STANDING COMMITTEE ON HUMAN SERVICES

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STANDING COMMITTEE ON HUMAN SERVICES

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[The committee met at 15:00.]

The Chair: — Well good afternoon, everyone. We'll start the Human Services Committee meeting today. My name is Larry Doke. I'm the Chair of the Standing Committee on Human Services. I'll introduce the committee members. First we have MLA [Member of the Legislative Assembly] Herb Cox. We have MLA Muhammad Fiaz, the Hon. Todd Goudy, MLA Nadine Wilson, and we have MLA Danielle Chartier who is also Deputy Chair here today.

General Revenue Fund
Health
Vote 32

Subvote (HE01)

The Chair: — Today we will be resuming our consideration of estimates and supplementary estimates for the Ministry of Health — vote 32, Health, central management and services, subvote (HE01). Minister Reiter is here with his officials. I see Minister Kaeding is here also with his officials. Minister, please introduce your officials and make your opening comments.

Hon. Mr. Kaeding: — Certainly. Thank you, Mr. Chair and members of the committee. We are pleased to be here with you again today to tell you about the Ministry of Health budget as it relates to mental health and addictions services and services for seniors.

I'm joined by Minister Reiter, Minister of Health; and I will quickly reintroduce you to the ministry senior leaders who are joining us: Max Hendricks, deputy minister of Health; Denise Macza, associate deputy minister; Mark Wyatt, assistant deputy minister; Billie-Jo Morrissette, assistant deputy minister; Rebecca Carter, assistant deputy minister; and Tracey Smith, assistant deputy minister. We have many other senior Ministry of Health officials who are also attending and will introduce themselves as they are called upon.

As was touched upon yesterday, COVID-19 has had an unprecedented impact on our health system. It required us to do extensive planning for additional pressures on acute care facilities and emergency departments. However, we all know that being healthy is about more than just physical health. Living through a pandemic has been stressful for us all. It has caused anxiety and worry and has in some cases intensified existing mental health challenges.

In addition to the health system's planning for increased pressure in health facilities, it was crucial that we would also plan for the impact COVID-19 would have on the mental health of Saskatchewan people, including our health care workers. Online resources have been developed to support front-line workers managing stress, including a workshop series, health care workers wellness package, and peer support training. A health care provider mental health support line was also implemented to offer brief intervention and assist those who may require urgent care. Work is already under way to improve and enhance mental health programs and services. However there are mental health supports already available that can be accessed by anyone in the public feeling additional stress during this difficult time.

To highlight just a few, the SHA [Saskatchewan Health Authority] maintain intake services for mental health and addictions services. Out-patient services continue virtually or by telephone. Family Service Saskatchewan has continued to provide walk-in counselling services through virtual means or telephone. The Saskatchewan division of the Canadian Mental Health Association implemented phone lines in ten locations across the province to support those struggling during these challenging times. Community recovery teams for people with chronic and persistent mental health illnesses were maintained, and mental health in-patient services for adults, children, and adolescents remain open for admission. Procedures are in place to maintain physical distancing practices.

Many mental health and addictions services had to adjust from traditional delivery models, but services have been maintained through the COVID-19 pandemic. Although we are proud of investments our government has already made in the mental health and addictions services in Saskatchewan, there are even more investments in this particular area that I will share with you today.

As noted yesterday, the Ministry of Health's overall budget for '20-21 is $5.8 billion. Beyond the key investments we highlighted yesterday, the budget includes significant funding to strengthen mental health and addictions treatment and support. It also makes investments to support our senior citizens. I am pleased to provide you with the details about these areas today.

The Government of Saskatchewan is committed to improving access to services for people with mental health challenges. I'm proud to say that our record of increasing investment in this area continues. About 7.5 per cent of Saskatchewan's total health budget will go to mental health and addictions. This year's budget includes record funding of almost $435 million for mental health and addictions services, the highest in Saskatchewan history.

We are committing $33 million in new mental health and addictions funding. This will include an increase of $12 million for targeted mental health and addictions services, 19.3 million for increased costs associated with hospital-based and other mental health and addictions services, and $1.6 million in increased operating funding for the Saskatchewan Hospital North Battleford. This funding also supports a new provincial addictions treatment centre with a special focus on crystal meth, improved access to mental health addictions treatment beds and supports, and intensive supports for children and youth, and increased partnerships in innovation.

We have heard from Saskatchewan people that more must be done to support people experiencing addiction. In particular, we have seen the impact that crystal meth addiction has had on people and families across the province. Responding to this need, our government has committed $1.4 million to establish a new in-patient addictions treatment centre in Estevan, St. Joseph's Hospital, that will have a specific and specialized focus on crystal meth.

This provincial centre will support people from across Saskatchewan who are seeking recovery from crystal meth addiction and will also bring people with specialized training to

the province. The centre will develop innovative protocols in medication use to support crystal meth treatment. It will also offer wrap-around services in Estevan and post-in-patient supports throughout the province. The $1.4 million investment will support 20 addictions treatment beds. Fifteen of these beds will be dedicated to people recovering from crystal meth addiction and five beds will be available for people seeking treatment for other kinds of addictions.

In addition to this funding, $150,000 has been committed to establish four pre-treatment beds and six post-treatment beds in Estevan. The centre will be an important resource for people in need of these services and will help Saskatchewan people successfully continue their recovery journey.

Outside of Estevan, we will increase the number of detox beds across the province. We have invested more than $1.7 million to develop up to 28 new detox beds in Regina, Saskatoon, Moose Jaw, Prince Albert, and North Battleford. We have also committed $800,000 to hire more addictions workers to provide services in emergency departments in Regina, Saskatoon, and Prince Albert. Having more staff will better support patients with addictions challenges and will help these patients navigate the services available to them.

We have also committed $680,000 to fund medical supports in detox. This will allow for the hiring of more registered nurses, licensed practical nurses, and paramedics, and will increase access to medication and medical treatment.

Last year we provided funding to develop three rapid access to addictions medicine clinics in communities across Saskatchewan. These clinics offer faster access to addictions treatments. They also reduce emergency department visits, shorten wait times, and improve patient outcomes. We're proud to invest $400,000 to establish a fourth RAAM [rapid access to addictions medicine] clinic in North Battleford and look forward to seeing the same success repeated in North Battleford that we've seen in Prince Albert, Saskatoon, and Regina.

Harm reduction services will get a $630,000 boost in this year's budget. Of this, 130,000 will support addition case workers for AIDS Saskatoon. The remaining 500,000 will improve other harm reduction efforts across Saskatchewan and will allow for more take-home naloxone kits and safer inhalation supplies to be purchased and provide more funding for needle exchange programs and expand other harm reduction services.

The federal government has continued to support opioid treatment in Saskatchewan through the opioid Emergency Treatment Fund. The 1.35 million in federal funding will allow us to recruit and train more health care professionals to better support people experiencing crystal meth and opioid addictions. This will allow Saskatchewan to have more opioid-substitution therapy prescribers.

In addition to these targeted addictions services and programs, our government has also committed funding into other mental health services. In total, we've invested 6.2 million to improve mental health services in Saskatchewan. Of this funding, 3 million will go towards the residential support beds created in 2019-20, bringing an annualized funding to $6 million. These residential support beds will help people transition from a hospital setting back into the community. This will free up hospital space for new patients and will also better support people on their journey to mental wellness by helping them build a life in their community.

We've also committed 1.3 million to develop intensive supports for children and youth with complex mental health needs. 1.25 million will go towards our suicide prevention efforts as outlined in our recently released suicide prevention plan, Pillars for Life. This will improve the use and monitoring of suicide protocols and will enhance research, data, and surveillance.

To respond to the need for enhanced mental health supports in rural communities, we'll provide $437,000 to a pilot project that allows nurses to work with RCMP [Royal Canadian Mounted Police] members. To better support EMS [emergency medical services] workers, we have committed $200,000 to continue mental health supports.

In addition to investments into mental health and addictions, I am pleased to tell you more about how our government plans to better support Saskatchewan seniors. As mentioned yesterday, the '20-21 health capital budget includes $15.7 million to continue the construction of a 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. Construction of this facility is under way, and we look forward to celebrating this project's completion.

Outside of Meadow Lake, we have also committed 2.3 million to continue our partnership with personal care homes in Regina. This investment has created 100 long-term spaces and has helped address the need for services in Regina. The 2.3 million in new funding is in addition to the 760 million that our government already provides for long-term care services across Saskatchewan.

As well this year's budget continues to invest in seniors' care in our communities. We have ongoing investments of more than 2 million for dementia and behaviour units in Regina and Saskatoon, 1 million for purposeful rounding, and $700,000 for geriatric services in Regina. We have once again committed 1.1 million to the Alzheimer Society of Saskatchewan to expand its programming. $300,000 is being provided to the Saskatchewan Seniors Mechanism to continue their work to reduce social isolation, ageism, and the lack of opportunities to participate in the community. To help seniors live in their homes for as long as they can, we have once again provided 8.25 million to the HomeFirst program. We have also provided 1.34 million in continued funding for the development and completion of a new hospice in Saskatoon.

We'd like to thank the committee for giving us the opportunity to outline these significant investments of our '20-21 Ministry of Health budget. With 7.5 per cent of this year's budget going towards mental health and addictions supports, we've reached our government's 7 per cent funding commitment benchmark.

We are proud of our work our health system partners have done to reach this important goal, but we also know that this work must continue. Whether improving access for people in need of addictions services or supporting people struggling in the midst of the COVID-19 pandemic, our government remains committed

to continued improvement on this important front. Our officials will now be pleased to take your questions.

The Chair: — Thank you, Minister. Before we begin our questions, I would ask that all witnesses to please state their name for the record before speaking at the microphone. Questions. Ms. Chartier.

Ms. Chartier: — Thank you, Mr. Chair. Thank you for your comments here today, and we always appreciate the time to get to ask some questions here. Just from your opening comments here, you mentioned the CMHA [Canadian Mental Health Association] phone line that started up during the pandemic. Did you provide any funding for those 10 locations?

Hon. Mr. Kaeding: — So there was no boost in funding but we do give them annualized funding each year, so they were using that as part of their budget.

Ms. Chartier: — So out of their existing budget they started 10 phone lines. Did they ask for resources to be able to do that?

Hon. Mr. Kaeding: — No, they did not.

Ms. Chartier: — They did not. Was that an initiative that they took upon themselves to start or was there a request from either the SHA or the ministry?

[15:15]

Mr. Havervold: — Brad Havervold with the Ministry of Health. No, they did not ask us for money. In fact I had a phone call from the Canadian Mental Health Association advising that they were going to start up those lines when they did.

Ms. Chartier: — In terms of CBO [community-based organization] funding for the Canadian Mental Health Association and other health CBOs — obviously the ministry supports health CBOs — what percentage increase in the last five years have organizations like the CMHA [Canadian Mental Health Association] gotten from the ministry? So a total in the last five years, what percentage? I understand there's a small lift this year, but I believe it's about 3 to 4 per cent over five years.

Ms. Morrissette: — Good afternoon. Billie-Jo Morrissette, assistant deputy minister. For the first question, which was the last five years' CBO lifts. So in '16-17, it was zero per cent; '17-18, zero; '18-19, zero; in '19-20, it was 1 per cent lift to salaries; in '20-21, as you mentioned, we also do have in our budget a 3 per cent increase to salary and a 1 per cent increase to operating for our CBO sector.

In addition to that, just with respect to the organization we are speaking about, in '19-20 we did provide an additional $420,000 to their base operating and that was really to enhance the existing programs.

Ms. Chartier: — So they got a 420,000 boost last year, after zeros, and that was directly for operational costs?

Ms. Morrissette: — That's correct.

Ms. Chartier: — Thank you. Okay. I appreciate that. I'm going to jump right into a question that's on everybody's mind: Samwel Uko, and the challenges that we have in our emergency rooms around people receiving care in a timely fashion or care at all. Where are you at with respect to . . . Are you supportive of a coroner's inquest to see what led to this young man's death?

Hon. Mr. Kaeding: — So currently SHA is doing their own internal review on this; the coroner is also doing a review. And then upon the conclusion of the review we'll determine if there's next steps required from there. So there's kind of two parallel reviews going on right now.

Ms. Chartier: — When do you anticipate the SHA review to be complete?

Hon. Mr. Kaeding: — It will be concluded within 60 days of when it was first initiated.

Ms. Chartier: — And what day was it first initiated?

Hon. Mr. Kaeding: — So it was initiated May 26th.

Ms. Chartier: — Unfortunately, I know, you know, and I think people who have any interaction with mental health in emergency rooms know, we all know full well that this isn't an isolated case. We had Steven Rigby's mother here in March. This is something that happens quite frequently.

But just in terms of people leaving without getting care or people feeling like they're not getting what they need in the emergency room when you present with a mental health or addictions condition, just in terms of quantifying some of that. I know you track stats around the number of people who leave without being seen by a physician. Just in some written questions I have, they were very specific to opioid use and stimulant use. But generally speaking, people who present with a mental health or addictions challenge to an emergency room, what numbers do you have here for the most recent year of people leaving without being seen?

Mr. Wyatt: — Hi, Mark Wyatt, assistant deputy minister, Ministry of Health. We have the ability to do various data runs, including patients left without being seen. I can't confirm whether we would be able to break that down in terms of people who present with a mental health concern. Unfortunately we don't have the left-without-being-seen data on hand right now, so it's something that we would have to bring back and table at a later time.

Ms. Chartier: — So I'm curious how you . . . So I'm just looking at two written questions where you've done data runs breaking down the percentage of emergency department visits in Saskatoon and Regina hospitals with problematic opioid use. And from 2013-14 those left-without-being-seen — so I'm speaking about addictions here obviously — .01 and then in the most recent quarter was .03. But around those using stimulants, it went from zero per cent in 2013 to .04. So clearly you do break these out into fairly fine detail.

I guess without knowing the data runs you do or the data runs you keep, I'm assuming if you've got it to that level around substance use that you probably have that around people who have presented with a mental health condition. Would that be fair to say?

Mr. Wyatt: — Yes, I would expect we can identify people who present to emergency with a mental health concern, condition, presentation. What I don't know is if we have then the ability to cross-reference that with people who left without being seen. But that's something I would have to follow up to understand if we can . . .

[15:30]

Ms. Chartier: — So you've been able to do that very thing around opioid and stimulant use. So I'm not sure I'm understanding why you wouldn't be able to do it with someone . . . So if someone reports saying that perhaps they're schizophrenic and then they leave without being seen, you're not sure if you track that information?

Mr. Wyatt: — I'm not sure if we've done similar runs based on the presentation of the patient. That may well be something that we can do with the other conditions that people present with.

Ms. Chartier: — What do you know off the top that . . . or with all the officials here it's obviously not off the top of your head. It might be, but you've got lots of officials here. What data are you aware of that you track for those who are leaving without being seen?

Mr. Wyatt: — Typically what we report is the number of patients, simply at a kind of a global number of patients who leave emergency without being seen, the percentage of the overall, you know, presentations to emergency. Then once you have that subset of patients who have left without being seen, it would just be a matter of whether you can then sort of cross-reference with other data coming in related to the patient condition, related to, I guess, other variables in the data. And that's the part where personally I'm the recipient of some of those reports, but I'm not the person who can tell you whether we have the availability to do those data runs.

Ms. Chartier: — As I said, I see that it's broken down into opioid, like very specifically both opioid and stimulant use. So I'm assuming that it can be, but how quickly can we find that out? And we have four hours here tonight. This is our last opportunity to ask these questions, and this is a pretty important and pertinent question pertaining to someone. We have Samwel Uko. We have people who leave on a regular basis. So this is a really important question, and I'm wondering how quickly we can get the answer.

Mr. Wyatt: — So we can confirm that we have the ability to do the data run involving patients left without being seen and cross-reference it against, you know, the reason for presentation. It would be a specific data run, and I don't think we can commit to getting it done today. So it would be just best efforts to have our data analysts prepare that as quickly as we possibly can, but it's not something that we can have done in the business day today.

Ms. Chartier: — Fair enough. Would it be possible to have it, the commitment to table it within the next week to two?

Mr. Wyatt: — Yes, I think we can.

Ms. Chartier: — How about we say the next week?

Mr. Wyatt: — I think we can commit to that, yes.

Ms. Chartier: — Okay, is that . . . Thank you. I look forward to seeing that number. So the numbers that I have around opioid and stimulant use for the last five years, if we could get the last five years, and I know you included quarter one in the 2019-20. So that would be great. Thank you.

Mr. Wyatt: — Perhaps if I could just confirm what is it that you're looking for. Mental health or . . .

Ms. Chartier: — Mental health . . . [inaudible interjection] . . . No, mental health. You've provided me with opioid and stimulant use, but I would like to know how many patients leave our emergency rooms with mental health conditions without being seen.

On that topic again, just with respect to Samwel, would it be the opinion of the minister, do you support . . . I know that you've got two reviews going on. You've got the investigation by the SHA, and the coroner will do his work. But in light of the fact that you have a young man who was at an SHA facility twice in a day and didn't receive care and died by suicide a short time later, do you support the idea of doing an in-depth review?

Hon. Mr. Kaeding: — The SHA is currently doing their review. Certainly support that, and that's something that they do on a regular basis. And the coroner, if the coroner decides that they want to take this further, we're certainly not going to impede the work of the coroner as an independent office.

Ms. Chartier: — Is the SHA review a critical incident review that is mandated by legislation to happen? Is that correct?

Hon. Mr. Kaeding: — Yes, that's correct.

Ms. Chartier: — So that would have to happen regardless. So I guess my question to you . . . I guess it doesn't actually even matter what happens with the SHA review. I'm asking if you support the coroner in terms of improvement to the system, the job of the coroner. You have the capacity or the Minister of Justice has the capacity in legislation to ask for an inquest, and I'm wondering if you support that.

Hon. Mr. Kaeding: — So I think the question would probably be best left to the Minister of Justice just to determine what their response would be to that.

Ms. Chartier: — Although you're the Minister Responsible for Health. So you do talk in cabinet I'm sure and in the hallways and . . . Why do you believe it would be best left up to the Minister of Justice? And why is it not something that the Health minister cannot fail . . . How can you not fail to see that there's a challenge here that maybe we should be looking in a little bit deeper?

Hon. Mr. Kaeding: — So ultimately we're going to support, you know, whatever decision that the coroner decides. But I believe that it's best asked to the Minister of Justice on the coroner's decision.

Ms. Chartier: — Fair enough. I would respectfully disagree but that's okay. At this point I've got lots to cover here.

With respect to suicide, so you've recently announced a suicide prevention plan. So as recently as December we had sat down and had a conversation, and that wasn't the direction you were going in. And we had a conversation. My colleague, Doyle Vermette from Cumberland, has had a bill now twice before the legislature calling for a suicide prevention strategy. He's spoken with far too many families who've lost loved ones and attends far too many funerals, particularly and especially for young people.

But there's been Doyle and . . . I can say that in here, can't I? . . . [inaudible interjection] . . . Sorry, committee. Sorry, the member from Cumberland. And with the help of so many families who've been impacted by suicide have tried to really put a strong voice forward for the need for a suicide prevention strategy. So I'm wondering . . . So in the 2019 *Leader-Post*, there's no commitment made by your government to create a suicide prevention strategy. And so just four months later, two of those months occupied by a pandemic, what changed your mind around the suicide prevention strategy?

Hon. Mr. Kaeding: — So I believe the position that was taken was that we never precluded that we would not have a strategy or a plan. What Minister Reiter has been on record saying through the fall in particular is that he initiated and wanted to have a jurisdictional scan as we looked at best practices, ultimately across North America, as to what was working and what wasn't working, and then get a better understanding as to what and how that would be utilized going into the future. So I would like Brad to just maybe elaborate as to how all of that came to be and where we're at now.

Mr. Havervold: — Thank you. So when we did the jurisdictional scan, we found that a number of items that other provinces are doing or have in their plans are consistent with many of the things that we had already been working on. And there were a few items that we did learn from other jurisdictions. I'd say I was pleased to see that, you know, the many investments that have been made over the recent past, maybe while not directly targeted to suicide but investments towards mental health and addictions with children and youth in particular, are really intended to influence that suicide ideation and the challenges with suicide.

[15:45]

But when we looked at the Pillars for Life, the Mental Health Commission of Canada, with which I'm sure you're familiar, is really our guidepost. And based on some information that they had learned internationally around best practice, so we based our pillars around the five pillars of the Mental Health Commission of Canada. And those would be, as you've seen in our plan which I'm assuming is online: specialized supports; training; awareness; means restrictions and means safety; and lastly research, surveillance, and evaluation. So we've encompassed many actions — so year one and future actions of the suicide prevention plan — under each of those pillars.

I think as the minister mentioned in his opening remarks, there were around $1.2 million available this year directly for this suicide prevention plan. And one of the key things that we're going to be working in collaboration with the SHA on is addressing the report of the Provincial Auditor to the suicide prevention protocols in the Northwest. And so part of the dollars that we're intending is to support the SHA to in fact do that work but also to ensure that the suicide prevention protocols are more widely implemented across the province, focusing initially on the Northwest, as part of the response to the Provincial Auditor, but not stopping there.

Ms. Chartier: — Just a clarification. So there's 1.1 million this fiscal year?

Mr. Havervold: — 1.2.

Ms. Chartier: — Sorry, 1.2 million this fiscal year. So the suicide prevention protocol has been in place since the former Health minister. I think like — I could be wrong — but 2011 or maybe even earlier than that. Am I correct? . . . [inaudible interjection] . . . Sorry, could I just make sure I've got the year right? The suicide prevention protocol has been around since when?

Mr. Havervold: — Sorry, I don't know the number. I could look on my papers but I don't have it.

A Member: — It's somewhere around there.

Ms. Chartier: — Around 2012.

Mr. Hendricks: — 2012, 2013 I think, but we can verify that.

Ms. Chartier: — Okay, so the suicide prevention protocol that's been around since 2012, that is supposed to be rolled out to . . . I think one of the concerns or challenges I've heard from folks is we have this protocol but it's not . . . In the time of having it, people who need to know what this protocol is don't have the training. So I'm glad that it's being rolled out but I would . . . and I'm glad it's part of a suicide prevention strategy, but our suicide numbers have been growing. There's more than 2,000 people who have lost their lives in the last decade to suicide.

So I'm looking at the pillar one, the specialized supports, and you talked about rolling out it in the Northwest. So when and how . . . Who will be all trained in the suicide protocol going forward? Who is trained now in this suicide protocol? I know you've talked about mental health practitioners in this document, but is that not something that everybody in emergency departments should have?

Mr. Havervold: — Well I can't recall the very specific occupations that would be trained, but I think . . . [inaudible] . . . reflect as you know, emergency department staff where there would be patients presenting with suicide ideation. There would be community-based mental health and addictions staff. There would be in-patient mental health staff that would be trained. There would be others who would be within the health system that might have an opportunity to interact with an individual that could be at risk of suicide. So I think the individuals that would implement a protocol or use a protocol would be anybody who would be regularly in contact with someone that could present with a suicide ideation.

Ms. Chartier: — And that's identified not in this year's action but in terms of future actions, just to be clear. So a protocol that we've had for probably eight years or so . . . Forgive me for not thinking that that's good enough. I was quite pleased that Friday when I saw the announcement for the suicide prevention strategy.

And then I opened it up. And my criticism is not dissimilar from that of Jack Hicks, who specializes in this. I was quite disappointed. It's a 2,500-word document; a thousand of those were the letter of transmittal, introduction, and the bibliography, and with the five pillars that you mentioned were copied from Roots of Hope.

So I'm curious how many resources were committed to creating this strategy in those four months. So from the time that we had the conversation in December, going forward, what resources went into creating the strategy and with whom did you consult?

Mr. Havervold: — So the resources that the ministry put behind developing the plan: the ministry dedicated two of its staff to work full time on the research and the project, do the jurisdictional scan, do the research through the Mental Health Commission of Canada, as well look at the FSIN's [Federation of Sovereign Indigenous Nations] suicide prevention strategy and how the information there could inform what we would be looking at.

I would say part of our consultation, we did talk with a number of psychiatrists and other mental health professionals in the province, including senior leaders with mental health responsibility within the Health Authority, to inform the plan, to understand, you know, have we missed anything, etc.

I think what's important now though is now that we have the plan, the next step really is where the heavy lifting begins, where we'll do more community consultation or more consultation with external partners including FSIN, the Métis Nation of Saskatchewan, to talk about implementation and what are the important factors of implementation. So we're just scoping out a plan right now to talk about this plan with many external partners and how we can work together to both support them in the work that they're doing but also how can our resources align to advance the plan.

Ms. Chartier: — You said you dedicated two full-time staff for what period of time?

Mr. Havervold: — I'd say at least six months. I'd have to recall specifically, but the jurisdictional scan was through the fall into the spring, so it could even be six to eight months.

Ms. Chartier: — So the jurisdictional scan that we saw in . . . Sorry. You had two staff working six to eight months on this and nothing else. And this is what was produced?

Mr. Havervold: — Well no, they would have had other . . . This would have been a priority of their projects, but it was not . . . I wouldn't say that they were seconded off and sequestered to work on this alone. They would have had other projects, but this would have been their priority work.

Ms. Chartier: — Just for clarification then because initially you had said you dedicated two staff full time to do this work. So just a clarification: you had two staff who this was a priority for them over a period of time but they had other work on their plate as well.

Mr. Havervold: — They would have had other small projects that they were following as well.

Ms. Chartier: — Okay. So I'm curious why the FSIN and the work that they've done wasn't mentioned in the suicide prevention strategy. And did you actually consult with the FSIN?

[16:00]

Mr. Hendricks: — Okay. So last fall when we met with you and Mr. Vermette and talked about this, you know, one of the undertakings was that we would review best practices, suicide strategies across Canada, and we did that. And what we discovered was that a lot of other provinces actually didn't have something that was very recent or very new. And a lot of other ones didn't have specific suicide strategies, but had strategies embedded within a broader mental health plan.

And I think we had kind of, you know, shared with you at the time that within our mental health and addictions action plan there were also strategies for suicide prevention embedded within that. But having said that, we recognize that, you know, in looking across the country and based upon our jurisdictional review, there were some areas that provinces were undertaking some initiatives that we thought would be useful and beneficial in Saskatchewan.

And so inasmuch as we were able to interact with those other provinces, see how that was working, get some insight into that, we embedded those in the pillars of life. And as Brad said, it's based on the Canadian Mental Health Association pillars and that sort of thing, and that's kind of our guidepost as we go forward. But you know, I think that, you know, our staff were, you know, as I said, they were very focused on looking at improvements in the plan.

One of the things that I really want to get across though is we don't view this as kind of the penultimate document. It's an evergreen document in the sense that it's a starting point. We need to continue the conversation on suicide prevention and work with our partners, with First Nations, with Métis in this province and people across the province to make sure that we are undertaking improvements and addressing the concerns of that community.

So I don't view this . . . You can be critical, I guess, about the number of words in the document, but it's a starting place. And you know, I think it's a good starting place to begin these conversations and to move forward with additional programming. You know, this is a tragedy that in many cases is avoidable, and as a health system and as a deputy minister — and I know my ministers are very concerned about it — it's something that we want to do as much as we can to address. And so you know, I guess as we go forward we continue to work on the document, work with communities to make sure that we're taking additional actions.

Ms. Chartier: — Just to be clear, it's not the number of words that I'm quibbling with; it's the content of the document. And just reflecting back on that meeting that we had in December, if I recall correctly on that jurisdictional scan the FSIN's report wasn't included nor was Quebec's suicide prevention strategy which I pointed that out, or my colleague and I pointed that out in that meeting that those were two pretty important documents that should be considered in a suicide prevention strategy in our particular province.

But again my question was around . . . I know you said this is an evergreen document, which is good. It's important to always keep thinking about how we can do things differently and better. But usually when you're coming up with something like this, the community who is incredibly impacted by it . . . I'm wondering who was consulted in coming up with this document and why the FSIN wasn't included as part of it.

Mr. Hendricks: — So to answer your question, we did pay very close attention to the FSIN document. As you know, the author of the FSIN document was the same one that was the author of the Nunavut strategy, which we also looked at. And it referenced the Quebec suicide strategy, as well as the White Apache in Arizona. And we also looked at those in developing our document. And so, you know, specific consultations weren't held with the FSIN, but we did look very closely at their document and yes, it is embedded in ours as well.

Ms. Chartier: — Well and just for clarification here, the news release that was issued with this didn't say this was a starting point. It was described as a comprehensive document. So I'm glad that things are always open to, as I said, evolving and improving. But just to be clear, this was described as a comprehensive suicide strategy.

So again I just need to more move on here, but my question around who was consulted then. I've got, like the number of . . . Can you give me a number? So I've heard some mental health practitioners, some psychiatrists. Can you tell me who and how many people were consulted on this document?

Mr. Havervold: — Thank you. Brad Havervold, again, with the ministry. In terms of some individuals that we spoke to in advance of the plan, as we were developing the plan, we did touch base and connect with a number of psychiatrists in Saskatchewan, so the area department leads of the departments of psychiatry, particularly in Regina and Saskatoon as well as the provincial department head of psychiatry, who happens to also be a child and youth psychiatrist. We had a good consultation session and conversation with them in advance of the release.

We did talk with a number of providers within the health authority, particularly leaders that are within the mental health and addictions field, just to make sure that we hadn't really missed anything from a provincial perspective. Certainly, as the team was doing their jurisdictional scan, they would have had conversations with individuals in other provinces, and in particular the Mental Health Commission of Canada with whom our staff have a fairly good close working relationship.

[16:15]

So that would've been sort of the specific individuals. I can't remember the exact numbers, but there would have been between four and five psychiatrists, I believe, and an equal number of staff in the mental health field. And then across the province, you know, we did both a written jurisdictional scan as well as followed up with phone calls for some that we had questions or clarifications.

Ms. Chartier: — Thank you. I think it's important to note, Mr. Hendricks, that you had said that you had referenced for this document the work by Jack Hicks who had worked with the FSIN on their strategy and the Nunavut plan. And he had scathing words for this particular plan in the *Leader-Post*, which had said this does not make for a successful plan in actually reducing suicides.

I'm sorry. My time here is really . . . I am going to switch gears here. I know we could talk about this. This is a pressing issue and we could talk for a long time about it, but . . .

Hon. Mr. Kaeding: — If I could just interrupt you.

Ms. Chartier: — Oh yes, you bet.

Hon. Mr. Kaeding: — So if I could just introduce Scott Livingstone. The CEO [chief executive officer] of SHA has joined us here, has been with us for probably 45 minutes now.

Ms. Chartier: — Just moving on to the Sask Hospital North Battleford, and I just need some clarification around numbers there. So there's a total of 284 beds. I'm looking at some written questions that I had asked, and so I'm wondering if all units in the hospital are open and up and running. I've talked to some health care providers who have said that you had a heck of a time recruiting psychiatric nurses so at least one unit isn't open. So I'm wondering where Sask Hospital North Battleford is with respect to being at full operational capacity of the 284 total beds.

Hon. Mr. Kaeding: — Okay, on the non-secure side, out of 188 beds, all but 24 are currently open.

Ms. Chartier: — How about on the secure side? I guess, sorry . . . So 188 beds that have been open now for a year and a half, so how come 24 beds aren't open?

Hon. Mr. Kaeding: — Generally a result of just recruitment of staff.

Ms. Chartier: — And on the secure side, I was noticing in the returns . . . So I'm not sure if I'm reading this correctly. So at November 2019 when I . . . And I just got these questions back. They were ordered and I just got them back a few weeks ago. It has total count at end of month as of November 14th, 2019 and it says 15. So on total count, does that mean . . . So I guess my question is, of the 96 offender spaces, where are we at?

Hon. Mr. Kaeding: — So on the secure Corrections side there's 96 beds there, and 48 are currently open.

Ms. Chartier: — So sorry, just some clarity of language here because you had said . . . So I just want to make sure I'm hearing what you're saying. You said on the . . . I'm going to go back to the 188. So you said all but 24 are open. So that means 164 are full with patients. This is like a bad comedy here. Who's on first, it sounds a little bit like. So I'm just clarifying.

Hon. Mr. Kaeding: — So there's 164 beds that are open but they are not all filled.

Ms. Chartier: — Okay, so 164 beds are open to admission but they're not filled. So that gives me some clarity there. So the 24 that aren't open, it's because the unit isn't open. So how many patients are . . . Of those 164 open and operational beds, how many patients are there on the rehab side? So the rehab beds. So

of the 164 . . . Sorry. Okay. I was wondering why you were looking at me strangely. So we have a total of 188 psychiatric rehab beds and 184 are open. So . . . [inaudible interjection] . . . Yes the occupancy. Thank you.

[16:30]

Mr. Hendricks: — So as of February 29th, 2020 the occupancy was 66 per cent or 124 beds.

Ms. Chartier: — On the psychiatric rehab side. Okay. And then on the correctional side, you said that of the 96 offender beds, 48 are open and functioning. So how many are occupied? Oh please don't walk away. I hope you conferred with each other about these questions. So how many of the 48 offender beds that are open are occupied?

Mr. Hendricks: — You'll have to direct that to Corrections. We don't have that number with us.

Ms. Chartier: — You don't have any? Do you . . .

Mr. Hendricks: — We don't have it with us, but like, that's the Corrections side of the facility.

Ms. Chartier: — Yes.

Mr. Hendricks: — Yes.

Ms. Chartier: — So on the other side, on the Health side of the facility then. So the whole point of adding more beds was to be able to create more opportunity for people who were having more challenges in acute psychiatric centres, the opportunity to actually get into SHNB [Saskatchewan Hospital North Battleford]. So when you're only operating at 164 beds open, when and how are you going to change this to make sure that people are getting the full benefit of a brand-new facility that's been open for a year and a half?

Mr. Hendricks: — So Ms. Chartier, you're absolutely right. Like one of the reasons obviously for constructing the new facility at SHNB was to increase the bed numbers and so we went from 156 to 188, so 32 additional beds, as you know. And I've talked about it at committee before.

Another part of that, an important component of that was community and residential supports so that people that were in SHNB were able to discharge into the community when they were ready. And I think previously one of the challenges was that we needed those additional supports in the community to be able to do that so that people could actually be admitted to and be discharged from SHNB rather than staying there for a long time. And some people do have to stay there a long time.

But I think when you look at the numbers, we had 156 beds before, currently we have 164 that are open, and we are moving to 188. This wasn't something that was ever going to happen overnight. As you increase that in that community you need to recruit staff to the area to work in the facility, and at the same time that we're increasing our mental health workers on that side of the facility, we're providing mental health supports to the Corrections side of the facility, too. So we're recruiting for a much larger program.

And so I think that, you know, we're going to get there, and it will be an improvement overall. But just I think also be mindful that we have invested in community residential supports at the same time. So theoretically we should be able to move people in and out of SHNB so we don't have any kind of, I guess, blockages in our acute psychiatric beds.

Ms. Chartier: — I will have some questions on that area for sure, too. But I'm just wondering here, what is your estimated target to get to 188 beds fully operational?

Mr. Hendricks: — Obviously we'd have them open today if we could. The funding's in place and so right now the challenge is recruitment. And as we're able to recruit to those positions, we'll be able to open those beds. And you have to do so . . . You can't open one at a time. You have to do it in a block. That's the only way that makes sense. So I think in that facility, it's in blocks of 12.

Ms. Chartier: — So that's two units or two blocks that aren't open. So the money's there but you don't have a timeline for when you want those?

Mr. Hendricks: — As soon as we can, yes.

Ms. Chartier: — So with respect to the 164 beds that are operational . . . And so you gave me a number; I think you said 122 as of February. I'm actually chatting with people who are looking for casework help sometimes and just recently spoke with someone who had a referral to SHNB and was put on a waiting list. So how is it possible that you've got beds that are open — 164 — and you've got vacancies, and people who get a referral don't immediately get an opportunity to go there?

Mr. Hendricks: — Unfortunately I think that we will have to get back to you with the answer. We have confirmed that there's a very small number of people waiting to get into SHNB right now. To be clear though that in March, we started to slow down admissions to SHNB because of COVID. And then now as of the 15th, yesterday, we're resuming admissions to the facility.

But the reason that I'm just hesitating a little bit and I would like to get you some additional information is because there's a forensics unit built into this as well in that 188 beds. And just between the two . . . There's kind of the normal therapeutic and then the forensics unit, and we will table a document that shows the occupancy on each.

Ms. Chartier: — Okay, thank you. Moving on here. Estevan, the crystal meth centre, $1.4 million for 20 beds. How was Estevan decided on as the place for the crystal meth treatment centre?

Hon. Mr. Kaeding: — So a number of factors went into the Estevan location. One was certainly the need in the area. Two was the very appropriate, convenient space that was available. The proponent in the area put a very strong case together as to being able to provide that service in the community. And we had the need provincially to ensure that there was those kind of beds available.

Ms. Chartier: — I don't dispute the need provincially at all, for sure, as we've had . . . I think went from 3 per cent to over 30 per cent in a five-year period of those reporting at facilities with

crystal meth use. But I guess, what are your stats around the province telling you about where crystal meth use is highest?

[16:45]

Mr. Hendricks: — So we're trying to retrieve the numbers. I'm convinced that I've seen them somewhere, and so we'll endeavour to get that tonight for you. But I just wanted to address where I think you might be taking this question in the sense that, if my recollection is correct that, you know, obviously the highest concentration of crystal meth users in the province is not in Estevan. It would be in one of our larger centres, which might raise the question, why didn't we locate the crystal meth beds there?

And I think, you know, there are a variety of factors, one of which is when we consult with addictions experts, they say in some cases it's actually very good for a person to be removed from the community into a different setting. Not always, but you know, I think the opportunity to go to a different community to go through that treatment.

One of the things we were looking for was we were looking for, you know, a program that could actually specialize in methamphetamine treatment and provide a longer-than-28-day program, which we've heard time and time again is very important in terms of recovery.

And so you know, in our discussions with St. Joseph's in Estevan, they had been doing some work on this and we feel like they were a good place. I'm not saying, and I don't think anybody's saying, that this will be the only time we consider this and the only place that we consider this. But it certainly was an opportunity that presented itself to provide some specialized treatment capacity in the province.

Ms. Chartier: — So who is the proponent then? So just for clarity's sake, I'm not quite sure I understand who the proponent . . . Because you'd said, Minister Kaeding, that the need in the area, it was an appropriate and convenient proponent and area, and we need this provincially. So who is the proponent?

Hon. Mr. Kaeding: — St. Joseph's.

Ms. Chartier: — St. Joseph's. So what do they bring to the . . . Sorry. I'm not familiar with St. Joseph's and perhaps I should be. But St. Joseph's is . . .

Mr. Hendricks: — Yes, so St. Joseph's is an affiliate of Emmanuel Care in Estevan. They operate the hospital down there and I believe a long-term care home as well. And so they had some space in their facility and the CEO of that facility had been doing considerable research and consultation with experts in the area of addictions. They were very interested in opening addictions beds and expanding capacity in that community and came to us with a proposal, and we worked together. And so you know, it's somebody that we have an existing relationship with. As I said, they work closely as an affiliate with the SHA and had a strong interest in developing this program. So it kind of came together.

Ms. Chartier: — So can you tell me what the program will look like?

Mr. Havervold: — The program, as the minister mentioned, is a 20-bed, in-patient residential treatment centre, 15 focused on crystal meth and five focused on other substances. The facility right now . . . Individuals that are from the Estevan area often detox in the hospital, so there will be detox beds continuing within the hospital that individuals will be able to transition over into the in-patient treatment unit. As well there will be people who've detoxed of course in other communities that will be admitted for in-patient treatment. So individuals will be able to detox on site.

The other investment that's made here is — I think the minister mentioned — 150,000 for four pre-treatment and six post-treatment beds. So individuals that may be detoxing elsewhere that just need a bit of time to adjust before they go into treatment could access those beds. And then six post- beds that will also be located in Estevan to facilitate that transition back to community.

I think another important facet of this program — like many other services that are operated now by distance — is individuals, once they leave the facility, if they spend some time in a post- bed in Estevan, as they transition back to their home community they have the ability to continue to link in with the counsellors and the professionals at Estevan through Telehealth or through virtual technology. So there will continue to be that relationship when those individuals are back in their home communities as well as a warm hand-off to the local addictions counsellor for continued follow-up wherever they may be residing in the province.

Ms. Chartier: — Okay, I have several questions here. What is the expected length of treatment of the program? What is the model of treatment that's going to be used? Are opioid agonist therapies going to be allowed or any other . . . not naloxone, the alcohol . . . I can't recall the name . . . [inaudible interjection] . . . no, no, no, it's often used in alcohol treatment.

So I'm wondering, will there . . . I want to know the length of the treatment, who will be providing the treatment. As St. Joe's obviously is a Catholic affiliate, is there a Catholic component or a religious component to the treatment? Again and the question about supported medical therapies, will they be allowed and utilized?

Mr. Havervold: — So the information that we've had in our discussions with the officials at St. Joe's is that the length of treatment, like in most treatment centres or in all treatment centres, is commensurate with the length of time required clinically for the patient. So we have heard over time that the 28-day treatment doesn't always work for everyone. The unique piece about this Estevan treatment-bed project is that the length of stay doesn't need to be cut off at 28 days. It could go on as long as the individual is required, you know, to be able to progress on their treatment till they're safe to be managed in the community. So that, I would say there is no prescribed length of stay for individual treatments. It's individualized based on the patient need.

I'd have to confirm with the officials, with St. Joe's, but I've not had an indication from them that they would not be accepting individuals on opioid substitution therapy or individuals on the medication to manage the withdrawal symptoms related to alcohol. I've not heard that that is not an availability, and in fact

I would suggest that that is probably very paramount in their treatment plan.

Ms. Chartier: — And in fitting with the guidelines that the . . . or not guidelines. Actually it's required by SHA, is it not, that addictions treatment facilities funded by SHA need to allow those treatments? It's naltrexone. That was the drug that I couldn't remember the name of. So I understand there's policy in place that ensures that any facilities that operate with SHA funding will in fact support those therapies. So I just want to confirm that that will be the case.

Mr. Havervold: — As I said we're not aware that Estevan is not going to accept individuals on that treatment. In terms of a policy, I would need to confirm that looking back at our policy documents. But it certainly is our expectation that publicly funded drug treatment centres do accept clients and patients who are on opioid substitution therapy.

Ms. Chartier: — And the kind of programming? So obviously 28 days hasn't been based on evidence. It was a convenient way of funding and we've developed the Minnesota Model of treatment which we provide, but I'm wondering if this particular proponent has chosen a method or model of treatment that they're planning. And like, for example, at Calder, it's psycho-educational, I believe. You go in and you have one week of this, two weeks, three weeks, four weeks. And if you stay five weeks, you don't get new programming. You go back to week one. So I'm wondering how well designed or what this will include for the unique needs of those 15 patients with crystal meth issues.

Mr. Havervold: — Sorry, I don't have the specific layout of what the treatment plans would look like week by week. But what I would say is that the staff in Estevan have done a lot of considerable research as to what the best practice model is that they believe. And they are working very closely with experts in the field to develop a treatment model that is leading edge, particularly as it relates to crystal meth. So I can't say, you know, what constitutes week one, week two, etc., but we can certainly get that information.

Ms. Chartier: — I'm not looking for week one, week two. I'm wondering what . . . So you're talking about a best practice model. So what did they pitch to the ministry in terms of being able to address the challenges around crystal meth, aside from having a facility that's already existing?

[17:00]

Mr. Havervold: — So again the treatment model that I think . . . You know, like I said I wasn't able to describe the specifics of what that treatment model is, but the staff in Estevan and at St. Joe's have been working very closely with an addictions agency in British Columbia that has a considerable amount of expertise in British Columbia of treating addictions. The organization there is bringing a lot of their clinical expertise into the Estevan project, so they will be bringing the expertise around policies and protocols and medication administration, the clinical protocols.

The program director within Estevan, I believe, is very closely linked if not employed by Cedars and will be physically located in Estevan, so the expertise of that organization is what is being brought in. I know that early on in the conversations the clinical leaders at Cedars had conversations within the province with addictions treatment physicians to describe the model that they were proposing in Estevan and received positive feedback.

The Chair: — It now being 5 o'clock or a little bit past, we'll recess until 6 o'clock. Thank you.

[The committee recessed from 17:01 until 18:00.]

The Chair: — Welcome back. Now we'll resume consideration of the estimates and supplementary estimates for the Ministry of Health. Just one note, we have MLA Laura Ross substituting for MLA Nadine Wilson tonight. Ms. Chartier, you're up.

Ms. Chartier: — Oh yes, thank you. Sorry about that. It was a quick break. So we were just talking about the crystal meth treatment facility in Estevan. Was this project tendered?

Hon. Mr. Reiter: — No, it wasn't. As was discussed earlier, St. Joseph's is an affiliate, runs the hospital there, runs the long-term care facility there. They approached the ministry and it went from there.

Ms. Chartier: — In terms of the relationship with Cedars, can you tell me a little bit about that? So Emmanuel Care, which runs St. Joe's, the hospital and the long-term care, like the broader body, is the proponent. But Mr. Havervold had mentioned Cedars. So I'm wondering how Cedars is connected and what that'll look like.

Mr. Havervold: — Okay, thanks. Thank you. Thank you for that. The role that Cedars will play, Cedars will be bringing the clinical expertise to the table. They will be bringing, as I mentioned, their expertise and addictions treatment from their centres, which is housed out of British Columbia. They will be developing the clinical protocols. I believe the clinical manager that will be running the program in Estevan will be a Cedars employee, but physically residing in Estevan, and they will have very close linkages back to the experts in Cedars. So they're really bringing the clinical addictions expertise and programming to the table.

Ms. Chartier: — Thank you for that. And I know that Cedars has a good reputation in BC [British Columbia], the work that they do. What is the relationship between Emmanuel Care group and the Cedars, like how will that . . . So it's 1.2 million in this budget for these beds. So is it Emmanuel Care that will be the contractor?

Mr. Havervold: — You know, our funding for this will flow to the Saskatchewan Health Authority, and from there the relationship will . . . The Saskatchewan Health Authority has a relationship already with the organization that operates St. Joseph's. I don't know whether that is a relationship with Emmanuel or with St. Joseph's directly. I don't know that. But I know St. Joe's is an affiliate with the SHA. So I can't say whether that contract will be with Emmanuel or with St. Joe's itself. That I don't know.

Ms. Chartier: — I'm not so concerned about that. Like St. Joseph's is part of Emmanuel, but I'm using that as the broader overarching term. But I'm wondering, so if Cedars employees are

going to be here and working here, I'm wondering, the relationship between Emmanuel Care and Cedars. And is the SHA contracting with Emmanuel Care or with Cedars?

Mr. Livingstone: — Scott Livingstone, the CEO of the Saskatchewan Health Authority. So with respect to the contracting arrangements for us at the SHA, for us it's going to be an extension of an existing affiliate agreement for an extension of services that will encompass the new programming at St. Joe's.

Ms. Chartier: — And so is your expectation then . . . Obviously we've just heard that staff from the Cedars are being hired and brought to Saskatchewan. So do you know if they are planning on . . . Will they have a contract with Cedars or how will they be . . . Will they simply be employing people on a one-off or how does that shape up?

Mr. Livingstone: — So similar to how we contract all services, whether they're long-term or acute, for all of our affiliates the funding flows from the ministry to the SHA. And then we would be putting an agreements in place with those affiliates and holding them to whatever standards or caveats would be in those agreements. How they provide the services as independent organizations is up to them with respect to as long as it meets the clinical services that have been decided upfront. And we would also put monitoring in place with respect to ensuring that the services were being delivered as expected.

Ms. Chartier: — The Cedars is a for-profit addictions centre in BC. Is that correct?

Mr. Livingstone: — I don't know. Sorry. The SHA did not contract Cedars and I believe part of the work that . . . and Brad might be able to verify it but part of the work with Cedars is to bring in that expertise and learning to St. Joe's as the program develops and then leave that knowledge in the community as the program matures. I'm not sure what the term is of the agreement or all the nuances behind it, but that's my understanding.

Ms. Chartier: — Just a question around . . . And I'm not sure if this is the case at the Cedars or not, because most substance use facilities aren't regulated provincially. There's only Alberta and Quebec where I believe that that's the case. I know some facilities offer publicly funded care. There's publicly funded beds and there are private beds in the same facility, so I'm just wondering if that is going to be the case. So I'm just trying to get a good picture of what was pitched to the ministry about this and if there will be any private beds offered at this facility.

Hon. Mr. Reiter: — I was just checking with officials to make sure, but there's been no discussion about private beds at Estevan, so no.

Ms. Chartier: — Okay. Can you describe a little bit more the model? We briefly talked about that, and I don't think I gave a good example. I was just mentioning around Calder and how they operate. But it's going to be patient-centred and focused in terms of their treatment plan, but I know . . . So you could be in the Cedars . . . are we expecting people to stay as long as three months? Or I'm wondering what was pitched to you by Emmanuel Care.

Mr. Havervold: — So again, as was mentioned earlier, the treatment is not prescribed at a 28-day time frame. It would be flexible to respond to the needs of the individual, so it could extend weeks beyond the 28 days. The philosophy of Cedars and the principles of the treatment program that they . . . [inaudible] . . . is really evidence informed. And "recovery oriented" is some of the language that they use, so it follows that recovery model.

It's also important that, you know, the time spent in the in-patient treatment bed, you know, carries on and treatment for that individual carries on as they transition back to a community bed and/or back to their individual homes. So the continuity of care continues between in-patient treatment into the community, which could be the community of Estevan into one of the post- beds, or it could be into another post- bed in another location.

[18:15]

And then that's again that warm hand-off and that warm transfer to a local addictions worker to continue the treatment in the community. And recognizing that sometimes people need to go back into in-patient treatment just like you would in any other kind of clinical care, sometimes you can manage in the community. You need to be in and out of in-patient depending on the need.

Ms. Chartier: — Thank you for that. So just a few logistical questions here. Mr. Livingstone had talked about it. Is it just being added on to the existing contract with Emmanuel Care or is it a separate, new contract with Emmanuel Care?

Mr. Livingstone: — So the contract has not yet been formed, but it could be either. It could either be an extension of services specific to the new programming in an existing agreement because we do have a master agreement with St. Joe's, because it's already been mentioned they do both acute and long-term care, and we work with them on many fronts inside some community programming as well. So it could be either, but it will be an agreement that's formed with the SHA under the same principles that we work with all affiliates. And we will have, like we do with the other programming contracts, have targeted goals for those types of investments and expectations of program plans over not just a one-year period of time, but looking at how the program will evolve.

Ms. Chartier: — Thank you. I've not been to St. Joe's in Estevan. So you've got the long-term care beds in the hospital. Are these 20 beds adjacent to all of this?

Mr. Livingstone: — The facility, if you looked at it from the air, would have sort of a central core and then it's got the wings of the facility. Long-term care forms one of those wings. They don't name them that way. They actually name the wings after local RMs [rural municipality] around the facilities. And then the new crystal meth program would take up one of those components.

Ms. Chartier: — Is there any capital? So there's 20 . . . Not knowing the facility, what has been in this former, or in this to-be crystal meth treatment facility? What used to be there?

Mr. Livingstone: — Acute care beds. There was a rehab . . .

[inaudible interjection] . . . Pardon me?

So for the last number of years, at least as long as I've been around at the SHA, it's being used by our primary health care team. But they'll be moving out to one of our other facilities in the community, and that will be repurposed for the unit. The renovations that will be required are mostly aesthetic — you know, refreshing walls and paint and that kind of stuff. I don't believe there's any other major upgrades because the facility already meets safety codes and that sort of thing around the entire facility. It's actually a pretty nice facility if you ever get the opportunity to see it.

Ms. Chartier: — Just clarifying then, there's no money built in to any of this for refurbishment or renovation of this space.

Mr. Livingstone: — There will be some small costs within, I believe, the 1.4 million to do that, but it's a very small component of the total cost. The majority of the costs are operating around hiring personnel.

Ms. Chartier: — Okay. So you said small, but just wanting to nail that down. Of the 1.4 million, what amount would be . . .

Mr. Livingstone: — We can confirm the exact figure, but I know it's small. It's under $100,000. And there was some money around relocation of primary care that might actually manage to deal with most of those. But we will get back with a confirmed number.

Ms. Chartier: — Okay. Of that 1.4 million, so in terms of what was pitched to you, so it's 20 beds. Obviously a budget has been made for that, so how many people will that serve in a year?

Mr. Livingstone: — We don't have a specific number for the first year of the programming, mostly because, as we've already talked about and Brad has talked about, as the new program develops it will be individualized based on evidence and supporting those individuals. If somebody stays for 60 days and somebody stays for 90 days, how many times those beds turned over won't be consistent because it's not a one-size-fits-all program.

But we will get some clarity. Brad will. And we'll follow up if there is some more specific numbers. But it's funded based on the treatment programming through Cedars and the available beds. But we just don't have a number of clients on an annual basis at this point in time. But that certainly would be a component of the discussions with the contractual arrangements we would be having with St. Joe's.

Ms. Chartier: — Just googling Cedars. Cedars charges about 20,000 per bed and it's a for-profit facility. So there's not been any . . . How did you pick this number of 1.4 million to support these 20 beds?

Mr. Livingstone: — So within the original proposal and just to clarify, the 1.4 million for this year is because it's not a full year. It would annualize out to be 1.8 in a full year of operations. It wasn't based on a number of clients, so that number wasn't determined based on 20,000 per client, but rather what type of resources would be required to open 20 treatment beds under this programming model. So that would include the specialized staff, which would be the majority of the costs, you know. Salaries would make up the most significant component, but it would also include other type of services that would be required to provide care for these individuals — the infrastructure which we've talked about, though a small amount of money, food services and other housekeeping and basic infrastructure costs of opening up 20 new beds because it's not just the clinical staff that you pay for. It's the security staff, the housekeeping staff, maintenance staff, and that sort of thing.

Ms. Chartier: — Have they given you a sense of how many staff of all varieties will be there?

Mr. Livingstone: — I believe they have, and we just don't have the numbers here with us tonight, but we could probably provide that to you.

Ms. Chartier: — Would it be possible to get that provided in short order? Obviously you have them, and much like the other numbers, could we have that tabled shortly? What time would it be possible to table . . . This week, if you've got them?

Mr. Livingstone: — Oh yes.

Ms. Chartier: — Okay, that would be good. So by the end of this week? Is that possible?

Mr. Livingstone: — Yes.

Ms. Chartier: — Yes, okay, thank you. So in terms of funding, when are they expected to be open?

Mr. Livingstone: — So the original plan was to have the facility open in July, but because of COVID and the other concerns that would be going on province wide, but including St. Joe's and the long-term care facility, they now project to be opening in early September of this year.

Ms. Chartier: — In early September. So 1.8 million in annualized costs supporting 20 beds. Obviously it's a slightly different service than something like Pine Lodge, but I'm just curious how the 1.8 million compares to how we fund and support other addictions centres in Saskatchewan.

Mr. Livingstone: — Brad will get the numbers to give you a comparison with the Pine Lodge and what it looks like compared to this model.

Ms. Chartier: — Okay. Just again going back to it not being tendered. So we have another organization here in Saskatchewan. I know that you've met with them. I think it's Prairie Sky Recovery in Leipzig who has offered to provide some of these services, and that's been turned down and I understand that. But I'm really curious around the process, why there wasn't a decision to tender something like this.

Hon. Mr. Reiter: — You know, you heard Scott a few minutes ago talk about it. I think the phrase he used was "extension of programming." So I think it would be fair to compare it. It's an affiliate with an existing relationship with the SHA that's providing programming. This is additional programming, if you will.

[18:30]

It would be no different than, I would say, if some additional programming was added to St. Paul's Hospital. You know, it wouldn't necessarily have to be tendered or it would be an extension of . . . Their services provided in the SHA would have them provide more services.

Ms. Chartier: — Just to be clear though, Emmanuel Care doesn't have any experience in substance-use programming though, do they?

Hon. Mr. Reiter: — I don't want to bog this down for time. We're not sure if they do or not, but they don't do any that I'm aware of anyway.

Ms. Chartier: — Okay, so it's not really an extension of existing . . . It might be providing an extension to an organization that provides other care, but it's not really an extension of a contract. But in terms of the space where the 20 beds are, is there room for more beds in that area?

Hon. Mr. Reiter: — Brad is just looking at an overhead sketch of it, and from what we can tell there is some common area and stuff, but he's saying from the look of the beds it doesn't look like there would be room for more.

Ms. Chartier: — Okay. I'd like to confirm that for sure if there's any space. I just need to clarify here that, to your knowledge, is there any for-profit connection at all to this project?

Hon. Mr. Reiter: — I think what we can't lose sight of here is SHA or the ministry haven't had any contractual arrangement with Cedars. That's through either St. Joseph's or Emmanuel Care. I'm not sure which. But no, from the provincial perspective is the ministry provides the funding to SHA; SHA has the arrangement with St. Joe's, which is an existing affiliate. And it's an extension of services that they offer now.

Ms. Chartier: — Okay. Just double-checking here. Will there be any client rates charged at all, or will it all be SHA funded?

Hon. Mr. Reiter: — No, there'll be no client rates charged.

Ms. Chartier: — I'm stuck on the not tendering. I need to confirm who it was who pitched this to the Premier. Was it in fact Grant Devine who brought this proposal forward? Don't look so incredulous there, Minister Reiter.

Hon. Mr. Reiter: — I am. No, it was the officials from St. Joe's. I believe it was the CEO, Greg Hoffort. He's had numerous meetings with our officials. I've met with him a couple times on it. That's where it came from.

Ms. Chartier: — I'm just looking at an email here sent December 2nd from former Premier Devine here. Hang on here. "Carson has put together a functional and profitable business model where his operation can be duplicated here in Saskatchewan, and it is scalable." So you have no knowledge?

Hon. Mr. Reiter: — I don't know what that is. What . . .

Ms. Chartier: — That is an email referring to this very project. Carson is with Cedars.

Hon. Mr. Reiter: — To who?

Ms. Chartier: — This is to a planning group including folks like Joe Donlevy, just to name one name. So you have no . . .

Hon. Mr. Reiter: — I don't. That's news to me. I'll check.

I'll just make a comment and then I'm going to ask Max to talk more about the arrangement here. But I don't have any knowledge of the email you're talking about. If you want to provide it to me, I'll look into it and get back to you. But having said that, Max had something he'd like to add.

Mr. Hendricks: — So as I said earlier, this proposal was brought to us by the CEO of St. Joseph's, you know, and basically it was a decision of St. Joseph's to go out and work with Cedars to get the basic knowledge, I guess, to develop an innovative new program. And that was not at the direction of the ministry. It was done of their own volition, that sort of thing.

And so my understanding is that the arrangement with Cedars is supposed to be for a time period during which knowledge transfer will take place, after which, you know, St. Joe's will run the program. And so, you know, I don't think that there was . . . You know, even if they had come to us, you know, proposing this and they had the expertise in-house, that would have been something we would have considered too. So it was their decision to go to Cedars.

Ms. Chartier: — I just want to read into the record here one more part to that email. It says, "Our objective is to present a well-documented model to Premier Moe in the new year." So I don't know how, Minister, that you weren't aware of this going on. But my concern isn't providing quality crystal meth treatment. I know as well or perhaps even more than anybody that crystal meth treatment is . . . We are in dire need of really good-quality crystal meth treatment here in the province, and we've been calling for it for several years now. So it's not taking issue at all with the fact that some substance use programming that may meet the needs of Saskatchewan residents is going to take place.

But I have some concerns that an untendered project in the far reaches of southern Saskatchewan, when we have problems and no public transportation and people in other parts of the province may have trouble accessing it, and it was an untendered contract to a well-connected Sask Party . . . or people with close ties to the Sask Party. So that's where my concern comes in.

Hon. Mr. Reiter: — I'm having trouble understanding this. The discussions with the CEO, Greg Hoffort, and St. Joseph's would have went on before, I think you said, December something. I'm at a loss. If you provide the email to me, I'll try and provide an explanation. I'm at a loss as to what you're saying.

And the contract, as you put it, with insider Sask Party supporters is just simply not the case. It's with an affiliate that has a long-standing relationship both with this government and your government before that.

Ms. Chartier: — And again, it's not the affiliate. It's how the

advocacy happened and how the tendering didn't happen and how the SHA couldn't provide this service itself. So have you had other organizations, are not advocating to create and develop this kind of treatment, who are sitting with beds empty? Is that not the case? Has Prairie Sky approached you about providing . . .

Hon. Mr. Reiter: — Prairie Sky is not an affiliate. They don't have an ongoing relationship like an affiliate does. At times when there are RFPs [request for proposal] issued, they would get an opportunity to respond to those. This is a completely different situation. This is an affiliate that there is an ongoing relationship with, and you heard the CEO say it's an extension of services. And while you might not agree with that, the fact of the matter is services are expanded and changed in St. Paul's, for example, all the time. You don't put everything out to an RFP. It's an existing contractual arrangement.

[18:45]

Ms. Chartier: — So an affiliate with no experience in substance use programming. Just to be clear about that, it's an affiliate with zero experience. So you could argue do you give it . . . Oh, and you're exasperated with my questions. I think these are fair questions.

Hon. Mr. Reiter: — Again you're slandering people. You're throwing insinuations around.

Ms. Chartier: — I'm not . . .

Hon. Mr. Reiter: — Well will you table the email and I'll look into it, or not?

Ms. Chartier: — Are you going to table lots of the documents in the past that we never . . .

Hon. Mr. Reiter: — So instead of tabling it, I can give you an accurate answer. Instead of that, you're simply going to insinuate and slander.

Ms. Chartier: — I'm not going to table it right here right now from my phone.

Hon. Mr. Reiter: — Well will you table it at some point?

Ms. Chartier: — I will double-check and take a look at the email. You know nothing about those conversations that happened prior to approving this?

Hon. Mr. Reiter: — I don't know what conversations you're even talking about.

Ms. Chartier: — You have people closely affiliated with your government who got an untendered contract to provide services they've never provided before to fill a really important . . . Admittedly it's a huge gap that needs to be filled. I would be the first person to say that we need to do far better on crystal meth treatment.

Hon. Mr. Reiter: — But that's not important enough for you that you just can't resist insinuations and slandering people.

Ms. Chartier: — No, I just want to make sure that . . .

The Chair: — Ms. Chartier, I'm going to have to interject here. If you're not going to table the email, then let's move on. Because the minister can't do anything unless you're going . . . if you're going to table that, or not. I mean, it's that simple.

Ms. Chartier: — I can't table it from my phone.

The Chair: — Well then, let's move on.

Ms. Chartier: — Yes. Okay.

The Chair: — If you can't table it, then I'm not going to hear it. Let's move on.

A Member: — [Inaudible] . . . print it.

Ms. Chartier: — Not from my phone at the moment. I'm in the middle of asking questions, Ms. Ross. So my issue again was around the tendering of the contract. Has the contract been signed?

Hon. Mr. Reiter: — I think the CEO, Scott Livingstone, said earlier that it hasn't been yet.

Ms. Chartier: — Okay. Thank you for that. Just give me a moment here. So you'd also talked about, in that particular facility, pre- and post-treatment beds. So there's 15 for crystal meth, five for other substance use issues. So where are the pre- and post-treatment beds going to be?

Mr. Havervold: — The location of those pre- and post-treatment beds hasn't been decided, like physically within Estevan. I know the intent is to have them in Estevan to complement the 20 beds, but in terms of physical locations within Estevan, I don't know that that's been determined yet.

Ms. Chartier: — Those five pre-treatment beds, I know you had said that it's to help seamlessly move people who might not quite be ready for residential treatment. So you're not expecting those to be on site?

Mr. Havervold: — There's four pre- beds and six post- beds. I don't know that they would be right on site in the facility, but they would be within Estevan in a community location.

Ms. Chartier: — Okay. Thank you for that. In terms of overdoses, there was a story in the *StarPhoenix* recently about 262 overdose calls that Medavie responded to last month and they administered Narcan 48 times. I know the numbers here in Regina haven't been good either and have gone up. What in this budget is going to address the growing opioid challenges people are facing?

Mr. Hendricks: — So I'm going to start. Then Brad will give you some of the specific budgetary details. I just wanted to acknowledge that, you know, this is a matter of considerable concern to the Ministry of Health, the rise in the number of overdoses that we've seen particularly in our larger cities, but it's also a problem in rural areas. And in January I had a meeting with Chief Evan Bray, Chief Troy Cooper, and Commanding Officer Mark Fisher to discuss kind of a renewal of the opioid drug task

force that I think we've talked about before.

I think what I have, I guess, concluded is that a lot of good work has been done there, but it's been more at an operational level. And as a health system and working with our partners in the SHA and with our colleagues in social services and the police, we need to elevate this.

So at that meeting what I proposed was that we set up basically the equivalent of a steering committee chaired by myself and working directly with the chiefs of police and these others to develop very specific strategies related to opioid and crystal meth substance abuse in the province to include things like measurement and reporting so that we can have kind of accurate statistics that policing are aware of and that the health system can monitor to develop innovative and new program designs.

And so I think this is something that is capturing the interests, I think, of a couple of our mayors as well who have had discussions with their chiefs of police. And unfortunately it was shortly after this kickoff meeting that we had — and we're in a kind of process of developing terms of reference for this kind of higher-level group that will work on this — unfortunately that was kind of at the end of January and we got hit by COVID and we haven't met since. But actually I just sent out a letter to them today talking about redoing work on that immediately. So again it's a high priority, something that we realize needs some work. And maybe I'll just get Brad to go through some of the specific budget information related to these areas.

Mr. Havervold: — Thanks. As I think the minister mentioned in the opening remarks, this year we have 1.35 million available from the opioid Emergency Treatment Fund. And 250,000 of that will be geared to increasing the number of opioid-substitution therapy prescribers between the SRNA [Saskatchewan Registered Nurses' Association], the College of Pharmacy Professionals, and the College of Physicians and Surgeons. And that builds on some standard operating funding that we'd provided to the college for OST [opioid-substitution therapy] prescribers historically.

There's about 925,000 that . . . We'll be going and seeking proposals from individuals, from organizations, CBOs, and others in terms of some one-time things that can be done to address opioid and substance abuse issues particularly around opioids. So that's the lion's share of that 1.35 million. As well it will continue to fund some work within the SHA around trauma-informed practice and crystal meth supports for there. So that's 1.35 there.

We've also got in this budget about 1.7 million available to open 28 new detox beds. And, you know, specific communities are being finalized but it would, you know, be the larger centres that the minister mentioned: Regina, Saskatoon, Moose Jaw, Prince Albert, and North Battleford. So again, 28 new detox beds that, while not specific to opioids, is of course open to people with opioid addictions.

The RAAM clinic in North Battleford, you know, our third RAAM clinic of course has a focus on opioids as well as other substances, but I think a large focus of the RAAM clinics has been on opioid addiction.

Some additional funds this year to enhance harm reduction, through take-home naloxone programs and other expanding outreach services and that sort of thing related to harm reduction. And again, while not specific to opioids, it is applicable to opioids. That is some of the investments this year related to opioids in particular.

Ms. Chartier: — Yes. Just wondering about the rationale for not funding the supervised consumption site in Saskatoon? And I'm wondering if you've had a chance to tour the facility?

Hon. Mr. Reiter: — I have. I have. I toured it sometime this winter. I'm not sure exactly when it was. AIDS Saskatoon does some very good work. As a matter of fact we're funding them for a couple more caseworkers this year. I think it's $130,000. It was just simply a matter of when you're doing a budget you have to make some decisions and they're not easy decisions. And this year it was determined that we needed to focus on increasing our capacity as far as addictions beds, treatment beds, pre- and post-, counsellors, medical supports, those sorts of things. Haven't ruled it out for some point down the road, but a decision needed to be made for this year.

Ms. Chartier: — Just to state the obvious. It's hard to get into treatment if you're dead, which is a real issue facing people who are living with opioid addictions. The risk of overdose is tremendous.

Did AIDS Saskatoon ask for the $130,000 for the caseworkers?

Hon. Mr. Reiter: — I don't know if they did a formal proposal or not, but it was discussed actually when I toured the facility. And the CEO was talking about, give me some numbers. And we had a discussion about how much their casework had increased and had said that that would have been beneficial. So we did that.

Ms. Chartier: — So philosophically we could see a supervised consumption site opening at some point.

Hon. Mr. Reiter: — I'm sure funding will be revisited again in the future.

Ms. Chartier: — I represent that community or right across the street from that community and many of my constituents frequent that area and use the services of AIDS Saskatoon, STC [Saskatoon Tribal Council], Westside Community Clinic. And I know people were disappointed about that because there are many unsafe and unsupervised consumption sites around the community.

Around our high rates of HIV [human immunodeficiency virus] and testing, I'm wondering in 2019 how many HIV tests were conducted and how many have been conducted to date in 2020? I know COVID would likely have an impact on that.

Hon. Mr. Reiter: — Sorry. Your question was?

Ms. Chartier: — HIV tests in 2019 . . .

Hon. Mr. Reiter: — Right, and 2020 to date?

Ms. Chartier: — To date, yes.

Hon. Mr. Reiter: — Sure. Officials tell me that in the 2019 calendar year, 95,467 tests were completed. They don't have the ones for this year to date, but we could get those to you.

[19:00]

Ms. Chartier: — Are the positive test numbers up from the 2019 tests? What are the most recent stats?

Mr. Hendricks: — So the total number of new HIV cases was 199 in 2019, up from 168 in 2018. So an increase of 18 per cent.

Ms. Chartier: — Okay. I would argue that's another reason for a supervised consumption site and more harm reduction. But I see that I really have got 55 minutes here left and I'm going to switch gears to seniors here for a little bit.

With respect to home care in the SHA, how many staff are employed in home care at the moment?

Mr. Hendricks: — So we don't have home care FTEs [full-time equivalent]. That's something that we aren't able to actually collect just based on the way the service is provided. But we do have numbers on the homemaking services, which is the number of units, and the number of meal services, and the number of nursing services for home care, if that's of interest to you.

Ms. Chartier: — So just a clarification. There's the homemaking services.

Mr. Hendricks: — Yes.

Ms. Chartier: — And then there's the health.

Mr. Hendricks: — The nursing services.

Ms. Chartier: — The nursing services.

Mr. Hendricks: — And then the meal services.

Ms. Chartier: — And is meal services also considered under homemaking? Or there's . . .

Mr. Hendricks: — They're a different category, yes.

Ms. Chartier: — Okay. And then where does the program . . . Why have I forgotten the name of the program when you leave the hospital, or when you approach the hospital, and there's intervention at the hospital? HomeFirst.

Mr. Hendricks: — Yes.

Ms. Chartier: — HomeFirst. I am clearly approaching my 50th birthday here. Oh my goodness. So is that broken out separately as well? So there's home care, so you've got the homemaking, nursing, and meals. And then is HomeFirst a separate item?

Mr. Hendricks: — HomeFirst is a program, but it does utilize home care services, right? And then there's people that access home care every day, right? And so HomeFirst is about transitioning from an acute care to a community setting, right?

[19:15]

Ms. Chartier: — Yes. At intervention point, right when you're in the hospital, I understand . . .

Mr. Hendricks: — Right.

Ms. Chartier: — Right when you show up at the hospital instead of an admission. So I know in the past when I've asked about that, that had been broken out into separate . . . It's been a few years, but that had been broken out separately. But that's neither here nor there. Let's get these numbers for units for home care.

Mr. Hendricks: — Yes, so in terms of nursing services, '18-19 is the last numbers that we have. So from '17-18 to '18-19 there was a 1.2 per cent increase to 472,628 nursing services. There was a slight decrease, or minus 6.6 per cent decrease in meal services from 264,000 to 247,000 services. And homemaking services, there was a minus 1.8 per cent decrease to 861,700 services.

Ms. Chartier: — So you've given those to me for '17-18 and '18-19. Or that was the difference.

Mr. Hendricks — I gave you the '18-19 and the percentage change.

Ms. Chartier: — Do you have that calculated over five years, like the differences between say 2013-14 to '18-19?

Mr. Hendricks: — We could do that. I'm pretty good at math but not that good.

Ms. Chartier: — Do you have the raw numbers?

Mr. Hendricks: — Yes. So from . . .

Ms. Chartier: — You know what. Sorry, instead of making you read the raw numbers for homemaking, nursing services, and meal services for those five years, would you mind tabling that?

Mr. Hendricks: — I would not mind that at all.

Ms. Chartier: — Okay, that would be very good.

Mr. Hendricks: — But can I table the . . . We would make something up for you. Is that okay?

Ms. Chartier: — Yes, is that possible to get in this soon time frame as well?

Mr. Hendricks: — Yes, yes, the soon time frame. Okay. Yes.

Ms. Chartier: — That would be great. Thank you. In terms of total expense for home care, so the last number that I have on record was 2016-17 at 178 million, so I'm just wondering . . . There's some blanks. For '17-18, what was the total expenditure for home care? In '17-18 and '19-20?

Mr. Hendricks: — '17-18 was 195.38 million and that was an increase of 1.1 per cent. And then in '18-19 which is the last number that we will have available . . . the '19-20 won't be available until July 2020. So '18-19 is 196.15 million for a 0.4 per cent increase.

Ms. Chartier: — Okay. And how much of that is . . . So from the recent bilateral agreement with the feds, how much of that is in the last, I guess it would be, three budget years?

Mr. Hendricks: — So for ’19-20, the home care allocation to the province out of the federal funding was $20.61 million and it will be the same for ’20-21. But you will, I think, recall that 1.2 million of that went to home care. The majority of funding, we submitted a proposal to the federal government to put that towards our community health centres which we’ve been establishing in Regina and Saskatoon. So market square in Saskatoon, that sort of thing.

Ms. Chartier: — And that 1.2 million was for individualized funding, is that correct? Am I recalling that?

Mr. Hendricks: — Yes, that’s correct.

Ms. Chartier: — Okay. So just going back to 2017, there were media reports of services being clawed back. Sorry, I’m just looking at my notes here. And I think it was for not the nursing services but services like personal care or the meals and home care services, I believe. But what was clawed back in 2017? Or was there a reduction in some services in 2017?

Mr. Havervold: — Thanks. So the services over time in home care, there has been a gradual trend to more of the acute style of home care or nursing services. So for example a home IV [intravenous] therapy, specialized palliative care in the home, that sort of thing that would be more, sort of, sub-acute or nursing-type services that are a higher acuity than things like, you know, basic supportive care. So the shift over time has been more towards the acute care and less towards the supportive care side.

I’m just going to try and find some statistics. The acute clients over time, so from ’15-16 to ’18-19, jumped from 17,500 clients to just over 19,600 clients and that would be on the acute side. And on the supportive side in that same time frame, there would have been about 18,971 clients. And then in ’18-19, the most recent time we have, it’s about 15,672 clients. That’s not services, that’s just clients that accessed one of those supportive. So the shift over time has been more toward the acute side of home care.

Ms. Chartier: — And that would be with the goal to get people out of hospital and keep people out of hospital, would that be correct?

Mr. Havervold: — I think it’s to facilitate an appropriate discharge and make sure that people are cared for in the most appropriate place where they can be supported most effectively.

Ms. Chartier: — Just for clarification then, that 15,672 number in ’18-19, the number you . . . sorry, the number you gave me before that, 18,971. Was that from ’15-16 as well?

Mr. Havervold: — Yes, it was.

Ms. Chartier: — Okay. During the pandemic, and I guess we’re still in the pandemic, but many home care staff were redeployed. How many remained in their home care position, and how many were redeployed elsewhere?

Mr. Livingstone: — So with respect to the number of home care staff that were redeployed as a result of the COVID response, I don’t have the specific numbers tonight because they would have been part of the labour pool that we created to support other initiatives for COVID. But I can certainly get them for you, and we’ll do that within that week time frame for you. We do have that data for the labour pool, and we’ll be able to pull that for you.

To keep in mind, not all home care services completely came to a halt. But because of the nature of home care, particularly in trying to protect our most vulnerable citizens who would be, you know, people living in assisted living, that reduction of services was created so there wasn’t an in-and-out of homes by home care staff early on. But now that we’re back in, they have appropriate PPE [personal protective equipment] and are doing so under the COVID protocols.

Ms. Chartier: — That was my next question. What settings were they removed from?

Mr. Livingstone: — So some of the big . . . you can imagine. So you know, coming from Saskatoon, I’ll just bring up, you know, that one square city block around Market Mall where we have multiple assisted living facilities. That would be where you’d see a lot of it because there would be multiple opportunities to potentially infect clients by coming in and out of their homes. We did rely on families early on in COVID to try to do some care for family members, but as I said, services weren’t completely halted but they were certainly reduced.

Ms. Chartier: — Okay. Were there specific . . . like location specific, obviously you were talking about multi-unit dwellings. But were there service-specific removals as well or was it more tied to location?

Mr. Livingstone: — Most likely tied to location and the type of visits. I don’t think there was any specific area that was just dramatically reduced, but again, I can follow up.

Ms. Chartier: — That would be great. Just switching gears here to long-term care. In the Ombudsman’s report in 2016 she referred to a system under strain, and in the 2016 election platform there’s a commitment for $7.5 million to be taken from executive salaries and put on the front lines.

[19:30]

And I know at one point some of that money — a small portion — had made it. And I know early on, Minister, that you said you didn’t think that was going to be possible. But I’m wondering how much money was saved from executive salaries and how much of it ended up directed into long-term care and how many positions that created.

Hon. Mr. Reiter: — So you had mentioned we had discussed this before. I have *Hansard* from last year. Max had answered the question. He says in part that we saved probably in the $6 million range in administrative savings. Unfortunately because of fiscal realities during that period and some deficits, they weren’t able to transfer that all to long-term care.

And to your question about long-term care expenditures, now

there's the government expenditures and then resident fees, so I'll focus just on the government expenditure part of that. In '15 -16 it was 737 million. In '18-19 it was 758 million. So an increase of $21 million.

Ms. Chartier: — That isn't necessarily directly for staff, because they spend money on their electrical bills and all those other things.

To a document you've tabled in the past, I'm just looking for some updated numbers, I guess. So I was trying to find that table and I finally just located it in my notes here. So you had tabled in the past the fiscal year, the number of long-term care staffing, paid FTEs, CCAs [continuing care assistant], LPNs [licensed practical nurse], RNs [registered nurse], RPNs [registered practical nurse], and then the total number. So the last number I've got is for 2017-18. Could I get the next two, 2018-19 and 2019-20?

Mr. Hendricks: — So to make sure we're doing apple-to-apple comparison, do you have your numbers from last year?

Ms. Chartier: — 2017-18. 5,084 CCAs.

Mr. Hendricks: — So '18-19 is 5,038.

Ms. Chartier: — 5,038?

Mr. Hendricks: — Yes. CCAs was 5,038. LPNs, 898.

Ms. Chartier: — 898.

Mr. Hendricks: — RN/RPN, 1,235.

Ms. Chartier: — 1,235.

Mr. Hendricks: — 7,171.

Ms. Chartier: — 7,171. So there's been a decrease in the total number and a decrease in the number of RNs and care aids year over year?

Mr. Hendricks: — By 40 paid FTEs over one year which could be any number of things like . . . yes.

Ms. Chartier: — But a decrease nonetheless when there was a commitment to put 7.5 million more into staffing in long-term care. There's fewer care aides today than there were in '15-16. There are a few more LPNs and just 20 more RNs.

Mr. Hendricks: — In '15-16, the year that that commitment was made — because I recall we've had this discussion a few times in estimates — in '15-16 the total number of paid FTEs was 7,108 and '16-17 the total number went up to 7,226, right? So it went up.

Ms. Chartier: — Oh and it's decreased. Yes.

Mr. Hendricks: — Yes, okay.

Ms. Chartier: — The last few years it's decreased here again, so I think it's reflective of what I'm hearing and what I know my colleagues and other people are hearing in long-term care around staffing. The CEO tour report, I think, indicates that as well that staffing is very much an issue in long-term care.

The auditor . . . I keep calling the Ombudsman the auditor. The Ombudsman in her report, some of her recommendations did recommended the Ministry of Health in consultation with the health regions identify the care needs of current and future long-term residents, identify the factors affecting the quality of long-term care delivery, develop and implement a strategy to meet the needs of long-term care residents, and to address the factors affecting the quality of long-term care in Saskatchewan and make that strategy public. Have you addressed that recommendation?

Mr. Hendricks: — So in response to the Ombudsman's report, there were several things that were done. As you know we implemented our annual senior leadership CEO tours to all health care facilities. The biennial resident family experience surveys, you know, there are some observations that are not positive, but the majority are positive; 85 per cent across the system agree that they're receiving good care.

We've introduced program guidelines as you know for special-care homes, and we're reviewing those right now and updating them. Purposeful rounding was another thing that's had a very positive impact on patient care. So those are very timed, deliberate visits with specific requirements to each resident's room. We've done chart audit. We're doing chart audits now on a very frequent basis.

And then the other thing too is in our most recent Accreditation Canada survey, which is 2019 to 2023, we received a 95 per cent score long-term care on our required operating procedures, which is the gauge by which they measure our performance. So I think we're feeling that in long-term care, you know, we're actually meeting the objectives that have been set out by Accreditation Canada. The guidelines are being met, and there are our CEO tours, and so we feel that we have a number of mechanisms in place to assess quality of care in those facilities.

Ms. Chartier: — So just for clarity's sake, the CEO tours, purposeful rounding, and biennial surveys I believe are all prior to the Ombudsman's report. So the CEO tours started in 2013; the biennial surveys were about the same time; but purposeful rounding started prior to the last election as well. That was under the former minister.

Regardless, the Ombudsman also points out that, recommendation 13:

> That the Ministry of Health implement a publicly accessible reporting process that families can use to see whether each long-term care facility is meeting the *Program Guidelines for Special-care Homes*.

[19:45]

So we regulate personal care homes, and you can google the personal care home. Obviously it's a private option so you can see what's going on and whether or not you want to purchase those services. But in this Ombudsman's recommendation no. 13 about the reporting process that families can use to see whether each long-term care facility is meeting the program guidelines

for special-care homes, is that something the minister is planning to take, not just into consideration, but put into action?

Mr. Hendricks: — So in reference to my earlier comments, just to correct myself, during my tenure as deputy there have been two Ombudsman's reports, so I've tended to cross lines a bit on different things. But what I did want to say is that we do, in terms of quality indicators, as you're probably aware there are quality indicators that are reported through CIHI [Canadian Institute for Health Information] and those reported on CIHI's database that look at things like the use of restraints, bed sores, fresh ulcers, and several factors around patient care, which are reported publicly. Also, as you do know we post our family resident surveys on our website, as well as the CEO tours. And so several things around how our long-term care homes are doing are published on websites that are available.

Ms. Chartier: — I would just add, just for some clarification here, the family and resident surveys. I was at Oliver Lodge, invited by a resident to sit in when they were reviewing their survey that was going to be submitted to the ministry. And people tend to like to say nice things about their staff because they're really wonderful people who generally work there. But I was there when the council passed a motion asking for the home to write to the minister asking for more staff.

So the family and residents survey say one thing, but people are saying something very clearly that short-staffing is an issue. You were talking just a moment ago about the indicators. I've got the most recent CIHI indicator on potentially inappropriate use of antipsychotics in long-term care. Canada's result is 20.7 per cent. In Saskatchewan it is 27.5 per cent, and has gone up in the last few years, down from 2014-15, but up a little bit in the last few years. So our indicators aren't showing that we're doing a stellar job.

But I only have a few minutes here. These are my last 10 minutes in Health estimates. I have to ask, like with all due respect, I have been in this place for almost 11 years. Seven of those years we've been hammering away around long-term care. I've been inundated as the Health and Seniors critic with stories from residents, from families, from staff.

There were staff on the front steps here today talking about their lived reality as care workers, what it looks like to have two care aides for 50 residents, some really awful ratios for people who are really in high demand. I had a father who spent 14 months in long-term care and it was the worst experience of my family's life.

With all due respect, do you really believe we're doing better in long-term care than we were five years ago?

Hon. Mr. Reiter: — You know, I've had instances with family in long-term care too, and to speak about the front-line workers, there's just some amazing people working in that field that do an amazing job. I think we can always do better. I think there's situations that obviously we can do better. That's why the CEO tours. Senior staff need to hear that so that we can take action so that we continue to improve.

But you know, I appreciate your passion for this, but frankly I think you're losing sight of the fact that you're saying, are we doing better than we did five years ago? And you always talk about not having enough staff, but how about when we formed government in 2007? There's hundreds more staff than there were then. If things are as dire as you're saying, what was the situation then?

Ms. Chartier: — I'm asking, Minister Reiter. I wasn't here in 2007; you weren't here in 2007. You've been the minister; you've been in this government. Nobody is making these stories up. When people talk about their loved ones, whether it's in a CEO tour story and they're telling their experience in the Saskatoon convalescent home or in any other facility, people aren't making these things up. Our most vulnerable citizens are going without much-needed care that they need.

And yes, my dad's story is new and fresh and raw. It was only a few months ago. But there have been scores of people who have come to the legislature and many, many more that I can tell you who don't tell their stories publicly because sometimes they're just in shock, in trauma, and caring for a loved one and trying to support them is very difficult.

We have auditor's reports. We've got Ombudsman's reports. We've got your own election commitment. We've got the CEO tour reports which, even with bureaucratic language, if you read the whole report you can see that short-staffing and recruitment and retention, particularly in rural Saskatchewan, is incredibly challenging.

And the fact that you haven't met the 7.5 million commitment from your budget speaks volumes. So I'm sorry. This is incredibly frustrating for me to see numbers drop in terms of the number of people who are caring, whether it's by a small number or not. But people on the front lines are telling you that the acuity level has gone up. What is the average length of time someone spends in long-term care these days? Eighteen months? Is that still the case?

When you get into long-term care, it's palliative. You're in high need. It's very difficult to get into long-term care these days. You have to be either assessed physically as needing a great deal of care or your dementia is an issue. You don't get in there as my grandma did when she was 70 and spent 30 years in long-term care. It's a very different story than it used to be.

Just a question about the 2011. So we've quibbled here a little bit about the 200-page book of guidelines. I just want a clarification here. In 2011 from the regulations, did your government cut a regulation that mandated an amount that allowed for a set amount of care and allowed the opportunity to staff it? Did your government cut that or not?

Hon. Mr. Reiter: — So I think what you're referring to is some changes that happened in 2011 where some language had been taken out that was very prescriptive, talking about how many hours per day or week that each resident would need to receive from staff. And it moved to a much more flexible version that could be personalized because different residents needed and wanted different levels of care.

So I think, you know, frankly what we're discussing has been discussed on the floor of the Assembly many times. It was discussed on, I think, the floor of the Assembly this week again,

the argument about whether the guidelines are actually minimum standards or not minimum standards. I think that discussion is one of those things that we'll likely just have to agree to disagree on.

Ms. Chartier: — Yes. I'm down to my last minute here. I am going to switch gears very quickly.

Just with respect to Estevan, I asked if this contract had been signed and the answer was no. But I'm wondering if the contract exists and is just waiting to be signed?

[20:00]

Mr. Livingstone: — So just to clarify, the contract has not been drafted. There's been negotiations around the terms of the agreement, particularly the principles in which we would engage with this new service and some of the parameters.

And it started, well I mean, it started near the start of COVID. So there's been some delays but we will start escalating those discussions. But there is no contract draft and there is no contract that's been signed.

Ms. Chartier: — In terms of the terms or length, has that been part of those discussions yet?

Mr. Livingstone: — No.

Ms. Chartier: — No. Okay. Thank you.

The Chair: — I'm sorry, we've reached the end of our time, Ms. Chartier. So we'll now adjourn consideration of the estimates and supplementary estimates for the Ministry of Health. Thank you, ministers and officials. And are there any closing remarks, Minister?

Hon. Mr. Reiter: — Thank you, Mr. Chair, I'd like to thank the committee members. I'd like to thank Ms. Chartier for the questions. I'd like to thank the staff here. And I'd like to thank all the Health officials as well for the many hours over the last two days. Thank you all very much.

Ms. Chartier: — Thank you. I'm going to get all emotional here. I just want to thank everybody. I don't know why I'm feeling all emotional. I love estimates. This is, like, my favourite part of this job, which I guess I'm a strange individual.

So I just wanted to thank the ministers for your time today and over the previous years of sitting for hours and hours and hours in committee and sometimes not always understanding my thought process. It always comes together but it takes us a minute to understand each other sometimes. So thank you to the ministers and to the officials for all the work that you do and for your time in committee, and your efforts in answering questions, and to committee members and staff.

Yes, I'm up in SaskEnergy but this is, like, where my heart is. So I thank you. It's been fun.

The Chair: — Thank you, Ms. Chartier and Mr. Reiter. I would now ask a member to move a motion of adjournment.

Ms. Ross: — I so move.

The Chair: — Ms. Ross has moved. Agreed?

Some Hon. Members: — Agreed.

The Chair: — This committee stands adjourned until June 18th, 2020 at 6:30. Thank you everyone.

[The committee adjourned at 20:03.]