Supplementary Report: Review of the 48 Recommendations from the "State of Emergency…" (2002)

"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

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Submitted to:

The Department of Health and Social Services
Yellowknife, Northwest Territories

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Summary of "Interim Report Card"

Review of the 48 Recommendations from the "State of Emergency…" (2002)

A. Overview

This review provides the reader with a summary of the 48 recommendations from the "State of Emergency…" (2002) report, as released by Chalmers & Associates Consulting Ltd. 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 integrating into a model of integrated service delivery. As well, family violence services were in transition in 2001 and were positioned to be integrated.

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.

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 Section 8 of this Final Report.

The ratings given in this "Interim Report Card" are those of the review team of Chalmers & 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)

Recommendation (2002)	Subject of Recommendation	Effort	Interim Result
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 Services	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)

Recommendation (2002)	Subject	Effort	Interim Result
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- ***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.***

Structure, Systems and Linkages

Recommendation (2002)	Subject	Effort	Interim Result
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	Nats'ejée K'éh 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 review team's review of the "Interim Report Card":

- Assessment of "A" (very good and continue to improve) were seen in overall effort, financial investments, prevention focus (Community Wellness Worker positions), development of the Community Counselling Program, community-based focus of the core service, and 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, such as Authorities, and the incorporation of Aboriginal perspectives on mental health and addictions.

- 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.

Review of 48 Recommendations from "State of Emergency…" (2002)

Legend of Findings

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-	***Measured through quality, effectiveness of efforts, degree of consultation, attention to community/cultural and context of services being delivered*** ***Not simply a quantitative measure of how many documents, or positions created.***
Interim Result-	***Evidence is available to assess, given that this is an interim report of the progress of the Mental Health and Addictions Strategy***

Administration and Management

2002 Recommendation Integration Mental Health and Addiction Services

1. The evaluation team recommends the Department of Health and Social Services, NWT communities and Regional Health and Social Services Authorities work together to incorporate the findings and recommendations of this evaluation report into the proposed model of integrated counselling services which is inclusive of mental health, addictions and family violence counselling services.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- § ISDM is inclusive of mental health and addictions services (GNWT, 2004).
- § Family Violence services continue to be supported within the Territory.
- § Work continues within each region and across the NWT to fully realize an ISDM continuum of services.

What are relevant links to research and best practices?

- § Working within interdisciplinary and integrated teams of health and social services is consistent with quality and timely care (Romanow, 2002).

What do the people say?

"With any new system, there are things to work out, but we are on the right track."

Discussion/Comments:

There has been significant work completed with the development of mental health and addictions as a core service since 2002 across the NWT.

The Community Counselling Program is evidence of the work accomplished to date. The general framework is in place and it is now time to "stay the course", adapt the Program as needed, to be responsive to the needs of communities, and build support to continue with the improvements already made.

Also, as ISDM planning and the reforming of facility and medical services occurs, there is an ongoing need to integrate the full range of mental health and addiction services within these plans, including improved delineation of activities for each member of the ISDM team.

Next Step/Further 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."
(Suggested Timeline: Ongoing)

2002 Recommendation Definition of Addictions

2. The GNWT must develop a working definition of addictions that is inclusive of the biopsychosocial model, family/cultural values, disease model of addictions, relapse prevention and chronic conditions.

This definition could form part of the program standards on addictions services in the Northwest Territories to ensure a service that is consistent and of an excellent quality.

	Effort	Interim Result
Assessment	**C**	**Unable to Evaluate**

What is the evidence for this finding?

§ Different resource people define mental health and addictions differently; some are inclusive of gambling and others are not. Some interviewees lack understanding of the continuum nature of addictions, scope of diagnostic categories, concurrent and/or dual disorders and cross-addiction.

§ Confusion exists from region to region as to what is the scope of addiction/mental health receives assessment, intervention, treatment and/or ISDM services.

§ Without a core definition of what constitutes mental health and addictions, there is a challenge to understand what services are needed.

What are relevant links to research and best practices?

§ Various groups, including the World Health Organization, the Addiction Research Foundation (ARF), Health Canada and National Native Alcohol and Drug Abuse Program (NNADAP), have compiled models and definitions of addictions and mental health to serve various purposes (ARF, 1997; Health Canada, 2001; WHO, 2002).

What do the people say?

§ "The children need education about drugs, in addition to alcohol."

Discussion/Comments:

An NWT working definition of addictions has not yet been completed. It will be important within an ISDM continuum of services and working with different resource persons to have a common language, definition, understanding and reference as to mental health and addictions. In addition, communities across the NWT may have histories of what is considered mental health, and what is considered an addiction.

Therefore, any definition needs to be respectful of community values, traditions and practices. This work would need to be done in consultation with communities and resource/caregivers who would provide mental health and addiction services.

Next Step/Further Recommendations:

Work with communities, Authorities, and PCCT 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 planning, implementation, human resource management, training and prevention efforts.
(Suggested timeline: in the next 12 months)

2002 Recommendation Expertise

3. Addictions expertise, in terms of knowledge and skills, must be developed in the NWT and/or sought out from other areas across Canada and integrated into all aspects of addictions services.

	Effort	**Interim Result**
Assessment	**B**	**C**

What is the evidence for this finding?

- With the incorporation of community wellness workers, mental health counsellors and clinical supervisors, the Community Counselling Program is addressing the issue of relevant expertise.

- Different levels of expertise are available across the NWT, with a limited network of communication among these resources.

- The Department of Health and Social Services has policy, organizational and planning/evaluation expertise, and some mental health and addiction expertise but is viewed as being disconnected from what happens in NWT communities.

- There are gaps in knowledge, skill and awareness of the complexity of the bio-psychological- social implications of mental health and addictions problems within the entire ISDM team.

What are relevant links to research and best practices?

Addictions and mental health problems are complex issues that cannot be explained by any single set of factors or addressed by any one resource (ARF, 1997). The best approach requires the input of the person seeking help, their family, a variety of resource persons and a range of possible treatments, approaches and medications, if needed.

The field of mental health and addictions is inclusive of many groups of health, education and prevention personnel (medicine, nursing, psychology, social work, counselling and therapy, prevention, education, religious and spiritual approaches, traditional healers, youth and criminal justice personnel, recreation and leisure, early childhood and prenatal approaches and others…).

What do the people say?

"We need qualified staff in all areas of addictions and mental health."

Discussion/Comments:

- Disconnect between what is needed and provided elsewhere in Canada, and believed to be a " luxury" in the NWT.

- Challenges in recruitment and staffing all positions across the NWT was assessed by some interviewees as an indication that the standards are too high; however, very few have these views, but it causes confusion regarding the move to address the "State of Emergency…" (2002).

- Expertise is needed from a variety of sources, disciplines, approaches and communities across the NWT to address mental health and addiction problems in the NWT.

Next Steps/Further Recommendation:

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. (Suggested timeline: ongoing)

Continue to work on developing standards for what skills, knowledge and competencies are needed by all PCCT members, including nurses, physicians, and all those working in health and social services delivery across the NWT. (Suggested timeline: in the next 12 months)

2002 Recommendation Quality of Community Addiction Programs

4. There is an urgent need to address the quality of community addictions programs across the NWT in terms of program definition, management, scope of delivery, clinical content and education and prevention activities offered in the community.

	Effort	Interim Result
Assessment	**A**	**In Progress**

What is the evidence for this finding?

§ There has been great improvement in the scope of human resources within mental health and addictions across the NWT. Some isolated areas have ongoing challenges that are complex such as the transition to a new health Authority in the Sahtu region, changes in senior management at others and negotiations with Authorities for workers who were already in the system. However, despite these challenges, improvement is very evident and the impacts are beginning to be realized through these improvements.

§ Work is needed to solidify this new workforce in mental health and addictions and to continue with financial resources to maintain this growth and also to address specific areas where challenges remain.

What are relevant links to research and best practices?

§ Skilled and knowledgeable personnel are necessary in addictions, and there is an indication of specialized training needed to address the needs of women, youth and other at-risk populations (Health Canada, 2001).

What do the people say?

§ "We need trained and educated people at the community level to impact change; but also we need our own people to get that training and education, just like the nurses and teachers."

Discussion/Comments:

§ It may be challenging at this point in the implementation of the strategy to fully realize quality programs to the degree desired due to a number of factors such as recruitment, space allocations, community integration.

However, a developmental timeline approach to realizing the desired community mental health and addiction program is needed, which includes identification and prioritizing of relative issues. For example, long range planning for a "made in the NWT" workforce of mental health counsellors and supervisors is needed over the next 10 to 20 years.

- In the interim, short-term solutions, flexibility to provide community solutions to HR shortages, housing problems and space limitations may be needed. For example, Norman Wells has contracted out services in the short term, while their Health Authority gets established, as it has only in operation since April of 2005.

Next Steps/Further Recommendation:

- 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 detracts from the process of improving mental health and addictions services. (Suggested timeline: ongoing)

2002 Recommendation Building Accessibility

5. Any programs that require relocation of services should be housed in buildings that are accessible to all. This is an area that should be investigated by the appropriate Authorities.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

6. In the future, the design/layout of Community Health Centres should be inclusive of counseling/social service agencies so as to provide a coordinated approach to care.

	Effort	Interim Result
Assessment	**A**	**Unable to Evaluate**

What is the evidence for this finding?

- Where possible, visits were done with Community Counselling Programs to assess accessibility issues in addition to other factors. Many Community Counselling Programs remain in the same locations as per the 2001-02 site visits.

- Many community counselling sites are aware of challenges to accessibility for older adults, those with limited mobility and also for clients who prefer privacy and strict confidentiality. Some sites have poor accessibility and counselling staff compensate by providing home visits.

- ISDM implementation is ongoing, which is inclusive of mental health and addiction services within a primary care setting. Some resource persons in mental health and addictions are ***not in favour*** of co-location in community health centres if new facilities are developed in the decades to come.

- Other community counsellors are in favour of co-location with other Primary Community Care Team members for treatment planning, continuity of care, shared use of reception services, provision of safe working areas, and integration of health services.

What are relevant links to research and best practices?

- In general terms, the concurrent disorders population refers to those people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of substances. These clients and others with medical or mobility problems may require adapted environments for counselling services. (Health Canada, 2002)

What do the people say?

> "My office is not ideal, as elders and people with physical challenges may have a hard time to climb the stairs. That is why I do home visits."

Discussion/Comments:

Clients with mental health and addiction problems that have mobility challenges are more than likely to have complicating problems such as visual problems, other chronic health problems such as diabetes or heart difficulties.

It is here where a team approach, that is the use of the Primary Community Care Team or PCCT, and an integrated service delivery model (ISDM) can deliver services for these clients.

Next Steps/Further Recommendation:

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. (Suggested timeline: 3 to 5 years and ongoing).

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. (Suggested timeline: 5 to 10 years)

2002 Recommendation Space and Equipment

7. Serious consideration should be given by the Health and Social Services Authorities to the physical space and equipment required by addiction programs.

	Effort	Interim Result
Assessment	**B**	**In Progress**

What is the evidence for this finding?

- § HSS personnel are aware of the requests being put forward for office equipment, comfortable furniture for counselling and other equipment.

- § There appears to be uncertainty about the availability of resources for equipment that could be made available for Community Counselling Programs.

- § Priority for the new positions was evident, with the realization that equipment needs were secondary to hiring of these new positions.

What are relevant links to research and best practices?

"Co-location means services are physically located in the same place, or close by. Co-location is particularly useful for medical and mental health services." (GNWT, 2004).

What do the people say?

- § "We need filing equipment, such as a locked filing cabinet; the nurses have them at the Health Centre."

Discussion/Comments:

There are highlights here, where Authorities have moved Community Counselling Programs into larger facilities to accommodate the staff involved in the Program. There are incidences of social work and counselling staff housed in one building.

There are still ongoing concerns with regard to the capital needs for furniture, equipment and filing cabinets. This appears to be an Authority dependent variable, where some Authorities have been able to manage better than others.

Equipment needed for Community Counselling Programs is inclusive of reference materials, prevention materials/workbooks, paper supplies for filing, and equipment to ensure storage of client files such as filing cabinets.

Next Step/Further Recommendation:

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. (Suggested timeline: in the next 12 months)

2002 Recommendation Minimum Standards for Education and Training

8. There is an urgent need for the Department of Health and Social Services to set minimum standards for the post-secondary education and skills of addictions counselors.

It is recommended the minimum standard or entry level position be a post-secondary diploma in the social sciences (consistent with NWT social work).

It is recommended the general standard or junior level position be an undergraduate degree in the social sciences or an equivalent diploma program with additional course work or practicum hours completed.

The ideal standard would be a Masters in Counselling Psychology or Clinical Social Work; persons with this education and appropriate skills in addictions and counseling would suit a clinical manager or team leader position and would supervise entry and general level counselors.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- There is generally confidence in the raising of standards for skills and education of community counselor positions.

- There is precedence in the NWT with other resource and care professions, of the importance to have qualified persons in these positions. Nursing, social work and teaching have all worked through similar challenges in recruitment, training/education equivalencies and setting minimum standards, with good results in being able to provide qualified staff. The Community Counselling Program deserves the same respect as these professions in meeting minimum standards.

- There were few interviewees (3 of 70) who were unsure of the changes made to improve the minimum standards for training and education, as they had little background as to the history of mental health and addiction services in the NWT in the last five years. Also, these interviewees were mainly concerned with recruitment, and were also not aware of national and provincial standards for competency in these areas, which is inclusive of Aboriginal communities and services.

What are relevant links to research and best practices?

The University of Athabasca has recently introduced a new four-year degree program, Bachelor of Professional Arts. This degree is intended to prepare students for entry-level positions in counselling (Athabasca, 2005).

The Canadian Counselling Association only recognizes a Master's level training or Doctoral training in the social sciences for their designation of Certified Community Counsellor (CCA, 2005).

What do the people say?

- "It took us so long to raise the bar for what is needed in mental health and addictions."

- "I am not sure why we need these post-secondary levels of training/education to provide addiction counselling…."

Discussion/Comments:

The Department of Health and Social Services has set minimum standards for staff in the Community Counselling Program. The bar has been raised.

Many positions are being staffed by persons who hold appropriate education and credentials. Other positions are being filled with workers who are engaging in education and training to meet the new standards and skill levels. However, there is a perception from some communities that there is only recognition of academic approaches to addictions and mental health services through university degrees. The traditional element of life experience and work experience can be easily lost.

In reviewing the job descriptions, education is but one of the criteria needed and furthermore, the human services fields, such as counselling, psychology, nursing and social work rely heavily on practicum and field experience. It is in these areas, that many people have experience, but may lack knowledge in respective areas of prevention, mental health and family violence.

Care must be taken to ensure that equivalencies are considered in the mix of community wellness workers, mental health counsellors and supervisors working in the community counselling program.

Incorporate equivalencies in credentials, education and training for all positions, especially for those workers who were employed prior to the implementation of the Community Counselling Position. The element of "grand-fathering" is recognized in health care professions where a system is undergoing change.

Next Step/Further Recommendation:

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. (Suggested timeline: ongoing)

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 process and implementation of minimum standards in community counselling positions, and industry standards of training and education across Canada. (Suggested timeline: ongoing)

2002 Recommendation Prevention Positions

9. There is a need to establish community education positions within the delivery of addictions services. This position may be filled by workers already working within the addiction programs in NWT communities.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- The community wellness worker position has been adapted from the alcohol and drug worker positions that previously provided education. The community wellness worker is positioned to spend a majority of their focus on public education and prevention programming in most NWT communities.

- There is excellent community/regional support for these workers across the NWT to bring about prevention of mental health and addictions in the years to come. Also, remuneration and education and training opportunities are well laid out to encourage a Northern workforce in these positions.

- Over 70% of the Community Counselling Program positions are Community Wellness Positions.

What are relevant links to research and best practices?

The Primary Community Care Team already provide promotion and prevention core services in NWT communities, and a greater emphasis on health promotion and prevention is expected as these teams develop (GNWT, 2004).

Addictions and mental health experts emphasize the place of education and prevention work in working with young people to reduce addictions and to build resilience and minimize the impact of mental illness.

What do the people say?

- "We need to teach our young people about the dangers of new drugs."

Discussion/Comments:

Community education positions within the delivery of addictions services have been created in the form of Community Wellness Workers. 45 out of the newly created 77 positions within the Community Counselling Program are Community Wellness Workers.

The great majority of these positions are filled by individuals who were already working at the community level.

These prevention positions are one major highlight of the new strategy and the NWT can be a leader in the area of prevention and early intervention for other jurisdictions across Canada.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

2002 Recommendation Need to develop Aurora College Program

10. The Aurora College two year post-secondary addictions counseling diploma must be re-developed and re-designed within the next eighteen months to meet the need for entry level community counselors. This Diploma program needs to be linked with a University, which would offer transferability of Aurora College course credits towards further education.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- The Keyano College (Alberta) Wellness Certificate was used in the NWT to provide education/training for community wellness workers in the last two years. A number of people have completed the program, with others to come in 2006.

- Although the Keyano College program was accepted for the immediate training needs of wellness workers, there is a desire to have a "made in the NWT" program of post-secondary education.

What do the people say?

"We used to have a NWT certificate and diploma program in addictions."

Discussion/Comments:

A partnership has been established with Keyano College out of Alberta to deliver a Community Wellness Worker Certificate to the Community Wellness Workers employed by the Community Counselling Program. This has been a huge initiative and there have been many successes in 2005 and more to come in 2006, when another group completes the training.

The Community Wellness Certificate offered by Keyano College does have transferability to some universities across Canada.

There are several areas of concern:

a) Continuity – will this program be continually offered by the Department of Health and Social Services?

b) Competencies – there are still many competencies that need to be addressed within the scope of the training – not all competencies required by Community Wellness Workers have been addressed with the Keyano College Certificate Program.

c) "Made in the North" – This has been mentioned by many as work that Aurora College needs to address in providing a northern and territorial program. The issues of competencies and transferability of courses must be included in the design of any made in the NWT program.

Next Steps/Further 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. (Suggested timeline: ongoing)

2002 Recommendation Addiction Specialist & Treatment Referral

11. There is an urgent need to re-assess the Addictions Specialist position at the regional level in the short term, re-assign clinical responsibilities such as treatment referral to educated and skilled clinical staff and in the long term, re-assess the need for these positions within a new NWT structure of Addictions, Mental Health and Family Violence Counselling.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- There are no Addiction Specialist Positions in the Community Counselling Program across the NWT.

- Regional clinical supervisor positions have been created to address issues of supervision, mentoring and expertise in both mental health and addictions across the NWT and at Nat's éjée K'éh.

- These new positions are finding their way around issues including employee supervision, administrative responsibilities, working with NGO's (Tree of Peace, Tl'oondih Healing Society) and other duties as assigned by each Authority for their respective regions.

- Many of the responsibilities previously carried out by the Addictions Specialists are now performed as part of the responsibilities of Regional Clinical Supervisor. Also, referral to treatment occurs through a series of approvals, and a committee within the Department of Health and Social Services.

What do the people say?

"I like the role of the clinical supervisor; they act as a mentor, someone I can refer to for direction with my clients."

Discussion/Comments:

The position of Addictions Specialist at the Regional Level has been re-profiled in some regions. In other regions, the work has been undertaken by mental health managers, which may or may not include clinical supervision responsibilities.

However, problems remain with referral to treatment and the many stages and approvals needed, despite the changes made to these regional positions.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

Treatment and Program Effectiveness

2002 Recommendation Funding for Addictions Services

12. Current funding levels for human resources, program activities and physical space and equipment must be reviewed by the Department of Health and Social Services Authorities. Additional funding will be needed to match increased standards for education and skills and needs to be consistent with current funding structures for social work positions.

	Effort	Interim Result
Assessment	**A**	**In Progress**

What is the evidence for this finding?

- Additional resources were made available to the core service of addictions and mental health to improve staffing of positions within the community counselling program, at Nat's éjée K'éh and with selected NGO's engaging in addictions and mental health services.

- Few enhancements were made available for improvement of facilities, offices, equipment, resource materials etc.

- Funding levels for Addictions and Mental Health have ***not returned*** to previous levels seen in the 1990's when several residential treatment programs were in operation across the NWT.

What do the people say?

"We welcomed the increases in funds available for positions, but more is still needed to us to meet the needs in our region."

Discussion/Comments:

There has been an infusion of resources for the Community Counselling Program. Work remains to be done and some is, in fact, already in progress. For instance, the Department together with Authorities is looking at the physical space to house some Community Counselling positions in NWT communities.

The job descriptions of the new positions were completed. However, there is some concern as to the pay levels for some of the positions. Not all of the positions are at the industry standard; in fact, in some cases the funding levels when adjusted to northern standards fall well below industry standards. Wage comparisons in neighbouring provinces could be useful to the Department with regard to funding these positions, and assigning appropriate pay levels. Additional financial resources are needed to provide the appropriate salaries for these addictions and mental health positions.

Next Steps/Further Recommendations

Review job descriptions and pay scales for Mental Health and Addiction Counselors, 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. (Suggested timeline: within the next 12 months or sooner).

Address funding for operational costs, evaluation/monitoring tools (standardized instruments), office/reception support and furniture and computer equipment, where needed (Suggested timeline: within the next 12 months)

2002 Recommendation Cost Effectiveness

13. A formal cost comparison between the costs for addictions services and health care costs related to chemical dependency is recommended and should be monitored regularly by the Department of Health and Social Services.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

- There is no direct evidence of work on this recommendation; however, the DHSS has provided additional resources to the core service to address the problem of addiction across the NWT.

- Most interviewees believe that costs for health care, child protection and justice/corrections are largely driven by the problems and consequences of addictions in the NWT.

What are relevant links to research and best practices?

The Canadian Centre on Substance Abuse placed the costs associated with alcohol use in Saskatchewan at $266 million in 1992 or $265 per capita. This included $40.2 million in direct health care costs, $62.4 million in direct law enforcement costs, $0.5 million in direct losses in the workplace, and $139.6 million in indirect productivity losses. Today, those costs are likely higher, and will continue to rise without action to reduce problematic substance use and its impact on individuals, families and communities (Secretary on Substance Abuse, Prevention and Treatment, 2005).

Given the above reference figures, it can be estimated that a similar pattern is evident in that a high proportion of direct health care costs are associated with alcohol and drug use in the NWT.

What do the people say?

"We need to have our own NWT research tell us where to spend our health care dollars, as I am sure that many costs can be prevented through a reduction in addictions related costs."

Discussion/Comments:

This cost comparison can come out of work done over time, and can help to justify the necessary resources for the core service of mental health and addiction services across the NWT.

Team work within the core services will be essential to accomplishing this cost comparison, and can help guide the allocation of the necessary resources in the years to come for prevention, intervention and treatment of mental health and addiction services.

Next Steps/Further Recommendations:

Establish NWT research projects in the areas of program effectiveness, outcome monitoring, and cost effectiveness for mental health and addiction services. (Suggested timeline: in the next 3 to 5 years)

2002 Recommendation: Funding Partnerships within GNWT

14. Funding partnerships with the Department of Justice and the Department of Health and Social Services are suggested with respect to young offenders and repeat offenders. Provisions should be made to provide high quality addictions programming for young offenders and adults serving time in NWT correctional facilities.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

§ There is no evidence to evaluate.

What are relevant links to research and best practices?

There is a changing pattern in the type and number of offenses and crimes being committed in many NWT communities (NWT, 2005). These changing crime patterns are of concern to community members and leaders.

What do the people say?

"There is a link between crime and addictions; almost all of our community members who are in Corrections because of offenses they committed, are there because they committed these crimes while drinking or using drugs."

Discussion/Comments:

This interim report did not include reviewing addiction or mental health services in correctional facilities.

An NGO in Yellowknife, the Salvation Army, provides addiction programming to various groups, including the homeless and clients released from corrections.

Further exploration and integration of these programs is needed, especially with respect to chronic drug users, people with chronic mental illness, concurrent disorders and for clients needing withdrawal management services.

Next Steps/Further Recommendations:

Partnerships need to be formed with schools, Boards of Education, and the Departments of Education, Culture and Employment and Justice.
(Suggested timeline: in the next 1 to 2 years)

2002 Recommendation Approval process for residential treatment

15. The approval process for residential treatment services needs to be re-assessed following improved service delivery. Attention is needed to assure that qualified clinical staff is making the decisions in partnership with clients as to the appropriateness of residential addictions treatment.

	Effort	Interim Result
Assessment	**A**	**C**

What is the evidence for this finding?

- A procedural change was put in place to address referrals to residential treatment with the Authorities and the DHSS.

- Feedback regarding this procedural change has not been good throughout the NWT, as it seems as if decisions are made purely from a financial perspective, versus a clinical need.

- There are questions being raised as to the credentials, expertise and knowledge of the committee who reviews individual applications for residential treatment. It is believed that the committee is not qualified to make these clinical decisions.

What are relevant links to research and best practices?

Residential treatment is one part of a continuum of services of dealing with substance abuse (ARF, 1997).

There remains evidence that effectiveness rates for outpatient addiction treatment can be as effective as inpatient or residential treatment. Outpatient addiction treatment refers to a set program, over a period of time that is inclusive of various program topics/approaches and counselling (Health Canada, 2001).

What do the people say?

"My clients do not believe in the traditional ways that they use in Hay River, and there are no more choices of treatment."

Discussion/Comments:

There have been changes to the approval process for residential treatment services. Addictions specialists no longer provide this service consistently across the NWT.

However, there is disagreement among many resource persons throughout the NWT of the necessity of the "paperwork", approval processes, and use of an Authority and territorial management to make clinical decisions.

There is inadequate use of standardized, and clinical assessment material within the Community Counselling Program to assess suitability for residential treatment.

Until the expertise level in mental health and addictions is recognized, validated and managed with appropriate expertise throughout the NWT, at the single territorial treatment centre, and within all DHSS and Authorities, the approval processes for residential treatment will be problematic.

Next Steps/Further Recommendations

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. (Suggested timeline: ongoing).

See Supplementary Report: Residential Treatment

2002 Recommendation Confidentiality and Treatment Referral

16. Issues of confidentiality, dual relationships and conflict of interest need to be addressed with respect to the approval of clients for residential treatment. Health and Social Services Authorities should balance the need for client information for administrative purposes with maintaining confidentiality and ethical practice.

	Effort	Interim Result
Assessment	**B**	**B**

What is the evidence for this finding?

- Changes with the staffing and expertise of addictions and mental health counsellors has changed the approval process for clients to attend residential treatment, either in the NWT or outside of the Territory.

- Decisions about attending treatment are made by persons with little connection to the clients, hence addressing issues of dual relationships.

- Despite changes to the approval process to minimize dual relationships and problems with confidentiality, core service workers still express dissatisfaction with treatment referral processes.

- There is confusion among community workers regarding the role of the committee and how decisions are made.

What do the people say?

"It seems like a lot of paperwork to refer people to treatment, and I am not sure why all of this has to go to Yellowknife; where is the confidentiality?"

Discussion/Comments:

The assessment package has not changed and some of the detailed information regarding a client is still “available” to administrative personnel. Confidentiality remains a concern for many people who refer clients to treatment.

It needs to be recognized that treatment is a costly service, and may not be suitable for all clients.

However, residential treatment, which usually includes withdrawing from substances, developing coping skills and engaging in counselling, is often needed for many people with addictions.

"The use of the single residential treatment centre in Hay River as a fancy withdrawal management program is not such a problem, if that is what the client needs. They cannot do everything in one treatment centre, and I do not have a problem with that." (as said to this interviewer, from a regional interviewee).

Next Steps/Further Recommendations

Develop a consistent, working group of representation from across the NWT, different disciplines, community level personnel, NGO, Authority and DHSS, and hospital staff to advise, direct and provide the content for the DHSS to proceed. (Suggested timeline: ongoing)

See Supplementary Report: Residential Treatment

2002 Recommendation Regional Staff

17. Regional clinical staff need to perform the duties they are trained for and limit their time spent with administrative tasks.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

- A team approach is becoming evident within each Authority but requires ongoing work to secure these relationships, clarify position responsibilities and address issues that remain due to the transition of previous positions and workers into a new system of service delivery.

- Authorities have profiled their clinical supervisors and mental health managers as the next line of authority from the community based programs. In some Authorities, these positions provide direct service and in others, their roles are still being developed but also include administrative tasks.

- Regional psychologists positions do not appear in the new structure of Community Counselling Program, or PCCT or core service of mental health and addictions.

- The role and responsibilities of psychologists are less clear in the new core service of addictions and mental health, and yet they are the only regulated profession within the NWT through legislation.

What are relevant links to research and best practices?

Multi-disciplinary teams work in the fields of addictions and mental health; this often includes prevention workers, counselors or mental health counsellors, psychologists, social workers, nurses, physicians, recreation people and others. (ARF, 1997; Health Canada, 2001)

What do the people say?

"I am not sure what are the new positions in the Authority?"

Discussion/Comments:

Clarify/develop roles and communication systems with all staff that works with the core service of addictions and mental health.

Next Steps/Further Recommendations:

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

2002 Recommendation Continuum of Mental Health/Addiction Services

18. Addictions services need to be part of a continuum of health care services that are available for every woman, man, child and family in the NWT and should be managed, funded, monitored and evaluated in the same manner as Community Health Centres and Social Work Services.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- The ISDM is inclusive of the core service of mental health and addictions services, in addition to other core services (diagnostic and curative services, rehabilitation services, protection services, continuing care services and promotion and prevention services).

- Mental health and addiction services require the expertise of many health disciplines, community partners and the experience of certain NGO's that cater to targeted groups of clients and therefore belongs in the ISDM.

- Communities in the NWT vary greatly in size and level of services that can be provided. In keeping with the slogan "it takes a community to raise a child ", it is ill-advised to separate child and youth services from the work being done with their parents.

- People in communities have been asking for family based services, as it is not ideal to send a youth out for treatment, only to have them return to the same family situation in the community.

What are relevant links to research and best practices?

Mental health and addiction problems are physical, mental, psychological and socially complex problems that are of a relapsing, remitting nature, just as diabetes or MS (Leshner, 1998).

Recent research points to more and more physical consequences of alcohol and drug use and worsening of any other health problems such as diabetes, coronary artery disease, hypertension, lung problems and others with ongoing substance abuse and dependence (ARF, 2000).

What do the people say?

"We need community and family based services."

Discussion/Comments:

The Department of Health and Social Services has recently adopted an ISDM of health care services. Mental Health and addictions services are included as one of the core health services in this model. The Department is on the right track. The inclusion of these services into the ISDM must be re-iterated to the rest of the health care team. “We are here to stay.”

With regard to the services for children and youth, there has been much discussion throughout the interviews across the NWT. Many believe services exist as part of community services, where people have skills and experience. In other smaller communities, wellness workers and mental health counsellors have limited training in working with children and youth.

Strengthening of these services can come from within. For instance, there are regions where play therapy is used in the approach with children and youth. In terms of services for children and youth, look at the existing services in the community and build from the community up.

It is not feasible to have a territorial treatment centre for children and youth at this time for a number of reasons; lack of numbers to justify a continuous service, difficulty in recruiting clinicians, and the inconsistency with cultural beliefs of "taking away the child" from their home. This practice of moving children away from their home is similar to those experiences of residential schools, which have been problematic in the long term for Aboriginal families and communities.

However, additional community based services and regional supports need to be developed to address the specialized needs of children and youth with mental health and addiction problems. For example, expertise from the community, combined with the assessment and treatment planning services of a child psychologist can be used to help meet the needs of traumatized youth and children.

Next Steps/Further Recommendations:

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.
(Suggested timeline: ongoing)

2002 Recommendation Administrative Demands

19. Immediate action by the Health and Social Services Authorities is required to reduce the administrative demands on Community Addictions Workers and regional clinical staff so that they can provide clinical services.

	Effort	Interim Result
Assessment	**C**	**C**

What is the evidence for this finding?

- There were few Community Counselling Programs that have adequate office and administrative support. Some programs share office space with other community initiatives and have found creative ways to address the void of reception and administration support.

- Mental health counsellors would like to engage in client monitoring through self-report measures, but have no administrative time or staff to conduct this work. A few programs are already engaging in symptom monitoring and standardized assessment procedures.

- Some NGO's are given little flexibility from Authorities in deciding what program priorities are needed in their Community Counselling Programs.

- Counsellor safety is a concern for those who work in isolation, and without support and needs to be addressed, before an incident occurs.

What do the people say?

"We need to have reception services, even if we have to share with others, as it helps with the clients, provides safety, and we can also have them do paperwork."

Discussion/Comments:

There has been little action on the part of the funding partners to address the administrative load on Community Counselling Programs.

Administration/receptionist support is found in few programs, yet there is a critical need for these positions. This need relates to a workload and safety issue for the counselling staff, especially in small communities where there is only one staff member.

Lack of administrative support often translates into lack of data entry and this represents missed opportunities for program evaluation, client tracking and other risk management tasks involved with the maintenance of confidential information.

This issue may be resolved to some extent if Community Counselling Programs are fully integrated with PCCT, including the assistance of administrative support or co-location with other team members.

Next Steps/Further Recommendations:

Address funding for operational costs, evaluation/monitoring tools (standardized instruments), office/reception support and furniture and computer equipment, where needed (Suggested timeline: within the next 12 months)

2002 Recommendation Credentials in Mental Health and Addictions

20. There is a critical need to address the issues of credentials, knowledge, skills and education in the field of addictions and mental health in the NWT.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- Improvements are noted in the education and training of wellness workers across the NWT, which replaced previous alcohol and drug workers.

- Efforts were also noted in securing clinical supervisors and mental health counsellors across the NWT either through recruitment, direct appointments or through training plans of existing workers.

- Efforts were also noted with Nats' éjée K'éh program staff in terms of broader credentials, knowledge, skills and education.

- There was little change in the combined scope of credentials, knowledge and expertise within the DHSS core service mental health and addictions team. Also, due to turnover of senior management, there have been gaps in program specific leadership and management of the DHSS policy and core service group within the DHSS.

What are relevant links to research and best practices?

Program/client monitoring is useful through self-report and other measures and is part of an evidence-based service of mental health and addiction services.

A baseline measure of functioning can be measured with a standardized instrument, provided the counsellor has the relevant expertise and experience. After a counselling intervention, the same measure is given to the client so as to monitor progress and symptom reduction. This is one example of a performance indicator within a counselling program (ARF, 1997).

What do the people say?

- "As it stands now, the new requirements for education and training are still below what is provided in our neighbouring provinces of Saskatchewan and Alberta in mental health/addictions. It is a start in the right direction."

Discussion/Comments:

There remain misconceptions within the DHSS and at some Authorities of what are industry standards for credentials, education and skills needed to provide competent and skilled mental health and addiction services.

In most jurisdictions, government personnel provide leadership, policy direction and overall expertise in their respective fields of work. The NWT has a limited pool of government workers, management staff and teams, and often areas of health and social services are combined in one portfolio. This has led to fragmented leadership of the new core service of mental health and addictions.

Core service personnel within the DHSS have proceeded with program design, implementation and monitoring which has been moderately effective, and has largely driven by direction to re-build the system following the "State of Emergency…" (2002). However, several areas have been impacted by a lack of leadership and management expertise in mental health and addictions. This has indirectly impacted good work that has been clouded by management problems, especially in terms of relations with Authorities, communication regarding the core service, and connection with Aboriginal groups and communities.

Effort is not the problem, but expertise, management experience and working within a community development perspective is not consistently applied in the work of the DHSS, and the core service of mental health and addictions.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

2002 Recommendation Setting Standards

21. The Department of Health and Social Services needs to take the lead in setting the standards for appropriate qualifications, skills and education for the addiction and mental health counseling positions in the NWT.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- There was good evidence of the DHSS taking the lead to implement new standards for appropriate qualifications, skills and education for the community counselling positions across the NWT.

- Providing post-secondary training for affected workers, who remained below the new standard was also a strength for the DHSS, which demonstrated commitment to the new standards for education and training.

- A few minor problems arose with some Authorities and the DHSS who had affected employees or contracted workers who fell below the new standard, but have been in positions for many years. These isolated problems indirectly caused concern regarding the new standards.

What are relevant links to research and best practices?

The new Alberta Drug Strategy highlights the role of AADAC in providing leadership to provide strategic direction, developing health public policy, and coordinating multi-sector actions.

Furthermore, leadership within this new strategy (October 2005) will be demonstrated by promoting a shared purpose, engaging and sustaining participation by a variety of stakeholders, facilitating collaboration, supporting evidence-based program practices, and by fostering research and knowledge transfer (AADAC, 2005)

What do the people say?

"A lot of work was done to review what is needed in terms of qualifications and skills for the staff who will work in the mental health and addiction core services. There is room for everyone to help with addictions, and we need qualified staff to deal with these complex problems, just like we need qualified teachers, social workers and nurses in the NWT."

Discussion/Comments:

In the NWT, there are many agencies that have designated responsibilities for the administration and delivery of health and social service programs. This includes the DHSS, regional Authorities, Stanton Hospital, NGO's and private businesses. In this group of agencies, the DHSS is outlined to be at the top in terms of developing and implementing legislation, standards and policies, while the Authorities and NGO's deliver services. "We design it, and you deliver it…"

This breakdown of responsibilities appears vertical and horizontal with respect to input, collaboration and monitoring. However, in practice in the NWT, there are management, perspective problems, and disconnection within these lines of responsibilities.

The new ISDM and central role of PCCT should assist with ongoing developments and clarification of roles and responsibilities between the DHSS, Authorities, NGO's and businesses, to first and foremost, have its purpose in providing quality, timely and accessible mental health and addictions services across the NWT.

Next Steps/Further Recommendations:

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

Develop a consistent, working group of representation from across the NWT, different disciplines, community level personnel, NGO, Authority and DHSS, and hospital staff to advise, direct and provide the content for the DHSS to proceed. (Suggested timeline: ongoing)

2002 Recommendation Team Building with Health Care

22. The Department of Health and Social Services and the Regional Health and Social Services Authorities need to work cooperatively to bring nurses and physicians into the health care team that provides services to people with addictions. This action may require in-service training for nurses, emphasis on addictions management for new medical staff during orientation and inclusion of medical services in the re-structuring of addiction, mental health and family violence services at the community level.

	Effort	Interim Result
Assessment	**B**	**In Progress**

What is the evidence for this finding?

- Competencies are being developed for health care professionals working in diagnostic and curative services.

- Limited consultation was evident from medical and nursing groups regarding the re-building of mental health and addiction services.

- Consulting psychiatry services have been included in discussions regarding child and youth mental health services.

What are relevant links to research and best practices?

The medical and nursing professions have an important role to play in mental health and addictions, especially with respect to WMS, physical health monitoring of people with chronic mental health problems and addictions (concurrent/dual disorders) and those with health complications resulting from addictions (ARF, 2000; Health Canada, 2002)

What do the people say?

"There are misconceptions still about what addictions are all about; mental health is different, as people cannot always prevent these problems."

Discussion/Comments:

There are different opinions as to the roles of nurses and doctors in the work with people with addictions.

Addictions are disorders in the Diagnostic and Statistics Manual, Fourth Edition/Text Revision (DSM-IV-TR) of the American Psychiatric Association which is the guide for all mental health problems and addictions (APA, 2000).

Substance use disorders (addictions) make up the largest part of the DSM-IV-TR, and are inclusive of substance abuse, substance dependence, substance withdrawal, substance intoxication and substance induced problems such as psychosis, mood disorders, anxiety and other problems.

Research is pointing to more and more neurophysiological consequences of alcohol and drugs that influence behaviour, cognition, emotion and physical health. This is often referred to as addiction as a brain disease.

Next Steps/Further Recommendations:

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 (WMS) that involve hospital services.
(Suggested timeline: within 1 to 2 years or sooner if possible)

2002 Recommendation: Authorities Responsiveness

23. Health and Social Services Authorities should address their poor addictions qualities and effectiveness issues by providing and supporting an integrated service delivery model for addictions, mental health and family violence services.

	Effort	Interim Result
Assessment	**A**	**Unable to Assess**

What is the evidence for this finding?

- This Interim report did not allow for a site-by-site review of program quality and/or effectiveness as was done in 2001-02.

- However, it is evident from interviewees, document review, and observations that authorities are aware of areas that were highlighted in the "State of Emergency" (2002) report; many Authorities have made changes to improve their program quality.

- Several Community Counselling Programs have started an internal process of continuous program monitoring or auditing, to ensure adherence to program standards, issues of program quality and consumer satisfaction.

What are relevant links to research and best practices?

There is evidence to support that programs that engage in continuous monitoring, self-evaluation and/or processes of accreditation provide better quality programs (ARF, 1997; Health Canada, 2001; Health Canada, 2002; Romanow, 2002).

What do the people say?

"We are starting our own process of internal monitoring of our programs so that we can report on our own quality and effectiveness."

Discussion/Comments:

Quality monitoring is not a new practice in mental health program development, hospital systems or community programming. In previous years, practices known as quality assurance and total quality management were used to monitor quality and effectiveness.

In recent times of government accountability for health care resources, quality monitoring, performance measurement and general accountability and evaluation of program effectiveness have become the norm as part of providing services within the public and private sector.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

2002 Recommendation: Replacing of NWT Addictions Handbook

24. The Department of Health and Social Services needs to provide Health and Social Services Authorities with program definitions, goals, standards of care and performance indicators concerning the delivery of addiction counseling services. These policy directives should replace the *NWT Addictions Handbook (1997*) and should be all encompassing of all stages of addictions, from crisis intervention through intake, assessment, treatment and aftercare.

	Effort	Interim Result
Assessment	**A**	**B**

What is the evidence for this finding?

- A lot of work was put into developing NWT wide standards of care for mental health and addictions through work with independent contractors, input from Authorities and the DHSS. These standards have been distributed to all Community Counselling Programs in the NWT.

- Some workers at the community level remain unsure of how to use these standards and forms. Some clinical supervisors have conducted work with their staff to integrate standards into practice through on-going in-servicing and de-briefing.

What are relevant links to research and best practices?

Standards are needed to guide program delivery and to ensure quality and evidence-based practice and to tailor services to the needs of NWT client groups (Health Canada, 2001; GNWT, 2004)

What do the people say?

"We got a binder of standards and forms, and now we are adjusting the forms to suit our program in this region."

Discussion/Comments:

Communication and integration of the standards work is ongoing, and will continue as programs continue along their developmental timelines.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

2002 Recommendation Consultation to Develop Standards

25. The Department of Health and Social Services should work in partnership with existing community addictions personnel that are skilled and qualified, regional supports and experts in the field of addictions to produce these standards of care.

	Effort	Interim Result
Assessment	**B**	**C**

What is the evidence for this finding?

- The DHSS relied on contracted experts, Authority delegates and a few clinicians to produce the standards.

- There was little to no consultation with existing community addictions personnel, including Wellness Workers and mental health counsellors.

What are relevant links to research and best practices?

There is increasing agreement among experts that sources of information other than the formal "scientific literature" must also be tapped to gain a complete understanding of the factors that will influence the effectiveness of mental health services in any particular setting (Hylton, 1998)

Other types of knowledge, including that learned through client and family members, and traditional and cultural knowledge are especially important in areas servicing Aboriginal populations (Romanow, 2002; Ministry of Health Services, British Columbia, 2004; Addley, 2005; AADAC, 2005).

Discussion/Comments:

The perception is that the Department of Health and Social Services developed the standards of care with little or no community consultation from the community level. This may have resulted in the limited number of standards relating to cultural and traditional approaches in this document. As well, a lack of community consultation may have resulted in less buy-in and other transition problems, in not knowing how to use the document.

Next Steps/Further Recommendations:

Consider the next year as a pilot year of the 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. (Suggested timeline: within the next 12 months)

2002 Recommendation Tools and Documentation

26. There is a need to incorporate standardized addictions and mental health tools in the clinical assessment of clients as a means of self-reporting and clinical documentation. These standardized addiction and mental health assessment tools should be incorporated into the new standards of care for addictions in the NWT.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

- Although not fully assessed, as site visits to each program were not possible, some sites are using standardized addictions and mental health assessment tools such as SASSI and others.

- Other sites would like to use these resources, but lack funds for this, filing equipment and personnel hours to summarize them beyond individual assessment.

- It is not clear as to the use of standardized tools for cases referred for residential treatment either inside or outside the Territory.

What are relevant links to research and best practices?

Assessment tailored to the individual with the mental health or addiction problem is a complex, but important part of the scope of services (ARF, 1997; ARF, 2000; Health Canada, 2001; Health Canada, 2002).

What do the people say?

"I like seeing myself on the graph, as I know I have problems, but this really shows me what I need to do."

Discussion/Comments:

Few regions use standardized assessment tools. Direction from the DHSS and Authorities with regard to the use of standardized assessment tools and their respective application and interpretation is required.

Appropriate assessment tools lead to better assessment, which leads to better treatment in the sense that it is more appropriate treatment. As well, standardized assessment tools can be used to measure performance. For instance, a client may complete an inventory with regard to depression when he or she comes for counseling services. The same Inventory would be completed six months later and would provide an actual measurement of progress.

This may be an area where the Clinical Supervisor can play a lead role to allow for the tailoring of the tools to suit the specific regional problems, such as, relapse prevention, depression, etc.

This is a developmental piece of the Community Counselling Program, and work with a NWT wide working group may be able to find NWT wide and site specific tools that can assist with client assessment, performance measurement and quality monitoring.

This is also an area needed within the realm of residential treatment, child and youth, but requires appropriate expertise in test administration, psychometrics and test interpretation.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

2002 Recommendation Withdrawal Management (Social/Medical)

27. Medical detox services must be provided on a consistent basis across the Territories. Medical and social or alternative detox strategies are necessary for all clients prior to participation in residential treatment.

	Effort	Interim Result
Assessment	**B**	**C**

2002 Recommendation Balance of WMS across the NWT

28. Consider the placement of new detox services in the Inuvik Region so as to balance the number of spaces across the Territories.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

- There are a variety of withdrawal management services across the NWT, with more concentration in Yellowknife through the Salvation Army Program and access to a 24 hour emergency at Stanton Hospital.

- An attempt was made to develop a consistent program of Withdrawal Management Service (WMS) at Stanton Hospital through the core service of Mental Health and Addictions but was halted for a number of reasons.

- WMS has a history in the NWT and in various communities, and has been largely determined by ad-hoc responses to emerging problems with persons requiring detox, stabilization and/or safe shelter during withdrawal.

- Withdrawal management is a complex issue that will require much consultation, research into best practices, expertise from a number of disciplines and paradigm shifts in terms of who provides this service. Integration will also be needed for WMS to be cost effective.

What are relevant links to research and best practices?

The provision of withdrawal management services is highly dependent on the capacity and approach of an entire addiction system (Cathexus, 2005).

Withdrawal management needs to be tailored to the needs of the individual, whether she is pregnant, homeless or a youth (Health Canada, 2001).

What do the people say?

"Put a group of us, medical folks, in a room for half a day, and we will have the solutions for you when it comes to medical detox."

Discussion/Comments:

Currently medical detox services continue to be provided on an inconsistent basis throughout the Territories. Withdrawal management services (detox services) have historically existed in the Territories in a variety of programs and have a different look from region to region, depending on the availability of trained staff, including physicians skilled in withdrawal management.

The work done at the Department of Health and Social Services level must have extensive consultation from the medical profession, including nursing, medicine, emergency medicine, pharmacy and all others who would provide a continuity of services following detox.

There is some element of passive resistance in addressing withdrawal management across the NWT, in that it remains unclear as to the effectiveness of such processes within an acute care setting such as hospitals and health centres.

WMS and/or Detox services need to be part of the ISDM and work of the PCCT at the community level.

Next Steps/Further Recommendations:

Further study and consultation is needed with respect to 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. (Suggested timeline: ongoing)

See the Supplementary Report*: Withdrawal Management Services or WMS.*

2002 Recommendation Consistent Services Across the NWT

29. The Department of Health and Social Services and the Regional Health and Social Service Authorities must examine the scope and level of mental health services provided across the NWT so as to have a consistent service across the NWT for people with concurrent disorders.

	Effort	Interim Result
Assessment	**In Progress**	**In Progress**

What is the evidence for this finding?

- Interviewees were aware of the needs of a group of clients in the NWT who have concurrent or dual disorders, live with chronic health problems and/or are adults living with FASD.

- Concerns were raised as to the current and future capacity to address adults living with FASD in the health and social services system.

- It is not known what numbers of people in the NWT are living with concurrent disorders, but they are relatively small, based on population statistics.

- There are communities in the NWT with distinctive familial patterns of mental health disorders that require targeted efforts because of this.

What are relevant links to research and best practices?

Over the last two decades, the co-occurrence of addiction and mental health problems among people seeking treatment and support has emerged as an important issue for those who plan, and fund mental health and substance abuse programs (Health Canada, 2002).

What do the people say?

"Housing and emergency shelter are important issues when dealing with people with concurrent disorders."

Discussion/Comments:

The community team is set up and well on its way. There are standards of care and similar territorial positions. Supported living efforts are in progress.

With the advent of the PCCT and Integrated Services, it is hoped that in the near future, there will be consistent services for individuals with concurrent disorders across the NWT.

However, at present there remains inconsistency with regard to specialist services such as those received from psychologists and psychiatrists. Currently there are reports of individuals with concurrent disorders who are turned away from the health centres.

Next Steps/Further Recommendations

Work with communities, Authorities, and PCCT 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 planning, implementation, human resource management, training and prevention efforts.
(Suggested timeline: in the next 12 months).

2002 Recommendation Future of Mobile Treatment

30. The Department of Health and Social Services must clearly define mobile treatment programs in terms of goals, objectives, program content and rationale prior to any further planning or implementation of mobile treatment programming.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

2002 Recommendation Defining Mobile Services

31. It is necessary for the Department of Health and Social Services to define what is meant by mobile addiction treatment programs as to their goals, program content and rationale.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

2002 Recommendation Review of Mobile Treatment Resources

32. Mobile addiction treatment programs must be reviewed thoroughly from the inception to completion.

	Effort	Interim Result
Assessment	**In Progress**	**In Progress**

2002 Recommendation Follow-up Programming

36. In the next two years, consider the use of mobile addiction treatment as a follow-up program for the family of the addicted person at the level of the community. This could be scheduled approximately three months after treatment is completed.

	Effort	Interim Result
Assessment	**Unable to Assess**	**Unable to Assess**

What is the evidence for these findings?

- Mobile addiction treatment programs were reviewed in 2001-02, and funding allocations were re-directed within the core service of mental health and addiction services.

What are relevant links to research and best practices?

Hylton, in his 1998 review of mental health, discussed the challenges in providing mental health services throughout the NWT, given the population is spread out in remote and isolated communities, and that distinct Aboriginal cultures are represented throughout. He was clear in that Aboriginal health and healing systems must be founded on a basis of respect for cultural diversity.

Discussion/Comments:

The issue of mobile treatment plans was identified in a few documents used in the document review, including the Action Plan for Mental Health and Addictions.

As mobile treatment programs were problematic during their pilot years, it is wise to put on hold any future programs of this nature, until the Community Counselling Program and PCCT are well formed and developed in NWT communities.

A need that has been lacking within the new core service is specialized assessment by psychologists or specialists in remote communities. The mental health team through Stanton had provided this service for a few NWT communities in previous years, but this was not consistent across the territory.

Intensive, skilled and clinical assessment by a team of psychologists, nurses and physicians working in mental health and addictions is likely still needed in the new core service. They provide the roadmap and care plan for challenging cases, persons with concurrent disorders, and others that require intensive assessment planning.

Next Steps/Further Recommendations:

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. (Suggested timeline: within one to two years).

2002 Recommendation: Assessment of Youth and Treatment

33. A multi-disciplinarian team, including local community caregivers, health care providers and education staff, prior to youth being sent to treatment, should perform assessment for youth.

	Effort	Interim Result
Assessment	**In Progress**	**In Progress**

2002 Recommendation New DHSS Position to Address Youth

34. In the next year, create a new position in the Department at the same level as the current Consultants in Mental Health. This position should work as part of the team already in place (Addictions Consultant, Mental Health Consultant, Youth Consultant-Mental Health) to address Addictions, Mental Health and Family Violence. Expertise in the area of youth treatment and alternatives to treatment for youth can be developed through this position.

	Effort	Interim Result
Assessment	**B**	**C**

2002 Recommendation Consultation for Standards for Youth in Crisis

35. In the next six months, create a working group of Department of Health and Social Services consultants in nursing, social work and mental health/addictions to formulate standards of care for youth in crisis.

	Effort	Interim Result
Assessment	**In Progress**	**In Progress**

2002 Recommendation Family Programming

37. In the next two years, consider a different look at family programming such as through the use of a multi-disciplinarian team (addictions/counseling and youth) to travel into communities to deliver a 3 to 5 day family program in the community.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for these findings?

- The Department of Health and Social Services has begun the process of study, collaboration and consultation with NWT stakeholders with respect to the mental health and addiction service needs of children and youth.

- Also, Child and Family Services, within the DHSS, has established practice specialist positions within the last year.

- There is uncertainty as to the leadership and management of this core area of work, within the DHSS; this is an organizational issue within the DHSS, that which may affect further work with policy in child and youth prevention, early intervention and treatment services.

What are relevant links to research and best practices?

There are distinctive and program specific challenges in working with children and youth, given their developmental histories, connection to family, school systems and peer systems, and the urgent nature of prevention of harm due to substances, family violence and trauma (Health Canada, 2001).

Provincial governments across Canada are addressing child and youth mental health and addiction service needs within different organizational and contextual frames.

What do the people say?

"We need more services for children and youth, they are our future."

Discussion/Comments:

There is an urgency factor in addressing child and youth services across the NWT. However, urgency needs to balanced with work that is culturally relevant and sensitive to the population.

The scope of practice of these new DHSS practice specialists remains unclear in terms of effectiveness, given they are within the Child Protection scope of service, and have a social work education/background.

Much work in prevention and early intervention with children and youth is already occurring in communities across the NWT through community-based early childhood programs, prenatal programs, school based crime prevention through social development programs and others.

Caution is needed in proceeding with child and youth service planning, development and implementation due to levels of expertise needed in these areas, funding needs, linkages to existing community-based programs already in place, and best practices for child and youth.

Next Steps/Further Recommendations:

Develop multi-disciplinary assessment processes that are inclusive of child and youth priorities, and within a family and community context. (Suggested timeline: within the next 1 to 2 years)

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. (Suggested timeline: ongoing and over the next 3 to 5 years)

See Supplementary Report: *Children and Youth*

2002 Original Recommendation: Performance Indicators

38. Now is an opportune time to begin evaluation. Process and results based (outcome) evaluation should be built into the re-structured delivery of addictions services across the NWT. Performance indicators will need to be developed for all aspects of service delivery for addictions, mental health and family violence.

	Effort	Interim Result
Assessment	**B**	**C**

What is the evidence for this finding?

- Several Community Counselling Programs have initiated the process to integrate performance review into their scope of clinical services.

- An attempt was made by the DHSS to outline areas of performance indicators for the core service. A simplified logic model was used.

What are relevant links to research and best practices?

Demonstration of evidence-based practice in health and social services is the new accountability within a publicly funded health care system in Canada, and most provinces and territories have embraced the use of performance indicators.

What do the people say?

"We want to do internal monitoring of our Community Counselling Program."

Discussion/Comments:

It is timely at this point in the early stages of implementation of the new core service to pay attention to issues of process, outcome and financial monitoring and evaluation.

Next Steps/Further Recommendations:

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. (Suggested timeline: one to two years)

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. (Suggested timeline: 3 to 5 years)

2002 Recommendation Communication with Communities

39. The Department of Health and Social Services must communicate the benefits to clients, personnel and communities of integrating addictions, mental health family violence.

	Effort	Interim Result
Assessment	**C**	**C**

What is the evidence for this finding?

- Some public information is available about Integrated services, community counselling, residential treatment, Salvation Army Addiction Programs and the Women in Recovery Program on the DHSS website.

- Also, a plain language summary was put out that is inclusive of the new core service of mental health and addictions.

What do the people say?

"As a government, we are not the best at communicating to the consumer, clients or person on the street. It must be confusing for some people in communities to know what has happened to their alcohol centres."

Discussion/Comments:

Although communication flows from policy (DHSS) to service delivery and implementation (Authorities), ***this does not ensure*** that information about the new program is communicated to communities, clients and leaders.

Next Steps/Further Recommendations:

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

2002 Original Recommendation **ISDM Training in Mental Health and Addictions**

40. Health Centre staff including nurses, community health representatives and physicians need orientation and ongoing in-servicing as to the nature and progression of addictions and the management of people with concurrent disorders.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

- Terms of Reference (TOR) were developed in 2005 for the development of mental health and addiction core competencies and training options for the Primary Community Care Teams (PCCT) in the health and social services system in the NWT. This work is to be completed in early 2006.

What are relevant links to research and best practices?

In each Primary Community Care Team or PCCT setting, each team member has a role in providing mental health, addictions and family violence services to clients (GNWT, 2004).

What do the people say?

"We should have better prevention and early intervention efforts in mental health, addictions, and family violence, if all health care team members share in screening and early assessment."

Discussion/Comments:

The contractor for this work needs to be within health disciplines of nursing, medicine or clinical psychology or medical social work to incorporate the related jargon, systems and approaches that would be heard by these health care workers.

Adjustments to the TOR are suggested to complete this work so as to reflect the health care environment challenges in the NWT, incorporate expertise required to complete the work, and to select/advise on the use of mental health, addictions and family violence screening tools or standardized instruments.

The scope of work to develop these core competencies needs to address the current acute care focus of health services in the NWT, and bridge this to be inclusive of health promotion, prevention, intervention and post-vention.

Next Steps/Further Recommendations:

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

2002 Recommendation Transition Team

41. Build a facilitation team to expedite the integration of community addiction services with mental health and family violence services. This facilitation team would ideally consist of community representation, community personnel involved with addictions and mental health services, resource persons who have already been through the process of integration and personnel from the Department of Health & Social Services.

	Effort	Interim Result
Assessment	**B**	**In-Progress**

What is the evidence for this finding?

- § Transition planning and implementation was mixed across the NWT, with some regions and Authorities working hard to communicate, negotiate and bring new workers on board.

- § Other Authorities took different approaches, and are still working through some transition issues.

What are relevant links to research and best practices?

Addiction services have been delivered in different forms throughout the NWT for many years. Building on what was there has been documented in several key consultation works in the last 20 years (NWT, 1988; Hylton, 1998; GNWT, 2000)

What do the people say?

"We worked hard in this region to do good planning for the change-over to the new program."

"There should have been more work done to bring the previous employees into the new system, with better ways."

Discussion/Comments:

There remains some dissatisfaction throughout the regions, Authorities and within the DHSS regarding transitioning of the previous network of addictions and mental health programs with the new system.

Although it is easy to reflect back at this time about different approaches to transition, the fact remains that going forward is necessary.

Assistance is still needed in some regions to address transition issues and personnel problems that still remain. They are, by far, isolated problems that have workable solutions.

Next Steps/Further Recommendations:

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.
(Suggested timeline: ongoing).

2002 Recommendation Partnership with Aboriginal Groups

42. Build on the strength and creativity of Aboriginal organizations to improve addictions and counseling services in partnership with Government agencies.

	Effort	Interim Result
Assessment	**Unable to Evaluate**	**Unable to Evaluate**

What is the evidence for this finding?

- There was little evidence of partnerships with Aboriginal groups, agencies, and community leaders.

What are relevant links to research and best practices?

Work collaboratively with Aboriginal organizations in an inclusive manner on policy and program development to ensure that their interests are appropriately reflected in programs and services that affect all Aboriginal peoples. (First Ministers and National Aboriginal Leaders Strengthening Relationships and Closing the Gap, Kelowna, BC- November 24, 2005)

What do the people say?

"We have the solutions in the communities, and I would like to see Government and communities working together to address addictions, especially with our young people who are using too many drugs these days."

Next Steps/Further Recommendations:

The DHSS and the Authorities need to fully recognize Aboriginal organizations as equal partners in dealing with mental health, addiction and family violence services (Suggested timeline: ongoing)

2002 Recommendation Nats'ejée K'éh Treatment Centre

43. There is a need to include the Treatment Centre in the rebuilding and restructuring of addictions services in the NWT.

	Effort	Interim Result
Assessment	**B**	**In-Progress**

2002 Recommendation Areas to Address with Treatment Centre

44. Treatment Centre areas that require critical attention include: raising the education and skill levels of the counselors, program content, expertise in addictions and the incorporation of therapeutic counseling (individual and group) and relapse prevention. Also, the building of a multi-disciplinary team, including physicians/nurses and counseling practitioners is needed to provide medical support (supervised medication taking), back up for clients who may experience post-acute withdrawal problems and for educational purposes within the treatment program.

	Effort	Interim Result
Assessment	**A**	**In-Progress**

What is the evidence for this finding?

- § It is too soon to assess the recent changes made at the Treatment Centre in Hay River, but there is some concern that more changes are needed to increase the skill level and scope of programs offered.

- § Concern remains in the Regions of the ability of one residential treatment centre in the NWT to meet the increasing drug abuse needs, and those of people who do not engage in native spirituality practices.

What do the people say?

"We need more than one choice of treatment in the NWT; there used to be several treatment programs that offered different programs. I do not know what happened to them all."

Discussion/Comments:

See Supplementary Report: Residential Treatment

2002 Original Recommendation Changes to Delivery of Programs

45. There should be representation from the current Community Addiction Programs on the facilitation team that will provide guidance for any and all changes to the current system of delivery of addictions services.

	Effort	Interim Result
Assessment	**B**	**Unable to Evaluate**

What is the evidence for this finding?

- § Efforts were noted in the review for this interim report with respect to some Authorities working closely with their stakeholders to implement change.

- § Also, the DHSS engaged stakeholders at Authorities and some Community Counselling Programs to collaborate on standards, education/training for affected workers and to address isolated transition problems.

- § However, many interviewees believed efforts were not adequate given the scope of services being offered, historical linkages to mental health and addiction programs already in place for many years across the NWT.

- § Also, it was commented that new service implementation was much too rapid and time-pressured, which resulted in limited collaboration.

What are relevant links to research and best practices?

> “Not long ago, it was common for the public to look to professionals, experts, and government officials to "solve" their problems. Authorities believed that they had the answers to pressing community problems. Governments declared wars on crime and drugs. What these approaches have in common is a centralist, "top-down" approach to addressing community concerns.
>
> In these examples, the experts in centralized locations define the problems, and how they should be resolved. In most cases, communities are not asked to participate, since that is the role of the experts. Top-down approaches to social-development issues have been largely ineffective." (Hylton, 1998)

What do the people say?

"Put a community person who works in addictions and mental health in the Department of Health and Social Services and see what happens."

Discussion/Comments:

There is much history in the NWT, regions and communities of the involvement of grassroots efforts in the area of mental health and addictions. For example, the community mental health pilot project in the Inuvik Region, which was in place as a jointly funded initiative between Health, Education and Justice from 1994 through 1997, was initiated from work done in Fort McPherson following several traumatic deaths.

Also, Alcohol and Drug Societies were initiated in the NWT in the 1980's by single people getting sober and trying to encourage others to do the same.

Discussions are ongoing regarding the impact of the MGP and "the grassroots" focus is again in operation to design and develop appropriate, culturally-based approaches to mitigate the impact of the economic boom in the affected communities.

"…Together We Can Secure the Foundation that Has Been Built", in the title of this interim report, summarizes the importance of previous foundation work and community efforts, as well as working in partnership with government to move forward with mental health and addiction services.

Next Steps/Further Recommendations:

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. (Suggested timeline: ongoing)

2002 Recommendation Traditional and Cultural Practices

46. The Department of Health and Social Services and Regional Health & Social Services Authorities need to provide the option for people to incorporate traditional and cultural practices as part of the continuum of care required to address their addiction.

	Effort	Interim Result
Assessment	**C**	**C**

What is the evidence for this finding?

- Some communities are attempting to integrate and incorporate traditional and non-medical practices into their community-based counselling programs.

- There appears to be lack of support for communities to incorporate traditional healing practices, due to regulatory problems, financial limitations and overall dismissal of the place of traditional and cultural practices in mental health and addiction services.

- Traditional 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.

What are relevant links to research and best practices?

Traditional healing is a complex mix of traditions maintained, traditions reinvented, 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).

What do the people say?

"People turn to their traditions and culture when they are struggling in life."

Discussion/Comments:

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

- The need for mental health and addiction services among Aboriginal people is directly related to the social and economic conditions that Aboriginal people face in the NWT. Therefore, these underlying conditions must be addressed to address prevention of these problems. This is inclusive of housing programs, social policy that is empowering and an overall focus on respecting individuals, families and communities.

- Generalizing of traditional and cultural health practices, from one community to another is wrong, disrespectful and counter-productive for healing to occur. This further complicates the integration of traditional and cultural practices in a top-down approach to service delivery, but is consistent with a bottom-up approach that is community-based.

- The incorporation of traditional and cultural practices may not involve financial investments, but is more 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.

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

Next Steps/Further Recommendations:

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. (Suggested timelines: ongoing)

2002 Recommendation Building on Strengths to Re-build the System

47. Build on the strength of the women/men and children in the communities to rebuild the addictions programs at the community, treatment and management level.

	Effort	Interim Result
Grade	**B**	**B**

What is the evidence for this finding?

- There is history in communities developing addiction programs, suicide prevention teams and other grassroots initiatives in the last 15 years. These efforts are most effective because they come from the people.

- "We need, as health care workers, to work with these efforts that are already in each community and help them along to be even stronger."

- Addictions can be prevented and some mental health problems can be minimized through community empowerment, development, supportive housing, and healthy living.

What are relevant links to research and best practices?

When changing community/individual behaviour, especially lifestyle issues such as addiction/family violence behaviours, community-based responses have the best odds of addressing behaviour change over time (Hylton, 1998; WHO, 2002).

Discussion/Comments:

- The core mental health and addiction service is first and foremost a community-based approach and further work needs to have a major paradigm shift to fully realize this.

Next Steps/Further Recommendations:

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 teamwork, and supportive consultation is needed to continue with program design, delivery and monitoring systems of mental health and addictions services across the NWT. (Suggested timelines: ongoing)

2002 Recommendation **DHSS and Authorities Working Together to Re-Build the System**

48. The Department of Health and Social Services together with Regional Health and Social Services Authorities and communities need to work together cooperatively and openly to rebuild the entire system of addictions services across the NWT.

	Effort	Interim Result
Grade	**B**	**B**

What is the evidence for this finding?

- A total of 77 mental health and addictions positions are in place across the NWT, in regional settings, as well as smaller communities, with the majority of positions being community-based wellness workers.

- The DHSS and all of the Authorities have embraced the re-building of a stronger, community-based counselling program.

- In a short period of time, that is in three years, major efforts have been seen in human resource development, standards and the securing of a core service in mental health and addictions in the Health and Social Services of the NWT.

What are relevant links to research and best practices?

Evidence-based practices literature suggests that a broadly based, multifaceted, community response is the most effective way to address alcohol and drug use, and addictions (Hylton, 1998; Health Canada, 2000, Health Canada, 2002; Romanow, 2002; Addley, 2005).

What do the people say?

"I think we are on the right track; it is probably too soon to see changes in the numbers of addictions and mental health problems that are preventable."

Discussion/Comments:

- Throughout the fieldwork for this interim report, the evaluation team observed the re-building of a stronger, community-based system of mental health and addiction services.

- Communities were already providing addiction and/or mental health services prior to the re-building of the system, and are transitioning from previous service delivery to the current system of integration, promotion/prevention focus and improved quality and expertise.

- It needs to be recognized that re-building the mental health and addiction services is a process. This process of change will be maximized if done over time, in consideration of where communities are, and with the involvement of all stakeholders at the community level.

Next Steps/Further Recommendations:

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. (Suggested timelines: ongoing)

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