Final Report

"A STATE OF EMERGENCY…"

A Report on the Delivery of Addictions Services in the NWT

Submitted to:

Department of Health and Social Services
Community Wellness Programs and Services
Government of the Northwest Territories
Yellowknife, NT

May 31, 2002

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Submitted to:

The Steering Committee of the Evaluation of
Community Addiction Programs n the NWT

Government of the Northwest Territories
Department of Health and Social Services
Community Wellness Programs and Services

Submitted by:

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Forward

This final report titled: **"A State of Emergency…", a Report on the Delivery of Addictions Services in the NWT** represents the evaluation of Addictions Services for the fiscal year 2001-2002. This report does not pretend to have all of the answers and does not include the opinions of all residents of the NWT.

The positions and recommendations presented here represent the work of many people in communities across the NWT. Special care should be taken in its interpretation so as to be respectful to people in NWT communities who are dealing with the problems of addiction.

The nature of Addictions will, by itself be a personal experience and the contents of this report may bring out fear, resentment and some issues of denial that are all common parts of addiction. We encourage the reader of this report to seek assistance from supportive people, should the contents of this document bring personal issues to the forefront.

We would like to acknowledge the Department of Health and Social Services for their efforts to clearly look at the delivery of addiction services in the NWT. This in and itself, is one of the largest steps to take and for this, we commend the Department of Health and Social Services.

Also, as evaluation consultants, we are often faced with interviewing people who are dealing with personal struggles and this project has challenged our team to be respectful of our boundaries as evaluation consultants. We thank the communities and people we interviewed for allowing us to hear your stories, even though this may have caused some pain. Your struggles and experiences have helped us to outline what is needed in the future to improve addiction services across the NWT.

Evaluation Team Members

Acknowledgements

Community Addiction Program Evaluation Steering Committee Members:

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We would like to express our gratitude to all of the community caregivers, community members, leaders and clients for their cooperation and sincere interest in helping with this evaluation. We recognize the efforts that have gone into addressing the problems and we commend you for the hard work that is done on a daily basis. Dealing with addictions requires patience and courage, which was clearly seen throughout our site visits.

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This report and all related documents of the evaluation of addictions programs in the NWT have been prepared by Chalmers & Associates Consulting Ltd. The analysis, findings and recommendations are those of Chalmers & Associates Ltd and do not represent the views of the Department of Health and Social Services of the Government of the Northwest Territories.

Summary Report

Introduction

This report is a summary of a larger evaluation project entitled, **"A State of Emergency…A Report on the Delivery of Addictions Services in the NWT"**. As a summary, it does not include all the details of the larger report. For more detailed information, please refer to the aforementioned report. It provides more detail and also includes a review of the Pilot Mobile Addiction Treatment Programs as well as reports on the individual sites (Community Addiction Programs) that were evaluated. This Summary Report follows the format of the larger report to make it easier for a reader to obtain more detailed information on a particular subject.

1.0 Background and Context

Background Information

The greatest problem facing the people of the Northwest Territories ("NWT") in the year 2002 is addiction to substances such as alcohol, nicotine and marijuana and addiction to problem gambling. Over the last fifty years, communities in the NWT have been faced with increasing problems due to lost families, jobs, health and spirit as the direct or indirect result of addictions. Generations of northerners have been affected in a negative way by addictions. Improved economic opportunities as the result of oil, gas and mineral exploration have done little to decrease the incidence of addictions; in the year 2002, many problems related to addictions remain prevalent.

Currently, the delivery of addictions services in the NWT occurs on three major fronts:

1. Community Addiction Programs in most NWT communities which are generally based on an abstinence model of addiction with education and prevention as a secondary focus. Clients must access the services of Community Addiction Workers for referral to residential treatment for intake procedures and follow-up counselling sessions.

2. Nats' ejee K'eh Alcohol and Drug Treatment Centre, a 30 bed residential addictions treatment facility located on the Hay River Reserve – the only residential addictions treatment facility in the Territories that serves adults.

3. Southern treatment facilities for men, women and youth whose addictions cannot be adequately addressed in the NWT.

Additionally, in the fiscal year 2000–2001, the Department of Health and Social Services piloted Mobile Addiction Treatment Programs for women and youth in various regions of the NWT. These projects were developed in response to overwhelming requests by NWT communities to deliver culturally appropriate addictions treatment programs to clients in their home communities.

In recent years, there has been an increasing recognition of the effects of trauma, physical and sexual abuse from residential school experiences and family violence as major determinants in the progression of addictions in residents of the NWT. Many Aboriginal groups are now referring to healing as a more holistic way of dealing with addictions and their consequences.

The Community Addiction Programs Evaluation for 2001-2002

The Department of Health and Social Services decided in the fiscal year 2000 – 2001 to review Community Addiction Programs in terms of their effectiveness in the greater picture of addictions services in the NWT. This evaluation also included the evaluation of the Pilot Mobile Addiction Treatment Programs as completed in 2000-2001.

A request for proposals was developed and put out for tender in September of 2001 and the work began in late November, 2001. The evaluation project was to be completed within the context of several reports: *The Minister's Response to the 1988 Forum on Health and Social Services, It's Time to Act, A Report on the Health and Social Services of the Northwest Territories, Review of Nats' ejee Ke'h Treatment Centre and Working Together for Community Wellness, A Strategy for Addictions, Mental Health and Family Violence in the NWT.*

The Terms of Reference, as developed by the Department of Health and Social Services, outlined fifteen NWT communities that would form the basis for the evaluation. One additional community was added at the outset of the project to ensure inclusion of all representative groupings of Community Addiction Programs from across the NWT. The communities were chosen on the basis of community size, type of program and representativeness of all Aboriginal groups in the NWT.

The Department of Health and Social Services directed the evaluation team to:

1. Review the administration and management of the Community Addiction Programs;
2. Determine the treatment effectiveness of the Community Addiction Programs and to determine the efficiency and economic value of Community Addiction Programs in providing services to the residents of the NWT; and
3. Determine linkages within the system and to integrate the findings into recommendations about the roles, responsibilities and functions of the Community Addiction Programs.

This evaluation project was undertaken with an understanding of a shift in the direction and scope of Addiction Programming not only in the NWT, but also across Canada. The rationale for this shift in addiction programming is based on the following:

- The changing face of people with addictions now includes poly-drug use, concurrent disorders (mental illness and addiction) and a wide variety of age groups being affected by addictions.

- The effects of oil, gas and mineral exploration in the NWT have put an increased demand on services.

- There is an increased demand for collaborative practice among various health care professionals to avoid duplication and to recognize greater specialization.

- The effects of trauma, family violence and poor socio-economic stability and their influence on addictions have now been recognized.

- The increasing competition for health care resources has forced agencies to consider different models of service delivery.

- There is an increasing demand for staff working in the field of addictions to have appropriate post-secondary education in addition to experience in the field.

- There is a direction by governing bodies to consider less expensive means of treating addictions and less reliance on residential type addictions treatment programming.

The complete final report includes the evidence as obtained through site visits, documentation review, semi-structured interviews, a review of literature in the field of addictions and a review of field practices in the area of addictions across Canada and the United States.

Terminology

Various terms are used to delineate certain aspects of addictions. The language of addictions is a coded language based on history, passion and a belief system that has developed through the struggles of people living with addictions. The evaluation team has chosen the following terms and language to describe a difficult construct. This language is not static and will likely evolve in the future; the language chosen here is reflected in the common literature in the addictions field in the year 2002.

Addiction: Includes alcoholism and addiction to drugs and/or substances. In a few instances where the context dictates, addictions may refer to gambling and other process addictions.

A.A./N.A.: Refers to Alcoholics Anonymous and Narcotics Anonymous.

Addictions Specialist: Refers to Health and Social Service Authority positions in addictions.

Aftercare: An integrated, post-hospitalization, continuing program of outpatient treatment and rehabilitation services provided by a treatment facility or other facility. The program is directed to maintenance of improvement, prevention of relapse and adjustment to the community.

Blended Program: Refers to NWT Community Addiction Programs that are inclusive of an alcohol and drug program and a mental health and/or family violence program.

Client: Refers to people who undergo treatment for addiction; denotes a respect for the person seeking help.

Community Addiction Worker: Refers to the current positions held by staff in many Community Addiction Programs, as this is how they are called in most NWT communities.

Concurrent Disorders: Refers to a combination of mental/emotional/psychiatric problems experienced together with the abuse of substances such as alcohol and/or other drugs.

Counselling: A process of defining, understanding and addressing a specific problem as well as advice and suggestions given by a person acknowledged as being an expert in one or more areas, such as marriage, dependency on substances or vocations.

Detoxification Or Detox: Refers to procedures designed for the reduction or elimination of toxic substances in the body. Commonly referred to as detox.

Flooding: Uncontrolled and uncontrollable emotional expression.

Recovery: Refers to people in treatment.

Substances: Includes alcohol, inhalants/solvents, illicit drugs, over-the-counter medications and nicotine.

Treatment: Includes residential treatment and also the providing of services to a person with a condition such as an addiction.

2.0 Literature Review

There is much literature on the subject of addictions and their treatment. This discussion will be limited to areas of relevance to the evaluation of Community Addiction Programs including definitions and models of addictions, recent trends in the delivery of addiction services in other jurisdictions, a review of components of a typical addiction program and the various costs of addictions.

Definitions and Models of Addictions

The definition of addictions dates back to the mid-1800's. Terms such as confirmed drinkers, alcoholics, habitual drunkenness, problem drinker, substance intoxication, alcohol abuse, substance dependence have all been used or are currently being used to describe the condition of "addictions". The definition of addictions is linked to the conceptual models of alcohol problems and alcoholism. These models will be listed and briefly described:

1. **Disease Model of Addictions:** The disease of addiction is viewed as a primary disease in that it exists in and of itself and is not secondary to some other condition (Fisher & Harrison, 2000). In this model, addictions can be likened to an allergy to alcohol and is seen as arising from a combination of physical, psychological and spiritual causes; it is irreversible, incapable of being cured, but possible to arrest through total abstinence. The two elements are the loss of control over the use of the substance and the continued use of the substance despite negative consequences.

   The clear advantage of this model is to remove the moral stigma attached to chemical dependency and replace it with an emphasis on the treatment of an illness; the greatest disadvantage is the implication that a non-medical person cannot treat the illness.

2. **Addiction as a Moral Problem:** These models emphasize personal choice as a cause of alcohol and/or drug problems. The individual is seen as making choices and decisions to use alcohol and/or drugs in a problematic fashion and is seen as capable of making other choices. The implication of the moral model of addiction is that the health care system is not obligated to provide medical or psychosocial support.

3. **Addiction as a Brain Disorder:** Recently, advanced research shows a biological cause of addictions; some people are more prone to develop addictions because of genetic, psychological or physical risk factors.

   This research is still quite new and should be watched with much interest.

4. **Socio-Cultural Model:** This model relies heavily on the role of society and culture in shaping a person's drinking patterns and related problems. The role of society relates to the availability of alcohol, convenience of access, their costs, legal regulations, etc. The level of society stress, alienation and trauma influence the use of alcohol and other drugs as does the influence of peers.

The focus of interventions from this perspective is altering a person's relationship to their environment, building coping strategies, fostering healthy role models in the community and addressing the supply and demand aspects of alcohol and drug use.

5. **General Systems/Family Model:** This model is based on the premise that individual behaviour is part of a larger social system so that an addiction, for instance, cannot be understood without considering their relationship to other members of the system to which the individual belongs. Addiction can then be seen as a family disorder that can only be treated on a whole family basis. This model is consistent with the beliefs of many Aboriginal groups that centres around the family as their central institution.

   Treatment consists of family therapy and the use of role playing to demonstrate functional and dysfunctional roles within the family system.

6. **Mental Health Model:** The mental health model sees addiction as a symptom of mental health or psychological problems. Trauma and resulting stressors contribute to the development of an addiction.

   The treatment for addictions under this model would include "curing" the underlying mental health disorder in order to "cure" the addiction.

7. **First Nations' Model of Addictions:** Many First Nations researchers propose that alcohol and other drugs are used by Aboriginal people to temporarily relieve the pain they suffer as a result of sexual abuse, family violence, trauma from residential schools and other psychosocial stressors. The debate centres on whether addiction is a primary problem or whether it is the manifestation of deeply rooted problems.

8. **Biopsychosocial Model:** The interactions of biological, psychological, cognitive, social, developmental, environmental and cultural variables are considered to explain addiction. Addiction is a primary illness that is progressive developmentally from growing tolerance and dependency to a loss of control to deterioration of bio-psycho-social health.

   This model combines all models into a single model and directs that people working in the field of addictions must thoroughly assess clients, develop multiple hypotheses to explain the client's problem based on that assessment, avoid trying to fit the client into a rigid definition of addiction and use a variety of interventions to address the needs of the client. At this time, this model may be the most useful.

Key Areas of Addictions Programs

Physical Consequences of Addictions

The ingestion of alcohol and various drugs have many common consequences from the point of putting the alcohol and/or drug into the body to the metabolism of the substance by the liver. A short list of the physical consequences of addictions follows:

- Brain damage can be caused by long term use of substances resulting in confusion, disorientation and lowered cognitive abilities.

- Nerve damage can be caused by nutritional deficiencies of chemically dependent people leading to numbness, tingling, muscular weakness and paralysis.

- Cancer of the oesophagus and stomach as well as ulcers and gastritis are common leading to the implication that the process of digestion becomes less than optimal leading to malnutrition.

- Inflammation of the pancreas leading to problems with the metabolism of glucose.

- The liver can be seriously damaged in chemically dependent people leading to diseases such as cirrhosis of the liver.

- Chemically dependent people have a decreased ability to fight infections. The lungs are affected in that there is a higher risk of developing pneumonia and other serious lung diseases.

- Reproductive organs in both males and females are affected by prolonged and heavy use of substances. As well, a single dose of alcohol or drugs during pregnancy can have irreversible negative effects on the fetus.

- High blood pressure can also result from the use of chemical substances.

- Chronic muscle wasting and bone loss resulting from nutritional deficiencies are also common with addictions.

Psychological Consequences of Addictions

As with the physical consequences of addictions, there are also psychological consequences of the addiction to substances. These consequences are similar for alcohol and many drugs and can be summarized as follows:

- Mood swings are very common as the person uses substances to feel better and then is unable to maintain this good feeling and becomes fearful and depressed.

- Cognitive, memory and perception problems together with thought disorders and delusions are common among chemically dependent people.

- Anxiety and other mood disorders such as bipolar disorder, post-traumatic stress disorder and depression are also common among addicted people.

- The dependence and tolerance to most substances develops over a period of time. Some substances have a rapid tolerance while others are less dramatic.

Physical and Psychological Consequences of Addictions during Recovery

The physical and psychological consequences of substance abuse extent also to the recovery period when detoxification occurs. There are five stages of symptoms during the process, some more acute than others.

1. Stage One Symptoms: hyperactivity of the nervous system in the form of tremors, loss of appetite, sweating, nausea, vomiting, low stress tolerance, confusion and poor memory.

2. Stage Two Symptoms: distortion of reality, objects appear to move, noises may be heard, strong illusions creating confusion, excitement and fear.

3. Stage Three Symptoms: delirium and disorientation, hallucinations, confusion, incoherence and fear.

4. Stage Four Symptoms: Convulsive seizures can occur within 48 hours of the last drink and up to seven days later.

5. Stage Five Symptoms: Delirium tremens include serious delusions, hallucinations, high fever, fluid loss and physical exhaustion. The avoidance of these with good medical care and support should be pursued since this stage can be very serious, even fatal.

Trends in Addictions

In the United States, the price for illicit drugs is decreasing and the supply is increasing. Marijuana, methamphetamine (poor man's cocaine) and heroine are becoming more accessible, less expensive and more popular. Club or date rape drugs such as GHB, ecstasy and rohypnol have become popular among America's younger generation so that an evening out is often inclusive of such drug use.

Currently, the United States is caught between two addiction paradigms: one that sees addiction as a disease and the other viewing addiction as a wilful and criminal act.

The trend in Europe is to reduce the harm when dealing with core drug problems with a long term goal of abstinence. This is referred to as a harm reduction model. Treatment tends to be from two to six months in length, allowing for a strong behavioural component and the use of

medications for cravings and brain re-stabilization. The goal of abstinence is a long term goal and something that cannot be accomplished immediately.

Harm Reduction Models

A harm reduction model of therapy is one of the newest innovations in the treatment of addiction problems and refers to helping people reduce the harm associated with their behaviour. Abstinence may be the most certain strategy to protect a person from harm, but any move to reduce harm is a step in the right direction. Lack of complete treatment success is often the result of an expectation that total abstinence is the only measure of success. Harm reduction treatment engages a person in gradual change and measures success by steps in the right direction.

The main components of a harm reduction model for the treatment of addictions are:

- Accept the client where he or she is.
- Focus on reducing the harm caused by the substance use, not necessarily on the use of the substance.
- Allow the client to select goals ranging from abstinence to safer use.
- Methods are based on research in self-efficacy and change.
- Highly trained counsellors in the area of therapeutic approaches and biopsychosocial determinants of addictions.
- Based on the "do no harm" concept of medical practice.
- Clients do not have to be substance free to be in counselling/treatment.
- There is a neutrality to abstinence as a treatment; this is dependent on the client goals.
- No moral judgements regarding substance use are made.
- This model can be combined with existing treatment strategies and may be most effective in this manner.

This model is consistent with the biopscyhosocial model of addictions and will be a predominant force in the fight against addictions.

Concurrent Disorders

Concurrent disorders refers to a combination of mental health and substance abuse disorders and has been defined by the Centre for Addiction and Mental Health, Canada's Drug Strategy, Health Canada. The United States uses the term "dual diagnosis" for this disorder.

Canadian research sources recommend five sub-groups of concurrent disorders. The common thread is co-occurring substance use with one of five other disorders: mood and anxiety disorders, severe and persistent mental disorders, personality disorders, eating disorders and mental health disorders.

All the facts for the NWT population concerning concurrent disorders are not known and are complicated by the socio-cultural bias of not diagnosing mental disorders and a lack of mental health resources to make those diagnoses. However, a coordinated approach to assessment, treatment and prevention to meet the needs of people with mental disorders and addictions is required. The main principles of care for people with co-occurring mental disorders and addictions are summarized below:

- A comprehensive assessment is required to determine the severity and nature of the addiction and mental health disorder.

- Provide immediate problem resolution and long term monitoring, support and rehabilitation.

- Need highly skilled clinicians in mental health diagnosis and addictions.

- Require an integrated approach to treatment which may or may not include residential treatment.

- Intervention for substance abuse and severe mental illness should be planned and implemented concurrently.

Current estimates from Canadian and American sources predict that close to half the population with addictions may have a mental disorder. Current assessment, treatment and prevention efforts need to consider the best approach to reach this group of people.

Components of an Addiction Program

There are generally eight key addiction program areas recognized in the field of addictions as forming a comprehensive approach to the management of addictions. For the most part, these areas are based on the biopsychosocial model of addictions. It should be noted that clients do not necessarily progress from Stage 1 through Stage 8; however, such a sequential progression often results in optimal success in arresting symptoms and patterns of addictive behaviours.

1. **Stage 1 – Crisis Intervention and/or Entry into the System:** Often the first point of entry for an addicted person is through a crisis situation. The main goal is to engage the potential client to remain in contact with a helping person or professional. This is often the first time a client has addressed their addiction and it is therefore paramount that the worker is experienced in crisis intervention.

2. **Stage 2 – Intake and Risk Review:** This stage refers to putting information about the client into the system. This information would include name, date of birth and other required information, but would also include a current list of identified problems. This may be considered a pre-assessment stage.

3. **Stage 3 – Detoxification or Detox:** During this stage a client withdraws from substances often using various medications. Careful medical supervision is necessary. Detox services may be either on an in patient or out patient basis depending on the circumstances of the client (housing, medical stability, etc.).

4. **Stage 4 – Multi-disciplinary Treatment Assessment:** Assessment is generally defined as a process of evaluation and the gathering of information in order to arrive at a synopsis of the client's current level of functioning and may also provide a diagnosis. The goal of assessment is to develop a plan that will provide the client with the optimal chance of moving away from their addiction. Information concerning the client's history in the following areas will be obtained using various tools: psychosocial, family, legal, educational, occupational, medical and addiction. Each of these areas contribute to who the client is and where he or she wants to go. Once the information has been gathered an assessment report perhaps including a diagnosis of a substance related disorder is prepared – this is usually the first step towards a treatment plan.

5. **Stage 5 – Supportive Counselling and Treatment Planning:** The decision to refer a client to treatment is usually shared by the assessment team, the client and their family or may be mandated by the justice system. Treatment may be on an inpatient or outpatient basis and there are indications for both. Ongoing supportive counselling is essential for the client while they are awaiting treatment of any kind.

6. **Stage 6 – Treatment:** There is no single type of treatment model that will bring success for all clients. There are five major models followed, but often several models are used – Minnesota (Hazelden) Model of Treatment, Twelve Step Treatment, Behavioural Treatment, Cognitive-Behavioural Treatment and Motivational Enhancement Treatment Model. These models can be applied to either residential or non-residential treatment.

7. **Stage 7 – Step-down or Extended Treatment:** Step-down houses, a relatively new concept in the field of addictions, are used for clients following treatment who have few options for housing and who do not want to return to an addiction-filled environment. They are run as short term housing units that support an abstinence model.

8. **Stage 8 – Aftercare and Relapse Prevention:** The research has proven that extended care and contact with a formal support system following residential treatment dramatically affects a person's ability to recover. Aftercare can consist of individual counselling, follow-up with treatment staff, stress management, A.A. or N.A. meeting and any other support that encourages recovery from an addiction. Since relapse is part of addictions, it is essential that it be addressed in a "head-on" manner – relapse will almost always occur; but how that relapse is dealt with is the major key to long term recovery. This component of a treatment program must be very strong.

Health, Social and Economic Costs of Addictions

The Canadian Centre on Substance Abuse reported in 1992 that the cost of alcohol addictions accounts for $265 per capita per year and for illicit drugs accounts for $48 per capita per year. The majority of alcohol-related costs could be avoided. More recent research from the National Institute of Health in the United States reinforces these results in that the annual cost of alcohol and drug abuse has been set at $965 per capita. Left unattended to, addictions will continue to exact many costs and influence all areas of community life including the economy.

It is difficult to evaluate the cost effectiveness of treatment; however, research has indicated that approximately half the cost of treatment, including assessment and aftercare, was offset within a year by reductions in the health care costs of the addict and their family. Good treatment works and the general effects of treatment intervention (assessment, counselling, treatment and relapse prevention) indicates reduced alcohol and drug use, improved health, reduced risk of HIV/STD, decreased criminal activity, decreased housing problems and improved family and occupational functioning and reduced addiction related social costs.

Nothing works perfectly with all clients or even with the same client at a different time; however, this is the very nature of a chronic condition such as addiction.

3.0 Evaluation Methods

Approach to Evaluation

The evaluation included a review of fifteen Community Addiction Programs and four Pilot Mobile Addiction Treatment Programs. Various methods of inquiry, such as semi-structured interviews, program review within the context of the NWT Addictions Handbook and the review of client satisfaction data, were implemented.

Instrumentation and Time Lines For Data Collection

A review of the literature provided no tool to measure program content and program quality of addictions programs. However, a further review of the education literature provided for an environment tool used for the review and evaluation of early childhood classrooms and programs. This tool, the Early Childhood Environment Rating Scale or ECERS, measures on a one to seven point scale, classroom quality, program content, culture/language activities and

program administration. This tool was adapted for the NWT evaluation of a community addiction program.

The tool was designed at the outset of data collection to reflect key program areas of addictions, such as intake, assessment, scope of service and clinical supervision. Areas of program administration including accountability, funding levels and policy definition were added. The tool was called the Community Addictions Program Effectiveness Rating Scale (CAPERS) and has no overt reliability except with respect to its use at each Community Addiction Program visited for this evaluation.

The rating scale was also adapted from the ECERS and is based on a seven point scale where 1 is an inadequate rating and 7 is deemed to be excellent. Each Community Addiction Program was evaluated on the same scale to provide a consistent measure.

An additional tool was extracted from the CAPERS which was more distinct in that it focused on the building, space and issues of accessibility for elders and the disabled. The same scale was used for this tool.

Other summative tools were designed to record issues related to documentation and activities within each Community Addiction Program. This information was used in the final conceptualization of site reports and the general findings and recommendations.

Semi-structured interview questions consistent with the terms of reference were designed. These questions were modified for the various groups of people interviewed such as Health and Social Services Authorities staff, Community Addiction Workers and regional leaders.

Informal questions were used with clients in order to maintain respect and understanding for their position in their recovery.

The ethical guidelines for data collection as prescribed by the Canadian Counselling Association and the Canadian Evaluation Society together with consideration for evaluation activities among Aboriginal and other minority groups were followed throughout the evaluation process.

Data collection and the site visits occurred between December, 2001 and March 31st, 2002. As well, various telephone conferences were held and follow-up interviews were conducted well into April, 2002.

Analysis and Limitations of the Data

The evaluation team used a variety of qualitative techniques for data analysis including theme generation, triangulation and information verification with a view to accuracy and reproducibility. An analysis of documentation included reviewing the scope, presence, use and function of the documentation. Costing and budget information was analyzed using descriptive measures. Analysis of all information, data and interview comments was completed according to

standards of psychological research and assessment. The evaluation team paid particular attention to the limitations and generalization of data to other communities across the NWT.

A number of limitations in data collection were inevitable and subsequently reduced the level of scientific rigour in analysis of the CAPERS. The limitations include:

1. Generalization of data analysis to other communities in the NWT is not recommended since the data analyzed is limited to the fifteen Community Addiction Programs evaluated.

2. Some interview data was excluded due its confidential content. Data collection occurred over the four month period of December through March, a time that is often busy for many NWT communities. A longer time line for an evaluation of this scope would have been more desirable.

3. Since NWT communities vary in terms of cultural and political systems as well as geographical positions and access to various services, there is some question as to the appropriateness of conducting similar data collection and analysis of program effectiveness scores from community to community.

4. The instrument and tools were designed specifically to answer the questions from the Terms of Reference. This may have limited the scope and content and resulted in some inherent bias in the data collected.

4.0 Findings and Recommendations

The title of this report, "A State of Emergency" reflects the overall state of community addictions services in the Northwest Territories. The services are in urgent need of immediate attention, expertise, direction, policy directives, leadership and re-building. The analogy of calling a state of emergency is used to summarize that it is time to take action and re-build; the storm has already passed.

The findings are inclusive of more than 1,000 pages of documentation and over 150 interviews with Community Addiction Workers, community clients, community leaders, regional leaders, community agency people such as Health Centre staff and RCMP, Health and Social Services Authority personnel, Department of Health and Social Services staff and private industry.

Context of Findings and Recommendations

This evaluation was conducted in the context of four reports:

1. *The Minister's Response to the 1999 Forum on Health and Social Services*

2. *It's Time to Act, A Report on the Health and Social Services of the Northwest Territories*

3. *Review of Nats' ejee Ke'h Treatment Centre*

4. *Working Together for Community Wellness, A Strategy for Addictions, Mental Health and Family Violence in the NWT*

The last two reports were especially important background and contextual documents throughout the data collection and data analysis. The findings and recommendations as presented in this report were synthesized in the context of these documents.

One of the major issues presented in the *Working Together for Community Wellness* document is the issue of integrating community counselling services so that mental health, addictions and family violence workers would work together in a formal arrangement. Integration has been proposed as a viable option to improving the efficiency, skill and delivery of these services across the NWT. An integrated system of counselling services at the community level has been proposed as a good option for communities in dealing with overlapping conditions that require a holistic and integrated counselling approach.

The findings and recommendations, as presented in this report, support the move by the Department of Health and Social Services to integrate community-based counselling services over the coming years. This will not be a simple process; it will require much planning, communication and support for all those involved.

Administration and Management – Findings

The findings with relation to the administration and management of the Community Addiction Programs are summarized below. A summary of the recommendations contained in the complete report can be found in **Attachment 1 which forms part of this Summary Report.**

- The overwhelming majority of interviewees were unclear as to the definition of addictions. It is difficult, if not impossible, to treat a condition that has not been clearly defined.

- There is an overall lack of expertise, knowledge and skill of personnel involved in the delivery of addictions services; this lack of expertise extends from the community level through the regional level through to the Department level.

- Two-thirds of the Community Addiction Programs that were evaluated were found to be of inadequate quality; the remaining one-third scored at a minimal quality level.

- Only Community Addiction Programs that are located in Government buildings or Community Health Centres were physically accessible for elders and the physically disabled.

- Four of the sites evaluated had good to excellent ratings for office space and physical layout. These same sites had better ratings on the CAPERS and are programs that have

integrated their services with Health and Social Services Authorities or have blended their services with community mental health services.

- Community Addiction Workers do not have the necessary post-secondary education to provide quality addictions counselling.

- There is no post-secondary diploma or certificate addictions counselling program offered in the NWT.

- The roles and responsibilities of the Addictions Specialists are inconsistent across the Territories, lack in effectiveness and direction. Community Addiction Workers, on the whole, do not see a benefit in these positions and the Addictions Specialists themselves expressed uncertainty as to their role in the provision of addictions services in the NWT.

Treatment and Program Effectiveness – Findings

Thirteen findings are included in the data analysis. A summary of these findings appears below. Again, a summary of the recommendations contained in the complete report relating to all findings can be found in **Attachment 1 attached to this Summary Report.**

- Program funding for Community Addiction Programs is inadequate and does not compare favourably with funding levels for other Health and Social Services programs.

- Community Addiction Programs indicated a great frustration with the Health and Social Services Authority. This frustration extends to funding arrangements, multiple layers of approval for residential addiction treatment, inaccessible regional support and issues of accountability and confidentiality.

- Delivering addictions services through a contribution agreement between the Health and Social Services Authorities and community sponsors as opposed to core funding does not contribute to good practice.

- The scope of service which includes program content and definition, assessment, effective case management and clinical supervision is very poor in the great majority of Community Addiction Programs.

- Those sites that were rated as having higher quality addictions programming operate within an integrated service delivery model.

- Assessment tools are not used on a consistent basis in the delivery of addictions services.

- Medical detox services and the provision of mental health services for people with concurrent disorders is very inconsistent across the NWT.

- The Pilot Mobile Addiction Treatment Programs for women and youth held in 2000–2001 had significant problems with administration, program implementation, attendance and overall impact in terms of providing treatment at the community level.

- Youth requiring residential addictions treatment are sent to southern institutions for treatment; however, a full clinical assessment of the youth and their family generally does not occur since most communities do not possess personnel to conduct such assessments.

- Southern treatment facilities are seen as an inadequate solution for the addictions and mental health needs of the youth.

- In most Aboriginal families there is a strong family value in healing and recovery and this points to a need for family involvement in residential treatment.

Structure of Addiction Systems and Linkages – Findings

A summary of the findings with relation to the structure of the addiction system and linkages to other systems follows. The summary of recommendations as found in the complete report can be found in **Attachment 1 of this Summary Report.**

- Results-based evaluation activities were not evident in the review of the fifteen Community Addiction Programs.

- Some NWT communities have integrated their addiction programs under the Regional Health and Social Services Authorities; these transitions have been challenging, but are for the most part a step in the right direction for the quality of addictions programming.

- Health care providers, such as nurses and physicians, are poorly integrated in the delivery of health services to people with addictions. For some people with addictions, health care is being denied due to the moral stigma attached to having an addiction.

- The majority of Community Addiction Programs were very vocal in their will to have quality addiction services in the communities.

- Ninety (90%) per cent of Community Addiction Programs indicated dissatisfaction with the scope of services offered by Nats' ejee Ke'h, the only treatment centre in the NWT.

- Community Addiction Workers are aware that current programs do not meet the intensifying needs of addiction problems and also see the need to balance traditional ways of healing with new medical model styles of addictions treatment.

- The whole system of addiction services lacks credibility from within and without.

- The current system of addiction services, as structured, has failed the residents of the Northwest Territories.

5.0 Pilot Mobile Addiction Treatment Programs

In the 2000-2001 fiscal year, the Department of Health and Social Services provided funding to various Health and Social Services Authorities to pilot Women and Youth Mobile Addiction Treatment Programs. The purpose of the pilots was to "provide gender-specific addictions treatment programs in various geographic regions of the NWT. The programs were to be developed in great detail by the Addictions Specialists of the Health and Social Services Authorities together with the Community Addiction Worker. Four Health and Social Services (Deh Cho, Dogrib, Inuvik and Lutsel K'e) were provided funding to pilot these programs.

The review was conducted in the areas of administration/management, treatment effectiveness and program outputs/outcomes. The findings are summarized below:

- The Women's Mobile Addiction Addictions Treatment Programs generally lacked in terms of management practice especially in that programs were not adequately planned.
- Intake procedures were generally inadequate.
- The content of the Mobile Addiction Treatment Programs varied greatly.
- Cultural content was absent in many of the Mobile Addiction Treatment Programs.
- The lack of aftercare following a Mobile Addiction Treatment Program lead to treatment ineffectiveness.
- The qualifications of the facilitators were generally inadequate.
- Most interviewees were unable to identify reasons why the Department of Health and Social Services was piloting Mobile Addiction Treatment Programs.
- There was little cohesiveness among the various pilot programs.

The recommendations with regard to the Mobile Addiction Treatment Programs can be found in the Evaluation of Mobile Addiction Treatment Programs, which forms part of the complete report, **"A State of Emergency…A Report on the Delivery of Addictions Services in the NWT".**

6.0 Next Steps and Final Comments

Next Steps (2002/3 to 2005/6)

1. Expertise and knowledge must be developed through knowledge, resources and collaborative relationships with other jurisdictions in Canada. Position documents in the following key areas of addictions services could form part of the standards of care for

addictions: education and post-secondary/graduate level training, models for treatment of addictions, ethical considerations in providing counselling services and all aspects of residential treatment.

2. Standards of care must be developed. This would include the development of a policy directive and a new NWT Addictions Handbook.

3. Integration and transition will require a facilitation group comprised of staff from all levels of personnel involved in the delivery of addictions services.

4. Funding, recruitment and retention issues must be addressed especially when Community Addiction Workers seek out educational opportunities.

5. A "made in the NWT" entry level counsellor diploma should be developed in partnership with Aurora College.

Next Steps (2002/3 to 2007/8)

1. Consideration should be given to building locations of community-based counselling and social work services in the Community Health Centre.

2. The provision of residential treatment centre services for all residents of the NWT must be re-evaluated once the re-building of the Community Addiction Programs is complete.

Final Comments

The overall conclusion of the evaluation of the Community Addiction Programs in the NWT is summarized below:

> "Rebuild the whole Community Addiction Program system because to add resources to the current system would be counter-productive. The structure of the entire delivery of addictions services (assessment, counselling, pre-treatment, treatment, support in the community, relapse prevention and education/prevention) must first be re-designed and re-built in partnership with communities across the NWT.
>
> Investments in the system are needed to build a strong and effective system of community-based addictions services. These new investments need to be directed towards building a qualified work force for future generations of NWT residents who struggle with addictions.
>
> The starting point is now in providing good quality addictions services to the residents of the NWT. The system is already in a state of emergency and people are ready to affect change in their lives with the right supports and services. Good quality addictions services are not a luxury for NWT residents but a requirement for health, well-being and self-sufficiency."
>
> Evaluation Team Members

Attachment 1 – Summary of Recommendations

Administration and Management

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.

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 should form part of a policy document on the delivery of addictions services in the Northwest Territories to ensure a service that is consistent and of an excellent quality.

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

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 service delivery, clinical content and education and prevention activities offered in the community.

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.

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

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

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 counsellors in the NWT.

   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 Master's in Counselling Psychology or Clinical Social Work; persons with this education and appropriate skills in addictions and counselling would suit a

clinical manager position or team leader position and would supervise entry and general level counsellors.

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

10. The Aurora College two year post-secondary addictions counselling diploma must be re-developed and re-designed within the next eighteen months to meet the need for entry level community counsellors. This Diploma program needs to be linked with a University which will offer transferability of Aurora College course credits toward a Bachelor's degree.

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

Treatment and Program Effectiveness

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.

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

14. Funding partnerships with the Department of Justice and the Department of Health and Social Services is 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 corrections facilities.

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

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.

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

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.

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.

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

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 counselling positions in the NWT.

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 medial services in the re-structuring of addiction, mental health and family violence services at the community level.

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.

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 counselling 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.

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 additions to produce these standards of care.

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.

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 the participation in residential treatment.

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

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.

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 in the NWT.

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 prior to any further planning or implementation of mobile treatment programming.

32. Mobile addiction treatment programs must be reviewed thoroughly from the inception to completion. In the near future, financial resources for mobile programs should be re-directed towards the development and design of this model of addiction treatment prior to any new investments in these types of programs.

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.

34. In the next year, create a new position in the Department of Health and Social Services at the same level as the current Consultants in Mental Health. This position could 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.

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 across the NWT.

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.

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

Structure of Addiction Systems and Linkages

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.

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

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 addictions or concurrent disorders.

41. Build a facilitation team to expedite the integration of community addiction services with mental heath 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.

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

43. There is a need to include the Nats' ejee K'eh Treatment Centre in the rebuilding and restructuring and addictions services in the NWT.

44. Treatment Centre areas that require critical attention include: raising of the education and skill levels of the counsellors, program content, expertise in addictions and the incorporation of therapeutic counselling (individual and group) and relapse prevention. Also, the building of a multidisciplinary team, including physicians/nurses and counselling 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.

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.

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.

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.

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.

Table of Contents

Page

1.0 Background and Context

1.1 Background Information

Overview of Addictions in the NWT

"The most pressing, most pervasive and most shattering health issue and the symptom of a society broken down in the Northwest Territories, is substance abuse.

Communities, boards and front line workers talk of alcohol, drugs, inhalants, gambling, food, promiscuous sexual activity and nicotine use as addictions. Substance abuse problems in our communities are deeply rooted and long standing. People are beset with feelings of hopelessness, despair and impotent rage. From this come violence, suicide and sexual abuse.

Those affected must define, analyse and act upon the problems in their lives and communities. They must regain a sense of mastery of their lives. There is no quick fix for the situation, but the situation has to be addressed and appropriate programs, funds and resources must be allocated to alleviate the abuse and addiction problems in our communities."

> *(Our Communities, Our Decisions. Lets get on with it! Final Report of the Minister's Forum on Health and Social Services, pg 22- Yellowknife, January/2000)*

There is no greater problem facing many people in the Northwest Territories (NWT) in the year 2002 than addiction to substances (such as alcohol, nicotine, marijuana) and problem gambling. Over the last 50 years, communities have been faced with increasing problems due to lost families, jobs, health and spirit as the direct or indirect result of addictions. Generations of northerners have been affected by addictions. In the year 2002, problems continue despite improved economic opportunities as the result of oil, gas and mineral explorations.

Community Addiction Programs in the NWT

There were approximately 27 community based addiction programs in the NWT for the fiscal year 2001-2002. These community addiction programs work within a system of addiction services that includes a 30-bed adult residential addictions treatment facility known as Nats' ejee K'eh Treatment Centre. It is located on the Hay River Reserve and is the only residential addiction treatment facility in the NWT. It is core funded by the Department of Health and Social Services and administered through the Deh Cho Health & Social Services Authority. It is to this facility that the community based addiction programs refer clients who require a residential addiction program (Government of the Northwest Territories, 2001). In addition, men, women and youth may be referred outside of the NWT for residential addiction treatment services that are not available within the NWT.

The Department of Health and Social Services piloted the Mobile Addiction Treatment Programs for women and youth across the NWT in 2000/2001. The piloted projects were in response to the NWT communities overwhelming requests to deliver culturally appropriate addictions treatment programs to clients in their home communities, as opposed to sending people out of their communities and away from their families to access treatment (Government of the Northwest Territories, 2001).

Residents of the NWT access addictions services within their community and/or through their Regional Health and Social Services Authority. It is also a requirement for a referral to a residential treatment setting that residents see their Community Addiction Worker for an intake process and subsequent counselling sessions. Services are provided for status, non-status and Metis peoples in the NWT. These procedures are outlined in the *NWT Addictions Handbook (1997)* and are the current source of addictions policies and procedures for all communities addiction programs across the NWT.

Mental health services vary across the NWT with many communities having access to these services only through regional supports such as through hospitals. In some NWT communities, mental health services are currently integrated with addictions services through a blended model of services delivery or through a combined service. Clinical psychology services also vary considerably across the NWT with access mainly through a medical referral. Several NWT communities also rely on traditional healers as a source of support for addictions and mental health concerns.

Since Health Canada transferred responsibility of health services to the Government of the Northwest Territories in 1988, many programs and services have become more decentralized to regional Health and Social Services Authorities with communities moving more and more to building capacity within their own local people to provide addiction, mental health and counselling services. In recent years, there is an increasing recognition of the effects of trauma, physical and sexual abuse from residential schools and family violence as major determinants of the progression of addictions in residents of NWT. Many Aboriginal groups are now referring to healing as a more holistic way of dealing with addictions and their consequences.

The typical Community Addiction Program is based on an abstinence model of addiction with education and prevention as a secondary focus. Most NWT programs have evolved over the last 12 years to the present day where main activities include treatment intake, drop in-services, pre-treatment counselling and community education on the effects of addictions. In some locations across the NWT, the Community Addiction Programs have evolved to include a full scope of addictions counselling services with inclusion of mental health services. This combination program has been referred to as either an integrated program or blended program.

Community Addiction Programs Evaluation for 2001-2002

The Department of Health and Social Services decided in the fiscal year 2000-2001 to review the Community Addiction Programs for effectiveness within the greater picture of Addiction Services in the NWT. This evaluation included the evaluation of the Pilot Mobile Addiction Treatment Programs as completed in 2000-2001. This evaluation did not specifically include an evaluation of the Nats' ejee K'eh Treatment Centre located on the Hay River Reserve, as this was conducted in April/2000 by an external consultant. Although, as the Nat's ejee K'eh Treatment Centre is the only centre in the NWT, it was included in some aspects of the evaluation of the Community Addiction Programs.

The Terms of Reference for this evaluation project of the Community Addiction Programs were completed in 2001 and are included in **Appendix A**. A request for proposals was put out in September of 2001 and the work was started in late November of 2001. The evaluation project was to be completed within the context of the GNWT document: *Working Together for Community Wellness, A Strategy for Addictions, Mental Health and Family Violence in the NWT (2001),* in addition to other publications within the Department of Health and Social Services from the last 3 years (GNWT, 2001).

The Terms of Reference outlined 15 NWT communities that would form the basis for the Evaluation of Community Addiction Programs. One additional community was added at the onset so as to include a representative grouping of Community Addiction Programs from across the NWT. The communities were chosen based on the size of community, type of program and balance of all Aboriginal groups in the NWT and are listed in **Appendix A, Terms of Reference.**

The Evaluation Team

The evaluation team for this project consisted of Jennifer Chalmers, Liz Cayen and Sharon Snowshoe. All three evaluation consultants have experience with many of the communities in the NWT either through service delivery, program evaluation or program development in the area of community wellness (addictions and mental health), health promotion and education/training.

The evaluation team's combined expertise in counselling psychology, addictions, health promotion, human resources and Aboriginal governance provided for a great depth of knowledge and experience in addressing the questions outlined in the Terms of Reference. The team has had excellent success in working with communities unsure of evaluation processes. Understanding the rewards and challenges of northern living has been very useful in providing an environment of safely and comfort during site visits as all evaluation team members have had first hand experience in living and raising a family in the NWT.

1.2 Purpose of the Community Addiction Programs Evaluation

According to the Terms of Reference for this evaluation (**See Appendix A**), the main purpose of the Community Addiction Programs Evaluation was to review the three main components of the addiction services in the NWT. The three main components of addictions services that were reviewed in this evaluation are as follows:

a) To review the administration and management of the community addiction programs.

Main Question: Do the present qualifications of community addiction program staff provide the level of services expected and required in delivering a successful community based addiction program in the North?

b) To determine the treatment effectiveness of the Community Addiction programs. And to determined the efficiency and economical value of Community Addiction Programs in providing services to residents of the NWT.

Main Question: Are we getting value for our money?

c) To determine the linkages within the system and to integrate the findings into recommendations about the roles, responsibilities and functions of the Community Addiction Programs within the context of the *Strategy for Addictions, Mental Health and Family Violence (2001)*

Main Question: Is the current addiction system effective and efficient in its structure of providing services to people of the NWT?

1.3 Overview of the Report

This final report provides evidence of the Community Addiction Programs as they were in place form November of 2001 until March of 2002. Many of the Community Addiction Programs reviewed in this report have been in operation within the same structure similar to their current state of operation and structure for the last 5 years, with only two programs undergoing major changes at the time of writing this report.

This final report includes the evidence as obtained through site visits, documentation review, semi-structured interviews and literature/field practice review of practices across Canada and the United States in the field of addictions. Below is an overview of each section in this preliminary review.

Final Report

Section 1.0 **Background & Context** includes general information regarding the nature of addiction in the NWT, a review of the Terms of Reference as outlined by the Department of Health and Social Services and a brief summary of the terminology used throughout this report.

Section 2.0 **Literature Review** section is an abbreviated review that addresses the areas of relevance to this evaluation including definitions and models of addictions, program design, content, standards and recent trends in the delivery of addiction services in other jurisdictions across North America. A flow chart is presented in this section to provide the reader with a clear outline of the scope of service that is used for the most part in the provinces of Saskatchewan and Ontario with respect to addiction services.

Section 3.0 **Evaluation Methods** includes a review of the approach taken to this evaluation project, instrumentation used, time lines for data collection and a discussion of the procedures used in the analysis of the collected information. Limitations to the analysis and findings are also presented.

Section 4.0 **Findings and Recommendations** includes the evidence of the evaluation of Community Addiction Programs in the NWT. This Section is inclusive of the evaluation team's findings and recommendations so as to maintain continuity from the problem to the solution. The findings and recommendations are grouped according to the Terms of Reference (GWNT, 2001) in the areas of: administration/management, program effectiveness and structure/systems linkages.

Section 5.0 **Next Steps and Final Comments** includes a summary of the findings and steps needed in the next five years to re-build the addiction system in the NWT.

Section 6.0 **Bibliography** includes all references used in this final report, in addition to information sources on addictions for further reading.

Supplementary Information:

Part 1: **Mobile Treatment Program Review** includes more detailed information regarding the evaluation of the Women's and Youth Mobile Treatment Programs.

Part 2: **Site Reports (15)** includes specific information on each community assessed during the data collection time line from December/2001-March 22, 2002.

1.4 Terminology

Throughout this final report, a number of terms will be used to delineate certain aspects of addictions. The language of addictions is a coded language based in part on history, passion and a belief system developed through the struggles of people living with addictions.

The literature section will provide greater detail as to the definition of addiction, as to define addiction is anything but straight forward and for most people, addiction has a more personal influence rather than a clear cut definition. The complexity of addiction could be summarized in asking a group of people standing in the grocery checkout to define addiction and the result would be anything but consistent.

However, for the purposes of this report and other supplemental information, the evaluation team has chosen the following terms and language to describe an otherwise difficult construct. The language chosen is reflected in the common literature in the addictions field at this time, 2002. It is noteworthy to remind the reader that addictions language has been evolving for over 300 years and will likely continue to evolve in the future.

Terminology

Addiction: Includes alcoholism and addiction to drugs and or substances. In a few instances where the context dictates, addictions may refer to gambling and other process addictions.

A.A/N.A: Refers to Alcoholics Anonymous and Narcotics Anonymous.

Addictions Specialist: Refers to Health and Social Services Authorities positions in addictions.

Aftercare: An integrated, post-hospitalization, continuing program of outpatient treatment and rehabilitation services provided by the treatment facility or other facility. The program is directed to maintenance of improvement, prevention of relapse and adjustment to the community.

Blended

Programs: Refers to NWT community based programs that are inclusive of community addiction program and mental health and/or family violence program.

Client: Refers to people who undergo treatment for addiction; denotes a respect for the person seeking help.

Community Addiction Worker: Refers to the current positions held in many Community Addictions Programs, as this is what they are called in most NWT communities at this time.

Concurrent Disorders: Refers to people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of substances such as alcohol and/or other drugs.

Counselling: A process of defining, understanding and addressing a specific problem as well as advice and suggestions given by a person acknowledged as being an expert in one or more areas, such as marriage, dependency on substances or vocations.

Detoxification Or Detox: Refers to procedures designed for the reduction or elimination of toxic substances in the body. Commonly referred to as Detox.

Flooding: Uncontrolled and uncontrollable emotional expression such as continuous weeping.

Recovery: Refers to people in treatment.

Substances: Includes alcohol, inhalants/solvents, illicit drugs, over the counter medications and nicotine.

Treatment: Includes residential treatment and also the providing of services to a person with a condition such as an addiction.

2.0 Literature Review

The purpose of this literature review is to provide the reader with an overview of the most relevant information in the popular and scientific literature regarding addictions. This is an abbreviated literature review, as there is a vast amount of information available on addictions. This review will address areas of relevance to the evaluation of Community Addiction Programs in the NWT including definitions and models of addictions, recent trends in the delivery of addiction services in other jurisdictions across North America and a review of the common stages and program content of a typical addictions program from across Canada.

2.1 Definitions and Models of Addictions

According to one well know figure in the field of Addictions, there are as many as 200 definitions of addiction (Jellinek, 1960). Some of the earliest names for what is referred to today as addiction, were solely based on the use of alcohol such as confirmed drinkers, drunkards, hard cases and inebriates. In 1849, a Swedish physician, Mangus Huss introduced the term *alcoholism* to describe a state of chronic alcohol intoxication that was characterized by severe physical pathology and disruption of social functioning (White, 1998). Other terms emerged in the next century to describe the pathological craving for alcohol and the consequences of its excessive use such as intemperance, habitual drunkenness and the liquor habit.

In the early 1900's, Richard Peabody and Charles Towns, lay therapists from a drying out hospital, were the first treatment specialists to use the term alcoholism and alcoholic. Other addiction experts in the depression years preferred the use of problem drinker, as the term alcoholic and alcoholism were too stigmatizing and because they believed that alcohol was a problem for many people and not just those with a physical addiction. With the founding of Alcoholics Anonymous on June 10, 1935 by stockbroker Bill W. and physician Dr. Bob, the words alcoholic and alcoholism were solidified and remain key words in the recovery movement.

In 1957, the World Health Organization proposed the use of the term alcohol dependence, alcohol addiction and alcohol habituation. There was also a time when some people suggested alcoholism be replaced with Jellinek's Disease, based on his ground breaking work on the etiology of this condition. Later on in the 1970's, the language and definition debate continued with the playing out of the definitions by the American Psychiatric Association and the World Health Organization. Two new classifications were favoured in the 1970's, alcohol abuse and alcohol dependence as per the diagnostic classification system otherwise known as the Diagnostic and Statistical Manual of Mental Disorders or DSM. (White, 1998). In its most recent format, the DMS includes generic categories of substance intoxication, substance dependence and substance-induced disorders as well as alcohol dependence.

The problem of encompassing a term to be inclusive of multiple drug choices has been problematic. The term addiction, derived from the Latin root addicere, meaning to adore or to surrender oneself to a master, has become increasingly popular in the last decade (White, 1998). For many people in the field of alcohol and drugs, the term addiction and addict came to imply drugs other than alcohol, in particular the illegal drugs such as cocaine and marijuana.

Unfortunately, there will be an ongoing failure in the consensus of the wording and language of addictions and substance dependence due in part to the multiple personal, social, economic, professional and political utilities such language must serve (White, 1998).

Therefore, the reader is encouraged to be cautious in their choice of language with reference to addictions; their conceptual model of addictions will largely determine one's choice of language. Currently there are 10-15 conceptual models of alcohol problems and alcoholism, which adds to the confusion by many interested groups regarding the treatment of such problems. There is today, still some uncertainty and lack of agreement among experts in the field of the nature and etiology of alcohol and drug problems. I encourage the reader to consider not a single model of addiction but rather determining which model may be the most effective for different types of individuals with alcohol and drug problems.

Disease Model of Addictions

The disease model of addiction was first proposed in 1810 through the work of Dr. Benjamin Rush (White, 1998). Dr. Rush called for the creation of a sober house, where alcoholics could be confined and rehabilitated upon evidence of drunkenness, neglect of business and ill treatment of family members.

(1) Loss of control over the use of the substance
(2) Continued use despite negative consequences

"Alcoholism is a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with the drug alcohol, use of alcohol despite adverse consequences and distortions in thinking, most notably denial. Each of these symptoms may be continuous or periodic."

(Journal of the American Medical Association 268, no.8.: 1012-13, 1972)

The greatest advantage of addiction as a disease has been to remove the moral stigma attached to chemical dependency and to replace it with an emphasis on treatment of an illness. One clear disadvantage of the disease model implies that non-medical persons are unable to treat the illness. To perpetuate treatment solely on physical damage would be equally ineffective in the long range.

American Psychiatric Association and the Disease Model

The American Psychiatric Association began to use the term disease to describe alcoholism in 1965. Today the disease concept has been generalized to addiction to other drugs. According to the most recent Diagnostic and Statistical Manual for Mental Disorders for 2001 or DSM IV-TR, the criteria for Dependence and Substance Abuse are as follows:

Dependence

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following occurring within a 12-month period:

1) Recurrent substance use resulting in failure to meet role obligations.

2) Recurrent substance use in situations in which it is physically hazardous.

3) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substances.

Substance Abuse

A maladaptive pattern of substance use, which leads to clinically significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the same 12-month period.

1) Tolerance, as defined by either a need for increased amounts of the substance to achieve intoxication or desired effect or a diminished effect with continued use of the same amount of the substance.

2) Withdrawal, as manifested by either of the following: a) the characteristic withdrawal syndrome for the substance, or b) the same substance is taken to relieve or avoid withdrawal

3) The substance is often taken in large amounts or over a longer period than was intended.

4) There is persistent desire or unsuccessful efforts to cut down or control substance use.

5) A great deal of time is spent in activities necessary to obtain the substances, use the substance or recover from its effects.

6) Important social, occupational or recreational activities are given up or reduced because of substance use.

7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

Is Addiction a Moral Problem?

Moral models of addictions emphasize personal choice as a cause of alcohol or drug problems. For centuries, drunkenness has been viewed by some religions as sinful or demonic behaviour. According to Alcoholics Anonymous, it is viewed in part as a spiritual deficit. Others view addictions as wilful violations of societal rules and norms. At various points of history, public intoxication has been a punishable crime (Heister & Miller, 1989).

Whether understood as a spiritual or a criminal issue, these views agree in pointing to personal choice as a causal factor in problem drinking. The individual is seen as making choices and decisions to use alcohol in a problematic fashion and as being capable of making other choices. When the emphasis is spiritual, the logical change agents would be ministers of a religious community. When the moral emphasis is seen as a violation of social norms, punishment, such as prison becomes the only intervention.

The implications of a moral model of addiction are its the person's problem and health care systems are free of their obligation to provide medical or psychosocial support. The disadvantage is that many people will die of physical complications of their addiction.

Is Addiction a Brain Disorder?

In recent years, there has been advancing research that points to a biological cause of addictions such that some people are more prone to develop because of genetic, psychological or physical risk factors. Research on twin studies highlights the genetic predisposition to alcoholism whereby children of alcoholics are at greater risk of developing an addiction than children of non-alcoholic parents. Furthermore, researchers have identified several neurochemical abnormalities in the Dopamine receptor gene that may explain the transfer of addiction from generation to generation. Other researchers hypothesize there is a faulty switch in the brains of people with addictions that regulate desire pleasure which over time is damaged permanently by the continued use of an addicting substance (Fisher & Harrison, 2000).

Neuropsychological evidence for addiction as a disease of the brain includes neurochemical studies that have provided evidence to implicate several neurotransmitters, including Dopamine and Serotonin and carious brain regions (the ventral tegmental area and nucleus accumbens) in mediating alcohol reward and craving. Also, the Federal Drug Administration or FDA approval of Naltrexone for the treatment of alcoholism further highlights this point. Naltrexone blunts the activity of opiate receptors in the brain, which prevents the brain from producing a euphoric response to opiates and other drug like substances (Henderson, 2000).

Further evidence of an addiction as a brain disease includes findings that drugs with addictive properties are active in the ventral tegmentum part of the brain. This brain area is connected to relay centres in the thalamus and hypothalamus as well as to higher parts of the brain, where most learning and reasoning takes place (Henderson, 2000).

Implications for addiction as a brain disorder would include the development and use of pharmacological treatments for addiction. That is a person with an addiction could take a "pill" to cure or treat their addiction.

Socio-Cultural Model

A broad view points to the role of society and culture in shaping an individual's drinking patterns and related problems. The level of per capita alcohol use in a given community is powerfully influenced by the availability of alcoholic beverages: their cost, convenience of access, legal regulation and so forth.

In addition, the nature of drinking and drug use environments is also of interest within a sociocultural perspective. Community factors such as the level of societal stress, alienation and trauma influence the use of alcohol and other drugs. The influence of peers and others has been examined in the patterns of use by people and an environment of heavy use evokes others to join the crowd (Heister & Miller, 1989). Interventions from this sociocultural perspective focuses on altering the person's relationship to his or her environment, building on coping strategies, fostering healthy role models in the community and addressing the supply and demand aspects of alcohol and drug use.

General Systems Model or Family Model

A general systems approach views individual behaviour as an inherent part of a larger social system. Actions of the individual, such as addiction cannot be understood without considering their relationship to other members of the systems to which the individual belongs. The person's actions are an inherent part of a bigger system. A general systems model maintains that s system such as the family tends to maintain an overall status quo and will resist change. Working with the individual then is a very limited approach because it overlooks the extent to which that person's behaviour has functional importance within the family.

A variety of researchers and advocates in the field of addictions consider addictions as a family disorder, requiring the whole family system to be treated (Heister & Miller, 1989). The person's addiction is viewed as a coping strategy within the family structure. If the individual is treated alone, the family system may resist change, and if the individual does change, the family system may fall apart or another family member may become dysfunctional to compensate.

The author and lecturer, John Bradshaw in the 1990's described compulsive behaviour, including addictions as a reflection of an individual's effort to escape shame from the family origin (Fisher & Harrison, 2000). The use of family systems approaches from the treatment of addictions generally includes family therapy and the use of role-playing to demonstrate roles both functional and dysfunctional within the family system.

Aboriginal groups have relied heavily on the use of a general systems or family model of addictions due to the strong value on the place of the family within the context of a community. The family model of addictions is consistent with many Aboriginal groups beliefs and values in the strength of the family. Family is still the central institution in Aboriginal communities.

> "Many presenters at our public meetings argued that breakdown in traditional Aboriginal family structures and functions is a major factor in the social problems with which they are grappling. They argued for rehabilitation of Aboriginal families as part of the path to personal and community healing" (Highlights form the Report of the Royal Commission of Aboriginal People, p. 62).

Other Aboriginal conceptualizations of addictions go beyond the biological and experimental explanations provided by mainstream medicine. Many of the mental health problems including addictions experienced by Aboriginal People can be attributed to a disconnection from their culture. McCormick (2000) stated that for many Aboriginal People, consumption of alcohol has been their attempt to deal with the state of powerlessness and hopelessness that has arisen due to the devastation of traditional cultural values. Several prominent Aboriginal researchers have demonstrated that cultural breakdown is strongly linked with addictions, including Duran (1995) and York (1990).

The Mental Health Model

The mental health model describes addiction as a symptom of an underlying disorder. An implication of the mental health model is that once the underlying disorder is "cured" the addiction will be "cured". This model posits that trauma and resulting stressors, both physical, environmental and psychological contribute to development of addictions. Addictions are the symptoms of mental health or psychological problems.

First Nations' Model

Similar to the mental health model, many First Nations researchers would propose that people have emotional pain and use alcohol or other drugs to temporarily relieve the pain. The pain may be as a result of sexual abuse, family violence, unresolved trauma from residential schools and other psychosocial stressors. There is ongoing debate in health care circles and in Aboriginal Communities whether alcohol and drug addictions is a primary problem by itself or whether it is a manifestation of more deeply rooted problems. Other Aboriginal people believe addiction is a secondary cause of individual and community dysfunction (Dennie, 2001).

Biopsychosocial Model

This model has emerged from clinical practice in the last decade and has been well described in recent literature (Fisher & Harrison, 2000, Downing, 1989). This model describes addiction as a primary illness, which progresses developmentally from growing tolerance and dependency to a progressive loss of control to deterioration of bio-psycho-social health. This

model was developed to be inclusive of the multiple conceptualizations of addictions, as proposed over the last 50 years. In the bio-psycho-social model of addiction, the interactions of biological, psychological, cognitive, social, developmental, environmental and cultural variables are considered to explain addiction (Fisher & Harrison, 2000).

The biopsychosocial model is reasonable in combining all other models into a single model. This model presents that people working in the field of addictions thoroughly assess clients, develop multiple hypotheses to the explain the client's problem based on the assessment, avoid forcing the client to fit a rigid definition of addictions and use a variety of methods and interventions to address cooperatively the needs of the client (Fisher & Harrison, 2000).

Integration of the Models of Addiction with the Biopsychosocial Model

Several models have been proposed to understand the etiology of addiction that is the reasons, causes and mechanisms of addictions. The moral model is not widely accepted, as it discourages people from seeking help, discriminates people based on behaviour choices and further alienates people in communities and family systems. The disease model continues to have wide acceptance due to its medical orientation and because abstinence (method to control the disease) is a logical factor to this model. The disease model has also benefited from the Alcoholics Anonymous or AA movement over the last 50 years. The biopsychosocial model of addiction incorporates all relevant variables in the etiology and treatment of addiction and therefore, may be the most useful model at this time.

2.2 Key Areas of Addiction Programs

Consequences of Addictions

The body is an intricate machine with many systems such as the nervous system, digestive system, cardiovascular system, reproductive system and the immune system. These systems in the body function in balance and chemical interrupt this balance eventually leading to the body's breakdown. Use of any chemicals, such as nicotine, alcohol, marijuana and others affect the entire body and damage in one area affects other areas. Because of the toxic nature of alcohol and other harmful drugs such as nicotine and marijuana, one system after another in influenced by the dependence of addiction. Damage to the body from substances can be acute, where the body usually recovers or the damage can be chronic and permanent where cells and tissues die and cannot be repaired (Miller, Gorski & Miller, 1992).

A complete review of all the physical and psychological consequences of addictions to substances is beyond the scope of this abbreviated literature review. Each substance or drug has particular effects on the body but there are also many commonalities with the body's handling of substances, as they follow similar patterns of metabolism.

The following list of physical and psychological consequences of addictions to substances are listed here for the benefit of the reader (Gorski, 1992 & Merk Manual of Diagnosis and Therapy, 1992).

Physical Consequences of Addictions to Substances

- The brain itself can be damaged by short or long term use of substances such as alcohol, marijuana, cocaine and inhalants. Prolonged intake can result in confusion, disorientation and lowered cognitive abilities. Irreversible brain damage, such as Korsakoff's psychosis and Wernicke's syndrome are two examples.

- The peripheral nerves in chemically dependent people are affected by nutritional deficiencies due to chronic ingestion of alcohol. This leads to a degeneration of the nerves, which causes numbness, tingling, muscular weakness and paralysis.

- Problems with the digestive system are common such as cancer of the esophagus, stomach problems as ulcers/ gastritis and the whole process of digestion is less than optimal, meaning persons with addictions to chemicals are prone to malnutrition.

- Inflammation of the pancreas, a vital and fragile organ needed for the metabolism of glucose is common in chronic drinkers.

- The liver can be seriously impaired in chemically dependent people. Fatty liver develops because of the liver's decreased ability to break down large amounts of alcohol and other drugs. Cirrhosis of the liver is one of the ten major leading causes of death in North America and it is also one of the most gruesome ways to die, that is with seizures, coma, bloating, hallucinations and prolonged suffering.

- The lungs of chemically dependent people are at high risk of developing pneumonia and other serious lung diseases caused by bacteria or viruses. Chemically dependent people have a decreased ability to fight infections. Smoking and substance is the major risk factor for lung cancer.

- Reproduction systems are affected by prolonged and heavy use of chemicals as will as by a single dose of alcohol or drugs during pregnancy. In females, chemicals such as alcohol, smoking and the use of other drugs contribute to higher rates of infertility, miscarriages, stillbirths and low birth weight babies. In males, chemical use results in lower testosterone levels causing impotence. Damage to a fetus by a mother who drinks is called fetal alcohol syndrome or FAS, which can also be referred to as irreversible brain damage.

- The use of chemical substances has been implicated in the development of high blood pressure, which can lead to heart disease and strokes. Atherosclerosis, a build up of fatty material in the arteries is common among cigarette and alcohol users. Cardiovascular disease is the number one cause of death in Canada, according to the Heart and Stroke Association (2001).

- People with addictions to chemicals such as alcohol, nicotine and marijuana, have problems with their immune systems and hence have greater levels of day-to-day infections. Intravenous drug users are at risk for HIV infection.

- People with addictions have chronic muscle wasting and bone loss due to nutritional deficiencies as the result of addiction and the toxic effects of alcohol and other drugs.

Psychological Consequences of Addiction to Substances

- Mood swings are common as people with addiction to substances use chemicals to feel better. People are unable to maintain these good feelings and then become depressed and fearful.

- There may be cognitive, memory and perception problems resulting from the use of substances. Thought disorders and delusions can occur and are more common among substances such as cocaine, stimulants, opiates and hallucinogens.

- Development of anxiety and other mood disorders such as bipolar disorder, post-traumatic stress disorder and depression.

- Dependence and tolerance develop with the use of most substances and time for dependence varies depending on the drug. Depressants like alcohol and cocaine have a rapid tolerance. Tolerance to marijuana is less dramatic and is subject to individual differences.

Withdrawal and Delirium Tremens or the DT's

Withdrawal from chemicals such as alcohol, nicotine, marijuana and other drugs has both immediate and long-term effects. Recovery from addiction means detoxification or ridding the body of the toxin. Withdrawal also means recovery from neurological (brain and central nervous system) damage as well as organ (liver, heart, pancreas) damage (Miller, Gorski & Miller, 1992).

Withdrawal is different for various drugs and for the purposes of the abbreviated literature review; the general process for alcohol withdrawal will be presented here. The first stage is characterized by the acute symptoms of withdrawal. These first symptoms are what cause most people with an addiction to drink again. Withdrawal symptoms may become severe and can last from one to ten days.

The first symptoms are as follows:

a) Hyperactivity of the nervous system, which takes the form of tremors, loss of appetite, sweating, nausea, vomiting, low stress tolerance, hyperactivity, confusion and poor memory.

The second stage of symptoms is as follows:

b) Reality becomes distorted, objects appear to move, noises may be heard, physical sensations may be felt which in reality are not occurring; strong illusions create confusion, fear and panic.

The third stage of symptoms is as follows:

c) Delirium and disorientation, person is confused as to where they are, hallucinations occur, confusion, excitement, incoherence and fear set in.

The fourth stage of symptoms is as follows:

d) Convulsive seizures, which can occur within 48 hours after the last drink and can also occur up to seven days later.

The last stage of symptoms is as follows:

e) Delirium tremens or the DT's as they are know in the addictions field. With good medical care and support, the DT's which can include serious delusions, hallucinations, high fever and fluid loss and physical exhaustion. The DT's can be very serious and/or fatal.

Mortality rates as high as 15-20% were reported for people going through the DT's (Kinney & Leaton, 1995).

Addiction Trends in the United States

America is caught in the transition between two addiction paradigms: one that views addiction as a disease condition emanating from biopsychosocial vulnerability and the other view of addiction as a wilful and criminal behaviour emanating from the flaws of moral and personal character (White, 1998). In the 1980's, America moved addiction from the arena of public health into the arena of public morality. As indicated by some authors in the field of addictions, if this trend continues, it is likely that addiction will be de-medicalized and increasingly criminalized for all but the most affluent of our citizens.

> "Wholesale movement of poor addicts from treatment programs to justice. This reverses the trend toward integrating the treatment of addiction into local communities and re-initiates a pattern of isolation, sequestration and punishment" (White 1998-p.341).

Another major trend in the United States involves the War on Drugs, which was put in place to address the growing supply of illegal drugs in the 1990's has been all but declared a lost war, as prices for cocaine and other imports are going down and supplies are anything but decreasing (Troiani, 2002). Law enforcement and corrections costs are at an all time high in the United States with close to 80% of people being arrested test positive for any drug including alcohol (Troiani, 2002).

Trends in the United States include marijuana as the most readily available illegal drug with methamphetamine or the poor man's cocaine becoming more accessible and less expensive that cocaine. According to the 2000 Annual Report to the White House office of National Drug Control Policy, Heroin has become more popular among young people (Troiani, 2002).

Lastly, the advent of club drugs or date rape drugs such as GHB, ecstasy and rohypnol has changed the social fabric of America's younger generation where an evening out now is inclusive of attending an all night dance party, called a rave and using pleasure drugs to lower sexual inhibition and to heighten sensory experiences (Troiani, 2002).

European Trends

Of relevance to the Community Addiction Programs in the NWT is that the Europeans rely on models of harm reduction in dealing with core drug problems such as heroin and other opiates with a long-term goal of abstinence (Buhringer, Gossop, Turk, Wanigaratne & Kaplan, 2001). Overall abstinence rates for most well designed studies in Europe are anywhere from 9 to 44%; that is depending on the treatment setting or follow-up period, the abstinence rates vary between 9 and 44%.

European treatment programs range in time from 2 to 6 months for treatment, which is inclusive of a strong behavioural component and the use of medications for cravings and brain restabilization. The main distinction between the priorities and concerns of Europe and the United States has been with respect to the treatment goal of abstinence. On the other hand, European addictions experts are much more influenced by the literature on cravings and the physiological roots of problems in regulating cravings for drugs or alcohol (Buhringer, Gossop, Turk, Wanigaratne & Kaplan, 2001).

Harm Reduction Models of Addiction Treatment

One of the newest innovations in the last 5 years in the treatment of drug and alcohol problems is called harm reduction therapy (Denning, 2001). This wide reaching term refers to different treatment models based on the international public health movement known as harm reduction. The variety of treatments known as harm reduction, recognize that problems with

substances affect people, families and the communities they live in. The common thread in harm reduction treatment is in helping people to reduce the harm associated with their behaviour. Other public health reduction interventions include vaccination programs, health screening fairs and needle exchange programs.

Harm reduction models of addiction treatment challenge the ideology of traditional addiction treatment that is based on abstinence from the substance of addiction. Harm reduction treatments focus on identifying and reducing substance related harm, and allows that while abstinence may sometimes by the most certain strategy to protect a person, any move to reduce harm is a step in the right direction.

Harm reduction models are also increasingly popular in Europe and the United States with respect to the criminal behaviour around drug seeking. Treatment may focus on avoiding criminal involvement first and on drug behaviour second. A harm reduction approach is inclusive of socio-cultural determinants of addiction such as poverty, lack of education and family structure in addition to the biological actions and sensitivities of substances. Therefore, the biopsychosocial model of addictions is consistent with a harm reduction model of treatment.

Harm reduction treatments have been receiving good reviews from clinicians in the field of addictions due to the recognition that addictions are by nature a chronic and relapsing condition for most people who become addicted. Lack of complete treatment success is often as a result of an exaggerated expectation of total abstinence for the traditional addiction treatment models. Harm reduction treatment models engage a person in gradual change and measures success not by abstinence but by steps in the right direction.

Main components of a harm reduction model for the treatment of addictions are:

- Harm reduction addresses and accepts the client "where he or she is"
- The focus is on reducing the harm caused by the substance use, not on the use of the substance, although that may be included.
- Allows the client to select goals that range from abstinence to safer use.
- The treatment is based on the rights of individuals to make choices.
- The methods are based on research is self-efficacy and change
- The counsellor needs to be highly skilled in therapeutic approaches and the biopsychosocial determinants of addictions.
- Based on "do no harm" concept of medical practice.
- Clients do not need to be substance free to be in counselling or treatment.

- Harm reduction is neutral with respect to abstinence as a treatment goal and is neither exclusive nor inclusive of abstinence; all is dependent on the goals of the client.

- Priority of goals depends on the immediate needs of the client, which may include a focus on individuals, communities or target groups.

- No moral judgements are made regarding the substance use; the benefits of substance use are taken into consideration as a means to understand the use of those substances.

- Harm reduction model of treatment can be combined with existing treatment strategies and may be most effective in this matter.

In summary, a harm reduction model is consistent with a biopsychosocial model of addiction and will be a predominant force in the fight against addictions in the 21st Century. It is a modern day solution to modern day problems associated with substance use by attempting to reduce the criminality and social destruction caused by substance use. As it is a new model of treatment for addictions, more research is needed to fully understand the implications and long-term outcomes of this type of treatment model.

Concurrent Disorders

Concurrent disorders is defined by the Centre for Addiction and Mental Health, Canada's Drug Strategy, Health Canada as a term to refer to those people who are experiencing a combination of mental/emotional/psychiatric problems with the abuse of substances such as alcohol and/or other drugs. Technically, concurrent disorders refer to a combination of mental health and substance use disorders, as defined by the DSM-IV-TR (Health Canada, 2002). American addictions sources use the term dual diagnosis, which remains in use in many addictions treatment centres in both the United States and Canada (Troiani, 2002, Lawson, 2002).

Current Canadian research sources have recommended the following five sub-groups of concurrent disorders:

- Group 1: Co-occurring substance use and mood and anxiety disorders
- Group 2: Co-occurring substance use and severe and persistent mental Disorders
- Group 3: Co-occurring substance use and personality disorders
- Group 4: Co-occurring substance use and eating disorders
- Group 5: Co-occurring substance use and mental health disorders

Prevalence rates of concurrent disorders is largely based on extrapolations from America data where 29% of people with a mental disorder were found to have a concurrent substance use disorder as compared to 16% of the population (Health Canada, 2002). Other studies from an Ontario study have found the co-morbidity of addictions and mental health disorders to be as high as 55% of those with a lifetime addiction diagnosis.

Facts for an NWT population are not know and would be further complicated by the sociocultural bias of not diagnosing mental disorders in addition to the lack of mental health resources to make such diagnoses across the NWT. There is also some question among Aboriginal Health research in using a DSM, medically based system of diagnosis, as it is inconsistent with a holistic view of health and may be counterproductive to an Aboriginal belief system of healing (Young, 1993; Royal Commission on Aboriginal Peoples, 1996 & McCormick, 1998).

However, the nature, high rates and costs of care for people with mental disorders and addictions requires a coordinated and integrated approach to assessment, treatment and prevention so as to meet the needs of this high risk group of NWT residents. Some main principles of care for people with co-occurring mental disorders and addictions are summarized below:

- Conducting a comprehensive assessment that provides information regarding the severity and nature of both the addiction and the mental health disorder.

- Need to provide immediate problem resolution and long term monitoring, support and rehabilitation.

- Need for highly skilled clinicians in mental health diagnosis and addictions; this is most likely provided through a team of health care professionals that could be inclusive of clinical psychology, psychiatry and/or addictions counselling.

- An integrated treatment approach is indicated that may or may not include residential treatment for addiction.

- Intervention for substance abuse and severe mental illness such as schizophrenia should be planned and implemented concurrently.

- Treatment and support for co-occurring substances abuse and post-traumatic stress disorders should be planned and implemented concurrently and would likely involve behavioural treatment.

In summary, people with concurrent disorders are an increasingly important target group in the mental health field due to their complex presentation and frequent contact with the health care system. It is unknown what the prevalence rates are for people with concurrent disorders in the NWT. Furthermore, there are potential problems in using a mental disorder classification system that is not consistent with a holistic view of health for many Aboriginal people living in the NWT. However, current estimates from Canadian and American sources predict that close to

half of the general population with addictions may also have a mental disorder. Therefore, current assessment, treatment and prevention efforts in the NWT need to consider the complexity and best practices approaches in reaching this group of people.

2.3 Components of an Addiction Program

There are generally eight addiction program areas that are recognized in the field of addictions as forming a comprehensive approach to management of addictions (Heister & Miller, 1989). These areas have been simplified for this abbreviated literature review and have also been cross-referenced with standards of practice in two Canadian provinces, Ontario and Saskatchewan. These key areas are presented here for reference purposes and were used as a basis for the evaluation of Community Addiction Programs in the NWT. In addition, these key areas are based for the most part on the biopsychosocial model of addictions, as discussed in section 2.1 of this literature review.

Please note that clients with addictions may not necessarily go from stage 1 to stage 8, but for optimal success in arresting symptoms and patterns of addictive behaviours, the stages are ideally sequenced from Stage 1 through Stage 8. A diagram of these 8 stages follows the presentation of all eight stages.

Stage 1: Crisis Intervention and/or entry into the system

The first point of entry for an addicted person can be through a crisis situation such as a suicide attempt, a hospitalization for driving under the influence (DUI) or through the loss of family or a job due to the addiction. The main goal of this stage is to engage the potential client to remain in contact with a helping person or professional. Helping the client to stay connected and to remain safe from further harm in a crisis situation is the addictions counsellor or other mental health counsellor's position where possible. The crisis that has led the client to seek support may be their first or fifth and further dealing with the exact nature of the addiction at this stage is often contraindicated due to problems of flooding and emotional instability. Medical attention may be needed at this stage, should physical problems be evident.

This first point of contact is very important for the client, as it represents their first attempt at addressing their addiction. Often workers at this stage are experienced counsellors who have a Master's degree and/or additional training in crisis intervention and critical incident stress de-briefing. Teams of crisis intervention workers are put together to respond to large disasters, both environmental and criminal. In some areas, workers in crisis intervention are will skilled with street people and hard-core drug problems and may or may not possess University education.

Stage 2: Intake and Risk Review

Some jurisdictions across Canada refer to this stage as intake or where information is first put into the system. Intake procedures can vary from location to location and usually involve a preliminary risk review for suicide and screening. Intake can also be seen as an input stage of

information such as name, date of birth, address, health care numbers, next of kin and current list of identified problems.

Depending on the system, this stage is usually completed by an entry-level addictions worker or intake worker familiar with the system of addiction services in the respective jurisdiction. In some scenarios, this intake is done over the telephone prior to the person having a first appointment with an addictions counsellor.

For some systems, this intake stage forms a pre-assessment or triage function, which is a classification of the addicted person. A priority ranking is developed to have the most needy clients seen sooner and others put into a waiting period for the next available appointment.

Stage 3: Detoxification or Detox

Detox is the period of time in which a client is withdrawing from substances and is frequently a time when medication is used. In the past, this process occurred in an inpatient, hospital setting. However, outpatient detox services are now a common practice due to the high costs of hospitalization. In the detox from alcohol and other central nervous system depressants, minor tranquilizers such as Valium and Librium are used to reduce the danger of seizures or other life threatening symptoms. Careful medical supervision with a gradually decreasing dosage is necessary (Fisher & Harrison, 2000).

In one study it was found that 90% of clients with appropriate resources could be detoxed on an outpatient basis with the protocols and monitoring of vials for safe and effective withdrawal. It is generally believed in the addiction field that inadequate detox of the addicted client is one of the major reasons for relapse.

Methadone is widely known for its use in treating heroin and other opiate addictions. Methadone is a synthetic narcotic with a longer duration of effect that heroin and ingestion blocks the euphoric effects of opiates. The client usually must visit a methadone clinic to receive the dose. However, some governments in the U.S. and Europe are experimenting with distributing methadone through primary care physicians.

Detox services are sometimes that first point of entry for some clients, depending on their housing circumstances and medical stability. Inpatient detox services are required when there are life threatening symptoms such ashen the client is hypertensive, in the DT's or where there is an indication the client will be dangerous to themselves or others. Inpatient psychiatric wards usually provide these services or, in larger centres a full detox unit may be present. Some treatment centres provide detox services as part of their services and this may occur prior to entry into the treatment program. There is a level of expertise needed in dealing with detox and the establishment of detox protocols and the field of Addiction medicine has been growing in the United States in response to the need for this expertise (Fisher & Harrison, 2000).

Stage 4: Multi-disciplinary Treatment Assessment

Assessment is generally defined to mean a process of evaluation and the gathering of clinical, social, family, legal, educational, occupational and behavioural information in order to come to a synopsis of the client's current state of functioning. The assessment stage can also provide a diagnosis (if the counsellor is qualified to do so) and to establish treatment goals and a plan (Fisher & Harrison, 2000). A thorough assessment may be done in an afternoon or could be done in several sessions over a month long time frame. Assessment is a process that should be ongoing during counselling, as a good counsellor should always be gathering new information that will assist the client in their recovery. Every assessment should consider individual characteristics of the client. An assessment or evaluation for treatment may take several sessions; the goal of assessment is to develop a recipe or plan that will offer the client the optimal change of getting those arrows pointed in the proper direction.

The types of health care providers that participate in the assessment stage could include: mental health or addictions counsellor, nurse, physician, nutritionist and career counsellor. Depending on available resources, assessment may be completed by the client visiting several different locations in order to access the appropriate health care provider. Usually a team approach works best and often staff completing assessment for addictions are specialized in the field of addictions with additional training and education in the methods and problems associated with addictions.

Psychosocial History- provides information about use of substances, quantity of use, living situation, location of use of substances.

Family History- including information about relatives who use substances, number of children, marital status and possibility of other problems of abuse, neglect, violence…

Involving the family in the assessment is very desirable and becoming the norm. This is so vital that it is hard to imagine why family involvement was not always the case. By including family members, the clinician can assess firsthand their needs and their ability to provide support, as well as engage them as partners in treatment. Predictors for addiction that are highly significant are a family history of addiction and being raised in a culture with a high rate of addiction.

Legal History- this may include prior arrests, current orders pending, whether the use of substances occurred with this arrest or prior arrests.

Educational History- this area is more important for younger adults and adolescents. Researchers have noted that academic failure and a lack of commitment to school were risk factors for youth addictions (Fisher & Harrison, 2000).

Occupational History- With many adults, work history may indicate more current problems with addictions than educational history. For example, frequent job changes, terminations and reports of unsatisfactory performance may be noted. Underemployment may be a significant problem, as a client with an addiction in only able to seek jobs that require less responsibility and/or skills.

Medical History- People with addictions have more sickness than do people without addictions and therefore, a thorough medical history including prior hospitalizations, surgeries, current problems and previous detox history will be important. A nutritional assessment may also be indicated, especially if people have been using substances. A risk assessment for HIV infection is usually done at this stage as well.

Addiction History- a complete review of previous interventions, assessments, treatments and outcomes is needed. Often, standardized assessment tools or self-report inventories are used to determine the degree of addiction and problem. Some common examples are the Michigan Alcohol Screening Test (MAST), the CAGE (Cut down, Annoyed, Guilt, Eye-Opener) screening instrument, the Substance Abuse Subtle Screening Inventory-3 (SASSI-3), the MacAndrew Alcoholism Scale from the Minnesota Multiphasic Personality Inventory or MMPI-2. The majority of these screening and assessment tools require the counsellor to have graduate level education at the Master's level in order to fully comprehend and use the tools appropriately. Alternatively, a team of health care providers sees a client, where one person on the team is supervising the administration of these assessment tools.

Treatment assessment for the relapsed client needs to include discussion regarding the prior treatment. What was the treatment? Did the client have a period of stable sobriety? What contributed to its maintenance? To what do the family and the client attribute the resumption of drinking? The counsellor needs to consider whether the same treatment will do the trick.

E.g. an infection may not respond to one antibiotic, so therefore, try a different one.

Considerations should include:

- Are they in the middle of a serious crisis and flooding of emotion is occurring? Do they need treatment or other social supports?
- Was appropriate detox done?
- Is there a need for more detailed assessment for concurrent disorders such as clinical depression, schizophrenia, and bipolar disorder?

After the assessment procedures are completed, the team or health care provider summarizes the information into a clinical report which may include a diagnosis of the substance related disorder as per the Diagnostic and Statistical Manual of Mental Disorders – Text Revision or DSM-IV-TR. Only those counsellors or health care providers with sufficient graduated level education and credentials can diagnose a substance related disorder. Some treatment institutions require a diagnosis as entrance criteria and for payment purposes under their respective health care formulas. Many mental health or addictions workers in settings that have supervision by qualified professionals (master's level, psychologist or medical doctor) that can diagnose substance related disorders. Each provincial health department designates what is required for entry into their respective alcohol and drug or addiction services. The assessment report is often the first step towards the treatment plan and often is shared with the client.

Stage 5: Supportive Counselling and Treatment Planning

The decision to refer a client to treatment is often a decision shared by the assessment team, the client and his/her family. In some situations, treatment is mandated by the courts due to child welfare issues and/or justice sentences. Treatment is highly recommended by the recovery movement, as it provides the client with the necessary clean time to start in their recovery program. Due to funding limitations and little availability of treatment resources, this option may not be available, or there may be a long waiting time line. The following lists provide an outline of the rationale for inpatient or residential treatment versus outpatient treatment:

Indications for inpatient treatment

- History of unsuccessful outpatient treatment
- Potential withdrawal problems
- Medical problems
- Few social supports
- A family that needs time out
- Marked ambivalence about the need for treatment

Indications for outpatient treatment

- First treatment attempt
- An intact and supportive family
- An ability to use available supports
- No medical complications
- Recognition of the need for treatment
- Little risk of serious withdrawal treatment

Ongoing supportive counselling and in-depth assessment may continue while the client is waiting for treatment. This process may be as short as two months (Saskatchewan) or as long as one year (Ontario). Therefore, supportive counselling and participation in community support systems such as A.A or N.A form part of the pre-treatment time line and often are very important for the recovery of the client.

Stage 6: Treatment (residential, outpatient, other…)

A full description of treatment programs is beyond the scope of this literature review. However, a list of various types of treatment centres is presented here for the reader's information. Generally, treatment programs use several models of treatment within their program so as to provide a best practice program. Other programs are limited in scope due to their level of staffing and expertise.

a) **Minnesota Model of Treatment (Hazelden):** started in 1949 and is based on the disease model of addictions. Recovery is the goal through total abstinence. The use of Alcoholics Anonymous is predominant with support from an interdisciplinary team of physicians, nurses, counsellors, psychologists, social workers, and addictions counsellors. A combination of professionally trained and A.A volunteers form the staffing group.

   The Hazelden Foundation has done extensive outcome research, which supports the effectiveness of the Minnesota Model in treating addictions. Improvement rates from these outcome studies range from 34 to 80 percent, when the full treatment model is used (Downing, 1989).

   "Good treatment works!" (Troiani, 2002)

Most treatment programs across North America are based on the Minnesota Model including the use of a multi-disciplinary team.

b) **Twelve Step Treatment:** this model of treatment is based on the disease model and recovery through abstinence is the goal. There is little or no use of a multi-disciplinary team and most staff members are recovering alcoholics or drug addicts with in-service type training.

c) **Behavioural Treatment:** this model of treatment involves the use of behavioural strategies for the management of addictions. The use of medications such as antabuse, which is a form of aversion therapy are common. When antabuse is taken and alcohol is ingested during the following 24-48 hours, the client experiences facial flushing heart palpitations, rapid heart rate, difficulty breathing, nausea and vomiting. This type of behavioural treatment is often combined with the Minnesota Treatment Model and/or other types of residential inpatient treatment.

d) **Cognitive-Behavioural Treatment:** this model of treatment is based on social-learning theory and skills are taught to address signs and symptoms, address relapse prevention and cravings (Fisher & Harrison, 2000). This type of treatment is often combined with the Minnesota Model and/or other types of residential inpatient treatment.

e) **Motivational Enhancement Model:** this model of treatment is designed to help clients identify and use personal resources to effect change. Hey issues that are addressed in this model include a clients' motivation, use of denial and the stages of change model as described by Prochaska and DiClemente. These researchers assert that people go through various stages of change including precontemplation, contemplation, action, maintenance and relapse (Prochaska &DiClemente, 1982). The stages of change have received widespread application in the health disciplines over the last 15 years, especially with respect to smoking cessation, diabetes management, weight control and addictions (Hester & Miller, 1989). This type of treatment is often combined with the Minnesota Model and/or other types of residential inpatient treatment.

The list of treatment models, as listed above highlights the importance of recognizing that there is no single type of treatment model or approach for all individuals. Most treatment programs have specific models they follow and then include several other treatment modalities within their treatment program.

In North America, the length of time a client would spend in residential treatment is anywhere from 28 days to 60 days, depending on the addiction and recovery period (Bellwood, 2002). Recent trends in residential treatment have reduced the time spent in treatment to 21 days, but this is only due to financial restrictions imposed by Provincial Government Health Budgets.

Stage 7: Step-down or extended treatment

This is a relatively new concept in the field of addictions and has been adapted from the halfway house models used for parole purposes. Step down houses are used for clients following treatment who have few options for housing and who do not want to return to an addiction filled environment. They are often run by community groups and run as short-term housing units that support an abstinence model (Alcohol and Drug Services Saskatchewan, 2002). Extended treatment programs are provided for clients who are poly-drug abusers or who have concurrent disorders and require additional treatment time (Bellwood, 2002).

Stage 8: Aftercare and relapse prevention

Clinical research studies prove that extended care and contact with a formal support system following the end of residential treatment dramatically affects an individual's ability to recover. In one follow-up study in Ontario, 88% of clients who were abstinent after one year regularly participated in aftercare (Bellwood, 2000). Aftercare in the addictions field generally refers to support systems, strategies and techniques all geared towards supporting someone with an addiction who has completed a treatment program. Aftercare can be individual counselling, follow-up with treatment program staff, stress management, group counselling, A.A or N.A meetings, alternative therapies such as reflexology, massage therapy and any other support that encourages recovery form an addiction.

The chronic, relapsing nature of alcohol problems has long been recognized and in the last 20 years, research attention has shifted to address the factors affecting relapse (Heister & Miller, 1989; Gorski & Miller, 1982). Aftercare programs that are successful are often strongly rooted in relapse prevention strategies and processes. Relapse prevention is a very large topic area in the addictions field and beyond the scope of this abbreviated literature review. A well-known expert source in this area of addictions is Terence Gorski and references are listed in **Section 6, Bibliography** of this report.

Of relevance to the evaluation of Community Addiction Programs in the NWT, is the overall significance of relapse prevention in the cycle of addictions. According to one study, about 40% of all people addicted to alcohol who initiate treatment that involves both A.A and professional addictions counselling, will find themselves drawn into the ranks of chronic recidivism or relapse (Gorski & Miller, 1982). In comparison, people engaging in weight loss diets have a relapse rate of 95%, in that only 5% of people who have lost weight will maintain their loss within 5 years of losing it.

According to the literature on relapse, relapse itself is a minor issue; the more important issue is what a person does once they relapse, as this is the key to long-term recovery (Gorski, 1982). Many treatment programs devote a great length of time to relapse prevention or coping with relapse and it is a weak treatment program that fails to address this most important issue in the field of addictions (Bellwood, 2002).

> " Not dealing with relapse would be like not dealing with hypoglycemia for a person with diabetes who is on insulin; almost everyone will relapse at some point. It is how you deal with it that is important."
>
> (Evaluation Team Members, 2002)

In summary, the eight stages as presented here form the structure of most approaches to the management of addictions. Clients may enter the system at any of the first four stages of crisis intervention, intake, detox, and assessment and may or may not cycle through stages five through eight, that is treatment planning, treatment, step down and aftercare. Also, clients may relapse and begin to cycle again at any of the first four stages.

With recent government trends to reduce costs in the areas or residential type programs, addiction services will need to be creative in replacing the vast amount of support and resources given to addicted clients during treatment. Alternatively, with increased resources at the community level and the use of well educated and skilled multi-disciplinary mental health teams, many more clients with addictions may well be served from an outpatient environment.

Table 2-1: Flow Chart of Addiction Services
(Adapted from Alcohol and Drug Services of Saskatchewan & Ontario, 2002)

Stage 1: Crisis Intervention and/or Entry Into the System	Stage 1 persons/staffing involved: Family, EAP, RCMP, Hospital, mental health
	↕↕
Stage 2: Intake and Risk Review	Stage 2 staffing involved: Intake worker or addictions or mental health
	↕↕
Stage 3: Detox	Stage 3 staffing involved: Medical staff (inpatient or out patient) medical detox & staff involved with social detox programs
	↕↕
Stage 4: Multi-disciplinary Treatment Assessment	Stage 4 staffing involved: Team of addictions or mental health, nurse, doctor…
	↕↕
Stage 5: Supportive Counselling & Treatment Planning	Stage 5 staffing involved: Addictions or mental health counsellors, A.A/N.A
	↕↕
Stage 6: Treatment (residential/ Outpatient)	Stage 6 staffing involved: Treatment Centre Team: counsellors, medical…
	↕↕
Stage 7: Step down/Treatment Extension	Stage 7 staffing involved: Step down or Treatment Centre Team
	↕↕
Stage 8: Aftercare and Relapse Prevention	Stage 8 persons & staffing involved: Addiction or mental health, community A.A, family, clergy, EAP, career counselling, schools…

2.4 Health, Social and Economic Costs of Addictions

The costs associated with the use of alcohol, tobacco and illicit drugs in Canada have been summarized in the document: *The Costs of Substance Abuse in Canada, Highlights of a major study of the health, social and economic costs associated with the use of alcohol, tobacco and illicit drugs, by the Canadian Centre of Substance Abuse (1992).* This document summarizes the first comprehensive study of the costs of addictions in Canada, as previous attempts have been plagued by problems of validity and reliability.

This study examined the literature on estimating alcohol, tobacco and drug costs. By using the cost of illness approach, a detailed list of costs were drawn up and existing data systems were inventoried for the specific information. The overall results were to provide the economic costs of addictions nationally and to develop estimates for each province (the study did not include data from the Territories). This study and the figures presented below represents the costs as they relate to the whole society and not just to government accounts. The Costs of Substance Abuse in Canada report provides the basis for completing a cost-benefit analysis that is, determining whether the costs of addictions programs are justified by the benefits they produce.

The costs addressed in this analysis included but were not limited to the following:

- Costs associated with health care: hospitalization, treatment, prescription drugs, and ambulance services.
- Indirect costs associated with lost productivity (illness, death, incarceration).
- Social welfare costs.
- Research and education (training programs for health professionals, prevention programs).
- Law enforcement expenditures (police, courts, corrections, customs and excise).
- Avoidable costs such as life years saved as a result of effective government and programming.

> "The figure of $18.45 Billion or 2.7% of GDP, represents the estimate of the costs of addictions in Canada in 1992. This represents $649 per capita. Alcohol accounts for more than $7.5 billion in costs or $265 per capita. Tobacco accounts for $9.56 billion in costs or $336 per capita. Illicit drugs accounts for $1.37 billion or $48 per capita.
>
> (Canadian Centre of Substance Abuse p. 6, 1992)

With respect to alcohol specifically, the authors concluded that most of the economic costs are avoidable as about half of deaths and hospitalizations result from acute causes such as accidents, alcohol toxicity, suicide and assault. Most of these deaths involve young people so that the number of potential years of life lost and premature deaths are very high. The authors concluded that the majority of alcohol related costs could be avoided.

The results found within the Canadian context are reinforced by the more recent data coming from the National Institutes of Health in the United States which placed the annual cost

of alcohol and drug abuse at $246 billion or $965 per capita. Of these costs, roughly 60 percent had to do with alcohol and 40 percent with drugs. These figures have increased in the United States since the 1980's largely because of a higher level of drug abuse (Henderson, 2000).

The economic concept, opportunity costs, summarizes the importance of this cost information, as these figures denote the great problems with addiction; that is resources are diverted from productive use to less productive use because of addictions. Regardless of the definition, model or treatment modality, addictions exact many costs that if not addressed, will influence all areas of community life, including economical losses.

Cost Effectiveness and Addictions Treatment

Studies evaluating the cost-effectiveness of treatment have indicated that the costs of treatment are recouped in reductions in other social costs. One study found that approximately half of the cost of treatment, including assessment and aftercare was offset within a year by reductions in the health care costs of the addict and his/her family (Holder, H., Lennox, R., & Blose, J. 1992).

> A California Department of Alcohol and Drug Programs concluded that every dollar invested in addiction treatment generated a societal reduction of $7.14 in future social costs, most of which was achieved by reductions in the post-treatment criminal activity (California Department of Alcohol and Drug Programs, 1994).
>
> > "Good treatment works; the general effects of the treatment intervention (Assessment, counselling, treatment and relapse prevention) evaluated in recent decades indicates:
> >
> > - Reduced alcohol and drug use
> > - Improved health
> > - Reduced risk of HIV/STD
> > - Decreased criminal activity
> > - Decreased housing problems
> > - Improved family and occupational functioning and reduced addiction related social costs" (White, 1998-p. 312)

These main findings regarding the benefits of addressing addictions were sufficient for policy markers to conclude that treatment works. However, this is not a linear relationship and it is much more complex that a simple evaluation and comparison. Research from the ***National Treatment Improvement Evaluation Study, the preliminary report: the persistent effects of Substance Abuse Treatment-One year later, 1996*** demonstrated most of all that addicts were not a homogenous population. It was found that nothing worked perfectly with all clients, or even with the same clients at different points in time. This is the very nature of a chronic condition and most people in the health fields are just beginning to understand the nature of addiction as a chronic condition.

Our treatment-evaluation research tells us that certain interventions work with certain people at particular points in their lives. The most significant implication of this finding is not that we need to match treatments to particular clients at particular times but that we must monitor responses to such interventions and re-intervene strategically to shorten the intensity and duration of relapse and to minimize the personal and social costs of relapse. The best predictor of long-term positive outcomes is the monitoring of client responses to treatment and early reintervention where necessary (White, 1998).

3.0 Evaluation Methods

3.1 Approach to Evaluation

The evaluation of the Community Addiction Programs and the Mobile Treatment Programs as conducted in 2001-2002 can best be described as a formative evaluation (an evaluation that gives guidance and help to improve or form the program it is evaluating) that was collaborative and participatory. This formative evaluation included the review of the 15 Community Addiction Programs and four Mobile Addiction Programs. If a program does not meet its expectations, a formative evaluation attempts to answer the question, why.

In addition, an important approach used in this evaluation was to provide a learning experience for the community caregivers. Various methods of inquiry were used such as semi-structured interviews, documentation reviews, triangulation of program and administrative data, client interviews, program reviews within the context of *The NWT Addictions Handbook (1997).*

3.2 Instrumentation and Time Lines for Data Collection

How were evaluation tools designed?

A review of the literature provided an overview of many self-report inventories and addictions but no program content or quality measure. A secondary review of the education literature provided for an environment tool used for the review and evaluation of early childhood classrooms and programs. This tool, called the Early Childhood Environment Rating Scale or ECERS by Harms, Clifford and Cryer, 1998, measures classroom quality, program content, culture/language activities and program administration. The ECERS tool includes 42 characteristics of an early childhood program. It was the program administration area that provided a good starting point for the adaptation of this tool to the evaluation of a community addictions program.

The tool was designed by the evaluation team to reflect key program areas of addictions, such as intake, assessment, scope of service, clinical supervision and so on. Areas of program administration were added including accountability, funding levels and policy definition. The tool, as designed specifically for this evaluation of the Community Addiction Programs in the NWT, was called the Community Addictions Program Effectiveness Rating Scale or CAPERS. There is no overt reliability with this tool, except with respect to its use at each community addictions program visited for this evaluation.

The rating scale was also adapted for the ECERS and is based on a seven-point scale. The following description highlights the various ratings for each level.

Table 3-1: Community Addictions Program Effectiveness Rating Scale

Rating	Description
Score of 1	Inadequate
Score of 3	Minimal
Score of 5	Good
Score of 7	Excellent

Ratings of 2, 4 and 6 do not have a word identifier. Each Community Addiction Program site was evaluated with the same scale so as to provide for a consistent measure that has some objective properties. An additional tool was extracted from the CAPERS tool, which was more distinct in terms of its focus on the building, space and issues of accessibility for elders and the disabled. The same one through seven scale was used with the same descriptors.

Other summative tools were designed to record various issues related to documentation and activities within each community addiction program. These summative sheets were used in the final conceptualization of site reports and the general findings and recommendations.

Semi-structured interview questions were designed that were consistent with the evaluation's Terms of Reference and included questions on three main areas of the project: administration/management, program effectiveness and structure. Questions were modified for the various groups of people interviewed such as health authority staff, community workers and regional leadership persons.

An informal interview set of questions was used with clients so as to maintain respect and understanding for their position in their recovery. In some cases, clients were actively seeking out counselling from the evaluation team due to the void of services in the respective community. **See Appendix C, Community Addictions Program Effectiveness Rating Scale (2001)** for further information regarding the data collection tool designed for this evaluation.

Ethical Considerations for Data Collection

In designing the evaluation tools and data collection instruments, the evaluation team referred to their previous experience in conducting evaluation activities with Aboriginal groups and also the relevant literature on conducting ethical evaluation for minority groups. Also, the evaluation team used the ethical guidelines of the Canadian Counselling Association and the Canadian Evaluation Society throughout this evaluation.

The following ethical considerations were of central importance throughout the evaluation time line, including design, data collection, analysis and report writing.

A. Use of informed consent forms where necessary for client interviews. Clients were a consent form, but all declined to sign and stated they did not wish their names to be used.

B. Data collection was conducted by persons with the applicable training and skill for the task. The evaluation team had support from external counsellors for their own clinical supervision.

C. Data results were put in the proper perspective for each measure; the effects of culture and community distinctiveness were considered.

D. Statistical limitations were considered including specific issues of validity and reliability. Data collection activities were used as outlined by the author(s) of the respective tool. Also, interpretation of all evaluation material was interpreted with caution and perspective.

E. Identity of interviewees was protected; no names were used in the presentation of findings. Many interviewees expressed concern of repercussions for disclosing problems with the system.

F. Focus on the Strengths of Programs; this point serves to balance the evaluation project and to give credit where credit is due.

G. Minimize the possibility of misleading findings; evaluation outcomes may fall short due to methodological validity and evaluators need to de-limit their findings.

H. Encouraging local/community based evaluation assistants: The involvement of local personnel through interviews was the preferred method of inquiry.

Who collected the Data and what was the schedule?

The three main evaluation team members, Jennifer Chalmers, Liz Cayen and Sharon Snowshoe, collected the evaluation data. The start of data collection through site visits was in December 2001 and the last site visited was on March 22, 2002. Some follow-up interviews were being completed at the time of printing this report.

3.3 Analysis & Limitations of the Data

What was the analysis of the data?

The evaluation team used a variety of qualitative techniques for data analysis including these generation, triangulation and information verification as to accuracy and reproducibility. The CAPERS results were tabulated using basic descriptive measures such as a mean and outlined using a bar graph.

Documentation review analysis included a review of scope, presence, use of documentation and function. A more detailed analysis of costs associated with one or two indicators was planned but will not be useful, as few if any sites collect the same client information other than intake information such as name, address and health care number.

Costing and budget information was analyzed using descriptive measures such as percentages and by using a pie graph or chart. Again, cost effectiveness analysis is not prudent given the lack of clear client data and lack of consistency across all community addiction programs.

Analysis of all information, data and interview comments was completed according to standards of psychological research and assessment and the evaluation team pain particular attention to the limitations and generalizing of their data to other communities across the NWT.

What were the limitations of the analysis and interpretation?

A number of limitations in the data collection were inevitable and subsequently a reduced level of scientific rigour was necessary in the analysis of the Community Addiction Program Evaluation. Some limitations are listed here:

- Data analysis was limited to the sites visited, that is, 15 sites across the NWT and complete generalization to all remaining communities is less than ideal.

- Some interview data was excluded due to confidential content.

- The data was collected over a 4-month period and over a time line that was extremely busy for many NWT communities, that is January through March. This time frame was established by the contract time line and was less than ideal, as an evaluation of this scope requires a 6-12 month time line for design, data collection, verification, and report synthesis.

- NWT communities vary in terms of their cultural and political systems as well as geographical positions and access to various services. Although data was compiled across the NWT, there is some question as to the appropriateness of conducting similar data collection and analysis of program effectiveness scores from community to community.

- The instrument and tools were designed specifically for this evaluation so as to answer the relevant questions from the Terms of Reference. This tie to the Terms of Reference may have limited the scope of content and provided some inherent bias in the data collected.

Despite these limitations, the findings are useful and do tell a "very important story" about the challenge in the delivery of addictions services across the NWT.

4.0 Findings and Recommendations

This next section, Findings and Recommendations, forms the body of this final report. The findings are inclusive of over 1000 pages of program documentation and over 150 interviews with Community addiction workers, community clients of addictions services, community leaders, regional leaders, community agency people such as Health Centre staff and RCMP, Health and Social Services Authority personnel, Department of Health and Social Services personnel and private industry.

Site visits to the 15 designated communities were completed over a four-month time line with an average of two days spent at each site. The evaluation team relied on the review of documentation before and after each site visit to complete the review an analysis of the 15 community addiction programs. A rich compilation of site specific materials, contribution agreements, mobile treatment reports, client files, intake forms, minutes of meetings and all other available documentation was used for the synthesis of the finding in this section.

The format for this section follows a simple yet informative style and is described below for the reader:

- **Finding:** This section summarizes the data and information as analysed by the evaluation team into a finding or a result.
- **What does this finding tell us?** This section provides more detail of each finding.
- **How do we know this?** This section provides the source of data/information.
- **Recommendation:** This section provides the recommendation(s), as developed by the evaluation team based on each finding.

4.1 Context of Findings and Discussion

The Terms of Reference (**see Appendix A**) for this evaluation of Community Addiction Programs stated that the evaluation be conducted in the context of four reports:

a) *The Minister's Response to the 1999 Forum of Health and Social Services*

b) *It's a Time to Act, A Report on the Health & Social Services of the Northwest Territories,* conducted by George B. Cuff and Associates.

c) *Review of Nats'ejee K'eh Treatment Centre* conducted by Paul Hanki.

d) *Working Together for Community Wellness: A strategy for Addictions, Mental Health and Family Violence in the NWT.*

The last two reports, *Working Together for Community Wellness: A Strategy for Addictions, Mental Health and Family Violence in the NWT* and *Review of Nats'ejee K'eh Treatment Centre* were important background and contextual documents throughout the site visits and data analysis of this evaluation project. The formulation of the findings and recommendations were also synthesized within the context of these two addictions documents.

One of the major topics presented in the document, *A Strategy for Addictions, Mental Health and Family Violence in the NWT* is the integration of mental health, addictions and family violence workers in a formal arrangement. For many years, communities have commented on the confusing role and relationships of different counsellors and having to be more than one person or agency in order to meet their psychosocial needs. The theme on integration has been proposed as a viable option to improving the efficiency, skill and delivery of addictions, mental health and family violence services across the NWT.

Further indications for an integrated model of community counselling services are reflected in the knowledge that many people with addictions also have some elements of mental health problems such as anxiety, depression or post-traumatic stress disorder. People with addictions and mental health problems are also referred to in the medical context as people with concurrent disorders (previously also referred to as dual diagnosis). Alternatively, many people with issues of family violence in the NWT also have turned to drugs or alcohol to cope with the problems of abuse and trauma. Therefore, an integrated system of communities in dealing with overlapping conditions that require a holistic and integrated counselling approach.

The evaluation team based the review of Community Addiction Programs within the context of this working model of community counselling services. Site visits included asking questions regarding the proposed integration of services and what that would mean for each community evaluated in this evaluation project. Interviews with Health and Social Services Authorities personnel also were framed within this integrated context. And lastly, clients were asked if having a "one stop shopping" approach to addictions, mental health and family violence would be helpful.

The evaluation team for this project set out as one of their first directives to confirm whether or not the Department of Health and Social Services should proceed with the integration of Addictions, Mental Health and Family Violence across the NWT in the years to come.

The title of this report: **"A State of Emergency"** reflects the overall poor state of community addiction services in the NWT that is in urgent need of immediate attention, expertise, direction, policy directives, leadership and re-building. The analogy of calling a state of emergency is used to summarize that it is time to take action and re-build, as the storm has already passed.

The following pages may discourage the reader but at the same time there is hope in looking to learn from what has not worked at to re-build the system of addiction services.

> "…To accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference."
>
> (Interviewee, as quoted from A.A)

Administration and Management:

Findings and Recommendations

Finding #1

Most interviewees reported good support for the Department of Health and Social Services to integrate all community based counselling services.

Many of the findings in this report provide further evidence and support for the move to integrate community based counselling services (mental health, addictions and family violence) across the NWT.

The recommendations highlight major areas of program structure, development and human resource management that are needed for this integration to effect improvement in service delivery.

What does this finding tell us?

- Community members and agency personnel support the proposed integration of mental health, addictions and family violence services in NWT communities. Integration of services for community agencies and addictions programs is understood by many people to be a step in the right direction but many are concerned about job positions, funding arrangements and community ownership.

- Fragmented systems of counselling services exist in many NWT communities and are problematic for some clients with challenging needs.

- Integration of community counselling services was supported by most interviewees as a means to be fiscally responsible.

How do we know this?

- Semi-structured interviews were conducted throughout the NWT. The question was asked: What do you think of the integration of community counselling services? What would mental health, addiction and family violence services look like in your community if it were integrated? Would this be helpful for clients?

- A review of NWT documents produced over the last 5 years speak very clearly about the need for agencies to work together; qualitative and quantitative data from this evaluation are also consistent with these other NWT reports.

Recommendation

- 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.

Finding #2

The interviewees, including Health & Social Services Authority personnel, Community Addiction Workers and community leaders were unclear as to the definition(s) of addictions.

What does this finding tell us?

- It is difficult to treat a condition that you have not clearly defined.
- Those involved in the delivery of the addiction programs are unaware of the various definitions and terminology used in the addictions fields.
- This speaks to the lack of knowledge about the field and the general confusion surrounding the delivery of addictions services.

How do we know this?

- Semi-structured interviews were conducted throughout the NWT with respect to core areas of an addictions program. The question was asked: What do you define as addiction?
- Many people did not include gambling as an addiction and some people defined it as a personality problem. There w as a range of definitions and little consistency, even if to say, it could be many things.

Recommendation

- 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 condition.

  This definition should form part of a policy document on the delivery of addictions services in the Northwest Territories to ensure a service that is consistent and of an excellent quality.

Finding #3

There is an overall lack of expertise, knowledge and skill of the personnel involved in the delivery of addictions services in the NWT. This lack of clinical and policy expertise in the NWT includes: the definition of addictions, the treatment environment of addictions and the complexity of the management of addictions from assessment to relapse prevention.

There is little addictions knowledge and skill evident in the work of most of the addiction personnel from community level to the level of Health & Social Services.

What does this finding tell us?

- This lack of expertise is especially evident in the area of counselling, treatment strategies, aftercare and relapse prevention. Aftercare in the NWT is not well defined and is therefore extremely limited in its scope and content.

- Regional Health and Social Services Authorities and Community Addiction Workers do not rely on the Department of Health and Social Services to provide addictions knowledge and expertise. Many people reported that they believed that the Department lacked credibility with respect to addictions knowledge and program direction.

- Other interviewees stated they were unsure as to the skills and direction of the Department in moving to improve addictions and mental health services. Some believed the Department of Health and Social Services together with the Health and Social Services Authorities were the least prepared in terms of having a road map in dealing with this issue. An analogy could be made to: building a house without a plan and without appropriate skills.

> "The bar is so low they are tripping on it."
>
> (Interviewee, Yellowknife)

How do we know this?

- Semi-structured interviews revealed this information, as well as through a review of the scope of services being offered and general knowledge base of the interviews.

Recommendation

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

Finding #4

Out of the 15 sites evaluated 10 sites were rated to be of inadequate quality and 5 sites were rated to be of minimal quality. This quality rating was based on the overall content and scope of clinical practice of the Community Program in the 15 communities selected for this evaluation in the NWT.

A rating scale was designed for this evaluation: The Community Addiction Program Effectiveness Rating Scale.

What does this finding tell us?

- Figure 4-1 (next page) summarizes these findings in a bar graph comparing the NWT overall average on the Community Addiction Program Effectiveness Rating Scale result of 2.2 with the range of scores for the 15 sites evaluated.

- The rating of inadequate as outlined by the Community Addiction Program Effectiveness Rating Scale represents a total score of one on a seven-point scale, where 1 is of inadequate quality and a total score of 7 is of excellent quality.

- 66% or 10/15 of the Community Addiction Programs were rated to be of inadequate quality and 33% or 5/15 were rated to be of minimal quality.

- Inadequate and minimal quality services in the area of addictions services is not acceptable. All 15 programs are considered to be of an unacceptable quality.

How do we know this?

- Each site visit to the selected communities was rated on 20 measures of quality for an addictions program such as program content, intake, assessment, aftercare, clinical supervision, charting, educational support, in-service training, administration, accountability… (**See Appendix C & D** for the tool and ratings of the 15 communities).

Recommendation

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

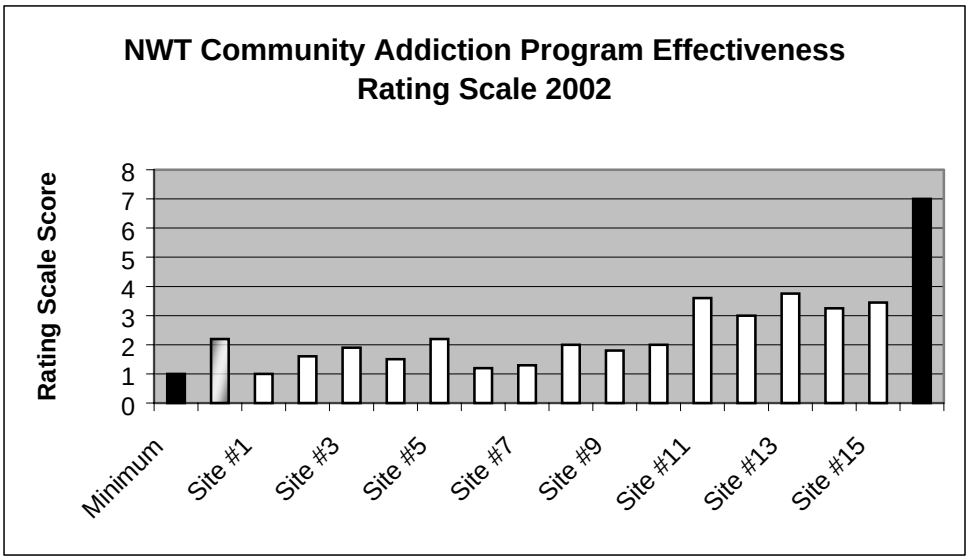

Figure 4-1 The 2001-2002 Community Addiction Program Effectiveness Rating for the 15 NWT sites are outlined above.

The NWT average effectiveness rating was 2.2 on a scale where 1 is inadequate and a total score of 7 is excellent.

Rating of 1 is considered to be inadequate quality
Rating of 3 is considered to be minimal quality
Rating of 5 is considered to be good quality
Rating of 7 is considered to be excellent quality

Finding #5

10 out of the 15 Community Addiction Programs of the sites evaluated had buildings that were not physically accessible for elders of the disabled.

The addiction sites reviewed in this evaluation that had accessible buildings were located in Government buildings and/or Community Health Centres.

What does this finding tell us?

- Figure 4-2 (next page) summarizes these findings in a diagram comparing sites with accessibility and those without accessibility.

- There is a lack of planning regarding the needs of the physically disabled and elderly clients in the provision of Community Addiction Programs.

- Many of the Community Addiction Workers try to overcome this physical barrier by conducting home visits. Home visits are very acceptable in NWT communities, but this leaves the worker at risk in terms of their personal safety.

How do we know this?

- Each site visit to the selected communities was rated on a measure of whether the building was accessible or inaccessible (ramp or location that is easy for elders or those with physical limitations to access). This measure was included in the Community Addiction Effectiveness Rating Scale (See Appendix C for the tool and ratings).

Recommendations

- 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.

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

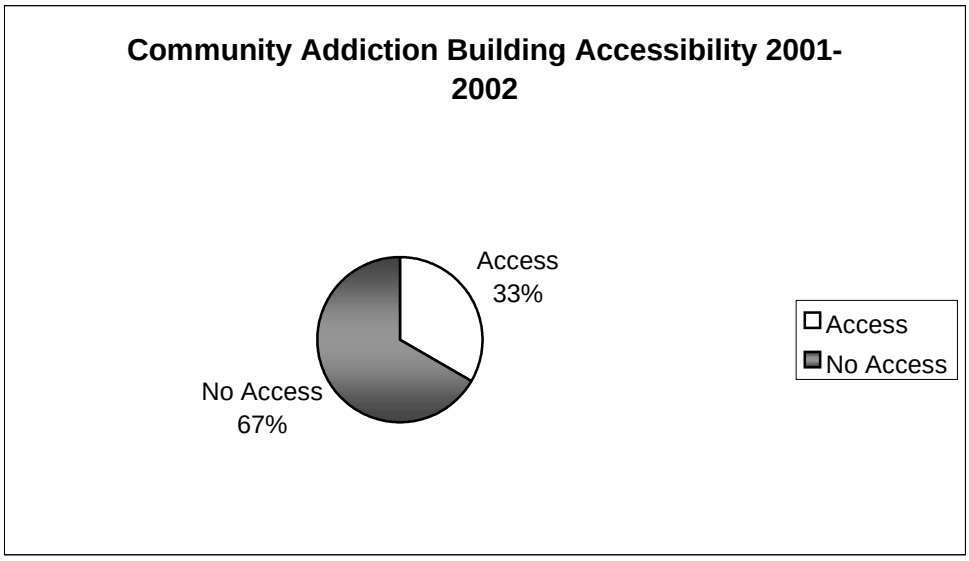

Figure 4-2 Chart of Community Addiction Program building accessibility across the NWT where accessibility was defined by wheelchair and/or elderly.

Finding #6

Four out of the 15 sites evaluated had good to excellent ratings for office space and physical layout.

These same four addiction programs had better ratings on the Community Addictions Program Effectiveness Rating Scale and were programs that have integrated their services with Health and Social Services Authorities or have blended their services with community mental health.

What does this finding tell us?

- Figure 4-3 (next page) summarizes these findings in a bar graph comparing the integrated programs with the non-integrated programs.
- An important aspect of program effectiveness is program space and accessibility.
- Space that is well designed and appropriately laid out is more conducive to effective addictions counselling.
- The physical layout and available furniture may be part of the ineffectiveness of some Community Addiction Programs.
- Equipment and office space for many Community Addiction Programs are of lesser quality that other social services agencies. This may translate for clients and community groups that Addiction services are not important and/or deserving of respect.

How do we know this?

- Each community addiction program facility was rated on a measure of whether the space and layout was suitable for addictions counselling. Level of reception, privacy, suitable furniture that was in good condition, safety in terms of fire hazards and pleasing quality were assessed. (See Appendix C for the tool and ratings).

Recommendation

- ➢ Serious consideration must be given by the Health and Social Services Authorities to the physical space and equipment required by addiction programs.

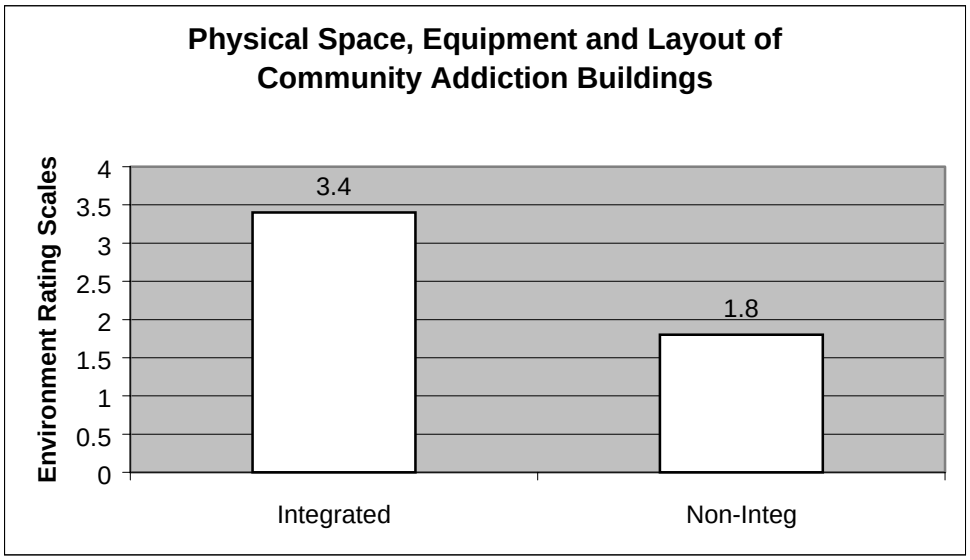

Figure 4-3 Community Addiction Programs that have integrated services had better ratings on the Community Addiction Program Effectiveness Rating Scale (CAPERS).

Finding #7

There were 35 Community Addiction Workers that formed part of the evaluation of the 15 Community Addiction Programs. 37% of these staff have no education/qualifications in the area of addictions; 37% have a certificate in addictions; 11% have a diploma in social work; 11% have degree in social work and .02% have a Masters degree in social work.

(Equivalencies were considered for the level of Post-secondary certificate)

What does this finding tell us?

- Figure 4-4 (next page) summarizes these findings in a bar graph comparing the post-secondary levels of education of staff from the sites reviewed.

- 74% of the Community Addiction Workers were not adequately equipped with the education and skills to provide effective addiction counselling. While many of the NWT community addictions staff have sobriety, the literature does not support sobriety alone as adequate skill to address the complexity of addictions (Fisher & Harrison, 2000).

> "One worker's recovery is only their experience; each recovery experience is unique."
>
> (Interviewee, Treatment Programs in Ontario)

- The Community Addictions Training ("CAT") and the Advanced Counsellor Training ("ACT") series as provided by the Nechi Institute are common "training" in the NWT.

  However, the CAT and ACT series alone, do not provide the NWT addictions worker with a post- secondary certificate.

  According to the Nechi Institute's literature, the CAT and ACT series are only equivalent to the first semester of the Keyano College, Fort McMurray, Alberta, Aboriginal Addictions Services Certificate.

  Many community addiction workers and other agency personnel believe the CAT and ACT series provides good training in place of post-secondary education.

Recommendations

- 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 counsellors in the NWT.

  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 Master's in Counselling Psychology or Clinical Social Work; persons with this education and appropriate skills in addictions and counselling would suit a clinical manager position or team leader position and would supervise entry and general level counsellors.

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

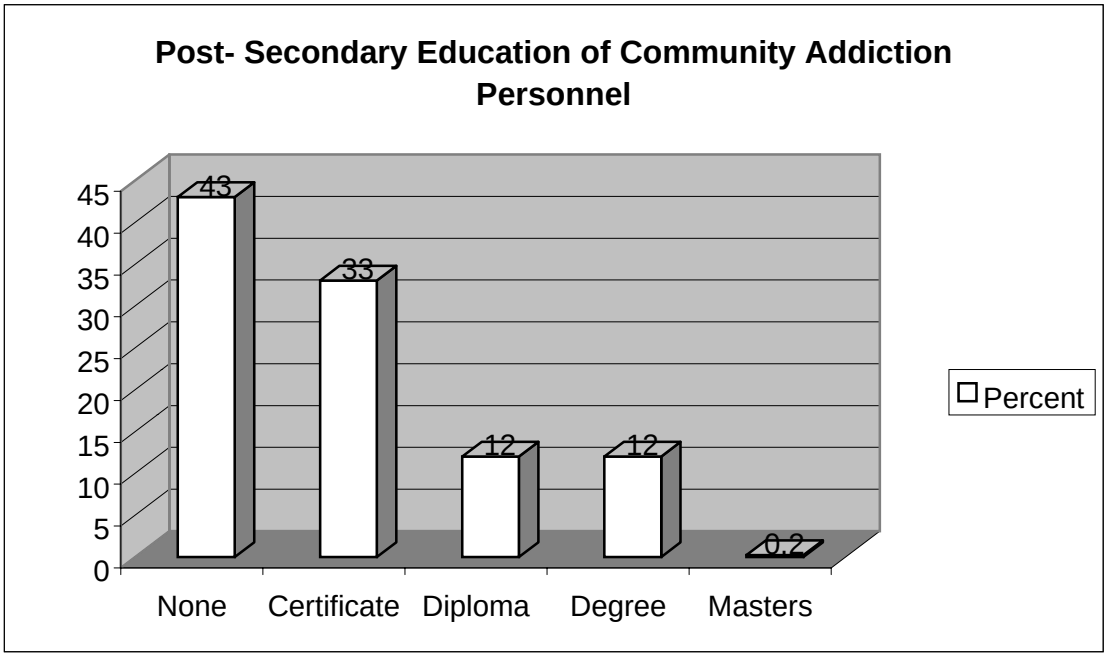

Figure 4-4 Breakdown of current Post-Secondary education levels for Community Addictions Personnel in 15 sites across the NWT.

(Equivalencies were given where applicable; persons having a certificate program did not necessarily have a High School Diploma or GED).

- None is no post-secondary education (or equivalent)
- Certificate is a certificate program in Alcohol/Drug Counselling
- Diploma is a Diploma in the field or a related field such as Social Work.
- University Degree in a related field
- Master's Degree in the field or a related field

** At time of printing of this final report, five community addictions workers have left their positions and all five had education at the Diploma, Degree and Master's level.

Finding #8

At this time, there are no post-secondary diploma or certificate addictions counselling program being offered in the NWT.

What does this finding tell us?

- In 1995, there was an alcohol and drug counselling certificate program and a two-year diploma program as offered by the former Arctic College, now Aurora College. These programs were delivered in Hay River, by the Dene Cultural Institute (DCI). In 2002, there are no post-secondary programs in the field of counselling or addictions delivered in the NWT. There is a diploma in Social Work program offered by Aurora College in 2002.

- The Nechi Institute from Alberta has been used to provide training services to addictions counsellors for many years. This training has been mainly in the form of in-services training of staff and does not equate with a full post-secondary diploma level. The Nechi Institute's programs form only one component of post-secondary education and skill development.

How do we know this?

- Interviews with Aurora College, Department of Health and Social Services personnel and documentation reviews regarding the diploma and certificate programs as offered in the past.

Recommendation

- The Aurora College two year post-secondary addictions counselling diploma must be re-developed and re-designed within the next eighteen months to meet the need for entry level community counsellors. This Diploma program needs to be linked with a University which will offer transferability of Aurora College course credits toward a Bachelor's degree.

Finding #9

The roles and responsibilities of the eight Addictions Specialists are inconsistent across the various Health and Social Services Authorities, lacking in effectiveness and direction.

80% of the Community Addiction Workers do no see the benefit in the Addiction Specialist positions.

Six out of eight Addictions Specialists expressed uncertainty as to their role in the provision of Addiction Services across the NWT.

What does this finding tell us?

- There are currently eight Addictions Specialist positions in the NWT, as per the information provided by the Department of Health and Social Services. These positions appear to have been created in the early 1990's to provide regional expertise to the Community Addiction Programs, community agencies and to regional Health and Social Services Authorities.

- The function of this position varies across the Territory. The only consistency in the role of these specialists is in the approval for residential addictions treatment in and out of the NWT and for the dissemination of information from the Department of Health and Social Services.

How do we know this?

- Through interviews with the Community Addiction Workers and agencies, the evaluation team was able to cross-reference the responsibilities of these positions. Interviews with 6 of the 8 positions revealed that there does not appear to be a need for a full position at the level of the Health and Social Services Authority.

- Much of the role of Addictions Specialist is in being the "gatekeeper" of financial accountability for southern treatment referrals and non-insured medical travel resources.

- The Addictions Specialists are not viewed by the Community Addiction Workers as having knowledge and skill in addictions and are not used for clinical supervision.

- Most Community Addiction Workers expressed great frustration with these "positions" as they are frequently out of the region on travel for other business

other than addictions and therefore not accessible for supervision and for approval for treatment.

> "I wear the hat when it is needed"
>
> (Health & Social Services Authority Interviewee)

Recommendation

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

Treatment and Program Effectiveness:

Findings and Recommendations

Finding #10

100% of the Community Addiction Workers reported that the funding for their program was grossly inadequate.

What does this finding tell us?

- Inadequate funding provides inadequate services. It has been well documented that addictions is the biggest issue affecting most NWT communities.

How do we know this?

- According to the Department of Health and Social Services financial statements as published on the NWT website (2002), the main estimate for all of the Departments' expenditures for 2001-2002 was $179 million. Only 3% of the estimated total health and social services budget was spent on all addictions services, including southern/NWT treatment, mobile & detox programs, women's recovery programs and community programs.

> "You get what you pay for."
>
> (Community Addiction Worker Interviewee)

Recommendations

- 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.

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

- Funding partnerships with the Department of Justice and the Department of Health and Social Services is 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 corrections facilities.

Finding #11

Many of the Community Addiction Programs indicated a great frustration with having to deal with many layers of government bureaucracy with the Regional Health and Social Services Authorities. This frustration is founded in having to deal with yearly contribution agreements, multiple layers of approval for residential addiction treatment, inaccessible regional support from the Addictions Specialists and issues of accountability and confidentiality.

What does this finding tell us?

- The transfer of documentation is inefficient. The current system of addiction services is not conducive to the provision of continuous counselling services.

  For example, local programs do not know from year to year whether they will receive funding for the following year, and if so, what level? This adds to uncertainty and does not allow the Community Addiction Programs to do long term planning such as program development, professional development, etc.

How do we know this?

- In many regions, the clinical staff are spending large amounts of time in administrative duties with medical travel and treatment application forms.

- There is much duplication, time delay and confusion regarding the confirmation of treatment approval across the territory. In some cases, clinical decisions are made by administrative staff in isolation of qualified clinical opinion.

Recommendations

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

- 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.

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

Finding #12

The current delivery of addictions services via contribution agreements between the Health and Social Services Authorities and community sponsors is seen as being punitive and restrictive rather that contributing to good practice.

What does this finding tell us?

- There is little effective communication between the Regional Health Authorities (Chief Executive Office, Addiction Specialists, Director of Social Programs) and the community service providers, despite the flow of paperwork back and forth.

- The contribution agreement system is a very limiting process. Community Addiction Workers and/or their sponsors are expending resources in terms of time and skill in managing the paper flow for what they believe should be a core service provided by the Department of Health and Social Services of the NWT.

> "Do the Health Centres write yearly proposals and wait to see if they are funded from year to year?"
>
> (Community Addiction Worker Interviewee)

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

- Administrative duties such as the management of contribution agreements which includes quarterly financial reports and yearly audits and proposal submissions takes away valuable time from both the regional clinical staff and the local service providers.

- According to "The Health and Social Services System Action Plan - 2002-2005", multi-year contribution agreements would replace yearly contribution agreements.

Recommendation

- 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.
- 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.

Finding #13

The scope of service including program content and definition, assessment, effective case management, and clinical supervision are done very poorly in most Community Addiction Programs across the NWT, as seen through the site visits to each of the 15 communities that form this evaluation.

What does this finding tell us?

- It is generally recognized by the Community Addiction Workers that they are inadequately skilled and educated in many areas required for their positions.

- The positions are poorly structured and financed and do not include the clinical perspective needed to do the job in dealing with people with addictions (alcohol, marijuana, cocaine, date rape drugs, poly drug use, concurrent disorders and other addictions such as gambling).

- Other factors that may have contributed to the limited scope of service are lack of education and skills, standards, physical space and equipment and lack of respect for the field of addictions.

- Health Centre staff such as nurses and physicians have virtually no case management with the Community Addiction Workers, with the exception of one community in this evaluation. In addition, many Health Centre Staff do not see that it is within their scope of practice to address health and illness issues that are directly related to addictions.

How do we know this?

> "I did not come to this community to deal with drunks; it is their job to deal with them."
>
> (Community Health Centre Interviewee)

- The scope of addiction services, including the provision of medical services as delivered in the NWT do not compare favourably with the scope of services offered in other jurisdictions across Canada such as Saskatchewan and Ontario as determined by the literature review of addictions practice across Canada.

Recommendations

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

- 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 counselling positions in the NWT.

- 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 medial services in the re-structuring of addiction, mental health and family violence services at the community level.

Finding #14

Four out of five sites that were rated as having higher quality addictions programming are currently operating within an integrated service delivery model under their respective Regional Health and Social Services Authorities or are a blended program (mental health and addictions).

What does this finding tell us?

- The communities of Hay River, Fort Smith, Rae-Edzo and Tulita have begun the task of improving the quality and effectiveness of their programs through a process of integration and/or blending of addictions and mental health programming.

- The community of Tulita blended their addictions and mental health services three years ago and Hay River, Fort Smith and Rae-Edzo have integrated their Health and Social Services Authorities within the last 18 months.

- The four integrated or blended programs are operating at a higher level than other programs but there still remains work to be done, as their ratings were at the minimal quality level. Areas for further development include improved scope of service, accountability, communication, financial resources and clinical expertise through assessment, relapse preventions and addressing concurrent disorders and poly drug use.

"It is easy to know where to go for help."

(Blended Mental Health and Community Alcohol and Drug Program Community)

Recommendations

- 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.

- 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 counselling 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.

- 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 additions to produce these standards of care.

Finding #15

Assessment tools are used very sporadically. Only three of the fifteen sites uses standard addictions assessment tools on a consistent basis.

What does this finding tell us?

- Figure 4-5 (next page) summarizes these findings in a pie graph.

- There is a lack of knowledge and skill in the use of standardized addictions assessment tools such as the Alcohol Use Questionnaire (ADS), Substance Abuse Subtle Screen Inventory (SASSI) and Substance Abuse Relapse Assessment (SARA).

- There was little evidence of standardized addiction and/or mental health assessment tools or self-report indicators at each Community Addiction program visited. Given that many people with addictions have co-occurring mental disorders such as depression and anxiety, community addictions programs should be screening for both disorders.

How do we know this?

- Most Community Addiction Program personnel do not have the post-secondary educational background to support the use of some of the standardized tools used in the field of addictions, as per the publishers' criteria for use. The SASSI tool, as published by Psychological Assessment Resources or PAR, outlines a bachelor's degree with education in the use of statistics and psychological measurement as a requirement for purchase and use of this tool. Although a few site have copies of these tools in their programs, it appears that they are used inconsistently and incorrectly.

- Without accurate assessment, it is difficult to provide appropriate counselling and treatment.

Recommendation

- 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.

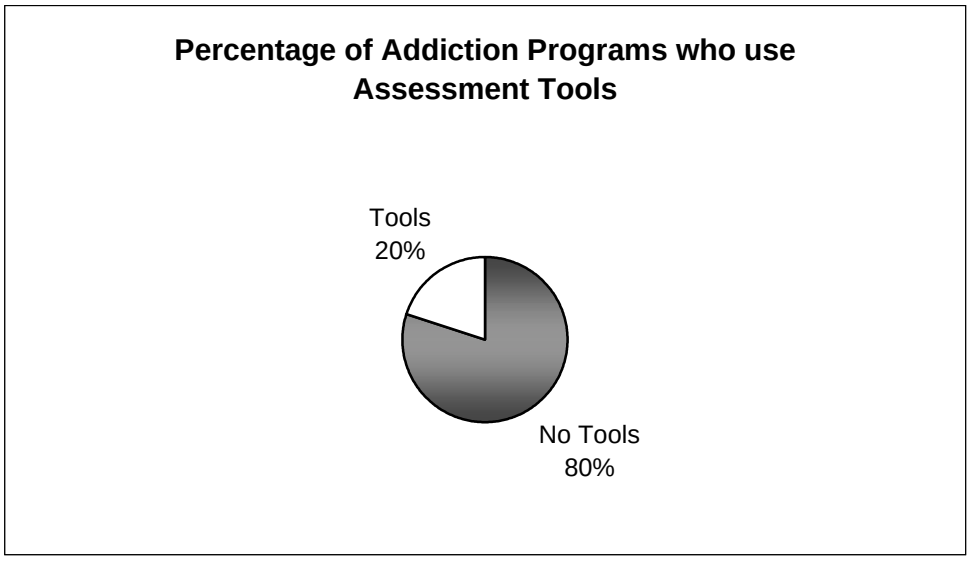

Figure 4-5 Chart of percentage of Community Addiction Programs and use of standardized tools in the assessment of addiction problems.

Finding #16

According to community addictions personnel, there are inconsistent medical detoxification or "detox" services across the NWT. Yellowknife and Hay River are the only communities that appear to have designated detox beds and these services are inconsistent.

Social detox/withdrawal management services were also found to be an inconsistent part of the continuum of services provided for people with addictions.

What does this finding tell us?

- As the addictions literature denotes detox to be a vitally important part of the management of addictions treatment, this important link is missing in the current delivery of addictions counselling services in the NWT.

- The literature on the medical complications of addiction suggests the death rate for people going through the DT's (part of withdrawal) can be as high as 20% (Fisher & Harrison, 2000).

How do we know this?

- Interviews with Community Health Centre staff demonstrated that they do not appear to have background knowledge in the used of detox protocols. Although, it is not expected that Health Centre staff would provide medical detox, they do need to be aware of the process of medical detox and social/withdrawal management.

Recommendations

- 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 the participation in residential treatment.

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

Finding #17

There is a difference in the scope of mental health services for people with addictions and concurrent disorders across the Territories. The services provided by the Stanton Mental Health Team are not accessible to all communities in the NWT. Specifically the Inuvik and Sahtu regions have little access to the multi-disciplinary team of professionals that provides coordinated services to other parts of the NWT.

What does this finding tell us?

- There are inconsistent and fragmented mental health services provided at this level across the NWT. This could have a negative impact on people with concurrent disorders.

How do we know this?

- The Stanton Mental Health Team includes physician's services, registered psychologists and the services of a psychiatric nurse. This mental health team provides contracted services to some NWT communities, as per historical patterns of contracted services. This team liases with medical personnel and provides three day site visits on a clinic type schedule.

- The services of the Mental Health Team are considered to be less than adequate in terms of community based counselling but appear to serve a role in assessment and consultation with the medical staff regarding concurrent disorders.

- The Inuvik and Sahtu regions have access to a registered psychologist and consulting psychiatrist from Edmonton. A team approach has been discussed as important for the residents of the Inuvik region.

Recommendation

- 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.

Finding #18 **

Four Women's Mobile Addiction Treatment Programs were piloted in the Dogrib region, Deh Cho and Lutsel K'e during the 2000-2001 fiscal year. Approximately 40 women attended them. There were significant problems in the areas of administration, program content, intake/assessment, and organization.

**A separate report on Mobile Addiction Programs provides additional information and is included in supplemental information to the full preliminary report.

What does this finding tell us?

- The concept of a mobile addiction treatment program, that of bringing addiction treatment closer to home, was well-received and has been a goal for many of the communities for some time. However, the design of the program including goals, objectives, target group, program content and follow-up requires significant redevelopment.

- There was no consistent definition of what the mobile addiction program was designed to do. There was even less agreement that these mobile programs were implemented to address addictions.

    a) Was mobile addiction treatment meant to replace residential treatment?

    b) Was mobile addiction treatment meant to be culture based?

    c) Was mobile addiction treatment meant to be personal development?

    d) Was mobile addiction treatment meant to operate similarly to that of the mobile team in Ontario (Fort Frances and Thunder Bay), where a team travels to ten northern communities and provides a component of treatment for 2-3 days?

- The Addictions Specialists and Health and Social Services Authorities coordinated the administration of these programs. This conflicts with the view of community-based programming.

How do we know this?

- The evaluation team reviewed all information with respect to mobile addiction programs; in addition, considerable time and questioning was done at each site visit to gather and triangulate existing information from reports provided by the Addictions Specialists.

Recommendation

- 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 in the NWT.

"Mobile treatment is great but needs more work"

"Mobile treatment programs may be a part of the service the communities provide"

"Mobile treatment programs are a stepping stone in the right direction".

(Comments from Interviewees across the NWT)

Finding #19**

Two Youth Mobile Addiction Programs were held between September/2000 and March/2001 in Fort Providence/Fort Simpson, Fort Liard and Rae-Edzo. These programs were of short duration and were educational in nature.

** A separate report on Mobile Addiction Programs provides additional information and is included in supplemental information to this full report.

What does this finding tell us?

- Youth Mobile Addiction Treatment Programs were poorly defined. Little formal intake and/or assessment were done for attendance at these mobile addiction programs.

- Were these mobile programs intended to be educational workshops or residential treatment in the community? The evaluation team was not able to define these programs based on the information on reports, interviews with sponsors and interviews with community agencies.

- The end result of these Youth Mobile Addiction Treatment Programs was that they were effective in terms of exchanging information over a short period of time, but in no way were representative of a treatment program.

How do we know this?

- The evaluation team reviewed all information with respect to mobile addiction programs; in addition, considerable time and questioning was done at each site visit to gather and triangulate existing information from reports provided by the Addictions Specialists.

- The programs that were held were difficult to assess in terms of effectiveness as treatment as they were educational in nature and more in line with a community workshop.

- The expected outcomes of a program such as the mobile treatment programs need to match the design and content of the program. For example, if a program were educational in nature, you would expect an increase in knowledge. If the program was designed to be treatment, as in the residential treatment for addictions then you would expect a change in addiction behaviours and/or increased awareness regarding addictions.

- Most people interviewed with respect to the Youth Mobile Addiction Treatment Programs reported great uncertainty as to their implementation as treatment.

Recommendations

- 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 prior to any further planning or implementation of mobile treatment programming.

- Mobile addiction treatment programs must be reviewed thoroughly from the inception to completion. In the near future, financial resources for mobile programs should be re-directed towards the development and design of this model of addiction treatment prior to any new investments in these types of programs.

Finding #20

All youth requiring residential Addictions treatment are currently sent to southern institutions. Youth undergo an intake process only as per the NWT Addictions Handbook. A full clinical assessment of the youth and their family is done haphazardly across the NWT, as most communities do not possess the skilled personnel to conduct such assessments.

What does this finding tell us?

- There is a question as to the appropriateness of the referrals for youth to southern treatment Centres, given the formal assessment procedures are minimal. Intake procedures are not the same as a clinical assessment.

- At the community and regional level, there is a void of expertise in youth services. For instance, some youth are sent for chemical dependency treatment when in fact they require crisis support regarding a suicide attempt.

- There is a void of Youth Intervention services in the NWT for such problems as trauma and suicidal ideation and communities are left with little alternatives but to use Addiction Treatment programs for troubled youth.

- The issues of youth intervention, assessment and treatment require distinct expertise and planning, as youth have inherently different needs than adults.

> "I have yet to see a chemically dependent teenager that meets criteria for a substance abuse diagnosis. Most problems with youth require crisis intervention and community programming."
>
> Interviewee, Youth Worker

Recommendation

- 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.

Finding #21

Community caregivers reported that the southern treatment facilities are in inadequate solution for the addictions and mental health needs of their youth.

Community Justice personnel reported that there is an inadequate provision of services for youth in custody and better links need to be formed to address addiction problems with troubled youth.

What does this finding tell us?

- This is a major issue as there is a high rate of suicide attempts among the youth population in the NWT and recent public documents such as the Ministers Forum on Health and Social Services reinforce the need to address the health of the youth in the NWT.

- The literature indicates that this is a challenging area for all jurisdictions across Canada and the United States. No one has found an ideal solution for the residential treatment of youth. Currently, there are few Youth treatment facilities across Canada due to the high costs of such treatment and scope of expertise needed to work with youth.

- There may be a need to bridge Youth Justice programming with Addiction and Mental Health programming.

- There is a strong buy-in on behalf of the community and Aboriginal groups to provide community based services for the youth (recreation centres, youth centres, on the land programs, school based workshops, etc). Many community wellness programs already direct much of their resources towards youth programming and yet problems continue.

Recommendations

- In the next year, create a new position in the Department of Health and Social Services at the same level as the current Consultants in Mental Health. This position could 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.

- 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 across the NWT.

Finding #22

Community caregivers reported a need for family involvement in residential treatment because of the value of the family in healing and recovery among most Aboriginal families.

What does this finding tell us?

- Currently, the individual requiring treatment has to leave the community to access residential services at the Nats' ejee K'eh Treatment Centre located on the Hay River Reserve. The family does not have the benefit of understanding the addiction and their role in the family dysfunction, as travel costs are problematic.

- There is little expertise concerning the role of the family in addiction throughout the addiction program system in the NWT.

- The addictions literature states that addressing the needs of family is critical for the recovery of the person with the addiction. This is even of greater importance given the beliefs and values of the family in aboriginal communities. Some references in the literature would define addictions as a family disease (Heister & Miller, 1989).

- There is a need for a strong family component in Community Addiction Programs and in the residential treatment program.

How do we know this?

- Interviews with clients, Community Addiction Workers and Aboriginal group leaders all discuss the importance of the family in the management of addictions in the NWT.

Recommendations

- 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.

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

Structure of Addictions Systems and Linkages:

Findings and Recommendations

Finding #23

Outcome or results-based evaluation is extremely limited with respect to Community Addiction Programs. There are no guidelines or performance indicators for this type of evaluation to be conducted with the current Community Addiction Programs.

What does this finding tell us?

- It is difficult to measure the overall results of the Community Addictions programs including outcomes, cost effectiveness and general satisfaction, as most sites collect little data that could be effectively used in a formal evaluation. As an example, the number of people dropping into the alcohol centre does not translate into the number of people seeking addictions services.

- It is recognized that evaluation presents a challenge in terms of measuring outcomes in the counselling and addictions field. Nevertheless, it is an important aspect of program accountability for everyone involved in the system from the client to the policy maker.

- An external evaluation was conducted in 1995 and 2000 for the Nats' ejee K'eh Treatment Centre. This report was used as a background document for some aspects of this evaluation. No formal evaluation process was put in place other than this community addiction program evaluation in past years to address the system from top to bottom.

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

Recommendation

- 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.

Finding #24

4 out of 15 programs (27%) are in various stages of integrating their alcohol and drug/mental health and family violence services.

3 programs have integrated their services under the Regional Health and Social Services Authorities and one program has remained under a NGO within the community, as a blended service.

What does this finding tell us?

- Figure 4-6 (next page) summarizes these findings in a bar graph comparing the integrated programs with the non-integrated programs.

- Most Community Addiction Programs have not made any move to integrate their counselling services in spite of the integrated model being viewed as the ideal model. This reluctance may be attributed to the lack of direction and guidance from the Department of Health and Social Services as to the benefits and consequences of the integration of addictions, mental health and family violence services.

How do we know this?

- During interviews with Community Addiction Workers, program sponsors and community and regional leadership, the evaluation team assessed a lack of "buy-in" and general knowledge of the strategy, "*Working Together for Community Wellness: A Strategy for Addictions, Mental Health and Family Violence in the NWT*." For most workers that may be affected, there is uncertainty as to what this document will mean for their positions.

> "Get with the agenda."
>
> Interviewee, Management

Recommendation

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

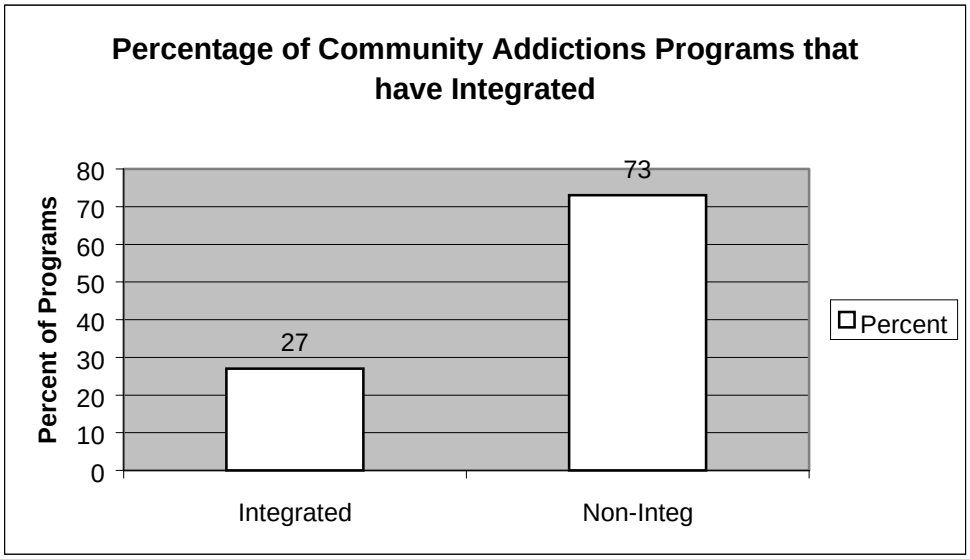

Figure 4-6 Percentage of Community Addiction Programs that have integrated addictions and mental health services.

Finding #25

80% of the Health Centre staff (nurses) that were interviewed has a very poor working knowledge of addictions, treatment strategies and the physical and mental progression of this disorder.

What does this finding tell us?

- People with addictions in the communities are not being well served by the health centre staff.

- Nursing staff is not well informed about addictions and yet it is one of the most common health issues in NWT communities.

- Nursing staff is often the first health care provider that a person with an addiction may see for care and yet they are poorly informed about the nature and progression of addiction.

- Nursing staff are overworked and often understaffed, as reported during the site visits; they are also very frustrated with the lack of qualified staff in addictions.

  This statement summarizes many of the nurses' views on addictions; that is

> "It is not my problem, it is the community's problem"
>
> Interviewee, Health Centre

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

Recommendation

- 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 addictions or concurrent disorders.

Finding #26

The move to integrate addiction, mental health and family violence services with the Regional Health and Social Services Authorities has been challenging but appears to be the right move to make for the improvement of addictions services across the NWT.

What does this finding tell us?

- Integration problems that have occurred include lack of policy, roadmap and effective communication with community groups.

- In the sites where integration has occurred, there have been issues regarding appropriated education and qualifications, such as university degree vs. International Certified Alcohol and Drug Counsellor certification or ICADC, loss of positions, reduction in service (no emergency call-outs, reduced hours), loss of credibility from clients.

- This process requires policy, time, resources and transition planning in order to ascertain the appropriate financial resources and appropriate skill and education levels for all positions within the addictions and mental health system in the NWT.

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

Recommendation

- Build a facilitation team to expedite the integration of community addiction services with mental heath 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 and Social Services.

Finding #27

Approximately 75% of the Community Addiction Programs indicated that there is a strong will to have quality addictions services in the communities.

What does this finding tell us?

- People recognize the need to see an integrated service at the community level, provided by well-educated and well-trained counsellors.

  For example, in 1999, an addictions strategy, "For the Sake of our Children," was developed by the Dogrib Community Services Board in response to a request by the Treaty 11 Chiefs.

  The implementation of this strategy included capacity building for local community caregivers and a core group of trained addictions counsellors. Over a five-month period, 28 people from the four Dogrib communities were trained in CAT and ACT series form the Nechi Institute. 15 people were working in caregiver positions and 13 were from community groups. Only 2 out of the 28 individuals received certification for one semester of the Addictions Counselling Certificate from Keyano College in Fort McMurray, Alberta due to the requirements for this equivalency.

- At the last Annual General Assembly of the Gwich'in Tribal Council, a motion was passed to support the education and training of Alcohol and Drug Workers, especially in light of the impact that gas and oil exploration will have in the Gwich'in Settlement Area.

- The Inuvialuit Regional Corporation is also looking at community prevention programs from a wellness perspective. Consultations are underway to complete a wellness plan for each Inuvialuit community.

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

Recommendation

- ➢ Build on the strength and creativity of Aboriginal organizations to improve addictions and counselling services in partnership with Government agencies.

Finding #28

90% of the Community Addiction Programs indicated dissatisfaction on some level with the scope of services provided by Nats' ejee K'eh, the only treatment centre in the NWT.

Nats' ejee K'eh Treatment Centre does not meet the needs for addiction treatment for non-status clients and others in the Inuvik region.

There is a disconnection between residential treatment and Community Addiction Programs, especially in the area of aftercare and relapse prevention.

What does this finding tell us?

- This dissatisfaction stems from the lack of flexibility of programs (lack of programs for youth and families), skill level of counsellors, cultural differences and little medical detox. The sites evaluated recognized that Nats' ejee K'eh is providing an entry-level treatment program. However, as the only Treatment Centre, it is unable to provide the diversification of services required for the population of the NWT.

- Nats' ejee K'eh is only meeting the needs of a small portion of the population, an estimated 30% of the Territorial adult and youth population. It does not meet the needs of the Inuvialuit, Gwich'in, non-status, youth under age 18 years and Metis persons due to cultural practices.

- There is also great concern about the level of aftercare provided by Nats' ejee K'eh. Generally, treatment centre staff and Community Alcohol and Drug Workers are poorly equipped to implement this crucial part of addictions treatment.

- The findings in this report concerning the effectiveness of the Community Addiction Programs are consistent with those found by Mr. Paul Hanki in his report, **"Review of Naatse'ejee K'eh Treatment Centre".** Particular areas of concern include the following:

    a) education and skill acquisition (MSW for clinical supervisor)
    b) academic upgrading for the counselling staff
    c) program content (to increase the quality of service)
    d) need to address core areas of the residential treatment of addictions

- Overall, many community caregivers expressed that there are serious problems system-wide with respect to treatment including assessment, treatment and aftercare.

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

  Also, a site visit was conducted at the treatment centre to verify information and comments from communities.

Recommendations

- There is a need to include the Nats' ejee K'eh Treatment Centre in the rebuilding and restructuring and addictions services in the NWT.

- Treatment centre areas that require critical attention include: raising of the education and skill levels of the counsellors, program content, expertise in addictions and the incorporation of therapeutic counselling (individual and group) and relapse prevention.

  Also, the building of a multidisciplinary team, including physicians/nurses and counselling 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.

Finding #29

Community Addiction Workers realize that the current programs are insufficient to meet the intensifying needs of the addiction problems in the community but also see the need to balance traditional ways of healing with newer medical model style of treatment for addictions.

What does this finding tell us?

- There is a great desire on the part of the Community Addiction Workers to participate in the rebuilding of addiction services. However, they lack direction and expertise.

- Some community workers and clients believe strongly in traditional and cultural practices of healing in addressing addictions and mental health problems.

- Some NWT communities rely more on traditional healers that others; other NWT communities rely on organized religion as a form of treatment for addictions, mental health and family violence problems.

How do we know this?

- Through semi-structured interviews and documentation review with Community Addiction Program sponsors, workers and regional staff.

Recommendations

- 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.

- The Department of Health and Social Services and regional Health and 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.

Finding #30

The whole system of addictions services lacks credibility from the client's perspective, the government perspective, from the health care sector, and from the community perspective.

What does this finding tell us?

- The system of addiction services is inconsistent and problematic across the NWT.

- There is a great compassion, sadness and empathy for the people and families living with the consequences of addictions, which has not been enough to provide good quality services across the NWT.

- The system, as it exists today, has evolved over a number of years and over many developmental stages and restructuring.

  For example, the NWT Alcohol Board, the federal transfer of health services to the GNWT and the regional focus of Health Boards. These stages have contributed to the building of a system with an extremely weak foundation.

- The current system, which provides addictions services has failed the residents of the Northwest Territories.

- However, there is hope in the will and strength of people in communities and government personnel in working to develop better solutions and services for people with addictions.

Recommendations

- 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.

- 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.

4.5 Summary of Recommendations

Administration and Management

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.

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 should form part of a policy document on the delivery of addictions services in the Northwest Territories to ensure a service that is consistent and of an excellent quality.

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

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 service delivery, clinical content and education and prevention activities offered in the community.

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.

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

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

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 counsellors in the NWT.

   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 Master's in Counselling Psychology or Clinical Social Work; persons with this education and appropriate skills in addictions and counselling would suit a

clinical manager position or team leader position and would supervise entry and general level counsellors.

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

10. The Aurora College two year post-secondary addictions counselling diploma must be redeveloped and redesigned within the next eighteen months to meet the need for entry level community counsellors. This Diploma program needs to be linked with a University which will offer transferability of Aurora College course credits toward a Bachelor's degree.

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

Treatment and Program Effectiveness

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.

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

14. Funding partnerships with the Department of Justice and the Department of Health and Social Services is 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 corrections facilities.

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

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.

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

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.

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.

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

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 counselling positions in the NWT.

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 medial services in the re-structuring of addiction, mental health and family violence services at the community level.

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.

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 counselling 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.

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 additions to produce these standards of care.

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.

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 the participation in residential treatment.

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

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.

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 in the NWT.

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 prior to any further planning or implementation of mobile treatment programming.

32. Mobile addiction treatment programs must be reviewed thoroughly from the inception to completion. In the near future, financial resources for mobile programs should be re-directed towards the development and design of this model of addiction treatment prior to any new investments in these types of programs.

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.

34. In the next year, create a new position in the Department of Health and Social Services at the same level as the current Consultants in Mental Health. This position could 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.

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 across the NWT.

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.

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

Structure of Addiction Systems and Linkages

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.

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

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 addictions or concurrent disorders.

41. Build a facilitation team to expedite the integration of community addiction services with mental heath 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.

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

43. There is a need to include the Nats' ejee K'eh Treatment Centre in the rebuilding and restructuring and addictions services in the NWT.

44. Treatment Centre areas that require critical attention include: raising of the education and skill levels of the counsellors, program content, expertise in addictions and the incorporation of therapeutic counselling (individual and group) and relapse prevention. Also, the building of a multidisciplinary team, including physicians/nurses and counselling 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.

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.

46. The Department of Health and Social Services and regional Health and 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.

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.

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.

5.0 Next Steps and Final Comments

It is unfortunate to report such disappointing news regarding the total inadequacy of the Community Addictions Services in the NWT but at the same time, it provides a very good starting point for taking major steps towards re-building the entire system. The real positive findings and strengths to be taken from this final report, as seen through the site visits are interviews with local people, is the strong will of people and leaders to make communities a better place for the next generation of Northerners.

The remaining sections of this final report on the evaluation of Community Addictions Program Evaluation includes a list of priorities for the Department of Health and Social Services and regional Health and Social Services Authorities to consider in responding to this report. The recommended actions are consistent with the findings and recommendations but are listed here in terms of action needed by Government systems prior to and concurrently with the suggested restructuring and re-building of the delivery of addictions services across the NWT. They are listed in order of importance.

5.1 Recommended actions for the Department of Health and Social Services over the next three years (2002-2005)

Expertise and knowledge- Develop expertise through knowledge, resources, collaborative relationships in addictions with other jurisdictions across Canada. This should include developing position documents in the following key areas of addiction for the NWT that would form part of standards of care for addictions.

- Education and Post-secondary/graduate level training requirements for providing good quality programming in addictions.

- Models of treatment for addictions includes definitions, procedures, skills needed, resources needed, case management systems, need for clinical supervision.

- Ethical considerations in providing counselling services in addictions and mental health in the NWT.

- Residential Treatment including scope of service delivery, detox services, program content, skills needed, supervision, case management, aftercare, relapse prevention.

Standards of Care- build a working/facilitation group of knowledgeable resource persons in addictions and mental health to develop a complete policy directive and documents that will serve to replace the NWT Addictions Handbook. Consider the use of experts in the field across Canada that has worked in various parts of the field of addictions.

Some of the items to be included in this new policy directive should be:

- Definitions of addictions, scope of services, integration of community counselling services.
- What level of addiction services should be provided at small, regional and Territorial levels?
- Standards of care for all health care providers in terms of addictions; including directives for health centres, physicians, psychologists, social workers, schools, community counsellors.
- Flow charts for client referrals (Inside the territory, outside the territory, youth, women, concurrent disorders…)
- Performance indicators for all aspects of service delivery.
- Risk management and ethical directives with respect to dual relationships, scope of services, providing services with required training and education, clinical supervision, issues of information gathering, storage and transmission, conflict of interest, safety and duty to inform, informed consent, consent for minors, sexual and physical harassment…

Integration and Transition- Build a working/facilitation group of Department personnel, regional Health and Social Services Authority personnel, community addictions workers and resource persons in addictions to develop community-by-community plans for the integration of addictions, mental health and family violence services. To include community consultation and input regarding the integration of community counselling services. Other considerations:

- Working out transition plans with communities during the process of change so that services continue despite ongoing structural changes.

- Provide ample opportunity for community members, leaders and affected positions to have input with respect to proposed changes.

- Consider short-term positions to fill gaps until workers are trained at the appropriate levels.

- Consider special project status for positions that may be found unnecessary.

- Consider building a community education and prevention position be created within the integrated structure service delivery.

Short and Long Term Human Resources Strategy – Address funding resources, recruitment and retention procedures to attract qualified personnel to fill positions in the NWT while local workers seek out education opportunities.

Development of Post-secondary Education Plan with Aurora College and/or other Institutions. Work in partnership with Aurora College to develop an entry level counsellor position at the Diploma level. Could bridge some coursework with social work and possible nursing. Other considerations:

- Need to consider practicum courses and also sites to provide clinical supervision to students while working in practicum.

- Location of Diploma program will need consideration; also, previous programs from 1995-96 can be used as a guideline but will require confirmation of quality and coverage of core competencies in entry level addiction counselling.

5.2 Recommended actions over the next five years (2002-2007)

Capital/Resource Allocation- Consider building location(s) of community based counselling and social work services under Health Centres. Will need to address this issue in terms of long term planning when new Health Centres are being constructed and/or during renovations of older Health Centres.

Residential Treatment Centre for Addictions- Re-evaluate the provision of residential treatment centre services for all residents across the NWT following re-building of community based addictions services

Address issues of standards, expertise, skill and scope of services for all residential treatment centres that NWT residents access both in and out of the NWT.

Consider location of short-term residential treatment centres in another part of the NWT as an adjunct to the Hay River location.

Mobile Treatment Programs- Re-assess the need for mobile treatment programs following the improvement and re-structuring of community based Addictions Programs across the NWT. Consider the use of an expert team of treatment counsellors to provide follow-up in each NWT community on a yearly basis.

Development of Post-secondary Education Plan with Aurora College and/or other Institutions. Work in partnership with Aurora College to develop a

"made in NWT" Bachelor's degree in Social Work with a speciality in Addictions and Mental Health Counselling.

Program change monitoring and Instructive evaluation- Develop a two-year process, outcome and cost effectiveness evaluation plan. Conduct these evaluation activities every five years. Implement appropriate database systems to provide client outcome data in a manageable format. Conduct client satisfaction surveys on a yearly basis within each community.

Consider building partnerships with Education and Research Institutions to conduct more specific research in the NWT such as the comparison of treatment strategies, outcomes for youth, experiences of children in families with addictions….

5.3 Final Comments

In conclusion, the evaluation team has provided the reader with a comprehensive look at the results of the evaluation of Community Addiction Programs in the NWT for the year 2001-2002. The recommendations presented in this report were considered with great care and attention to the needs of all people, men, women and youth in communities across the NWT. The overall conclusion of the evaluation of the Community Addiction Programs is summarized below as follows:

> **"Rebuild the whole community addiction program system because to add resources to the current system would be counter-productive. The structure of the entire delivery of addictions services (assessment, counselling, pre-treatment, treatment, support in the community/relapse prevention and education/prevention) must first be re-designed and re-built in partnership with communities across the NWT.**
>
> **Investments in the system are needed in to build a strong and effective system of community-based addictions services. These new investments need to be directed towards building a qualified work force in the NWT for future generations of NWT residents who struggle with addictions. In the short term, investments are needed to provide ongoing addictions services through qualified staff during this re-building phase.**
>
> **The starting point is now in providing good quality addiction services to the residents of the NWT. The system is already in a stage of emergency and people are ready to affect change in their lives with the right supports and services. Good quality Addictions services are not a luxury for NWT residents but a requirement for health, well-being and self-sufficiency."**
>
> (Evaluation Team Members, May 2002)

Final words of this report from a youth interviewee:

"I do not want to live like this, I see what has happened to my parents and I want to be different; I have some troubles with alcohol but I am going to beat it."

Interviewee, Youth Client

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Appendix A: Terms of Reference

PROJECT TITLE:

<u>Community Addiction Programs Evaluation</u>:

Program evaluation of Community Based Addiction Programs and Mobile Addiction Treatment Programs in the Northwest Territories.

BACKGROUND:

In 2000/01 the Department of Health and Social Services decided that all the Community Addiction Programs will be reviewed for effectiveness. The Department recognizes that the Community Addiction Programs are part of a greater whole when it comes to addiction services in the NWT, therefore, the evaluation will include the Mobile Addictions Treatment Programs.

The Health & Social Services Boards are core funded by the Department of Health & Social Services, GNWT to provide community-based addiction programs across the NWT. There are approximately 23 community based addiction programs in the NWT. For the majority of the addiction programs, Band Councils or Hamlets administer the programs with funding through contribution agreements from the Health & Social Services Boards, though there are some addiction programs that are administered through non-government organizations (NGO). Hence, the Alcohol & Drug Worker is therefore an employee of the Band or Hamlet/NGO, as opposed to an employee of the Health & Social Services Board. There are some exceptions to this in that some of the Alcohol & Drug Workers are Board employees. Several of the community- based programs in the Inuvik Region are blended addictions and mental health programs.

The community based addiction programs work within a system of addiction services, which includes a 30-bed adult residential addictions treatment facility known as Natsejee K'eh Treatment Center. It is located on the Hay River Reserve and is the only residential addiction treatment facility in the NWT. It is core funded through the Department by the Deh Cho Health & Social Services Board. It is to this facility that the community based addiction programs refer clients who require a residential addiction program.

The Department piloted Mobile Addiction Treatment Programs for women and youth across the NWT in 2000/2001. The piloted projects were in response to NWT communities' overwhelming requests to deliver culturally appropriate addictions treatment programs to clients in their home

communities, as opposed to sending people out of their communities and away from their families to access treatment. The Mobile Addiction Treatment Programs were approximately 21 days in length and many of the treatment forums were out on the land, as opposed to confined to a facility. Treatment facilitators/counselors from various treatment facilities in Alberta, were contracted by the community leaders and paired with the addiction counselors from the community based addiction programs, in the hopes of building community capacity at the grass roots level of service delivery.

The Department of Health and Social Services funded four Health and Social Services Boards in 2000/2001 to deliver Mobile Addiction Treatment Programs for women. The Boards that submitted proposals for the funding were; Dogrib Community Services Board, Lutsel K'e Health and Social Services Board, Deh Cho Health and Social Services Board and Inuvik Regional Health and Social Services Board. The Department funded Deh Cho Health and Social Services Board and the Dogrib Community Services Board to deliver Mobile Addiction Treatment Programs for youth.

The Department committed to evaluate the 2000/2001 piloted mobile addiction treatment programs in 2001/2002. The evaluations will analyze the rate of success of the treatment programs and review the outcome measures. With these results in place, the Department will be able to set mobile treatment standards for both the Women and Youth Mobile Addiction Treatment Programs. A brief description of the mobile addiction treatment program is attached. (Please see Appendix A3)

PURPOSE:

This Request for Proposals is for a ***Community Addiction Programs Evaluator*** to evaluate the ***NWT Community Based Addiction programs and the Mobile Addiction Treatment Programs for Women and Youth.***

The evaluations will be conducted in the context of four reports: the Minister's Response to the 1999 Forum on Health and Social Services, It's Time To Act, A Report on the Health & Social Services of the Northwest Territories conducted by George B. Cuff and Associates Ltd., Working Together for Community Wellness A Strategy for Addictions, Mental Health and Family Violence in the NWT and Review of Natsejee K'eh Treatment Center conducted by Paul Hanki.

The purpose of the evaluations is to review three main components of addiction services offered in the NWT, they are as follows: administration/management, treatment effectiveness, and linkages in the system.

The administration/management component of the review will be to evaluate the Health & Social Services Boards' administration and management of the community addiction programs' contribution agreements that are in place with the various Band Councils/Hamlets/NGO's. This

will also involve reviewing the Board's relationship/support to the community addiction program through the position of Addiction Specialist, where this position is applicable within its respective Board. Part of this analysis will involve determining if the individual addiction programs are in compliance with the ***NWT Addiction Handbook***, which outlines the standards for the community based addiction programs and treatment centers. Additional areas of evaluation will be on the addiction/treatment counselor job descriptions and analysis of appropriate qualifications of community addiction program staff. The contractor will answer the question, "Do the present qualifications of community addiction program staff provide the level of services expected and required in delivering a successful community based addiction program in the North?" The contractor will evaluate the appropriate duties and responsibilities expected of the addiction program positions and determine if the current human resources and fiscal funding arrangements available, meet the demands of differing client treatment and counseling needs.

Treatment effectiveness will be evaluated, i.e. clinical supervision, case management, follow-up and aftercare of the client, client orientation to the service, assessment tools. In addition, this part of the evaluation will look at whether or not the core services are being delivered in a manner, appropriate to the community or region for which it provides services. The evaluation will analyze the "value for money" of these services, i.e. are we receiving optimum services for the money we spend on addiction programs. The evaluation will not base the addiction system's effectiveness only on recidivism rates or relapse rates, as the nature of the recovery from addiction expects and predicts relapse during interventions/counseling/treatment. Therefore, one measure of success must be found in answering the question, "Are we getting value for our money?"

In addition, program outcomes and program outputs will be reviewed in the context of treatment effectiveness, in assisting with answering such questions as, "Are the community based addiction programs referrals made to treatment centers appropriate in nature?" The evaluators will review basic statistics, for example, number of client intakes, number of clients on an average caseload, number of clients referred to residential addiction treatment centers both north and south, etc.

The third and final component of the evaluation will look at NWT addictions services as a "system" in answering the question, "Is the current "addictions system" effective, efficient and economical in its operational structure of providing services to residents in the NWT?" Thus, the evaluation will address the overall cost effectiveness of the community addictions programs and mobile addiction treatment programs from a system wide perspective and recommend appropriate changes and improvements to the addictions system as a whole. Recommendations about the roles, responsibilities and interrelationships of the Department, the Boards and the service providers will also be included. It is important to conduct this part of the evaluation in the context of the document, *Working Together for Community Wellness A Strategy for Addictions, Mental Health and Family Violence in the NWT.* The Department will be moving ahead in its implementation of the integration of addictions, mental health and family violence

services over the next few years, therefore recommendations speaking to systems and structure, as it relates currently to addiction services will be important.

DESCRIPTION OF THE PROJECT:

The evaluations of the community-based addiction programs will address the following communities of the NWT: Yellowknife, Hay River, Fort Smith, Fort Simpson, Fort Liard, Rae Edzo, Wha Ti, Lutsel K'e, Fort Resolution, Inuvik, Holman, Tulita, and Fort Good Hope. (Please see Appendix A1)

The evaluations of the mobile addiction treatment programs for women will be held in Rae Edzo, Lutsel K'e, Fort Simpson, and Inuvik. The evaluations of the mobile addiction treatment program for youth will be held in Rae Edzo and Fort Simpson. (Please see Appendix A2)

METHODOLOGY:

Community Based Addiction Programs

As stated in the "purpose" of the terms of reference, the review will focus on the administration/management of the community addiction programs and mobile addiction treatment programs, as well as looking at the treatment effectiveness and linkages in the NWT Addiction Services system of these two programs.

The review will focus on the following questions:

- A key question to be answered in the review will be, "Are we getting value for our money?" (The contractors should propose a means by which "value for money" can be assessed.)
- What is the relationship between the Health & Social Services Boards and the Community Addiction Program staff and Program Sponsors?
- How effective is the administration of the Community Addiction Program by the Program Sponsors, i.e. Band Council Administrators?
- Is there effective administration/management of the contribution agreements by the Health & Social Services Boards?
- Are the contribution agreements, themselves, effective in their design to facilitate outcomes that we require in the community addiction programs?
- Is there effective use of the Health & Social Service Boards' positions of Addiction Specialists?
- Is there compliance to the *Community Addiction Services standards* of the ***NWT Addictions Handbook?***
- Are the community based addiction programs "effective"?
- A series of evaluations will be organized in the 13 communities listed in the ***Description of Project*** where community based addiction programs operate. The following groups to include in the interviews are as follows:

- Alcohol & Drug Worker
- Band Council/Hamlet Supervisors of the Community Addiction Programs
- Band Council/Hamlet Financial Manager
- Health & Social Services Board, Addictions Specialist and Chief Executive Officer
- Present clients
- Past clients
- Referral agents in the community
- Department of Health and Social Services staff

Mobile Addiction Treatment Programs

As stated in the "purpose" of the terms of reference, the review will focus on the administration/management, treatment effectiveness and program outputs/outcomes of the Mobile Addiction Treatment Programs. A key question to be answered in the review will be, "Are we getting value for our money?"

The review will include an analysis of all statistical data relating to participation rates (numbers of clients in treatment program), client demographics, follow-up, and aftercare with clients, management practices, financial controls, effectiveness of facilitators, degree of culturally specific healing components of treatment program, client/staff ratios, staff training, individual staff/supervisor qualifications, downtime between sessions, treatment referral process, the intake systems employed, changes in substances use/abuse by former clients, the appropriateness of the clients referred to this program in terms of their readiness for treatment.

An evaluation will be conducted of the mobile treatment programs via a series of interviews. The following groups to include in the interviews are as follows:

- Mobile Treatment Facilitators/Counselors
- Community Addiction Program Alcohol & Drug Counselors
- Sponsoring community interagency members (where applicable)
- Health and Social Services Board, Addictions Specialist, and Chief Executive Officer
- Past clients
- Referral agents (Alcohol & Drug Workers, etc.)
- Department of Health and Social Services Staff

As part of this project, the contractor will be expected to work in concert with the staff of the Community Based Addiction Programs, community interagency members involved in mobile treatment programs, the various mobile treatment facilitators, and the Health and Social Service Boards' Addiction Specialists.

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

SCOPE OF THE PROJECT:

The contractor will be evaluating the community addiction programs and mobile addiction treatment programs with in the communities that the programs operate. Therefore, the contractor will travel to the required communities (see Appendix A1) to conduct interviews and review documentation related to the evaluations.

The contractors will also be evaluating the community addiction programs and mobile addiction treatment programs in the context of the overall territorial system of addictions treatment, and will provide recommendations on changes or improvements to how the service delivery model should be structured to deliver addiction services to NWT residents.

DELIVERABLES:

A) Separate draft reports on each community addiction program and mobile addiction treatment program will be provided by the contractor to be reviewed by the Department Project Manager, steering committee and other Department contacts, prior to final distribution of the report.
B) The final submission will include a detailed description of the findings and recommendations on each of the community addiction programs and mobile addiction treatment programs, as well as overall conclusions on the effectiveness of addictions programs and services as part of a "system", including cost effectiveness of the system in the NWT.
C) The contractor will provide recommendations to improve the overall service delivery model/structure of addiction services in the NWT, based on the findings.

RESOURCES:

The Consultant, Addictions is the Project Manager of this contract for the Department. The key contact for the Contractor will be the Project Manager.

The Department has a steering committee tasked with over seeing the implementation of the contract. The Project Manager is the link between the steering committee and the contractor.

The contractor will have complete access to all necessary records and documents of the Department of Health & Social Services, Mobile Addiction Treatment Programs, and the Community Based Addiction Programs across the NWT.

The contractor will therefore sign and be bound to a confidentiality agreement.

PROJECT TIMEFRAME:

- The Contract for the Program Evaluator will commence in October 2001 upon the awarding of the contract.

- Final summary report and individual program evaluation reports on the community addiction programs and mobile addiction treatment programs will be submitted to the Department by February 28, 2002.

PROJECT BUDGET

This contract budget ranges between $80,000.00 - $100,000.00. The contractor will be asked to stay within this budget throughout the duration of the contract.

PROPOSAL GUIDELINES:

The proposal should include the following:

- Cover letter
- Executive summary
- Description of the project team
- Relevant experience
- Division of labour among team members
- Proposed methodology
- Detailed workplan
- Budget with breakdown of fees and expenses
- Resumes of team members
- Insurance certificates, etc.
- Copies of other evaluation reports done by the proponent
- Two references preferably from similar projects

QUALIFICATIONS OF CONTRACTOR:

The preferred contractor will have:

- Appropriate academic qualifications in a related field, e.g. Graduate degree in Social Work or Psychology; undergraduate degree with direct relevant experience will be considered in lieu of a higher designation
- Diploma or Certificate in community based addiction programs (outpatient) and residential addiction treatment programs (inpatient) with related work experience in these areas would be an asset
- Evaluation expertise and experience in relevant area

- Knowledge and experience in research methods
- Superior management skills
- Strong communication and interviewing skills
- Contractor will comply with the Canadian Evaluation Society's Guidelines for Ethical Practice (http://www.evaluationcanada.ca/ethique/CESethics.pdf)
- Knowledge of Northern Canadian Aboriginal cultural and Northern Canadian wellness issues, such as addictions
- Ability to speak an Aboriginal language is an asset

SELECTION CRITERIA

A Selection committee will screen each confidential proposal according to the following criteria:

1) Project team qualifications
2) Past relevant experience
3) Methodology
4) Project Schedule
5) Cost
6) References

Each rating is confidential; therefore, ratings will not be released for any proposal.

FINANCIAL TERMS

1) The Contractor will submit a budget for all costs for the Evaluations, including a detailed breakdown of all expenditures incurred in this project.
2) The Contractor will pay for all costs associated with all items as outlined in their proposal, and will be reimbursed based on actual expenditures. No invoices submitted to the Department will be paid over and above the maximum amount of the agreed contract.
3) The Contractor will maintain financial records and submit a financial report at the conclusion of the Evaluations.
4) The Contractor will ensure that the final financial report is submitted to the Department by February 28, 2002.
5) Fees and disbursements should reflect an appreciation of each project objective. Indicate costs related to time involved and clearly list the total basis of the fee structure, including reimbursable expenses.
6) No additional fees or reimbursable costs will be entertained unless the Department of Health and Social Services changes the scope of the work and agrees to renegotiations of costs.

APPENDIX A1

COMMUNITY ADDICTION PROGRAMS

YELLOWKNIFE **N'Dilo**	The Tree of Peace Friendship Center Alcohol & Drug Program 5009-51st Street Yellowknife, NT Ph: 867-873-2864 Alcohol & Drug Worker Yellowknives Dene First Nation Yellowknife, NT Ph: 867-920-2925
HAY RIVER	Community Addiction Programs Hay River Community Health Board 10-E Gagnier Street Hay River, NT Ph: 867-874-2446
FORT SMITH	Alcohol & Drug Program Uncle Gabe's Friendship Center Fort Smith, NT Ph: 867-872-2440
FORT SIMPSON	Fresh Start-Addiction Program Fort Simpson, NT Ph: 867-695-2715
FORT LIARD	Alcohol & Drug Program Fort Liard, NT Ph: 867-770-4770
RAE EDZO	Alcohol & Drug Worker Dogrib Community Services Board Rae Edzo, NT Ph: 867-392-6931
WHA TI	Wha Ti Alcohol and Drug Center Wha Ti, NT Ph: 867-573-3220
LUTSEL K'E	Alcohol & Drug Counselor Lutsel K'e Health & Social Services Lutsel K'e, NT Ph: 867-3370-3115
FORT RESOLUTION	Deninu Drug & Alcohol Program Fort Resolution , NT Ph: 867-394-4291
INUVIK	Turning Point Alcohol & Drug Program Inuvik, NT Ph: 867-777-2725
TUKTOYUKTUK	House of Hope Alcohol Center Tuktoyaktuk, NT Ph: 867-977-2176
TULITA	Tulita Wellness Agency Blended Mental Health/A&D Program Tulita, NT Ph: 867-588-4019
FORT GOOD HOPE	Alcohol & Drug Counselor K'asho Gotine Community Council Fort Good Hope, NT Ph: 867-598-2919/598-2352
FORT MCPHERSON	Peel River Alcohol Society Fort McPherson, NT Ph: 867-952-2245

APPENDIX A2

COMMUNITY MOBILE ADDICTION TREATMENT PROGRAMS

WOMEN'S MOBILE TREATMENT PROGRAMS
2000/2001

REGION	COMMUNITY	DATES	FUNDING	AGREEMENT
Dog Rib	Rae Edzo	May 22 - June 11/00	$ 40,145.00	Contract
	Follow-up	October 20-22/00	$ 6,301.50	Contribution Agreement
Lutsel K'e	Lutsel K'e	October 2-22/00	$ 45,616.08	Contribution Agreement
	Follow-up	March 19-23/01	$ 10,885.00	Contribution Agreement
Deh Cho	Fort Simpson	July 23-August 13/00	$ 38,380.00	Contract
Inuvik	Tl'oondih	February 26-March 31/01	$ 55,602.75	Contribution Agreement
			$ 196,930.33	

YOUTH MOBILE TREATMENT PROGRAMS
2000/2001

REGION	COMMUNITY	DATES	FUNDING	AGREEMENT
Deh Cho	Fort Simpson	September 3-9/00	$ 32,618.22	Contract
	Fort Providence	December 5-8/00		Contract
Dog Rib	Rae Edzo	November 24-26/00	$ 34,650.00	Contract
		January 18-20/01		
		February 23-25/01		
		March 23-25/01		
			$ 67,268.22	

APPENDIX A3

COMMUNITY MOBILE ADDICTION TREATMENT PROGRAMS FOR WOMEN AND YOUTH 2000/2001

In 2000/01, the Department of Health and Social Services funded various health and social services boards to pilot Women Mobile Addiction Treatment Programs as well as Youth Mobile Addiction Treatment Programs. The Women's Mobile Addiction Treatment Programs were delivered for 21 days either in a residential setting or out on the land.

The purpose of the pilots was to provide a treatment programs specifically for women in the NWT. Gender specific addictions treatment programs had never been funded by the Government of the Northwest Territories or by the regional health & social services boards, nor had there ever been a treatment program in the NWT designed specifically for women with all forms of addictions and substance abuse issues.

The community addictions counselors developed the schedule of sessions delivered during the twenty-one day treatment programs for the women and youth, identified facilitators, and provided the required budgets to implement the pilots in the regions. All the programs included background information of all the participants, rules of conduct, admission forms, budget for the programs, evaluation of the facilitators and programs by the participants, aftercare planning for the participants and recommendations on how the programs could be improved.

In 2000/01, the Deh Cho Health and Social Services Board, Dogrib Community Services Board, Inuvik Regional Health & Social Services Board and Lutselk'e Health and Social Services Board completed Women Mobile Treatment Pilot Programs in their regions. The Deh Cho Health and Social Services Board implemented the youth mobile pilot programs in the communities of Fort Simpson and Fort Providence. The Dogrib Community Services Board implemented their youth mobile pilot projects in the form of four workshops between November 24, 2000 and March 30, 2000.

Appendix B: Evaluation Questions

1.01 <u>Administrative and Management of the Community Addictions Program (Process Review)</u>

Question 1: What is involved with the Health & Social Services Authorities' administration and management of the Addictions' program contribution agreements with the various funding agencies (Band Councils/Hamlets/NGO)?

How effective are these systems? How are the management systems evaluated over time for effectiveness by the Health & Social Services Authorities? By the project sponsors such as Band Council/NGO/Hamlet Council?

How are problems identified? What are the corrective measures?

What is working? What is not working?

Question 2: What is the role and responsibilities of the position of Addictions Specialist (where applicable) in relation to community programs, Health and Social Services Authorities, community project sponsors such as Band Councils/NGO/Hamlet Councils?

What are the challenges faced by Addictions Specialist positions (where applicable) in supporting Community Addiction Programs services within their area of education, skills and training?

Question 3: How is the Community Addictions Program in compliance with the NWT Addiction Handbook?

What are the systems and processes used to monitor this compliance?

What are the areas of non-compliance? Why?

What is the role of the Addictions Specialist and the compliance with the Handbook?

Question 4: What are the job descriptions and expected duties of the addiction/treatment counsellors? What are their respective credentials, skills and training?

Do the present qualifications of community addictions staff match the needs of the positions according to the NWT Addictions Handbook?

How do the current human resources and funding match the client needs in terms of treatment and counselling?

What are the barriers and challenges faced by community addictions staff in providing services to the diverse needs of the client group (youth, women, elders, clients with multiple problems?

What are the available education and training systems for community addictions workers?

Question 5: Were there any environmental factors (political, worldwide, self-government concessions, community disasters/tragedies…) that have positively or negatively influenced the delivery of Community Addiction Programs and mobile treatment programs; if so, what is the nature of the influence?

Question 6: How effective was the integration of Community Addiction Programs with other community services and with the mobile treatment programs for women and youth?

Question 7: What were the strengths of the approach used by the community addictions program staff to implement the programs according to the NWT Addictions Handbook?

Question 8: Where the target groups, communities and local organizations satisfied with the administration and management of the Community Addiction Programs and mobile treatment programs?

Question 9: What evidence is there of the working together of community groups to provide a continuity of program delivery?

2.0 To determine the effectiveness of the Community Addictions Program (Outcome Analysis)

Question 10: What evidence is there of the Community Addictions Programs/mobile treatment programs providing activities sufficient to ensure results?

Program Indicators:

- Client participation
- Short-term changes: using services, access to education and information about addictions
- Intermediate term changes: awareness, knowledge, motivation, small behavioural changes, changes in the family
- Long-term results: relapse prevention, behaviour change, functioning in employment, education or traditional activity
- Traditional/cultural skills (pro-social, interest in community)
- Self-report measures such as satisfaction surveys, post-program self-reports

Question 11: What evidence is there of current addictions methodology being used by the program staff (local and regional) and with the mobile treatment programs?

Program Indicators

- Scope of clinical supervision (by whom, when, hours, skill of supervisor, resulting action)
- Scope of case management activities (services involved, coordination, reduced duplication, streamlined)
- Scope of assessment services offered (team, multi-level, family, use of home visitation, follow-up during assessment time line, initial coping strategies)
- Scope of aftercare services offered (frequency, how evaluated as good practice)
- Client groups served (frequency, intensity, hours)

- Frequency of problem identification and prioritizing
- Frequency of use of current research (harm reduction, health promotion, coping and relapse prevention models)

Question 12: What evidence is there that the Community Addictions Program and Mobile Treatment Programs have had the desired effect within the community?

Program Indicators:

- Community satisfaction and perception of service
- Cultural traditional involvement (role model, function as safe place, place for community involvement)
- Leadership satisfaction and perception of service

Question 13: Which specific community addiction program activities were more effective in assisting people to address the consequences of addictions such as involvement with crime, family violence, poverty, suicide and poor health?

Program Indicators:

- Client feedback
- Community satisfaction
- Community Agencies and Regional Agencies feedback
- Statistics on pro-social impacts such as employment, reduced ill health/visits to health centres, reduced involvement with Justice, education/training, family stability, reduced crisis intervention such as medi-vacs.

3.0 To determine the efficiency and economical value of Community Addiction Programs in providing services to residents of the NWT (Cost Effectiveness)

Question 14: What evidence is there that the Community Addictions Programs, project sponsors and Regional Health and Social Services Authorities provided community addictions services within established budgets?

Question 15: What were the systems used to monitor costs and expenses? How effective were these systems?

Question 16: What is the perceived benefit financially in providing community addiction programs and mobile treatment programs across the NWT by program sponsors, community agencies, regional Health & Social Services Authorities and GWNT Community Wellness Staff?

What is the actual benefit financially in providing community addiction programs and mobile treatment programs across the NWT?

4.0 <u>To integrate the findings from the review of Community Addiction Programs within the context of the *Strategy for Addictions, Mental Health and Family Violence*</u> <u>(Relevance and Integration)</u>

Question 17: How does the actual Community Addiction Programs fit into the proposed *Strategy for Addictions, Mental Health and Family Violence*?

Question 18: What are short-term and long-term recommendations for the structures and systems of community addictions programs?

Question 19: What are the financial implications (savings and necessary resources) of this integration?

Question 20: What is the cost saving to communities in terms of benefits as a result of the integration of community addiction programs?

Appendix C: Community Addictions Program Effectiveness Rating Scale (CAPERS Tool)

I. Administration

1. Policy Definition

Rating Description

1. No policy descriptions or mission statements made. No clear direction for the program.

3. General policies are known and communicated. Some grey areas.

5. Policies are clear and well communicated.

7. All policies are clearly defined. There are no grey areas.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

2. Funding Levels

Rating Description:

1. No funding provided.

3. Little funding provided.

5. Adequate funding provided.

7. Excessive funding provided.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

3. Accountability

Rating Description:

1. Staff members are not accountable to anyone. There are no records kept or reports written.

3. Staff members are accountable to supervisor. Poor records are kept and brief reports are written.

5. Staff members meet regularly to discuss incidents. Staff members are involved in an evaluation process. Detailed records and reports are written of most incidents and clients.

7. Staff members participate in self-evaluations and receive frequent feedback from the supervisor. Complete and detailed records and reports are written for every incident and client.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

4. Communication

Rating Description

1. No access to phone. No communication among staff members of necessary information to meet client's needs. Staff duties not shared fairly. Interpersonal relationships interfere with staff's responsibilities. No communication between staff and clients.

3. Staff and clients interact. Staff duties are shared fairly. Interpersonal interaction among staff does not interfere with staff's responsibilities. Some basic information to meet client's needs are communicated.

5. Client related information is communicated daily among staff. Staff interactions are positive and add a feeling of warmth and support. Staff and clients interact freely.

7. Responsibilities of staff members are clearly defined. Staff promotes positive interaction with clients. Clients feel free to communicate with staff.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

5. Administration

Rating Description:

1. No orientation to program provided for staff. No staff meetings held. No records are kept. No staff hired to handle administrative concerns.

3. Some orientation for new staff including emergency, safety, and health procedures. Some staff meetings held to handle concerns.

5. Thorough orientation for new staff. Monthly staff meetings are held. Some professional resource material available on site. Administrative assistant hired for part-time.

7. Administrative assistant hired on full-time basis. Office and books are kept neatly and organized.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

II. Program Content

6. Program Definition

Rating Description:

1. No clear definition of addictions.

3. Clear definition of addictions.

5. Clear definition of addictions. Treatment plan for one type of addiction.

7. Treats all forms of addiction (alcohol, drugs, gambling). Has a clear definition of each addiction and an extensive treatment plan, including aftercare.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

7. Content

Rating Description

1. Does not identify the stages of addictions.

3. Incorporates some of the stages of addictions.

5. Incorporates all of the stages of addictions and includes assessment of concurrent disorders.

7. Goes beyond the stages of additions.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

8. HR - Staffing

Rating Description:

1. No support staff hired. (Receptionist and Administrative assistant). No access to nutritionist or psychologist.

3. Support staff hired on a part-time basis.

5. Support staff hired on a full-time basis.

7. Support staff hired on a full-time basis and has direct access to other professionals and community resource people.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

9. Supervision

Rating Description:

1. No supervision over administration.

3. Little supervision over administration.

5. Adequate supervision over administration.

7. Professional supervision over administration.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

10. Charting

Rating Description:

1. No charting is done.

3. Charting is not complete or done with every client.

5. Charting is done completely.

7. Charting is done completely and with every client.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

11. Scope of Practice

Rating Description:

1. Program does not have intake, make assessments, or referrals and does not have aftercare.

3. Program does have intake and make assessments but they do not do referrals or have aftercare.

5. Program does have intake, make assessments and do referrals but have no aftercare.

7. Program does have intake, make assessments and do referrals. It also has an aftercare program.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

12. Intake

Rating Description:

1. No forms are completed.

3. Minimal information is gathered on a written form.

5. Information is gathered as shown in the NWT handbook.

7. Information is gathered as shown in the NWT handbook and is linked to ongoing assessment procedures.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

13. Assessment

Rating Description:

1. Program provides no assessment.

3. Assessment is provided by trained staff members.

5. Assessment is provided by trained staff members on a full-time basis.

7. Assessment is provided by professionals on a full-time basis.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

14. Referrals

Rating Description:

1. No referrals are made with community or regional agencies.

3. Few referrals are made with community or regional agencies.

5. Referrals are made as needed.

7. Excellent use of regional and territorial resources.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

15. Case Management

Rating Description:

1. Inadequate case management.

3. Minimal case management with one other community resource person.

5. Case management is done with a variety of community resource people.

7. Exchange of clinical reports with a variety of community resource people.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

III. Staffing and Support

16. Professional In-Service

Rating Description:

1. No in-service training is provided.

3. Some in-service training is provided.

5. In-service training is provided regularly by program.

7. Support is available for staff to attend courses, conferences or workshops not provided by the program.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

17. Clinical Supervision

Rating Description:

1. No clinical supervision provided.

3. Minimal clinical supervision provided. Supervision is done on an individual basis.

5. Good clinical supervision provided. Supervision is done on a weekly basis within a counselling team.

7. Excellent clinical supervision provided. Supervision is done on a weekly basis within a counselling team.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

18. Education/Prevention

Rating Description:

1. No attempts made to educate clients or community about addictions. No prevention program in place.

3. Few attempts to educate clients and community about addictions. A prevention program is in place.

5. Program offers courses and literature about addictions.

7. Variety of alternatives are used to educate clients and community about addictions. Trained staff members run a prevention program.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

19. Aftercare

Rating Description:

1. No aftercare provided for clients.

3. Aftercare is available upon request.

5. Aftercare provided only for referred clients.

7. Extensive aftercare program is provided for all clients.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

20. Community Development

Rating Description:

1. No community outreach initiative in place.

3. Education is provided for community.

5. Program takes active role in assisting the needs of the community.

7. Strong emphasis on community development.

Rating Given:

Inadequate		Minimal		Good		Excellent
1	2	3	4	5	6	7

Appendix D: Community Addictions Program Effectiveness Rating Scale Results (CAPERS Results)

Community Addiction Program Effectiveness Rating Scale (CAPERS)
NWT Community Addiction Programs 2001-2002

Assessment Item	Rae	Wha Ti	Fort Smith	Hay River	Fort Simpson	Fort Liard	Fort Resolution	Fort McPherson
1. Policy Definition	4	1	4	4	2	2	2	2
2. Funding Levels	4	1	4	4	1	1	1	1
3. Accountability	2	1	4	4	1	1	1	1
4. Communication	2	1	4	4	1	3	1	3
5. Administration	5	1	3	4	2	2	2	5
6. Program Def'n	2	1	3	4	1	1	1	1
7. Content	3	1	3	4	1	2	1	1
8. HR-Staffing	5	1	5	5	1	1	1	1
9. Supervision (admin)	5	1	5	5	1	1	1	1
10. Charting	4	1	3	5	1	2	1	1
11. Scope of Practice	3	1	3	5	1	1	1	1
12. Intake	5	1	5	5	4	5	5	5
13. Assessment	2	1	2	4	1	1	1	1
14. Referral	2	1	2	4	1	2	1	1
15. Case Management	3	1	2	3	1	1	1	2
16. Prof. In-Service	5	1	1	1	1	1	1	1
17. Clinical Supervision	3	1	3	3	1	1	1	1
18. Education/ Prevention	4	1	4	2	3	3	3	5
19. Aftercare	3	1	3	4	1	2	1	1
20. Community Development	3	1	2	1	1	4	1	5
Average	**3.45**	**1**	**3.25**	**3.75**	**1.6**	**1.9**	**1.5**	**2.2**

Rating Scale: 1-Inadequate 3-Minimal 5-Good 7-Excellent

Community Addiction Program Effectiveness Rating Scale (CAPERS)
NWT Community Addiction Programs 2001-2002

Assessment Item	Inuvik	Tuk	Good Hope	Tulita	Lutse K'e	Tree of Peace Yk	Ndilo
1. Policy Definition	1	1	2	3	1	4	2
2. Funding Levels	1	1	1	1	1	2	1
3. Accountability	2	1	3	4	2	4	3
4. Communication	1	1	2	3	2	4	3
5. Administration	2	2	3	3	3	5	3
6. Program Def'n	1	1	1	3	1	3	1
7. Content	1	1	1	3	1	4	1
8. HR-Staffing	1	1	1	3	1	4	1
9. Supervision (admin)	1	1	1	2	2	5	2
10. Charting	1	1	3	3	3	4	1
11. Scope of Practice	1	1	3	3	1	5	1
12. Intake	2	2	5	5	5	5	4
13. Assessment	1	1	2	2	1	2	1
14. Referral	1	3	3	3	1	3	1
15. Case Management	1	2	2	3	3	3	2
16. Prof. In-Service	1	1	1	2	1	2	1
17. Clinical Supervision	1	1	1	3	1	3	3
18. Education/ Prevention	1	1	1	3	1	4	4
19. Aftercare	1	1	2	2	2	3	1
20. Community Development	1	2	2	4	2	3	4
Average	**1.2**	**1.3**	**2.0**	**3.0**	**1.8**	**3.6**	**2.0**

Rating Scale: 1-Inadequate 3-Minimal 5-Good 7-Excellent

Community Addiction Program Space Effectiveness Rating Scale
NWT Community Addiction Program 2001-2002

Assessment Item	Rae	Wha Ti	Smith	Hay River	Simpson	Ft Liard	Ft Res.	Fort McPher
1.Esthetics: -equipment -furniture	5	3	4	7	6	3	2	6
2. Conducive to counselling: -privacy	3	2	5	7	5	5	1	6
3. Reception	6	4	1	7	1	1	1	3
4. Group/Resource space	1	1	5	6	2	1	3	6
5. Safety	5	5	5	6	2	1	3	6
6. Access for disability and elders	1	7	1	3	1	1	5	7
Average	**3.5**	**3.7**	**3.5**	**5.6**	**3**	**2.8**	**2.3**	**5.5**

Rating Scale: 1-Inadequate 3-Minimal 5-Good 7-Excellent

Community Addiction Program Space Effectiveness Rating Scale
NWT Community Addiction Program 2001-2002

Assessment Item	Inuvik	Tuk	Good Hope	Tulita	Lutsel K'e	Tree of Peace	Ndilo
1.Esthetics: -equipment -furniture	3	1	5	4	5	4	5
2. Conducive to counselling: -privacy	3	3	5	5	3	5	5
3. Reception	5	1	4	5	1	6	2
4. Group/Resource space	5	1	5	5	4	5	4
5. Safety	4	4	3	5	3	5	4
6. Access for disability and elders	1	7	1	7	1	1	2
Average	**3.5**	**2.8**	**3.8**	**5.2**	**2.8**	**4.3**	**3.6**

Rating Scale: 1-Inadequate 3-Minimal 5-Good 7-Excellent

Supplemental Information:

Evaluation of
Pilot Mobile Addiction Treatment Programs

"A STATE OF EMERGENCY…"

A Report on the Delivery of
Addictions Services in the NWT

May 31, 2002

Mobile Addiction Treatment Programs

Introduction

In the 2000-2001 fiscal year, the Department of Health and Social Services provided funding to various Health and Social Service Authorities to pilot Women's Mobile Addiction Treatment Programs as well as Youth Mobile Addiction Treatment Programs. The purpose of the pilots was "to provide gender-specific addictions programs", a new venture for the Government of the Northwest Territories and were developed in response to the overwhelming requests of communities in the NWT to deliver culturally appropriate addictions treatment programs to clients in their home communities. The programs were to be developed in great detail by the Addictions Specialists of the Health and Social Services Authorities together with the Community Addiction Workers and were to be of 21 day duration either on the land or in a residential setting.

In the fiscal year 2000-2001, four Health and Social Services Authorities (Deh Cho Health and Social Authority, Dogrib Community Services Authority, Inuvik Regional Health and Social Services Authority and the Lutsel K'e Health and Social Services Authority) were provided the funding to pilot Women's Mobile Addiction Treatment Programs in their regions. Follow-up pilot programs were held in the Dogrib Area and in Lutsel K'e. The Deh Cho Health and Social Services Authority implemented a Youth Mobile Pilot Program in Fort Simpson and Fort Providence; the Dogrib Community Services Authority implemented a Youth Mobile Program in the form of four workshops.

A total of $263,900 was expended on both the Women's and Youth Pilot Mobile Addiction Treatment Programs for the fiscal year 2000-2001.

Sources of Information

The evaluators were provided with some of the final reports for the Women's Pilot Mobile Addiction Treatment Programs; there were no reports for the Youth Pilot Mobile Addiction Treatment Programs. Interviews were conducted with Community Addiction Workers, Mobile Addiction Treatment Facilitators, representatives of the Health and Social Services Authorities involved in the pilots, clients and referral agencies.

Findings and Recommendations

The Terms of Reference of this Evaluation requested that the Mobile Addiction Treatment programs be evaluated in terms of administration/management, treatment effectiveness and program outputs/outcomes. These topics will be addressed in this report.

I. Administration/Management

Finding #1

The Women's Mobile Addiction Treatment Programs generally lacked in terms of management practice. Most programs were not adequately planned.

The Women's Pilot Mobile Addiction Treatment Programs were generally poorly attended; between 5 - 7 women attended each of the programs. There was an increase of one participant in one of the follow-up programs. Poor participation rates may be the result of inadequate advertising. Various interviewees indicated that this was in fact the case. As well, there was not always enough lead time between advertising and the beginning of the program.

The pilot programs did not fully anticipate the needs of the clients from a practical point of view. For instance, there were cases where child care had not been considered and in fact, this required that the program be moved from an on-the-land program to a residential setting in the community. The program had to be re-designed to meet the changes in the setting.

The physical setting of the program was also inadequate in some of the pilot programs. The problems with the setting ranged from too many interruptions from telephone, clients and house guests to buildings with uncomfortable temperatures.

Other management issues include lack of advertising, lack of organization with regard to speakers, scheduling and a possible conflict of interest issue. The conflict of interest issues centres around the facilitators. In some cases, the facilitators for the Mobile Addiction Treatment Programs were also the Community Addiction Workers and/or the Addictions Specialists of the Health and Social Services Authorities. This could be construed as a conflict of interest especially if the planning of the program and writing of the proposal is also done by the same person. The original intent was that the Authority's Specialists would plan the Mobile Addiction Treatment Program together with the Community Addiction Worker. The Community Addiction Worker would be involved in order to facilitate aftercare and follow-up. However, this was not the case. It was the Addictions Specialists who planned the programs and, in some cases, implemented them. In some cases, the Community Addiction Worker also helped in the facilitation of the program.

Recommendations

1. Adequate time must be spent in the planning stages of the Mobile Addiction Treatment Programs to allow for the delivery of these programs in a professional and adequate manner from an administrative/management point of view. Time must be spent in the planning of logistics (child care, setting and scheduling). The planning process must

include the Community Addiction Workers to ensure that community needs are met.

2. The issue of advertising the Mobile Addiction Treatment Programs must be addressed. Advertising must be done at least two months prior to the commencement of the program to allow for sufficient notice to perspective participants as well as for an adequate intake process.

3. Review conflict of interest issues.

II. Treatment Effectiveness

Finding #2

The intake process implemented in the Pilot Mobile Addiction Treatment Programs was generally inadequate.

The original intent had been that referral to Pilot Mobile Addiction Treatment Programs would be the same as referral to treatment as set out in the NWT Addictions Handbook. However, there was only one mobile program that indicated any type of intake. This particular program required medicals, a pre-treatment check list and an actual alcoholism questionnaire.

For all other programs, the intake process seemed little more than a "sign-up" sheet.

Recommendations

1. Intake and assessment procedures for Mobile Addiction Treatment programs must be greatly improved. Intake and assessment should include, at the very least, a medical examination, the regular treatment form (as set out in the NWT Addictions Handbook) and some pre-counselling. Further assessment such as self-report inventories, family history and psychosocial history are needed to deliver even a basic Mobile Addiction Treatment program.

2. Assessment tools must be implemented to determine the appropriateness of the client for the program (ie. Is the client suffering from a concurrent disorder? an addiction?).

Finding #3

The Pilot Mobile Addiction Treatment Programs varied greatly in terms of the actual content of the program. There was everything from personal healing to self-care and the Twelve Step Program. The topic of peer counseling was part of the Youth Program.

Each of the Pilot Mobile Addiction Treatment Programs was very different in terms of the various aspects of addictions that they dealt with. In some programs, the emphasis was on dealing with personal issues such as grieving and loss; in others, it was substance abuse education programs, such as the effects of alcohol on the body; in others it was on providing support for each other.

It should be noted that there was an attempt to explore different models or approaches to Mobile Addiction Treatment programs. This, in part, resulted in the great diversity of program content resulting in a great deal of confusion for clients. Not only did the clients not know what to expect, but the diversity in program content makes it difficult to assess whether a client's needs will be met by a particular program. The general public was also somewhat confused as to the purpose of the Mobile Addiction Treatment Programs.

Recommendation

1. While it is not necessarily bad to have Mobile Addiction Treatment programs address different issues, at this early stage in its development, it is important to keep the program purpose, that is, the treatment of addictions, as consistent as possible. This will allow for a stronger program foundation to be built.

2. Mobile Addiction Treatment Programs could address certain components of an addictions program, such as a follow-up program for the family of the addicted person at the community level or treating a whole family at the same time.

Finding #4

Many of the Pilot Mobile Addiction Treatment Programs were severely lacking in cultural content.

The cultural activities of the various programs again varied greatly across the Territories. Some programs listed their cultural activities as berry picking, while others had traditional healers and elders come to the program and offer their knowledge to the group. While these activities are cultural in nature, only a small portion of time was dedicated to such activities. In many cases, they were limited to "leisure" activities.

Recommendation

1. The inclusion of cultural components is essential to Mobile Addiction Treatment programs since they were designed to bring treatment to home and thus cater to the needs of the local community.

2. There should be consistency in the delivery of this aspect of the program.

Finding #5

The Mobile Addiction Treatment Programs lacked in treatment effectiveness with reference to aftercare.

There was inconsistency between the programs in terms of the aftercare component of the program. Written aftercare plans were not prepared in each of the programs. One of the follow-up workshops was in fact designed to deal with aftercare plans; however, most of time was spent on personal healing rather than developing aftercare plans. Not every program had access to the Community Addiction Workers as had been the original intent of the Department of Health and Social Services. There is a very weak link between treatment and aftercare.

Recommendations

1. Aftercare plans must become an integral part of each treatment program.

2. Aftercare plans should include a referral to the Community Addiction Workers and perhaps a report to the referring agency.

3. Ensure that the Community Addictions Program is strong so that appropriate aftercare will be available for clients.

Finding #6

The qualifications of the facilitators were generally at the certificate in addictions level; several of the facilitators had training in special topics such as family violence, spousal abuse and adult children of alcoholics.

From documented evidence as well as interview data, there was only one documented case of an outside facilitator having a university degree in the Social Sciences. Generally external facilitators had some level of training from the Nechi Institute and some basic counselling training.

As indicated in Finding #1, there were cases where the Addictions Specialists and Community Addiction Workers facilitated the Mobile Addiction Treatment Programs. These facilitators did not have university degrees; their addictions training was acquired from the Nechi Institute.

Originally, the intent was that highly qualified and skilled facilitators in the area of addictions would team up with the local Community Addiction Workers. However, this was not the reality in most cases.

Recommendation

1. Facilitators should have superior facilitation skills coupled with superior knowledge and experience in the addictions field. This would assume that facilitators have at least a university degree in the Social Sciences as well as extensive training in the addictions field and facilitation skills.

III. Program Outputs

Finding #7

The majority of participants completed the program in which they were enrolled.

Having achieved close to 100% completion by participants, it would seem that the participants were ready to make some changes in their lives - they seem to be ready for treatment. The Community Addiction Workers as well as the Addictions Specialists observed that it was very difficult to determine if there had been changes in the substance use and abuse. This might indicate that none of the programs were a "success".

Recommendations

1. The definition of success must be clearly delineated - does success mean completion or is it reduction in addictive behaviour?

2. Behaviour change does not occur quickly; appropriate evaluation and interviews with the clients should take place approximately 3 - 6 months after the program is completed. This would help determine the actual change in behaviour experienced by the client.

3. An evaluation component could be built into the aftercare and/or follow-up of the Mobile Addiction Treatment Programs thus providing valuable input as to the effectiveness of the program and how that program contributed to the change in behaviour, if any.

Finding #8

The majority of interviewees were unable to state why Mobile Addiction Treatment Programs were being piloted by the Department of Health and Social Services.

The rationale for having Mobile Addiction Treatment Programs was viewed by some as a way to have treatment brought home as opposed to attending residential treatment away from home; by others it was viewed as a cost saving to the system; to yet others it was an alternative to treatment, not a replacement for residential treatment. Some people thought that the Mobile Addiction Treatment Program was a healing program and still others believed it was aftercare.

One client thought the Mobile Addiction Treatment Program was training and that they would be available for casual work at the local alcohol centre.

Recommendation

1. Given that Mobile Addiction Treatment Programs are a relatively new phenomenon in the NWT, it would be prudent to ascertain the rationale for providing this type of treatment as opposed to residential treatment. Once this rationale has been determined, it should be included in the "advertising" of the program.

Finding #9

The Mobile Addiction Treatment Programs were regional in nature. There was no cohesiveness among the programs.

The Pilot Mobile Addiction Treatment Programs were delivered in three separate regions. There was no communication between the regions concerning the programs – either in terms of management or actual program delivery. In fact, it could appear that the programs were delivered by the Region and were not necessarily part of a Territorial Addictions Treatment initiative. Many of the problems experienced among the Pilot Mobile Addiction Treatment Programs were similar in nature.

Recommendations

1. A team of highly qualified and specialized facilitators be developed to deliver Mobile Addiction Treatment Programs across the Territories. The team should be multi-disciplinary in nature so that it could address the needs of various groups of people (youth, adults, women, men) with various problems (addictions, counselling, etc.). The Team could still obtain community input as to the specific needs of the community at that time. Mobile Addiction Treatment Programs be delivered on a rotational basis so that each community has access to the team at a "regularly scheduled" time. Having such a team could potentially also solve many of the "management" type problems that were encountered by the Pilot Programs.

2. The team could have a "home base" in Nats' ejee K'eh Alcohol and Drug Treatment Centre so that it would be seen as a component of the Territorial Addictions Treatment System.

Summary/Conclusion

To a large extent, the evaluation of the Mobile Addiction Treatment Programs mirrors the Community Addictions Program. There is little or no planning for programs; there is no assessment process in place; there is little program definition (what is the program supposed to accomplish?); the aftercare component of the programs is lacking; the qualifications of many of the facilitators are not adequate. The Community Addictions Program is currently weak; it would not be wise to add yet another "block" to a weak foundation - the whole "building" might crumble.

Many of the problems related to the delivery of the Pilot Mobile Addiction Treatment Programs were similar in nature and there was no cohesiveness among the Pilot Programs. Therefore, it might be advisable for the Department of Health and Social Services to look at developing a Mobile Addiction Treatment Team that could deliver such services. The Team could be based out of the Nats' ejee K'eh Alcohol and Drug Treatment Centre. However, before the Department of Health and Social Services adds Mobile Addiction Treatment Programs of any type to their mix of addiction services in the Northwest Territories, it is essential that a strong Community Addictions Program is built.

This supplemental information is part of a larger evaluation project, The Evaluation of the Community Addictions Programs in the Northwest Territories. For further information with respect to the methods used in the review of Mobile Addiction Treatment Programs, please see the report:

A State of Emergency…A Report on the Delivery of Addictions Services in the NWT (May, 2002)

This report and all related documents of the evaluation of the Community Addiction Programs in the NWT have been prepared by Chalmers & Associates Ltd. The analysis, findings and recommendations are those of Chalmers & Associates Ltd. and do not necessarily represent the views of the Department of Health and Social Services of the Government of the Northwest Territories.