



**GOVERNMENT OF NORTHWEST TERRITORIES
DEPARTMENT OF HEALTH AND SOCIAL
SERVICES ASSESSMENT AND REVIEW OF
WITHDRAWAL MANAGEMENT SERVICES**

FINAL REPORT

MARCH 31, 2014

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1. BACKGROUND

1.1 PURPOSE OF THIS REVIEW

The purpose of this project is to identify viable options for withdrawal management services in the NWT. It is essentially a comprehensive needs assessment that must consider the varied needs in different communities. The following review questions are based on the initial request for proposal as articulated in the detailed review plan and were used to gather information to carry out this review.

1. What medical and social withdrawal management services are currently offered in the NWT Health and Social Services System?
2. To what extent are these services consistent with successful withdrawal management programs and protocols, looking at small, medium and large isolated communities within Canada?
3. What is the gap between what is needed and what is available?
4. What program and protocol options are feasible in the NWT?
5. What is the NWT's ability to provide the options safely?
6. What are the recommended addictions continuum of care options including withdrawal management programs for three 'levels' of programming: withdrawal management in small isolated fly-in communities, regional-level withdrawal management programs and territorial withdrawal management programming?

1.2 LIMITATIONS OF THE REVIEW

The NWT is seeking options with risk assessment tools and depiction of the pathways within the continuum of care that are consistent with the Department's *Integrated Service Delivery Model*¹ and reflect the realities of the current context. Some of the factors that we were asked to consider in the development of options include:

- The realities of the NWT such as vast distances and low population densities.
- The planning of withdrawal management services needs to occur within the existing resources. Consequently options are limited to reallocation within the system or solutions to which there is no cost attached.
- The services should be consistent with the Integrated Service Delivery Model, the framework which services as the foundation for all health care planning in the NWT.
- The services are consistent with Shared Path Towards Wellness Report – Mental Health and Addictions Plan.

¹ Northwest Territories Health and Social Services (March 2004) Integrated Service Delivery Model for the NWT Health and Social Services System

Although all of the review questions were addressed in the research we conducted, the reality of the NWT's small population with approximately half of the people located in Yellowknife and the remainder dispersed across the territory only allows for a very limited means of addressing the issue unless the GNWT is able to take a more integrated approach that places withdrawal management services within the broader context of addiction services, health care services and healthy communities. All northern Canadian communities struggle with the issue of addiction and only those that have taken a more holistic approach have begun to see progress. Increasing withdrawal management services on its own will be extremely costly and contribute in only a minor way to addressing the issues of addictions.

Consequently, this report looks at best practices, assesses the current NWT withdrawal management services against those best practices and provides options for improving withdrawal management practices. The report moves beyond looking at withdrawal management services in isolation.

1.3 OVERVIEW OF THE REVIEW METHODOLOGY

Information for this report was gathered through three primary means:

1. **Document review** contributed to a better understanding of what exists in the NWT, the needs of the various populations and communities and the desired direction for withdrawal management services, based on the strategic direction for health services overall. The information from the documents was organized by research question. The analysis will draw emerging themes related to each of the questions and provide specific information regarding the current usage of services and plans related to the addictions system. A list of the documents reviewed is attached in Appendix A.
2. **Literature review** provided information regarding best practices in withdrawal management, standards, practices and protocols being used across Canada. A list of the literature reviewed is attached in Appendix B.
3. **Key informant interviews** were conducted with people knowledgeable about the addictions system in the NWT and/or knowledgeable about best practices in withdrawal management services. Additionally interviews were conducted with some current users of the Salvation Army withdrawal management services located in Yellowknife.

1.4 DEFINING WITHDRAWAL MANAGEMENT SERVICES

Throughout this report the following definitions of withdrawal management services will be used.

Withdrawal Management includes support provided while a client is in withdrawal from alcohol and/or drugs and assistance in determining the next steps towards treatment, based on the wants and needs of the individual.

Medical Withdrawal Management is required when there are complications, such as an existing medical condition or seizures causing the person to require medical supervision during the withdrawal. It frequently involves medication management. Most withdrawal management does not require medical support and an individual can often move to non-medical support once the medical crisis is over.

Detoxification (detox) is the process during which harmful substances leave the body. If a substance dependency or addiction exists, the withdrawal will occur and may need to be managed. The terminology ‘detoxification services’ is often used synonymously with withdrawal management services.

Non-medical Residential Withdrawal Management is for people who are intoxicated or in severe withdrawal from alcohol and/or other drugs, whose usual place of residence or home environment is not conducive to recovery and who are assessed to be suitable for non-medical withdrawal. It includes supervision and monitoring to ensure the person does not need medical support. It involves helping the individual to be as comfortable as possible. Once the withdrawal process is complete, the services also support the individual in planning for treatment. Non-medical withdrawal management is often referred to as **social detoxification** in the Northwest Territories

Home Withdrawal Management is for people who are intoxicated or in severe withdrawal from alcohol and/or other drugs, whose usual place of residence or home environment is conducive to recovery and who are assessed to be suitable for non-medical or social withdrawal management. It includes supervision and monitoring to ensure the person does not need medical support. It involves helping the individual to be as comfortable as possible. Such individuals may attend community or day withdrawal programs once they have passed the crisis stage.

Mobile Withdrawal Management refers to when a team goes to the location of a person in withdrawal and provides the necessary service. The team would provide non-medical or social withdrawal management, referring to a hospital if necessary.

1.5 THE POLICY CONTEXT

In March, 2004, the Northwest Territories (NWT) Health and Social Services Department adopted an Integrated Service Delivery Model² (ISDM) which established three levels of service delivery: territorial support services, regional support services and primary community care with collaborative processes and procedures for clients and family. Addiction services at the community level varied among communities with a variety of mechanisms including community addiction programs, assessment, and referral services to residential addiction treatment programs. Services at a regional level included residential treatment services for children and counselling centres. Residential addictions treatment services were offered at a territorial level in Hay River, which has since closed. The ISDM noted that detoxification protocols would be adopted and provided in hospitals in Yellowknife, Hay River and Inuvik.

The 2012 – 2015 NWT Mental Health and Addictions Action Plan³ established four overarching goals. Pathways to Wellness: An Updated Action Plan for Addictions and Mental Health 2014 - 2016 (February 2014) reviewed progress to date and set out additional actions related to each of the four goals. This updated plan continues to promote an integrated approach to planning with a focus on community wellness. The following are some of the planned actions related to addressing addictions.

- **Promote understanding and awareness** by working with regional Health and Social Services Authorities (HSSA) to facilitate inter-agency professional development events focused on youth addictions issues, involving health professionals, education professionals, youth workers, justice officials, and others to share best practices and approaches.
- **Focus on the person** by defining care pathways, standardizing position roles and responsibilities and developing protocols for referring and supporting clients through traditional healing and other culturally appropriate programs. This includes revising the Community Counselling Program Standards and Procedures Manual. It notes that the Global Appraisal of Individual Needs – Short Screener (GAIN-SS) will be included as a standard within the revised Community Counselling Program. This is not a withdrawal assessment tool, rather it is a tool to screen a general population for behavioural health disorders in order to determine whether the use of the full GAIN tool would be appropriate.
- **Improve availability of and access to services** through a number of activities including the review of the withdrawal management services.
- **Improve the effectiveness of services** through a number of activities such as provision of training and the improved use of assessment tools.

² Northwest Territories Health and Social Services (March 2004) Integrated Service Delivery Model for the NWT Health and Social Services System

³ Northwest Territories Health and Social Services (June 2012) 2012 – 2015 A Shared Path Towards Wellness

2. REALITIES OF THE NWT

The need for services and the actual demand for services can be different. This section looks at potential service demand, based on the information available on the prevalence of addictions and the current demand on the system.

Prevalence of Addiction in NWT

Determining the prevalence of addictions in the NWT is challenging because the Canadian Addiction Survey Report and the Northwest Territories Addiction Report indicate use and use which causes harm, which is not the same as reporting on the prevalence of addictions. It does not cover severity, acuity, complexity and chronicity which are necessary to gain a full understanding of potential demand. The Northwest Territories Hospitalization Report⁴ indicates that approximately 430 individuals were hospitalized 615 times with alcohol and drug-related issues, resulting in 3,250 bed days annually, costing \$7.5 million annually. Alcohol or drug use was the primary issue for between 37% and 50% of those patients. The remainder had alcohol or drug use as a secondary issue. Alcohol abuse was the diagnosis in 89% of the patients. Crack/cocaine abuse was the diagnosis in 9% of the patients. Approximately 20% of patients with alcohol and drug related issues, also suffered from a concurrent (additional) mental health disorder such as depression, schizophrenia, or anxiety disorders.

Table 1 indicates the percentage of Canadians and NWT residents, fifteen years of age or older who report using illicit drugs.

Table 1: Percentage of Canadians 15+ Reporting Use of Illicit Drugs

	CAD 1994	CAS 2004	CADUMS 2011	NWT 2009
Lifetime				
Overall	28.5%	45.0%	40.9%	24%
Male	33.6%	50.6%	47.3%	30%
Female	23.5%	50.6%	34.8%	17%
Past Year				
Overall	7.6%	14.4%	9.9%	na
Male	10.1%	18.5%	13.0%	na
Female	5.1%	10.0%	6.9%	na

(sources: Canadian Addiction Survey Report⁵, Canadian Alcohol and Drug Use Monitoring Survey⁶, Northwest Territories Addiction Report⁷)

⁴ Northwest Territories Department of Health and Social Services (April 2013) Northwest Territories Hospitalization Report

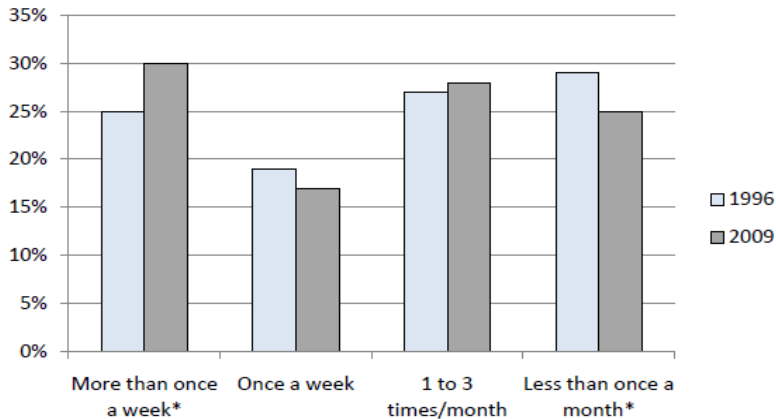
⁵ Health Canada (March 2005) Canadian Addiction Survey Prevalence of Use and Related Harms

⁶ http://www.hc-sc.gc.ca/hc-ps/drugs-drogués/stat/_2011/tables-tableaux-eng.php#t1

⁷ Northwest Territories (2009) NWT Addictions Report, Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories

The Northwest Territories Addiction Report⁸ indicates that frequency of alcohol consumption has been increasing from 1996 through 2009 as has the percentage of drinkers that consume five or more drinks at a time. This is shown in *Figures 3 and 4*.

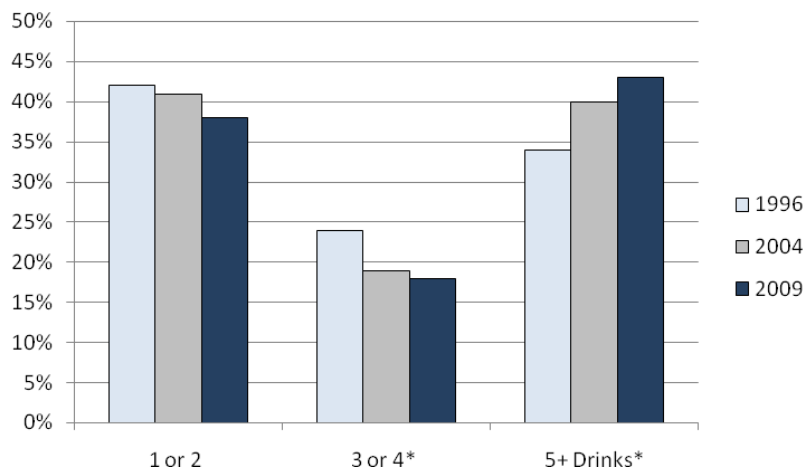
Figure 3: Overall trends in the frequency of drinking among current drinkers aged 15+⁹



* Significant difference at the .05 level between 1996 and 2009.

Source: Northwest Territories Addiction Report

Figure 4: Overall trends in the usual number of drinks consumed on a single occasion among current drinkers 15+¹⁰



Source: Northwest Territories Addiction Report

The report indicates that more males than females consume alcohol and that while more younger people consume alcohol, over 35% of people over 60 years of age continue to drink. In 2009, 23% of current drinkers aged 15 and over reported at least one type of

⁸ Northwest Territories (2009) NWT Addictions Report, Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories

⁹ Northwest Territories (2009) NWT Addictions Report, Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories

¹⁰ Northwest Territories (2009) NWT Addictions Report, Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories

harm as a result of drinking including harmful effects on friendships or social life (14%), physical health (10%) and home life or marriage (8%)¹¹. More of the Aboriginal population (~40%) reported experiencing harm from their own drinking than did non-Aboriginal people (~8%). It is important to keep in mind that these statistics are based on self-reporting so are likely to be conservative. Reporting of harm as a result of someone else's drinking was much higher with over 50% reporting at least one or more harms.¹²

Chalmers and colleagues¹³ reported that drug usage patterns in the NWT are “changing and being influenced by improved economics, drug availability, mainstream societal acceptance, and media pressures/influences for experimentation”. They indicate that drugs of concern include cocaine, crack cocaine, crystal methamphetamine, ecstasy, and heroin. However, as indicated in *Figure 5*, there is no evidence to support this concern.

The use of some illicit drugs is increasing, with the primary increase occurring with hallucinogens, as indicated in *Figure 5*. In 2009, 27% of drug users reported experiencing at least one type of harm such as harm to physical health (12%), harm to work or education (11%), and harm to friendships or social life (9%). As with alcohol, these are self-reported so are likely somewhat conservative estimates.

Figure 5: Prevalence of cocaine/crack, hallucinogens, speed, ecstasy and heroin ‘ever used in lifetime’ among residents 15+

Type (%)	1996	2004	2006	2009	Trend
Cocaine/Crack	10	12	11	11	n.s
Hallucinogens	14	12	12	20	*
Speed	6	3 ^E	3	3	-
Ecstasy	..	3 ^E	4	6	-
Heroin	1 ^E	1 ^E	F	1	-

^E Moderate sampling variability - interpret with caution.

^F High sampling variability - data was suppressed.

.. Data not available.

* Significant difference at the .05 level; n.s not significant; - No significance test.

Source: Northwest Territories NWT Addictions Report

Because not all users are addicted, it is difficult to extrapolate the demand for withdrawal management services from these figures.

¹¹ Northwest Territories (2009) NWT Addictions Report, Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories

¹² Northwest Territories (2009) NWT Addictions Report, Prevalence of alcohol, illicit drug, tobacco use and gambling in the Northwest Territories

¹³ Chalmers, Jennifer H., Liz Cayen, Cheryl Bradbury and Sharon Snowshoe (2005) Stay the Course and Together we can Secure the Foundation that has been Built: An Interim Report on Mental Health and Addictions Services in the NWT

Challenges in Estimating Service Demand

Determining the actual service demand is challenging because not everyone in need of services will seek help. However, it is important to get some idea of demand because estimating the percentage of people at different levels of risk and harm who will seek some form of assistance provides an empirical basis for making decisions about operationalizing and resourcing the appropriate mix of addiction services.

The following information was used to look at estimates for demand for the Northwest Territories, for this report:

- The Northwest Territories Hospitalization Report and people who provide addiction services indicate that alcohol abuse is by far the most prevalent type of substance abuse (89%) with crack/cocaine being about 9%.
- The Northwest Territories Addiction Report (2009) indicates:
 - In the 12 months prior to the 2009 addiction survey, 77% of the NWT residents 15 years and older reported they consumed alcohol.
 - That 30% of these current drinkers consume alcohol more than once a week and 43% consume more than five drinks on any single occasion.
 - That 23% of current drinkers aged 15 and over reported at least one type of harm as a result of their drinking.
 - Around 51% of the NWT population 15 and over experienced at least one type of harm from someone else's drinking.

One of the first steps in the treatment process is generally withdrawal management which occurs prior to treatment and ideally allows the individual the opportunity to detoxify in a safe environment and develop a treatment plan. It is important to remember that often an individual's motivation for seeking withdrawal management services is not 'contemplating change'¹⁴ but is motivated by other factors such as illness or getting out of the cold. Even for those people, a welcoming withdrawal management environment provides that initial opportunity for contact and may help move a person from 'pre-contemplation' to 'contemplation' (based on Prochaska and DiClemente's Stages of Change Model attached in Appendix C). The Stages of Change Model has been widely used with addiction and other medical conditions to identify motivational interview techniques that have been demonstrated to work at the various stages of change.¹⁵ Although it is not possible to ascertain the exact number of NWT residents that may seek withdrawal management services, it is safe to assume it would be a very small number which would not allow for any economies of scale in planning.

¹⁴ Prochaska, James and Carlo DiClemente (1983) Stages of Change Model

¹⁵ http://www.cellinteractive.com/ucla/phycian_ed/stages_change.html

3. THE NWT CURRENT WITHDRAWAL MANAGEMENT SYSTEM

3.1 COMMUNITY-LEVEL SERVICES

Community mental health and addictions care includes screening, assessment, referral, support during withdrawal management and follow-up and aftercare support. The NWT Community Counselling Program Mental Health and Addiction Counsellors and nurses are the primary health and social services providers in medium-sized and smaller communities. They also serve larger communities such as Yellowknife. They provide addiction screening, assessment, counselling and referral. The counsellors may travel to smaller communities in their region as well. In many instances they may be the person who supports individuals going through detoxification and withdrawal. They can make referrals to Poundmaker's Lodge, Fresh Start, or Aventa, the treatment services located in Alberta and used by the GNWT's Department of Health and Social Services. While usually the withdrawal management process needs to be completed by the time a referral is made, in some instances, individuals arrive in Alberta needing withdrawal management services. They are either provided by the treatment centre or referred to a withdrawal management service in Alberta.

Health care workers such as nurses located in health centres are the other primary resource at the community level. Their knowledge of addictions including withdrawal management varies.

Key Issues

Services available in communities differ substantially depending on the size of the community. Approximately half of the 43,500 people in the NWT live in Yellowknife, about a quarter live in communities that range from about 1,250 to 3,500 people, and the remaining quarter live in 27 communities ranging in size from about 50 to 1,000 people.

Yellowknife is the best serviced community with the population having easier access to services. For example, the Salvation Army, funded by Yellowknife Health and Social Services Authority (YHSSA), provides withdrawal management services with six withdrawal management beds, four for men and two for women. The Tree of Peace Friendship Centre, also funded by YHSSA, provides addiction screening, assessment, counselling, and referral services. Both services are intended to serve the Yellowknife area. Yellowknife also has a number of other services, such as the Yellowknife Day Shelter or Bailey House, that might refer an individual for withdrawal management services and/or provide support after a person has completed withdrawal. Within Yellowknife, methadone treatment is available, while it is not possible in most communities because of the lack of medical supervision available.

A few people who were interviewed expressed concern that too often the RCMP or local police are the first point of contact, particularly if the person is being disruptive. Those

who raised this concern indicated RCMP often are obliged to keep people in a jail cell, which is not a suitable environment for withdrawal management.

The lack of knowledge regarding withdrawal management and the immediate supports that are needed was also a concern expressed by some of the front-line service providers and managers.

3.2 REGIONAL LEVEL SERVICES

At a regional level, Clinical Supervisors provide clinical support and supervision of the Mental Health and Addiction Counsellors and the Community Wellness Workers. There is one Clinical Supervisor for each region.

As noted previously, the Salvation Army and the Tree of Peace most immediately serve the Yellowknife community providing residential withdrawal management and counselling. Inuvik has developed a system which makes use of the Mental Health and Addiction Counsellors as well as the nurses in the community. They work with the individual to find a safe place to go through withdrawal. This may include two to three days in hospital, with the remainder of the process occurring in the community.

Hospitals, located in Inuvik, Hay River and Fort Smith provide withdrawal management services at a regional level. The Stanton Territorial Hospital in Yellowknife also serves the Yellowknife region. People frequently seek help from hospitals, either for symptoms related directly to substance use or withdrawal or because of an injury related to substance use. The emergency department in these regional facilities are often the first point of contact for someone needing addiction services.

3.3 TERRITORIAL LEVEL SERVICES

The Stanton Territorial Hospital will admit patients for detoxification and medical management of withdrawal symptoms. They use a medical model for withdrawal, providing medication to ease the symptoms. One of the challenges faced by the hospital is that people who come in for medical treatment other than addiction frequently go into withdrawal because alcohol is not available to them.

Both the Salvation Army and Tree of Peace indicate that because people from small communities migrate to Yellowknife that they, in fact, provide withdrawal management services for the territory. However, they are not funded to be a territorial level service and only provide services to individuals who are actually within their regional boundaries.

4. CONSISTENCY OF THE NWT WITH BEST PRACTICES

4.1 BEST PRACTICES

The literature on best practices points out the need to have an integrated system that is supported by policy, principles, standards, appropriate staff qualifications, appropriate service design and effective client care practices. These are discussed in this section.

Policy Framework

Best practices for developing a policy framework are an integrated comprehensive approach that links all parts of the system to each other as well as linking to other systems that serve the same population including the rest of the health care system, housing, criminal justice and social services. The policy framework needs to consider the full range of services that might be provided and allow for flexibility in order to meet the varying needs of communities. The diagram, Figure 6, on page 14 provides an overview of a comprehensive system.

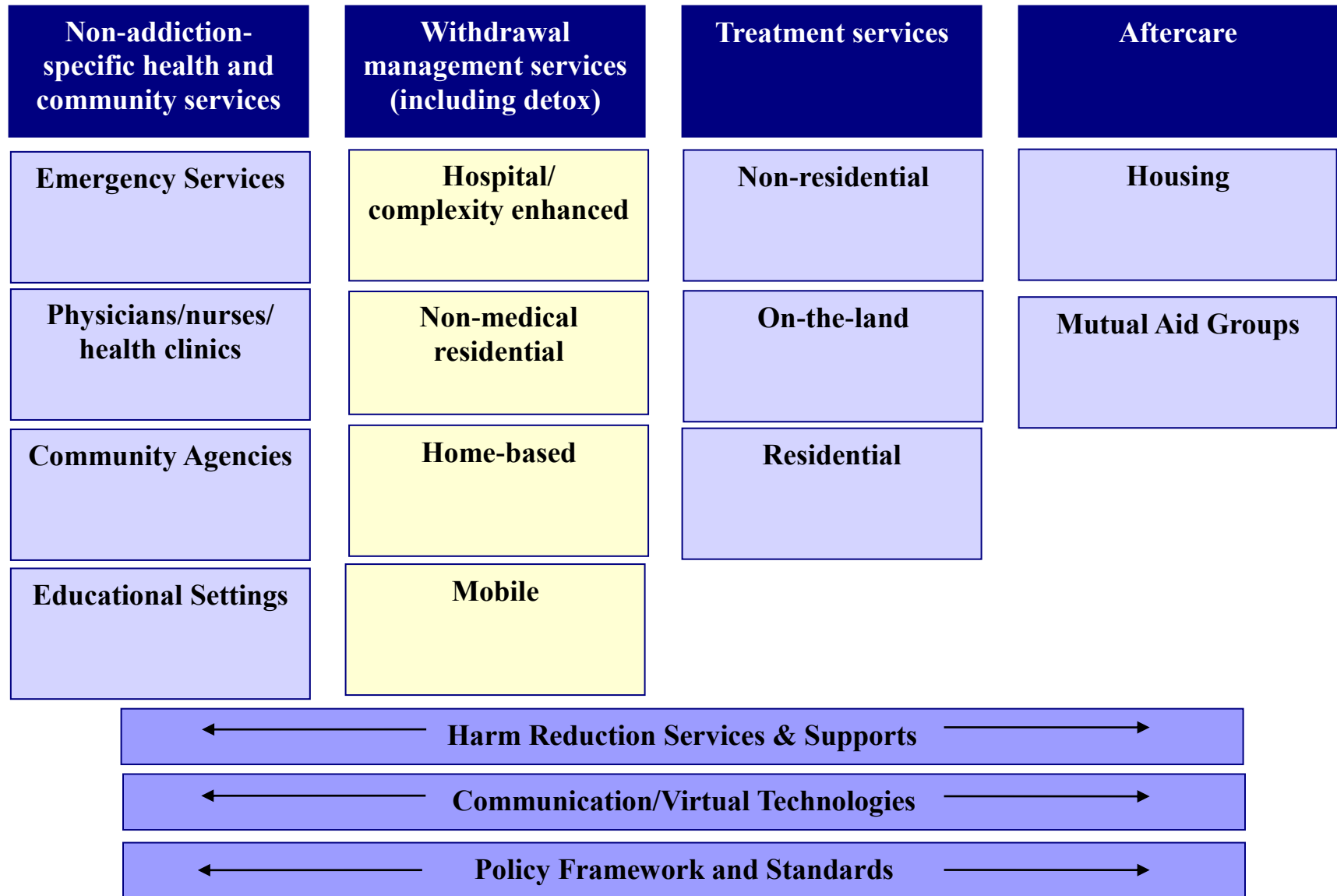
Principles

Recognizing the complexity of assessing need and planning services that respond to that need, Rush¹⁶ has developed a number of principles:

1. Substance use and related problems **exist along a continuum** which includes severity, acuity, complexity and chronicity.
2. A **broad systems approach** is needed in order to address the range of substance use and related problems in the community, including severe substance use problems, and achieve a population-level impact with treatment programs needing to connect to a range of other systems including schools, criminal justice, self-help groups, primary care, internet supports, drinking and driving programs, workplace programs, harm reduction programs, mutual help groups, emergency services and general medicine making the system accessible through the full broad range of entry points.

¹⁶ Rush, Brian (2013) Unpublished document

Figure 6: Comprehensive Addiction System Components



3. Accessibility and effectiveness of services for people with substance use problems are improved through **collaboration across multiple stakeholders** in order to be better equipped to support people with complex conditions, have improved access to services, promote earlier detection and intervention, provide integrated care, improve continuity of care, have more satisfied health care consumers, improve client outcomes and reduce costs.
4. **Prevention and health promotion policies and services** should be planned along with treatment and support services, viewing health as a “state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”¹⁷. This requires considering the social and physical environment, the biology of the individual, opportunities and constraints, and human behaviour.
5. **A core, universal set of service and support functions are needed** to adequately serve those at different levels of risk and need including health promotion and prevention, harm reduction, early identification and intervention, outreach, case management, assessment, delivery of specific bio-psycho-social-spiritual interventions and supports, delivery of integrated psychosocial medical and psychiatric interventions and supports and continuing care and recovery monitoring. **Proactive systematic screening** is necessary to improve detection and access to required services, taking into account the stage of development of the individual and the level of client engagement. This has become easier with the development of screening tools that are relatively easy to use.
6. **A staged approach to assessment** is required to ensure comprehensive exploration of strengths and issues and to connect the person to the right level of care with the development of a client-centred, individualized treatment plan.
7. Once an individual is placed in the initial level of care **more detailed assessment**, conducted through semi-structured interviews, is required to match an individualized treatment plan with the right mix and duration of psychosocial and clinical interventions ensuring the treatment is grounded in the present context of the person’s life situation.
8. The **strength of the therapeutic relationship** is important with the relationship emphasizing empathy, warmth, acceptance, problem-solving, encouraging risk taking, communication and trust building.
9. People and their families receiving the service they require when **transitioning from one service or sector to another** as part of their treatment and support plan in order to ensure continuity of care and to be able to monitor outcomes.
10. **A wide range of systems supports are needed to support the effective delivery** of services including policy, leadership, funding, performance measurement and accountability, information management and research and knowledge exchange.

¹⁷ <http://www.who.int/about/definition/en/print.html>

11. **Age/developmental considerations and a range of equity and diversity issues** are critical to effective treatment design recognizing that the needs of adolescents, adults and older adults are different.
12. The different **Aboriginal peoples have unique strengths and needs** with respect to substance use and related problems. This population would benefit from services and support that blend principles and practices of non-indigenous people with those based on traditional healing, taking into account the economic conditions in their communities, their health status, and the strengths of their traditional teachings.¹⁸
13. **Harm reduction** includes the full-range of treatment options including abstinence, substance use management and life style management. It allows for a client-centred individualized approach to treatment planning, creating a situation where the harm related to addiction is reduced and the person is better able to move towards a life where substances no longer interfere with wellness.

Standards

Addictions Ontario has developed one of the most comprehensive sets of standards in Canada. It was developed by a committee consisting of managers of withdrawal management services, supported by a project consultant and project coordinator and included broad consultation with key stakeholders. It is interesting to note that in Ontario withdrawal management services are designated as provincial services, hence do not serve a specific catchment area within Ontario. They are also supported by a central provincial help line that tracks the availability of beds and directs anyone seeking withdrawal management to the closest available bed.

The standards were developed to support best practice, recognizing that some agencies would have difficulty meeting such high standards. The approach in Ontario has been to set out the goals to be achieved, then develop a transition plan to reach those goals. Hence, in this case, standards represent best practices rather than minimum requirements.

The standards cover the following types of withdrawal management services:

- Residential withdrawal management services are provided in facilities with beds dedicated solely for this purpose. Service is available on a 24/7 basis. The services are sponsored by a hospital, giving them immediate access to hospital services should it be required.
- Community withdrawal management services are provided by a mobile team that goes to the client.

¹⁸ Brian Rush, Unpublished document

- Day withdrawal management services are frequently provided as an adjunct to residential services, allowing the individual to participate in programming without residing in the facility.
- Telephone withdrawal management services are provided to those supporting a person going through withdrawal in their own home or other safe place.

For each type of withdrawal management services, standards are provided for administration, program design, client care, staff education, and physical plan and structure.

Staff Qualifications

The Ontario withdrawal management standards include education of staff, orientation of new staff, and ongoing professional development standards. It notes that the addiction field is complex with new findings regarding effective treatment occurring as ongoing research continues.

The minimum education requirement for Ontario withdrawal management services staff is a two-year post-secondary diploma in a Health or Human Service Program, complemented by addiction studies. A newly hired staff person should have demonstrated knowledge in:

- | | |
|--|---|
| • Cultural sensitivity and inclusivity | • Group dynamics |
| • Theories of addiction | • Stages of change |
| • Fundamental concepts of addiction | • Motivational interviewing |
| • Treatment approaches and modalities | • Trauma as it relates to addictions |
| • Pharmacology relevant to withdrawal management | • Admission and discharge tools |
| • Self-help groups | • Relevant best practices |
| • Relapse prevention | • Behaviour management |
| • Harm reduction | • Mental health issues |
| • Effective withdrawal management | • Models of withdrawal management |
| | • Computer skills |
| | • Recognition of signs and symptoms of impairment |

The mandatory training for staff includes C.P.R., first aid, non-violent crisis intervention, and Core Knowledge and Skills for Withdrawal Management or Integrating a Concurrent Disorder Approach to Withdrawal Management.

Supervisors and Coordinators are expected to have a Bachelor Degree in a health or human service discipline and three years' clinical experience in the addiction field. Required competencies include:

- Leadership skills

- Interpersonal communication skills
- Problem solving skills
- Staff management/supervision skills
- Organizational skills
- Diversity management
- Clinical supervision

For residential and community services, there should be adequate housekeeping, dietary, clerical and maintenance staff who are sensitive to the needs of people going through withdrawal.

Service Design

Approximately 20 – 40% of individuals in need of withdrawal management services require a residential setting such as a specialized withdrawal management centre or hospital unit and approximately 60 – 80% of people can benefit from service provided at several different levels of care depending on the needs of the patient¹⁹. Lower levels of care include home detoxification and office based outpatient services.

Withdrawal management services at mid-level of care includes residential services with non-medical staff. Higher levels of care include residential services that are medically supervised and residential services that are medically managed. The following outlines eight levels of withdrawal management services²⁰:

1. At home, with family or friends providing ongoing monitoring;
2. At home, with a volunteer providing 24 hour monitoring during physical withdrawal;
3. At home, with periodic medical supervision, with or without volunteer monitoring;
4. At a friend's or volunteer's home, with or without periodic medical supervision;
5. Residential withdrawal management in a social or non-medical setting; and
6. Outpatient/day withdrawal management to which clients travel;
7. Outpatient/day withdrawal management which travels to clients; and
8. Residential withdrawal management in a hospital setting.

Options one through four use the home environment to deliver withdrawal management services and may not require ongoing regular visitation by the home detox team. Some of the services may be delivered through phone contact, Internet (with or without video) or a local family physician as well. Option five is a model whereby clients come to the site office where the home detox team is located to get services and support. Options six and seven are models whereby the home detox team travels to the client where they are

¹⁹ Stockwell, T. (Oct 2005). *The relative cost-effectiveness of community-based and inpatient hospital care for people with substance use problems and dependence*. Brief prepared for the Standing Senate Committee on Social Affairs, Science and Technology Inquiry into Mental Health and Addictions

²⁰ Fraser Valley Health Authority. Research into levels of care for withdrawal management

staying and on a much regular basis than options one to four. “Home” can be defined as the client’s, a friend’s or a volunteer’s or could involve the use of addictions short term stabilization beds. Medical management can be delivered through the co-operation of a family doctor, a sessional physician or a nurse. The addition of a health care worker to this team can have added benefits.

The following table shows a set of criteria to determine the type of service required based on the assessment of the individual.

Table 2: Criteria for Assessing Appropriate Withdrawal Management Service

Home/mobile/ambulatory criteria	Hospital or specialist criteria
No severe or complicated withdrawal is anticipated	Simultaneous dependence on alcohol or other drugs that would satisfy the criteria for hospital admission
No medical complications requiring close observation or treatment in a hospital setting are evident	Severe dependence such that complicated withdrawal is anticipated
Psychiatric symptoms such as psychosis or depression are able to be safely managed in a community setting	Serious medical complications requiring close observation or treatment in a hospital setting are evident
Client has strong social supports (family members and caregivers require education & support themselves)	Significant psychiatric complications, specifically psychosis symptoms or severe depression and/or suicidal ideation that pose significant risk to the person or others & cannot be adequately or safely managed in a community setting
Has a drug-free supportive & stable “home” environment	The person has had multiple previously failed attempts at ambulatory detoxification

Client Care Practices

Client care starts with the underlying philosophy that drives the care and includes such things as:

- Clients are to be treated with respect, dignity and autonomy
- Individual needs are to be recognized
- Clients are full partners in their care
- Safety is a primary consideration in the delivery of care and the care environment
- Client care adheres to the standards of professional practice governing the care providers

Care practices include the procedures for assessment, screening, admission, client orientation (including client rights), monitoring, ongoing assessments, supports, documenting, crisis management, preparation for treatment, development of a therapeutic

plan, discharge and follow-up. This varies somewhat, depending on the type of withdrawal management services.

The Ontario addiction service system uses a number of assessment tools²¹ to determine client needs, including:

- The Psychoactive Drug History Questionnaire
- The Adverse Consequence of Substance Use Questionnaire
- The SOCRATES (measures readiness for change)
- The Treatment Entry Questionnaire
- The Drug-Taking Confidence Questionnaire (DTCQ-8)
- The Behaviour and Symptom Identification Scale (BASIS-32)
- The Perceived Social Support Tool
- The Health Screening Form
- Withdrawal Assessment of Alcohol scale (in Appendix D)

One of the significant changes in client care practices is the use of motivational counselling techniques. These include:

- Validation of the individual's level of readiness for change
- Clarification that decision-making rests with the individual
- Encouraging self-exploration and looking at own behavior
- Explaining and personalizing risk
- Encouraging behavior change
- Encouraging new and positive outcome expectations
- Assisting with problem-solving
- Helping the individual identify emotional supports
- Verifying the individual's ability to change
- Supporting small initial steps
- Bolstering self-efficacy for dealing with obstacles
- Combating feelings of loss

4.2 EXAMPLES FROM OTHER COMMUNITIES

This section provides a number of examples of communities and the ways they have addressed withdrawal management. Each section provides a brief overview, an indication of how well it is working and indication of similarities to and differences from the NWT. Many of the examples are from Ontario because it has one of the oldest and most developed addiction systems in Canada.

²¹ Cross, Susan and Linda B. Sibley (2010) Admission and Discharge Criteria and Assessment Tools Manual (Revised), Centre for Addictions and Mental Health

Examples of Withdrawal Management Services (WMS)

Fraser Valley Health Authority - Riverstone

Two WMS options are provided within Riverstone. One is a home/mobile withdrawal management service which essentially involves taking the services and supports to the individual and his/her family whether that be in the person's home, the home of a family member or friend, a shelter, a support recovery facility or, in the case of youth, the home of a family that is participating in a family home-care model of withdrawal management. Thus, the appropriate places for withdrawal management to take place can vary and will depend on client needs and resources. Likewise, the length of the service varies from client to client, with an average of five to eight days per client to allow for both the detoxification and post-detox planning process.

The other alternative is the Daytox Program that is a six-week early recovery, intensive relapse prevention day program. Clients present to the program site but do not reside there during their program. Clients must commit to attend for six weeks, at least four hours per week. The program consists of educational support for withdrawal management, relapse prevention, group and individual counselling, family education and support, and referrals to appropriate community resources.

Inclusion criteria for people seeking the Riverstone home/mobile withdrawal services include:

- A safe and quiet “home” environment that is free from substance use
- Strong social supports, including the commitment of someone trusted and reliable who can give support through the withdrawal process
- No or low-risk of severe or complicated withdrawal
- No medical complications that require close observation or treatment in a hospital setting
- Psychiatric symptoms, if any, that can be managed safely in a community setting; and
- Commitment to the withdrawal process.

There is a close relationship with an existing residential withdrawal management centre (Creekside) suggesting the need for a continuum of withdrawal management and treatment resources that works well together. For clients whose withdrawal is too severe to be handled by the home/mobile team and for pregnant women, Creekside would be the designated site and transportation would be provided/supported by the home/mobile detox team. For clients already at Creekside, the home/mobile service interfaces with Creekside approximately 24 - 48 hours after a client is admitted and the team would begin to plan, along with the Creekside team, for the eventual return of the client to his/her home community. The home/mobile team continues to support and monitor the client during the last stages of his/her withdrawal. This reduces the number of bed days required at Creekside for some of these clients and can lessen the wait for other clients wanting to enter the facility. In addition to this, the home/mobile and daytox program offer the opportunity to provide education to the clients (including mini workshops on the weekend), and to family and other caregivers on a wide variety of essential topics

through the use of a compressed daytox program modelled after the existing one at Creekside.

Physician involvement is seen as critical and all services are provided under the oversight of a General Practitioner or Nurse Practitioner and with the support of a nurse and/or substance use service provider. Staffing consists of a nurse, a health care assistant (HCA), a program clerk as well as a physician. The physician conducts client medical needs assessment, prescribes relevant medications and remains available to the home/mobile detox team on a “needs only” basis for consultation.

Upon completion of the home detox or daytox program, a discharge summary is completed by the team outlining the client’s course of treatment as well as recommendations made to the client and family/support persons to access relevant supports along the continuum of care.

Fraser Valley has a population of 277,593 and only 6,726 are First Nations, so its demographics are quite different from the NWT. However, its well-developed mobile withdrawal management service that is closely linked to a residential withdrawal management service provides ideas that the NWT can draw upon, looking at the procedures that support safety and at the back-up services available.

Manitoulin Community Withdrawal Management Service (MCWMS)

Manitoulin is an island located in the Georgian Bay about a two hours’ drive from Sudbury, Ontario.

MCWMS provides support to clients voluntarily withdrawing from alcohol and/or other drugs. Clients may be residing at their home, the home of a significant other, or in another safe setting. MCWMS staff members also provide information and assistance to guide the support provider(s) supervising the "in-home" care. MCWMS offers three main components in managing withdrawal: intake and assessment, withdrawal management, and continuing care. A team will go out to an individual’s home, conduct an assessment and provide supervision during withdrawal. It operates using the Addictions Ontario Standards as well as the Admission and Discharge Assessment Tools. An assessment is made of the safety of the environment, using the checklist attached in Appendix E. MCWMS also provides telephone support to caregivers in the home once the team is no longer attending.

Manitoulin Island is similar to NWT in that many of the residents live in isolated situations without adequate transportation to reach services located in the larger communities. The population is 12,600 scattered in small communities across the island. There are two First Nations located on the island so the permanent population is largely Aboriginal. Both of the Aboriginal communities have been struggling to address substance abuse issues. It is different in that all communities are accessible by road. A withdrawal management facility is located in Sudbury and can be accessed by the residents.

Niagara Regional Women's Withdrawal Management Service

The Niagara Regional Women's Withdrawal Management Service is a 14-bed program located in close proximity to the hospital in St. Catharines. It is sponsored by the hospital and has direct access to hospital services and support. The centre provides crisis intervention, withdrawal management, rest, nutrition and hygiene restarts, assessments, supportive counselling and self-help groups, consultation, treatment referrals and discharge. Similar to other similar services in Ontario, the service is provided to a protected environment with access to non-clients restricted. During the first few days of withdrawal, the woman will spend most of the time in a quiet room where she can rest and is monitored. It was the first women-only withdrawal management service in Ontario. It provides a protected home-like environment with a stronger emphasis on helping the women feel safe. Many have been victims of abuse so the emphasis on safety is one of the first steps in the healing process. Similar services for men are provided a short distance from the women's facility. Both operate within the context of the Ontario Standards.

With a population of 131,400 in St. Catharines and over 390,000 residents in the Niagara Region the population served is substantially different than the NWT. The provision of gender-specific services is made much easier with a larger population base.

Sioux Lookout Meno Ya Win Health Centre

Sioux Lookout Meno Ya Win Health Centre (the local Sioux Lookout hospital) has a 5-bed medical withdrawal unit with nursing, counselling and medical care available. It is a secure unit with a "no visitors" policy. Criteria for admission include: 18 years of age or older, in need of medical help to withdraw from substances, and willingness to participate in a formal intake and admission process. The services include:

- Individualized supportive patient care
- Symptom management and treatment options
- Educational sessions and group work
- Addiction and mental health counselling in groups and individual sessions
- Discharge planning and assistance with referrals to treatment programs

Traditional support such as Elders and traditional healing medicines are available. On-going support is available by telephone to those completing the program. In addition, follow-up is conducted at two weeks, one month and six months. A strength of this program is the availability of traditional healing. However, while it may provide gender-specific programming, there is not a separation of men and women. It is part of the broader Ontario mental health and addiction service system.

Sioux Lookout is a community of 5,037 in northern Ontario. It is similar to the situation in Inuvik rather than the entire NWT because services located in Sioux Lookout are intended to serve a number of remote communities in northern Ontario.

Smooth Rock Falls Withdrawal Management Service

Smooth Rock Falls is a small community of 1,376 people in northeastern Ontario. Its withdrawal management centre serves both men and women and has 20 beds: four crisis beds, 10 detoxification beds and six residential support services which are fully utilized. It also provides a 24/7 crisis line, providing advice and support. The crisis beds are for individuals who are in crisis, intoxicated or in active withdrawal. Once an individual is stabilized they will move into a detoxification bed where assessment and planning processes can start. The program is non-medical and is sponsored by the local health centre and has access to hospital physicians in case of emergency.

This program is part of the broader Ontario mental health and addiction service system and expected to conform to the Standards. However, it serves both men and women without a clear distinction of gender-specific programming or separation of men and women. It is not necessarily a good example of best practices. Rather it is serving a relatively small population so makes compromises in order to do so cost-efficiently.

Smooth Rock Falls' population is quite different from the NWT in that despite being a small community it is located an hours' drive from Timmins with a population of 43,165.

Thames Valley Addiction Services

The Addiction Services of Thames Valley provides telemedicine to enhance community withdrawal management and crisis supports. It is medically focused with registered nurses and nurse practitioners supported by physicians. The community withdrawal management is an alternative to residential withdrawal for individuals who can safely withdraw from substances in a supportive community environment with low to moderate addiction and health needs. Typically, they do not require 24/7 medically managed withdrawal and have formal or informal supports in place. Support is provided through the use of telemedicine, telephone and face-to-face encounters. Telemedicine is the use of telecommunication and information technologies to provide clinical health care at a distance. The services provided include:

- Comprehensive assessment of needs
- Treatment planning
- Acute and post withdrawal assessment
- Case conferencing
- Multidisciplinary consultation
- Relapse prevention
- Community referrals
- Education

The program takes a client-centred harm reduction approach and provides services at any point in the withdrawal spectrum including pre-withdrawal, acute withdrawal and post-withdrawal. To be eligible, a client must be willing to enter the program, be 16 years of age or older, be accompanied by a support person for appointments, must be able to attend a site with the technology and must not be exhibiting aggressive or violent behaviour. Additionally, the individual needs to have a safe and supportive environment for withdrawal.

While the location of this service is significantly different than the NWT, the use of technology is worth exploring.

Yukon Territory

The Yukon Territory does not have a rural withdrawal management model. People in smaller communities either come to Whitehorse to the withdrawal management service, are treated in their local hospital if it is available, or are supported by a nurse in the Health Centre that is in each community. The 10-bed withdrawal management facility is located in Whitehorse. It uses a medical model staffed with nurses, recovery unit attendants and a social worker. As well there is a contracted physician who provides services three hours a day, two days per week. The admission criteria includes: willingness to voluntarily participate in services, be at least 16 years of age, be able to provide basic information on admission, be able to sign the admission consent form, and be willing to answer questions about personal medical history and substance use. The average length of stay is generally three to five days, but varies depending on the withdrawal symptoms, health status and treatment plans. A client who has been discharged must wait 24 hours before readmission. This medical model is relative new and currently being evaluated.

The Yukon Territory is similar to the NWT in that it has a small population and a large land mass. However, it is quite different in the way the population is distributed. While the NWT has half of its population living outside of Yellowknife, the Yukon Territory has only 31% of its population living outside of Whitehorse. It has fewer smaller communities than does the NWT and most have a road connection to Whitehorse. This makes planning of services far less challenging.

Non-withdrawal Management-Specific Examples

Some communities have not focused on addiction services specifically, but have taken a healthy communities approach to address addiction issues, with the intent of becoming a community where withdrawal management is not an issue.

Alkali Lake is a small Aboriginal community located about 600 km north of Vancouver. In 1973, the life-style of the community, which included alcohol abuse, was challenged by a newly elected chief. Although it did not happen immediately, the community began to move towards healthier lifestyles. Some of the key elements in the success of the community were the leadership, the readiness of the community for change, no longer selling alcohol in the community, a voucher system at the store so those with the worst problems did not have cash, creating a 'safe' place within the community, when someone went out of the community ensuring the children would be cared for within the community, and providing work for everyone. Ten years later, the community hosted international conferences focused on healing indigenous communities.

Similarly in Moose Cree First Nation, located on the island of Moose Factory in the southern James Bay, leadership and determination of a community to address its

addiction issues resulted in significant improvement in the levels of alcohol abuse and a vastly improved economic climate. Alcohol was not allowed in the community, except for very limited amounts for the monthly ‘wet’ dances. However, alcohol was readily available in Moosenee, located just across the river. The key elements of this significant change process included strong positive leadership, an emphasis on education, and a focus on economic development.

Although alcohol continues to be an issue for some people in both communities, as it is in all communities in North America, the negative impact on the communities has been reduced substantially. This can be contrasted with the community of Attawapiskat, located north of Moosenee along western James Bay. The Ontario Aboriginal Healing and Wellness Strategy funded the development and operation of a healing lodge in the mid-1990’s. The lodge was constructed without consideration of other elements needed to bolster the community. Attawapiskat is a fly-in community of 2,800. The healing lodge was intended to serve all of the communities along western James Bay. It encountered problems getting qualified staff. Once it was open, it was not used for two reasons. The first it was too isolated and difficult to reach. The second was its reputation for being an unhealthy community. It provides an example of why improving the health of the entire community needs to occur along with or prior to developing addiction services within the community.

4.3 COMPARISON OF NWT WMS TO BEST PRACTICES

The table on the following page provides an overview of some the best practices emerging from the literature as well as exploration of services in other parts of Canada. In most instances, the NWT already has some practices consistent with best practices.

Best Practice	NWT Current Practice	Feasibility for NWT
Planning that is consultative.	The GNWT has established a number of mechanisms for consultation including the Minister’s Forum on Addictions and Community Wellness and inclusion of key stakeholders in the data collection of this review. The current consultation processes are too superficial to address the variation in perspectives particularly among the different service providers.	Yes
Withdrawal management as part of a comprehensive system with many entry points.	People can and do enter the system from a number of different points: emergency services, community health clinics, and community-level mental health and addiction services. Not all workers have the skills and knowledge to address the needs of people with addictions, so some misdirection may occur. The varying philosophies regarding addictions and its treatment may deter some people from getting the help they need.	This is more challenging because small populations make it impossible to have the full range of services in all communities. However, thinking in terms of communities having access to services will help to address this issue.
Standards and guidelines.	There are Community Counselling Program Standards and Resources (January 2005). While these provide generic standards, they are not specific to withdrawal management or even addiction treatment. Ontario and Fraser Valley have good examples of addiction-specific standards and guidelines.	Yes – it is a natural progression to the revision currently underway for the counselling standards.
Common tools and supports across the system.	Many of the addiction services use the Substance Abuse Subtle Screening Inventory (SASSI), a tool that screens for substance use disorders. The Stanton Hospital uses the Clinical Institute Withdrawal Assessment of Alcohol Scale (CIWA) to assess 10 common withdrawal signs. Although it is a tool that can be used by non-medical withdrawal management service providers to help assess the need for medical support, it is not used. There are numerous other tools that could also be used for treatment planning that look at readiness for change, assess an individual’s network of support, and assess the severity of addiction.	This is entirely feasible and important to go beyond what is currently used.

Best Practice	NWT Current Practice	Feasibility for NWT
Staged approach to assessment that includes assessment at point of entry into the system, CIWA assessment throughout active withdrawal, and assessment of readiness for change, severity of addiction, personal networks and connectivity to the health care services.	People entering the addiction system through the Tree of Peace or the Salvation Army are assessed using SASSI. This may also be used by some Mental Health and Addiction Counsellors. Stanton Hospital uses CIWA to monitor withdrawal symptoms. There is no consistent protocol for a staged approach that takes an individual from entry into the system through to the development of a treatment plan.	This is realistic once a suite of tools is introduced into the system.
Policies, leadership, funding, performance monitoring, information management and knowledge exchange support a comprehensive system.	The GNWT HSS has developed a number of policy documents including: • Integrated Service Delivery Model for the NWT Health and Social Services Description (March 2004) • A Shared Path Towards Wellness 2012 – 2015 Mental Health and Addiction Plan • Pathways to Wellness: An Updated Action Plan for Addictions and Mental Health 2014 – 2016 Reports that contribute to an understanding of addiction needs include: • 2013 Hospitalization Report • Northwest Territories Addiction Report (2010) There is little activity in the areas of performance monitoring, information systems and knowledge exchange.	While feasible to a great extent the policies and funding need to take into account the realities of the small population dispersed across the NWT and the limited resources.
Special consideration of specific populations including adolescents, Aboriginal people, women, older adults and concurrent disorders.	Although there are recommendations for consideration of youth, this is not reflected in the withdrawal management system. There are no detoxification services available specifically for youth. The Minister's Forum on Addictions and Community Wellness brought forward recommendations for addiction treatment that is culturally appropriate for Aboriginal people. This refers more to on-the-land treatment as opposed to withdrawal management services.	It is feasible for Aboriginal people and adolescents. It is more challenging to provide separate facilities for women because of the small numbers.

Best Practice	NWT Current Practice	Feasibility for NWT
	There is a high recognition of the mental health issues occurring concurrently with addictions, requiring treatment that addresses both. There is little consideration of the needs of women or older adults as a separate population group.	
Emphasis on strong therapeutic relationships.	Some services place an emphasis on a strong therapeutic relationship. The disconnect of services as people move from their communities can undermine the development of a strong therapeutic relationship.	This is feasible and can be enhanced by professional development and training that is based on evidence.
Taking a harm reduction approach that allows for individualized treatment that meets the person where he/she is at.	Many addiction services providers and policy makers do not understand that importance of a harm reduction approach that supports individualized treatment that includes abstinence.	This is feasible but will take time given the extent of misconception about what harm reduction is.

5. ASSESSMENT OF FEASIBLE OPTIONS

The table on the following page outlines five different options for service, a description of what is required at the community, regional and territorial level to implement, indicates the inclusion criteria, and assesses the feasibility for implementation in NWT. These options are not mutually exclusive. Rather, they represent a range of options that cannot be accessed based on individual need. In fact, to work well the options should be linked providing an easier transition for a person to readily move from one to the other if the individual's situation changes.

In looking at the feasibility of the options, it is important to keep in mind that no one solution is appropriate. Rather an integrated system with options will support a client-centred approach that ensures individuals are provided services that are appropriate to their particular needs. It is also important to keep in mind that the communities in the greatest need and with the fewest resources are small and remote, making it challenging to provide the full range of options. The existing community Mental Health and Addiction Counsellors, Community Wellness Workers and health centre nurses provide a foundation for enhanced services at the community level. However, they need to be better supported and provided with ongoing training in addiction services, specifically withdrawal management.

The existing regional Clinical Supervisors do provide supports for addressing addictions. Again, this can be enhanced by the Clinical Supervisor supporting inter-disciplinary case conferences and ensuring that the Clinical Supervisors receive regular professional development in the area of addictions.

Significant change is required at the territorial level including the development of standards, provision of professional development and training, provision of a 24/7 addiction helpline that can be accessed by anyone supporting an individual going through withdrawal, and transforming the existing non-medical withdrawal management service into a territorial service that is supported by Stanton.

Type of WMS Service	Description	Inclusion Criteria	Feasibility in NWT
Medical residential withdrawal management services	• Territorial service located in Yellowknife with the only regional service in Inuvik • Located in hospital or health centre • Provides medical support for withdrawal and any complicating medical issues • Provides medical supports to non-medical withdrawal management services • Physicians would supervise methadone treatment for heroin or opiate withdrawal • Referral to non-medical withdrawal management once medical needs are addressed • Staff includes nurses, nurse practitioners and physicians	• Polysubstance use • History of severe alcohol related disorders (seizures, alcohol psychosis) • Major psychiatric disorders (e.g. schizophrenia, suicidality) • Severe cognitive deficits • Severe medical disorders (pneumonia, tuberculosis or other infectious diseases) • Head injury • Severe liver cirrhosis • Erosive gastritis or pancreatitis • Cardiovascular disorders²²	It is already occurring within Inuvik and Yellowknife. Stanton Territorial Hospital provides the service for the entire territory. Not feasible in health centres in smaller communities because of the staffing requirements – at least two people 24/7 – the costs would be prohibitive. Patients can be flown in through emergency medical evacuation if they cannot take a regular flight.
Non-medical residential withdrawal management services (adult)	• Territorial service located in Yellowknife • Affiliated with a hospital so that there is easy access to medical services if needed • Separation of men and women with separate programming • Services include assessment, monitoring, support, motivational counselling, treatment planning and referral • Staff has relevant post-secondary diploma and addiction service training • Length of stay would vary depending on individual need – generally 3 – 7 days	• At least 16 years of age • No serious medical or complicated withdrawal issues • Willing to voluntarily attend detox and other programming • Able to provide basic information on admission • Willing to answer questions about personal medical history and substance use	Not feasible at a regional level because the numbers are too small and costs extremely high. There is currently a six-bed facility provided by the Salvation Army in Yellowknife. There needs to be a dedicated territorial facility which offers programming similar to the Withdrawal Management Services program offered at the Salvation Army.

²² Soyka, M. and M. Horak (2004) Outpatient alcohol detoxification: Implementation efficacy and outcome effectiveness of a model project, European Addiction Research, 10 180 - 187

Type of WMS Service	Description	Inclusion Criteria	Feasibility in NWT
Home-based withdrawal management services	- Carried out in the community - Supported by a 24/7 help line - Initial detox carried out by family members or friends with support from community mental health and addiction worker, community wellness worker or health centre nursing - Services from staff include assessment, monitoring support, motivational counselling, treatment planning and referral - Staff has relevant post-secondary diploma and addiction service training	- Existence of a safe supportive home environment (friend, family, relative) - No violent or aggressive behaviour - No serious medical or complicated withdrawal issues - Voluntarily participates in detox process	One of the biggest challenges is finding a safe place for withdrawal. This is feasible as an option for some people if it is appropriately supported and safe conditions exist.
Mobile withdrawal management services	- A two-person team goes to where the person is - Services include assessment, monitoring support, motivational counselling, treatment planning and referral - Staff has relevant post-secondary diploma and addiction service training	- Existence of a safe supportive home environment (friend, family, relative) - No violent or aggressive behaviour - No serious medical or complicated withdrawal issues - Voluntarily participates in detox process	This works best where clients can be reached by road access and the team can see multiple individuals in a day. It is a costly option for remote communities because of the cost of flying in two staff and paying for their accommodations and time while they are in the community.
On-the-land withdrawal management services	Withdrawal occurs in a wilderness setting supported by Elders, healers and other appropriate support people	None because of safety factors	This is not a recommended option because of the extreme vulnerability of the individual going through withdrawal – medical and other assistance would not be readily available, putting everyone at risk.

6. RECOMMENDED CHANGES TO THE SYSTEM

As indicated, all of the options have limitations. The NWT's small and disbursed population makes it particularly challenging to develop a withdrawal management system that meets all of the best practices. However, the system could be enhanced, becoming more integrated so that services at the territorial and regional levels can better support community services.

At the Community Level

1. Where appropriate, provide greater supports to families assisting with home withdrawal management. This could include a 24/7 helpline and guidance on use of the CIWA.
2. Ensure that every health, social and judicial service in the community is a potential entry point into the addiction treatment system. This will require the building of strong inter-disciplinary teams and education about best practices in addiction treatment, including withdrawal management.
3. Ensure that withdrawal management incorporates cultural practices that are important for the person going through withdrawal. This might include practices such as smudging, talking circles and sweat lodges for Aboriginal people. It is important to ask each individual what is meaningful to them. A client-centred approach would address this.
4. Ensure that training is available to those providing services in the community. Some areas to focus on include:
 - Understanding harm reduction
 - Development of strong therapeutic relationships
 - Use of motivational interviewing
 - Use of assessment tools including CIWA

At the Regional Level

1. Establish Regional Addiction Planning tables that include mental health and addiction workers, health centre nurses, local physicians (if they are there), and the RCMP in order to determine the best use of existing services as well as determine how a safe place for withdrawal management could be established in each of the communities. Yellowknife and Inuvik have already established such planning tables and could serve as an example for other regions.

2. Continue to provide clinical supervision at this level.
3. Continue to provide regional medical withdrawal management in Inuvik.

At the Territorial Level

1. Develop standards and guidelines that are specific to addiction intervention including specific attention to withdrawal management and specifically support a harm reduction approach. Such standards and guidelines should include a suite of tools that can be used to assess withdrawal severity, stages of change, addiction severity and personal networks and supports.
2. Establish policies that introduce a common language across the system and require the use of a range of common assessment tools in order to support a more comprehensive staged assessment.
3. Maintain Stanton Hospital as the territorial medical withdrawal facility, developing linkages with the non-medical withdrawal management services throughout the territory and ensuring that current best practices are being applied for withdrawal management.
4. Designate the existing non-medical withdrawal management services as a territorial facility that can be accessed by anyone in the NWT. This will need to be supported by providing transportation out of the community, including emergency evacuation if required.
5. Develop a 24/7 addiction support line that can be accessed by families, mental health and addiction workers, RCMP and anyone else in the community who is providing support to an individual going through withdrawal. This could connect with resources in Yellowknife and beyond. The GNWT HSS may want to collaborate with Alberta, British Columbia and/or Ontario in establishing such a help line. It may be possible to build on an existing service.
6. Provide ongoing training in withdrawal management to the full range of people who are likely to be the first point of contact for someone with an addiction. This would include nurses, physicians, mental health and addiction counsellors, social service workers, child protection workers and the RCMP. Training should include an introduction to best practices, motivational interviewing techniques, and the use of a full range of assessment tools. Such training could be carried out through video-conferencing. Again, HSS may want to collaborate with Alberta, British Columbia and/or Ontario in order to tap into any distance training that is already available.

7. CONCLUSION

Currently, formal withdrawal management services do not exist in the majority of NWT communities. Although best practices point towards options like ‘home withdrawal management’, these would prove to be difficult options to implement in the Northwest Territories due to the lack of medical supports and of suitable environments to safely provide this practice. As a result, it is recommended that the Department of Health and Social Services maintain the current service delivery model by continuing to provide the withdrawal management services that currently exist within the Inuvik Regional Hospital and Stanton Territorial Hospital.

In addition, it is further recommended that a territorial service, similar to the Salvation Army’s Withdrawal Management Services, be created in order to make this service available to all residents of the Northwest Territories rather than just those who live in Yellowknife. The creation of a territorial service of this nature would enable residents requiring non-medical support to receive it in as safe an environment as possible. In addition, should the need for medical attention arise, it would be readily available, thereby maximizing the safety of the service.

Lastly, it is recommended that the Department of Health and Social Services continue to monitor and evaluate options for withdrawal management on an ongoing basis as part of overall addictions service management.

APPENDIX A: LIST OF DOCUMENTS REVIEWED

Community Counselling Program Standards and Resources (January 2005)

GNWT A Shared Path Towards Wellness: Mental Health and Addictions Plan 2012 - 2015

GNWT Health and Social Services – Community Counselling Program (no date)

GNWT Health and Social Services Authorities/Regions (no date)

GNWT Health Status Report (2011)

GNWT Integrated Service Delivery Model for the NWT Health and Social Services System

GNWT Making the Case For Change Advancing the NWT Chronic Disease Management Strategy (no date)

GNWT Pathways to Wellness An Updated Plan for Addictions and Mental Health 2014 - 2016

Healing Voices – The Minister’s Forum on Addictions and Community Wellness

NWT Addictions Residential Treatment Referral Process

NWT Addictions Report (December 2010)

NWT Hospitalization Report (2013)

Stay the Course . . . and Together We Can Secure the Foundation that Has Been Built (December 2005)

Supplementary Report: Withdrawal Management

The Canadian Addiction Survey

The Canadian Alcohol and Drug Use Monitoring Survey

APPENDIX B: LIST OF LITERATURE REVIEWED

- Addictions Ontario (2008) The Ontario Withdrawal Management Standards
- Australian Government: Australian Institute of Criminology (2005) Australian responses to illicit drugs: Harm reduction strategies
- Australian Institute of Health and Welfare Canberra (2003) Alcohol and other drug treatment services in Australia 2001/02 Report on the National Minimum Data Set
- Centre for Addictions and Mental Health (2004) Current Issues in Addictions and Mental Health
- Champlain District Mental Health Implementation Task Force (2002) Discussion Paper on Meaningful Collaboration: Substance Use and Mental Health
- Christie, Grant and Helen Temperton (2008) Guidelines for the Management of Acute Substance Withdrawal in Adolescents, New Zealand
- City of Toronto Public Health Department (2005) Substance Use in Toronto: Issues, Impacts and Interventions
- Currie, Janet C. (2001) Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems, Health Canada
- Effective Interventions Unit (2002) Integrated Care for Drug Users – Principles and Practice
- Government of New South Wales (2008) Drug and Alcohol Withdrawal Clinical Practice Guideline
- Government of Ontario (2002) 14 Common Indicator Areas of Health and Health System Performance
- Health Canada (March 2005) Canadian Addiction Survey Detailed Report: Prevalence of Use and Related Harms
- Kenny, Pauline, Amy Swan, Lynda Berends, Linda Jenner, Barbara Hunter and Janette Mugavin (2009) Turning Point Alcohol and Drug Centre Alcohol and Other Drug Withdrawal Practice Guidelines
- McGuire, Martha, David MacCoy, Susan Scott, Melissa McGuire and Nan Prasad (2005) A Review of the Withdrawal Management System in Ontario, Ministry of Health and Long-Term Care
- National Treatment Agency for Substance Misuse (2002) Models of care for the treatment of drug misusers
- North Shore Task Force on Substance Abuse (nd) North Shore Substance Abuse Strategy
- Nova Scotia (2005) Addiction Services: Standards and Best Practices
- Ontario Federation of Community Mental Health and Addiction Programs (2003) The Success of Community Mental Health and Addiction Programs

Ontario Women's Service Strategy Work Group (nd) Best Practices in Action: Guidelines and Criteria for Women's Substance Abuse Treatment Services

Prince Edward Island Government (downloaded 2013) Health Information Resources Provincial Addictions Treatment Facility

Rush, Brian and Julie Aiken Harris (2000) Client Satisfaction and Outcomes within Ontario's Withdrawal Management Centres

Saskatchewan Ministry of Health (2008) Concurrent Disorders and Withdrawal Management Protocols/Guidelines and Services

Scottish Executive Effective Interventions Unit (2004) Residential detoxification and rehabilitation services for drug users

Seeking Solutions (2004) Best Practices: Alcohol and other Substance Use Withdrawal Information Sheet

Seven Oaks General Hospital Winnipeg (2003) Inventory of Specialized Programs: Substance Use Management, Intervention and Treatment

Soyka, M. and M. Horak (2004) Outpatient alcohol detoxification: Implementation efficacy and outcome effectiveness of a model project, European Addiction Research, 10 180 - 187

Stockwell, T. (Oct 2005). *The relative cost-effectiveness of community-based and inpatient hospital care for people with substance use problems and dependence*. Brief prepared for the Standing Senate Committee on Social Affairs, Science and Technology Inquiry into Mental Health and Addictions

Tjepkema, Michael (2004) Alcohol and illicit drug dependence, Statistics Canada Catalogue

Toronto WMS Work Group (2004) Toronto Regional Withdrawal Management Services: Consolidated Operating Plan 2004 – 2005

Treatment Research Institute and National Rural Alcohol and Drug Abuse Network (2005) The Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers

APPENDIX C: STAGES OF CHANGE MODEL

Stage of Change	Characteristics	Motivational Techniques
Pre-contemplation	Not currently considering change: "Ignorance is bliss"	• Validate lack of readiness • Clarify: decision is theirs • Encourage re-evaluation of current behavior • Encourage self-exploration, not action • Explain and personalize the risk
Contemplation	Ambivalent about change: "Sitting on the fence" Not considering change within the next month	• Validate lack of readiness • Clarify: decision is theirs • Encourage evaluation of pros and cons of behavior change • Identify and promote new, positive outcome expectations
Preparation	Some experience with change and are trying to change: "Testing the waters" Planning to act within 1 month	• Identify and assist in problem solving re: obstacles • Help patient identify social support • Verify that patient has underlying skills for behavior change • Encourage small initial steps
Action	Practicing new behavior for 3-6 months	• Focus on restructuring cues and social support • Bolster self-efficacy for dealing with obstacles • Combat feelings of loss and reiterate long-term benefits
Maintenance	Continued commitment to sustaining new behavior Post-6 months to 5 years	• Plan for follow-up support • Reinforce internal rewards • Discuss coping with relapse
Relapse	Resumption of old behaviors: "Fall from grace"	• Evaluate trigger for relapse • Reassess motivation and barriers • Plan stronger coping strategies

Note: While this table presents this as a linear model, in fact, progress through the stages frequently involves moving back a stage or more before progressing further.

APPENDIX D: WITHDRAWAL ASSESSMENT OF ALCOHOL SCALE

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: _____ Date: _____ Time: _____ (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: _____ Blood pressure: _____

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

- 0 no nausea and no vomiting
- 1 mild nausea with no vomiting
- 2
- 3
- 4 intermittent nausea with dry heaves
- 5
- 6
- 7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

- 0 none
- 1 very mild itching, pins and needles, burning or numbness
- 2 mild itching, pins and needles, burning or numbness
- 3 moderate itching, pins and needles, burning or numbness
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.

- 0 no tremor
- 1 not visible, but can be felt fingertip to fingertip
- 2
- 3
- 4 moderate, with patient's arms extended
- 5
- 6
- 7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

- 0 not present
- 1 very mild harshness or ability to frighten
- 2 mild harshness or ability to frighten
- 3 moderate harshness or ability to frighten
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.

- 0 no sweat visible
- 1 barely perceptible sweating, palms moist
- 2
- 3
- 4 beads of sweat obvious on forehead
- 5
- 6
- 7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

- 0 not present
- 1 very mild sensitivity
- 2 mild sensitivity
- 3 moderate sensitivity
- 4 moderately severe hallucinations
- 5 severe hallucinations
- 6 extremely severe hallucinations
- 7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.

- 0 no anxiety, at ease
- 1 mild anxious
- 2
- 3
- 4 moderately anxious, or guarded, so anxiety is inferred
- 5
- 6
- 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

- 0 not present
- 1 very mild
- 2 mild
- 3 moderate
- 4 moderately severe
- 5 severe
- 6 very severe
- 7 extremely severe

AGITATION -- Observation.

0 normal activity

1 somewhat more than normal activity

2

3

4 moderately fidgety and restless

5

6

7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask

"What day is this? Where are you? Who am I?"

0 oriented and can do serial additions

1 cannot do serial additions or is uncertain about date

2 disoriented for date by no more than 2 calendar days

3 disoriented for date by more than 2 calendar days

4 disoriented for place/or person

Total CIWA-Ar Score _____

Rater's Initials _____

Maximum Possible Score 67

The CIWA-Ar is not copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction* 84:1353-1357, 1989.

APPENDIX E: HOME ENVIRONMENT CHECKLIST

Home Environment Checklist Re: Suitability for CWMS

- Availability of supporters (co-habitants)
Comments: _____

- Attitude of supporters
Comments: _____

- Commitment of supporters
Comments: _____

- Noise level
Comments: _____

- Availability of nutrition
Comments: _____

- Space to be alone
Comments: _____

- Presence of young children and/or pets
Comments: _____

- Cleanliness
Comments: _____

- The presence of alcohol and/or other drugs
Comments: _____

- Presence of other drinkers/users
Comments: _____

- Ease of access (getting there)
Comments: _____

- Other supports needed to make it suitable
Comments: _____
