

***Final Report***

**"Stay the Course...  
and Together We Can Secure the Foundation  
that Has Been Built"**

An Interim Report on the Mental Health and  
Addictions Services in the NWT

**December 9, 2005**

Submitted to:

The Department of Health and Social Services  
Yellowknife, Northwest Territories

Submitted by:

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## ***Forward and Acknowledgments***

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This report summarizes the findings of Chalmers & Associates Consulting Ltd. in completing a review of a document entitled “*A State of Emergency...Community Addiction Program Evaluation*” and the Department of Health and Social Services’ progress in implementing the recommendations.

Many people have provided valuable input to this document and we would like to acknowledge them for the time and effort that has been expended by these individuals. We want to thank all those who contributed to this report for being available on short notice; timelines were extremely tight on this project, and many people accommodated the team during evenings, holidays and weekends.

Information was provided by Community Wellness Workers, Mental Health and Addiction Workers, Clinical Supervisors, Directors of Community and Social Programs and Chief Executive Officers (at the Health and Social Service Authorities), Authority Chairs, Directors and Managers at the Department of Health and Social Services, the Steering Committee, the Assistant Deputy Minister, the Deputy Minister and the Minister of Health and Social Services.

The members of the Steering Committee for A Review to “*A State of Emergency...Community Addiction Program Evaluation*” (May, 2002) were:

Rachel Dutton-Gowryluk	Project Manager, Mental Health and Addictions Core Services Implementation
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We thank the communities and people we interviewed for their frankness. It is our hope that mental health and addictions services continue to be improved across the NWT. This interim report has been prepared by Chalmers & Associates Consulting Ltd. and the analysis, findings and recommendations are those of Chalmers & Associates Consulting Ltd. and do not necessarily represent the views of the Government of the Northwest Territories.

Review Team: Dr. Jennifer Chalmers, Liz Cayen, Dr. Cheryl Bradbury and Sharon Snowshoe

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## **1. Background Information**

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### **A. Why this Progress Report at this Time?**

In 2001/2002, the Department of Health and Social Services (“DHSS”) funded an evaluation of Community Addiction Programs across the Northwest Territories. As well, the evaluation also reviewed the Mobile Addiction Treatment Programs that had been piloted the previous year. Chalmers & Associates Consulting Ltd. was contracted to complete the evaluation and **“A State of Emergency... .A Report on the Delivery of Addictions Services in the NWT”**, which was released in May of 2002.

In 2003, action was taken to look at the Chalmers report and recommendations, and to begin the development of a framework for mental health and addictions services in the NWT. The Minister of Health and Social Services, in consultation with the working group, determined it was important to build mental health and addiction services at the community level, to build community capacity, and then to focus planning at regional and territorial levels. The Framework for Action: Mental Health and Addictions Services (2003) report was completed and the first year of implementation of core mental health and addiction services began in 2003/2004.

Addictions and mental health problems, and the health and social problems that can follow, remain the greatest problem for many people living in the Northwest Territories. Concerns regarding the changes in illicit drug use, and the potential social and economic impacts of resource development in the NWT have been raised by the public and various leaders throughout the NWT.

Amid these concerns and other questions from constituents, MLA’s, Health Authorities and the DHSS, the Minister of Health and Social Services in consultation with the Joint Leadership Committee and the Joint Senior Management Committee determined that this would be a time to “take the temperature”, to ensure that the Mental Health and Addiction Services are meeting the needs of the community, and that funding resources, and priorities should continue. It is time to look at “where we are and where we are going”.

## **B. Emerging Issues**

An environment rarely remains the same. There are many emerging issues that need to be acknowledged in the backdrop of this interim report:

### **Changing Socio-Economics**

First, the changes to socio-economic opportunities in families and communities across the NWT have already begun with improved economies, employment opportunities at BHP and work leading up to the Mackenzie Gas Project (MGP). At the time of writing this report, there is much excitement about the proposed gas pipeline project in the Mackenzie Valley. It has recently been announced that the Joint Review Panel will begin hearings in January of 2006, to review the impact of the proposed gas pipeline project. This project, if it goes ahead, may have a profound impact on the people in the Northwest Territories, especially communities in the affected areas.

The Federal Government has recognized the social impact of such a project by pledging \$500,000,000 over ten years to the five aboriginal groups that are most directly affected by the proposed pipeline (Gwich'in, Inuvialuit, Sahtu (2) and Deh Cho). The need for additional health and social services is anticipated. It is therefore of great importance that the Department of Health and Social Services lay a strong foundation for the delivery of its programs, especially in communities that will be most affected by the pipeline project.

### **Drug Usage Patterns**

Secondly, drug usage patterns in the NWT are changing and being influenced by improved economics, drug availability, mainstream societal acceptance, and media pressures/influences for experimentation. There has been widespread outcry for education and prevention services to address the use and experimentation with "hard" drugs. These drugs include cocaine, crack cocaine, and crystal methamphetamine. Other specific drug concerns are less prevalent, but nonetheless of grave concern, and they include intravenous (IV) drug use, cross-addiction, date-rape drugs (ecstasy), and heroin. While NWT drug reports emphasize the predominant substances as being alcohol, nicotine and marijuana, these "hard core" drugs and their supply throughout the NWT, are of great concern.

For the young people, nicotine and marijuana remain the "gate-way" drugs for experimentation with other drugs. Therefore, due to the increased reporting of use of marijuana, and the reduced costs of these substances, it is wise to address drug usage, experimentation and dependence. With the influx of additional money if the pipeline project goes ahead, it is necessary that the Department of Health and Social Services (including Authorities and Community

Programs) have access to good educational tools so that prevention services can be delivered in an expert and efficient manner.

Furthermore, the increased reports and incidences of Sexually Transmitted Infections (STI) are perhaps heavily influenced by alcohol and drug usage, especially among the youth and young adult groups. HIV, hepatitis C, and other public health problems that result from substance abuse/dependence, although not prevalent in the NWT, may worsen and challenge the health delivery system and community health in the years to come.

### **Other Emerging Issues (Aging population, Gambling, Adults with FASD...)**

There remain many emerging issues that could directly, indirectly or remotely affect communities across the NWT to influence rates, presentation and degree of addictions, mental health and family violence problems in the years to come. Further discussion of these emerging issues is beyond the scope of this interim report, but they are listed here.

- Aging population, and addictions and mental health issues with elders, older adults and those with chronic health conditions such as diabetes.
- Prevalence of dementing illnesses, depression, suicidal ideation and gambling in older adults.
- Problem gambling, compulsive gambling.
- Adults living with FASD (Fetal Alcohol Spectrum Disorder)
- Addiction medicine as a medical specialty (U.S trend since 1990's)
- Role of self-government and Aboriginal land claims.
- Role of residential school programs and healing services.
- Child/youth early intervention, demand for services and expertise.
- Primary Community Care Teams (PCCT) and role of Nurse-Practitioners.
- Reduced reliance on specialties such as psychiatry, and more mental health diagnosis/treatment by general practitioners and family physicians (U.S and Canadian trend since 1990's).
- Increased regulation of human service providers (counselors, social workers, psychologists) with legislated scopes of practice.

## **C. Context of this Interim Report**

In the last few years, the Department of Health and Social Services has developed Community Counselling Services. This continuum of services encompasses mental health, addictions and family violence through prevention, treatment, and aftercare, and is delivered as an integrated program in the Northwest Territories. The Community Counselling Program is implemented by regional HSS Authorities, and several NGO's throughout the NWT.

The Community Counselling Program now includes 77 positions at the community and regional levels. The Program is comprised of three newly developed positions: the Community Wellness Worker, the Mental Health and Addictions Counsellor, and the Clinical Supervisor. It is important to recognize that these new positions were created and re-designed from existing positions across the NWT, that have been working in various community settings. A key context to keep in mind when reading this report is the ongoing development of a continuum of care of mental health and addictions services, that which has been developed from the experiences and work done in communities to develop mental health and addiction services.

Another contextual factor is that mental health and addiction services are delivered at the community level, either through Regional Authorities, or through community-based Non-Government Organizations or NGOs. These NGO's have been in place for many years, and work through contribution agreements with regional authorities to deliver mental health and addiction services.

### **Community Wellness Worker**

The primary role of the Community Wellness Worker (CWW) is to provide education, health promotion and prevention activities to all community members in the area of addictions, mental health and family violence. Secondly, the CWW is the first point of contact for many clients in community settings, and these workers generally provide screening, and early assessment of the addiction or mental health problem.

Of great importance is the work of these community-based workers in suicide intervention and crisis stabilization, as these workers are likely the first point of contact in many remote and isolated communities across the NWT. Much of this "crisis and suicide prevention work" has been done by these workers for many years, and teams of workers, community members and ad-hoc agency personnel (RCMP, Suicide Intervention) form these informal, but critical early response and crisis intervention groups. In addition, Wellness workers may refer clients to the Mental Health and Addictions Counsellor and provide the link to referral for residential treatment centres.

## **Mental Health and Addictions Counsellor**

The Mental Health and Addictions Counsellor is responsible for providing therapeutic counseling services for individuals, groups and families. The Mental Health and Addictions Counsellor also refers clients to residential treatment programs.

## **Clinical Supervisor**

The Clinical Supervisor provides clinical and sometimes managerial supervision to the Mental Health and Addictions Counsellor and the Community Wellness Worker. Clinical Supervisors act as a resource specialist in the area of addictions, mental health and family violence to the Team and to the Primary Community Care Team (PCCT). In some regions and/or communities, there are Mental Health Managers, who provide clinical supervision, and who also work in program administration.

## **Regional Authorities and NGO's**

Most individuals providing services under the Community Counselling Program are now employees of the Regional Health and Social Service Authorities. There are several non-governmental organizations or NGOs that provide mental health and addictions services to various communities. Many of the NGO's have been in place in communities for 5, 10 or even 20 years, and have community-based mandates, non-profit structures, community boards and serve a variety of client groups, and stand free of Band Councils or other local governing bodies. The NGO's reviewed in this report are listed here, but it is recognized that others across the NWT may also provide mental health or addiction type services.

- Family Counselling Centre (Inuvik) – established in 1970's and currently has mental health counsellors.
- Tulita Counselling Agency (Tulita) – established in 1990's and currently has Community Wellness Workers.
- Tree of Peace (Yellowknife) – established in 1980's and currently has Community Wellness Workers/Addictions Counsellors
- Salvation Army – established in Yellowknife in and currently has Withdrawal Management Program (non-medical)
- Tl'oondih Healing Society (Fort McPherson) – established in 1990's and currently has Mental Health and Addictions Counsellor/Trainee

The continuum of care for mental health and addictions services includes residential treatment as offered at the Nats'ejéé K'éh in Hay River. It remains as

the primary residential treatment centre within the NWT for addictions. Where the services offered at the treatment centre in Hay River are not appropriate, referrals are made to approved treatment centres south of the NWT.

The Department of Health and Social Services is currently moving to implementation of an Integrated Service Delivery Model of six core health and social services provided to residents of the Northwest Territories. These core health and social services include mental health and addictions. It is intended that staff of the Community Counselling Program will be integrated with the Primary Community Care Team (PCCT). It is anticipated that people in the NWT will be provided with a continuum of services that allow them to remain in their communities as much as possible and/or referred to regional or territorial hubs.

According to the Terms of Reference for this report (See Appendix A), the purpose of this review was to conduct a report focusing on the Health and Social Services Department and Authorities, focusing on the key stakeholders of mental health and addictions services in relation to the 48 recommendations, since the release of **“A State of Emergency...”** in 2002.

The review was to examine the mental health and addiction core service in the context of several areas including the following:

- System design/delivery
- Administration/management
- Key stakeholder buy-in/satisfaction
- Leadership/spokesman
- Identification of gaps and barriers
- Implementation of Community Counselling Programs
- Setting priorities for action
- Chalmers report (2002) recommendations.

In addition, this review examines the implementation of the mental health and addiction core service within the larger context of the overall health and social services as reflected in the Primary Community Care Model (PCCT) and in the Integrated Services Delivery Model (ISDM). Implementation of the recommendations found in the “State of Emergency...” report, and the multi-year implementation plan, and Cabinet/leadership directions, also provided direction and a broad context for this review.

## **D. Format of this Interim Report**

The format of this Interim Report was divided in recognition that different readers, including the public can and use this information.

The Interim Report, on its own uses a combination of narratives, abbreviated discussion and qualitative analysis to present the findings.

The supplementary report: the "Complete Report Card", provides detail, references and linkages to the findings, with relevant discussion of each recommendation from (2002) that was reviewed.

The supplementary reports on children and youth, withdrawal management, and residential treatment programs are specific topics that were requested to be addressed in this report, and/or require further descriptive analysis and discussion.

Where possible, jargon and terminology is defined for the reader, as the field of mental health and addictions, like any other, has its own choice of language, terms and abbreviations, which may not be understood by all readers.

Section 1	Introduction to this interim report
Section 2	Methodology used, documents reviewed, limitations
Section 3	Findings: Regional Highlights from each Authority
Section 4	Findings: Planning, implementation and Capacity
Section 5	Findings: Summary of "Interim Report Card"
Section 6	Findings: Emerging Issues
Section 7	Summary of Recommendations and Next Steps; this includes suggested timelines for these recommendations
Section 8	Final Comments of the evaluation team
Appendices	Terms of Reference and Summary of Evaluation team credentials

Supplementary Reports on specific topics: Complete Report Card, Children and Youth, Withdrawal Management, and Residential Treatment Programs.

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## **2. Methodology**

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### **A. Approach to Review**

The Follow-up Review to “*A State of Emergency ... Community Addiction Program Evaluation*” (Chalmers and Associates, 2002) as conducted in the late fall of 2005 provides insight as to the Department of Health and Social Services’ progress in implementing these recommendations. This report included a review of the Community Counselling Programs delivered through the eight Regional Health and Social Services Authorities and a short review of the services offered at Nats’ éjéé K’éh Alcohol (Territorial Residential Alcohol and Treatment Centre). As well, a review of documentation produced by the Department of Health and Social Services, with regard to mental health and addictions services, was undertaken particularly in light of how these services form part of the core services provided by the DHSS.

The “*State of Emergency...*” report was an evaluation of addictions services that were in communities at the time of review in 2001 throughout the NWT. Since that time, the Department of Health and Social Services has integrated their mental health, addictions and family violence services into a core service of mental health and addiction services, with the Community Counselling Program or CCP as the core and central part of the service across the NWT. Therefore, any references made to “addictions” with relation to the 2002 document, will in this interim report include broadly, mental health and addictions services.

### **B. Analysis and Limitations**

#### **What was the Analysis?**

Various methods of inquiry were implemented in the completion of this review including semi-structured interviews conducted in person or by telephone, if necessary.

Semi-structured interviews were conducted from October 30<sup>th</sup>, 2005 through December 3<sup>rd</sup>, 2005. The interview questions were designed to be consistent with the Terms of Reference, and with the overall scope of work in providing an interim report of the progress of the core service. Modifications to these questions were made for the various groups of individuals interviewed. A list of potential interviewees were outlined by the project contact and included the Minister of Health and Social Services, the Deputy Minister and Assistant Deputy Minister, staff of the Department of Health and Social Services, Board Chairs and

Chief Executive Officers of Health and Social Services Authorities, other staff of Health and Social Service Authorities, NGO's who deliver mental health and addiction services, and board's of directors of NGO's.

As well, there was a review of selected Health and Social Services documents, as outlined by the project manager. Additional documents were reviewed based on information given by interviewees, and at the discretion of the interviewers. A number of Canadian and provincial government documents were reviewed, in relation to scope of work, for example Withdrawal Management, drugs and residential treatment. The documentation was reviewed with respect to the recommendations in "A State of Emergency...", their content and applicability for future service development.

Analysis of all information and interview data was completed according to ethical research guidelines prescribed by the Canadian Counselling Association, and the Canadian Evaluation Society, together with respect for cultural diversity evaluation techniques among Aboriginal, and minority groups. Particular attention was paid to the limitations and generalization of data to specific communities in the NWT and individuals. Overall, the data collection and analysis was conducted within the context of the known population of the NWT, which includes 12 recognized Aboriginal groups (First Nations, Métis, Inuvialuit), Caucasian, and other minority groups. The geographical location of the population studied includes communities of various sizes (50 people to 20,000).

To ascertain accuracy of information obtained, the evaluation team used various qualitative techniques for data analysis including theme generation, triangulation and information verification.

This review, in contrast to the "State of Emergency..." (2002) report, did not include site specific analysis and program evaluation. Instead, the review team was tasked with conducting interviews at the regional and administrative level with Health Authorities and NGO's. Interviews were conducted with Chief Executive Officers, Directors of Social Programs, Clinical Supervisors, Board Chairs and some Community Counselling Program workers, where available in regional settings. The interviews conducted with Community Counselling Program workers were limited to those available in regional centres or NGO's and where time permitted and scheduling allowed for this. For instance, Community Counselling Program staff was interviewed in Fort Simpson, representative of the Deh Cho, Family Counselling Centre staff in Inuvik, and some Yellowknife Health & Social Services Authority staff.

A total of 73 interviews were conducted in a very short period of time, over a five week time span in November, 2005. Of these 73 interviews, only 25% of the interviews were with front line staff. This is a major limitation of the review, in that the focus from the Terms of Reference was to interview administrative and management personnel, as well as policy and program development staff.

Furthermore, only 10% of the current complement of Community Wellness Workers was interviewed, as the focus again was to interview management and supervisory staff members. Caution is needed in the review of this report, as it does not reflect input from all mental health and addiction core service workers across the NWT.

Separate visits were conducted with the NGO's that continue to provide community counseling services through contribution agreements with Authorities in the NWT. These NGO's include: Tree of Peace (Yellowknife), Salvation Army (Yellowknife), Tulita Counselling Agency (Tulita), TI'oondih Healing Society (Fort McPherson), and Family Counselling Centre (Inuvik).

The extremely tight time lines for this review limit the analysis and generalization of the findings. Unfortunately, not all interviews could be conducted in person, given the six week schedule of the project and the incompatibility of travel schedules between interviewees and interviewers. The evaluation team would have preferred to review the same sites that were evaluated in the "State of Emergency..." (2002) report to provide a better comparison of the "before and after" picture. Time/budgetary constraints prohibited this comparison and type of analysis at this time.

Also, it needs to be recognized that a "before and after" comparison of sites is premature, given that some workers are still being trained and hired. It is usually unwise to evaluate programs in their early developmental stages. Alternatively, it is better to provide implementation support to help guide the early stages of program delivery. The overall focus of this report is to provide external feedback, support and guidance as to the future planning, implementation and progression of the mental health and addiction core service in the NWT.

### **Who Did the Analysis?**

The team for this project consisted of Dr. Jennifer Chalmers, Liz Cayen, Sharon Snowshoe, and Dr. Cheryl Bradbury. Three of the team members have experience with many of the communities in the NWT either through service delivery, program evaluation or program development in the area of community wellness (addictions and mental health), health promotion and education/training. Two of the team members live and work in the NWT on a full time basis, another team member has lived in the NWT in past years, and now does contract work throughout the NWT, and the last team member lives and works throughout Ontario. Combined, team members have a vast array of clinical, program development, research and evaluation and community development expertise with a variety of populations, and with an emphasis on Aboriginal populations in Canada's three territories.

The team for this project consisted of individuals who have experience with many communities in the Northwest Territories either through service delivery, program

evaluation or development in the area of community wellness, health promotions and education/training, and their work in the NWT began in the 1980's, which provides for a historical perspective on the development of Health and Social Services across the north.

This team's combined expertise in counseling/clinical psychology, addictions and mental health, health promotion and prevention, human resources, and Aboriginal governance provided for a great depth of knowledge and experience in addressing the questions outlined in the Terms of Reference and in providing a culturally sensitive context for this review. Whether visiting workers in Community Counselling Programs or interviewing the Minister of Health and Social Services, this team primarily provides for an environment of safety and comfort as the team members have had first hand experience in living, working and raising a family in the NWT.

Furthermore, the evaluation team was especially sensitive to the degree of coping, organizational culture, and "burn-out" of interviewees, given that this review may suggest changes in course, focus and scope of work in the years to come. Also, as for all work conducted in mental health and addictions, the interviewers were sensitive to current events such as recent trauma in communities, for example the suicide of a youth in Fort McPherson, the larger context of investments in Aboriginal communities (First Ministers' meetings in Kelowna, BC), changes to the administration of early childhood and community funded early intervention projects for children and youth (due to the ELCC National framework) and other emerging events.

See Appendix B for further details of the evaluation team's credentials and experience.

### **C. Scope of Field Interviews and document review**

The review and interim report was to focus on the system design, administration/management, implementation, priority action items and recommendations made by Chalmers & Associates in 2002.

The following questions were given as the focus:

- How have we progressed in the planning and implementation of mental health and addiction services since 2002?
- How has the system design/delivery incorporated and/or addressed the 48 recommendations made in "A State of Emergency"?
- Is the mental health and addictions framework addressing the needs of the community?

- Are there any changes or modifications that must be made to the design or delivery models?
- What are the challenges that have impeded success or progress in any of the phases of implementation and planning?
- What are some of the successes?
- How effective is the administration/management of mental health and addiction services in the Department?
- How effective is the administration and management of mental health and addiction services in the Health and Social Service Authorities?
- What is the impact of leadership on the decisions for what becomes a priority action item, and hence what portions of the design are funded?
- Are the right people/leadership involved?

The field interviews included the questions set out in the Terms of Reference (See Appendix A, Terms of Reference). The questions focused on an individual's knowledge about the Community Counselling Program, the transition process, "what is working well and what is not working well", how can the Department help, and how can the Health and Social Service Authorities help.

The team evaluated documents provided by the Department of Health and Social Services, both public and internal documents. The documentation review was completed with a view to monitor the progress that has been made across the NWT with regard to the delivery of mental health and addictions services. As well, documents were reviewed to see how, and if, the core service of mental health and addictions services are consistent with the scope and context of those documents, and the future direction of the DHSS. For example, planning for future changes in the composition of ISDM complement of health care workers, that could include a greater emphasis on Nurse Practitioners or NP, ongoing emphasis and further development of PCCT, and role of Aboriginal organizations and structures in program and service delivery.

An abbreviated list of documents used in this review follows:

- § Primary Community Care Framework
- § Action Plans 2003-04, Mental Health and Addictions Services Framework for Action Status Report 2002-2005 and Performance Measurement- 2003-04, Progress report, September 2005.

- § Integrated Service Delivery Model for the NWT Health and Social Services System: A detailed description (March, 2004)
- § Integrated Service Delivery Model for the NWT Health and Social Services: Plain Language Summary
- § Community Counselling Program Standards (December, 2004)
- § Position Descriptions (Job Descriptions) for Clinical Supervisor, Mental Health/Addictions Counsellor and Community Wellness Worker
- § "A State of Emergency..." A report on the Delivery of Addictions Services in the NWT (2002)
- § Healthy Choices in a Healthy Community. A report on Substance Abuse, Prevention and Treatment Services in Saskatchewan (2005).
- § Mental Health and Addictions Services: Competencies Inventory, A Summary Report (2003)
- § Report to Residents of the Northwest Territories on Comparable Health and Health System Indicators (2004)
- § Mental Health and Addiction Services Scope Document (October, 2005)

#### **D. Limitations of Interim Report**

A number of limitations with this Interim Report are listed here, and figure prominently in this scope of work. Caution is needed in reviewing this material, given that these limitations may have affected content in this interim report.

The review team ***did not*** report on findings it could not verify, and therefore, many omissions are known. The reader is encouraged to read all supplemental reports to gather a better picture of this interim review process.

#### **List of Limitations:**

- Time frame (6 weeks) - extremely short period of time to do this review!!
- Few specific numbers are reported and other factual data, as there was insufficient time to verify, analyze and format these figures.
- An area of limitation is discrepancies in DHSS figures and funding parameters with those at Authorities; also, DHSS and Authority documents have different numbers of allocated positions, actual positions,

different labels of workers, and over different fiscal years. Broad analysis revealed some communication and documentation problems in the accurate recording of what was planned, what occurred and what is remaining vacant in terms of human resource positions. Accurate reporting on these human resource figures was therefore not possible.

- Program implementation is ongoing.
- DHSS and Authority administrative/management re-organization, changes and uncertainty was evident, which likely clouded the review process for some DHSS and Authority positions.
- The Terms of Reference were drafted by program consultants within the DHSS only. Senior DHSS personnel directed a NWT wide perspective, while the steering committee appeared to prefer a DHSS perspective.
- There was little time for the project manager and steering group to review drafts of the final report and make changes/suggestions to the report; much tension was felt because of the lack of time for the steering committee to review and discuss the findings/recommendations prior to its public release.
- Aboriginal/community context and perspective is extremely limited.

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### **3. Findings: Regional Highlights** **"Build on Success...Learn from Challenges."**

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This section of the report findings provides the reader with a glance at the scope of work being done across all regions and authorities. Due to the limited time allowed for this review (6 weeks), highlights and areas being developed and planned are limited to a few. The evaluation team regrets not being able to highlight all that is happening, and apologizes for this, as a lot is truly happening in all communities across the NWT.

#### **A. Fort Smith**

The Fort Smith Health & Social Services Authority provides health and social services, to approximately 2,500 residents in the Town of Fort Smith. The Community Counselling Program (CCP) is located in a government building away from the Health and Social Service offices. The Program is staffed by Community Wellness Workers, and Mental Health and Addictions Workers. The Clinical Supervisor position has become vacant in recent months, but is being actively recruited at this time.

<b>Highlights*</b>	<b>Areas being Developed/Planned*</b>
Good "preliminary" space (there are plans to move the program to the hospital with the new addition).	Need to complete renovation, add central phone system to existing location.
Good leadership from Authority.	Flexibility regarding funding arrangements; hire administrative/intake support.
Authority leaves them alone to do their job but supports the Community Counselling Program when needed.	Ill-equipped to deal with hard-core drug problems (crystal meth & cocaine).
Community Wellness Workers work well as a team.	"Make us credible"
Almost fully staffed (Clinical Supervisor position is out for competition)	Need team building and strong leadership from Clinical Supervisor.
	CWW need specific practical training in community outreach.
	Confidentiality issues within ISDM

*\*The comments in the Highlights and Areas Being Developed/Planned Sections are the comments made by interviewees in each region. This could include Authority administration and management, Community Counselling staff and other individuals.*

## B. Hay River

The Hay River Health and Social Services Authority reaches approximately 4,000 people in the Town of Hay River, and in the community of Enterprise. Mental health and addictions services are provided at a location away from the hospital. The Hay River Community Counselling Program is staffed by a Manager/Clinical Supervisor, mental health counsellors, addictions counselors and administrative support.

Highlights*	Areas being Developed/Planned*
<p>Good physical space for program set-up with separate entrance and administrative support.</p> <p>Play therapy room developed.</p> <p>Good resource library</p> <p>Cohesive and strong counselling team</p> <p>Good leadership from Authority</p> <p>Good opportunities with training supervision by phone (use videotape and then review).</p> <p>Good working relationship with Community Wellness Worker on the Hay River Reserve.</p> <p>Staff is specializing in different areas.</p> <p>Use client satisfaction surveys and focus groups with the community to see if client needs are being met.</p> <p>Good effort with tobacco cessation program.</p>	<p>Need more space – are crowded and more staff is on the way through Health Accord.</p> <p>Continued flexibility regarding Operation and maintenance expenditures.</p> <p>Not part of the GNWT union and affects wages.</p> <p>Addressing confidentiality issues and ISDM implementation.</p> <p>Withdrawal management services – one respite bed in hospital with a five day detox protocol which includes medical and counselling support.</p> <p>What role does community counselling program play with Bosco Homes in 2007?</p> <p>Working on day program to target specific addictions, such as cocaine.</p> <p>Prevention activities in school are better received when working with other resource persons such as RCMP; also do presentations at Aurora College.</p> <p>Wanting external audit on program and adherence to program standards.</p>

*\*The comments in the Highlights and Areas Being Developed/Planned Sections are the comments made by interviewees in each region. This could include Authority administration and management, Community Counselling staff and other individuals.*

### C. Deh Cho

The Deh Cho Health and Social Services Authority provides health and social services to approximately 3,500 people in eight communities: Fort Liard, Fort Providence, Fort Simpson, Hay River Reserve, Jean Marie River, Kakisa, Nahanni Butte, and Wrigley. Mental health services and addiction services are provided in a variety of locations, depending on the community. Community Wellness Workers are found in the Communities of Fort Liard, Fort Providence and on the Hay River Reserve. Services are provided to the smaller communities by the Clinical Supervisor and Mental Health and Addictions Counsellors who are located in Fort Simpson.

Highlights*	Areas being Developed/Planned*
<p>Have filled most of their positions.</p> <p>Good team work with Community Counselling staff with regular staff meetings; telephone support is ongoing with smaller communities.</p> <p>New positions come with no baggage, should be easier to integrate into primary health care services.</p> <p>Some of the Community Counselling Programs are co-located with Social Services and/or Health Centres – good move to integrate services.</p> <p>Have regular Health Newsletter; each unit will have chance to do the newsletter to highlight their particular core service.</p> <p>Renovation to Health Centre will provide more privacy in the provision of mental health and addiction services.</p>	<p>Integration of all health and social services –developing lines of communication and outlining roles and responsibilities</p> <p>Looking to tele-health services to help mitigate barriers around distance to the smaller communities in the region.</p> <p>Still working through transition and core service planning issues</p> <p>Would like improved communication with DHSS – need to be able to trust Department to support them.</p> <p>Continue training workers, as an ongoing process.</p> <p>Looking to understand and incorporate relapse prevention content in their services</p> <p>Looking to adolescent/youth as a targeted group for services.</p> <p>Would prefer clarity as to long term funding arrangements (HR, equipment, space).</p>

*\*The comments in the Highlights and Areas Being Developed/Planned Sections are the comments made by interviewees in each region. This could include Authority administration and management, Community Counselling staff and other individuals.*

## D. Yellowknife Regional Health and Social Service Authority

*At the time of writing this Interim Report, the Yellowknife Health and Social Services Authority and the Stanton Territorial Health Authority are engaging in a review of their mental health and addictions services.*

The Yellowknife Health and Social Services Authority provides services to Yellowknife, Detah, N'Dilo, Lutslek'e, and Fort Resolution, with a combined population of just over 20,000 people. The Family Counselling Centre is staffed with five mental health workers, and a clinical supervisor who are employees of the Authority. There are community wellness workers in N'Dilo, Fort Resolution, and Lutslek'e. As well, the Authority has contribution agreements with the Tree of Peace Friendship Centre and the Salvation Army to provide addictions counseling services. Family Counselling, Tree of Peace, Salvation Army, Lutslek'e and Fort Resolution have their independent locations away from each other and generally away from health care facilities. Also, Family Counselling provides a mental health counsellor to the Great Slave Medical Clinic.

<b>Highlights*</b>	<b>Areas being Developed/Planned</b>
<p>No vacancies in the current allocation of positions.</p> <p>Efforts made to work together, that is Family Counselling and Tree of Peace.</p> <p>Use of traditional person in Family Counselling (contracted services).</p> <p>Integrated Service Delivery Model – Great Slave Medical Clinic is an example of integrated services.</p> <p>New Horizons facility for mentally handicapped is popular.</p> <p>Withdrawal Management program at Salvation Army-social WMS.</p> <p>Salvation Army works with people at the street level helping them connect with the appropriate services; change view on treatment, as more than just residential treatment.</p>	<p>Better communication with Stanton Territorial Health Authority regarding mental health and addictions services.</p> <p>Need coordinated efforts in YK re: Withdrawal Management, both medical and social WMS.</p> <p>Need central referral agency for services available in the community.</p> <p>Day program for addictions treatment at Tree of Peace is being considered once new building is completed.</p> <p>Need strong, and knowledgeable leadership from DHSS.</p> <p>Add to the training for mental health and addictions workers.</p> <p>Strengthen local recruitment and retention.</p> <p>Need to be prepared for new patterns in illicit drug use.</p>

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## E. Stanton Territorial Health Authority

*At the time of writing this Interim Report, the Yellowknife Health and Social Services Authority and the Stanton Territorial Health Authority are engaging in a review of their mental health and addictions services.*

The Stanton Territorial Health Authority provides services for the Stanton Regional Hospital and to two medical clinics, the eye clinic, the mental health clinic and the health promotion and protection office. The Authority provides these services to all residents of the Northwest Territories, and residents of the Kitikmeot Region of Nunavut. Mental health and addictions services are provided both at the hospital, through the psychiatric ward, and also at the Mental Health Clinic located away from the hospital.

<b>Highlights*</b>	<b>Areas being Developed/Planned*</b>
The staff at the Mental Health Clinic have been in place for many years. This provides for consistency of services.  Provide service to some outlying communities.  The Manager Position of the Mental Health Clinic is located in the Mental Health Clinic, and at Stanton Hospital.	Need communication and team work with the Yellowknife Health and Social Services Authority with respect to mental health and addictions services.  Withdrawal management services to be clarified within the NWT Health and Social Services system – what is the role of Stanton Territorial Hospital, as a Level D facility, in withdrawal management in Yellowknife and across the NWT?

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## F. Tlichó

The Tlichó Community Services Agency provides health and education services to a population of approximately 2,800 individuals located in the communities of Behchoko, Rae Lakes, Wekweeti and Wha ti. Behchoko and Wha ti provide satellite services to the communities of Rae Lakes and Wekweeti through the Tlichó Healing Path.

Highlights*	Areas being Developed/Planned*
<p>Tlichó Healing Path is just starting as a community based continuum of services, including mental health workers, community wellness workers, and community health nurse working with alternative therapies.</p> <p>Have administrative support.</p> <p>Strong team work with regular staff meetings including staff in other communities</p> <p>Have Wellness Centre in Wha ti</p> <p>Positions have recently been filled with Wellness Worker trainees.</p> <p>Have some support groups in place.</p> <p>Using some standardized assessment tools.</p> <p>Have integrated service delivery in terms of addictions, mental health, social workers and education</p> <p>Looking at providing counseling in the community school.</p>	<p>Want flexibility for their Authority with wellness positions.</p> <p>Continue to build labour force from within the Tlichó communities.</p> <p>Need training for new Community Wellness Workers.</p> <p>Develop more formal aftercare program.</p> <p>Want traditional and cultural supports and services to be strengthened and integrated with mental health and addictions services.</p> <p>Withdrawal management needs to be community based (safe place, free from criticism)</p> <p>Day program needed to assist those who want a safe place to maintain sobriety.</p> <p>Youth programs are best received if community and family focused.</p>

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## G. Beaufort Delta (Inuvik)

The Beaufort Delta Health and Social Services Authority provides health and social services to approximately 7,100 people in eight communities: Aklavik, Fort McPherson, Holman, Inuvik, Paulatuk, Sachs Harbour, Tsiigehtchic and Tuktoyatuk.

Services are provided in the eight communities by employees of the Beaufort Delta Health and Social Services Authority (formerly Inuvik Health and Social Services Authority) and two NGO's (Family Counselling in Inuvik, and TI'oondih Healing Society in Fort McPherson).

The Beaufort Delta Authority is in a process of transition, as the Sahtu Health Authority began delivering services as of April 1, 2005.

Highlights*	Areas being Developed/Planned*
<p>Family Counselling Centre has a long history of providing community counselling services in Inuvik. They have a stable board of directors, well-credentialed mental health workers. Provides service to people in the Beaufort Delta including referrals by outlying communities; provide service to Tsiigehtchic; networking/linkages with other community services, such as Aurora College.</p> <p>TI'oondih Healing Society is sharing space with other community agencies.</p>	<p>Need continued administrative support in community settings.</p> <p>Improved communication and team work with the DHSS, the Authority, Community Counseling Services and the clients.</p> <p>Work is ongoing to fill a few remaining positions.</p> <p>Work with NGO's continues to build Community Counselling Programs (Family Counselling and TI'oondih Healing Society)</p> <p>NGO's are addressing their current program in their historical context (Family Counselling has been providing services for more than 20 years; TI'oondih Healing Society has been providing services for 11 years).</p>

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## H. Sahtu

The Sahtu Health and Social Services Authority began delivering services on April 1, 2005. This Authority provides services to Colville Lake, Deline, Fort Good Hope, Norman Wells, and Tulita, with a combined population of 2,600 people. Services are provided in a variety of locations. The Authority maintains one contribution agreement with Tulita Counselling Agency.

A few positions are vacant in this Authority. However, contributing factors are involved in the vacancy with positions in this Authority. Where vacancies remain, interim service needs are being provided through contracted personnel, and by Authority personnel with applicable education and training. These vacancies are not surprising in this Authority, given its new structure just months ago, limited housing, if any, and small communities with limited pools of workers. Historically, this region was involved with the Mental Health Pilot Project (1994 to 1997), and relied on highly skilled out-of the territory staff to provide mental health counselling to people in Fort Good Hope, Tulita, and Deline.

<b>Highlights*</b>	<b>Areas being Developed/Planned*</b>
<p>New Authority – gives them the ability to “start fresh.”</p> <p>Authority problem solves to provide services where there are vacancies.</p> <p>Have been flexible with regard to filling Mental Health &amp; Addictions Workers positions.</p> <p>NGO receives Clinical Supervision from Authority.</p> <p>NGO is delivery its CCP within its historical context, as it has been in existence for 11 years.</p>	<p>Include NGO’s workers in training opportunities.</p> <p>Filling vacant positions – difficult due to housing and salary levels for this region.</p> <p>Want ongoing training for Community Wellness Worker positions to allow them to be competent (only 13 competencies out of 35 competencies addressed); want practical application of learning.</p> <p>Encourage ongoing tele-counselling.</p> <p>WMS provided through Stanton Hospital and Salvation Army; would like more community-based services for withdrawal management.</p>

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## **4. Findings: Planning, Implementation, and Capacity Analysis of Key Areas of Mental Health and Addictions**

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This section of the report provides the reader with findings on program planning, implementation, capacity, gaps and challenges within the core service, key stakeholder buy-in and satisfaction, as well as an overview of leadership issues.

An approach of highlighting successes, and identifying areas for further strengthening was used in this section. An encouragement focus is best for evaluating human service programs, which recognizes that no one person, or group is at fault for gaps, or weaknesses.

The review team recognizes the hard work done by many, many dedicated people in the NWT to bring to this point the mental health and addictions core service. Too often, there is little encouragement of efforts put forward and far too much focus on end results.

It needs to be recognized that the areas outlined below do not fully represent all of the successes, or future successes and challenges, as work continues on the development of mental health and addiction services.

This section on findings, presents the review team members' recommendations, which are also itemized Section 8: Summary of Recommendations.

### **A. System Planning & Readiness for Change**

**Question:** How have we progressed in the planning, & design?

This first section reviews the core service of mental health and addiction services in terms of planning and design. The planning for the re-building of mental health, addiction and family violence services had begun at the time of the review of addiction services across the NWT and the report titled: "A State of Emergency..." (2002). This planning was documented in the form of a strategy document that integrated addictions, mental health and to a lesser extent family violence services. The following analysis discusses the areas of success in this planning and the areas that require further and ongoing development.

## Areas of Success/Strength

- Response to "State of Emergency..."

The GNWT responded to the reports from the late 1990's through to "the State of Emergency... Report" (2002) and provided financial resources, priorities and direction to address the addiction and mental health and family violence services across the NWT. This infusion of effort and financial resources was most realized in terms of attention to community-based counselling services, which are the stability, strength and core of all mental health and addiction services in the NWT.

The GNWT also decided "to stop, look and listen" in 2005, to assess the impact of the re-building of the system to date, and reassess financial investments in terms of emerging trends, impacts in the NWT, and other community/leadership feedback, through informal and formal processes such as letters written, MLA questions from constituents and "talk in the communities."

Although this interim report forms a part of this "stop, look and listen action" in December of 2005, and may directly/indirectly cause a halting of implementation activities, it is wise to review progress to date, and make adjustments at this point in time.

The GNWT is to be commended for taking this bold action to "stop, look and listen."

- Community/NGO Response to "State of Emergency..."

Communities also responded to the direction of the GNWT by taking a closer look at their role in the design and delivery of core mental health and addiction services. Some of these organizations, mainly NGO's with histories of providing services, took it upon themselves to look to the future needs of their populations, and reaffirm their mandates, scope of practices and place in a re-built system of mental health and addictions program delivery.

For some NGO's this work entailed internal reviews (Ti'oondih Healing Society, Tulita Wellness), and for others it was within the scope of larger mandates and planning already underway (Tree of Peace and Salvation Army).

- New Program Standards, Job Descriptions and Competencies

New program standards, job descriptions/competencies and structures of accountability within the Community Counselling Program were completed.

This work, in 2003-04, allowed for the implementation of a new system throughout the NWT that would be consistent, have built-in elements of accountability to program standards and job descriptions, and a continuum of services.

- Integration of Mental Health and Addictions

The combining of mental health and addiction services was strategic in: (1) centralizing of resources could be done in regional locations, (2) minimizing duplication of counselling services and (3) improved approaches to dealing with client's issues through a holistic and client-centered approach.

In the NWT, the integration of mental health and addictions reflects the complexity of clients' personal and social issues that often cross over issues of mental health, addictions and family violence. Other jurisdictions across Canada and in the United States separate these services. In fact, some U.S jurisdictions are re-dividing mental health and addiction services to separate out funding streams, areas of expertise needed, and because these systems do not run smoothly in large communities.

However, the scope and complexity of mental health and addiction problems/issues seen in the NWT, the limited availability of resources and expertise, and the holistic nature of Aboriginal health and wellness, firmly directs that integration of mental health and addiction services is the right decision in the NWT.

- Openess to Change

As the result of many years of fiscal restraint, the closing of Territorial treatment centres in 1996, and several community-based documents revealing the need for change (Social Agenda Work, Minister's Forums on Health and Education, State of Emergency..), communities were open to a process of change to improve design, delivery and accountability of mental health and addiction services.

Communities and government systems "hit bottom" with existing structures and design, and wanted to have a range of high quality and community-based mental health and addiction services.

- Financial investments

Financial investments were highlighted in the "New Design", with additional funds directed towards human resources in mental health and addiction services across the NWT. These investments were of considerable scale given competition for health and social services funding in current fiscal realities.

Prevention positions, namely in the form of Community Wellness Worker positions and their education/training opportunities are a definite highlight, given the nature of addictions and mental health, and communities concern about prevention of these problems.

A total of \$7.1 million dollars\* has been directed for the fiscal year 2005-06 for community based mental health and addictions services, which is an increase from previous funding for mental health and addictions.

(\*figures do not include psychiatry services, and other residential type programs that cross-over with addictions and mental health.)

It is difficult to compare new investments with previous levels of funding with respect to mental health and addiction services, as the method of service delivery has changed in the last 10 years from previous reliance on residential type services (previously funded through treatment centres such as Delta House, Northern Addiction Services, Tl'oondih Healing Camp) to community-based services.

Some interviewees speculated that the GNWT has simply put back into the mental health and addictions system what was taken out in the mid- 1990's, and has labeled this "new funding".

Regardless, the current funding of community-based services is a huge step in the right direction, and ongoing investments are needed to further develop and solidify these investments in the mental health and addiction core service for the benefit of people and communities across the NWT.

## Areas for Further Strengthening and Development

Further strengthening and development is warranted in any new system of delivery of programs. The points discussed below do not indicate any lack of effort on the part of DHSS, authorities and community personnel with respect to planning and program design, but are developmental processes that are needed to continue with growth, integration and continuous improvement of core mental health and addiction services in the years to come.

Generally, planning and program design in the core service of mental health and addictions needs ongoing integration with other core services in the NWT, continued financial investments for human resources, some equipment and materials specific to Community Counselling, expertise/capacity in planning/health promotion/prevention and in mental health and addictions program management, and communication and evaluation structures to support the core service.

Specifically, there are changes that are needed to the overall approach taken to the design and planning of the core service of mental health and addiction services. A major shift in perspective and approach to the design of the new core service is needed that emphasizes a working together of individuals, families and communities, as well as government systems.

- Further Work to Integrate Mental Health and Addictions

Much work has been done in the core service of mental health and addictions and now it is the time to strengthen what has been built.

This includes all levels of the core service, including the DHSS, the Authorities, communities and NGO's in making adjustments where needed, building stronger links within the PCCT, and with other mental health and addiction services across the NWT.

- Continued Financial Investments

Communities and authorities remain concerned that new investments into the core service of mental health and addictions are unstable and not clearly established.

Given that one of the major health and social problems in the NWT is directly or indirectly related to addictions, mental health problems or family violence, in addition to their negative influence on education, training, employment and justice, it is warranted to continue with current investments in the core service.

In addition, further investments are needed for improvements to the mental health and addictions core service, in terms of dealing with more complex issues involving poly-drug use and improving expertise and skill with planning and management systems of the core service. Furthermore, investments will be needed in the targeting of child/youth problems that require greater expertise, assessment processes and "outpatient" therapeutic services provided at the regional and community level.

- Equipment/materials for Community Counselling Program

Financial resources were allocated for new positions within the Community Counselling Program. However, equipment, furniture, materials and other essentials needed to do prevention, counselling or other tasks were minimized, and/or not allocated. Management and Authorities are aware of the urgent needs in this area, so as to maintain safe and effective worksites for these new positions.

Further needs in this area may come about following the development of assessment services, evaluation and performance indicators work. Funding resources will be needed for computer systems, purchasing of standardized tools and instruments, and other psychological assessment materials, especially so for children and youth, and those with chronic mental health problems.

- Communication and Evaluation

As the core service of mental health and addictions services was being developed and implemented in 2003-04, information exchange among key groups, and to the public was inconsistent, fragmented, and poorly done. Different Authorities and communities received different information as to the facts about the new program, investments and plans for transition and integration.

Evaluation and monitoring systems are also needed in all stages of planning and implementation of new program efforts. The best time for this planning work is during the earliest stages, and with persons/groups skilled in performance measurement, quality assurance systems and counselling statistics management.

- Build on Strengths to Re-build the System

A paradigm shift is necessary to be inclusive of efforts, and processes undertaken to date to address addictions and mental health problems by communities, NGO's and Aboriginal organizations, many of which are part of the new core service.

The "We design it, and you deliver it..." approach is counterproductive to community-based development processes, self-determination and doing for people what they can do for themselves. The nature of addictions and mental health problems requires responsibility and the desire to change, which needs to be reflected in program planning, design and delivery.

In addition, communities need to be part of the process of planning of mental health and addiction services, even if, this takes longer, and is more costly. The end product of consistent, continued and ongoing input from this grassroots perspective is a stronger result for sustainable, accepted and respected systems of mental health and addictions program delivery.

## **Recommendations:**

"Stay the course..." Continue to work together with communities, Authorities, and the Government of the Northwest Territories, Department of Health and Social Services, to secure the foundation that has been built.

Develop a consistent, working group of representation from across the NWT, different disciplines, community level personnel, NGO's, Authority and DHSS, and hospital staff to advise, direct and provide the content for the DHSS to proceed. Provide sufficient resources for this expert working group to meet, plan, develop and evaluate the developing core service of mental health and addiction services in the next two to three years.

Maintain funding investments in mental health and addictions in the years to come, to secure the foundation that has been built. Emphasis needs to be on human resources, developing expertise and community counselling programs.

A communications strategy is needed for the mental health and addictions core service in the NWT to explain, discuss, get feedback and include ongoing consultation with all stakeholders; community workers, leaders, clients, regional/Authority workers, NGO's, hospitals, treatment centres and the DHSS.

Maintain and strengthen mental health and addiction services as a core service within the NWT ISDM. Provide direction, management support, expertise and financial resources to this core service throughout the NWT.

Develop systems of continuous monitoring, quality assurance and performance measurement for all mental health and addiction services across the NWT. Tailor timelines and approaches to services, based on their stage of implementation and development.

The DHSS, Authorities, and communities in the NWT need to address the issue of equipment and capital needs, community by community. An emphasis on flexibility and adaptability by each Authority, and within each community is necessary for the efficient use of equipment, and available resources.

Address funding for operational costs, evaluation/monitoring tools (standardized instruments), office/reception support, furniture and computer equipment, where needed.

## **B. System delivery, administration and management**

**Question:** How have we progressed in the transition, implementation, and delivery?

This second section reviews the core service of mental health and addiction services in terms of transition, delivery of service, program administration and management. The following analysis discusses the areas of success in overall program delivery, implementation of new prevention positions, otherwise known as Community Wellness Workers, and the development of a continuum of mental health and addiction services that is an ongoing process across the NWT.

### **Areas of Success/Strength**

- New Positions in Core Service

The Community Counselling Program, which forms the stability and central focus of the core service of mental health and addictions services across the NWT, has a complement of three newly developed positions, with minimum education and training standards, competencies and requirements for practicum/clinical hours as part of their training.

Although, minimum qualifications for these positions were developed, Authorities and communities could hire above these qualifications.

There is excellent confidence in this complement of positions that includes a community wellness worker, mental health/addictions counsellor and a clinical supervisor.

Over 90% of those interviewed for this review agreed with the new qualifications in general, in that the core service of mental health and addictions requires a certain degree and level of education and training. 25% of those interviewed believed the qualifications remain too low (mostly for the mental health/addictions counsellor),

but they understand the difficulties in recruiting and training these clinical workers in the NWT.

Those who disagreed with the qualifications of workers were unfamiliar with Canadian standards for these workers, and/or were concerned with recruitment issues.

- Quality of Community Counselling Programs

With investments in human resources for community counselling programs across the NWT, the quality of these services has begun to be realized. Clinical supervision has provided communities with a non-administrative focus and emphasis on clinical practice. Mental Health and Addiction Counselors are forming new alliances and working in teams in some communities. Community Wellness Workers are beginning their focus on education and prevention.

These investments in human resources were a necessary first step to improve the quality of counselling programs and mental health and addiction services in communities across the NWT.

Work is ongoing throughout the NWT to tailor programs to communities' needs, work on priority areas, for example smoking cessation for youth, and responding to emerging needs such as suicide prevention and intervention.

In addition, some Authorities are using quality improvement measures to help monitor and improve their services within their communities.

- Focus on Prevention and Early Intervention

Most of the research on addictions and mental health emphasizes, without a doubt, the importance of prevention and early intervention efforts in any program, system or approach to dealing with addictions and mental health.

The Community Wellness Worker position, a new position in the core service of mental health and addictions services, is primarily a prevention and education position that is positioned in many communities across the NWT.

Over 50% of the new positions created in the new system are Community Wellness Workers, who work in community settings to educate, prevent, provide early intervention and screening, and in

some communities work as part of crisis/trauma groups to provide suicide intervention and other supports.

These positions are positioned to provide service from a prevention focus, and to work with the PCCT to empower individuals, families and communities to address addictions, mental health and family violence issues from a community perspective.

As part of the commitment to improve the quality of programs in NWT communities, Community Wellness Workers were prioritized for transition education and training, supported by the DHSS financially, for direct appointments and priority for community allocations.

- Continuum of Mental Health and Addiction Services

The implementation of mental health and addiction services has set a mark that states: "This core service is here to stay."

With a territory wide implementation of new positions, program standards and emphasis on an ISDM of care, the continuum of mental health and addiction services has been solidified. As a result, new areas of need and priority are coming forth (child and youth, responding to industry, planning for the impacts of the Mackenzie Gas Project and others), which further highlights the importance of this core service.

- Transition and New Program Implementation

A major challenge for any new delivery of service is transitioning from a previous system to a new one. Overall, the new program was "rolled-out" by the DHSS, and the Authorities in each region.

After three years of implementation, only a few transition problems remain from the previous system, and for the most part Authorities and communities embraced the new program, at least in the short term. Some Authorities took an active role in transition planning, and communicating with Aboriginal groups.

It is expected that some problems will arise with the transitioning of previous personnel to newly developed positions, and for the most part the few problems noted, were due to poor communication, and a lack of understanding of the history of mental health services in specific communities. Also, expertise at all levels was lacking in dealing with isolated transition problems for workers, who "did not fit" the new requirements.

It needs to be recognized that a few transition problems, do not amount to poor implementation, a problem with design and/or a need to lower position credentials and minimum training.

### **Areas for Further Strengthening and Development**

Further strengthening and development is warranted in program implementation, administrative and management of the core service. It is timely to address these issues at this point in the implementation of this new program. Firstly, it is now apparent that management and administrative issues are present in the new system of delivery, and secondly, these factors, if not addressed, could impact further development in the core service.

- Pay Scales

There has been an investment of financial resources for the Community Counselling Program in the last three fiscal years by the Government of the Northwest Territories. Improved salaries have been realized for Community Wellness Workers, who are in line with comparable jobs across the NWT.

However, pay scales for Community Mental Health/Addiction Counsellors and Clinical Supervisors are below comparable jobs such as teachers, social workers and nurse-managers respectively.

Procedures were followed to develop the job descriptions in line with industry standards for these two clinical positions. Nevertheless, the GNWT uses a human resource system of job description review that does not recognize the complexity, levels of training, degree of supervisory tasks of these new positions.

The use of the Hay Plan has been identified as being "ill-friendly" to health and social service positions, including nursing, social work and psychology. Furthermore, the processes of job description review does not seek out expertise in the Human Services fields of clinical psychology, counselling or other related fields in order to conduct its review, and relies on their own internal inherent knowledge and possible bias of what mental health and addictions personnel do.

In fact, much bias was heard with respect to how job descriptions are reviewed - "people do not need a degree or that pay...to talk with people who have addictions."

Much work is needed within management and administrative systems to educate, facilitate and address personal bias towards the work of mental health and addictions core services.

As well, a thorough study of comparable pay scales for these positions is needed, "South of 60", to bring NWT pay scales for the community mental health/addictions counsellor and clinical supervisor in line with appropriate pay levels.

Appropriate pay for positions within the new Community Counselling Program will potentially assist with recruitment and retention, but is also an issue of risk management in securing appropriate personnel to do the work that is needed, and within safe and ethical parameters.

- Program Management of the Core Service

Overall program management and administration is ideally shared among all stakeholders in the core service of mental health and addictions in the NWT. Questions remain across the NWT about who does what, who makes decisions, who has the final say, and who is responsible for program design and delivery.

These questions were heard throughout this review at all levels of the core service, including the DHSS, Authorities, NGO's and communities. Furthermore, in some instances great lengths were taken to direct responsibility outside to regional Authorities and community partners, and vice versa back towards the DHSS.

This form of bilateral "finger pointing" is counter-productive to program design, delivery, implementation and evaluation, as it only serves to be "be part of the problem". It is also problematic for the process of change, contributes to power imbalances and takes too much effort and time away from productive and solution focused efforts to address internal and external management problems.

Relationships between Authorities, the DHSS, NGO's and communities are relatively new with respect to collaborative and mutually respectful practice. Also, to note, mental health and addiction employees have only just recently moved to community-based service lines of reporting, that is inclusive of being "Authority Employees."

The de-centralizing of Government expertise, systems and program implementation to regional Authorities is also relatively new, and

further refinements are needed to fully realize these complex systems of accountability, responsibility and guidelines for who does what, when, where and how.

What is needed is true collaboration, management/administrative maturity and a philosophy of "be a part of the solution, and not part of the problem."

Management experience, leadership and expertise, organizational analysis and a review of historical linkages and development of mental health and addiction services within communities in the last 10 years, is critical in addressing this "passive-resistance" within administrative avenues that are part of the core service of mental health and addiction services in 2005.

As well, key positions within the organizational structure of program planning, delivery and accountability (the Department of Health and Social Services and at Authorities) of the core service of mental health and addictions, require immediate strengthening, leadership and clinical and expertise to lead a focused, and respectful approach to addressing the current problems in core service administration, management and accountability.

This problem of core service management, and administration is the most pressing and critical component facing the GNWT in its efforts to re-build mental health and addictions services. Without proper, timely and skilled action in this area, this problem alone will quickly become the weakest link in the new system of program implementation of mental health and addiction services.

### Ongoing Transition Issues

Transition issues remain in the implementation of new positions in Community Counselling Programs. These transition issues are just that, and are largely isolated to a few instances, where previous employees, either through contribution agreements or otherwise, do not neatly fit into the new job descriptions.

Human resources expertise, improved communication and awareness of resistance to change and understanding of the history of developing mental health and addiction services (or wellness approaches as referred to in some communities) is needed to more effectively deal with these isolated cases of transition problems. Inflexible approaches proved to be damaging to NGO and Authorities/DHSS working relationships, but these issues are on their way towards resolutions.

Ongoing transition issues remain, as several skilled employees, who were doing the work in a previous system of program delivery, need to be recognized in the new system.

Issues of "grand-fathering" are very well established in most health care and social service fields, where new systems are brought in, and previous employees are affected. Being demoted, sidelined or "re-structured" are all approaches that alienate and isolate dedicated persons that have worked effectively in positions for many years. Again, management and administrative expertise were lacking in planning for these transition issues, which needed to build in flexibility, the use of equivalencies and overall respect of established systems of program delivery.

Transition issues require ongoing efforts to address new reporting relationships for employees now under the Authorities, new supervisory relationships with clinical supervisors, and other areas of the core service of mental health and addictions.

Furthermore, transition planning is needed to integrate the Community Counselling Program within the PCCT, an area that is already demonstrating resistance to change, due largely to established methods of practice in nursing and social work circles.

- Role of Residential Treatment

As the new core service of mental health and addictions is realized in communities across the NWT, questions were heard regarding the place, type of services offered at residential treatment and ongoing developments to be responsive to poly-drug use, abuse and complex addiction problems.

The single territorial treatment program, Nats' éjée K'éh in Hay River, is positioned to provide entry-level residential treatment to adults of the NWT. Further program developments have occurred in recent months to address drug usage/abuse. Also, improvements have been noted in the credentials and skills of workers with new investments in human resources.

However, there is much discussion across the NWT about the approach, scope of services provided and expertise at the treatment centre, that which could not meet all the needs of clients seeking and needing residential treatment in the NWT.

Further leadership and expertise is needed within the administrative and management structure responsible for the single Treatment Centre in the NWT to better outline its client focus, strengths and areas of service that can be provided safely.

Also, the history of Nat's éjée K'éh, being focused on Aboriginal and spiritual practices remains, and is not consistent with many groups or communities across the NWT. Broad communication, improved assessment procedures, including the use of standardized instruments, and improvements to community liaison, after-care and core service linkage are expected, and will come in time with appropriate leadership and resources.

In the 1990's there was a choice of treatment centres for addictions in the NWT, which provided a continuum of services, tailoring of needs, and also skill level of treatment centre staff and management.

Learning from those treatment centres (NAS, Delta House and TI'oondih Family Healing Program) may provide viable solutions to what the "people are asking for", and may be feasible within a one centre approach, given program flexibility, use of contracted staff and much improved assessment procedures that are clinically based, and less "crisis-driven."

At this time, it is ill-advised to construct, consider or plan for additional structures for NWT Treatment Centres, given the history of only just recently closing three facilities and the advent of a larger focus on Community Counselling Programs.

***A supplemental report will further address this issue of the usage, place and future of residential treatment for mental health and addictions, both in and Out-Of-Territory (OOT).***

- Need for Consistent Working Group, Communication and Evaluation systems

As stated in the previous section on mental health and addictions core service planning, improvements are needed in the areas of communication systems of how, when, and where system delivery is occurring. Also, ongoing evaluation and monitoring systems are needed to track changes, rates of implementation, transition problems and change management.

Finally, a consistent working group of broad representation is needed to guide, facilitate and be dedicated to monitoring the

delivery of the new and re-built system of mental health and addiction services in the NWT.

## **Recommendations:**

Continue to work, with each community, and with each Authority, to realize quality programming, while ensuring there is flexibility, and transition planning over time. Avoid inflexibility and rigid planning that serves to alienate communities, disregard community ownership and histories, which further distracts from the process of improving mental health and addictions services.

Reinforce the importance of minimum standards for all staff working with the core service of mental health and addiction services throughout the NWT, in communities, Authorities and within the DHSS that is consistent with what is needed in the core service.

Training of DHSS leadership, senior management and newcomers to the Department is needed regarding the history of addictions and mental health in the NWT, the implementation of minimum standards in community counselling positions, and industry standards of training and education across Canada.

Keep working on the scope of prevention services and application of learning for the Community Wellness Workers across the NWT. Reinforce a broader scope of services for these workers, especially in terms of crisis intervention in small and remote communities, where there are limited resource persons, and where they have already been providing these services such as suicide prevention.

Support clinical supervisors and regional program managers to meet the new standards, provide quality and evidence-based services and to raise the bar of their own expertise and training to meet the emerging needs in addictions and mental health in the NWT.

Work to integrate residential treatment services, both in the NWT and out-of-territory services into the scope and continuum of mental health and addiction services. Work to improve knowledge of residential treatment services, their part in addiction treatment planning, assessment procedures, and client matching for residential treatment.

Transition issues remain, and need to be addressed appropriately, in a timely manner, and in consideration of community histories, context and stage of development of core mental health and addiction services.

Review job descriptions and pay scales for Mental Health and Addiction counsellors, and Clinical Supervisors positions for pay equity across the NWT, in

comparison with other health/educational professions (teachers, social workers, psychologists, nurses...) and in consideration of Canadian equivalencies.

Address funding for operational costs, evaluation/monitoring tools (standardized instruments), office/reception support, furniture and computer equipment, where needed.

### **C. System Capacity, Expertise, Application of Knowledge, skill and experience?**

**Question:** What is the capacity, expertise, application of knowledge, skill and experience of the entire workforce in the core service of addictions, mental health and family violence?

This third section reviews the core service of mental health and addiction services in terms of capacity, expertise, application of knowledge, skill and experience throughout the entire system in the NWT.

The following analysis discusses the areas of success in capacity development at the community, regional and territorial levels as well as areas for further development of expertise in all areas of the core service of mental health, addictions and family violence services.

#### **Areas of Success/Strength**

- Capacity at the Community Level

There is history in NWT communities in developing community-based approaches to deal with addictions, trauma, family violence, suicide and other challenging social and mental health issues. Many of the current approaches to dealing with these chronic, relapsing and devastating issues come from the work of many hard working people from the last 50 years.

Communities are at various stages of development in their grassroots approaches to dealing with the many social ills. People and groups at the community level realize there are no quick fix solutions, no miracle programs and few complete answers in dealing with the magnitude, and complexity of addiction and mental health problems, especially so in the NWT.

What was apparent during this review for this report in 2005 was the encouragement and renewed hope in addressing mental health and addiction problems in communities across the NWT. This was also evident in a trend of increasing capacity from within

communities, large and small, to attention to human resources, increased funding for positions, and the highlighting of the Community Counselling Program within the core service of mental health and addictions.

The workforce in communities, albeit still transitioning, is hopeful, looking for further direction and re-directing efforts to integrate with community efforts to address addictions, mental health and less so with awareness of family violence.

This is very good news, and with ongoing supports, financial investments and increased capacity, true community-based programming can become a reality within the core service of mental health and addictions.

- Capacity at the Regional, NGO and Authority Level

Authorities are also at different stages of development in terms of the implementation of the Community Counselling Program, and other related services such as withdrawal management, residential treatment and programs for children and youth. Prior to the release of the "State of Emergency..." (2002), three authorities were well on their way to integration of mental health and addiction services within the Authority Structure. Other Authorities have inherent challenges in serving diverse Aboriginal groups, large geographical distances and are affected by the Mackenzie Gas Project work.

Therefore, it is safe to say that Authorities are progressing within their own developmental timelines, given where they were at, and in consideration of their unique needs and populations. Furthermore, it is evident that Authorities are embracing the new Community Counselling Program, and are proceeding to further enhance, refine and develop systems that meet their unique populations. For example, the Yellowknife Health and Social Services Authority and Stanton Territorial Health Authority are engaging in an internal review process to improve efficiency, and systems delivery within the mental health and addictions core service. This work was originally proposed and addressed by Dr. Hylton in his **1998 review of "Mental Health Services in Yellowknife: A long Term Plan for Mental Health Services."**

NGO's and regional Aboriginal groups are also engaging in their own internal processes of review, monitoring and program development, perhaps in response to new investments in mental health and addiction services, and the apparent stability in that these "investments are here to stay".

- Capacity at the Territorial Level

Various capacities are evident at the Territorial level, namely in the extensive work being done on the Primary Community Care Team (PCCT) and the Integrated Service Delivery Model (ISDM). Long term visions, plans and human resource planning is underway to effect change throughout the NWT, through the expanded potential role of Nurse Practitioners, increased reliance on community-based counselling services, and integration of a number of health care professionals at the community and regional level. Much of this work is ongoing, but this increased capacity will benefit the delivery of mental health and addiction services.

As well, the workload of the DHSS core mental health and addictions personnel in working with committees, other agencies, other GNWT departments, and working groups (child and youth), reveals the expanded roles of this personnel in mental health and addiction services.

A territorial wide professional development conference on mental health and addictions is planned for January/2006, which will be a first of its kind in the NWT in recent years.

In addition, Yellowknife will be hosting the Canadian Association for Suicide Prevention (CASP) in 2007, bringing experts from across the country to present and network in an NWT setting, where suicide remains a critical issue. These are small, yet significant directions of increasing capacity within the NWT to attract and host such professional conferences.

### **Areas for Further Strengthening and Development**

Further strengthening and development is needed to continue with capacity building at all levels of program delivery and implementation with the mental health and addictions core service.

Ongoing efforts to empower local communities to use grassroots approaches is widely believed in the research literature on community development to be the most effective, cost-efficient manner of improving health and well-being of individuals and families (Hylton, 1998).

Of critical importance is the strengthening of clinical and program development expertise in mental health, addictions and family violence in program planning, policy, administration and management positions throughout the NWT.

- Family Violence Focus

Family violence issues are far too common in NWT communities. They speak to a number of problems involving the abuse of alcohol and drugs, and directly and indirectly cause inter-generational mental health and addictions problems for children and youth exposed to family violence.

Previous community wellness initiatives, prevention programs and efforts to address the widespread problem of family violence have been visible.

It is unclear in the approaches and efforts to implement Community Counselling Programs, whether family violence is included in the list of issues to address.

Ongoing core service planning, implementation, communication and capacity building need to be inclusive of family violence issues, problems, challenges and program needs.

- Continue to Develop Capacity in Community Settings (Best use of money and reaches whole NWT)

Human resource planning is an ongoing process in the NWT, and is a complex issue, given the number of professions, employers and jobs that are all competing for the same "trained in the NWT" worker. As well, workers entering human services fields, such as social work, counselling, teaching, nursing, are a small pool of workers in the NWT, and generally across Canada as well.

People who enter human services fields are often attracted to these positions to help others, and less so for financial compensation. However, the workload, stress and level of education//training and degree of safety deters many from entering these fields, that are of increasing complexity and personal risk.

Nevertheless, ongoing efforts to empower community-based workers by improving pay scales, providing education/training opportunities, ensuring safety and good working conditions, and providing recognition of their work, is needed in the years to come.

A broad, human resources strategy is needed for mental health, addictions and family violence positions throughout the NWT. This human resource strategy needs to recognize the limited pool of workers in the NWT, and realize that out-of-territory recruitment will

be an ongoing necessity, much like nursing, social work and education, at least for the present time.

- Incorporation of Program Standards, Forms, Monitoring Systems

It is recognized that different Authorities and Community Counselling Programs, are at different places in their developmental timelines for implementation. Some regions are further developed in some areas, while others are dealing with greater numbers of NGO's that offer their own scope of services, policies, and systems of program monitoring.

Furthermore, some sites are ready to incorporate standardized tools and assessment protocols, together with statistical reporting of related findings and program usage.

Encouraging and respecting the natural progression of Community Counselling Programs along their own stage of implementation, while assisting others to reach minimum target levels of service delivery is needed. Also, it would be helpful for Authorities and Community Counselling Programs to network with each other, so as to learn from others experience, share expertise and tailor program, assessment, tools and monitoring systems to their respective communities. A strong clinical supervisors group and resources for them to network is essential here.

- Expertise and Capacity at Territorial Level

This overall guidance and check on the system (like clinical supervision) is currently fragmented, spread-out over many authorities and not devoted full time to program planning, implementation, policy development, evaluation and research.

Good, hard working and well-meaning people are doing the work of many at the territorial level, without the required leadership, teamwork, expert guidance, and timeframes to gather that expertise from throughout the NWT or outside of the NWT.

- Expertise, Study and Consultation

Children and youth were a consistent topic across all interviews, regions, communities and many NGO's. Some Community Counselling Programs are already providing services to children and youth, where others are in the process of developing community-based assessment type and prevention efforts for youth. As well, efforts at the Territorial level have begun to study

the issue through historical lenses of what services are out in the NWT, what programs are already addressing prevention programming for children and youth, and what are growing needs in dealing with complex mental health and addiction problems in young people in the NWT.

One point is clear, and that is that community-based solutions, within a family focus are much preferred to residential type, out-of-territory mental health solutions.

Firstly, the history of taking away "aboriginal children/youth", for mental health treatment, is grossly similar to the experiences from residential schools. History should not repeat itself!

Secondly, children and youth problems, whether mental health, addictions or as a result of family violence, are rarely separated from issues of family, community and culture.

However, some children/youth, will require residential type mental health programming, which is usually needed to provide safety, a structured environment, or where medical needs are beyond what can be provided in a home, community or regional setting. These numbers are few in the NWT, and should not "colour the picture" of what is needed for children and youth across the NWT.

Therefore, at this stage of the implementation of the Community Counselling Program, it is advised by this evaluation team (Dr. J. Chalmers, Dr. C. Bradbury, Liz Cayen and Sharon Snowshoe), in consultation with interviewees across the NWT, ***that no new structures be built at this time for child and youth treatment.***

Furthermore, what is needed is a broad study of the relevant issues with child and youth, a review of past efforts throughout the NWT, and most importantly, ongoing and continuous dialogue with all Aboriginal groups and relevant stakeholders, including Education, schools, early childhood programs, prenatal/postnatal (CPNP) type programs, FASD efforts, Justice and Corrections, and others.

***A supplemental report will address further, the relevant issues with Child and Youth Mental Health and Addiction Services.***

## **Recommendations:**

Work with Aurora College to create a transferable, two year Diploma Program that can meet the needs of Community Wellness Workers, Mental Health Counsellors and possibly other human service workers in the NWT such as Justice, Social Work, and Early Childhood Services.

Continue to work on maintaining and improving the standards for the skills, education and training needed by all NWT positions that work with mental health and addictions, including staff at community level, Authority level, DHSS, NGO and medical/nursing staff.

Continue to educate/facilitate all mental health and addictions core service workers of the program standards, their use, purpose and place in the Community Counselling Program.

Continue to work on developing standards for what skills, knowledge and competencies are needed for all PCCT members to have, including nurses, physicians, and all those working in health and social services delivery across the NWT.

Planning, study and much consultation are required to proceed with specialty services for children and youth. It is recommended that children/youth services be enhanced within the context of families and communities in the NWT, and therefore integrated with core mental health and addiction services in the immediate future and over the next three to five years.

Partnerships need to be formed with schools, Boards of Education, and the Departments of Education, Culture and Employment and Justice to further mental health and addiction services, especially with respect to prevention and early intervention with children and youth.

Human resource planning is needed to encourage young people in the NWT to work in the mental health, addictions and family violence core services. Work with Education, Culture and Employment to encourage a Northern Workforce in these human services, and consider the implications of competition for Northern workers in the various human services fields.

## D. Gaps, Barriers and Challenges

**Question:** What are the current gaps with mental health and addiction services in the NWT?

What are some of the challenges that have impeded success or progress in any of the phases of implementation and planning?

This fourth section reviews the core service of mental health and addiction services in terms of gaps in services and challenges that are present, and may or may not impact planning, implementation and ongoing development of mental health, addictions and family violence services.

Gaps in this analysis are those which were discussed in interviews across the NWT, and where a mismatch is evident between client needs and services.

Challenges in this analysis are external, internal and NWT wide, and are limited here to those discussed in review interviews. There are many challenges to the design, delivery and monitoring of mental health and addiction services, and a full discussion of them is beyond the purpose of this section. The reader is encouraged to review the **Supplementary report: The Review of "State of Emergency..." (2002) Recommendations for further discussion of gaps, challenges and barriers.**

### Gaps

- Medical/Nursing Advisory Group

Nursing and medical employees are consistent health care providers across the NWT, and are part of the PCCT. As such, their role in mental health and addictions screening, assessment, care planning and ongoing follow-up of medical consequences, in addition to crisis management, is critical to effective management from a team perspective.

As such, beyond informal consulting with physicians that work in psychiatry at Stanton, and others where possible (for example, two interviews were scheduled with other medical staff, and were cancelled), this group of key PCCT members are absent from design, planning and implementation work within the mental health and addictions core service.

Furthermore, the NWT relies heavily on locum type physicians to cover medical services, and contracted nurses to fill Health Centre staffing, which contributes to an inconsistent pool of medical staff

that may or may not be familiar with mental health and addiction services in communities, regions and at the Territorial Level.

Therefore, it is paramount to have some form of medical/nursing advisory to contribute to mental health and addictions core service delivery. Other provincial jurisdictions have medical advisory groups for a number of health issues such as HIV management, addictions and infection control.

- Withdrawal Management (Social and Medical)

Currently, there are several places for clients to receive withdrawal management support from substances and/or alcohol. There is more concentration of these withdrawal management services in Yellowknife, through the Salvation Army program (formal), and services through Stanton (informal provided case by case). In addition, protocols have been developed in Hay River, that are inclusive counselling support.

Efforts were proposed to develop a new, Withdrawal Management Services (WMS) program at Stanton that would be formal in nature, with hospital beds, and a core group of WMS staff. This proposed WMS service was halted for a number of reasons, mainly due to communication and lack of consultation with key medical/nursing resources, as well as, some potential bias towards the provision of these services at Stanton ("not in my hospital").

Problems remain across the NWT in accessing consistent WMS (either social or medical). Further study, consultation with all stakeholders and expertise is needed to address WMS within the Integrated Service Delivery Model. It may be that WMS is better managed in diagnostic and curative services, which has a medical model approach, and would fall under nursing and medical responsibilities. Other options are possible, with further study of this aspect of care for people with addictions.

***A supplementary report addresses Withdrawal Management Services in greater detail.***

- Supportive living and attention to the needs of chronic mental health/addictions

The number of clients in the Health and Social Services system that require supportive living, income support and psychiatric support services are unknown, but can be estimated based on those already in the system. Within the new Community Counselling

Program, addressing the needs of people with chronic addictions and mental health disorders (such as schizophrenia, Fetal Alcohol Spectrum Disorder, bipolar and others) from a community perspective is rather limited, with the exception of those clients living in larger centres.

Programs such as New Horizons, the Salvation Army and others provide bridge services for these clients, who are attempting to live on their own, or in supportive living environments.

However, given the scope and numbers of clients seeking out Community Mental health and addiction services, it is highly possible that these chronic, dependent clients may fall through the cracks. Systems are needed to target these clients in remote and isolated communities, and to where possible to provide community-based supports in areas of housing, employment opportunities and social/recreational. This gap in service even exists in Yellowknife, where there are more resources for those clients needing psychiatric supports.

Addressing the ongoing needs of this small group of NWT residents is important, and potentially more cost-effective, if dealt with sooner, rather than later.

- Consumer and Family Initiatives

There are gaps in consumer/survivor initiatives across the NWT, with greater availability in Yellowknife, Hay River and Fort Smith. These self-help and support programs can provide a necessary support system for some people, and are generally cost-effective and requiring minimal space and materials. Often, an initial start-up is needed by employed staff, to establish support group formats, provide the meeting space and so on. These groups work on an ad-hoc basis, and could fall into the realm of prevention, early intervention and after-care.

Further work with the Community Wellness Workers to assist in these support networks is needed. It is recognized that not all support programs are possible in NWT communities, but that each community needs to tailor these groups to their culture, history and mental health/addiction needs.

- Centralized Assessment and Treatment Planning

Several interviewees recognized a gap in clinical assessment and treatment planning (here treatment planning is referred to planning over the short or long term to address mental health/addiction symptoms, address behaviour/motivation, suggest further investigations such as medical work-ups, and ongoing follow-up).

The research points to a lack of expert clinical assessment in the reasons why clients fail to get better, fail to complete recommended treatment options, fail to take medication, and generally cycle back into substance abuse/dependence or other mental health problems/crises.

Dr. Hylton (1998) discussed at length the need for a range of specialized resources and clinicians to develop comprehensive assessments and service plans for complex cases. In 2005, these assessment services are in greater demand, due in part to the increasing complexity of addictions, mental health and other health related problems of clients.

Several NGO's have already begun work to realize improved and formal assessments, that would form "a consistent road-map" for clients and agencies to follow in assisting them along their way to improved mental health and less problems from addictions and other unhealthy behaviours.

- Housing and Emergency Shelter

Much of the discussion regarding housing and emergency shelter is beyond the scope of this interim report. However, housing and emergency shelter needs are a significant gap in services available for those clients dealing with mental health, addiction and family violence issues. Safe housing, transition housing and emergency shelter for many different groups of clients, including youth, chronic mentally ill, and clients withdrawing from substances, are mentioned as gaps in service throughout the NWT.

- NWT Evaluation and Research on Mental Health and Addictions

The landscape, communities, peoples, resources and available human resources for health, social services, education and other employment are unique to the NWT. Program evaluation and relevant research on mental health, addictions and family violence are often transplanted from across North America.

Applicability of these "best practices" to a northern environment is less than ideal.

Program evaluation, performance measurement and scholarly and traditional research are very limited in the NWT, and generally are not funded within existing services. Although much research and exploration is occurring with ecological systems of plants, wildlife and land based resources, there is minimal active research with the human side of life in mental health and addictions.

Other provincial jurisdictions engage in evaluative and scholarly research initiatives to better guide service delivery. Also, national health directives are now routinely reporting on general indicators of health, such as cancer rates, low-birth weight babies, healthy weights and other indicators of health. In terms of mental health and addictions, these national and NWT indicators are reported in terms of suicide rates, depression, and unintentional deaths. This data is useful, but insufficient to truly guide the core service of mental health and addictions in the years to come.

Program effectiveness, outcome measurement (interim and long-term) evaluative processes are needed, to account to the public, monitor trends and adjust program systems as needed.

## **Challenges**

- Crisis Management

Many NWT communities have developed their own community-based crisis management approach in dealing with trauma, suicide intervention/completion, and other emergent type of problems. For example, in recent years, communities have come together to address the complete burning of the community school, a plane crash and the tragic deaths of young people due to suicide.

In fact, many communities would argue that they are pretty good at crisis management, but lack supports to follow-up after the first 12 to 24 hours has passed, due to limited numbers of volunteers, and employed human service workers.

In larger centres, crisis management is more challenging, as families and organizations are less accustomed to working together, there is more frequent turnover of staff, and there is also reliance on more modern type emergency services, such as RCMP, Fire and the Emergency Room at Stanton.

There is a perception in Yellowknife that a territorial wide crisis intervention program is needed. However, there was **no evidence** for this during this review, with the exception of Yellowknife. This is clearly a gap in communication, consultation and knowledge of what outlying communities are already providing. What is preferred for remote and isolated communities is resource enhancements to provide better support to clients, and staff members, during and following a crisis situation.

In fact, suicide prevention programming aims to enlist many community volunteers, workers and others to step up to the task, and make crisis intervention a community-based response, which is better received in the long run.

Also, Aboriginal communities have for many years advised against a "fly-in" response to crisis, where they are left waiting for resources to arrive, prior to addressing a crisis in their own community. Many Aboriginal communities have moved beyond a "fly-in" crisis management approach, and are now positioned to ask for what they need, following a crisis in the community.

- Dealing with Isolated Problems

A challenge for management and leadership, particularly in the DHSS and at the Authority level is to address isolated core service problems in a timely, and skilled manner.

Furthermore, isolated problems in a new program of delivery of mental health and addictions are to be expected. The challenge is to avoid the generalizing of an isolated or community specific problem, to the entire core service. Unfortunately, this may have already occurred with respect to vacancies and work with NGO's, and ongoing efforts to put these transition issues into the proper perspective.

- Dealing with Staff Turnover and Vacancies

Staff turnover is a reality in any work environment, and especially so in the NWT. Some reports document the average stay of employees in NWT human service positions as 1.8 years (ISDM, 2004). Vacancies are often a result of staff turnover, lateral moves within human services in the GNWT and "burnout".

Staff vacancies and turnover are also problematic in management positions within the DHSS and authorities. Consistency is lost

during times of management turnover, and knowledge of the historical work and services delivered in the last 10 to 20 years is also lost. This lack of historical basis can result in misinformation regarding the role of NGO's in delivering mental health and addiction services, limited knowledge of the capacity of communities, and a learning curve to understand the core service of mental health, addictions and family violence services.

- Working in a Changing Environment

There is rarely an environment that remains the same, for any length of time. This is especially so in the NWT, which has various levels of government, including Aboriginal and community governments, changing environment and increasing economic and geo-political developments throughout the NWT.

A challenge for the core service, including the mainstay, the Community Counselling Program, is to remain current in its application of new knowledge regarding mental health and addictions, be responsive to changing demographics and the complexity of problems facing people in NWT communities.

## **Recommendations:**

Further study and consultation is needed with respect to Withdrawal Management Services (WMS), and with all groups of health care providers and community workers in the NWT, to reflect community needs, best practices and availability of resources within local, regional and territorial health and social services facilities.

Consider developing an addiction medicine advisory group/committee with possible assistance from out-of-territory specialists in addiction medicine, who can contribute to the distinct medical processes involved in mental health and addiction services. This group would be a critical part of any Withdrawal Management System that involved hospital services.

Consider the development of a mobile assessment service that could serve small and isolated areas, either through tele-health, regional locations or through a mobile structure. This may be a service targeting children, youth and families.

Develop multi-disciplinary assessment processes that are inclusive of child and youth priorities, and within a family and community context.

Accountability activities such as continuous monitoring, quality assurance and effectiveness monitoring need to be incorporated throughout the core service of mental health and addiction services.

Establish NWT research projects in the areas of program effectiveness, outcome monitoring, and cost effectiveness for mental health and addiction services.

Leadership and expertise are needed to manage, outline, analyze and report on process, outcome and cost-effectiveness measures of the core service of mental health and addictions services.

## **E. Key Stakeholder, Buy-In/Satisfaction**

**Question:** Is the mental health and addictions core service addressing the needs of the community?

This fifth section reviews the level of buy-in, acceptance and satisfaction to date of the core service of mental health and addiction services.

The following analysis discusses the areas of success in the buy-in of the new core service in mental health and addictions, and provides direction for further strengthening, especially in communities where NGO's have provided services for many years, and where they continue to do so in 2005.

Buy-in and program acceptance is a developmental piece in any new program delivery system, and perhaps more so in mental health and addictions, where the impacts of these problems are in the foreground of communities, and where all members of a family unit feel the impact of addiction or mental health problems.

### **Areas of Success/Strength**

- General Acceptance and Buy-in of Core Service in Mental Health and Addictions

As stated in the "State of Emergency..." report of 2002, many communities, agencies and addiction workers were frustrated with the system of addictions and mental health services, which was of poor quality across the NWT, lacking in funding and commitment for ongoing funding, lacking in expertise and overall direction in dealing with addictions in the new century.

There is good acceptance of the new core service, and its financial investments in human resources. This buy-in at this time, is widespread, and was evident in the majority of interviewees seen for this review (approximately 73 informants were used). This

acceptance is strongest within the DHSS and Authorities, and less so in communities and within some Aboriginal organizations.

Financial investments, that is funding, are the best indicator of buy-in, as Authorities have worked consistently to fill re-built positions, and/or staff new positions.

Remaining positions are left to be filled across the NWT, but this in no way reflects lack of buy-in or acceptance, but more so challenges by all human services across the NWT in attracting skilled and qualified employees.

In fact, vacancy rates for mental health and addictions positions are below levels of NWT social work and nursing.

- Rapid implementation of New Core Service Personnel

It is likely that a rapid response to the implementation of new core service positions, direct appointments from existing positions, and the availability of Community Wellness Worker education/training provided for buy-in and acceptance of the new direction in community-based mental health and addiction services.

Whether this was planned or not, a quick response to "roll-out" the new core service had a direct impact in getting people on side very quickly. However, there are also consequences of these quick movements, which have led to less buy-in by some communities and Aboriginal groups. This can now be addressed more fully, respectfully and within the context of groups of individuals that make up the NWT.

### **Areas for Further Strengthening and Development**

- Aboriginal Input, Monitoring, and Involvement in Every Step

Approximately one half of the population in the NWT has an Aboriginal ancestry. In addition, many of the most challenging problems for the mental health and addiction system are related to providing services to Aboriginal communities in the NWT, many of which are isolated from large centres and with small populations.

Reports and studies including territorial and national scope reports such as the Royal Commission on Aboriginal Peoples (1996) and the Romanow Report (2002), highlight the critical importance of collaborative and direct involvement of Aboriginal communities in

designing, delivering, and monitoring ongoing program developments, especially so in mental health and addictions.

Designing programs, and then placing them in Aboriginal Communities has failed more times than not, and is considered to be "unacceptable practice", as firmly stated in recent discussions with National Aboriginal Leaders and Provincial and Territorial First Ministers in Kelowna, BC (2005).

A paradigm shift is needed to fully embrace a community-based core service of mental health and addictions, for all communities in the NWT. This requires some shifting in attitudes, less emphasis on "roll-out" and "fix later" program initiatives, resources set aside for the development of an NWT working group, internal cross-cultural awareness training, exposure and awareness of grassroots community efforts in mental health and addictions to DHSS/ Authority management personnel, and other circular type sharing and consultation.

The shift in paradigm, to be inclusive of Aboriginal perspectives and people, is beyond consultation, and is regarded as being proportional to the acceptance and incorporation of health and education programs.

It is good timing to re-consider how Aboriginal groups, communities, and persons are included in the ongoing design, implementation and monitoring of the new core service of mental health and addictions services. Consulting with Authorities and a few clinicians is not sufficient to guide the next stages of service strengthening, enhancements and ongoing development.

- Traditional and Cultural Practices

A difficult area related to buy-in and program acceptance is the issue of the place of traditional and cultural practices in mental health and addiction services. This is a challenging topic, and below is merely a brief summary of some of the points raised during the evaluation team's interviews across the NWT.

Some communities and regions are attempting to integrate and incorporate traditional and non-medical practices into their community-based counselling programs; for example, one region uses the alternative treatment of Reiki as part of their healing services, where others directly contract to specific "Aboriginal Healers" as part of their scope of family counselling services.

However, despite these highlights, there is much debate and discussion around the incorporation of traditional healing practices or activities. Limitations for inclusion are often cited due to insufficient regulation of the practice, financial limitations, and even overt dismissal of the place of traditional and cultural practices in mental health and addiction services.

From the review of interviews done across the NWT in administrative and management levels, healing and cultural practices are poorly understood within a Westernized and medical model approach to mental health and addictions, and are only viewed as pertinent for Aboriginal persons.

Traditional healing is a complex mix of traditions maintained, re-invented, and traditions borrowed. It is both community-based and global in institutional form. Healers combine knowledge from family, clan and elders, from other tribal/community traditions, and from other cultural sources. It is grounded both in ancient cultural ideas about health and wellness and oriented to responding to contemporary health and social problems (Hylton, 1998).

"People turn to their traditions and culture when they are struggling in life, whether they are Aboriginal or from other cultural groups."

The re-building of mental health, addiction and family violence services must take account of traditional/cultural approaches to wellness; this goes beyond the incorporation of traditional healers, and is inclusive of holistic, integrated, community-based and culturally relevant service planning, delivery and less conventional approaches to prevention and early intervention.

The incorporation of traditional and cultural practices may not involve direct resource or financial investments, but is more so an issue of respect and understanding of the place of traditional and cultural practices when addressing mental health and addiction issues for all residents of the NWT.

For example, many people turn to organized religion during times of stress and addiction, and Twelve Step Programs (AA, NA) focus on a general philosophy of "power greater than oneself" to address destructive behaviour, and issues of spiritual bankruptcy, "turn it over..." and "believe in something outside of yourself", are all belief structures that have proven to be helpful in addressing addictions, and less so for mental health problems.

Furthermore, the incorporation of traditional healing and cultural practices is inclusive of many different types of activities such as; on-the-land programs, services of a traditional healer, gatherings of people following a suicide to have a sing-song, healing circles with young people, grieving workshops, and community walks to remember people who have died from addictions/family violence.

## **Recommendations:**

The Department of Health and Social Services and the Authorities need to fully recognize Aboriginal organizations as equal partners in dealing with mental health, addiction and family violence services in the NWT in the immediate future and in the long run.

The Department of Health and Social Services and Authorities need to be knowledgeable and open to the incorporation of traditional and cultural practices as part of an approach taken to addressing mental health and addiction services. This involves respect and understanding of the place of traditional and cultural practices for all people across the NWT, when addressing mental health issues.

### **F. Leadership/Guidance and overall direction for entire core service of mental health and addictions**

**Question:** What is the impact of leadership on the decisions for what becomes a priority action item, and hence what portions of the design/delivery are funded? Are the right people/leadership involved?

This sixth section reviews the core service of mental health and addiction services in terms of leadership, guidance and decision-making regarding priority items and funding of services.

#### **Areas of Success/Strength**

- People talking about their Program Concerns in Public

Throughout the design, planning, and implementation, and currently, community members, leaders and other relevant stakeholders are discussing concerns and questions they have regarding the new core service of mental health and addiction services.

This has happened in a number of areas with implementation of the core service of mental health and addictions, including job security for "affected workers", education/training, recognition of education/experience, and transition issues such as flexibility of finances at the Authority level, numbers of positions allocated.

These public discussions, although time-consuming for the DHSS, legislative staff and others, is part of an open system of dialogue, public access to their elected Members of the Legislative Assembly (MLA), and an accountability measure for the health and social services of the NWT.

- Efforts to address staffing in DHSS

Efforts have been noted within the Department of Health and Social Services to address leadership issues, in response to changes within the DHSS staffing mix in the last three years. Individuals have been delegated program management functions, within the new core service, other team members have taken on implementation activities such as the training program for Community Wellness Workers, PCCT development, and Child and Youth priorities. In addition, practice specialists in child and youth, and assistance from evaluation consultants have been pulled into the mix of DHSS mental health and addictions core service staff.

However, leadership issues have arisen from within and from the outside, in terms of consistency, expertise and management presence. Senior management is aware of these leadership concerns, which is a first step in the recognition of an organizational or structural problem in any organization.

### **Areas for Further Strengthening and Development**

- Strengthening of Mental Health and Addictions Leadership

The core service of mental health and addiction services is fixed within a new Integrated Service Delivery Model of health and social services across the NWT. Within a publicly funded system such as that within the DHSS, a number of layers of accountability, responsibility are needed to ensure the efficient use of resources, proper processes being followed, and where services are integrated within broad health and social services mandates.

Leadership in this system is public and complex, but yet important to ensure quality service delivery.

In an ideal setting, "leadership" comes from the people and the communities for program design, implementation and evaluation. This is the preferred direction of decision- making, which facilitates direct impacts on mental health and addictions problems. Decision making by one person, or level of government alone is ill-advised, unlikely to lead to buy-in, and not consistent with community-based program development. It is also not consistent with a team, or PCCT approach, which encourages the use of a multi-disciplinary team of people working towards the best service possible.

Therefore, questions of leadership are first and foremost best dealt with broadly in terms of program design, delivery and implementation. Secondly, questions of leadership within given departments, agencies and/or authorities are best done on an internal basis, as they do not directly impact core service delivery for the whole system across the NWT.

## **Recommendations:**

As previously stated, recommendations to improve communication, the development of a consistent working group, clinical and program development expertise, management and leadership support and performance measurement systems are needed to address concerns of leadership within the core service of mental health and addiction services.

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## **5. Summary of "Interim Report Card"**

### ***Review of the 48 Recommendations from the "State of Emergency..." (2002)***

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#### **A. Overview**

This section of the report provides the reader with a summary of the review of the 48 recommendations from the "State of Emergency..." (2002) report, as released by Chalmers & Associates. These recommendations came about as a result of a community-based review of addictions programs from November 2001 until May of 2002. At that time, mental health services and addiction services were in the process of molding into an integrated model of service delivery. As well, family violence services were in transition in 2001, and were positioned to be integrated as well.

Further background on the "State of Emergency..." Report is available on the GNWT website under Health and Social Services, Reports. A brief overview of the report from 2002 is discussed in Section 2 of this report.

#### **B. Explanation of "the Interim Report Card" A Review of 48 Recommendations**

A qualitative process was designed by the evaluation team to review the implementation of the "State of Emergency" recommendations. This process was modeled after previous work done in the "State of Emergency..." which relied on subjective measurement, simplifying ratings, and theories of qualitative analysis.

The evaluation team wanted to give the people of the NWT, an interim "report card" of the administration, management, treatment/program effectiveness and structure/systems of the core service of mental health and addictions. In reviewing the 48 recommendations, most areas of the core service of mental health and addictions are inclusive in these recommendations.

The complete "Interim Report Card" is included as a ***Supplementary Report: An Interim Report Card on the "State of Emergency..." Recommendations (2002).***

This supplementary report is in a user-friendly format, includes a rating scale for each recommendation, provides evidence for the rating from the 2005 review process, relevant links to research and best practices, anecdotal information from interviewees, discussion/comments, and recommendations for further development and enhancement. The recommendations are consistent with those cited in previous sections of this report, and are also summarized in Section 8 of this Final Report.

What is presented here in this section is a summary of that "Interim Report Card", as requested by the project steering committee. Readers are encouraged to read the full supplementary report for more information regarding the effectiveness of the mental health and addiction core service. There is much overlap between all of the findings sections of this report, as the "Interim Report Card" was used as the basis for the evaluation team's findings of "where we are, and where are we going".

***Legend of the "Interim Report Card"***

<b><u>Assessment</u></b>	<b><u>Description of Assessment</u></b>
<b>A</b>	<b><i>Very Good; continue to nurture and support</i></b>
<b>B</b>	<b><i>Good and could use improvement</i></b>
<b>C</b>	<b><i>Needs improvement</i></b>
<b>IP</b>	<b><i>In-Progress</i></b>
<b>UE</b>	<b><i>Unable to Evaluate at this time</i></b>
<b>Effort-</b>	<b><i>This was measured through an assessment of level and quality of effort.</i></b>
<b>Interim Result-</b>	<b><i>This measure was used to assess relative effectiveness, scope of work done/indicated, and to some degree interim outcome and finding.</i></b>

The ratings given in this "Interim Report Card" are those of the evaluation team of Chalmers and Associates, and do not represent ratings by interviewees, the DHSS, communities or Authorities. They serve as a measurement for quality improvement only.

### ***Administration and Management Recommendations (2002)***

<b>Recommendation (2002)</b>	<b>Subject of Recommendation</b>	<b>Effort</b>	<b>Interim Result</b>
1	Integrated Mental Health and Addictions Services	A	B
2	Definition of Addictions	C	Unable to evaluate
3	Expertise	B	C
4	Quality of Community Addictions Programs	A	In-Progress
5	Physical Building Accessibility	Unable to Evaluate	Unable to Evaluate
6	Future Facility Development	A	Unable to Evaluate
7	Space and Equipment	B	In-Progress
8	Minimum Standards for Education and Training	A	B
9	Prevention Positions	A	A
10	Need to Develop Aurora College Program	A	B
11	Addiction Treatment Referral	A	B

**Assessment    Description**

**A**                    ***Very Good; continue to nurture and support***

**B**                    ***Good and could use improvement***

**C**                    ***Needs improvement***

**IP**                   ***In-Progress***

**UE**                   ***Unable to Evaluate at this time***

**Effort-**                    ***This was measured through an assessment of level and quality of effort.***

**Interim Result-**                    ***This measure was used to assess relative effectiveness, scope of work done/indicated, and interim outcomes.***

## **Treatment and Program Effectiveness**

Recommendation (2002)	Subject	Effort	Interim Result
12	Funding for Addictions	A	IP
13	Cost Effectiveness	UE	UE
14	Funding Partnerships within GNWT	UE	UE
15	Approval process for residential treatment	A	C
16	Confidentiality and Treatment Referral	A	B
17	Regional Staff	UE	UE
18	Continuum of Services	A	B
19	Administrative Demands	C	C
20	Credentials of Mental Health and Addictions	A	B
21	Setting Standards	A	C
22	Team Building with Health Care Professionals	A	IP
23	Authorities' Responsiveness	A	UE
24	Replacing of NWT Addictions Handbook	A	B

### **Assessment    Description**

**A**                    **Very Good; continue to nurture and support**

**B**                    **Good and could use improvement**

**C**                    **Needs improvement**

**IP**                   **In-Progress**

**UE**                   **Unable to Evaluate at this time**

**Effort-**                    **This was measured through an assessment of level & quality.**  
**Interim Result-**            **This measure was used to assess relative effectiveness, scope of work done/indicated, and interim outcomes.**

**Treatment and Program Effectiveness (Continuation)**

<b>Recommendation (2002)</b>	<b>Subject</b>	<b>Effort</b>	<b>Interim Result</b>
25	Consultation to develop standards	C	C
26	Tools and Documentation	Unable to Evaluate	Unable to Evaluate
27	Withdrawal Management	C	C
28	Balance of Withdrawal Management across the NWT	Unable to Evaluate	Unable to Evaluate
29	Consistent Services across the NWT	In-Progress	In-Progress
30	Future of Mobile Treatment	Unable to Evaluate	Unable to Evaluate
31	Defining Mobile Services	Unable to Evaluate	Unable to Evaluate
32	Review of Mobile Treatment Resources	Unable to Evaluate	Unable to Evaluate
33	Assessment of Youth and Treatment	In-Progress	In-Progress
34	New DHSS Position to Address Youth	C	C
35	Consultation for Standards for Youth in Crisis	In-Progress	In-Progress
36	Follow-up Programming	Unable to Evaluate	Unable to Evaluate
37	Family Programming	Unable to Evaluate	Unable to Evaluate

**Assessment    Description**

**A**                    ***Very Good; continue to nurture and support***

**B**                    ***Good and could use improvement***

**C**                    ***Needs improvement***

**IP**                   ***In-Progress***

**UE**                   ***Unable to Evaluate at this time***

**Effort-Interim Result-**                    ***This was measured through an assessment of level & quality. This measure was used to assess relative effectiveness, scope of work done/indicated, and interim outcomes.***

## **Structure, Systems and Linkages**

<b>Recommendation (2002)</b>	<b>Subject</b>	<b>Effort</b>	<b>Interim Result</b>
38	Performance Indicators	B	C
39	Communication with Communities	C	C
40	ISDM Training in Mental Health and Addictions	Unable to Evaluate	Unable to Evaluate
41	Transition Team	B	In-Progress
42	Partnership with Aboriginal Groups	Unable to Evaluate	Unable to Evaluate
43	Territorial Treatment Centre	B	In-Progress
44	Areas to Address with Treatment Centre	A	In-Progress
45	Representations and Changes to Delivery of Programs	B	Unable to Evaluate
46	Traditional and Cultural Practices	C	C
47 & 48	Building on Strengths and DHSS and Authorities Working Together to Re-Build the System	B	B

### **Assessment    Description**

**A**                    ***Very Good; continue to nurture and support***

**B**                    ***Good and could use improvement***

**C**                    ***Needs improvement***

**IP**                   ***In-Progress***

**UE**                   ***Unable to Evaluate at this time***

**Effort-**                                    ***This was measured through an assessment of level & quality.***

**Interim Result-**                                    ***This measure was used to assess relative effectiveness, scope of work done/indicated, and to interim outcomes.***

### **C. Review Team's Comments of "the Interim Report Card"**

Overall, the "Interim Report Card" of the implementation of recommendations to re-build the system of addictions is a **good one**. What is important to consider is the timeline in the development and implementation of the core service of mental health and addiction services. In just three years, many changes and improvements were noted. Also, it is important to note that not all areas of the core service could be, nor should they be, developed in such a short period of time. In fact, problems have arisen in the new Community Counselling Program, because of time pressures, inflexibility and lack of study to address specialized areas of the core service.

Highlights of the evaluation team's review of the "Interim Report Card":

- § Assessment of "A" (very good and continue to improve) were seen in overall effort, financial investments, the prevention focus (Community Wellness Worker Positions), the development of the Community Counselling Program, the community-based focus of the core service, and the development of minimum credentials for staff in the core service.
- § Assessment of "B" (good and could use improvement) were mostly seen in interim results with integration within the larger PCCT, development of an education/training focus, development of program standards, transition activities in some regions and initial work at Nats' éjée K'éh.
- § Assessment of "C" (needs improvement) were in program administration/management, involvement of grassroots personnel in design, transition and implementation, expertise in specialized areas and mental health/addictions program development, communication with all stakeholders and partners, and the incorporation of Aboriginal perspectives.
- § Areas "In-Progress" are many, and include efforts to address transition and implementation issues, addressing the distinct needs of children and youth, addressing quality, human resources and systems of referral, developing consistent access and services across the NWT, secure financial investments in the core service,
- § Areas "Unable to Evaluate" were due to insufficient data, time for evaluation and/or not being addressed at this time. These areas in this "Interim Report Card" were in areas of physical/building accessibility issues, funding partnerships with other GNWT departments, implementation of tools and standardized instruments, family programming and the place of mobile treatment.

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## 6. ***Findings: Emerging Issues & Setting Priorities***

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### A. **Emerging Issues**

**Question: What are emerging issues that may impact the delivery and design of mental health and addiction services?**

This section reviews the core service of mental health and addiction services in terms of emerging issues, and priority areas that the Department of Health and Social Services has identified in 2005.

#### **Areas for Further Strengthening and Development**

- Recognition of a changing environment

No environment remains the same, and there is a need to recognize emerging issues that may require program planning, and development, especially so in the core service of mental health and addictions. The Government of the Northwest Territories, Department of Health and Social Services, Regional Authorities and Communities are responsible for providing timely and necessary services in mental health and addictions.

Without attention to a changing environment, including improved expertise and ongoing input regarding emerging issues, the core service would become obsolete within a short period of time.

Most health care and social services across Canada are dealing with changing environments, changing best practices, improved methods of service delivery, improved treatment plans and so on. It is simply part of health and social service care to integrate change and responses to emerging issues.

- Response to Community Concerns about Drug Usage Patterns

The Government of the Northwest Territories is to be commended for its response to concerns raised by many communities, leaders and health and social service personnel of the changes with respect to drug usage, drug abuse/dependence and poly-drug use, which is the use of many different substances.

National attention in Canada has been directed towards the drug, crystal methamphetamine, or crystal meth. This drug is actually not new, but is more easily made in recent years. It is an upper, or stimulant that was widely available in the 1960's. Its attention in pop-culture, television and through provincial government awareness campaigns is valid, given that its use can cause health problems, addiction and is often associated with criminal activity.

However, in the NWT, concerns are more commonplace with other drugs, which include cocaine, crack cocaine, and pot. According to the Alcohol and Drug Survey conducted in the NWT (2002), changes to drug usage are as follows:

- § Yellowknife has a greater density of alcohol users
- § 78% of people over age 15 reported alcohol use
- § Alcohol is still the "drug" of choice in the NWT
- § There is an increase in pot usage from 1996, and usage of pot is more common in smaller communities.
- § 10% of people surveyed reported use of cocaine, heroin or crack cocaine in their lifetime; 1% in the last year
- § 82% report having been involved with gambling, with women twice as likely to play bingo
- § Binge patterns of drug usage are more common with Aboriginal users

The results from the 2002 Alcohol and Drug Study are likely underestimating substance usage, as items were of a self-report nature. Regardless, there appears to be changes to the usage pattern of drugs, and alcohol.

The core service of mental health and addictions requires ongoing efforts to address the concern of drug usage, abuse, prevention and treatment. Recommendations are outlined below.

- Industry and Addictions and Mental Health

Addictions and mental health problems cause direct and indirect losses to NWT employers, safety concerns and problems due to lost wages and employment. In the NWT, there are specific industries that are concerned about the impact of addictions more specifically on their employees, and their abilities to work on a consistent basis.

As more and more choices become available for Northern workers, the relapsing, chronic nature of addictions and some mental health problems may become more prominent in the years ahead.

Several recommendations are listed below to guide the discussion regarding industry and addictions.

- Impact of the Mackenzie Gas Project

As this report is being written, negotiations and work is ongoing to bring the Mackenzie Gas Project (MGP) to a reality.

Representation from the Inuvialuit Region, the Gwich'in Region, Kahsho Got'ine District, Tulitlat/Deline District and the Deh Cho regions together with the Government of Canada, and the Northwest Territories will determine how the socio-economic impact dollars will be spent.

Recommendations are listed below with respect to mental health and addiction services and the MGP.

- Aging Population

As the lifespan of NWT residents increases, addictions and mental health issues may become more prominent in an older population. As well, depression, suicide, gambling, and dementia are inclusive of the problems faced by this older age group.

Specific approaches may be needed to deal with mental health and addiction problems in older adults across the NWT.

## **Recommendations:**

### **DRUGS**

1. A Strategic approach to address the changing patterns of illegal drugs in the NWT is needed:
  - (a) early intervention focus – building healthy families.
  - (b) healthy children, social skills, healthy relationships and bodies, stay in school focus.
  - (c) educate, educate, educate of dangers/problems and get help early on.
  - (d) strengthen Community Counselling Program - harm reduction, assessment for drugs, early support, treatment specific strategies etc.

- (e) treatment, if needed, including withdrawal management.
- (f) train/educate northern workforce – all involved in core service of mental health, addictions and family violence.
- (g) residential treatment in NWT to address less complicated cases, where drug usage is experimentation or infrequent usage
- (h) complex cases involving medical, poly-drug use and where specialized residential treatment is needed, and/or longer term (beyond 40 days), refer to Out-Of-Territory (OOT) facilities that have specialized drug programs. Re-assess on a yearly basis depending on the change in drug use.
- (i) Re-assess need to develop in the NWT drug specific treatment cases on a yearly basis, and address territorially, if numbers justify the service, specialty of mental health and addictions specialists, facility needs and medical/nursing support required.
- (j) Further study is needed to more fully document usage levels, degree of usage, experimentation, methods of usage, and poly-drug abuse.

## **Industry**

Addictions raise problems for industry due to the chronic relapsing nature of addictions, poor health, on the job safety issues and general costs/services needed to replace workers.

### Recommendations

1. Help industry develop solution focused counseling and intervention processes that target the individual worker. Specifically, industry would likely benefit from counselling strategies that incorporate structured relapse prevention, solution focused methods, brief counseling and maintenance strategies.
2. Research with industry the nature of the problem – is it industry-specific? Is it location-specific? Is there a gender difference (ie. Men more often than women, or not); Financial planning issues? Are there marriage/family problems? Relationship issues? Planning for individuals and families and going away to remote work places?
3. Help industry develop gender specific prevention and intervention services prior to employment – orientation session.

4. Because of the nature of mental health and addiction issues present in the NWT for people working/returning to work, there is a need to have mental health workers, and clinical supervisors with expertise in marriage/family counseling, specific counselling modalities, and to be able to work with industry, employers, and various systems of program delivery across the NWT. Also, there is a need to have similar resource persons within DHSS and Authorities to design, develop and implement policy and program supports that consider the needs of industry.

### **Mackenzie Gas Project**

1. The DHSS and the Authorities in the affected areas of the MGP need to educate themselves generally in terms of the Project and the potential impact on Health and Social Services:
  - (a) geographical areas
  - (b) Aboriginal groups
2. The DHSS and the Authorities need to fully recognize Aboriginal organizations as partners in dealing with the social impacts of the MGP.
3. The capacity to respond to the potential impacts need to be community-based and built on what is already there. The capacity needs to be built at the community level in order to respond to the socio-economic impacts in a culturally and respectful manner.

### **Aging Population**

As the lifespan of NWT residents increases, addictions and mental health issues may become more prominent in that age group. Depression, suicide, addiction to alcohol and gambling, and dementia are inclusive of the problems that this population could face.

Educate Primary Community Care Team of the distinctive mental health/addictions needs (assessment and treatment) of older adults.

## **B. Setting priorities for action**

**Question: What are priorities for action in mental health, addiction and family violence services?**

Priorities for Action at this stage of the development of the core service of mental health and addictions are as follows (in random order):

1. Strengthening the Community Counselling Programs across the NWT as part of the PCCT within an ISDM of health care delivery.
2. Developing effective communication systems within the core service that reach Authorities, employees, NGO's, and communities in the NWT regarding the core service.
3. Developing, engaging and securing broad, clinical and community-based expertise in mental health and addictions at the policy, program development and management level of the core service of mental health and addictions.
4. Responding to emerging issues in the NWT environment that can impact on the delivery of mental health and addictions services.
5. Securing financial investments in the core service of mental health and addiction services in the short and long term.

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## **7. Summary of Recommendations & Next Steps**

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### **A. Ongoing recommendations**

1. "Stay the course..." Continue to work together with communities, Authorities, and the Government of the Northwest Territories, Department of Health and Social Services, to secure the foundation that has been built.
2. Develop a consistent, working group of representation from across the NWT, different disciplines, community level personnel, NGO's, Authority and DHSS, and hospital staff to advise, direct and provide the content for the DHSS to proceed. Provide sufficient resources for this expert working group to meet, plan, develop and evaluate the developing core service of mental health and addiction services in the next two to three years.
3. Maintain funding investments in mental health and addictions in the years to come to secure the foundation that has been built in communities across the NWT. Emphasis needs to be on human resources, developing expertise and community counselling programs.
4. Continue to work, with each community, and with each Authority, to realize quality programming, while ensuring there is flexibility, and transition planning over time. Avoid inflexibility and rigid planning that serves to alienate communities, disregard community ownership and histories, which further distracts from the process of improving mental health and addictions services.
5. Reinforce the importance of minimum standards for all staff working with the core service of mental health and addiction services throughout the NWT, in communities, Authorities and within the DHSS that is consistent with what is needed in the core service.
6. Training of DHSS leadership, senior management and newcomers to the Department is needed regarding the history of addictions and mental health in the NWT, the implementation of minimum standards in community counselling positions, and industry standards of training and education across Canada.

7. Keep working on the scope of prevention services and application of learning for the Community Wellness Workers across the NWT. Reinforce a broader scope of services for these workers, especially in terms of crisis intervention in small and remote communities, where there are limited resource persons, and where they have already been providing these services such as suicide prevention.
8. Work with Aurora College to create a transferable, two year Diploma Program that can meet the needs of Community Wellness Workers, Mental Health Workers and possibly other human service workers in the NWT such as Justice, Social Work, and Early Childhood Services.
9. Support clinical supervisors and regional program managers to meet the new standards, provide quality and evidence-based services and to raise the bar of their own expertise and training to meet the emerging needs in addictions and mental health in the NWT.
10. Work to integrate residential treatment services, both in and out of the Territory services into the scope and continuum of mental health and addiction services. Work to improve knowledge of residential treatment services, their part in addiction treatment planning, assessment procedures, and client matching for residential treatment.
11. A communications strategy is needed for the mental health and addictions core service in the NWT to explain, discuss, get feedback and include ongoing consultation with all stakeholders: community workers, leaders, clients, regional/Authority workers, NGO's, hospitals, treatment centres and the DHSS.
12. Maintain and strengthen mental health and addiction services as a core service within the NWT ISDM. Provide direction, management support, expertise and financial resources to this core service throughout the NWT.
13. Continue to work on maintaining and improving the standards for the skills, education and training needed by all NWT positions that work with mental health and addictions, including staff at community level, Authority level, DHSS, NGO and medical/nursing staff.
14. Develop systems of continuous monitoring, quality assurance and performance measurement for all mental health and addiction services across the NWT. Tailor timelines and approaches to services, based on their stage of implementation and development.
15. Continue to educate/facilitate all mental health and addictions core service workers of the program standards, their use, purpose and place in the Community Counselling Program.

16. Further study and consultation is needed with respect to withdrawal management services, and with all groups of health care providers and community workers in the NWT, to reflect community needs, best practices and availability of resources within local, regional and territorial health and social services facilities.
17. Planning, study and much consultation are required to proceed with specialty services for children and youth. It is recommended that children/youth services be enhanced within the context of families and communities in the NWT, and therefore integrated with core mental health and addiction services in the immediate future and over the next three to five years.
18. Transition issues remain, and need to be addressed appropriately, in a timely manner, and in consideration of community histories, context and stage of development of core mental health and addiction services.
19. The Department of Health and Social Services and the Authorities need to fully recognize Aboriginal organizations as equal partners in dealing with mental health, addiction and family violence services.
20. The Department of Health and Social Services and Authorities need to be knowledgeable and open to the incorporation of traditional and cultural practices as part an approach taken to addressing mental health and addiction services. This involves respect and understanding of the place of traditional and cultural practices for all people across the NWT, when addressing mental health issues.
21. A major shift in perspective and approach is needed that emphasizes a working together of individuals, families, communities and government structures. Approaches that support a top down ("we design it, and you deliver it") perspective are counter-productive to community-based programs. A circular system of team work, and supportive consultation is needed to continue with program design, delivery and monitoring systems of mental health and addictions services across the NWT.

**B. In the next 12 months...**

22. Work with communities, Authorities, and PCCT team members to define, outline and summarize what are mental health and addictions in the NWT that can be addressed in the core service of mental health and addictions. This planning work will assist with all levels of program development, implementation, human resource management, training and prevention efforts.
23. Continue to work on developing standards for what skills, knowledge and competencies are needed for all PCCT members to have, including nurses, physicians, and all those working in health and social services delivery across the NWT.
24. The DHSS, Authorities, and communities in the NWT need to address the issue of equipment and capital needs, community by community. An emphasis on flexibility and adaptability by each Authority, and within each community is necessary for the efficient use of equipment, and available resources.
25. Review job descriptions and pay scales for Mental Health and Addiction Counsellors and Clinical Supervisors positions for pay equity across the NWT, in comparison with other health/educational professions (teachers, social workers, psychologists, nurses...) and in consideration of Canadian equivalencies.
26. Address funding for operational costs, evaluation/monitoring tools (standardized instruments), office/reception support, furniture and computer equipment, where needed.
27. Consider a pilot year of the program standards, and get constructive feedback from front-line mental health and addictions workers as to their effectiveness, and the changes needed for this reference document in the NWT.

**C. In the next 1 to 2 years**

28. Partnerships need to be formed with schools, Boards of Education, and the Departments of Education, Culture and Employment and Justice to further mental health and addiction services, especially with respect to prevention and early intervention with children and youth.
29. Consider developing an addiction medicine advisory group/committee with possible assistance from out-of-territory specialists in addiction medicine, who can contribute to the distinct medical processes involved in mental

- health and addiction services. This group would be a critical part of any Withdrawal Management System (WMS) that involved hospital services.
30. Consider the development of a mobile assessment service, that could serve small and isolated areas either through tele-health, regional locations or through a mobile structure. This may be a service targeting children, youth and families.
  31. Develop multi-disciplinary assessment processes that are inclusive of child and youth priorities, and within a family and community context.
  32. Accountability activities such as continuous monitoring, quality assurance and effectiveness monitoring need to be incorporated throughout the core service of mental health and addiction services.

**D. In the next 3 to 5 years**

33. Look at a long-term plan, community by community to address space, location and future of PCC team, that is inclusive of mental health and addiction services.
34. Establish NWT research projects in the areas of program effectiveness, outcome monitoring, and cost effectiveness for mental health and addiction services.
35. Leadership and expertise are needed to manage, outline, analyze and report on process, outcome and cost-effectiveness measures of the core service of mental health and addictions services.

**E. In the next 5 to 10 years  
(System Wide in Department of Health and Social Services)**

36. Consider co-location of PCCT services, where possible, in communities where capital planning may include the renovation or construction of new health and social services facilities or Health Centres.
37. Human resource planning is needed to encourage young people in the NWT to work in the mental health, addictions and family violence core services. Work with Education, Culture and Employment to encourage a Northern Workforce in these human services, and consider the implications of competition for Northern workers in the various human services fields.

## **F. Recommendations and Emerging Issues**

### **DRUGS**

1. Strategic approach to address the changing patterns of illegal drugs in the NWT:
  - a) early intervention – building healthy families. (Ongoing)
  - b) healthy children, social skills, healthy relationships and bodies, stay in school focus. (Ongoing)
  - c) educate, educate, educate of dangers/problems and get help early on. (Ongoing)
  - d) strengthen Community Counselling Program- harm reduction, assessment for drugs, early support, treatment specific strategies etc. ( 1 to 2 years)
  - e) treatment, if needed, including Withdrawal management (Ongoing)
  - f) train/educate northern workforce – all involved in core service of mental health, addictions and family violence. (within 1 to 2 years & ongoing)
  - g) residential treatment in NWT to address less complicated cases, where drug usage is experimentation or infrequent usage (Ongoing)
  - h) complex cases involving medical, poly-drug use and where specialized residential treatment is needed, and/or longer term (beyond 40 days), refer to Out-Of-Territory (OOT) facilities that have specialized drug programs. re-assess on a yearly basis depending on the change in drug use. (Ongoing)
  - (k) re-assess need to develop in the NWT drug specific treatment cases on a yearly basis, and address territorially, if numbers justify the service, specialty of mental health and addictions specialists, facility needs and medical/nursing support required. (Yearly)
  - (l) further study is needed to more fully document usage levels, degree of usage, experimentation, methods of usage, and poly-drug abuse.  
(In the next 1 to 2 years)

## **Industry**

Addictions raise problems for industry due to the chronic relapsing nature of addictions, poor health, on the job safety issues and general costs/services needed to replace workers.

## **Recommendations**

1. Help industry develop solution focused counseling and intervention processes that target the individual worker. Specifically, industry would likely benefit from counselling strategies that incorporate structured relapse prevention, solution focused methods, brief counseling and maintenance strategies.

Suggested timeline: 1 to 2 years

2. Research with industry the nature of the problem – is it industry-specific? Is it location-specific? Is there a gender difference (ie. Men more often than women, or not); Financial planning issues? Are there marriage/family problems? Relationship issues? Planning for individuals and families and going away to remote work places?

Suggested timeline: 1 to 2 years

3. Help industry develop gender specific prevention and intervention services prior to employment – orientation session.

Suggested timeline: 1 to 2 years

4. Because of the nature of mental health and addiction issues present in the NWT for people working/returning to work, there is a need to have mental health workers, and clinical supervisors with expertise in marriage/family counseling, specific counselling modalities, and to be able to work with industry, employers, and various systems of program delivery across the NWT. Also, there is a need to have similar resource persons within DHSS and Authorities to design, develop and implement policy and program supports that consider the needs of industry.

Suggested timeline: 1 to 2 years

## **Mackenzie Gas Project**

Representation from the Inuvialuit Region, the Gwich'in Region, Kahsho Got'ine District, Tulitait/Deline District and the Deh Cho regions together with the Government of Canada, and the Northwest Territories will determine how the socio-economic impact dollars will be spent. Given this directive the following recommendations with respect to mental health and addiction services are outlined below with suggested timelines.

It is important to recognize that the MGP timelines are very tight, and work is already underway in many areas to plan for the social impacts of the project, especially with respect to addictions, youth and communities.

### **Recommendations:**

1. The DHSS and the Authorities in the affected areas of the MGP need to educate themselves generally in terms of the Project and the potential impact on Health and Social Services:

- (c) geographical areas
- (d) Aboriginal groups

Suggested timeline: within 6 months

2. The DHSS and the Authorities need to fully recognize Aboriginal organizations as equal partners in dealing with the social impacts of the MGP.

Suggested timeline: within 6 – 12 months

3. The capacity to respond to the potential impacts need to be community-based and built on what is already there. The capacity needs to be built at the community level in order to respond to the socio-economic impacts in a culturally sensitive and respectful manner.

Suggested timeline: within 6 – 12 months

## **Aging Population**

As the lifespan of NWT residents increases, addictions and mental health issues may become more prominent in that age group. Depression, suicide, addiction to alcohol and gambling, and dementia are inclusive of the problems that this population could face.

### **Recommendation:**

1. Educate Primary Community Care Team of the distinctive mental health and addictions needs (assessment and treatment) of older adults.

Suggested timeline: within 5 – 10 years

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## **8. Final Comment: Moving Forward**

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These final comments from the review team reflect encouragement and hope that further strengthening will improve what is developing into an effective core service of mental health and addictions services.

Mental health, addictions and family violence issues bring a sense of urgency, emotion and personal bias for most people working in the human services field.

The passion and devotion to addressing the mental health, addiction, and family violence problems is limitless right across the NWT. However, this passion and dedication needs to be directed within the context of providing quality, effective and community-based services for all residents of the Northwest Territories.

### **A. Six Major Themes**

Six major themes summarize the final comments regarding this interim review on the mental health and addictions core service in the NWT.

They are broad themes that may be recognized by some as being part of a process of recovery and renewed hope. For others, they are familiar slogans that can be used in the future to strengthen the system of mental health and addictions across the NWT and to move forward with ongoing improvements and adjustments where needed.

#### **1. Keep it simple**

The Community Counselling Program or CCP is the "roots and trunk of the system". It is likely that most mental health, addiction and family violence problems would come through, be assisted by, referred by, supported by and/or possibly prevented by the CCP.

This is the highlight, the focus, and the strength of the mental health and addictions system throughout the NWT.

Other specialized services, such as psychiatry, residential treatment, Withdrawal Management Services, psychological assessment, placement in residential child and youth facilities, and others work in close ties to the CCP. The Primary Community Care Team and the Community Counselling Program work together with the client to empower, assess, plan for treatment, support, refer, and support after relapse, crisis.

A system of "many programs" is counter-productive to a core service that emphasizes community-based services. Therefore, it is important to consider a broad perspective of a core service of mental health and addictions services, where all things fit together, especially with respect to Aboriginal priorities, values and perspectives.

A historical review of mental health and addictions services reveals a pattern of fragmented, disconnected services, all with good intentions, but lacking in a solid base, which is the Community Counselling Program/ Primary Community Care Team.

There is a need to "Keep it Simple" and avoid too many program labels or additional programs, and maintain the community-based focus for the core service of mental health and addictions.

## **2. Easy Does it**

This comment and slogan refers to the essence of timing, doing effective planning and taking responsibility.

Too often, new government initiatives are driven by crisis-type management, planning and reaction to isolated occurrences. Yet, there is an urgent need to provide quality and effective mental health and addiction services across the NWT, and to be accountable to the people of new investments.

It is critical to minimize crisis-style planning, and to maximize effective planning, study and implementation of mental health and addiction services. Taking responsibility for what is necessary requires leadership, expertise in the field, and the wisdom to: "Stop, look and listen..."

The new system of mental health and addiction services is at a critical time period in its implementation, and where strong, effective and skilled leadership in the field of mental health and addictions is needed.

## **3. Re-use and Recycle**

Mental health, addiction and family violence problems are not new to the people, communities and agencies across the NWT. Many groups, Authorities/Health Boards, NGO's, Aboriginal organizations, and grassroots groups have developed, piloted, studied, and implemented a variety of approaches, and programs to address these problems over the last 50 years and even longer.

It is most critical to re-use and recycle these approaches and efforts, so as to not repeat the same mistakes, and to build on the strengths of what is there in communities across the NWT. The NWT people are leading the change in mental health and addiction services, based on what has worked in the past, and what has not.

#### **4. Consider the Context of the NWT**

The NWT is a large geographical area made up of large and small communities, and includes distinct groups of children, youth, adults and families from various cultural and ethnic backgrounds.

The context of who lives throughout the NWT, and who may or may not seek services from the GNWT, needs to be at the forefront of all planning, design, implementation, monitoring, and communication regarding the core services of mental health and addictions.

Furthermore, the population, its health status, and health care needs, as well as its social-political frames are in a constant state of change. Close to half of the territory's population identifies with one or more Aboriginal group, and there must be consideration of Aboriginal perspectives, histories, social and economic disparities when designing, delivering and monitoring/evaluating programs.

Lastly, developing a Northern workforce in the field of mental health and addiction is necessary. However, this "made in the NWT" workforce will not meet the human resources needs in its entirety. Therefore, ongoing out-of-Territory reliance on southern workers will be needed in the NWT, just as for education, nursing and social work, at least for the present time.

#### **5. Communicate, Communicate, Communicate**

Communication is the key to ongoing success, further integration of mental health and addiction services, connection with communities feeling left out of the design and delivery and transition planning, in bringing previous workers/systems into an integrated service delivery model.

#### **6. Quality is not a luxury, but a necessity...**

Quality services are not a luxury but a necessity for the people of the NWT. This means attention to standards for all workers in the system, including policy and administrative/management personnel, community workers and others that are part of the network of care providers.

**B. "Stay the Course...and Together we can secure the Foundation that has been built"**

The "Interim Grade is a "B", and is an improvement from 2002.

The evaluation team was pleased and, in fact, surprised by the goals achieved in the mental health and addictions core service across the NWT in the last three years.

Now it is time to review what has been done, improve areas that are needed, seek out relevant expertise in mental health and addictions, and continue to strengthen what has been built.

**"Stay the Course...  
and Together we can secure the Foundation  
that has been built"**

Words from the People:

"Let's get on with it..." (Minister's Forum, 1999)

"We are on the right track" (Interviewee for this report, 2005)

"Creating an environment that supports healthy people is truly a shared responsibility and requires each of us to do our part"  
(GNWT Strategic Plan, 2004)

"The emergency has been recognized, and now the work begins"  
(Interviewee for this report, 2005)

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## **Appendix A** Terms of Reference (TOR)

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### **Project Title:**

Follow-up Review to “*A State of Emergency ... Community Addiction Program Evaluation*” (Chalmers and Associates Consulting Ltd, 2002)

### **Background:**

In 2001, the Department of Health and Social Services (DHSS) funded an evaluation of all the Community Addiction Programs that, at the time, were provided by NGO’s or Band Councils across the NWT. In addition, the evaluation looked at the Mobile Addiction Treatment Programs that had been piloted the previous year. Chalmers and Associates were contracted to complete the evaluation and “*A State of Emergency... Community Addiction Program Evaluation*” which was released in May 2002.

The Chalmers Report (2002) provided the GNWT with 48 recommendations that were written in the context of:

- Administration and Management
- Treatment and Program Effectiveness
- Structure of Addiction Systems and Linkages

In 2002 the DHSS unveiled the Integrated Service Delivery Model (ISDM), which identifies six (6) core services; Mental Health and Addiction Services being one. An NWT-wide consultation group was struck in 2003, to look at the Chalmer’s report and recommendations and begin the development of a territorial framework for mental health and addiction services in the NWT.

The years of consultation with communities, key stakeholders and leadership provided direction for selecting priority action items that would be implemented first throughout our system. The Minister of Health and Social Services felt that it was important to build mental health and addiction services at the community level, to build community capacity, and then to focus planning to regional and territorial levels, as outlined in ISDM. The Framework for Action; Mental Health and Addiction Services (2003) report was completed along with supporting documents, and the first year of implementation of services began in 2003/04.

DHSS and Health and Social Service Authorities (HSSA) have implemented Community Counselling Programs focusing on mental health, addictions and family violence. This new program model has funded 77 new positions at the community and regional levels. This new program is comprised of three positions:

- Community Wellness Workers;
- Mental Health\Addictions Counsellors and;
- Clinical Supervisors

The role of the Community Wellness Worker (CWW) is to provide education, health promotion and prevention activities to the community, family and clients in the area of basic health and well being in the areas of addictions, mental health and family violence. In addition, the Community Wellness Worker is the first point of contact for the client in providing identification\screening and aftercare\follow-up as well as basic counselling to clients in accordance with the program standards and protocols of the community-counselling program. The individuals who fill these positions were directly appointed to their current positions when the former alcohol and drug program was discontinued in favour of the Community Counselling Program. In order for these individuals to acquire the competencies to perform their roles in the new service the Department entered into a partnership with Keyano College. The aim of this partnership was to offer individuals who did not possess the competencies necessary to fill the new job description with the training necessary to do so. Upon successful completion of the program and meeting the Keyano College requirement for English 150, individuals will be eligible to receive the university level certificate from Keyano College in community wellness.

The Mental Health\Addictions Counsellor (MHAC) is responsible for providing a therapeutic counselling element of the team's service provision. The Clinical Supervisor (CS) will be responsible for providing the team's clinical supervision and in some cases administrative supervision. It is expected that these positions will be filled using the normal competition process and possess a minimum bachelor's degree from an accredited university with at least two to three years experience in a field of practice related to addictions, mental health and/or family violence.

### **Purpose:**

Request that Chalmers and Associates conduct an internal (health and social system) and external review (key stakeholders) of Mental Health and Addiction Services in relation to the 48 recommendations, since the release of "A State of Emergency ...". The review will examine the mental health and addiction core service in the context of:

- System design/delivery
- Administration/management
- Key stakeholder buy-in/satisfaction
- Leadership/spokesman
- Identification of gaps and barriers
- Implementation of Community Counselling Programs
- Setting priorities for action
- Chalmers report (2002) recommendations

## **Scope of the Project:**

The contractor will provide a follow-up review of Chalmers' report and assess the Department's progress implementing Chalmers' recommendations. The contractor will assess implementation within the larger context of MHA core services including the multi-year plan for implementation and Cabinet/Leadership directions.

The Chalmers review will require interviews and perhaps focus groups with a variety of key stakeholders and NGO's that have been involved in the planning, design, delivery and management of the Mental Health and Addiction Services (see methodology section). Therefore, the contractor will travel to the required regions to conduct interviews with key informants in the health and social service authorities and the Department.

The contractor will be developing the deliverables in the context of the overall health and social services system whereby integrated mental health and addiction service provision and a system-wide collaborative process are reflected in the Primary Community Care model.

Recommendations on changes/modifications or improvements to the overall design, delivery and future planning of mental health and addiction programs are expected. As well as recommendations as to how to support ongoing transition and change management of the multidisciplinary teams and collaborative practice in the HSS system, through which mental health and addiction services are provided.

## **Methodology:**

As stated in the purpose of the terms of reference, the review will focus on the system design, administration/management, implementation, priority action items and recommendations made by Chalmers and Associates.

The review will focus on the following questions:

- How have we progressed in the planning and implementation of mental health and addiction services since 2002?
- How has the system design/delivery incorporated and/or addressed the 48 recommendations made in "A State of Emergency ...." ?
- Is the mental health and addictions framework addressing the needs of the community?
- Are there any changes or modifications that must be made to the design or delivery models?
- What are some of the challenges that have impeded success or progress in any of the phases of implementation and planning?
- What are some of the successes?
- How effective is the administration/management of mental health and addiction services in the Department?
- How effective is the administration and management of mental health and

- addiction services in the health and social service authorities?
- What is the impact of leadership on the decisions for what becomes a priority action item, and hence what portions of the design/delivery are funded?
  - Are the right people/leadership involved?

A series of interviews will be organized in the Department of Health and Social Services, Health and Social Service Authorities, and NGO's. The following groups to include in the interviews are as follows:

#### Department of Health and Social Services

- Minister of Health and Social Services
- Deputy Minister and Assistant Deputy Minister
- Director of Territorial and Integrated Services
- Director, Children & Family Services
- Director of Finance
- Director of Human Resources
- Mental Health and Addictions Core Service Project Manager
- Mental Health and Addiction Core Service Team

#### Health and Social Service Authorities

- CEO's
- Board Chairs
- Directors/Managers of Health and Social Programs
- Clinical Supervisors, Community Counselling Programs

#### Non-Government Organizations

- Salvation Army
- Tree of Peace
- Inuvik Family Counselling
- Tulita Wellness Agency
- TI'oondih Healing Society
- Tli Cho Healing Path

The review work plan should be prepared in such a way as to best provide an efficient use of both time and travel expenses.

#### **Project Timeframe:**

- The contract for the follow-up review to "A State of Emergency" will commence with Chalmers and Associates on October 30, 2005.
- Draft report will be submitted to the Department by November 18, 2005.
- Final report will be submitted to the Department by December 9, 2005.

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## **Appendix B Summary of Evaluation Team Credentials**

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### **Dr. Jennifer H. Chalmers**

Dr. Chalmers has been the principal investigator in over 60 research and program development projects that emphasize community development, Aboriginal priorities, public health, education & training, early intervention, and crime prevention through social development. Her clinical work includes private practice work in substance abuse, psychological trauma, aboriginal healing, and clinical supervision of northern community mental health workers. Dr. Chalmers also works in forensic assessment and program development, and continues to be a group facilitator for male offenders.

Dr. Chalmers has over 20 years of experience as a clinician in various settings, including large urban hospitals, residential treatment settings in substance abuse, and in remote communities in the NWT as a community mental health specialist. She has extensive clinical and program development expertise with addictions, trauma, suicide intervention and community development to address social problems within families. Dr. Chalmers has worked with adults, children and families. Dr. Chalmers and her family have lived in the NWT, and have experienced the challenge and beauty of Northern living.

She holds two Bachelor's Degrees in Psychology and Physiology from the University of Western Ontario, a Master's Degree in Counselling Psychology and a Doctor of Psychology, in Clinical Psychology from the Adler School of Psychology in Chicago, Illinois. She also has a post-graduate certificate in Substance Abuse, post-graduate training in group therapy, neuropsychological assessment and child psychology, and maintains registration in various professional associations including the American Psychological Association, the Canadian Counselling Association, the Canadian Evaluation Society and others. She has published numerous peer reviewed articles, and has presented at professional association meetings across North America.

### **Research Associate- Elisabeth (Liz) Cayen**

Elisabeth (Liz) Cayen is an evaluation and research consultant based in Inuvik, Northwest Territories. Liz has lived across the Northwest Territories and in Nunavut as well in very small communities (population 750) and larger centres (population 17,000). Liz's practice focuses on social programs in their various stages of development – from needs assessment, creating a vision, designing programs, implementing programs and then in the evaluation process of various programs – social programs especially targeted at the needs of Aboriginal people in Canada's North.

Liz has been a research associate in over forty (40) research and program development projects emphasizing Aboriginal priorities, early childhood interventions, education and training, social development, corrections and crime prevention through social development. Her work includes planning and implementation of evaluation strategies and analysis and presentation of results. Liz works with various government agencies at local, regional and territorial levels through various projects to move forward positive social change in Aboriginal communities. Liz has taught at Aurora College in Yellowknife and in Fort McPherson, NT.

Liz holds a Bachelor Degree in Psychology from the University of Waterloo, a Masters in Education from Athabasca University and a Masters of Social Science from Leicester University in England.

### **Research Associate- Dr. Chery Bradbury**

Dr. Cheryl Bradbury is a researcher and post-doctoral fellow engaged in clinical practice with remote communities, Traumatic Brain Injury clients and assessment.

Dr. Bradbury has worked with Chalmers & Associates over the last 4 years as a research associate, and colleague in advancing research methodologies with minority groups. Her clinical work includes institutional work in substance abuse, psychological trauma, anxiety through Bellwood Health Services and the Clarke Institute. Dr. Bradbury has interests in neuropsychological impacts on social development, such as the effects of poor social development and resulting learning deficits. Other research interests include community-based prevention, eating disorders, anxiety disorders and cross-cultural adaptation of psychological tools and instruments.

She holds a Bachelor's Degree in Psychology from York University, a Master's Degree in Counselling Psychology, and a Doctor of Psychology, in Clinical Psychology from the Adler School of Psychology in Chicago, Illinois. She also holds a certificate in neuropsychological assessment.

## **Research Associate- Sharon Snowshoe**

Sharon was born and raised in the NWT and has lived in many communities across the Territory. Sharon is a member of the Gwich'in Nation and many of her family members maintain some aspects of a traditional lifestyle. Currently, Sharon lives in Fort McPherson and has served on many community boards and committees including community education council.

Sharon is well respected in the Beaufort Delta and is well known for her consistent work ethic, involvement in preserving Gwich'in culture and in helping people. She has worked for many community organizations including the Language Centre, Tetlit Gwich'in Council as Band Manager, the Gwich'in Enrollment Board, Wellness group, and the Gwich'in Tribal Council Education and Training. She is currently employed with the Gwich'in Social and Cultural Institute in Inuvik.

Sharon has completed post secondary education in career counselling and also has lifeskills training. Sharon has worked with NGO's and Community Band Councils in the areas of social programs. Sharon was also a Foster parent of an FAE child for one year and understands first hand the issues facing children and families dealing with Fetal Alcohol issues in the NWT. Also, Sharon has been an active member of the Fort McPherson Suicide Intervention group, that assists in addressing this devastating problem within First Nation's Communities.

Sharon is a hard working Northerner who is very well respected for her work ethic, analytical skills and link to the people throughout the NWT. Sharon loves her work in the north, and has the respect of elders in being a future leader.

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\* A full reference list is included in the Supplementary Report: An Interim Report Card on the "State of Emergency..." Recommendations (2002).