that they've adapted, continued to adapt. If new things come out, we can get that knowledge dissemination out as quickly as possible. So some of the funds in the ETF [Emergency Treatment Fund] are very specific to that.

We also have funds in the Emergency Treatment Fund that will target health care provider capacity building for a trauma-informed practice, which is I think one component of good practice, and with the population that experiences crystal meth addiction, that often needs to go hand in hand. They have often a burden of traumatic experiences in their life, and we want to I think generally raise our capacity to offer a trauma-informed practice throughout the continuum as well.

So those are, you know, really targeted areas within the Emergency Treatment Fund, which are just really getting under way now in the Saskatchewan Health Authority.

Ms. Chartier: — I couldn't agree with you more about alcohol. Really, it kills more people than anything else. Opioids and crystal meth are a huge concern, and we've watched those numbers climb. I'm not diminishing the role of alcohol, but crystal meth we've watched since 2013, all those stats tick up directly related to crystal meth or methamphetamine. So I don't disagree with you, but there is a lot of work to be done on better supporting people with different substance-use disorders.

And I'm glad you answered the . . . I was going to ask you about co-occurring disorders because you rarely see a substance-use disorder without trauma of some kind at some point in someone's life, whether it's a first responder or a child who's experienced or an adult who's experienced traumatic things as a child. So I'm glad to see that's a component.

So that money is rolling out this year. When do we expect both the work around trauma-informed practice to sort of be integrated and flow out to health care professionals? When are we expecting that work to filter out?

Ms. Willerth: — So we're working with the Saskatchewan Health Authority on their project plan for both the trauma-informed practice work and the crystal meth work. Just going to the trauma-informed practice, we've actually been working, we've had some previous federal resources to work on that and we're really trying to build on it. It's been quite a few years; I don't have the original date when we started that work.

Right now we're part of a national project, have been a few years, and it's in its phase 2. So we were on the phone recently to plan for some more training opportunities this summer and early into the fall. That's in addition to the funding. So those two projects will dovetail together, and there'll be more capacity within the Saskatchewan Health Authority to really embed that.

You know, it's been very focused on aftercare in this last round. We're hoping that they will, you know, have more opportunities to reach out to all of the treatment centres, to outreach workers, and just have much more capacity. But we're really building on a lot of work that's gone on already.

With the crystal meth, there again has been . . . The spending is to support work that's gone already. We've worked in partnership with the Saskatchewan Health Authority on really a work plan. And this will put resources into it to ensure that it has greater capacity to touch a larger group of addiction-service providers.

So with the kinds of work that has occurred in '18-19 already that we want to build on, we have our resource guide for clinicians that includes recommendations on effective treatment options when working with individuals who use crystal meth. So that was completed and has been shared with addictions providers.

We've also worked with the Saskatchewan Health Authority to further protocols and clinical responses for individuals who are withdrawing from crystal meth, trying to minimize the suffering that they experience as they go through crystal meth withdrawal. And they've developed a package, an education and prevention presentation package, and they've worked on disseminating that. So it's available as a standard way of educating the community about crystal meth and about prevention and about awareness and

how to recognize why you might not want to be involved with this substance.

Ms. Chartier: — Thank you for that. Just going back to a question earlier that I didn't explore, I think, fully enough. So we talked about the 700 people who are on the caseload of the doctors who are losing their . . . or not practising prescribing opioid-assisted therapies as of April 1st and May 1st.

So you have a physician who will be doing this work and recruiting other physicians. You've got pharmacists. But how are you going to connect these 700 people to these services? So I was just talking to my colleague who represents that community. And again I'm just really emphasizing the urgency of this issue. But what is the plan for connecting these 700 current patients to other service providers?

Mr. Havervold: — Thanks. So in my conversation with officials with the Health Authority, the patients who would have been under the care of those two physicians who are no longer have the ability to prescribe, my understanding is that those physicians are also working very closely with the Health Authority to hand those patients off to new providers. I suspect that's happening already.

And the Health Authority would have the ability, in collaboration with those physicians to be able to identify every one of those clients who was being seen, to ensure that they have a hand-off to another provider that could carry on that prescribing.

Ms. Chartier: — So just to double-check then in terms of how many people, we talked about two who will no longer have the ability as of May 1st, April 1st and May 1st. We've got the SHA who's hired the one physician. How many other physicians are prescribing these medications in this area?

Mr. Havervold: — Sorry, I don't have that number in front of me at this moment, but we can get that.

Ms. Chartier: — Thank you. Yes because I'm just curious how that hand-off will . . . So I'm glad to hear that the physicians are working on . . . with their patients to hand them off. But if there's not providers to hand them off to, that is a bit of a challenge. So if you could get me that number at some point here soon that would be great. Thank you.

Addictions counsellors. Someone raised an issue with me just actually last week about naloxone kits and access to naloxone. So I just want to read this part of the email:

I'm writing this to highlight the barriers I encountered while trying to navigate obtaining naloxone for a group of people in need.

Someone had recently passed away very close to this group. The messaging out there is that naloxone is free and easily available to those that need it, yet when I took them to the pharmacy after their training was complete, I was surprised to be told that they were \$40. The free ones are only available at certain locations during certain times and with this being a Saturday of a long weekend, it will be a Tuesday before we can even try to sort this out.

With my experience at work, it is vital to be able to intervene in the moment and waiting days can sometimes make all the difference in the world. So despite the pharmacy having many kits on hand, having certificates from a certified trainer, and being in need of this life-saving medication, this group of grieving friends were unable to receive their kits.

So can you describe for me a little bit how people access naloxone though? So folks had their training. So they identified that they had their training and the pharmacy had the kits available, so could you explain why they weren't able to . . . Are there only X number of available naloxone or free available naloxone kits?

[19:30]

Ms. Kratzig: — Just to provide a bit of information about the take-home naloxone program in Saskatchewan. Take-home naloxone kits are available now in 25 communities across the province. We counted 37 locations on the website. There's actually an interactive map. You could go type in your address and see exactly what location, so 37 locations and growing.

As you probably know, a lot of effort has been made in the past year or two to really expand the take-home naloxone program. Up until January of 2019, more than 1,750 kits have been provided to individuals. More than 4,000 have completed training. And probably the most amazing statistic, we know that as of January, 101 lives been saved because of take-home naloxone. So certainly we recognize the importance of take-home naloxone and its use.

Recently there has been an expansion in the Saskatchewan Health Authority. It's now available in emergency departments in Regina and Saskatoon. So it's available for people who are leaving the emergency department. It's something that's provided to folks. And we also waived a policy early in 2019 where training is still recommended but it's not a requirement. We had heard that some people were leaving; they didn't have time for training. So we wanted to get those kits in the hands of people.

So again a lot of work has been done. They're now available through more community-based organizations who are able to distribute them more broadly. So we think there's quite broad distribution of take-home naloxone kits in the province. I didn't catch the community that you were referring to.

Ms. Chartier: — Saskatoon. A group of people whose friend died of a fentanyl overdose, they all decided that they needed this training and needed these kits and couldn't get free kits despite having a certificate and despite the pharmacy having kits. It was the Saturday of a long weekend and so they were under the . . . So again, despite the pharmacy having many kits on hand, having certificates from a certified trainer, and being in need of this life-saving medication, this group of grieving friends were unable to receive their kits.

So is there only X number of free kits that are allocated in a year? They could have got their kits if they would have paid \$40. But are there only certain pharmacies or certain times where you can get a free kit? If that is the case, I hadn't realized that.

Ms. Kratzig: — There's no limit to the number of take-home naloxone kits that are available to individuals who complete the training and are there to get the kits, so I don't think that would have been one of the issues. In Saskatoon there are three locations: the Mayfair Clinic, the Methadone Assisted Recovery services, and AIDS Saskatoon. Just looking on the website, some are open Monday to Friday; hours vary. Some are closed on weekends. So if you were wanting a free kit, that would be the location that you would get it at. Again without understanding where the individuals who corresponded with you would have received their training or why a kit wasn't available, you know, when they were getting the training, that type of thing, I wouldn't be able to respond.

But there is no limit on the number of kits that are available in the Saskatchewan Health Authority. We've provided funding and there are kits available free of charge to individuals.

Ms. Chartier: — So it's just all becoming clear to me here. So there a few locations where you can get free kits, but to walk into a pharmacy with your certificate and identifying the need, I think that that's what this individual is saying here. So they went to a pharmacy. The pharmacy had the kits and the people had the training, but they couldn't get the kit from the pharmacy. So I think what this individual is saying is that these should be accessible and free for those who need it, and the ministry or the SHA should reimburse pharmacies for providing the kits.

So just to clarify then, I couldn't go to the pharmacy with that information and get a free kit? Or are there some pharmacies where you can get kits from?

Ms. Kratzig: — When Saskatchewan introduced the take-home naloxone program, one of our priorities was ensuring that we were reaching people who were at risk of an overdose. And we took the approach we did to expand the program. The kits are available, again, in locations where we know that community-based organizations are working with clients who potentially could be at risk, or friends of individuals.

We've done, as I indicated, a number of things over the past couple of years to make them more accessible. They're now in emergency departments. We have waived the requirement for training for those individuals who are not wanting to take that tack. We know that there are . . . Free kits are now available to people who would be friends of individuals, not necessarily only family members, or people who might just witness an overdose, rather. But they currently in Saskatchewan are not free in pharmacies. That is not a part of our current program.

So as we look to expand the take-home naloxone program, are we reaching people? What are we hearing from community in terms of ways to improve access? Again the kits are available in 25 communities, 37 locations and growing. But we will always assess how to make sure that these valuable kits are getting in the hands of individuals. Again, 100 lives saved is an amazing number and we want to make sure that these kits get to the people who need them.

Ms. Chartier: — Just emphasizing that this individual is suggesting that being available in a pharmacy would be even more accessible for lots of people outside of the Monday to Friday day.

I just want to talk a little bit about mental health here in particular. So last year I'd asked some written . . . Well last year in committee, actually, and the answers got tabled in December, which was good — a little longer than I expected. But I had asked on May 9th about children and youth in the mild and moderate categories waiting for their initial outpatient mental health appointments. And in Saskatoon as of end of June, there were 416 children in the moderate category and 80 in the mild.

I'm wondering if you . . . And then you've given me the list of the former health regions. So I'm wondering if you have that most up-to-date list on . . . And I've been told that those numbers have improved a little bit, by folks, but can you let me know where we're at in terms of kids in the mild and moderate categories waiting to see an outpatient appointment?

[19:45]

Ms. Kratzig: — I do have some information that I think aligns with what you were asking for. I just want to confirm that you were looking for the number of children and youth waiting for their initial in-patient, initial outpatient appointment in the mild and moderate categories?

Ms. Chartier: — Yes.

Ms. Kratzig: — So we do have information as of March 31st, 2019, so as of this year. And I think you were looking for Saskatoon.

Ms. Chartier: — For all of . . . Well you said March 2019?

Ms. Kratzig: — Yes.

Ms. Chartier: — So Saskatoon.

Ms. Kratzig: — Yes. So for Saskatoon in the moderate category, it's 304, and in the mild it's 28.

Ms. Chartier: — Okay. And then how about for the other regions?

Ms. Kratzig: — Sure. Maybe I'll just start with moderate only. So for Cypress, it's 17; Five Hills, 5. I should mention that I'm providing this by former RHA [regional health authority] only because of the geographic location.

Ms. Chartier: — Yes, I got that.

Ms. Kratzig: — Okay perfect. Great. Kelsey Trail is 1, or pardon me, Keewatin Yatthé is 1 and Kelsey Trail is 22. Prince Albert Parkland is 33; Prairie North is 4; Regina is 131; Sun Country is 1; and Sunrise is 11.

Ms. Chartier: — And then how about in the mild?

Ms. Kratzig: — In the mild category, we have Cypress with none; Five Hills with 2; Kelsey Trail with 22; P.A. [Prince Albert] Parkland with 7; Prairie North with 47; Regina, 69; Saskatoon, 28; Sun Country is 8; and Sunrise is 6.

Ms. Chartier: — I've written that down and I'll look at *Hansard*, but would it be possible to table that so it's in a readable format?

Hon. Mr. Reiter: — We can get it in a readable format for you. If not today, I'll get it to you tomorrow or on Wednesday, if that's okay.

Ms. Chartier: — Sure, yes. That would be great. Okay, thank you for that. Have you been doing anything different to try to . . . Some of those numbers . . . I mean Saskatoon's still pretty high in the moderate category. But what have you been doing different to try to bump those numbers a little bit more effectively?

Ms. Kratzig: — One of the most sort of direct correlations can likely be made with the budget investments in '18-19. So in '18-19 we invested \$2.97 million in expanded access for child and youth mental health services, and I can give you a bit of an update in terms of those dollars in terms of how they were allocated.

So of that 2.97, I'm going to divide the province into three areas: integrated northern health, urban health, and integrated rural health. So again you know, as we've shifted from the regional health authorities to the Saskatchewan Health Authority, the dollars were allocated in that way.

So for integrated northern health, I can tell you that there were two community mental health nurse positions hired serving North Battleford and Ile-a-la-Crosse and two continuing care aid positions serving Ile-a-la-Crosse; one Master of Social Work position in North Battleford; one child psychiatrist contracted for one day a month in North Battleford; one psychologist for one day per week serving the north-northeast part of the province; a Bachelor of Social Work position located in Kelsey Trail; one community mental health nurse, one Master of Social Worker, one Bachelor of Social Worker located within the former Prince Albert Parkland.

In the rural area of Saskatchewan, there is a social work position, a child and youth counsellor position located in the Outlook area; community mental health nurse positions serving Moose Jaw, Swift Current, Estevan and Weyburn; and one mental health therapist position located in Yorkton.

And then for integrated urban health, a Bachelor of Social Work position, two master positions, three community mental health nurses in Saskatoon; and in Regina, two Masters of Social Work positions and one community mental health nurse position.

So in total, there were 25 new positions providing services and two contracts dedicated solely to child and youth mental health services. So I think that is something that across the province you would see increased access to services because of those new positions.

In the '19-20 budget, '19-20, there is an incremental \$1.13 million, and so we would expect 10 to 12 new FTE [full-time equivalent] positions to be hired to provide mental health assessment and treatment for child and youth with that funding. And again the funding that we talked about in '18-19 continues on and the people who are hired remain in place.

Ms. Chartier: — Okay. So just to double-check that I make sure we're talking about the same language here. So when we're talking about waiting for an initial outpatient mental health appointment, that would be with an ongoing . . . so your first

meeting with someone who will be an ongoing therapist; is that correct?

Ms. Willerth: — I want to answer that by explaining that I think what's most important is that you get your service by the right provider at the right time and offering the right intensity. And so when we're talking about, in particular talking about a mild and moderate client group, it may well be the therapist that offers you the treatment that you need for that intervention.

But it may be something else as well like a group, you know. So if a group is what is the most appropriate treatment service and that's what the client wants, it may be that as well. And we would consider that a service offered.

And we also want to recognize that people's needs change sometimes too, so whether we need to ramp up or ramp down if people, you know, get better quicker than we expect. You know, they go to the group and they say, this has met my needs and this has solved the issues for me. Then that works well.

Or if people's needs change and are more intense, we need to be able to say we can ramp up services as well. So the mild and moderate, measuring what we know at that time, matching that to a service that meets that level of need, which often is a therapist or an individual counselling situation, but not always if that isn't the best match for the service that is needed by the client.

Ms. Chartier: — So I just want to clarify here. Okay, so I recognize not everybody needs one-on-one counselling all the time for sure, but do you have any other way you quantify, so if someone is waiting to see, needs to see a mental health professional, whether it's a social worker or a psychologist or whomever it might be, is there a different list that you have then? So this is for first appointment with someone with a connection with mental health. So they're getting offered some service, whether it's a group or it's a meeting with a therapist. Do you have another list that you . . . Am I missing something here?

[20:00]

Ms. Willerth: — Maybe I haven't explained that well. So when we're talking about mild and moderate waiting, they're waiting for that first service. I just wanted to clarify that it may well be an individual counsellor, but there would be situations where it wouldn't be, that the client wants to join a group, the group is being offered, and they're waiting to get into that group. So yes, you're right. In many times, many situations, it would be an individual therapist. But I think the way you had worded it, I didn't want you to think that it is exclusively that. It is a match of the client's needs to the services available.

Ms. Chartier: — Okay. Thank you for explaining that. So in a place like Saskatoon, where your number of children in the moderate category is currently 304 as of March 2019, what does that look like in terms of a wait?

Ms. Willerth: — So in order to answer your question, I have information about the wait times according to the former RHAs for the mild and moderate category. And we have, according to the triage benchmarks that we have provided with the SHA in setting.

So for moderate, a wait of 20 days . . . not a wait, an appropriate benchmark to meet, to be seen in this 20 days; and for a mild, 30 days. And so when we're measuring the work that the former RHAs have done in meeting that, we measure them by percentage of individuals who have been seen within that. And I can give you that percentage for the former RHAs in both the mild and moderate.

Ms. Chartier: — So you said moderate is the 20-day benchmark?

Ms. Willerth: — Right.

Ms. Chartier: — And mild is 28 days.

Ms. Willerth: — 30, sorry.

Ms. Chartier: — Sorry?

Ms. Willerth: — 30.

Ms. Chartier: — 30 days, sorry. Yes, 30 days . . . [inaudible interjection] . . . You probably did. Sure, that would be great.

Ms. Willerth: — So starting with Athabasca, they are meeting both moderate and mild 100 per cent of the time. Cypress is meeting moderate 96 per cent of the time and mild 92 per cent of the time. Five Hills, the former Five Hills, 99 per cent of the time for moderate and 100 per cent for mild. Heartland, 100 per cent for moderate and 99 per cent for mild. The former Keewatin Yatthé, 100 per cent for moderate and 100 per cent for mild. And Kelsey Trail is the same, 100 per cent in both moderate and mild. Mamawetan Churchill, 100 per cent in both moderate and mild. The former Prairie North, 89 per cent for moderate and 91 per cent for mild. P.A. Parkland, 100 per cent for both. Saskatoon is 96 per cent for moderate and 95 per cent for mild. Sun Country, 75 per cent for moderate and 83 per cent for mild. And Sunrise, 98 per cent in moderate and 100 per cent in mild.

So I'll just also comment that in, for example, in Saskatoon, one of the things they've worked hard at doing is offering a first service. And so when we're looking at the 96 and 95 per cent in Saskatoon, that's ensuring individuals have a first service. Part of the role of that first service is to measure the level of need, be able to ensure that there's not risk factors including suicide risk factors, be able to confidently say that this is a moderate or a mild. So they've done that kind of initial service. And then the wait that's reflected in the numbers that you spoke about would be waiting for a next appointment. So there's been a lot of work to do for the front end, ensuring that we understand what people's needs are, have an appropriate, standardized triage methodology, and then can assign services based on that information at the front end.

Ms. Chartier: — Okay. So again, going back to that list with Saskatoon with 304, there's 304 children and youth waiting to have that first service.

Ms. Willerth: — They may well have been seen already for that first service because they have a 96 and 95 per cent. So I think they are also including, when they're reporting those numbers, they're being very transparent by saying we have these people waiting because they're waiting for a second service.

Ms. Chartier: — Okay. So that is not entirely clear to me then because we were just talking about how these numbers, I thought, were for the first service, so the first list of numbers we talked about.

Ms. Willerth: — The percentage that they are seeing, so they're seeing 96 and 95 per cent. But we are aware that they count that as a first service and then so people are getting a first mental health service but some people may be waiting. And so when they're reporting that larger number . . .

Ms. Chartier: — So they may not be yet connected to . . . They've seen someone, and someone in the moderate category may not be identified as being experiencing suicidal ideation but they may be identified as moderate and may need to wait.

Ms. Willerth: — For the next service.

Ms. Chartier: — For the next service. So I guess that was my question around benchmarks. And sorry, you didn't give me the number for former RQHR [Regina Qu'Appelle Health Region] I don't think, in that last. So I just need the RQHR number for the benchmark.

Ms. Willerth: — And we don't have reports from the former Regina Qu'Appelle on them.

Ms. Chartier: — Okay. Is Saskatoon the only one who is measuring the first service in that number?

Ms. Willerth: — Those are the ones that we followed up on because of the numbers that they reported last year when we collected that and provided that and so we followed up on ensuring that we understood what that measured. And so they certainly are meeting these benchmarks by offering a service.

Ms. Chartier: — So I'll just repeat that back to you to make sure that I understand. So in Saskatoon, because the numbers were higher, like last year 416 kids last June waiting in the moderate category for services, you clarified with them and they may have already been triaged with one, a meeting with someone, but they may be waiting to see a social worker at child and youth services in Saskatoon. So they're still waiting. They've been cleared as not suicidal or not a high level but they're still waiting for services.

Ms. Willerth: — Yes.

Ms. Chartier: — Okay. Thank you, I just needed to clarify that. Thank you.

Just in terms of acute mental health beds . . . Or you know what? Sorry, I'm going to go back to addictions and you're here so I will go back to addictions here for one moment.

Around methamphetamine, I'd mentioned this community event a few weeks ago in my constituency around safety and I've seen numbers from the Saskatoon Police Service before on crystal meth charges stemming from 2013 to recent years and the spike in crime related to crystal meth. And for example in 2012, they went from 19 possession and trafficking occurrences to 457.

So just in terms of stats that you keep, I had a slide from the

police service from a couple years ago and I couldn't find it, but I know that you track admission to a mental health facility with admitted use of methamphetamines. Like I've seen that data so I know you guys keep track of it but I'm wondering if you happen to have that on hand. So admission to an acute psychiatric facility with a use or admitted use of methamphetamine.

Ms. Willerth: — Can I just clarify, it's to a mental health centre, not an addictions centre, is what you're asking?

Ms. Chartier: — A mental health centre, yes. That was the stats that I had seen.

[20:15]

Hon. Mr. Reiter: — Sorry, can I just get you to clarify? Officials have numbers for the numbers you're asking for to addictions treatment services. I think that's not what you asked though. You said for . . .

Ms. Chartier: — Saskatoon Police Service had numbers from the ministry, I believe, or from one of the departments in the ministry, on admission to a mental health facility with admission to use of crystal meth. I have the slide; I don't have it here. I couldn't find it in my stack of papers.

Hon. Mr. Reiter: — Sorry, just to clarify, you got it from Saskatoon Police Service but they had got it, you think, from SHA or ministry or somewhere?

Ms. Chartier: — Yes, about three years ago.

Hon. Mr. Reiter: — We're at a bit of a loss here. We don't know where those numbers would have come from. We do have the ones for drug treatment services. Would you like those and we'll try to follow up on the other ones if we can?

Ms. Chartier: — Yes. I guess my question then instead of trying to figure out what I had, and I'm 99.999 per cent sure it was admission to acute psychiatric facilities with use of crystal meth, but since we can't figure that out, what stats do you track around opioid and crystal meth use?

Ms. Willerth: — I can give you the admissions to in-patient addictions for individuals who've identified crystal meth. Would you like that now?

Ms. Chartier: — Sure. Yes.

Ms. Willerth: — Was that your question?

Ms. Chartier: — That, and what . . . So you track those who have admitted meth use into in-patient addictions facilities. What other stats do you track around crystal meth and opioid use?

Ms. Willerth: — I think that's our most useful one. And I have that here. I can give that to you now if you want to start with that question.

Ms. Chartier: — Sure.

Ms. Willerth: — And then identify others?

Ms. Chartier: — Yes.

Ms. Willerth: — So one of the things that we've seen is that actually the number of admissions to addictions services, treatment services, has remained relatively stable. But what we have seen also is an increase in the number of individuals who are saying crystal meth is the issue that's bringing them to addictions treatment services.

So it's not that we have more people coming, but rather the substances that individuals are using is changing. So we're measuring it by percentage of the total provincial admissions. And when we talk about admissions in the alcohol and drug area, it's to both in-patient and outpatient. That's the way our system collects it.

So for example, in 2012-13, we had 3 per cent of the admissions were saying crystal meth . . . were identifying crystal meth as the issue that brought them to addictions treatment centres. Again as we had said before, often it would be polysubstance-use situations but they've included crystal meth. This is self-reported; it's not anything more.

Ms. Chartier: — Yes.

Ms. Willerth: — Yes just self-reports. So people are saying this is what brought me here. In 2013-14 it was 5.22 per cent; in '14-15 it was 8.76 per cent; in '15-16 it was 15.23 per cent; and in '16-17 it was 22.66 per cent.

Ms. Chartier: — You don't have '17-18?

Ms. Willerth: — I don't have it here. If we have it, I can get that for you another time.

Ms. Chartier: — If you could get '17-18. And would you have '18-19?

Ms. Willerth: — Not yet.

Ms. Chartier: — Yes. Do you have opioid use for those as well?

Ms. Willerth: — I have to check.

First I'll offer you the '17-18 percentage of clients who've identified crystal meth as an issue, and I apologize for not having it on my other chart. So '17-18, 30.58 per cent.

Ms. Chartier: — Okay, and if you could endeavour, if you do have '18-19, if you could . . .

Ms. Willerth: — I don't have that here.

Ms. Chartier: — Okay, '18-19, crystal meth. Okay.

Ms. Willerth: — And your other question was about, do we have something similar for opioids in addictions treatment centres. Sorry, just hang on a second. My apologies. I was misreading the label on this. So we don't have that in the same way that we have it for crystal meth.

Ms. Chartier: — No worries then. That's okay. I have a couple other ways to think about accessing that kind of information. The

time goes so fast; it's already 8:30.

Funding to our CBOs, to our health CBOs. So there was a 1 per cent lift this year, I think zeroes the previous two years, and I think it's been 3 per cent in the last five years. So I just want to double-check. The 1 per cent lift to CBOs, is that just for wages? And how does that have to get allocated and used by CBOs?

Hon. Mr. Reiter: — Yes, that's right. It's for salaries.

Ms. Chartier: — So the 1 per cent this year was for salaries. Can you just confirm for me that it was zero the last two years and then I believe 1's the previous two years? Is that correct?

[20:30]

Hon. Mr. Reiter: — Sorry, officials are looking for the breakdown per year. It was 1 per cent this year. It was zero last year. They're trying to find the previous years, but beyond that all we have is '07-08 to '18-19, and that overall was a 49 per cent increase, 49.5. So 15.6 million to 23.3. That's Ministry of Health and SHA. CBO spending went from 12.6 to 22 million, which is a 74 per cent increase.

Ms. Chartier: — That's over the last five years though?

Hon. Mr. Reiter: — They're still trying to find those. We might have to follow up with you on that.

Ms. Chartier: — Okay. I'm quite certain it's 3 per cent over the last five years, but if it is in fact 3 per cent, that would've just been for wages. Just to double-check, those percentage increases would've been directly tied to wages?

Hon. Mr. Reiter: — Sorry, this year the 1 per cent?

Ms. Chartier: — This year but previous, like the previous lifts of 1 per cent and 1 per cent . . .

Hon. Mr. Reiter: — This year was for sure. The numbers I just gave you from '07-08 on, that would've been. Because every year is different. Depends where it's targeted. Some years were just wages; some years it was for growth. So that would be all encompassing those numbers. The 1 per cent is just for wages, and then we'll get you the breakdowns for the years you asked for and let you know what those were targeted for.

Ms. Chartier: — That would be great. And I'm just going to jump to last year's budget because I think CBOs this year . . . Last year, of the \$11.4 million investment in new mental health initiatives, not all of it was spent because the CRTs didn't roll out, like things didn't get rolling for the full fiscal year. So how much money . . . First of all, was there any money carried forward to this budget year?

Ms. Kratzig: — So in '18-19, as you know, there was \$11.42 million given to mental health and addictions services. So the breakdown was 9.42 million in federal funding and 2 million in provincial funding, and that was allocated between mental health and addictions and also enhancing community mental health and addictions supports and improved addictions service delivery.

All of the initiatives that were announced in the '18-19 budget

have now been fully implemented. Just to walk through what a few of those are, the community recovery teams, enhanced addictions medicine services for P.A. and northern Saskatchewan. We have police and crisis team expansion, internet cognitive-based therapy, suicide prevention program in Meadow Lake, mental health capacity building in schools, and the increased access for child and youth that we had talked about.

As we'd been working with the Saskatchewan Health Authority throughout the year, it became clear that the timing of these initiatives was going to result in — and I think we chatted about this actually at Public Accounts — that there would be some one-time funding. So we have allocated or provided the SHA with the authority to allocate or reallocate any unspent funds in '18-19. So that has happened now. And within that bucket, over \$1 million has gone to CBOs throughout Saskatchewan.

Ms. Chartier: — So just to clarify then, of the 11.42 million, 1 million didn't get spent on the previous initiatives and was reallocated.

Ms. Kratzig: — More than 1 million. But 1 million did get reallocated to community-based organizations, to a range of them, for a number of things.

Ms. Chartier: — For like capital projects like furniture?

Ms. Kratzig: — Yes, primarily capital and equipment.

Ms. Chartier: — Yes, furniture that they had to throw out because of bed bugs, those kinds of things.

Ms. Kratzig: — Furniture and equipment, yes, for sure.

Ms. Chartier: — Yes, computer. Yes, had lots of conversations with CBOs about those things.

Ms. Kratzig: — So they did receive funding. Again about \$1 million did go to CBOs with that one-time funding. And then there was other allocations that were made also to priority mental health and addictions one-time initiatives.

Ms. Chartier: — How much of the 11.42 million . . . I recognize that now last year's initiatives are all rolled out, but what was the money that was reallocated? What was the amount of money that was reallocated?

Ms. Kratzig: — So we were able to reallocate . . . The Saskatchewan Health Authority, of the 11.42 that we talked about, they received \$10.2 million. And of that, as our most recent information from them which is to end of February, we were able to reallocate \$6.9 million for one-time funding this year to a number of priorities across the province.

Ms. Chartier: — Okay. So more than half of it didn't, because some things didn't get rolled out.

Ms. Kratzig: — Primarily, yes. Primarily because of the timing. And so again the things that did happen in '18-19 we talked about. There were 25 new child and youth positions. The mental health capacity building in schools program is up in five schools, four communities across the province. We've implemented the targeted physician training program to improve, you know, the

capacity for physicians to treat child and youth mental health conditions. We have the third Roots of Hope suicide project happening. All of these programs, community recovery teams, so they're now all up and running.

The timing to hire into some of those positions, do some of the planning, did result in again a one-time funding. So we sort of had this opportunity where we worked with the Saskatchewan Health Authority, with community, to determine what other priorities would we be able to fund. So I could give you an example of some other areas that we were able to fund for sure.

Ms. Chartier: — Actually, instead of reading that into the . . . So I just want to double-check then. So 6.9 million of the 11.42 million didn't get spent on the planned initiatives.

Ms. Kratzig: — Yes.

Ms. Chartier: — But they were allocated to other priorities. Do you have a list of priorities that you could table? Because time is getting short here.

Ms. Kratzig: — Yes, I have some information. I probably want to put it into a format, but I could get it for you in the next day or two for sure.

Ms. Chartier: — Yes, that would be great.

Ms. Kratzig: — I think it's important though to recognize that it's not that these are unspent funds. These funds were held to account obviously through the federal government. The bulk of them are through bilateral funding. We've had discussions with the federal government about the allocation of these funds to one-time priorities, so I don't want to leave any impression that the funding lapsed or is not being used for other priorities. As you know, the need is great in this area. And we had an opportunity — because of how the money rolled out in the '18-19 and the timing on some of these other initiatives — that we did have an opportunity to provide, you know, lots of one-time dollars to areas of need. So I can get you that list for sure.

Ms. Chartier: — That would be great. I'm just curious. So there was about one and a half million, I think, that got bumped forward from '17-18 to '18-19, so I'm just curious about the different approach. That money was bumped forward to the budget instead of reallocated. So why the different approach?

Ms. Kratzig: — The '17-18 funding that you talked about, that was the year when we signed the bilateral quite late in the fiscal year and we hadn't had an opportunity to actually allocate that to priority areas. We're in a bit of a different situation now in that this annualized funding is needed going forward. This is truly one-time funding that's available because it was not used for the programs that it's needed for, but it is needed in '19-20. Because all the programs are now up and running and annualized, so it made more sense to allocate one-time priorities. We knew what the priorities were. The Saskatchewan Health Authority and community were, you know, very clear in being able to assess the situation, so we felt that allocating it now made sense.

Ms. Chartier: — Okay, thank you. So if you would be able to table a list even by Wednesday — I know we're back here on Wednesday — of those reallocated dollars in '18-19, that would

be greatly appreciated.

Ms. Kratzig: — Sure.

Ms. Chartier: — The CRTs, how many patients . . . So I know they're in multiple communities and are doing important work. And I've actually just sat down with one fellow in Saskatoon who is connected now to the CRT in Saskatoon. But it was interesting. I'm a bit of a pack rat and I save everything. And I just wanted to know how different the CRT is from the Connecting to Care pilot which . . . not the connected . . . not the primary health care pilot, but the hot-spotting basically, I think, is what it was called.

But this is just from a document:

In collaboration with Primary Health and First Nation and Métis health, the Connecting to Care pilot project is using an innovate, patient-centred care model that identifies clients who repeatedly utilize hospital services. Case managers, a nurse practitioner, psychologists and elders are working with clients and as a result are seeing significant reductions in hospital visits and an enhanced quality of life for participants.

So this is from the St. Paul's Hospital Foundation annual review in 2015-16. So that sounds like the CRTs are really important, and it's important to put those resources around people. But can you tell me the difference between the previous Connecting to Care pilots in Saskatoon and Regina and the CRT?

[20:45]

Hon. Mr. Reiter: — So we're going to do a little bit of teamwork here. Margaret is going to quickly walk through the Connected Care hot-spotting for you, and then Kathy will sort of explain the difference on the CRTs, okay?

Ms. Chartier: — Okay. Sounds good.

Ms. Baker: — Hi, I'm Margaret Baker. I'm assistant executive director of Connected Care services branch. And just to give you a really quick overview of hot-spotting or Connected Care, two pilot projects — one in Regina and Saskatoon — they were focused on supporting those individuals who were high users, who were showing up in the emergency department on a frequent basis. So that was a key criteria for identifying those individuals. It wasn't necessarily . . . it could be anything.

What we found in Regina were many of those people were experiencing chronic conditions, not necessarily mental health. They may have an associated mental health issue, but we had diabetes, COPD [chronic obstructive pulmonary disease], so it wasn't limited to mental health in any way. It was really focused on those individuals that needed some specialized attention because their care in the community wasn't meeting their needs. So again not specific to mental health issues, and the care was they would be provided team-based care that was very targeted to support them until they could transition back to a primary care provider that could provide their ongoing care.

Ms. Chartier: — Okay, but often co-occurring disorders or health concerns?

Ms. Baker: — Yes, so oftentimes chronic conditions, but many different types of chronic conditions, not exclusive to mental health in any way.

Ms. Chartier: — And substance use?

Ms. Baker: — Yes, primarily it wasn't really focused on substance use. It was really focused on those more chronic conditions.

Ms. Chartier: — Substance use would be classified as a chronic condition, would it not?

Ms. Baker: — Yes, the number of people that they identified in those pilots, there wasn't a high prevalence of individuals with substance abuse.

Ms. Chartier: — Okay and just to clarify, those pilots are wrapped up a couple years . . . We're not doing Connected Care or hot-spotting.

Ms. Baker: — No. They have rolled into the SHA base as of '19-20. Those pilots continue and, for example, in Saskatoon are rolled into some of the outreach programs that are located at community health centres.

Ms. Chartier: — Okay, thank you.

Ms. Willerth: — So in contrast, the community recovery teams are in the eight communities. I think we talked about them last year, so you know about those. And they're reaching out to individuals with serious and persistent mental illnesses, so that is the target population for those and to individuals for whom their needs haven't been met by the traditional mental health services available both by the level of intensity, the ability to reach into where they live and where they need their services, and also to have atypical hours of service delivery as well.

So they are multidisciplinary teams. They typically have a community mental health nurse, sometimes social workers, addiction workers, occupational therapists, and have a peer support component as well based on the model of assertive community treatment that has been common to other jurisdictions.

Ms. Chartier: — I think the CRTs are great but they're not quite . . . What I've been told and I'm looking at literature around assertive community treatment, it's not quite there. It's like there's many other components of assertive community treatment that aren't quite there with the CRTs. So like, I know it's modelled after that, but there's a few pieces that aren't quite there, from what I've been told.

Ms. Willerth: — I'm not sure. Is that a question or . . . Sorry.

Ms. Chartier: — Yes.

Ms. Willerth: — Yes, okay. Are there some components of . . .

Ms. Chartier: — Yes.

Hon. Mr. Reiter: — The officials are trying to give you a comprehensive answer, but we're struggling a bit. What

components have you been told that are missing?

Ms. Chartier: — That's neither here nor there. I'm running . . . I've read lots of literature on them. Anyway, how many people in the eight communities are being served by the CRTs, just in terms of clients in each area?

Hon. Mr. Reiter: — They're saying we don't have the numbers yet. We'll have to follow up with you.

Ms. Chartier: — What is budgeted or planned for this fiscal year?

Hon. Mr. Reiter: — 4.2 million was budgeted for '18-19, and then it continues in this fiscal.

Ms. Chartier: — Okay. So it's allocated at 4.2 million for the CRTs then this year?

Hon. Mr. Reiter: — Yes, that's right.

Ms. Chartier: — Do we have a sense of what we . . . So that's in eight communities. I'm suspecting it's not equally allocated between all eight communities. Like are the larger centres receiving more? You must have some sense of how many people with whom you'd like to have that 4.2 million.

Hon. Mr. Reiter: — You want the breakdown of the communities?

Ms. Chartier: — Or actually just a rough number of how many people we expect 4.2 million to support. Yes.

Hon. Mr. Reiter: — The eight teams and the 4.2 million is sort of all we have with us now, but we'll try to get the breakdown for the estimate for the individual ones from the SHA and follow up with you.

Ms. Chartier: — Okay, yes. So eight teams at 4.2 million is great, but I just really, well not just the breakdown but wondering how many people we think that will support — that's the big question. And if there's room for expansion.

Okay, I am really running short of time here. I'm going to switch gears here. Oh, one last question around mental health and addictions. So with respect to publicly funded services, either detox or treatment facilities, I know one concern that's been flagged for me is at one of the detox facilities, getting on a list and then expecting people, while they're waiting to access that detox bed having to call by 11 in the morning or noon, the barriers put in front of people who are needing to detox who really might not have a phone, might be drug sick, all kinds challenges.

So does the ministry have any policy or does the SHA have any policy or expectation of those organizations providing detox services? Is that okay with the ministry that folks have to jump through hoops like that?

Hon. Mr. Reiter: — So your concerns about that callback provision, I share those concerns. The Provincial Auditor raised that. So December 18th I'd sent a letter to the CEO [chief executive officer] of the Health Authority. I won't read the whole

letter but, you know, I referenced the Provincial Auditor's report and, well I summarized it this way. I said:

For these reasons I'm writing today to request that the Saskatchewan Health Authority develop an alternative to the callback process that is used by the Brief and Social Detox Centre in Prince Albert and other facilities.

And I asked for an update. I had gotten an update a couple months ago that refers to, it kind of explains the first-come, first-call, first-served basis and how it works. And then it says, "We recognize there's potential for an individual to be counted as a refusal more than once. From time to time . . ." That speaks to the Provincial Auditor's concern. "From time to time we have individuals that refuse to leave their name or their name is missed."

[21:00]

It says, "We do admit this process is not 100 per cent accurate and stress the importance of tracking these requests. Our staff, the brief and social detox manager, is in the process of . . ." And it goes on with some other information then it says, "In addition, the team are also looking at alternatives to the callback system that would also ensure that beds are operating at capacity."

So we are following up with them too, but just generally speaking I share your concerns about that.

Ms. Chartier: — Okay, thank you. Sorry, switching gears here to long-term care. Where are you with the RFP for Grenfell and Pioneer Village?

Hon. Mr. Reiter: — The RFPs are closed right now. The SHA is doing some work with that; it'll take them some time to do some evaluation, those sorts of things. And I'm told that probably we anticipate probably early summer we'll have something more concrete.

Ms. Chartier: — How many submissions were there for the RFPs?

Hon. Mr. Reiter: — Sorry for that delay. So I'm told RPV [Regina Pioneer Village], there was seven. Grenfell, I'm going to have to follow up with you because apparently SHA, they're considering right now doing an extension on that. So I don't know all the details around that, so I'll have to follow up on the Grenfell one with you.

Ms. Chartier: — Okay, but in Regina there was seven?

Hon. Mr. Reiter: — Yes.

Ms. Chartier: — Okay. But around Grenfell they're considering extending? Okay. Do you know when we'll know whether or not it's extended?

Hon. Mr. Reiter: — Probably within the next couple weeks.

Ms. Chartier: — Just staying on long-term care here, in La Ronge, do we know how many people are currently on the wait-list for long-term care in La Ronge?

Hon. Mr. Reiter: — I'm told it's 55.

Ms. Chartier: — Fifty-five for La Ronge. Do you know — two things — the average number of days people wait for a bed, and how many folks end up in another community?

Ms. Kratzig: — We don't know how many people from Mamawetan Churchill or La Ronge area actually would have received long-term care in another health region or another area of the province. In terms of how long people in the area wait, that number really has varied quite a lot in Mamawetan Churchill. The last number we have from them is from March 2018 and it was a 20-day wait. But I should just flag that, you know, before that, September of 2016, it was 166-day wait. So there seems to be a lot of variation in Mamawetan Churchill River.

Ms. Chartier: — Sorry. That wasn't an average. That was a snapshot in time.

Ms. Kratzig: — Snapshot in time. We do a snapshot twice a year in terms of how long people are waiting for long-term care across the province.

Ms. Chartier: — Okay. Could I get that list tabled? The snapshot in time, a couple points of reference for what people are waiting for, for long-term care?

Ms. Kratzig: — Sure. Similar to other documents, I think we'd want to put in a format that would be appropriate for tabling, but we could follow up.

Ms. Chartier: — That would be great. Probably for, let's say, the last four years if possible.

Ms. Kratzig: — Sure.

Ms. Chartier: — That's a random number.

Ms. Kratzig: — And I could just share with you that provincially the average wait time in days is 24 days at the last time we measured.

Ms. Chartier: — Okay. And in the larger centres?

Ms. Kratzig: — In Saskatoon it was 43 days on average, and in Regina it was 20 on average.

Ms. Chartier: — Great.

Ms. Kratzig: — So that number really over the years has gone down consistently in terms of average time people are waiting and also sort of it looks like also the number of people who are on the wait-list has also gone down over the years.

Ms. Chartier: — Which is interesting because our demographics are getting older. So what would explain that?

Ms. Kratzig: — I think there might be a number of things. There's, you know, other options for people in society. We know that we have, you know, a robust home care system that is keeping people at home longer. More people are choosing to stay at home longer. We have personal care homes that people may be going into. But I think a lot of effort and investment has been

made in the home and community side of the health system, and I think you might be seeing that in terms of people just simply able to stay at home longer.

Ms. Chartier: — I'm seeing more and more . . . Like I see lots of people as the critic because that is what my role is. People come to my office to complain about lack of access to services because that's what my job is. So I see lots of people who feel like they're pushed into the personal care home system because they don't assess as needing long-term care. And I've seen folks who have quite high levels of needs who end up in personal care homes.

So I'm interested. I really will appreciate seeing that document just in light of our changing and aging demographic here.

One thing I don't think I've ever asked in the past and I don't know why, but in terms of allocations to long-term care, is there a rate that all long-term care facilities, like is there a flat rate or how do we allocate funding to long-term care facilities?

[21:15]

Ms. Kratzig: — Long-term care in Saskatchewan, the allocation to individual homes is based on historic funding. There isn't a formula. So it's based on historic funding that has been increased over the years to ensure that needs are met. It might be based on layout of the home, that sort of thing. And just to give a bit of an update, since '06-07, government expenditures through the SHA have increased by 45.5 per cent into the long-term care sector. So there's been quite healthy growth in that area, again 45 per cent since '06-07.

Ms. Chartier: — Someone had flagged for me that it was frozen in '16 at '14-15 levels. Is that correct?

Ms. Kratzig: — The Ministry of Health funds the Saskatchewan Health Authority global funding for long-term care, so there was no freeze that we would be aware of. And certainly when we look at government expenditures through the SHA for long-term care, they have increased every year. So they're not familiar with a freeze that you would be referring to.

Ms. Chartier: — Okay. So when we talk about historic funding, so home X may have a different allocation. So the money is allocated now to the SHA but to the former regions. And former regions determined how that money was spent in long-term care?

Mr. Hendricks: — Max Hendricks, deputy minister. So this actually goes back decades in some cases. The union hospital districts, the districts, the health regions, they all apportioned funding differently to long-term care. The affiliates made different decisions based on their available revenues. And so you know, it really is a historic thing and it's not based on any pre-determined staffing level necessarily or anything. They're decisions that have been made over the years.

Ms. Chartier: — So separate contracts with . . . So help me understand this a little bit better then. So the ministry gives the SHA global funding for long-term care, or global funding, and then the regions, the former regions and now a region, determine how that's allocated based on historic . . .

Mr. Hendricks: — Yes. So previously, like with health districts, we provided them with global funding. They would have made decisions regarding staffing and long-term care, decisions on how much to spend in that particular area, which varied because some of them had less of an acute-care presence. So there were differences in the allocations. And then going forward, yes, again with when they became regional health authorities, same thing. They would apportion it. And now the SHA, same thing. The one thing that is consistent is in terms of how we fund collective agreements through that period for long-term care workers, but other decisions were made at the regional level.

Ms. Chartier: — Okay. The 7.5 million that was committed in 2016, I know a year and a half or two years ago now, I was told that you'd managed to save more than 6 million from executive salaries and just over a million had gone back into long-term care. So I'm wondering where that's at now.

Mr. Hendricks: — So what the ministry did was we directed that the regional health authorities at the time — it was '16-17 — had to reduce administration expenditures by \$7.5 million and to reinvest that money in long-term care. It was kind of that straightforward.

Ms. Chartier: — Yes. I was told by Ms. Kratzig though, back at that point in time, that over 6 million had been saved and only a million or so had been redirected. And then the minister had said that that money was all . . . Like, the money couldn't be . . . I wish I had my *Hansard* here. But the minister had said at that point in time, that that money couldn't be redirected because of fiscal constraints. So I'm wondering if that 7.5 million ever did make it into long-term care.

[21:30]

Mr. Hendricks: — So of the seven and a half million, they were able to — the number that Kimberly quoted to you — save probably in the \$6 million range in administrative savings. But unfortunately because of fiscal realities during that period and some deficits, they weren't able to transfer that all to long-term care. However, long-term care spending in that fiscal year did go up by \$5 million. So the admin savings didn't all make it to long-term care as additional funding.

Ms. Chartier: — Okay. And in terms of the reasons for long-term care funding going up, was it for more FTEs? Was it for more beds? Was that Swift Current coming online? So what would explain that increase of that 5 million?

Mr. Hendricks: — We're told that we can get you some information on how FTE salaries, that sort of thing, changed in that fiscal year. We just don't have it with us. But we can follow up next time with you.

Ms. Chartier: — That would be great because the commitment was to put that money directly into the front lines of long-term care. So it's great the funding increased, but I'm wondering where we are with FTEs prior . . .

The Chair: — Excuse me. We have reached the time of adjournment, so we can carry this on on Wednesday.

Ms. Chartier: — Please may I just finish the question so they

know what to table? They've just offered to provide me some information.

The Chair: — Very short.

Ms. Chartier: — Thank you. With respect to FTEs then, can I find out where we were at prior to 2016 and now in long-term care?

Mr. Hendricks: — Sure.

Ms. Chartier: — That would be great. Thank you.

The Chair: — Okay. Thank you very much. We will move to adjourn considerations of vote 32, Health. Does the minister have any final comments before we wrap up?

Hon. Mr. Reiter: — I would just like to thank Ms. Chartier and thank the officials and thank the committee. And we look forward to continuing on Wednesday.

The Chair: — Ms. Chartier, do you have any closing comments?

Ms. Chartier: — Thank you to all the officials. We always appreciate the information you provide and to other committee members and to the officials and the ministers for your time.

The Chair: — Okay. Thank you. I would ask that a member move a motion of adjournment, please. Mr. Steinley has so moved. Is that agreed?

Some Hon. Members: — Agreed.

The Chair: — Carried. This committee stands adjourned to tomorrow, April 30th, 2019 at 3 p.m. Thank you very much everyone.

[The committee adjourned at 21:33.]