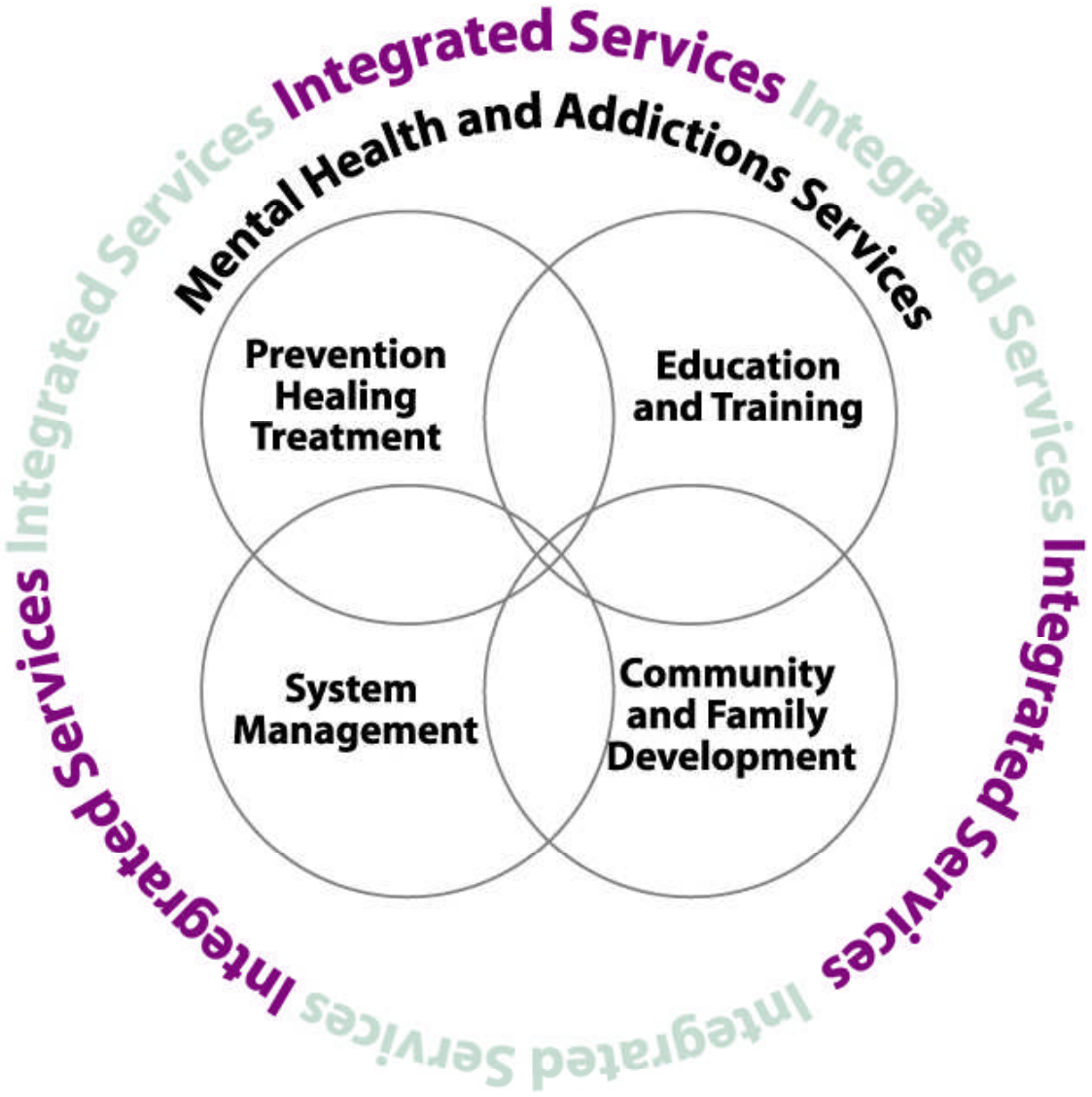


Performance Measurement - 2003/04

Mental Health and Addictions Services

Northwest Territories Health and Social Services

March 2005

Introduction

This document is a report of the Performance Measures/Indicators for the Mental Health and Addiction Services, 2003/04. It has been developed to meet the Department of Health and Social Services requirement that accountability and performance measurement become an integral part of every new program and initiative. This report is based on Department data related to implementation outcomes for 2003/04 (year-one).

System Design - Rationale

Best practices and research indicate strongly that in order to assist and support an individual dealing with an addictions or family violence issues, it is critical to address the underling mental health issues that contribute to the addiction or violence/abuse experienced by an individual or family. One cannot separate the two when counseling and treating the individual and /or family.

NWT Mental Health and Addiction Services has undergone a paradigm shift; its definition/philosophy, clinical structure, service delivery model to name a few. The silos of addiction and mental health programs were combined and integrated into one service delivery model, where the provision of services are delivered through multidisciplinary teams which will provide prevention, treatment and aftercare services at multiple levels (community, regional and territorial). The staff and other service providers for Mental Health and Addiction Services will be integrated into the Primary Community Care Team of the Health and Social Service system.

The Mental Health and Addiction Service logic model is provided in Appendix 1 and explains the basic parts of what is expected of this paradigm shift in 2003/2004. The tasks (activities), outputs, and outcomes of the project have been identified for first year of implementation 2003/04 (Year 1).

The first initiative of the Mental Health and Addiction Service (core service) as laid out by the logic model is the **Community Counseling Program.** This is an integrated mental health, addiction and family violence counseling program delivered at the community levels throughout the NWT. In step with Primary Community Care Teams and an integrated service delivery model, the Community Counseling Program (CCP) will reflect a multidisciplinary team, i.e. a team consisting of multiple professionals, operating with in the PCC team. The CCP team will consist of the following positions:

- Community Wellness Workers
- Mental Health/Addiction Counselors
- Clinical Supervisors

Health and Social Service Authorities (HSSA) will be able to tailor their Community Counseling Programs to offer therapeutic and clinical counseling in the areas of addiction, mental health and family violence. A variety of practitioners will be recruited from such professions as social work, psychiatric social work, psychiatric community-based nursing, mental health counselors, addiction counselors, all having a wealth of experience in "front line" community-based work. These teams will be operating at the community and regional levels.

Community Counseling Program – Position Allocations

Community Wellness Worker (CWW) - provide communities with prevention and public education initiatives regarding issues related addictions, mental health and family violence. The CWW work within the PCC team, with a focus on education, prevention, and after care. They provide information about the negative impacts of substance abuse, unresolved mental health problems, and untreated mental illness. The CWWs also provide support to self-help groups and assist with the development of recovery and aftercare groups. The CWW plays an important role in community development and support of interagency activities.

CWWs refer clients to a Mental Health/Addiction Counselor or other members of the PCC team, either in their community or in a larger community. Clinical supervisors (who may be located in another community) provide clinical supervision.

Mental Health/Addiction Counselors (MH/AC)- provide integrated community counseling services in addressing mental health, addiction and family violence issues. The Mental Health/Addiction Counselor is a member of the PCC team, providing care to people living with mental illness and those who require specialized mental health and addiction services. The MH/AC will:

- Provide therapeutic individual, group, and family counseling in the areas of mental health, addictions, trauma, marital, sexual abuse, etc.
- Provide comprehensive mental health and addiction screening / assessments
- Monitor and manage psychiatric medication regimens
- Utilize case management techniques
- Organize referrals to specialized addictions and psychiatric services at the regional and territorial levels as required
- Assist with crisis intervention.
- Community development approach to services using the context of the client's family and home environment.

Mental Health/Addiction Counselor positions are being staffed in medium and large communities. Their duties may include travel to the smaller communities in their respective regions. The Mental Health/Addiction Counselor positions are staffed with professionals who have clinical qualifications in psychology, addictions, social work and/or mental health appropriate to the position. They refer to other members of the PCC team as needed and are clinically supervised.

Clinical Supervisors – provide clinical supervision to Community Wellness Workers and Mental Health/Addiction Counselors and this will be imperative to the success of the mental health and addiction programs and services. The Clinical Supervisors are members of the Primary Community Care team. Their main responsibility is to provide clinical and managerial supervision for the CWW's and the MH/AC's. They act as a resource specialist in mental health and addictions to the PCC team, such as providing consultation and assessments for clients at risk or clients posing complex challenges to the PCC team. It is expected that Clinical Psychologists, Social Workers with Masters Degrees, or Degree Nurses who specialized in Psychiatry who have several years of front line / direct clinical experience will staff these positions.

Table 1 illustrates the Community Counseling Program position allocations throughout the Health and Social Service Authorities in the NWT.

Table 1 **Community Counselling Program**
Regional Staffing Allocations 2003/04

Region	CWW Allocation	MH/AC Allocation	Clinical Supervisor Allocations
Yellowknife	**9**	**1**	**0**
Inuvik	**17**	**4**	**2**
Deh Cho	**7**	**2**	**1**
Dogrib	**5**	**2**	**1**
Fort Smith	**3**	**1**	**1**
Hay River	**4**	**1**	**0**
Grand Total	**45**	***11**	**5**

* Note: an additional 5 Mental Health/Addiction Counsellor positions were created and funded through Health Accord funding. See below for details.

The Department used a population-based formula to determine staffing levels for the CCP programs. Communities with populations greater than 1200 would be allocated 3 CWW, 3 Mental Health/Addiction Counsellors and a minimum of 1 Clinical Supervisor. Communities with populations between 300-1200 would be allocated 3 CWW/1000 and 3 Mental Health/Addiction Counsellors/1000. Communities with populations less than 300 would not be allocated positions but would receive services from their larger/regional communities.

Applying this population-based formula to the staffing mix cost over $5.5M. Even after subtracting $2M for the Band/NGO community addiction program funding, the FMB was greater than $3.3M. It should be noted that the 3.3M provided funding for FTE's but excluded the CWW training and shelter increases. Because the FMB submission was for a significant amount of funding the Department was asked to reduce the budget considerably.

Table 1 represents the reduction to the original costing and therefore a reduction in the staffing model. After months of renegotiating the staffing model (beginning with a best practices model to one that was "affordable"), the result was that all NWT communities with a population greater than 300 would be allocated 1 CWW FTE and the regional sites would receive a minimum of 2 CWW, 1 MH/AC and 1 CS with the hopes of obtaining more funding in subsequent years.

The renegotiated funding formula was a great disappointment and concern to the Project Team, and was not supported by our HSSA partners. Great dissatisfaction loomed and growing concern for the integrity of the Community Counseling Program ensued.

In summary, the staffing model went from an optimum staffing model of 99 positions in total (39 CWW, 53 MH/AC and 7 CS) emphasizing the importance of the MH/AC positions, to a total of 77 positions (45 CWW, 24 MH/AC and 8 CS) thereby reducing the counseling positions by 45%. Please see **Table 1** for the 2003/04 position allocations.

Funding Conditions

The assessment of the required level of resources took into consideration 2002/03 core funding in the areas of mental health and family violence, a re-profile of community addictions funding, and additional base funding. Main Estimates for 2003/04 approved $1,515,000 and approved funding from Health Accord funding of $276,000. This was the 2003/04 budget for Year 1 of Mental Health and Addiction Services; i.e. first year human resources for the Community Counseling Program, CWW training and family violence shelter O&M increases.

Table 2 **Mental Health and Addiction Services 2003/04 Funding**

Region	Community Wellness Worker	Mental Health/ Addiction Counselor	Mental Health Addiction Counselor (Health Accord)	Clinical Supervisor	Community Wellness Worker Training	Family Violence
Department					120,000	96,000
Deh Cho	462,652	93,592	52,148	99,960		
Dogrib	313,289	90,988	52,530	97,356		
Fort Smith	181,682	91,159	2,384 (O&M)	97,525		
Hay River	240,839	90,808	2,174 (O&M)			
Inuvik	1,150,844	193,206	113,828	205,942		
Yellowknife	542,139		52,936			
Subtotals	**2,891,445**	**559,753**	**276,000**	**500,783**	**120,000**	**96,000**
Total						**$4,443,981**

Funding was flowed to the Authorities as *core funding* and became part of their base funding for Mental Health and Addiction Services. The H&SS Authorities were not required to submit quarterly variance reports to the Department. Rather, H&SS Authorities were required to submit "frequent" expenditure reports to the Department. These expenditure reports reflected how the Authority's spent the MH/A Services funding throughout 2003/04.

The funding required for 2003/04 implementation of the Mental Health and Addiction Services is presented in **Table 2** above. The highlighted column reflects the Federal Government Health Accord funding that was secured in September 2003. The criteria for this funding was strictly focused on clinical positions, therefore 5 additional MH/A Counsellor positions were funded through this initiative. The full amount of 2003/04 Health Accord funding allocated to Mental Health and Addiction Services was $576,000 but as the funding was flowed mid-way through the fiscal year it was prorated to October 2003 at $276,000.

The overall funding allocation has become the base funding for Mental Health and Addiction Services; however, the base was insufficient to provide funding beyond Year 1of implementation. As a result, the Department of Health and Social Services will submit FMB submissions to Cabinet each year requesting additional funding that would allow the Department to effectively complete the full 10-year implementation plan of Mental Health and Addiction Services.

Performance Measurement

The Department of Health and Social Services requires that the discipline of performance measurement and evaluation be incorporated into the lifecycle management of any new programs or initiatives that are developed. This also includes any new programs and services that are being initiated under the Mental Health and Addiction Core Service umbrella. Incorporating performance measurement and evaluation at the forefront of a program or initiative will ensure that:

- results-based management and accountability frameworks are developed for each new or renewed programs and initiatives;
- ongoing performance monitoring and performance measurement practices are established;
- issues related to the early implementation and administration of the program or initiative, including those that are delivered through partnership arrangements are evaluated (formative or mid-term evaluation); and
- issues related to relevance, results and cost-effectiveness are also evaluated.

The Performance Measurement Strategy identifies the data that will be collected and used to provide information on the progress of Year 1 and outlines details for each performance measure/indicators on how often the information was collected. It is included as Appendix 2 of this report and is measured below.

Action Plan Items – Year 1

These are the actual action plan items that were completed in 2003/04:

✓ ***Community Counselling Programs***

- *Re-profile community addiction program funding*
- *Design an integrated Community Counselling Program for addictions, mental health and family violence*
- *Clinical supervision will be part of the program*
- *Implementation of Community Counselling Programs (CCP) for Addiction, Mental Health and Family Violence*
    - *Three new positions: Community Wellness Worker, Mental Health/Addictions Counsellor, Clinical Supervisor*
    - *Developed core competencies*
    - *Job Descriptions*
    - *Job Classifications/Job Evaluation*
    - *Program Standards and Toolkits*

- *15 Direct Appointments – CWW*

- *Staff Mental Health/Addiction Counsellors and Clinical Supervisors positions*
- *Shelter O&M enhancements*
- *CWW training*

✓ ***Increases to O&M for NWT Shelters***

✓ ***CWW Training***

- *Partnership with Keyano College and Nechi Institute*
- *Community Wellness Certificate Program*
- *2 streams of students identified*
  - *Steam 1 – 5 CWW*
  - *Stream 2 – 10 CWW*
- *Health and Social Service Authority training for Training Supervisors of the Community Counseling Programs*
- *CWW training plans*
- *Stream 1 completed 4 courses of the Community Wellness Certificate*

Actual Implementation Activities – Year 1

Mental Health and Addiction Services

Actual Implementation Events/Timetable

2003/04 Initiatives	Completion Dates
Community Counselling Program Job Competencies and Job Descriptions **(Chalmers and Associates Consulting)**	
• Contract awarded • Contractor drafted Competencies for 4 positions (Community Wellness Workers, Family Violence Workers, Mental Health Workers, Clinical Supervisors) • Consultation group (HSSAs, family violence and addictions partners) for feedback • Competencies finalized	March 3, 2003 March 25, 2003 March 25, 2003 May 2, 2003
• Draft Job Descriptions for 3 positions (Community Wellness Workers, Mental Health/Addiction Counselors, Clinical Supervisors) • Shared with Consultation group (HSSAs, family violence and addictions partners) for feedback • Second Draft • Shared with Consultation group – for feedback	April 23, 2003 April 23, 2003 April 30, 2003 May 6, 2003

• Consultation group teleconference • JSMC/ISDM meeting – approval of JD's. ▪ JSMC set deadline HSSA JD packages into Dept by May 28/03 for the June 12 job evaluation meeting	May 7, 2003 May 16, 2003
Contractor's work	*March 1-April 30, 2003*
Department's work after contract completed	*May 1-August 30, 2003*
CPP Job Classifications (CWW, MH/AC, CS)	
• HSSAs missed May 28th deadline for June 12/03 Job Evaluation meeting – classification of JD's • Job Evaluation committee meeting - classification of JD's (no meeting in July) • HR prepared official letter of classification outcomes – addressed to HSSA CEO's • HR faxed official letter of classification outcome (hard copy followed in the mail)	(Missed) June 12, 2003 August 14, 2003 October 31, 2003 November 4, 2003
Department Job Classification process in total	*May-November, 2003*
Community Wellness Worker Direct Appointments (starting dates November 2003)	
• HSSA provided list of CWW direct appointees (4) • Cabinet submission • Appointments approved (effective November 1/03) ▪ 2- Fort Smith ▪ 2- Deh Cho ▪ Record of Decision	August 4, 2003 September 30, 2003 October, 2003 November 25, 2003
Community Wellness Worker Direct Appointments (starting dates Feb/Mar 2004)	
• HSSA prepare list of CWW direct appointees • Cabinet submission • Appointments approved	**None**
HSSA advertise and Hire New Positions (MH/AC & CS)	
• Deh Cho, IRHSSA, FS, DCSB, HR HSSA will hire through standard HR job competition process for MH/A Counselor and CS positions • Yellowknife HSSA hired Addiction Counselor	**None** **June 2003**
Program Development Contract (CCP program standards and toolkits) **(Chalmers and Associates Consulting)**	
• Contract awarded	April 4, 2003

• First draft • Distribution to consultation group • Teleconference-consultation group • Second draft • Distribution to consultation group • Teleconference-consultation group • Third draft • Face to face meeting with contractor • Contract completed (Standards and toolkits) • Final (fourth) draft	June 11, 2003 June 11, 2003 June 18, 2003 July 23, 2003 July 25, 2003 August 8, 2003 August 14, 2003 August 18-20, 2003 August 29, 2003 Sept 12, 2003
Contractors Work	April 4-August 29, 2003
Department's work after contract completed	August 29-December 1, 2003
Standards and Toolkits (Department)	
• 4th draft distribution to consultation group • Feedback deadline • Project team compiled feedback • Consultation group meeting - Yellowknife	Sept 15, 2003 Sept 29, 2003 Oct 1-10, 2003 December 2-3, 2003
Skills Inventory Contract (A&D workers both HSSA and Band employees) **(Human Sector Resources)**	
• Contract awarded • Interview with A&D Workers (Band) • Final Report • Presentation to MH/A Consultation Group	September 15, 2003 Sept 29-Oct 10, 2003 November 28, 2003 December 2-3, 2003
Regional Transition Planning	
• Face to face meetings have taken place with all Financial and human resource reviews have been completed to identify key issues. • HSSA Implementation/Transition Plans • Various presentations to community/NGO/aboriginal leadership as requested	February – April, 2003 April 2003-March 2004 April 2003-March 2004
Communication Plan • Draft (Communications) shared with JSMC • Revised Communication Plan for community meetings • Communication plan and power point presentations distributed to HSSAs for their use • Several presentations have been provided to various aboriginal leadership groups by Department and HSSA.	 January, 2003 May, 2003 June, 2003 Ongoing

Training Research	
Establish Consultation Group	April, 2003
Prior Learning Assessment (PLA) • Draft Learning Outcomes & Learning Objectives (based on draft competencies) • Research into Prior Learning Assessment standards and protocols • Research into existing training programs in southern Canadian colleges and universities • George Brown College, Human Services Diploma	 May, 2003 May, 2003 April, 2003 May, 2003
2003/04 Training for Direct Appointed CWW's **(Nechi Institute)**	
• Nechi Communicating With Youth - Addictions – Hay River Reserve (NJK) CWW Certificate Program • Health Promotion Theory • Program Integration 1 • Program Integration 2 • Community Resources	January 21-25, 2004 February 8-13, 2004 February 22-27, 2004 March 14-19, 2004 March 21-26, 2004
Training Supervisor Training **(Genesis)**	
• Contract awarded • First draft • Second Draft • Final Document • Training Manuals mailed to Training Supervisors • 2-dayTraining for Training Supervisors	February 10, 2004 Feb 23, 2004 March 2, 2004 March 12, 2004 March 15, 2004 March 29-30, 2004
Aboriginal Mental Health Consultation – CCP **(Alberta Mental Health Board)**	
• 2-day meeting/workshop with MH/A Consultation Group	March 24-25, 2004

Logic Model and Performance Measurement Strategy Results

The following tables provide the results for the logic model and performance measurement strategy, as developed in May 2003 with Jennifer Carey, Evaluation Specialist for the Department of Health and Social Services. These can be found in Appendix 1.

Logic Model Results

Task	Outputs	Completed
Fill 45 Community Wellness Worker Positions	Competency profile	**DONE**
	Prior Learning Assessment tool developed	**DONE**
	Job Description created and classified	**DONE**
	Addiction Counselors and Family Violence Workers complete PLA's	**DONE only with Addiction Counsellors**
	Training modules developed	**DONE**
	All Addiction Counsellors and self-identified FV workers develop individualized training plans	**DONE only with Addiction Counselors**
Community Mental Health Worker positions	Competency profile	**DONE Competency profile completed for a Mental Health/Addiction Counsellor**
	Job description created and classified	**DONE JD's completed for Mental Health/Addiction Counsellor**
Develop Clinical Supervisor positions	Competency profile	**DONE Competency profile completed for Clinical Supervisor**
	Job description created and classified	**DONE JD's completed for Clinical Supervisor**
Develop Regional Transition Plans	Regional transition plans developed	**DONE Completed by HSSA**
	Meetings conducted with each HSSA	**Done Conducted via conference calls and in person throughout the year**
Increase O&M funding to Family Violence Shelter	Funding covers essential basic shelter necessities	**DONE The increase to O&M for each shelter does not meet all basic shelter needs**

Performance Measurement Strategy Results

Task	Outputs	Performance Measurement	Completed
Fill 45 CWW positions	Competency profiles completed	Timeline: 01 March 2003	**May 2, 2003**
	Prior Learning Assessment Tool developed	Timeline: 01 April 2003	**1. CWW Draft PLA's completed June 2003** **2. CWW PLA's and training manual completed March 2004** **3. CWW PLA supervisor training competed March 2004**
	Job description created and classified	Timeline: 01 April 2003	**1. Job descriptions completed – July 2003** **2. Job Classifications completed – August 2003** **3. HSSA received results of classifications November 2003**
	Addiction Counselors and Family Violence Workers complete Prior Learning Assessments	Timeline: 15 July 2003	**NOT COMPLETED** **1. Family Violence workers did not have PLA's** **2. CWW's PLA commenced 04/05**
	Individualized training plans are administered to Addiction Counselors and Family Violence Counselors	Timeline: 01 September 2003	**1. Ongoing with CWW's** **2. PLA's not offered to FVW's**
Fill 6 Community Mental Health Worker positions	Competency profile completed	Timeline: 01 April 2003	**May 2003**
	Job description created and classified	Timeline: 01 April 2003	**July 2003**
Fill 5 Clinical Supervisor positions	Competency profile completed	Timeline: 01 April 2003	**May 2003**
	Job description created and classified	Timeline: 01 April 2003	**July 2003**
Develop regional transition plans	Regional Transition Plans developed	Timeline: 01 April 2003	**Ongoing between April 2003-March 2004**

O&M funding increased	O & M funding increased	Timeline: 01 April 2003	1. **HSSA core funded April 1, 2003** 2. **$ not actually flowed until mid-year**

Performance Measurement Strategy - Results

Immediate Outcomes	Performance Measurement	Completed
45 CWW positions filled	Proportion of CWW positions filled	35
	Proportion of CWW positions filled by current A&D Workers	35
6 Community Mental Health Worker positions filled	Proportion of MHW positions filled	1
	Proportion of MHW positions filled by current workers	0
	Average time between MHS positions being advertised to the time each position is filled	2-3 months
5 Clinical Supervisor positions filled	Proportion of Clinical Supervisor positions filled	0
	Proportion of Clinical Supervisor positions filled by current workers	0
	Average time between Clinical Supervisor position being classified to the time each position is filled	N/A as none were filled
HSSA complete transition plans specific to the unique needs of their region	# of regional transition plans completed	All HSSA had completed transition plans
Develop regional transition plans	Proportion of Mental Health and Addiction core service workers hired as per regional transition plans	1
Adequate funding	Funding covers essential basic shelter necessities	1. $96K divided between 5 shelters 2. insufficient funding

Staffing Summary

Initially, the Department's staffing plan for the CWW positions was to cancel all contribution agreements (effective June 30, 2003) HSSA held with NGO's or Bands/Hamlets for the provision of community addiction programs (old A&D projects), which employed community people in the positions of Alcohol and Drug Workers. These workers were to be offered direct appointments into CWW positions effective June 30, 2003.

HSSA began negotiations with communities, aboriginal governments and leaders who opposed the cancellation of the A&D contribution agreements and asked that the Department and HSSA consult with all the communities, ultimately allowing communities to decide for themselves if they wanted to continue in contribution agreements or to come under HSS Authorities in the new initiative. The Minister's office was overwhelmed with letters from community leaders, asking that he negotiate with each community. The June 30th deadline was eliminated and the cancellation of contribution agreements was not implemented.

Between May 2003 and December 2003 HSSAs traveled extensively to communities to discuss the implementation of Community Counseling Programs and which community A&D workers would become HSSA employees under the new integrated program.

Fort Smith HSSA directly appointed 2 Alcohol and Drug Workers into CWW positions, effective November 2003. The Deh Cho HSSA made 2 offers of direct appointments for CWW's effective November 2003. One was accepted and one was declined.

The DCSB was still in negotiations with their chiefs at the end of this fiscal year and no decision was made in 2003/04; thus no CWW positions were staffed. The Tlicho Healing Path Wellness Center was being developed as one of the Primary Health Care Transition Fund Projects funded by Health Canada. This project would come to stand as an integrated mental health and addictions counseling center that would eventually provide outreach services to the Dogrib region. It was not staffed during 2003/04.

The IRHSSA succumbed to multiple obstacles throughout their region; some related to already blended programs and blended funding, other reasons stemmed from lack of capacity at the HSSA level and damaging messages from regional staff in community consultations that opposed the initiative completely. These and many other issues have significantly delayed the direct appointment process in the Inuvik region and therefore no appointments were made. All of the communities in 2003/04 continued in contribution agreements, with the exception of Sachs Harbor, Tsiiggehtchic, Holman, Aklavik and Paulatuk which

all had vacancies. Therefore the funding was held at the IRHSSA where they planned to put the CWW positions out for competition in 2004/05.

Hay River HSSA did not have contribution agreements with NGO's for addiction programs, as their Community Counseling program had been a HSSA program for several years prior to the Department's initiative. The CWW allocated positions were not filled in 2003/04.

YHSSA had an agreement with the Tree of Peace Friendship Center to direct appoint their A&D Workers mid-way through 2003/04; however, during the summer months the NGO's Board of Directors rescinded their decision and the contribution agreement continued throughout the duration of 2003/04. YHSSA does not know what the decision will be regarding the funding arrangement with Tree of Peace in 2004/05.

Table 3 summarizes the HSSA staffing of the Community Wellness Workers for the Community Counseling Programs across the NWT for 2003/04 and **Table 4 and 5** summarize the HSSA staffing of the Mental Health/Addiction Counsellor and Clinical Supervisor positions respectively:

Table 3 Community Wellness Workers Staffing 2003/04

Region	Community	Band/NGO	Authority	CWW Allocation	Total Funding
Yellowknife	Yellowknife	4		6	**354,875**
	Dettah	1		1	**59,944**
	Lutselk'e	2		1	**64,307**
	Ft Resolution	1		1	**63,013**
Total		**8**		**9**	**542,139**
Inuvik	Tuktoyaktuk	2		2	**136,450**
	Paulatuk	1		1	**70,796**
	Aklavik	1		1	**67,495**
	Holman	1		1	**70,937**
	Sachs Harbor	1		1	**70,796**
	Inuvik	1		3	**196,187**
	Ft. McPherson	1		2	**132,020**
	Colville Lake	1		0	**5,000**
	Norman Wells	1		2	**133,228**
	Deline	2		1	**67,587**
	Tsiigehtchic	1		1	**66,118**
	Ft Good Hope	1		1	**66,805**
	Tulita	1		1	**67,425**
Total		**15**		**17**	**1,150,844**
Deh Cho	Fort Simpson	0	1	2	**125,988**
	Fort Providence	1		2	**124,372**
	Fort Liard	1		1	**61,450**
	Wrigley	0		1	**65,153**
	Trout Lake	0		0	**5,000**
	Kakisa	0		0	**5,000**
	Jean Marie	0		0	**5,000**
	Hay River Reserve	1		1	**60,689**
Total		**4**		**7**	**452,652**
Dogrib	Rae Edzo	1		2	**120,780**
	Wekweti	0		1	**64,467**
	Gameti	1		1	**64,411**
	Wha Ti	1		1	**63,631**
Total		**3**		**5**	**313,289**
Fort Smith	Fort Smith	**0**	**2**	**3**	**181,682**
Hay River	Hay River	**0**		**4**	**240,839**
Total		**32**	**3**	**45**	**2,891,439**

Table 4 Mental Health/Addiction Counsellor Staffing 2003/04

Region	Community	#MH/A hired in HSSA	MH/A Counsellor Allocation (Including Health Accord positions)	Total Funding
Yellowknife	Yellowknife	1	1	**105,872**
	N'Dilo	0	0	
	Dettah	0	0	
	Lutselk'e	0	0	
	Fort Resolution	0	0	
Inuvik	Tuktoyaktuk	0	0	
	Paulatuk	0	0	
	Aklavik	0	0	
	Holman	0	0	
	Sachs Harbor	0	0	
	Inuvik	0	3	**323,650**
	Ft. McPherson	0	0	
	Colville Lake	0	0	
	Norman Wells	0	1	**97,212**
	Deline	0	0	
	Tsiigehtchic	0	0	
	Fort Good Hope	0	0	
	Tulita	0	0	
Deh Cho	Fort Simpson	0	2	**197,888**
	Fort Providence	0	0	
	Fort Liard	0	0	
	Wrigley	0	0	
	Trout Lake	0	0	
	Kakisa	0	0	
	Jean Marie	0	0	
	Hay River Reserve	0	0	
Dogrib	Rae Edzo	0	2	**196,049**
	Wekweti	0	0	
	Gameti	0	0	
	Wha Ti	0	0	
Fort Smith	Fort Smith	0	1	**91,159**
Hay River	Hay River	0	1	**90,808**
Total		**1**	**11**	**1,102,638**

Table 5 **Clinical Supervisor Staffing 2003/04**

Region	Community	#CS in HSSA	Clinical Supervisor Allocation	Total Funding
Yellowknife	Yellowknife	0	0	**0**
	N'Dilo	0	0	
	Dettah	0	0	
	Lutselk'e	0	0	
	Fort Resolution	0	0	
Inuvik	Tuktoyaktuk	0	0	
	Paulatuk	0	0	
	Aklavik	0	0	
	Holman	0	0	
	Sachs Harbour	0	0	
	Inuvik	0	1	**102,362**
	Ft. McPherson	0	0	
	Colville Lake	0	0	
	Norman Wells	0	1	**103,580**
	Deline	0	0	
	Tsiigehtchic	0	0	
	Fort Good Hope	0	0	
	Tulita	0	0	
Deh Cho	Fort Simpson	0	1	**99,960**
	Fort Providence	0	0	
	Fort Liard	0	0	
	Wrigley	0	0	
	Trout Lake	0	0	
	Kakisa	0	0	
	Jean Marie	0	0	
	Hay River Reserve	0	0	
Dogrib	Rae Edzo	0	1	**97,356**
	Wekweti	0	0	
	Gameti	0	0	
	Wha Ti	0	0	
Fort Smith	Fort Smith	0	1	**97,525**
Hay River	Hay River	0	0	**0**
Total		**0**	**5**	**500,783**

Table 4 and 5 illustrate that out of a possible 11 Mental Health /Addiction Counsellors to be staffed; only 1 position was staffed in 2003/04 by the YHSSA. No Clinical Supervisor positions were staffed in 2003/04. In consultation with the HSSA's, it was determined that the Department's change in mandate from cancellation of all A&D contribution agreements to a more consultative approach of community by community consultations, had significantly delayed the CWW staffing. As the CWW had been the most politicized process of all the new positions most of HSSA's time and energies were focused on this area at the sacrifice of the MH/A and CS staffing. Here are the vacancy rates for all three positions in 2003/04:

Table 6 Community Counseling Program Position Vacancy Rates

Position	Allocated Position	Vacancies
Community Wellness Worker	45	10
Mental Health/Addiction Counsellor	11	10
Clinical Supervisor	5	5
Total	**61**	**25**

At a joint JSMC/JLC meeting in February 2004, the Minister of Health and Social Services requested that HSSA's move their efforts towards staffing the clinical positions (counsellors and clinical supervisors). The CWW direct appointments being processed at that time would proceed to Cabinet for approval but that future direct appointments would be delayed until a reasonable quota of the clinical positions had been staffed in the regions. This directive did not decrease the total number of vacancies by the end of the 2003/04 fiscal year.

Community Wellness Worker Training

Community Wellness Worker training was extremely complex and had to take into consideration the type of training to be offered, when and for whom. While negotiating with communities on the process of contribution agreements vs. CCP, HSSA had to simultaneously transition CWW's into their system. This was initially a very slow process and very difficult for the HSSA and Department to track accurately as sometimes decisions were reversed. Support from the HSSA with respect to the CWW training waned from time to time as the Department's perceived credibility fluctuated due to funding priorities for the training was challenged.

Neither the Department nor the HSSA were prepared for the very complex and lengthy process in developing the CWW training from completing the CWW

competencies, developing the prior learning assessments, developing CWW training supervisors in the regions and negotiating with a college.
The following areas were developed to provide a comprehensive CWW training plan for those A&D Workers directly appointed into CWW positions:

- CWW competencies developed
- CWW job descriptions developed
- Competency inventory completed
- HSSA Training Supervisors identified and trained
- CWW skills assessments (PLA's) developed and completed
- Cabinet Submissions completed
- Direct Appointments approved
- CWW training delivered

In many communities, A&D Workers from NGO's/Band/Hamlet Addictions Programs were direct appointed into their respective HSSA as Community Wellness Workers. Community Wellness Workers primary responsibility is health promotion/prevention initiatives focused in the areas of addictions, mental health and family violence. The ***Competencies Inventory Summary Report*** by Human Sector Resources (November 2003) provided a competency inventory of the A&D Workers. The report emphasized the gaps in knowledge/theory in addictions, mental health and family violence and illustrated the lack of formal education of these workers.

A competency-based training was developed to ensure that each Community Wellness Worker would have an individualized training plan to meet the requirements of the job. The training process was adapted individually and included many routes to obtain the same outcomes, i.e. Community Wellness Workers were provided training only where gaps in knowledge and/or skills were identified.

Table 7 CWW Competencies

Competency Area	Number of Competencies
1. Health Promotion/Prevention	3
2. Screening and Referral	1
3. Communication Skills	10
4. Interpersonal Relations	3
5. Crisis Intervention	1
6. Addictions	6
7. Mental Health	6
8. Family Violence	4
9. Other (CPR/First Aid)	1
Total	**35**

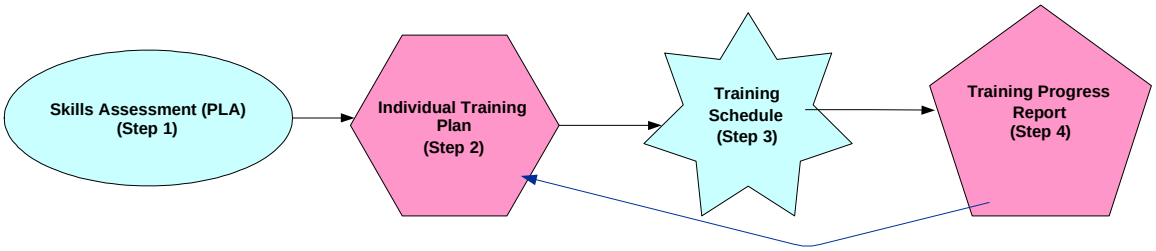
Training Supervisors

HSSA's provided support to CWW's by implementing the training process. Authorities identified staff (human resources program managers and supervisors in mental health and addictions) who were responsible for the new CWW training plans. Training was provided to Authority employees in March 2004, based on the process and competencies developed by the health and social services system. Employees were trained on the role and function of the training supervisor, as well as the process and adult education principles to better enable them to provide accurate training plans for CWW's.

Training Supervisors and Human Resource staff implemented and monitored the following process to ensure that CWW's attained mastery in all the 35 competencies.

Process

A competency based training approach had to ensure that each Community Wellness Worker was provided with the tools and support required to reach mastery in each competency area. The following was the employee training development process.



Step 1	Step 2	Step 3	Step 4
A **Skills Assessment (PLA)** is completed with each Community Wellness Worker identifying current knowledge and skills and identifying gaps in knowledge and skills;	An **Individual training plan** is developed with each Community Wellness Worker to address any gaps in skills and knowledge;	A four month **training schedule** is developed with each Community Wellness Worker to plan priority training areas to address these gaps based on guidelines established;	A quarterly **Training progress report** is done based on the training plan and schedule and the training plan is revised to address competencies completed and plan for the next four months of training, if required;

The above process was completed when all competency areas were mastered.

Streams of Students

Because direct appointments of Community Wellness Workers was delayed and became such a staggered process, the Department designed a staged approach in training in order to accommodate the employment and training requirements of the students. Two streams of students were created in order to complete the Keyano College, Community Wellness Certificate Program. They are as follows:

Stream 1 (2003/04): 5 Community Wellness Workers from the Inuvik, Deh Cho and Fort Smith Authorities – began the Keyano College, Certificate Program in 2003/2004 and will complete the certificate in 2004/2005.

Stream 2 (2004/05): Ten Community Wellness Workers from various regions – begin the Keyano College Certificate Program in 2004/2005 and complete in 2005/2006

Community Wellness Worker Certificate Program

The goal of the Keyano College's Community Wellness Worker Certificate Program is "to ensure that graduates will have the skills necessary for enhancing emotional, mental, physical and spiritual well being of children and families in their communities by reducing risk factors and increasing protective factors." [1]. Community Wellness Workers spent 50% of their time providing health promotion/prevention information to their communities.

The Keyano certificate program provided Community Wellness Workers with the knowledge and skills to provide health promotion/prevention information to individuals and groups at the community and territorial levels.

The Keyano College Community Wellness Program has transfer agreements with three universities;

- ✓ Athabasca University
- ✓ Brandon University
- ✓ University of Victoria

The Keyano College Community Wellness Worker certificate completes 13 of the 35 CWW competencies throughout the 10-course program. They are as follows:

1 Keyano College Community Wellness Program Description, www.keyano.ca/programs/wellness.htm

Table 8 CWW Competencies Covered by Keyano College Program

Competency Category	Competency	
	Number	Title
Health Promotion/Prevention	1	Facilitation
Health Promotion/Prevention	2	Event Planning
Health Promotion/Prevention	3	Client Centered Needs
Communication Skills	5	Interviewing
Communication Skills	6	Presenting Information Effectively
Communication Skills	7	Teamwork and Cooperation
Communication Skills	9	Listening
Communication Skills	10	Social Marketing
Communication Skills	11	Reflective Questioning
Communication Skills	12	Personal Boundaries
Interpersonal Relations	15	Emotional Intelligence
Interpersonal Relations	16	Cultural Sensitivity
Addictions	21	Relapse Models
Total # of competencies covered	**13**	

Data Analysis

Staffing Challenges

There were numerous challenges that proved difficult for many HSSAs that were both internal to our HSS system as well as external to the HSS system. They are as follows:

Internal to the "system"

- The preferred community counseling program staffing model (mix of staff and numbers of positions) was reduced numerous times due to funding constraints
- Decreased staffing model was unpopular to HSSA partners and led to credibility issues for the Department
- The additional support required to implement the community counseling program initiatives, from both Departmental and Authority levels, with in the Finance and HR areas was compromised primarily due to lack of human resources
- The Departmental implementation work plan was subject to changing political priorities and sometimes budget reductions
- Significant problems with the contractor who developed the job descriptions – the Department worked for an 2 months to complete the JD's
- The significant delay in the job evaluation process delayed HSSA hiring and also delayed the CWW direct appointment processes, e.g.

job evaluation meeting August 2003 and letters were not sent out to HSSA with the classification results until November 2003
- Job evaluation resulted in lower classifications for the clinical positions; i.e. Mental Health/Addiction Counsellors and Clinical Supervisors
- As a result of the low pay levels for the clinical positions, HSSA have had significant problems recruiting for these positions
- Significant anxiety and uncertainty about funding stability of the new initiative had many HSSA proceeding cautiously; i.e. very slowly

External to the "system"
- A desperate lack of housing in communities have made recruiting for the new positions nearly impossible in regions like the Sahtu and Beaufort Delta
- Insufficient office space and infrastructure throughout the regions
- Political backlash (position moves seen as counter to devolution), resulting in reluctance to transfer employees to HSSA, higher rents in office space suddenly charged by communities and resources not being shared

CWW Training Challenges

During the time of costing the CWW training, the project team was running on the premise that all the A&D program contribution agreements would be cancelled by June 30, 2003 and that the training program would have to accommodate approximately 30-35 HSSA employees. The costing of even a staggered approach to training was estimated to be over $3M dollars. The Department decided that the original FMB submission would only consist of the costing for the Community Counseling Program FTE's and increases to the family violence shelters; the CWW training submission would be separate to keep the numbers "palatable".

As the year progressed, the CWW training FMB was not submitted. The Department's Main Estimates was approved and $1.5M was budgeted/approved for staffing the Community Counseling Program with the increases to the family violence shelters. The budget line for CWW training ($120,000) appeared indiscriminately, without any consultation with program staff. Therefore the project team had to develop the CWW training in accordance to the budget as opposed to the ideal situation – the budget corresponding with the planned training.

With the realization of a significantly reduced budget, forecasted successes in the CWW training were greatly compromised, therefore, senior management agreed to reinvest $490,000 which was the 2001/02 Mobile Addiction Treatment funding that had been suspended following the outcomes/recommendations of

the 2002 State of Emergency Report. The $262,000 of NNADAP funding was also utilized in the CWW training budget as it met federal criteria.

With a $3M CWW budget reduced by 96%, the training design/delivery plan was reduced and redesigned to meet the budget. Competency-based training was the logical fit and the team researched already established University/College programs that would meet the most competencies possible. The delivery of the program(s) also had to be taken into consideration and be very economical in nature so the delivery was also a factor in the choice of the institution and program.

In addition, the lateness in the fiscal year and a reduced budget, the team decided to complete a skills inventory of the present A&D Workers to confirm speculations that the requirements of training would be addressing gaps in health promotion/public education skills, mental health and family violence theory/skills. Human Sector's report (September 2003) substantiated these assumptions.

Prevention was very much a priority set by the Department and communities alike and the main staple of the CWW job description was an emphasis on health promotion/public education skills/competencies. The Department decided that this would be the priority area for training, followed by the theory/knowledge courses in mental health and family violence and a few of the other specialized areas reflected in the job description. The choice of program was not arbitrary; Keyano College had developed a Community Wellness Worker Certificate program that focused exclusively on health promotion/public education skills and knowledge as well as facilitation. Keyano also had partnered with Nechi Institute in the delivery of the certificate program, which meant that the instructors could deliver the courses in the NWT, in a staggered timeline throughout the year. The certificate program covered 13 of the 35 CWW competencies. See table on page 20.

Simultaneously, as mentioned earlier in this report, the HSSA's were experiencing significant challenges in negotiating with communities the HSSA Community Counseling Program implementation with politics playing a significant role in the outcomes of the negotiations. The traveling to communities, especially in the larger regions such as Inuvik, was incredibly time consuming. Communities were having difficulty making the decisions of whether to relinquish the A&D programs and would sometimes rescind their decision of partnerships.

While trying to negotiate the contract with Nechi Institute, our CWW student numbers were constantly changing which further delayed the delivery of training. Finally, following the JSMC/JLC meeting in February 2004 the Department was instructed to proceed with the CWW training with the CWW direct appointees we had to date (3) with the inclusion of two workers from the Sahtu whose direct appointments were being processed.

In summary, the CWW training was significantly compromised by a significant reversal of a key employment strategy for the CWW's resulting in very low numbers of CWW and therefore low training numbers. Other factors that compromised the training were significant fiscal constraints, declining political will, difficulties in negotiating the training contract due to these factors and ultimately adversarial relations between some HSSA and the Department.

Next Steps

The success of the Community Counseling Programs is reliant upon the continued investment in the clinical positions; i.e. Mental Health/Addiction Counsellors and Clinical Supervisors. Attainment of the renegotiated staffing mix will require new monies in both 2004/05 and 2005/06 to fund the new clinical positions. As discussed in this report, 61 positions were funded in 2003/04, with a total of 16 clinical positions left to fund in the upcoming fiscal year(s).

CWW training will continue in 2004/05; Stream 1 will complete the remaining courses of the Keyano College Community Wellness Worker certificate and graduate in March 2005. Stream 2 students will begin their coursework in the certificate program and graduate in the following fiscal year (January 2006). In addition to the Keyano College program both Stream 1 and 2 students will complete coursework specific to youth and family violence. These courses will be facilitated from three separate organizations; BC/Yukon Society for Transition Houses, Nechi Institute and The Speers Society. It will be paramount to ensure that the CWW training budget ($610,000) be approved in 2004/05.

To build on the foundation of the Community Counseling Programs another level of services are required to help support psychiatric clients and clients experiencing a psychosocial crisis to live independent lives at home in their communities or at a minimum, in their region. Crisis Stabilization Units (CSU) and Mobile Crisis Teams (MCT) will be developed in 2004/05 to provide this segment of the population with early interventions to help support the client in resolving their perceived crisis in the least intrusive manner and avoiding the situation from escalating to an acute psychiatric crisis and thus a more intrusive intervention.

Most of the services developed and implemented to date in this core service area are focused on the adult population. Services and programs for children and youth with mental health and addiction issues will be researched in 2004/05 with the possibility of contracting much of the data analysis, cost analysis and development of a planning tool for future services.

The Community Counseling Program Standards toolkits will be finalized, printed and distributed to all community programs and regional HSS offices. Work on the Aboriginal Advisory committee will commence in 2004/05 with community consultation and a terms of reference completed.

Outcomes and recommendations of the Facilities Review Committee and the pending changes to the policies on the out of territory southern placements will no doubt affect this core service work. As a result, additional work may be added to the project team work plan and new priorities may be identified during the 2004/05 fiscal year.

Recommendations

1. The enormity of the work associated with the Mental Health and Addiction core service development/implementation has been underestimated. It was insightful to designate a Project Manager for the project but near sighted to expect already over-extended consultants to place large pieces of the implementation plan on their plates. As a result, research, planning and development was delayed as the program consultants had competing priorities much of the time.

   Throughout 2003/04, the four ICS consultants that were appointed to this project on a part-time basis were unable to meet all timelines consistently due to their overextended workloads. The Project Manager found this particularly challenging, as did the rest of the project team.

   Recommendation: Senior management must allow the program consultants to shift workload priorities and support consultants in putting this core service at the top of their priority list by designating a percentage of their work time to the project. This would be reflected in their work plans and that of the unit work plan. If senior management doesn't support the shifting in workload priorities, it will be very difficult to continue with the momentum that has been created to-date (energy, enthusiasm, funding) and to meet continued expectations of our colleagues/partners, HSSAs, Ministers and MLA's and the public.

2. Identifying priority action items is very much determined by political influence. This is understandable to a point, however, when building a "system" from the ground up, it must be understood that each level of program/project development is interdependent on the other, especially when building such a vast range of complex services such as mental health and addictions. The folks who have the best judgment of what action items must be prioritized is the Project Team and their recommendations for action items are reflected in projected work plans. This area of decision-making was challenging in 2003/04 and already priorities for 2004/05 are being discussed at political levels and senior management tables instead of program/project tables.

   If this issue is not addressed, and the project is driven by unconnected priorities, the end product will not be sustainable nor will it be stable as foundational pieces that may have been omitted or rearranged in their priority, don't get implemented and this will compromise the integrity of the entire project.

   Recommendation: More opportunities must be given to the Project Manager and their manager/director to present rationale for the process of the core service development and implementation. The most

appropriate arena for this discussion is at JSMC so I would recommend that there be a closer feedback loop between the Project Manager and JSMC. Information items should, at minimum, be quarterly with an opportunity for updates via presentations. This may assist in a better understanding of the rationales for program driven project priorities.

3. The scope of this project went far beyond the expertise of program consultants as various stages of planning involved expertise/knowledge in human resources, financial planning/costing and information management. The team relied heavily on a lead from each of these respective divisions to lend their expert advise/direction/input to the project. The degree of input/support varied, again in relation to the workloads of the various consultants at any given time and the varied support of the various Directors. For the most part, the project has been well supported throughout the various divisions.

Recommendation: Continued support and collaboration between the Department's divisions and the Project Team throughout the life of the project. The divisions that need to continue to be involved are; Human Resources, Finance, Territorial Services, Planning, Accountability and Reporting and the MH/A project. Senior management's support of the necessary coordination of project specific work has been beneficial and must be sustained to produce optimum results.

4. Performance measurement reporting is critical to the success of projects, particularly those with such a vast scope. However, it must be noted that there is a lack of vision with respect to "how" to report on such a project and how to express the data/outputs, etc.

It was incredibly helpful to have the support and guidance of the Department's Evaluation Specialist, in developing the 2003/04 RMAF and all that was entailed in setting up the reporting requirements. This is a critical area to any project and to have Jennifer Carey's leadership on this part of the project was invaluable and will continue to be as we develop similar RMAF's for successive years in the project.

Recommendation: A template or set of guidelines must be developed to assist in the performance measurement reporting. It was noted that this project's evaluation report was going to stand as a "pilot project" as far as formal performance measurement reports submitted, hence the challenges.

5. One of the most significant challenges in operationalizing the Community Counselling Programs in the regions and communities was hiring the new positions. Without these new positions filled with competent people there isn't a program. There were a multitude of factors related to the challenges of

filling the new positions, many of which have been discussed in this report. However, the classification process for these new positions, and ultimately the low pay levels, vastly underserved the magnitude and scope of responsibility of the clinical positions. Thus it has hampered recruitment efforts and has plagued HSSA hiring process.

The Project Team consulted with HR regarding the process of appealing job evaluation outcomes related to pay levels. HR explained a "request to review" pay levels would have to be forwarded to the Job Evaluation Committee. Further, the HSSA would have to substantiate and justify their request by showing similar positions already within their organization with similar responsibilities and their respective pay levels. HR indicated that the HSSA would have to forward their individual requests or submit a joint request representing all HSSAs. HR explained that the request could not come from with in the Department.

Recommendation: One of the program consultants from the Project Team lead the work around compiling all the HSSAs information (rationale/justification) and condense the material into one document and forward onto HR. The program consultant would need to work with the project HR lead, Hazel McKiel, to ensure that the necessary information was included.

APPENDIX 1

Mental Health, Addictions Logic Model
Year One – 2003/2004

Goal: To create a Mental Health and Addiction core service that assists those with a mental illness, addiction, or concurrent disorder so that they can receive the care and support they need to live in optimal health.

How?				Who?	What do we want?
Objective	**Task**	**Activities**	**Outputs**	Target Group	Immediate Outcomes
Build an appropriate staffing mix	Fill 45 Community Wellness Worker Positions	• Create competency profile for Community Wellness Worker positions • Develop Prior Learning Assessment Tool • Develop job description for Community Wellness Workers that incorporates competency profile • Evaluate job description and assign appropriate pay level • Prior Learning Assessments conducted for all Addiction Counselors and self-defined Family Violence Workers • Training modules developed in collaboration with Aurora College • Individualized Training Plans developed for all Addiction Counselors and self-defined Family Violence Workers based on Prior Learning Assessments	• Competency profile completed • Prior Learning Assessment Tool developed • Job description created and classified • Addiction Counselors and Family Violence Workers complete Prior Learning Assessments • Training modules developed • All Addiction Counselors and Self-identified Family Violence Workers develop individualized training plans	• All Addiction Counselors • Self-identified Family Violence Workers	45 Community Wellness Worker positions filled
	Fill 6 Community Mental Health Worker positions	• Create competency profile for Community Mental Health Worker positions • Develop job description for Community Mental Health Worker that incorporates competency profile • Evaluate job description and assign appropriate pay level	• Competency profile completed • Job description created and classified	• Qualified Mental Health Workers	6 Community Mental Health Worker positions filled
	Develop Clinical Supervisor Positions	• Create competency profile for Clinical Supervisor positions • Develop job description for Clinical Supervisor position that incorporates competency profile • Evaluate job description and assign appropriate pay level	• Competency profile completed • Job description created and classified	• Qualified Clinical Supervisors • Community Wellness Workers • Community Mental Health Workers	5 Clinical Supervisor Positions filled
	Develop Regional Transition Plans	• Develop a Regional Transition Plan • Schedule and conduct meetings with Authorities to discuss development and implementation of Regional Transition Plans • Each H&SS Authority flags their unique requirements for implementing Transition Plans	• Regional Transition Plans developed • Meetings conducted with each H&SS Authority	• H&SS Authorities • Regions/ Communities	H&SS Authorities complete Transition Plans specific to the unique needs of their Region

Mental Health, Addictions Logic Model
Year One – 2003/2004

Goal: To create a Mental Health and Addiction core service that assists those with a mental illness, addiction, or concurrent disorder so that they can receive the care and support they need to live in optimal health.

How?				Who?	What do we want?
Objective	**Task**	**Activities**	**Outputs**	Target Group	Immediate Outcomes
Obtain an appropriate funding level	Increase O&M funding	Adequate funding	Funding covers essential basic shelter necessities	• Family Violence Shelters • Family Violence Workers	• Balanced budgets
Communicate changes associated with the Mental Health and Addiction core service	Develop Territorial Plan	• Provide Authorities with materials and resources that will aid them in communicating the changes • Department develop Territorial Communications plan that will inform public about the changes associated with the core service	• Authorities are provided with the materials and resources • Territorial Communication Plan developed by the Department	• Department of Health and Social Services • H&SS Authorities • Stakeholders of the H&SS system • Residents of the NWT	• Consistency between what the Health and Social Services Authorities communicate and the Departmental Communication plan

APPENDIX 2 Mental Health, Addictions Performance Measurement Strategy

Objective	Task	Outputs	Performance Measure/Indicator	Data Source/Collection Method	Timing/Frequency of Measurement		
					Ongoing	Process Evaluation	Outcome Evaluation
Build an appropriate staffing mix	Fill 45 Community Worker Positions	Competency profile completed	Timeline: 01 March 2003	Project Manager, Mental Health and Addiction Core Service	√	√	
		Prior Learning Assessment Tool developed	Timeline: 01 April 2003	Project Manager, Mental Health and Addiction Core Service	√	√	
		Job description created and classified	Timeline: 01 April 2003	Human Resources	√	√	
		Addiction Counselors and Family Violence Workers complete Prior Learning Assessments	Timeline: 15 July 2003	Project Manager, Mental Health and Addiction Core Service	√	√	
		Individualized training plans are administered to Addiction Counselors and Family Violence Counselors	Timeline: 01 September 2003	Project Manager, Mental Health and Addiction Core Service	√	√	
	Fill 6 Community Mental Health Worker positions	Competency profile completed	Timeline: 01 April 2003	Human Resources	√	√	
		Job description created and classified	Timeline: 01 April 2003	Human Resources	√	√	
	Fill 5 Clinical Supervisor Positions	Competency profile completed	Timeline: 01 April 2003	Human Resources	√	√	
		Job description created and classified	Timeline: 01 April 2003	Human Resources	√	√	
	Develop Regional Transition Plans	Regional Transition Plans developed	Timeline: 01 April 2003	Project Manager, Mental Health and Addiction Core Service	√	√	
Obtain an appropriate funding level	O & M funding increased	O & M funding increased	Timeline: 01 April 2003	Financial Services Division, Department of Health and Social Services	√	√	

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