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

Supplementary Report: Residential Treatment

December 9, 2005

Submitted to:

The Department of Health and Social Services
Yellowknife, Northwest Territories

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Residential Treatment

This supplementary report on Child and Youth is part of the larger report titled: **"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.

In particular, this supplementary report was initiated following discussions with senior management and leadership with respect to future needs for residential treatment in the NWT.

Sufficient time to conduct a thorough review of this specific subject was not possible, given the short timeline for this interim report. Where possible, information about residential treatment was requested, but a decision was made by the program manager and this contractor to provide analysis with the data available, realizing not all appropriate people and documents were reviewed adequately. Further time spent in Hay River and with other key stakeholders in residential treatment was not done beyond review of the entire core service. This would have provided greater insight, data and suggestions for ongoing developments in residential treatment, both in and out of the NWT.

Also, there are limitations with respect to the generalizing of this supplementary report to future planning and resource allocation, as much more study, consultation and collaboration is needed to give this issue its full attention.

However, next to Children and Youth, Residential Treatment, both in and out of the Territory, was the most common area of future concern mentioned throughout the interviews conducted in November of 2005.

The issues, points and comments mentioned here are those of the evaluation team, and do not represent policy of the DHSS, NWT facilities and other stakeholders.

1. Background Information

What is residential treatment?

There is no easy answer to this question. Also, the language of mental health and addictions is such that the word "treatment" refers most often, and especially in the NWT, as going someplace for 28 days to address alcohol and drug problems.

Treatment broadly refers to the administration of appropriate measures for example, drugs or therapy, designed to relieve a pathological condition. Examples include biological treatment, combined, residential and so on. Related terms in the medical field refer to treatment planning, treatment plan and so on.

These medical terms rarely refer to the 28-day type program. Within the medical model, treatment plan is the action that is taken following assessment through physical, laboratory or psychological assessment. It is the treatment plan that provides nurses, doctors and allied health professionals with the "roadmap" of what is needed to alleviate symptoms, arrest disease or provide comfort for irreversible and often fatal consequences of disease.

For the purposes of this supplementary report, treatment will be understood as residential treatment for addiction and/or mental health in a residential facility, for a given length of time.

Key Features of Residential Treatment for Addictions

Broadly there are several key features that make up a residential treatment program, and which relate to the service needs of persons in the NWT.

Key features:

- **Location:** The physical surroundings are often in remote or isolated areas, within a calm and geographical setting, which is helpful when addressing addictions and mental health.

- **Team Approach**: Many different groups of people work in residential treatment centres, and generally include a mix of medical model and psycho-social supports. Usually includes services of physicians, nurses, psychologists, therapists, nutritionists, recreation therapists, occupational/career personnel, volunteers and previous clients. In Aboriginal driven programs, there are traditional healers and other cultural resource persons.

- **Have areas of specialty:** Most residential treatment programs do not serve all populations, and usually have a few areas of specialty. For example, youth and family specific centres in large urban areas will only see youth and families. Some residential treatment centres will not take in clients that are HIV positive, as they do not have medical supports. Other centres specialize in eating disorders, chronic mental health, forensic or justice and other issues. It is rare for any one treatment centre to "do it all".

- **Residential and Outpatient:** Many treatment centres that are large enough in scale, provide residential treatment and outpatient treatment. Outpatient treatment is where clients come during the day for services, but return to another location or their home for the evening.

- **Linked with Community Agencies:** Residential and outpatient treatment programs are rarely seen in isolation and are most often linked with community agencies that provide screening, addiction services, and aftercare support, as well as other services to address housing, education/vocation and other needs. Women's programs are often linked with childcare programs, social services and family violence services, in addition to others.

- **Assessment is Key:** This is likely the most distinctive factor in high quality versus minimal quality programs.

- **Waiting timelines:** There is often a waiting period for entry to a residential treatment program. There are different thoughts on waiting timelines.

  First, with good assessment, catching people with addictions at the right time, can be therapeutic and help them confront their problems. A second theory is that people need to go to treatment when they are ready. Thirdly, it is often recommended that residential treatment be part of a plan of care that may include withdrawal management. Lastly, it is rarely recommended that people go to residential treatment when in a crisis state.

- **Approaches to treatment vary:** There are many different approaches to residential treatment, which include recovery model, medical/biological model, women's perspective, Aboriginal/cultural approach, cognitive-behavioural, religious, and multi-systemic. No one model has proven to be more effective than the other.

- **Treatment is part of a continuum:** Residential treatment is not necessary for all people to address their addiction. It is often a successful component for many to become abstinent, but for others it is only part of their healing process. It is widely held that residential treatment is only effective with 30% of cases seen in their centres, and effective has many variations. As addiction is a relapsing, chronic condition, several forms of treatment, services may be needed, and not all cases can be treated.

3. What does the research tell us about residential treatment?

Research has identified many key factors with respect to residential treatment.

1) Residential versus Outpatient

Recent findings in the addictions literature highlight the cost-effectiveness of outpatient treatment programs. This was good news for policy makers and governments, but confusing evidence for program planners, clients and agencies that provide services. It is important to recognize where this evidence-based finding comes from and the mistake of applying this to rural and isolated areas, such as the NWT.

This finding of cost-effectiveness for outpatient treatment relates for the most part to large, urban settings like Toronto, Chicago and Vancouver, where people can access housing, emergency shelter and withdrawal management services. In remote areas, this cost-effectiveness has yet to be proven.

2) Youth and Family Programs

There are few effectiveness studies with youth, and even fewer with families. Youth residential treatment is again situated in large urban settings, where homelessness is an issue, and hard-core drug and prostitution problems are evident. In some other cases, youth residential programs are linked with corrections and young offenders' services such as in Saskatchewan.

There is often a harm reduction approach with youth, as many would state that dependence has not occurred with youth, due to their age, access to substances and pattern of usage is more experimentation than true dependence.

Family programs are often connected with residential treatment, in recognition that all members of a family unit are impacted by the addiction or mental disorder. Broad family programs are considered the ideal, but are financially not feasible for most publicly funded agencies.

Youth programs are also costly due to the linkages and supports needed such as recreation facilities (gyms), education support (teachers), increase in supervision needed, and expert clinicians who work with youth.

3) Concurrent or dual disorders

It is recognized that addictions rarely are the sole issue needing to be addressed through residential treatment. Studies document a high connection between clinical depression, post-traumatic stress disorder or trauma, personality disorders, anxiety and developmental problems as co-occurring with addictions.

In some cases, it is not clear what is the predominant problem is, addiction or mental disorder.

Aboriginal narrative research states that true addiction is not the case in Aboriginal communities. What this research states is that addiction is occurring as the result of colonization, changing lifestyles, poverty, discouragement, trauma and disconnection from Aboriginal self-determination, and due to the impact of geo-political consequences, such as oil and gas exploration.

Determinants of healthy development seem to work best, if they are reinforced over time, and in a number of environments.

4) Brain Research

Neurological research is pointing more and more to addiction as a brain disease, which is inclusive of problem gambling. It is believed that there is damage done to neurological pathways in the pleasure centre of the brain, that which affects and influences behaviour, judgment and emotions.

Ongoing research efforts into the physical and neurological aspects of addiction are suspected to lead to increasing reliance on non-residential treatment programs and increased reliance on outpatient therapy and medication to adjust neurological imbalances.

Findings from the NWT: Residential Treatment

In 2001, residential treatment services were a major area of concern during the review for the "State of Emergency…report." Prior to 2001, an independent review of the sole NWT treatment centre was completed by Paul Henke (Registered Social Worker or RSW). This report provided specific recommendations in personnel, program content and other facility logistics.

In 2005, many interviewees in all regions spoke of the importance and urgent nature with respect to residential treatment, both in and out of the Territory. There was even more emphasis in the 2005 review expressed by interviewees with respect to services to address hard-core drug dependence, the pressure to have more choices of facilities in the NWT and to address the emerging needs of communities that may be affected as a result of the MGP.

Areas of Success/Strength

§ History of Services in the NWT

Residential treatment has a history in the NWT, through a variety of programs that have operated in previous years.

NAS - Northern Addiction Services - a facility located just outside of Yellowknife, that has provided solvent abuse programs, alcohol and drug programs and trauma programs for men.

Nats'éjée K'éh - This program was initiated in 1990 by Shaadle Society, a group established by the Hay River Dene Band to address alcoholism from a native perspective. The program in its current facility started running several years later, and has maintained input from an Aboriginal advisory group/board.

Delta House - In the 1980's a new Alcohol Centre was opened in Inuvik under the direction of a local board. Several other community alcohol centres were established at the same time, such as the Peel River Alcohol Centre.

Years later, Delta House was put in place as an Inuvik Treatment Centre, and used a downtown building for its program.

Tl'oondih Healing Program - In 1995 the Gwich'in Tribal Council opened its Lodge facility, located south of Fort McPherson and along the Peel River. As part of their land claim, the Gwich'in wanted to design and deliver a family healing program, that would provide a residential program close to the land for families. This program was 90% funded by the Gwich'in and served families across the NWT.

Salvation Army - A withdrawal management program and Life Recovery Program are currently still available in Yellowknife. These programs are based on core addictions and change/recovery processes and emphasize healthy living, coping skills, dealing with maladaptive behaviour and working with people from where they are at. The addictions services located within the Yellowknife facility are part of a series of services offered there.

Currently, only the Salvation Army and Nats'éjée K'éh in Hay River are in operation and funded through the GNWT.

§ Capacity

Due to the changes in the core service of addictions and mental health, there have been changes to the skill level, staffing and scope of services offered at both the Salvation Army and Hay River residential treatment facility.

It is anticipated that more improvements will come in time, and with ongoing development of the Community Counselling Program in communities across the NWT.

Areas for Further Strengthening and Development

§ Crisis Focus with Residential Treatment

It is recognized that often youth present in crisis for mental health or addiction services. It is often easier to refer them to a residential treatment program out of the territory for "safety reasons" and to protect the youth from further self-harm. It is uncertain if a brief crisis, which may be able to be stabilized locally, merits a full residential treatment program.

Residential treatment for youth and adults is best received when withdrawal management, issues of a crisis nature and family turmoil are stabilized.

§ Expertise requires team approach

Residential treatment planning, policy, planning and collaboration work requires a selective expertise in addictions and mental health, including physiological and medical aspects of treatment such as withdrawal management, psychological consequences and concurrent disorders.

§ Assessment and Referral Procedures

This area remains problematic, and likely has only changed laterally from what was seen in 2001. Approval for treatment is still largely financially driven, completed by out-of-scope personnel, and not tied to solid clinical assessment.

Also, there is an understanding that Hay River has the first right of refusal for all residential treatment cases, yet they are not the service providing the clinical assessment of the case.

§ Reliance on Residential Treatment as the Cure

In the last decade, residential treatment has been seen as the "cure" for addictions. It needs to be recognized that treatment is just one small part of a care plan to address mental health and addictions in the NWT.

§ Problem of Choice and Expertise

Many interviewees raised the question of choice in NWT treatment, in that many groups, including Aboriginal groups do not relate to the model of programming in Hay River. In fact, some Aboriginal communities routinely do not use Hay River because of its Aboriginal focus, which is not Christian based.

Also, it was raised that non-Aboriginal people with addictions do not routinely get referred to Hay River because of its philosophical approach and "entry-level" type of therapeutic service.

4. Discussion & Recommendations

There are no easy solutions to addressing the concerns raised with residential treatment, many of which have been discussed in the previous decade in the NWT.

Much consideration is needed when addressing residential treatment services in terms of:

- What can the NWT attract in terms of highly skilled human resources for addictions and mental health?
- What can the NWT afford in terms of facilities that serve a very small population, and across a large geography?
- Avoiding the repeating of historical actions, including the closing of facilities for financial reasons in 1996.
- Linkage with the core work in addictions and mental health, which is being established in all NWT communities.
- One facility and staff pool cannot realistically provide services to meet all the needs of NWT clients with addictions and mental health.

- Reacting to emerging impacts of MGP, and increased drug usage, that is still not the common problem seen in the NWT.

Therefore we, as the review team, suggest the following:

We encourage:

1) Collaborative practice, and taking time to study the relevant issues with a broad group of stakeholders: community personnel, leaders, agencies professionals.

Yes, more study is needed with respect to residential treatment options in the NWT!

2) Doing a few things well

The treatment options available in the NWT are quality programs for what they provide, and given the resources provided.

"You get what you pay for…"

3) Ongoing work with the new core service.

Further improvements are likely to occur in the next year or so as a result of the increased staffing to the Hay River facility and availability of community counselling teams across the NWT.

"Give them time and direction…"

4) Use of Out-Of-Territory Programs that are High Quality

In isolated cases, there is still a need to use Out-Of-Territory Programs for addiction problems that are beyond what the NWT facilities can provide. However, these southern programs need to be monitored by knowledgeable personnel who can assess their suitability, quality and scope of services being provided.

5) Prioritizing child and youth services for solutions, as it is unlikely that an NWT facility could meet these needs, within cost-effective measures, have adequate human resource expertise and scope of programs to meet the isolated needs of a small group of youth.

6) Building on strengths from existing community counselling programs, and PCCT in addition to other community partners that have a relevant part to play.

7) Maintaining Funding resources for the current programs, and addressing gaps in service with increased funding. A system of performance indicators, improved usage of beds and timelines throughout the year is needed. However, this would likely come at a cost, with increased staffing.

"The staff in Hay River, provide the best service they can, within their areas of expertise and numbers of staff members. In comparison with Southern facilities, they are understaffed, in terms of numbers of personnel."

8) Ongoing collaboration and expertise!

9) Problem Gambling

This is becoming a cross-over addiction for many people in the NWT, as well as across Canada. It is more predominant among women and can have even more devastating effects on families, as there is no "pass-out time". Further study and decision at the policy level is needed to decide limits of responsibility of the DHSS with respect to problem gambling.

Note: Problem gambling, according to research, impacts the same brain centre as alcohol addiction, drug addiction and so on. It is being studied as a brain disease as well!

10) Services for Older adults with Addictions

As the population ages, it is likely that more and more older adults may seek out residential treatment. Many programs in large settings, already routinely take in adults over the age of 70 and 80.

"It is never too late…."

We suggest avoiding:

1) Residential treatment programs as the answer to addiction problems in the NWT.

Residential programs play an important part in the recovery of addictions, and it is likely that many people have become sober or clean as the result of these programs in the past, including leaders, workers and others.

Building new facilities is far from addressing the other core gaps and challenges. In fact, there are several facilities, that are currently sitting

empty, that could be re-opened with adequate resources, personnel and political will.

It is strongly recommended that the GNWT look to its history with residential facilities, learn from past experiences, and avoid crisis-style reaction planning in dealing with addictions.

2) Blaming current facilities for lack of capacity across the NWT

Most residential treatment facilities rely on their inherent human resources capacity to be successful and reach people in need.

The NWT is on the right track by improving capacity with qualified people in addictions and mental health. This will take time.

3) Making "one-size fits all"

It is recommended that current facilities do a few things well, rather than trying to meet political and community concerns in all areas of drug and addiction treatment.

Next Steps/Further Recommendations:

A considerable number of recommendations, as listed in the larger report: "Stay the Course…" (2005) are listed here for relevance to Residential Treatment.

It needs to be recognized that many of these recommendations are ongoing and are to be expected for the implementation of such a core service, like mental health and addictions, which is inclusive of residential treatment. The number of recommendations listed here from the larger report does not in any way imply or suggest that residential treatment services are "rock bottom".

On the contrary, these recommendations reflect the large scope of areas that relate to residential treatment and the need for integration.

The numbers beside each recommendation refer to the number as listed in the Interim Report.

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, Authorities 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.

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.

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 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.

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 what skills, education and training are needed for 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.

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.

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.

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…

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 what changes are needed for this reference document in the NWT.
(There were previous efforts to develop residential treatment specific standards in 1996.)

29. Consider developing an addiction medicine advisory group/committee with possible assistance from out-of-territory specialists in addiction medicine, that 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.

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.

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

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 is 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. 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)

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)

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 ability 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, Tulitat/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:

   (a) geographical areas
   (b) 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 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.