Transformational Process
for Mental Health & Addictions:

Future Directions & Promising Practices in the Northwest Territories(NWT)

McDermott consulting

Originally Submitted on February 21, 2011
Revised & Submitted on Monday, April 11, 2011

Acknowledgements

This report has been completed by the consultant firm McDermott Consulting Inc. The consultants: Irene McDermott, Denis Ostercamp and John McDermott wish to thank the individuals who contributed to this project and thus to the content of this report. We also thank the staff of the Department of Health and Social Services for initiating this important project.

The consultants also wish to mention some of the factors related to undertaking this project and that have had an impact on the direction contained in this report. First, in the initial stages of the project confusion arose about why we were contracted to carry out a review when so many reviews had already been done and so much had already been said. Second, the intent of the project was to set the direction for the mental health and addictions system; however, we found that the two areas had not been functionally integrated. Thirdly, as we moved along on the project it became clear that we would need to go beyond the mandate of the mental health and addictions systems. This took us to a different focus, specifically focusing on bigger issues around mental health and addictions problems rather than the problems with the system.

As we carried out the process and started to ask questions about the significant issues of mental health and addictions problems and not just about the system, we heard an overwhelming positive response. Although participants in the consultation process were able to identify changes and improvements to the mental health and addictions system what they really wanted to talk about was why the mental health and addictions problems existed in the first place and how communities could be involved in finding the solutions. This response confirmed the direction that the project was leading towards and helped to solidify the priorities and corresponding actions that flowed from the direction.

Again we thank people for their honesty in sharing information with us and for their enthusiasm for a ***Transformational Process*** for mental health and addictions for the NWT.

***A story to share*:**

During our visit to the NWT we went to Behchoko where we were to meet with a number of people who had used the mental health and addictions system and people who worked in that system. It was very cold that morning we headed out of Yellowknife, -36 as I recall and the temperature went lower as we drove the one hour on an isolated road to Behchoko. We ended up in Edzo and being lost went to the school to ask for help. We found the help we needed at the school and then headed back to Behchoko or Rae as it had been renamed by the Europeans who settled in the NWT. It was back to being called Behchoko, its original name. We found the large building that housed the mental health and addictions services and rushed in gasping from the crisp cold air. It was dark in the entrance of the building and we thought the lack of light was related to some maintenance being done, but we were wrong. The power was out. We asked if this was common as it is in some small isolated communities like Tofino on Vancouver Island for example. No, this was not common and it was of some concern. Nonetheless we were ushered into a room and enjoyed listening to the wisdom of the people we were meeting with. Two hours later we came out to find that the power was still out and that the outage extended all the way to Yellowknife some hundred kilometres away. We were also told that our other meetings for the rest of the day were being cancelled as the community was gathering to address the emergency. And an emergency it was, it was -37,the sun was starting to go down and without power how were people including us going to stay warm, let alone do any of the other things we do that requires power. It was strongly suggested that we head back to Yellowknife.

Just before we left we were looking out at the community and all the houses and buildings thinking about how cold it really was out there and about all the people in the town that must be getting cold. We did notice however that there were signs of warmth in the smoke coming out of some of the houses. Wood stoves? we asked. Yes, these homes did have wood fireplaces or stoves and other people in the community who relied on electricity to warm their homes were already starting to gather in these still warm homes. The basic need of being safe, staying warm in the cold became the priority and the people in the community had put aside normal practice and other tasks and had gathered to stay safe and warm.

I thought a lot of about the loss of power and the implications of the same as we made our way back to Yellowknife. We both hoped and prayed that the power would be restored by the time we returned. I also thought a lot about how the people in Behchoko had come together in consideration of each other and the vital need to stay warm. I wondered what we would do in Yellowknife. As we neared Yellowknife we saw the steam from the city generator. We were relieved but also a bit more respectful and grateful for the convenience of power.

What remained in my memory were people in Behchoko being welcomed in the homes with the smoke flowing from their chimneys. This made me wonder, if we in our communities can gather to stay warm maybe we can also gather to satisfy our other needs that, although maybe not as obvious, are vital just the same.

Final Report

TRANSFORMATIONAL PROCESS FOR MENTAL HEALTH & ADDICTIONS:

FUTURE DIRECTIONS & PROMISING PRACTICES IN THE NORTHWEST TERRITORIES

PREAMBLE

Mental health and addictions have been identified as critical issues for the Northwest Territories (NWT). These issues have been identified in several reviews and studies over the last decade. These issues are not restricted to the NWT but rather are global in nature. According to the World Health Organization (WHO) "alcohol use is the third leading risk factor for poor health globally" and "harmful drinking is a major avoidable risk factor for neuropsychiatric disorders"[1]. The "Global Burden of Disease" study conducted by the World Health Organization, the World Bank and Harvard University, notes that mental illness, including suicide, accounts for over 15 percent of the burden of disease in established market economies such as Canada and the United States, which is higher than for all cancers.

Within the NWT rising mental health concerns and mental illness as well as the impact of substance misuse and addictions have been clearly identified as needing attention. The NWT have identified and recommended many strategies to address these issues and have put some of these ideas into place. Yet the issues of mental health and addictions remain critical and continue to demand attention. Despite the many completed reviews within the last 10 years these issues have been examined in yet another review. Although it seems that everything has been said in previous reports and Health and Social services documents, little headway has been made in the ability to address mental health and addictions.

The ***Transformational Process*** presented in this document builds on what is already known, what has already been said and what is already happening to some degree. The ***Transformational Process*** however, is different in that it takes the issues and the discussion about mental health and addictions beyond the current boundaries of the mental health and addictions system and further beyond the "health and social services" systems to the broader community and across government. Attention to mental health and addictions is brought to all levels and areas of government and to the general public. The ***Transformational Process*** takes the issues of mental health and addictions outside the existing confines and declares that these issues belong to the entire population of the NWT. Previous reviews focussed on trying to "fix" the formal mental health and addictions systems and the collection of services and programs that exist. The perspective in this ***Transformational Process*** shifts the philosophical foundation to an emphasis on the health of the population, and to the broad array of needs of individuals with mental health and addictions issues. It also looks at individuals within their context and recognizes the importance of the culture, the environment and the capacity of the community to support its members. The impact of historic trauma transmission of the Aboriginal population is recognized as having an influence on the health of NWT communities. The

[1] WHO: Global Strategy to Reduce the Harmful Use of Alcohol (2010)

Transformational Process acknowledges that traditional Aboriginal healing practice must be integrated with the formal mental health and addictions services. Within the ***Transformational Process*** mental health and addictions are seen as symptoms of the larger problem of unhealthy communities. Further that they share the stage with a number of other social and health problems including chronic health issues, FASD, family and other violence, crime, injury, homelessness, unemployment and more.

This recognition shifts the concern and responsibility for mental health and addictions to the broad population. This perspective says that mental health and addictions issues are everybody's business. The process emphasizes that the solutions to these issues must be designed by the community and taken to and supported by government, not designed and directed by government. Nor can the design be restricted to fine-tuning of the formal mental health and addictions system, rather it must be broad and accepting of other forms of practice including traditional Aboriginal health practices and harm reduction strategies.

Mental health and addictions are not just the problem of the individuals directly impacted or the problem of mental health and addictions service providers that attempt to address these issues but are the concern of all people in each community and thus all people within the NWT. This means communities working with government and service providers and the public to confront these issues.

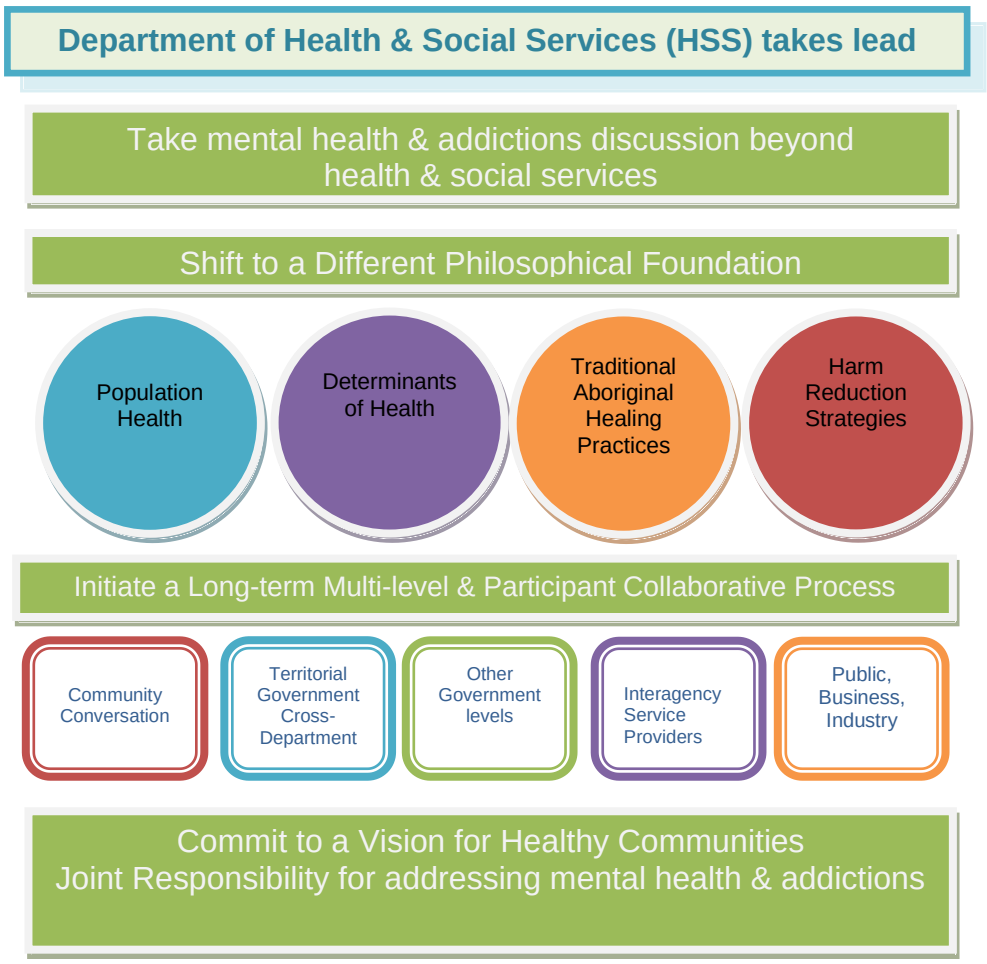
Now is the time for action. Now is the time to talk about mental health and addictions outside of the health system.

- *It is time to* take the challenge of mental health & addictions to the wide-ranging group of people within the communities and listen to their voices
- *It is time to* talk about the more expansive perspective of health and all the elements of life that impact a person's mental health
- *It is time to* acknowledge that people impacted by mental health and addictions need more than medical and social care
- *It is time to* acknowledge the Aboriginal culture and embrace it
- *It is time to* begin the dialogue about mental health and addictions with the community, not just the people providing the services
- *It is time to* acknowledge that the formal mental health and addictions system and the health system requires the knowledge of the community and all the people who make up the communities to find the solutions to the mental health and addictions issues
- *It is time to* take the time to begin to make a difference
- *It is time to* work towards healthy communities that support and nurture healthy individuals

EXECUTIVE SUMMARY

The ***Transformational Process for Mental Health and Addictions*: *Future Directions and Promising Practice*** calls for the Department of Health and Social Services (HSS) to take a leadership role in starting the process of addressing mental health and addictions within the broader definition of health. Focus on the context of a population health approach with particular attention to the determinants of health along with integration of Aboriginal healing practices and harm reduction strategies is required.

This takes the mental health and addictions, beyond treatment of individuals. Without the attention to individuals within their context, their issues are not adequately addressed. Finally, without attention to historic trauma transmission and attention to integration of traditional Aboriginal healing practices where appropriate, the transmission of trauma continues.

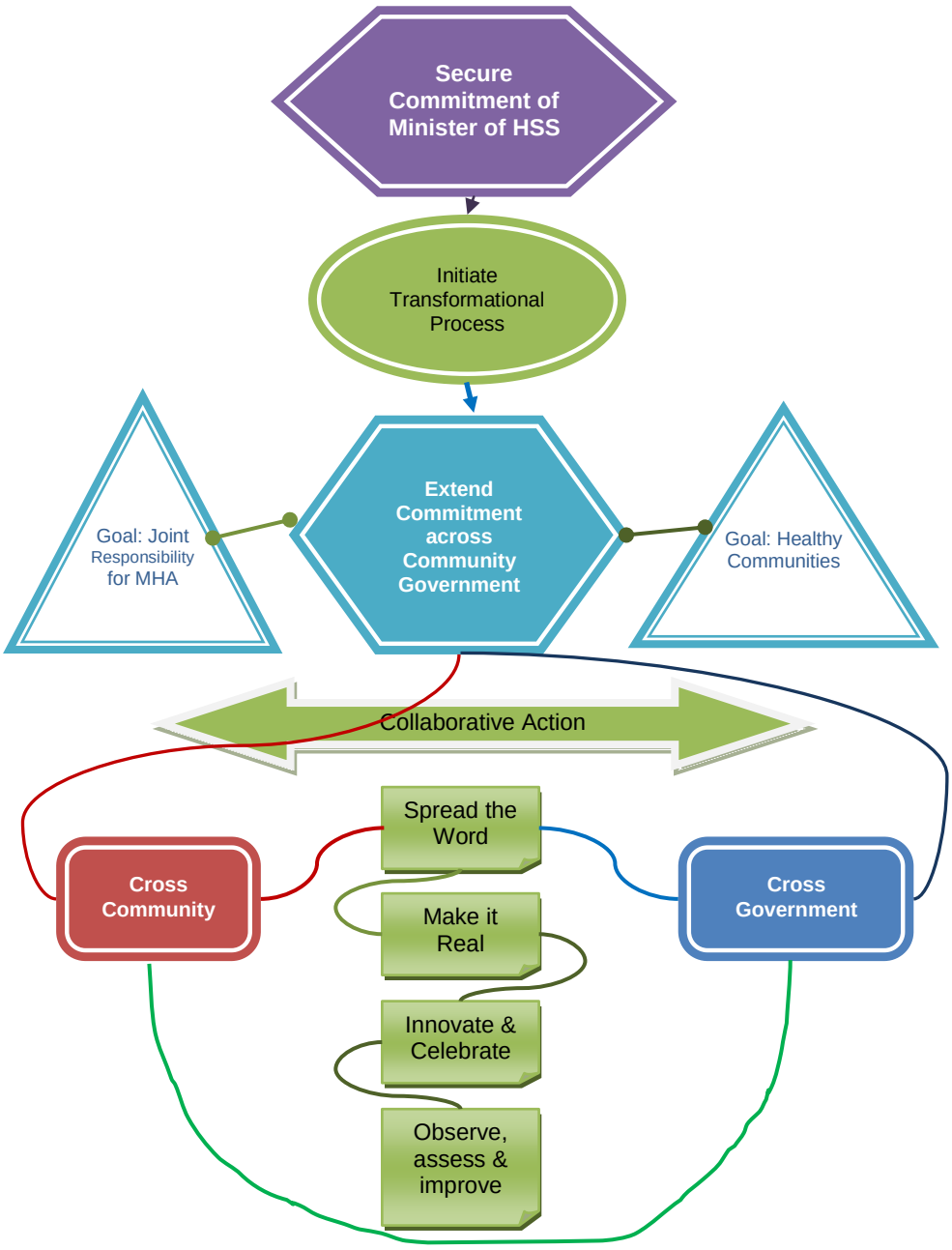


The overall strategy for the ***Transformational Process*** involves community conversation and multi-sectoral and multi-departmental commitment, together in a long-term collaborative process. This process brings the community, governments, Band Councils, service providers and business and industry together to address mental health and addictions. Health care and other sectors not traditionally involved in mental health and addictions must become involved and work together for effective outcomes.

The overall goal is to develop healthy individuals, healthy communities and a healthy society. This will result in a corresponding decrease in the number and intensity of mental health and addictions issues as well as improved outcomes for individuals with mental health and addictions difficulties.

The ***Transformational Process*** including the philosophical approaches, the long-term collaborative process and the specific actions validate that mental health and addictions are everyone's business.

The key action steps inherent in the ***Transformational Process*** are as follows:



Initial ideas about how these steps could be actualized are outlined in the tables on the following pages.

Action Steps	*Specific Steps*	*Details and Considerations*
Secure commitment of Minister of HSS	DM to work with Minister to secure commitment to ***Transformational Process***	• Department of HSS take the lead in shifting the philosophical direction and initiating the collaborative process

Initiate the Transformational Process	• Set up project management structure	• Establish Project Management team (neutral facilitators)
		• Establish consultative bodies:
		  • Aboriginal Wisdom Group
		  • Cross Department groups

	• Develop guiding principles	Consider principles of dialogue, relationship, trust, community driven, not government driven and process expectations such as progressive, inclusive, evolutionary, long term
	• Develop education and awareness materials of foundational philosophical shift and community collaborative process	Build the educational materials to include a focus on: • What the ***Transformational Process*** & philosophy is • Why it is important • Why (participants) should care
	• Develop mechanisms to track the story of the ***Transformational Process***	Track the progress, the activities and thus be able to contribute to replicating the process.

Extend commitment across governments & community	• Commit to:
	  • ***Transformational Process***
	  • healthy public policy
	• Commit to a common vision for healthy communities
		• Within HSS
		• Cross Territorial Government
		• Link to other Governments including Band Councils
		• Community

	• Establish statement of joint responsibility for addressing mental health and addictions	
	• Establish relationships between and among groups	

Action Steps	*Specific Steps*	*Details and Considerations*
Collaborative Action: Spread the Word	• Provide Information about Foundations of Philosophical shift through Open Community Forums; meetings in government • Conversation about impacts of applying ***Transformational Process*** through Open Community Forums; meetings in government; • Create ownership within departments and within communties • Educate and dialogue about application of ***Transformational Process***	Participants in process HSS: • MHA staff • All HSS sectors • Regional Authorities CEO's and staff • Agency Other Territorial Government Departments • Leadership • Staff • Agency/service providers Other Governments/Band Councils Community General public Business and industry
Collaborative Action: Making it real	• Identify readiness of communities • Establish Geographic Action Teams based on RHAs or communities • Establish Cross – Department mechanisms • Utilize Wisdom Committee(s)	• Start in communities that are most ready • Work with communities that need more help • Initiate cross department activities that have been identified in review process • Include community and government representatives • Continue the process • Monitor and report on progress
	• Dialogue about how to make it real through Open Community Forums; meetings in government • Create action groups: Focussed groups identified by community/group	Include a focus on: • What the ***Transformational Process*** & philosophy is • Why it is important • Why (participants) should care • What solutions can be found

Action Steps	Specific Steps	Details and Considerations
Collaborative Action: Innovate & celebrate	• Select initiatives to focus on and implement • Encourage innovative ideas • Celebrate small successes both in process and activity	Include sharing the word and dissemination of successes
Collaborative Action: Observe, assess & improve	• Develop evaluation and monitoring framework • Develop indicators and measures of program inputs, outputs and outcomes as a basis to analyze and understand the impacts and effects of process and activities • Implement framework	• Acknowledge missteps and process for moving past • Dissemination of results

SECTION 1: INTRODUCTION

SYNOPSIS: *TRANSFORMATIONAL PROCESS*: FUTURE DIRECTIONS & PROMISING PRACTICES

This document presents the ***Transformational Process* for Mental Health and Addictions: Future Directions & Promising Practices in the Northwest Territories (NWT).** Evident in the information presented is the need to take the issues of mental health and addictions to a broader level of discussion with a wider group of public representatives and citizens. The direction described in this document sets the stage for the Department of Health and Social Services to take the lead in action related to mental health and addictions for the NWT.

Challenges and Opportunities

The unique features of the NWT point to the need to develop different approaches to provide for the needs of the population. NWT is vast geographically with many small and often isolated communities. This isolation is influenced by the climate which in turn impacts transportation. Similar to the rest of Canada and globally, issues of unhealthy communities and unhealthy people (e.g. obesity; lifestyle, substance misuse) need attention but strategies developed south of NWT do not always fit the northern environment. Northern solutions are needed for northern issues.

The nature of the NWT also offers unique opportunities to attend to these needs and to move in a direction that will lead to a healthier population. Health and Social Services leaders want action as do community leaders. Being a small jurisdiction in numbers of people and a smaller bureaucracy, NWT will be more able to use approaches that are collaborative across sectors, departments and disciplines; community-based; community-focused and community building. Communities are small and can support open and inclusive community dialogue and action. With a large cohort of youth and children within the population and a focus on this group there is an opportunity to shift direction in the health of future communities.

The historic trauma off the Aboriginal population had been identified as impacting mental health and addictions issues. Across governments, within service systems and in communities there is acknowledgment that the traditional Aboriginal ways need to be respected and applied in developing values for addressing mental health and addictions. Communities are clear in stating that they wish to see a return to more traditional family values and practices. Some communities are acting on their wishes.

The Department of Health and Social Services have made a commitment to implement an Integrated Service Delivery Model for the delivery of mental health and addictions services in the NWT. Recognition of the need for change is beginning in important areas such as the merging of mental health and addictions as well as the recognition of the importance of health promotion and prevention. All HSSA's across the NWT have implemented initiatives and activities focused on mental health promotion and education. Communities appear to be recognizing the value of working together across the sectors of health, social services, justice, education, housing, employment and income supports. Private industry is coming forward more actively to support initiatives.

The newly signed Devolution Agreement is in the process of being implemented which may result in new resources being available. The Federal Government provides considerable funding for programs that provide opportunity to improve the mental health of a community. There is an opportunity to work together to ensure there is good communication, planning and linkages around the implementation of these programs across the NWT and that they work in collaboration and support of the mental health and addictions programs being delivered by other government sectors in the NWT. The Devolution process may facilitate this.

The HSSA's and the Territorial Health Authority feel that they have many energetic and talented people working in mental health and addictions services. They have expressed a desire that the time is right for leadership to come from the Territorial Government level to create a thrust to move the mental health and addictions system forward into an integrated and collaborative service delivery model.

Through attention to the ***Transformational Process*** and the actions, the NWT Department of Health and Social Services has a unique opportunity to take a leadership role in advancing the NWT forward in addressing the mental health and addictions problems that currently exist and achieving a corresponding positive impact on the health of the population of the NWT.

Transformational Process

The review included focussed consultation, review of documents, examination of issues and reflection within the broader context. The review findings point to a new direction that takes consideration of the mental health and addictions system beyond the confines of the formal mental health and addictions system and into the realm of population health incorporating the principles of the determinants of health. This focus also goes beyond the current "health care system" and takes it beyond the provision of medical care to an expanded definition of health that includes attention to all the determinants of health. Without the attention to individuals in context their issues are not adequately addressed. Finally, without attention to historic trauma transmission and attention to integration of traditional Aboriginal healing practices where appropriate in addressing some of the cultural issues, the transmission of trauma continues.

Children see their future in their parents. If they so not see a hopeful future they lose hope. By focusing on youth and children there is an opportunity to increase the hope and stop the transmission of trauma.

In order to move forward in addressing the mental health and addictions issues within the NWT, attention must shift to a broader focus. A different direction is essential. Focusing solely on the health or the mental health and addictions systems will no longer work. It is clear that tinkering with the current mental health and addictions systems is not the solution to the current situation. Instead current information and wisdom substantiates the need to rethink, refresh and expand attention to a broader definition of health and mental health, to recognize the determinants of health within the cultural context. In addition it is time to develop healthy public policy that takes the responsibility for mental health beyond the medical model and treatment of illness, beyond the health department or the health system.

The ***Transformational Process***: ***Future Directions and Promising Practice*** calls for the Department of Health and Social Services to take a leadership role in addressing the issues of the mental health and addictions system and issues within the broader definition of health and a focus on the context of a population health approach and particular attention to the determinants of health along with integration of Aboriginal healing practices and harm reduction strategies.

The overall strategy involves community conversation and multi-sectoral and multi-departmental commitment bringing health care sectors and other sectors together to address mental health and addictions. This includes the various levels and types of government such as the Territorial, Federal, and Municipal governments and Band Councils. The overall goal is to develop healthy communities and therefore healthier individuals and therefore a decrease in number or intensity of mental health and addictions issues and improved outcomes for individuals with mental health and addictions issues.

The ***Transformational Process*** including the philosophical approaches, the collaborative process and the specific actions validate that mental health and addictions are everyone's business.

The following page outlines the ***Transformational Process*** for mental health and addictions for the NWT.

Department of Health & Social Services (HSS) takes lead

Take mental health & addictions discussion beyond health & social services

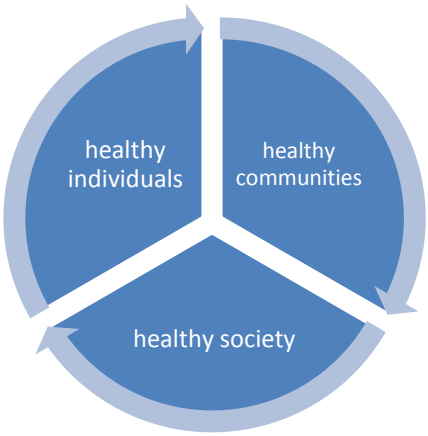
Shift to a Different Philosophical Foundation

- Population Health
- Determinants of Health
- Traditional Aboriginal Healing Practices
- Harm Reduction Strategies

Initiate a Long-term Multi-level & Participant Collaborative Process

- Community Conversation
- Territorial Government Cross-Department
- Other Government levels
- Interagency Service Providers
- Public, Business, Industry

Commit to a Vision for Healthy Communities
Joint Responsibility for addressing mental health & addictions



THE PROJECT

Intent of Project

As stated in the project overview and proposal, *"the purpose of the project is to develop action plan recommendations to ensure that Mental Health and Addictions (MHA) programs and services are current, accessible, meet the needs of communities throughout the NWT and are appropriately structured given the resources available in the region".*

The intent was to examine work, that focussed on mental health or addictions or both, that had been completed in the NWT over the previous ten years and to build upon this work to set the direction for advancing in terms of action. Work that had been undertaken and presented for the health system overall and other specific areas was also examined.

The intent was not to conduct a "review of the mental health and addictions system" but rather to identify how the NWT might advance using information about what was needed to address mental health and addictions, focussing on developing "future directions and promising practice" strategies.

Process

The process of the project included a number of activities including: consideration of previous reports; confirmation of direction through focussed consultation; an examination of best practice literature; analysis of information collected and finally development of the ***Transformational Process***.

Previous documents

The consultants working on this project have drawn significantly on the reviews, evaluations and reform activities that have taken place across the NWT Mental Health and Addictions Program over the past ten years. The information from these reviews has served to guide discussion in the consultation process.

The most recent of such reviews was the "Review of Mental Health and Addictions Services in the Northwest Territories". This internal review was conducted by the Department of Health and Social Services, Children and Family Services Division with a final draft report being put forward on April 30, 2010. The consultants have drawn on this report in order to form a starting point of reviewing the current mental health and addiction services available to residents of the NWT and to commence the formulation of mental health and addiction services future directions and promising practice recommendations. In addition many other reports including *A Foundation for Change* documents, the *Integrated Service Delivery Model; Alcohol and Drug Survey* and the *Addictions Awareness Campaigns for the NWT* were considered.

Confirmation of Direction

Consultation discussions with key stakeholders across seven HSSA's and one Territorial Health Authority were undertaken to confirm direction identified in previous reviews rather than focus on identification of issues per se. Discussions were conducted with at least one key stakeholder in each of these authorities, mainly at the mental health and addictions clinical supervisor level. However in several authorities there were discussions with Chief Executive Officers, mental health and addiction counsellors, justice workers/coordinators, wellness workers, school officials, RCMP, health nurses, mental health and addictions service consumers, band manager

and agency/non-government organizations involved with providing mental health and addiction services. A number of discussions were conducted with staff at the Department of Health and Social Services who are responsible for overseeing the provision of mental health and addiction services in the NWT. In addition to this consultation discussions were conducted with the Department of Justice in the NWT.

The consultants [2] traveled to the NWT in early December for a one week period. During this time direct face to face discussions were conducted with Department staff, staff from the Yellowknife Health and Social Services Authority, agency staff from the Beaufort Delta area as well as agency/non-government organization staff from Yellowknife. During this week one consultant traveled to the Sahtu HSS Authority [specifically to the community of Deline] where a number of direct face to face discussions were held with a variety of staff from that health authority as well as with local members of the community who are integral to the provision of mental health and addiction services in that community. Both consultants traveled to the community of Behchoko, during the same week, where face to face discussions were held with the clinical supervisor for mental health and addictions and two mental health and addictions service consumers. [Further discussions in that community were curtailed on that day due to a lengthy power failure and severe cold conditions which forced the closure of several health services.]

All other consultation discussions have taken place via telephone over the period of December 2010 into February 2011.

Best Practice

A search for literature relevant to mental health, addictions, Aboriginal healing practices and cultural loss was undertaken. Information collected was read, summarized and used to guide the development of the ***Transformational Process.*** Direct references to the literature are noted as footnotes in report. A full list of references for material used in the project is contained in Appendix B.

In addition, one consultation session conducted by the consultants served to provide best practice information relevant to the project. This took place outside of the Northwest Territories. This involved the Cowichan Band, Ts'ewultun Health Center, near Duncan, British Columbia. The Mental Health Team at the Ts'ewultun Health Center has adopted a population health approach to delivering mental health services to the people of the Cowichan Band. Discussions with this team served to clearly validate the ***Transformational Process*** presented to the NWT. The discussions highlighted the positive outcomes of applying this model and also identified the challenges. A complete continuum of mental health services with a strong emphasis on mental health promotion, prevention and education is provided. Many opportunities within this model of service delivery could clearly work well if applied to the future directions and promising practice for the delivery of mental health services in the NWT.

SECTION 2: CURRENT SITUATION

In considering the mental health and addictions issues in the NWT and determining how the NWT might advance in addressing these issues, attention was directed to describing the current situation. This includes examination of the general context as well as the system context.

GENERAL CONTEXT

Northwest Territories

The critical contextual point of departure for a transformation is that northern issues require northern solutions. The Northwest Territories is a culturally diverse and geographically large and unique part of Canada.

The unique features of the NWT point to the need to develop different approaches to provide for the needs of the population. The nature of the NWT also offers unique opportunities and challenges when attempting to attend to these needs and to move in a direction that will lead to a healthier population.

The NWT has a geographical area of 1,171,918 square kilometres. The northern location brings with it a number of unique challenges. These challenges include climate, geographic size, isolation of communities, etc. They also impact the population and how services are delivered to this population.

As of July 2010 there were 43,759 people in the Northwest Territories. Yellowknife is the only city. Approximately half the population of the NWT is Aboriginal. However, the mix of Aboriginal and non-Aboriginal is not consistent across the communities. For example, in Yellowknife, the population is almost 20,000 but only about one quarter is Aboriginal. In Hay River and Norman Wells the population split is about 60% non-Aboriginal and 40% Aboriginal. Other than these communities the majority of the population is Aboriginal and in most small communities the proportion is over 90%.

The population mix is also different from the southern parts of Canada in that there are more children, youth and young adults. In NWT, in 2010, 21.7 per cent of the population was under 15 years of age while for Canada as a whole just 16.5 per cent was under 15. In the NWT 38.5 per cent is under 25 (29.9 per cent in Canada) and nearly half of its population is under 30 years of age (36.9 per cent in Canada). Just 5.5 per cent is over 65 (compared with Canada's senior population of 14.1 per cent).

From a community population perspective the 2006 Statistics Canada census indicated the following for the ten largest municipalities in the NWT:

- Yellowknife……..18,700
- Hay River…….. 3,648
- Inuvik…… …… 3,484
- Fort Smith…….. 2,364
- Behchoko…….. 1,894

- Fort Simpson… ……. 1,216
- Tuktoyaktuk…….. 870
- Fort McPherson……. 776
- Norman Wells…… 761
- Fort Providence……. 727

Total…… 34,440

The remaining population of 7,024 [as per the 2006 census] live in approximately 21 smaller municipalities and settlements spread across the geographical area of the NWT.

With 50% of the population being Aboriginal, the issues of colonization, residential schools, and loss of culture have a major impact.

The Northwest Territories Official Languages Act recognizes eleven official languages. English is the mother tongue for 78% of the population but 99.1% report being able to converse in English and 89.6% uses English as a home language[2]. While English language services are universally available, there is no assurance that other languages will be used by any particular government service except in the courts or during debate and proceedings in the legislature. Access to services in any language is limited to institutions and circumstances where there is significant demand for that language or where it is reasonable to expect it given the nature of the services requested.

Opportunities:

- There is already a good foundation of programs and services (see pages 33 through 35)
- Department of Health and Social Services leaders want action; community leaders want action
- The new Devolution Agreement has been approved; implementation will make new resources available
- NWT is a small jurisdiction in numbers of people and bureaucracy so it should be easier to use approaches that are:
  - Collaborative across sectors, departments and disciplines
  - Community-based; community-focused
  - Community building

Challenges:

- NWT is vast geographically with many small, isolated communities; supports and services for those communities are adversely affected by extreme weather and distances and the difficulties these cause for travel and transportation
- There is a need to change mindset: solutions are not found by simply providing more of the same programs and services
- Not unique to the rest of Canada, there are unhealthy communities and unhealthy people (e.g. obesity, substance misuse, poor lifestyle choices, depression)
- Half the population is Aboriginal and that group has unique historical, health and economic challenges to overcome

[2] Statistics Canada 1986-2006

Aboriginal Context

As noted in the information on the NWT, 50% of the NWT population are Aboriginal. Within the Aboriginal population there are three main groups: the Dene, Inuit and Metis. There is diversity within each of these groups.

According to the Health Council of Canada, the overall health status of Aboriginal peoples is well below the national average. Aboriginal people also have higher rates of death from suicide, mental health concerns as well as other health concerns.[3] Key to the Aboriginal population is the need to recognize the complex history and the resulting reasons behind mental health and addictions. The well documented impacts of residential schools and the corresponding impact on the health of communities must be considered in examining and trying to address mental health and addictions. Cultural losses, disintegration of family structure, ongoing stresses and the corresponding economic issues directly impact the health and mental health of the Aboriginal population in the NWT.

It was not until the late 1990's that the Canadian Government acknowledged the impacts of the residential schools on the Aboriginal people. Even though the Canadian Government did not issue a formal apology they did make a statement of acknowledgement. They also did establish the Aboriginal Healing Fund and the Aboriginal Healing Foundation to address the "healing needs of all those impacted by residential abuse, including intergenerational impacts."[4] Further recognition was evident in 2006 when the Government of Canada signed the *Indian Residential Schools Settlement Agreement* and in 2008 with the start of the Indian Residential Schools Truth and Reconciliation Commission.

This healing process is underway but nowhere near completed. In addition, the trauma and impacts from the residential schools is only one source of historic trauma. As outlined in a number of studies and reports prepared by the Aboriginal Healing Foundation, the Aboriginal trauma began with the arrival of the Europeans beginning in the mid 1400's. Various forms of abuse and trauma have continued since. This trauma has resulted in physical, economic, cultural, social and psychological issues for the Aboriginal people. A model of "historic trauma transmission (HTT)" has been proposed in an article by the Aboriginal Healing Foundation[5]. This model proposes that the *"historic trauma is understood as a cluster of traumatic events and as a disease itself. Hidden collective memories of this trauma, or a collective non–remembering, is passed on from generation to generation, as are the maladaptive social and behavioural patterns that are symptoms of many disorders caused by historic trauma. There is no "single" historic trauma response; rather, there are different social disorders with respective clusters of symptoms. HTT disrupts adaptive social and cultural patterns and transforms them into maladaptive ones, which manifest themselves into symptoms of social disorder. In short, historic trauma causes deep breakdowns in social functioning that may last for many years, decades and even generations."*

Another way of describing the issues of the Aboriginal population is described as "generational grief", sometimes referred to as intergenerational or multigenerational grief. This is described by the Aboriginal Healing Foundation as follows: "*Intergenerational or multigenerational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored*

[3] Health Council of Canada, 2005
[4] Aboriginal Healing in Canada: Aboriginal Healing Foundation 2008
[5] Historic Trauma and Aboriginal Healing; Aboriginal Healing Foundation 2004

and there is no support for dealing with it, the trauma is passed from one generation to the next. What we learn to see as "normal", when children, we pass on to our own children. Children who learn that physical and sexual abuse is "normal", and who have never dealt with the feelings that come from this, may inflict physical abuse and sexual abuse on their own children. The unhealthy ways of behaving that people use to protect themselves can be passed on to children, without them even knowing they are doing so."[6]

Similar to and related to generational issues of physical and sexual abuse, mental health and addictions issues within the Aboriginal population are intergenerational and related to historic trauma transmission. Therefore any actions to address mental health and addictions must consider historic trauma transmission or generational grief and act to address it. This puts an emphasis on the need to shift the philosophical approach of the mental health and addictions system to include traditional Aboriginal healing practices that examine and consider the impact of HTT.

Mental Health, Addictions & Social Problems

Mental Health

Incidence and prevalence rates for mental illness across the NWT are not readily available. Consultants were informed by the Department of HSS that these statistics are not reported on a regular or uniform basis and thus there is no definitive information to draw upon to describe this situation. There is, however, considerable information available as to the prevalence and burden of mental illness on a global basis as well as for Canada specifically. In order to present the significance of this important aspect of the mental health system, in the NWT, these global and national figures are being presented in this report. The statistical detail of these findings can be applied to the NWT on a population prorated basis.

The Province of Alberta released a report in 2004 titled "Advancing the Mental Health Agenda, A Provincial Mental Health Plan for Alberta". Facts presented in this plan relating to prevalence rates and burden of mental illness are as follows:

In Canada:

- Six million or 20% of all citizens will experience a mental illness in their lifetime. Three percent will suffer a severe and persistent disability due to mental illness
- Mental illnesses affect people of all ages, education levels and cultures
- In 1999-2000over nine million hospital days were utilized by people with mental illness and in 1998-99, mental disorders accounted for 14% of the total days of care in general hospitals
- The economic burden of mental illness is estimated at $14.4 billion a year. Mental illness ranked fifth highest in spending on drugs and second highest in facility costs
- Mental health diagnoses rank among the most frequent diagnosis in primary care. Approximately half of all office visits resulting in a mental health diagnosis involve physicians who are not psychiatrists.

In Alberta:

- Over 600,000 people or 20% of the population will experience a mental illness during their lifetime
- In 2002-03, just over 500,000 Albertans [17% of the provincial population] were treated by a physician for a mental health related problem. There were more than 2.25 million visits to a physician for the primary purpose of receiving treatment for a mental health problem

[6] Aboriginal Healing Foundation 1999

- 39% of all general practice physician billings were mental health related
- mental health problems constitute the top reason why people consult their family physician
- over 34,000 Albertans went to a hospital emergency department in 2001-02 because of a mental health problem
- in 2002 $472 million public funding was spent on mental health service

In recent years the impact of concurrent disorders [mental illness and addictions] has received much attention. In a document by "The Concurrent Disorder Task Force of the Public Policy Committee", Canadian Mental Health Association, it was found that:

- In Edmonton, Alberta, 1/3 of the mentally ill also have a substance abuse problem
- In Ontario, 97% of individuals in mental health or addictions programs have a concurrent disorder
- Also in Ontario, 85% of programs that responded to the survey do not treat individuals with concurrent disorders[7]

In a study conducted in British Columbia it was found that:

- 55% of those individuals using mental health services had a substance abuse problem after their first episode of mental illness
- 50% of those individuals with a mental illness abuse drugs and/or alcohol, compared to 15% of the general population
- 47% of individuals with schizophrenia have a substance abuse problem
- 56% of individuals with bipolar conditions have a substance abuse problem
- more than 1/3 of individuals with anxiety disorder have a substance abuse problem.[8]

The Burden of Mental Illness

The impact of mental illness on the general public and the world is noted in the literature and many reports on mental health and mental illness both within Canada and world-wide. Based on the "Global Burden of Disease" study that was conducted by the World Health Organization, the World Bank and Harvard University, mental illness, including suicide, accounts for over 15 percent of the burden of disease in established market economies such as Canada and the United States. This is higher than the disease burden caused by all cancers.[9]. The study developed a single measure that could be used to compare the burden of disease across many different disease conditions. The measure which is called Disability Adjusted Life Years [DALYs] estimates lost years of healthy life due to either premature death or disability.

In addition to the defined burden of mental illness, the World Health Organization [WHO] has succinctly summarized the undefined burden and a hidden burden of mental health problems[10]. Although both of these types of burden are difficult to quantify, the impact is still recognized.

[7] Canadian Mental Health Association, Ontario Division , 1997
[8] BC Partners for Mental Health and Addictions Information
[9] Impact of Mental Illness on Society, National Institute of Mental Health, 2001
[10] World Health Organization: Fact Sheet N.218, Revised November 2001

The undefined burden includes the economic and social burden for families, communities and countries including:

- Lost production from:
  - premature deaths caused by suicide [generally equivalent to and in some countries greater that deaths from road traffic accidents]
  - people with mental illness who are unable to work, in the short, medium or long term
  - family members caring for mentally ill persons
- Reduced productivity from people being ill while at work
- Cost of accidents by people who are psychologically disturbed, especially dangerous in people like train drivers airline pilots, factory workers
- Supporting dependents of the mentally ill person
- Direct and indirect financial costs for families caring for the mentally ill person
- Unemployment, alienation and crime in young people whose childhood problems e.g. depression, behaviour disorder, were not sufficiently well addressed for them to benefit fully from the education available
- Poor cognitive development in the children of mentally ill parents, and
- Emotional burden and diminished quality of life for family members.

The hidden burden results from stigma associated with mental illness and violations of the human rights of individuals with mental illness. As noted by WHO , because of stigma, persons suffering from mental illness are:

- Often rejected by friends, relatives, neighbors and employers leading to aggravated feelings of rejection, loneliness and depression
- Often denied equal participation in family life, normal social networks and productive employment
- Stigma has a detrimental effect on a mentally ill person's recovery, ability to find access to services, the type of treatment and level of support received and acceptance in the community
- Rejection of people with mental illness also affect the family and caretakers of the mentally ill person and leads to isolation and humiliation
- Major causes of stigma associated with mental illness are the myths, misconception and negative stereotypes about mental illness held by many people in the community.

The importance of mental health and the burden of mental illness on society and the world are clearly articulated in a number of recent publications such as the "Kirby Report" on mental illness, the WHO Mental Health Report 2001, the European Union documents and planning documents released from Australia.

Addictions

Based on previous reviews and reports prepared within the NWT the following key information about addictions is presented.

ALCOHOL

The prevalence of current drinking among NWT residents aged 15+ remained constant at around 78% between 1996 and 2006. There was also little change in the frequency of alcohol use among current drinkers aged 15+. By 2006, 29% of current drinkers reported drinking more than once per week, 17% reported once per week, 33% drank 1 to 3 times per month and 22% drank less than once per month. Overall, there was little change in the normal amount of alcohol consumed on a single occasion. By 2006, approximately 42% of current drinkers reported consuming 1 or 2 drinks, 23% drank 3 or 4 drinks and 35% consumed 5 or more drinks in a single sitting. However, the proportion of Aboriginals who reported drinking 5+ drinks on a single occasion declined from 61% to 50%, while prevalence among Non-Aboriginals increased from 19% to 24%.

Although older residents, Non-Aboriginals, higher education and income groups tend to drink more frequently, younger residents, males, Aboriginals, lower education and income groups tend to drink larger quantities of alcohol when they do drink. Consuming 5 or more drinks on a single occasion at least once a month is an indicator of 'regular' binge drinking. The prevalence of monthly binge drinking among current drinkers increased from 33% to 45% between 1996 and 2006. For the population groups, prevalence increased from 44% to 60% among 15 to 24 year olds, 37% to 47% among 25 to 39 year olds and 18% to 38% among 40 to 59 year olds. Prevalence also increased among males (42% to 50%), females (24% to 39%) and Non-Aboriginals (24% to 37%) over the past 10 years.

Residents aged 15 to 24 were more likely than the older age groups to engage in regular binge drinking. Males were more likely than females and Aboriginals were more likely than Non-Aboriginals to binge drink. University graduates were less likely to binge drink than the other education groups, while high income households had a lower prevalence than both low and middle income households.

The prevalence of weekly binge drinking changed little between 1996 and 2006. By 2006, around 14% of current drinkers aged 15+ were weekly binge drinkers. Prevalence declined from 23% to 18% among males and from 27% to 16% among Aboriginals between 1996 and 2006. The Aboriginal and Non-Aboriginal drinking gap narrowed considerably. By 2006, there was no significant difference between Aboriginals and Non-Aboriginals in the prevalence of weekly binge drinking.

Approximately 37% of current drinkers aged 15+ scored eight or higher on AUDIT (i.e. an identifier of harmful/hazardous drinking patterns). This means that over one third of the NWT population engaged in hazardous drinking practices. Residents aged 15 to 24 were more likely than the older age groups, males were more likely than females and Aboriginals were more likely than Non-Aboriginals to engage in hazardous drinking. University graduates were less likely than the other education groups and high income households were less likely than both low and middle income households to drink hazardously.

MARIJUANA

The majority of the NWT population reported using cannabis at least once in their lifetime. Overall, the proportion of lifetime users increased from 53% to 60% between 1996 and 2006.

Since 2002, the prevalence of past year cannabis use has been stable at around 20% of the NWT population. Residents aged 15 to 24 were more likely than the older age groups, males were more likely than females and Aboriginals were more likely than Non- Aboriginals to have used cannabis in the year prior to the survey. University graduates were less likely than the other education groups to have used cannabis, while both high and middle income households had a lower prevalence than low income households. In 2006, it was estimated that around 49% of past year cannabis users were using cannabis at least once a week and could be considered 'regular' users. This means that at least 10% of the NWT population aged 15 and over was using cannabis on a regular or weekly basis.

OTHER DRUGS

Lifetime use of any of the five types of other illicit drugs (i.e. cocaine/crack, hallucinogens, speed, ecstasy and heroin) has remained stable at around 17% between 1996 and 2006. Males were more than twice as likely as females to have used other illicit drugs at least once in their life. Although not significant, the prevalence of past year use of any of the five illicit drugs increased from 2% to 4% between 1996 and 2006.

Although statistically not significant, the prevalence of past year cocaine/crack use increased from 1% in 1996 to 3% in 2006. By 2006, it is estimated that approximately 2% of the NWT population aged 15+ used either hallucinogens or ecstasy at least once in the year prior to the survey.

SYSTEM CONTEXT

NWT: Territorial Government

The Legislative Assembly of the Northwest Territories has 19 members and functions in much the same way as a provincial legislature, except that there are no political parties. The NWT Territorial Government departments are critical to the success of the ***Transformational Process***.

The government departments and a listing of major responsibilities that are relevant to mental health and addictions are understood as follows. In section 5 of this report how each department relates to the determinants of health is also presented.

Education, Culture and Employment

- Income security
- Adult and post secondary education student financial assistance
- Early Childhood
- K – Grade 12
- Adult and Post Secondary
- Apprenticeship & Occupational Certification
- Career & Employment Development
- Apprenticeship & Occupational Certification
- Employment Standards
- Occupational health and safety
- Early Childhood Development
- Culture, Heritage and Languages

Justice

- Law enforcement
- Courts
- Corrections
- Probations
- Youth criminal justice

Environment & Natural Resources

- Air quality
- Biodiversity
- Climate change
- Environmental assessment and monitoring
- Energy conservation and alternative energy technologies
- Hazardous materials/waste

Industry, Tourism & Investment

- Harvesters Assistance (Agriculture & Hunting/Furs
- Fishing Industry Support
- Arts & Crafts support

Municipal & Community Affairs

- Sport & recreation
- Development of youth
- Volunteerism
- Safety standards

Housing Corporation

- Housing

Health & Social Services

The Department of Health and Social Services is responsible for the following:

- Community wellness funding
- Seniors (continuing care)
- Persons with Disabilities
- Home Care
- Mental Health and Addictions
- FASD
- Family Violence
- Child Welfare
- Environmental Health
- Health Promotion
- Immunization
- Hepatitis C Prevention, Support & Research
- Population Health Fund
- Community Wellness Funding (with fed govt):
  - Aboriginal Head Start
  - Brighter Futures
  - Canada Prenatal Nutrition Program
  - Community Action Program for Children
  - Health Promotion Strategy Fund
  - Healthy Children Initiative
- Hospital services

The Department released the report: *A Foundation for Change: Building a Healthy Future for the NWT 2009-2012.* This report provides the basis for the philosophical structure to guide action related to Health and Social Services in the NWT. Three key goals of: *wellness, accessibility and sustainability* are presented in the report which recognizes the importance of healthy communities.

In addition the Principles identified in the document include

- ❖ Universality
- ❖ Personal Responsibility
- ❖ Sustainability
- ❖ Basic Needs
- ❖ Appreciation of Staff
- ❖ People-Oriented System
- ❖ Prevention –Oriented System,
- ❖ Cultures and Tradition
- ❖ Continuum of Care

The *Integrated Service Delivery Model* integral to the document combines the three elements of using a primary community care approach; ensuring all caregivers and their organization are connected and working together to describe and strengthen core services.

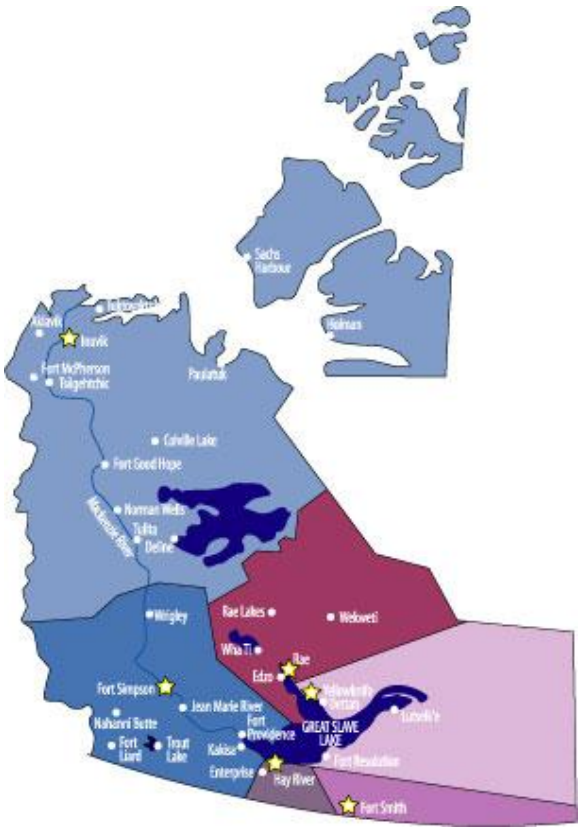
These goals, principles and the *Integrated Service Delivery Model* are all applicable to actions to address mental health and addictions issues.

Health Authority Structure

Seven Health and Social Services (HSS) Authorities, one Community Service Agency and one Territorial Health Authority exist in the NWT. They plan, manage and deliver a full spectrum of community and facility-based services for health care and social services:

- Beaufort-Delta HSS Authority
- Dehcho HSS Authority
- Fort Smith HSS Authority
- Hay River HSS Authority
- Sahtu HSS Authority
- Yellowknife HSS Authority
- Tlicho Community Services Agency
- Stanton Territorial Health Authority

Mental health and addiction services are delivered throughout these authorities and agency.



Mental Health and Addictions: Description of Current Services

The Department of Health and Social Services in the NWT has a vision that states: “People will be supported to live balanced lives by promoting, protecting and restoring their mental well being”. The Department holds forth that the people of the NWT will have access to a wide range of mental health and addiction services that will be delivered by Primary Community Care Teams, through collaborative practice, at the community, regional and territorial levels. Prevention, awareness and early intervention services are to be provided at the community level with a focus on addiction, mental health and family violence. Aftercare programs and services are to be offered as part of a continuum of mental health and addiction services. Counseling and support services are provided at the community and regional levels with residential treatment, tertiary care and psychiatric services offered at the territorial level. If specialized services cannot be made available in the NWT, for an individual with special needs, then referral outside of the NWT is made.

The Department provides leadership, policy, direction and funding to support the operations of the Health and Social Service Authorities across the NWT. These authorities, along with a number of agencies/non-government organizations, are delivering mental health and addiction services to the people of the NWT.

The current array of mental health and addiction services provided to residents of the NWT across the HSSA’s, the Territorial Authority and the agencies/non-government organizations is as follows:

COMMUNITY COUNSELLING PROGRAM

Following the development of a Territorial Framework for Mental Health and Addictions in 2004 the Department established the Community Counselling Program. This program was set in place for the purpose of unifying counselling services across mental health, addictions and family violence. The Community Counselling Program was implemented in the Health and Social Service Authorities complete with program standards, goals and performance indicators. The program was set up with three core positions being: 1) Clinical Supervisors 2) Mental Health and Addictions Counsellors and 3) Community Wellness Workers. This program has operated for more than six years with several reviews and evaluations having taken place which has transitioned the program into it's current state of operation. Overall it can be said that this program operates as it was originally set up however in some HSSA's adjustments have been made to job titles as well as to the roles and responsibilities for the Mental Health and Addictions Counselors and the Community Wellness Workers.

HOSPITALS, COMMUNITY HEALTH CENTRES AND HEALTH STATIONS

There are two regional hospitals in the NWT, located in Hay River and Inuvik. The Stanton Territorial Hospital in Yellowknife serves as a territorial hospital resource to the whole of the NWT. This hospital is operated by the Stanton Territorial Health Authority and offers specialized health services to residents of the NWT when needed. One such specialty this hospital provides is a 10 bed locked psychiatric unit. Psychiatric services are also available to residents of the Beaufort Delta HSSA through the services of a long time visiting psychiatrist who comes to that community each month from Alberta. However the hospital in Inuvik does not have a unit dedicated to psychiatric care and treatment. At times, as circumstances warrant such as when need exceed what can be offered in the NWT, arrangements are made for individuals from the NWT to be admitted to hospital outside of the Territories for psychiatric care and treatment.

Authorities in the NWT operate a total of 21 Community Health Centres in communities across their respective areas. In four smaller, remote communities, two HSSA's provide health services through Health Stations which are for visiting health care professionals on a regularly scheduled basis but do not operate on a regular daily basis. These four Health Stations serve communities that have very small populations which would not make the operation of a Health Centre a viable option.

EMERGENCY SERVICES IN THE NORTHWEST TERRITORIES

Individuals in the NWT can access emergency mental health and addiction services at the Community Health Centres, the Regional Hospital or through the Community Counseling Program. If it is deemed that an individual requires psychiatric care the Stanton Territorial Hospital Emergency Room is contacted with the emergency room physician determining whether to accept care of the individual. If care is accepted a medivac arrangement is put in place to transport the patient to Yellowknife. Residents in and around Yellowknife are able to access emergency mental health services through the Emergency Room at the Stanton Territorial Hospital.

TREATMENT RESOURCES FOR ADDICTIONS

Community Counseling Programs across the NWT are mandated to provide community treatment, support and aftercare for individuals suffering from addictions. In Yellowknife the Tree of Peace agency provides this service. There is no formally recognized and funded medically supervised detox service for people in the NWT. Detox services are provided by a variety of services such as hospital emergency rooms and hospitals. Some agencies who

operate shelters may take people in who are detoxing. Support is provided at the community level by Community Counselling Programs.

Residential treatment for addictions is available in one location in the NWT. This is by admission to the Nats'ejee K'eh Treatment Centre in Hay River. This facility offers 28 day residential treatment programs for adult male groups alternating with women's groups. It is also quite common for residents of the NWT to apply and be approved for support to attend residential treatment programs for addictions in facilities outside of the NWT. Indications for admission to facilities outside of the NWT are:

1. Residential treatment is required for a period of time longer than 28 days
2. Detox is required at a treatment centre
3. Specialized addictions treatment [such as crack cocaine] is required.

MENTAL HEALTH AND ADDICTIONS SUPPORT AGENCIES/NON-GOVERNMENT ORGANIZATIONS

The Tl'oondih Healing Society is funded by the Beaufort Delta HSSA for the provision of a Mental Health Worker. This is a non-government organization in Ft McPherson associated with the Gwich'in Tribal Council. This arrangement provides the community of Ft. McPherson with increased ownership of their mental health and addiction services.

The Gwich'in Tribal Council has been approved for a three year pilot project to fund activities related to workshops and on the land activities focusing on the entire family unit.

The Inuvialuit Regional Corporation in the Beaufort Delta area has been approved to develop a proposal for a comprehensive mental health and addictions model for the region. This work is being done in collaboration with the Beaufort Delta HSSA. The proposed model includes components of 1) evidenced based psychosocial treatment interventions 2) continuum of care 3) case management and 4) training for front-line workers in evidence based practice.

The YWCA in Yellowknife is funded through the Yellowknife HSSA to provide six supportive independent living homes for individuals with chronic mental health problems/organic brain injury and those with cognitive development impairments. Three Independent Living Support workers provide various outreach services to individuals living in these homes in order to maximize the functioning of these clients.

The YWCA also operates the Alison McAteer House which is a shelter for women and children fleeing family violence. In addition Rockhill Apartments are operated by the YWCA for families who have difficulty obtaining housing due to poor rental/credit histories and for transitioning to independent living. The YWCA offers programs for children and youth related to family violence, healthy relationships and empowerment.

The Salvation Army provides emergency housing shelter for men in Yellowknife. In many instances the men arriving to this shelter are mentally ill/intoxicated. The Salvation Army also operates a six bed withdrawal management service for residents within the Yellowknife HSSA in a three bedroom house. The withdrawal management services provided are considered "social withdrawal" as opposed to hospital based "medical withdrawal".

The Salvation Army also operates Bailey House Transitional Housing for men. This house is staffed with support to assist residents with various life skills. Residents must be in abstinence from drugs and alcohol. Bailey House is funded via the Yellowknife HSSA.

The John Howard Society operates a Day Shelter in Yellowknife. This shelter is open from 7AM to 7PM seven days a week to provide a safe and warm place for homeless individuals to go when the emergency shelters close each day. This shelter is currently funded by the Territorial Government, industry and the city of Yellowknife. Based on information received in the consultation, funding is seen as an issue for this shelter in that while the need for this type of service is evident it is not possible for the program to operate in a fashion which would address the safety of clients and staff involved.

The Centre for Northern Families provides emergency shelter for single women who may or may not be inebriated and many of whom are mentally ill. Women in this shelter can access a family physician once weekly with maternal and child health being a focus. A Community outreach worker provides system navigation for women from the Centre.

The Canadian Mental Health Association NWT Branch provides advocacy services, prevention initiatives, mental health information/public education and conducts research initiatives on relevant topics of concern/interest to clients and the public in general. CMHA also operates the Help Line with two part time staff who recruit and train volunteers to operate the line. Being able to recruit and retain volunteers, for this purpose, is difficult making it difficult for this agency to keep the Help Line open.

The Territorial Treatment Centre provides treatment for children of the NWT aged 8-12 with emotional, behavioural and psychiatric problems. The centre is located in Yellowknife and is funded by the Yellowknife HSSA. The centre accesses child psychiatry services through a visiting psychiatrist who comes to Yellowknife on a monthly basis for three day periods.

The Trailcross Treatment Centre is located in Fort Smith and offers residential therapeutic services for male and female youth aged 12-18 years who are experiencing emotional, social/behavioural problems. This centre has a capacity for nine young people and is usually fully occupied with a waiting list not being uncommon.

HEALTH CANADA AND FIRST NATIONS AND INUIT HEALTH

Funding is made available to communities/municipalities, Government Departments, HSSA's, and agencies/organizations in the NWT for programs designed to improve the health of the population. The programs for which funding is available are:

1. Brighter Futures
2. Canada Prenatal Nutrition Program
3. Injury Prevention
4. Aboriginal Diabetes Initiative
5. Fetal Alcohol Spectrum Disorder
6. National Native Alcohol and Drug Abuse Program
7. National Aboriginal Youth Suicide Prevention Strategy

In the 2007/08 fiscal year more than 5.2M dollars were allocated across the NWT to support these federal initiatives.

Other Health & Social Initiatives (Existing or Planned)

Within the Department of Health and Social Services there are a number of initiatives or strategies that have been developed or are in the planning stages that relate to the determinants of health. Many of these are directly related to mental health and addictions.

- Community counselling program
- Integrated service delivery model
- Family Violence
- Homelessness
- Supports for persons with disabilities
- Tobacco strategy
- Early childhood development
- Injury prevention
- Improving services for children in care of Child Welfare
- Healthy foods north project
- Healthy choices framework
- Health promotion fund
- MH programs targeted at youth
- School health
- Quality of life
- Planning improvements to programs for seniors
- Early childhood framework for action (healthy child development)
- Pandemic Plan
- Sexually transmitted infections strategy
- Safe water awareness
- Primary community care model
- Midwifery program
- Implementing quality improvement and accreditation for Authorities

This may not be an exhaustive list of initiatives.

SECTION 3: FINDINGS

CONFIRMATION OF DIRECTION

Previous reviews and in particular the April 2010 "*Review of Mental Health and Addictions Service in the Northwest Territories*" were used as a starting point in the project. The review was undertaken within the context of four key areas identified by the Department of Health and Social Services at the start of the project. These included: *rationale & relevance; program & service delivery; administration & operation and effectiveness & impacts*. These four key areas are not mutually exclusive but rather overlap and are interrelated. Issues within these four key areas were identified. These issues and information from the substantial previously completed reviews, evaluation and reform activities that have been undertaken in the NWT over the last ten years became the starting point for the project.

Within the context outlined above, current service approaches in the NWT were examined and gaps in the service continuum identified. The emphasis was on discovering promising practices that would address cultural relevancy for the region as well as address the challenge of providing a full continuum of service in small and often isolated communities. The need to provide a balanced approach to the service continuum that includes holistic approaches along with mainstream health system service approaches was considered. In addition, examining the needs of service users and professionals; within the context of the best use of existing resources was explored. Finally, the cultural context of the NWT was also crucial in the project.

As part of the project process issues that had been identified previously were confirmed as being current issues for individuals with mental health and addictions problems and the system. Each of these issues has an impact on the mental health and addictions needs of the population and on the capacity of the mental health and addictions systems to meet these needs. These issues are listed here within the four key areas. The main focus within each issue is presented in the following tables and more detail on the issues is contained in Appendix A.

Rationale & Relevance

- Cultural Concerns
- Geographic Characteristics
- Philosophical Views
- Professionalization
- Policy Direction
- Legislation

Program & Service Delivery

- Service Fragmentation
- Lack of Case Management
- Access to Services and Supports
- Lack of Full Continuum
- Integration of Services
- Service Gaps
- Role of Supplementary Personnel
- Housing Concerns

Administration & Operation

- Governance
- Staffing
- Information sharing
- Funding
- Mandate gaps
- Planning Mechanisms

Effectiveness & Impacts

- Standards
- Data Collection
- Outcomes
- Satisfaction with service
- Quality control
- Accountability

Mental Health and Addictions Issues

Rationale & Relevance	
Cultural Issues	➢ With half of the population being Aboriginal, it is critical that the issues related to historical trauma transmission be addressed. This includes the impact from the loss of culture, way of life, family break-up and other residential school impacts as well as loss of the elder role. There are also inconsistencies related to how mental health and addictions are viewed and thus responded to within the Aboriginal communities as well as between different Aboriginal groups and between Aboriginal and non-Aboriginal groups ➢ Formation of "Wisdom Committees" of elders across the NW that focus on Healthy Communities is seen as needed
Geographic Issues	➢ Small, isolated communities in a harsh environment involving vast distances across a very large geographical area which impacts cost and availability of services ➢ Concerns about use of the land; native land claims, environmental concerns
Philosophical Issues	➢ Stakeholders expressed need for more leadership from Government level and consistency in philosophical base ➢ Programs and change in services and support has to come from the "grass roots" or local level. In this regard community needs increased strength in areas such as education, housing, employment, income. ➢ Community capacity needs to be strengthened and included in the development and delivery of mental health and addictions services across the NWT.
Professionalization	➢ Conflict between the North American medical approach and the more indigenous approach ➢ It is felt that professionals are not taking the time to ask or to listen to the people especially in the more remote locations and unique cultures. ➢ Urban (Yellowknife) approach is often seen as the only way of providing services but it is not transferable to the other communities ➢ Communities want to have more say in how and what services are developed
Policy Direction	➢ It was generally felt that there is no evidence of a "true merger" of mental health and addiction services across the HSSA's and the Territorial Health Authority. ➢ Stakeholders expressed concern that more "leadership and direction" is required from the Department of HSS. Likewise it was stated that local Governments and Band Councils need to take more of a lead in addressing issues around prevention, education and intervention into MH&A
Legislation	➢ Issues related to culture, geographic isolation and resources availability need to be considered in drafting the legislation

Program and Service Delivery	
Service Fragmentation	➢ Communication across program areas within the Health and Social Services sector is seen as "weak" and often non-existent. Lack of recognition of issues broader than mental health and addictions symptoms e.g. poverty, unemployment, housing and lack of incentives to work
Lack of Case Management	➢ Although recommended in many reviews a case management mechanism has not yet been established ➢ Communication across sectors needs to be strengthened and is critical in a cross sector case management model of practice.
Access Issues	➢ Overall access to programs for children and youth is seen as very limited and very difficult across all part of the service continuum including access to residential treatment programs. ➢ Out of Territory referrals are often the only option but not the preferred one
Lack of full continuum	➢ Stakeholders felt that youth programs must start with interventions aimed at prevention of MH&A issues. ➢ Strong need evident from several HSSA's for more integration of service delivery between social service staff and MH&A staff across child and youth services. ➢ Harm reduction strategies need more emphasis and support in communities across the NWT. One such example where it was felt by stakeholders that this would be effective was in the area of teaching people how to drink responsibly as opposed to teaching abstinence. This was seen to be a particularly effective intervention for youth.
Integration Issues	➢ More discussion and development work is required to take the merger of mental health and addictions beyond a name change ➢ Concurrent disorders not well understood across the MH&A system. Interventions involving concurrent disorders are, for the most part, being done separately in either the mental health or addictions area rather than in an integrated fashion of MH&A interventions.
Service Gaps	➢ Aftercare follow-up services for individuals coming out of hospital treatment and residential treatment for addictions is seen as a void
Role of supplementary personnel	➢ RCMP often first and sometimes only responders. Mechanisms need to be developed to ensure these support service providers, and others of a similar nature, are involved in setting system directions and in implementing that direction into practice. ➢ Several stakeholders indicated a clear need to train local people to provide additional support to individuals with mental health and addictions issues
Housing Issues	➢ Housing is a major issue for people with mental health and addictions in the NWT. Affordability, access, safety and Housing Corp policies create major barriers in prevention and interventions ➢ Housing models for remote communities based on unique community needs/issues do not seem to be evident.
Other Issues	➢ There is a lack of collaborative involvement and policy direction across income support, justice, health and social services to support the most vulnerable individuals with mental health and addictions issues.

Administration & Operation	
Governance	➢ Leadership from the Department of Health and Social Services is seen as inconsistent and not strong. ➢ Need for increased communication across government, health authorities and communities
Staffing	➢ Staff recruitment and retention is an ongoing and serious issue across the NWT [this includes psychiatrists]. ➢ Job re-definition and education requires attention in regards to the practice model (Integrated Service model) ➢ Conflict with the indigenous approach needs to be considered
Info sharing	➢ Major lack of cooperation in sharing of information. Services work in silos and make little effort to resolve barriers around info sharing across sectors. This becomes an issue/barrier in instances when related case management information would clearly benefit integrated service delivery for individuals across sectors within health as well as across the social service sector and health.
Funding	➢ Federal Government has a large influence and presence in mental health and addictions program funding across the HSSA's.
Mandate gaps	➢ Confusion exists in many locales as to the role of the Federal Government in program planning, development and funding allocation and the connectedness of these programs to MH&A services.
Planning	➢ Ongoing planning mechanisms are either not in place or done in silos and on an inconsistent basis ➢ Indigenous people are not involved or adequately consulted around initiatives involving mental health and addictions planning. ➢ Cross sector involvement in planning is lacking thus creating greater barriers towards a true integrated model of service delivery.
Effectiveness and Impacts	
Standards	➢ Program standards [for CCP] are seen as outdated and require updating
Data Collection	➢ The Department has not taken clear and strong leadership in providing direction and requirements to the HSSA's/Territorial Health Authority for the provision of monthly Statistical Information in relation to MH&A activity and outcomes. *[Currently no data of this nature is available from the Department.]*
Outcomes	➢ No indication of outcomes indicators or measurements being in place.
Satisfaction with service	➢ Very little, if any evidence, that service users are canvassed on a regular or routine basis to determine their satisfaction with service.
Quality control	➢ A need for an accreditation model for the MH&A service across the NWT was cited. It was felt that this would ensure that services are being delivered to a consistent standard across all aspects of the system.
Accountability	➢ The Department's accountability requirements for the MH&A's programs are not evident or at best not comprehensive and consistently applied.

READINESS FOR A *TRANSFORMATIONAL PROCESS*

There is a sense for readiness for a new direction to address the many issues identified for the mental health and addictions system. This was evident in the opportunities identified during the project that suggest a sense of readiness. In addition, through consultation a number of examples of good practice within communities across the NWT were identified. These examples fit with the ***Transformational Process*** and would be supported through this process.

Opportunities

Through the project a number of opportunities for moving in the new direction were identified.

Opportunities that highlight readiness for ***Transformational Process***

Commitment to change	Department of Health and Social Services and community leaders want action
	The commitment to implement an Integrated Service Delivery Model for the delivery of mental health and addictions services has been made the time is right to take this commitment to full implementation across all HSSA's and the Territorial Health Authorities in the NWT.
	Recognition of need for change is beginning in important areas such as merging of mental health and addictions and extending the responsibility for mental health and addictions beyond the Department of Health and Social Services
Uniqueness of NWT	NWT is a small jurisdiction in numbers of people and bureaucracy to it should be easier to use approaches that are: • Collaborative across sectors, departments and disciplines • Community-based; community-focused • Community building
	Recognition that traditional Aboriginal ways need to be respected and applied in practice
	Understanding that northern issues require northern solutions
Linkage across other governments	Devolution agreement implemented; new resources available
	The Federal Government provides considerable funding for programs that provide opportunity to improve the mental health of a community. There is a need to close the gap and work together to ensure there is good communication, planning and linkages around the implementation of these programs across the NWT and that they work in collaboration and support of the mental health and addictions programs being delivered by other sectors.

Opportunities that highlight readiness for ***Transformational Process***

Cross sector initiatives	Communities generally appear to be looking for ways to work together to find improved ways of dealing with the increasing problem of mental health and addictions in their areas. In approaching this challenge, communities appear to be recognizing the value of working together across the sectors of health, social services, education, housing, employment and income supports while at the same time having consideration for traditional values and practices.
	All HSSA's across the NWT have implemented initiatives and activities focused on mental health promotion and education. It is now timely to take these initiatives further across other relevant service sectors for a more effective and collaborative approach to dealing with mental health and addictions issues.
	The Department of Justice has indicated a keen interest in jointly addressing mental health and addictions issues of individuals within the corrections system as well as within the law enforcement. This could include providing Mental Health First Aid to Justice staff; sharing resources, diversion and supportive care; and exploring opportunities to help people while in jail. In addition having community members participate in strategies to address issues of individuals.
Aboriginal Community readiness	The naming and description of historic trauma transmission through groups like the Aboriginal Healing Foundation sets the stage for beginning to address mental health and addictions issues from a meaningful starting point
	Communities are clear in stating that they wish to see a return to more traditional family values and practices. These communities are looking for support to broaden this undertaking in order to improve the overall mental health of their communities.
Interest of private industry	Private industry is coming forward more actively to support initiatives and to be involved in interventions that improve the health of communities.
	The possibility of moving ahead with the Mackenzie Gas Project is both a potential opportunity and a problem. The ***Transformational Process*** can be instrumental in ensuring that the proposed growth through economic development is balanced with attention to the social, cultural and environmental issues that are likely to arise.
Committed staff	The HSSA's and the Territorial Health Authority feel that they have many energetic and talented people working in mental health and addictions services. They have expressed a desire that the time is right for leadership to come from the Territorial Government level to create a thrust to move the mental health and addictions system forward into an integrated and collaborative service delivery model.

Examples of Good Practice within NWT

The following is a sample of good practice that is occurring within NWT. These may or may not have the full sanction or support of the health authorities or the Department of Health and Social Services. This list provides examples that the project team was made aware of and is not necessarily an extensive list.

Examples of good practice that highlight readiness for ***Transformational Process***

Community Development	In 2009 the Inuvialuit Regional Corporation [IRC] partnered with the Beaufort-Delta HSSA for the purpose of undertaking a process of designing a culturally relevant and sustainable mental health and addictions program delivery model for the Inuvialuit communities. In 2010 the final report titled "Inuvialuit Settlement Region Mental Health & Addictions Model" was released for consideration and discussion. The IRC and the BDHSSA are in further discussions with the communities involved in this study with the focus being to realign programming in accordance with community determined need.
	The Tlicho Community Services Agency has a Wellness Worker, who is an individual from the community, and who works as a Community Development Worker. This individual has demonstrated considerable success in bringing people forward to work together on issues like housing, community support, income support, suicide issues and other matters of concern that affect the health and well being of individuals and the community.
Traditional Aboriginal Approaches	A number of communities across the NWT have indicated that they are utilizing traditional cultural ways of addressing social issues which have a significant impact on mental health and addictions issues. The most common traditional cultural intervention mentioned was employing "back to the land" experiences. This form of intervention is particularly effective for youth and utilizes the services of elders in moving the values of young people back towards traditional values of family and community strength. The areas where this type of intervention was most heard about were in the Beaufort-Delta HSSA, the Sahtu HSSA however it is quite likely that similar forms of this type of intervention are underway in other HSSA's as well.
	Discussions with staff in the Deh Cho HSSA indicated that their efforts to work closely with elders and chiefs when planning and commencing community interventions, that deal with social and emotional issues, allows for the community to be on board and to foster cultural beliefs and practices into the interventions.
	The Deh Cho HSSA cited the value of incorporating natural supports through use of elders and traditional healers when moving forward with initiatives to strengthen community capacity in order to help support individuals encountering mental health and addiction issues.

Examples of good practice that highlight readiness for ***Transformational Process***

Integration of Services	All HSSA's have implemented Community Counseling Programs in their regions in order to address issues related to mental health and addictions. The significant point of having these programs in place is that all authorities recognize the significance of mental health and addictions issues in their communities and as such have built the foundations from which a more effective and collaborative cross sector model of mental health and addictions service delivery might be built upon.
	In the Hay River HSSA initiatives have been taken to diversify the role of Mental Health Counsellors and Wellness Workers into one. The diversification of roles has created opportunity for Mental Health and Addictions staff to be more actively involved in community and broadens the horizon of intervention initiatives
Collaborative Practice	A number of HSSA's have cited examples where they are making positive efforts to develop collaborative working relationships across other service sectors in their areas.
Cross Regional Collaboration	In Yellowknife the Stanton Territorial Health Authority, the Yellowknife HSSA and the Department of Health and Social Services have partnered together to form a Mental Health Advisory Committee. This initiative has seen improvement in communication and coordination of services across these service authorities.
	The merger of the Stanton Territorial Hospital Mental Health Clinic with the Adult Services Program in the Yellowknife HSSA has resulted in a more coordinated intake, discharge planning and overall improved case management system for people with mental health issues in Yellowknife.
Social Marketing	The Government of the NWT, Department of Health and Social Services, contracted with a private consulting firm in 2010 to review existing research and undertake additional research leading to the development of a social marketing strategy on addictions. Particular emphasis was focused on alcohol and drug addictions in the NWT. Currently work is underway to commence piloting the social marketing strategy, developed for this purpose, in the communities of Deline [Sahtu HSSA], Fort Simpson [Deh Cho HSSA] and Lutsel K'e [Yellowknife HSSA].
Innovative Practice	The Tlicho Community Services Agency has established a Community Action Response Team [CART] of four young people who connect with professionals, young people in the community and with the schools in the area to discuss areas such as suicide, addictions, sexually transmitted diseases and other social issues that affect the health of individuals and the community. This team has been in effect for approximately two years and has been well received through the awareness and education they have brought to individuals around mental health and addictions issues and other social issues of concern occurring in the community.

NEED FOR A NEW DIRECTION

In undertaking the review of documents, examination of the current system, confirmation of issues, examples of good practice and of best practice literature it became clear that much has already been said and recorded about the improvements that are required for the mental health and addictions systems to be "*current, accessible, and meet the needs of communities".* Much has also been done to define what is needed to "*better integrate our health & social programs and services*" (NWT: ISDM). In the review we found that*:*

Mental health & addictions problems have been extensively identified and studied	❖ Mental health and addictions issues including mental illness and various forms of substance abuse have been identified as problems for the NWT ❖ The numbers of individuals who have mental health and addictions problems have been identified in many studies and reviews over the last ten years ❖ Many reviews and reports that examined the mental health or the addictions service delivery systems have been completed and many relevant recommendations for improving the system have been made ❖ Although the problems have been identified and recommendations have been made, the same issues in the mental health and addictions systems continue to be identified and individuals continue to be ill or have mental health and addictions problems
Principles & strategies for the health system have been developed	❖ The Foundations for Change Report for the NWT identifies relevant recommendations and recognizes the need for healthier communities and attention to cultural concerns, however the recommendations are not firmly linked to mental health & addictions ❖ The recommendations focus on the mandated areas within HSS ❖ The NWT Integrated Service Delivery Model (ISDM) identifies that the various sectors of health are interrelated and describes the elements from a health service structure perspective
Separate reviews and strategies have been developed for other social/health issues	❖ Other issues like family violence, homelessness, persons with disabilities, tobacco use, early childhood development and injury prevention have also been studied and may or may not have included reference to mental health and addictions as they relate to these other areas
Aboriginal cultural issues have been acknowledged at the Federal & Territorial Government levels	❖ The historic trauma from loss of culture, residential school impacts and intergenerational issues has been acknowledged in Canada through the Indian Residential School Agreement & establishment of the Aboriginal Healing Foundation ❖ Work has been done to identify the transmission of the historic trauma and the corresponding impact on contemporary Aboriginal peoples ❖ Confusion remains about mandate of Territorial versus Federal government responsibility for follow-through on cultural issues

Mental health & addictions resources work diligently to deliver services	❖ Mental health and addictions staff provide a range of services within their capacity and within the structure of the system ❖ Resources are governed by the system and work within it as it is structured
Many examples of good practice are in place in NWT	❖ Many communities are working on initiatives to broaden the focus to include traditional Aboriginal healing and or to include the determinants of health ❖ Many of these initiatives are being pursued without support or sanction from government ❖ A solid philosophical framework to guide and support these initiatives is lacking
Issues remain constant and continue to be reviewed	❖ Over several years and within many different reviews of mental health and/or addictions similar or the same issues are identified ❖ Similar recommendations or strategies have been made in the various reviews undertaken over the years

In summary there has been extensive study and recognition of issues and examples of strategies in place. However, a comprehensive framework for moving forward is not in place. This begs the questions: With extensive identification and study of the problems why do the issues remain fairly constant over time and why do individuals with mental health and addictions continue to struggle? In particular the question becomes why is it necessary to continue to examine the mental health and addictions system? Further, if the previous reviews and reports have not been instrumental in moving the system forward, what is standing in the way?

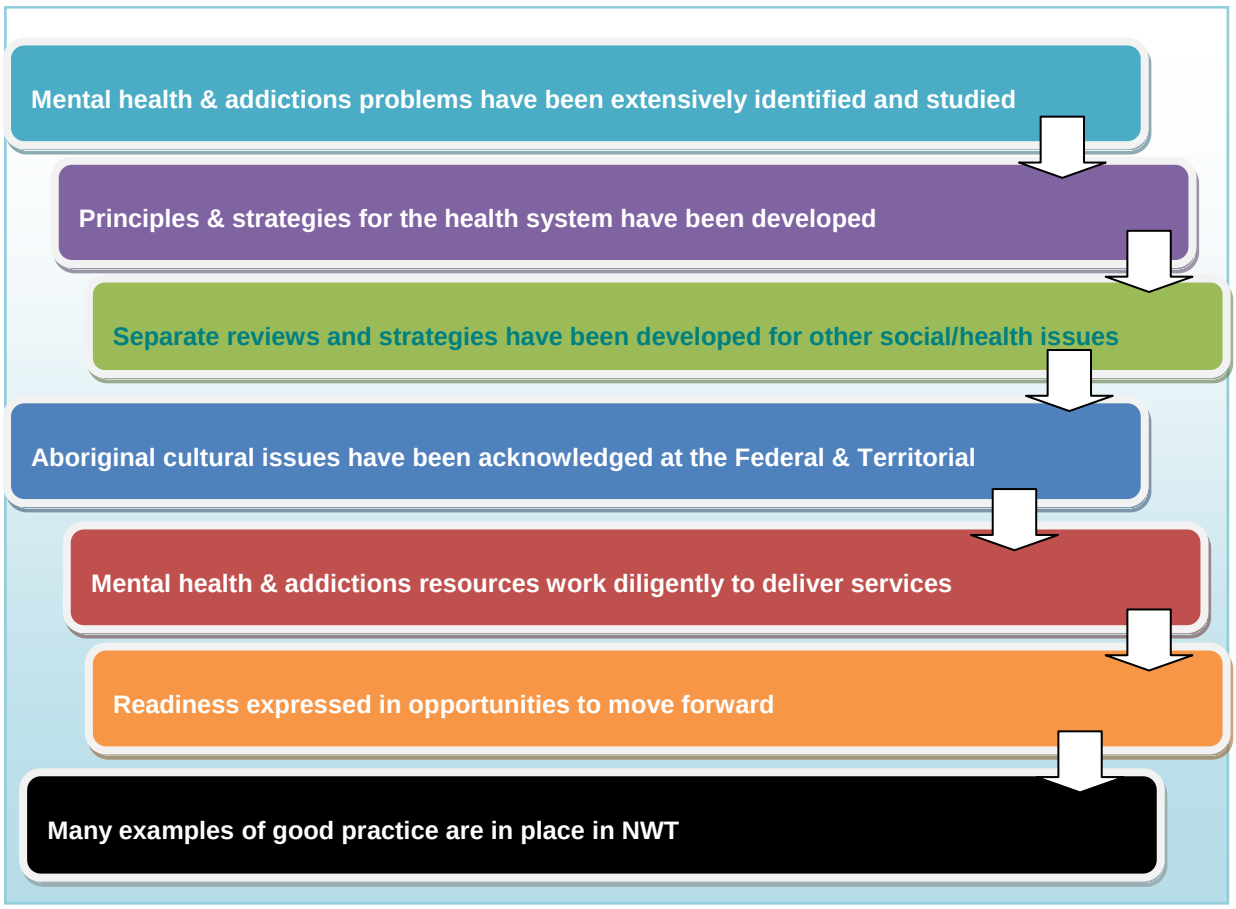
In reviewing the previous documents and hearing about some of the community initiatives and thoughts about ways to move forward, the development of an “action plan” becomes a bit of a puzzle.

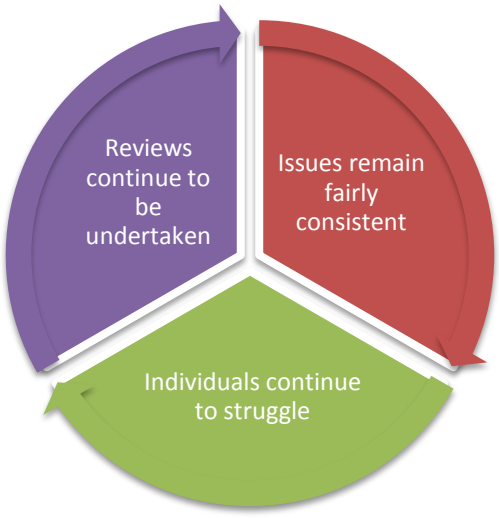
Upon analysis and reflection, a number of factors that are related to why progress in terms of system improvement seem to be stymied were identified. These factors fall into two main categories: first, the lack of full examination of cause and context and secondly, the use of a limited service perspective in undertaking reviews and in development of strategies.

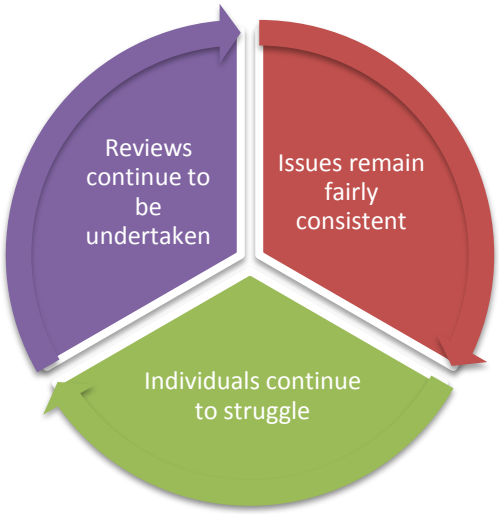
These factors are as follows:

LACK OF EXAMINATION OF CAUSE & CONTEXT	LIMITED SERVICE PERSPECTIVE
❖ Focus on symptoms/problems of individuals but not on the underlying cause and the deep-seeded issues	❖ The centrality of mental health is not recognized beyond the mental health and addictions systems
❖ Problems and needs of individuals do not naturally fall into service system categories	❖ Mental health and addictions issues examined through service system lens not from the perspective of individuals
❖ Cultural issues related to historic trauma transmission have not been dealt with	❖ Problems with mental health and addictions systems extend beyond health system and are not adequately addressed through that system only.
❖ Full range of physical, mental, emotional and spiritual health are not addressed through health & social service system alone	❖ Social and health services examined separately by sector and not as a set of interrelated services
❖ Focus on the symptoms of individuals rather than on individuals manifesting symptoms within a context	❖ Professionals focus on their particular area of the service structure and do not have mechanisms to consider other areas
❖ Overall lack of attention to the role of family supports or to the role of community context and societal context	❖ Review prepared within sectors and not examined beyond that sector therefore providing recommendations that are too narrow (eg. Other social issues not truly integrating mental health and addictions)
❖ Mental health and addiction problems of individuals and the corresponding needs extend beyond the health system and therefore are not adequately addressed through that system only.	❖ Mandate of service area restricts scope of review
❖ Difficulty in recognizing mental health and addictions as a symptom of an unhealthy community or society	❖ Diffusion of responsibility and misunderstood responsibility leaves gaps in service examination

The findings are summarized in the following graphic diagram.







Not considering cause & context

- Focus on symptoms/problems not deep-seeded issues
- Problems & needs do not naturally fall into service system categories
- Cultural issue related to historic trauma transmission have not been dealt with
- Full range of physical, mental, emotional and spiritual health not addressed through health & social service system alone
- Focus on symptoms rather than on individuals manifesting symptoms within a context
- Overall lack of attention to role of family supports or role of community context and societal context
- Mental health & addiction problems of individuals and corresponding needs extend beyond health system, not adequately addressed
- Difficulty in recognizing mental health and addictions as a symptom of an unhealthy community or society

Limited service perspective

- The centrality of mental health is not recognized beyond mental health & addictions systems
- Mental health & addictions issues examined through service system lens not perspective of individuals
- Problems with mental health & addictions systems extend beyond health system and are not adequately addressed through that system only
- Social & health services examined separately by sector and not as a set of interrelated services
- Professionals focus on their particular area of the service structure
- Review prepared within sectors, recommendations are too narrow
- Mandate of service area restricts scope of review
- Diffusion of responsibility and misunderstood responsibility leaves gaps in service examination

SECTION 4: *TRANSFORMATIONAL PROCESS*

The review included focussed consultation, review of documents, examination of issues, review of literature and reflection within the broader context. The review findings point to a new direction that takes the consideration of the mental health and addictions system beyond the confines of the formal mental health and addictions system and into the realm of population health incorporating the principles of the determinants of health. This focus also goes beyond the current "health care system" and takes it beyond the provision of medical care to an expanded definition of health that includes attention to all the determinants of health. Without the attention to individuals within their context their issues are not adequately addressed. Finally, without attention to historic trauma transmission and attention to integration of traditional Aboriginal healing practices where appropriate, the transmission of trauma continues.

In order to move forward in addressing the mental health and addictions issues within the NWT, attention must shift to a broader focus. A different direction is essential. Focusing solely on the health or the mental health and addictions systems will no longer work. It is clear that tinkering with the current mental health and addictions systems is not the solution to the current situation. Instead current information and wisdom substantiates the need to rethink, refresh and expand attention to a broader definition of health and mental health, to recognize the determinants of health within the cultural context. In addition it is time to develop healthy public policy that takes the responsibility for mental health beyond the medical model and treatment of illness, beyond the health department or the health system.

The ***Transformational Process*** *for Mental Health and Addictions*: *Future Directions and Promising Practice* calls for the Department of Health and Social Services to take a leadership role. Addressing the issues of the mental health and addictions system provides an entry point to start the process of addressing the broader definition of health within the context of a population health approach and particular attention to the determinants of health along with integration of Aboriginal healing practices and harm reduction strategies.

The overall strategy for the ***Transformational Process*** involves community conversation and multi-sectoral and multi-departmental commitment working together in a long-term collaborative process. This process brings the community, governments, Band Councils, service providers and business and industry together to address mental health and addictions. Health care and other sectors not traditionally involved in mental health and addictions must become involved and work together for effective outcomes.

The overall goal is to develop healthy individuals, healthy communities and a healthy society. This will result in a corresponding decrease in the number and intensity of mental health and addictions issues as well as improved outcomes for individuals with mental health and addictions difficulties.

The ***Transformational Process*** including the philosophical approaches, the collaborative process and the specific actions validate that mental health and addictions are everyone's business.

Department of Health & Social Services (HSS) takes lead

Take mental health & addictions discussion beyond health & social services

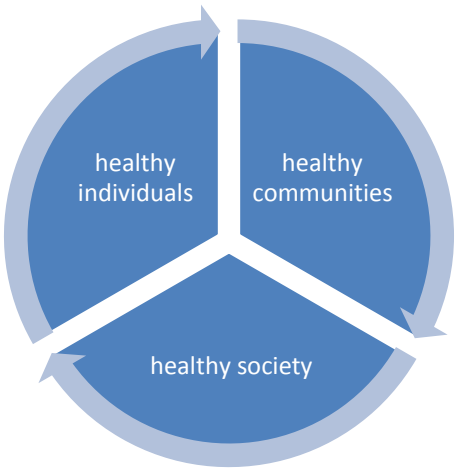
Shift to a Different Philosophical Foundation

- Population Health
- Determinants of Health
- Traditional Aboriginal Healing Practices
- Harm Reduction Strategies

Initiate a Long-term Multi-level & Participant Collaborative Process

- Community Conversation
- Territorial Government Cross-Department
- Other Government levels
- Interagency Service Providers
- Public, Business, Industry

Commit to a Vision for Healthy Communities
Joint Responsibility for addressing mental health & addictions



Shift to a Different Philosophical Foundation

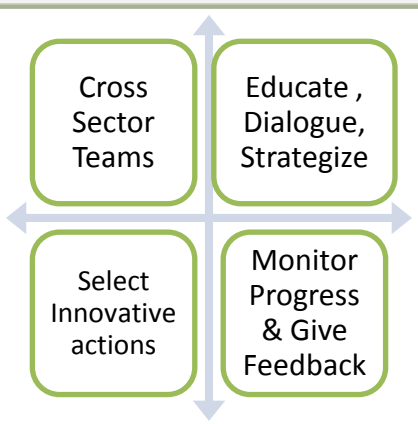
Population Health	Determinants of Health	Traditional Aboriginal Healing Practices	Harm Reduction Strategies
Focus on: • Broader definition of health • Health of the population • Individuals in context • Reduced Inequities	Focus attention on: • Culture • Social & Physical Environment • Income & Social Status • Social Supports • Education • Employment • Personal health Practices & Nutrition • Stress & coping skills • Healthy Child Development • Gender • Health Services • Biology & Genetics	Recognition of Historic Trauma Transmission Maintaining Balance between physical, mental, emotional & spiritual health Inter and Intra connectedness between family, community, culture and nature Transcendence of ego Reintegration of past, present & future to facilitate healing Medicine Wheel & Healing Circle	Broaden focus beyond abstinence to: • Meet people where they are • Allow for small steps • Work with individuals • Be realistic • Foster motivation

Holistic | Attends to Cause | Participatory | Interconnected | Beyond Health Services | Balance

Initiate Long-term Multi-level & Participant Collaborative Process

Community Conversation	Territorial Government Cross-Department	Other Government levels	Inter-agency/ Service Providers	Public, Business, Industry
Support Communities to participate in defining issues; coming up with solutions; carrying through on initiatives; monitoring progress and keeping the cycle alive	Take ***Transformational Process*** beyond HSS to other Government Departments Acknowledge joint responsibility for MHA Establish Territorial Healthy Public Policy	Link with Band Councils; local & federal government Link with their initiatives Share & Expand Territorial Healthy Public Policy Commit to planning	Reinforce & strengthen interagency collaboration Expand interagency collaboration beyond HSS Commit to planning together	Involve general public; business & industry in the process Provide incentives for joint ownership of the problems & solutions

Commit to a Vision for Healthy Communities
Joint Responsibility for addressing mental health & addictions



SECTION 5: FUTURE DIRECTIONS & PROMISING PRACTICES

OVERVIEW OF NEW DIRECTION

Based on the findings of the project, a new direction for addressing mental health and addictions is needed. The new direction takes into consideration the following conclusions:

That:

- mental health and addictions problems have been identified and extensively studied;
- principles & strategies for the health system have been developed;
- separate reviews and strategies have been developed for other social and health problems;
- Aboriginal cultural issues have been acknowledged;
- mental health and addictions resources work diligently to deliver services and
- there are many examples of good practice in place in communities around the NWT.

Yet the issues remain fairly constant, reviews continue to be undertaken and individuals continue to struggle with mental health and addictions.

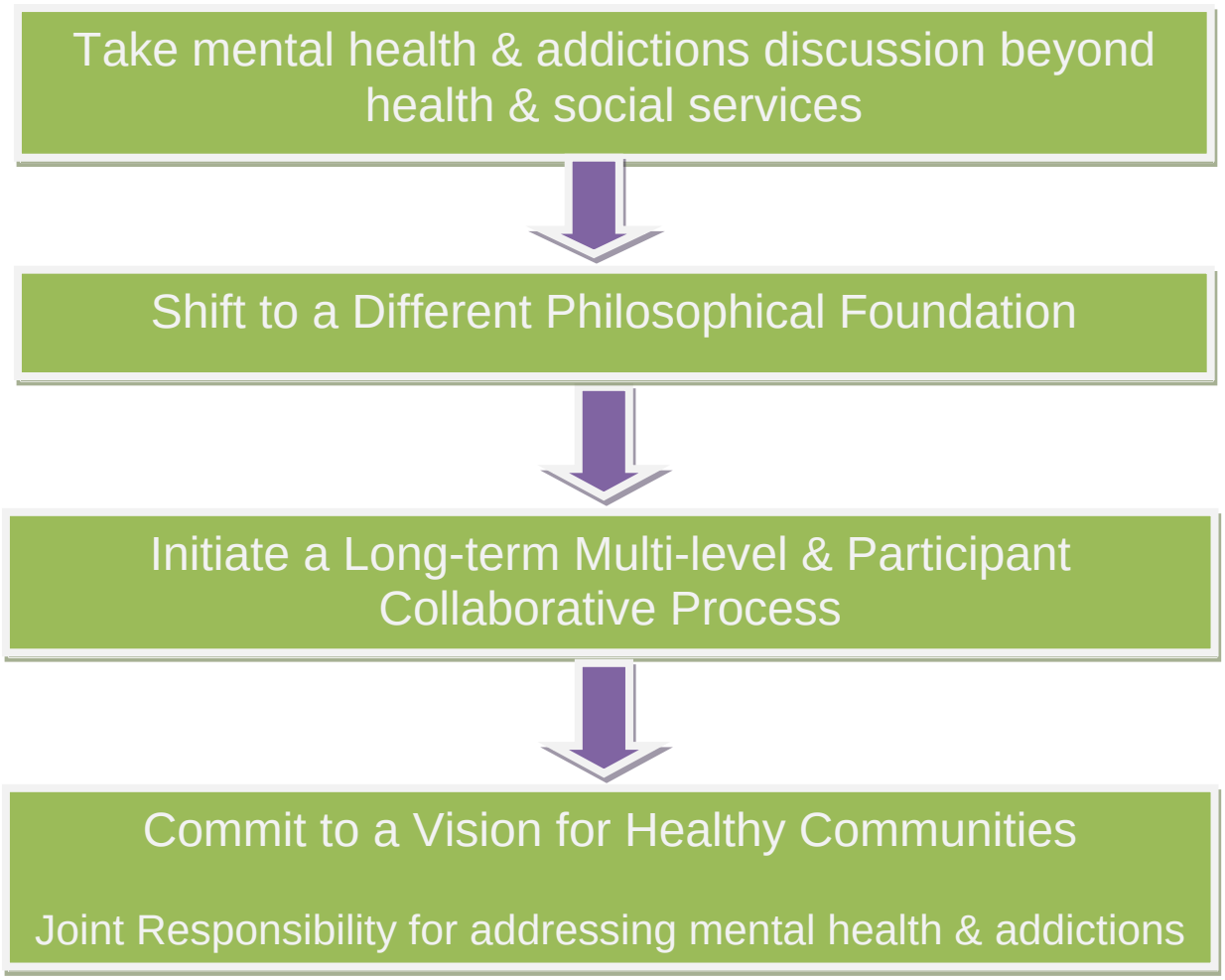
The new direction recognizes that by not considering cause and context, individuals with mental health and addictions issues only have their issues partially attended to. The full range of physical, mental, emotional and spiritual health is not addressed through the health and social service systems alone. In addition with limited service perspectives used to examine how to improve services, the broad needs of individuals and of systems are not recognized. Problems with the mental health and addictions systems extend beyond the health system and are not adequately addressed through that sector only. Housing for example is a critical element of maintaining health and that is determined outside the purview of the health and social service department. In summary without attention to the cause of mental health and addictions issues and a narrow focus on the health and social services systems in efforts to address these issues little progress is made.

This makes it essential to acknowledge the following in addressing mental health and addictions:

- Recognize the centrality of mental health, that it is identified as an issue and as having an impact in many areas beyond health and recognizing the need to go beyond the “formal mental health and addictions system” in examining mental health and addictions issues
- Acknowledge the connection between mental health and addictions, how they are interrelated and the interrelation of mental health & addictions and other social and population health problems
- Acknowledge that mental health and addictions are symptoms of a much larger problem and share the stage with a number of other problems including other chronic health issues such as diabetes, FASD, family and other violence, crime, injury, housing/homelessness, unemployment, lack of education

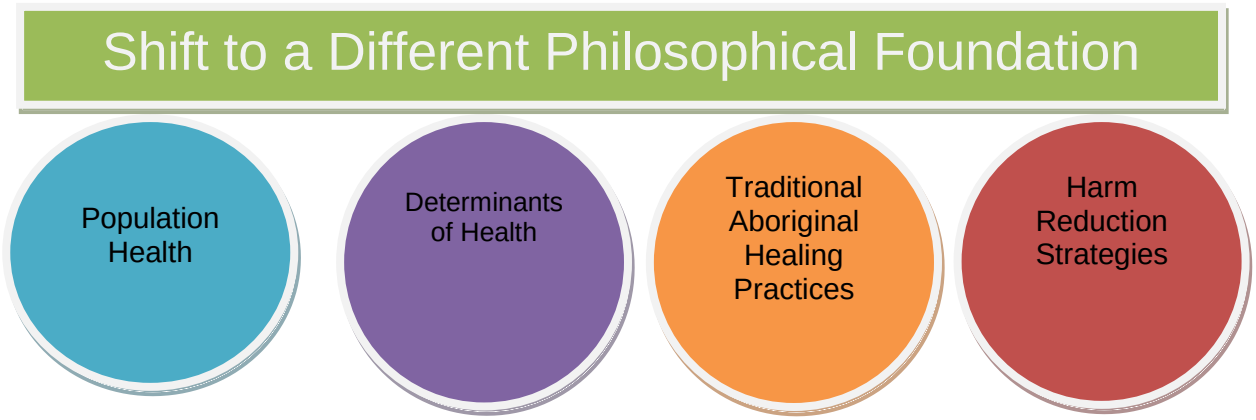
- Acknowledge that the larger problem is related to unhealthy communities and society which is thus larger than mental health and addictions or the Department of Health and Social Services
- Acknowledge the role of Aboriginal cultural issues in the perpetuation of unhealthy individuals, unhealthy communities, and society and recognize historic trauma transmission related to the loss of culture, residential school impacts, intergenerational problems
- Acknowledge that integration of traditional Aboriginal healing practices is necessary within the many communities of the NWT
- Acknowledge that the approach or process of review within the health sector alone perpetuates the service system focus and continues to ignore the whole picture or fully address issues of individuals
- Acknowledge that a northern solution is required to address the challenges of the geography on service delivery: e.g. climate, isolation of communities, transportation issues leads to lack of resources, high staff turnover, difficulty in providing all levels of service to all areas etc.

Within this recognition is the need to:



PHILOSOPHICAL FOUNDATION

The ***Transformational Process*** is dependent on a shift to a different and more expansive philosophical focus. This focus becomes the foundation for addressing mental health and addictions within a broader perspective that examines these issues as just one of several issues which impact the population. This requires attention to the population health and the determinants of health as well as joint responsibility for addressing these determinants. Given the population of NWT, traditional Aboriginal healing practices and principles must be incorporated into the philosophical foundation and integrated in practice. Introduction and encouragement of harm reduction and other supportive initiatives are included to increase the overall effectiveness of initiatives and range of options for addressing issues. The philosophical foundation includes four key approaches or areas of focus:



Based on review of literature and consideration of the NWT context, the principles of each of these approaches provide the foundation for how the ***Transformational Process*** is carried out.

Population Health

Population health approaches focus on the health of the overall population and not just on the illnesses or dysfunction of individuals. In Canada discussion about using a population health approach was evident in 1974 in the Lalonde Report and was given attention in the late 1990s. The Federal Government joined with the provinces and territories in identifying the population health approach and corresponding determinants of health as critical in addressing the health of Canadians. Consideration of population health approaches has continued since, however it seems to generally take a back seat to illness care and health crisis management.

The population health approach is defined by Health Canada as "an approach to health that aims to improve health of the entire population and to reduce health inequities among population groups. In order to reach these objectives it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health".[11] Further population health refers to the health of a population as measured and influenced by social, economic and physical environments, personal health practice, individuals capacity and coping skills, human biology, early childhood development and availability and quality of health services.

[11] Health Canada website

As noted by the Public Health Agency of Canada, the population health approach is characterized by:

- Strategies that include policies, programs and service that respond to evidence about the relative effects of multiple determinants of health;
- Actions and outcomes that have an impact on populations and sub-populations and which therefore address societal, community, structural or system level changes and;
- Collaboration amongst multiple sectors, given that influence over most of the determinants of health lies outside of the health sector.

Further the guiding principles of a population approach include:

- Health is a capacity, a resource for everyday living;
- The determinants of health are addressed, recognized as being complex and inter-related;
- The focus is upstream;
- Health is everybody's business;
- Decisions are based on evidence;
- Accountability for health outcomes is increased;
- Management of health issues is horizontal and
- Multiple strategies, in multiples settings and sectors are used.

Key to the principles is that they are applied as a coherent group, the value of which is only realized if all are attended to. Picking and choosing one or two principles to focus on will not have the same positive results as attending to all principles will have.

Desired goals for a population health approach are identified by the Public Health Agency of Canada as:

- Making health a societal goal, resulting in healthy communities and reduced disparities
- Developing the momentum for change from a focus on issues to a focus on determinants
- Increasing understanding of the societal role in creating health and changing perceptions of health
- Expanding accountability and responsibility for health decisions
- Leading to change in how everyone acts and thinks
- Fostering social cohesion and increasing citizen participation, leading to changes to Canadian infrastructure and eventually to a new health charter
- Increasing understanding of the determinants of health and their interconnectedness
- Providing a coherent framework for the work of (Health Canada) and other federal departments, and increasing the effective use of resources to improve the health of Canadians
- Making population health real and meaningful by generating experience of it, and providing evidence of its effectiveness.

These goals set the stage for the ***Transformational Process*** to address mental health and addictions within the NWT.

Although the conversation and application of population health approaches in Canada are not currently front and centre in the discussions about health care, the approaches nonetheless remain relevant.

Resurgence in the population health approach however is evident on the global health scene with the World Health Organization (WHO) release of the ***Adelaide Statement on Health in All Policies: moving towards a shared governance for health and well-being*** in 2010***.*** This statement highlights the importance of a population health and determinants of health approach as well as a broad collaborative approach across governments but also outside government.

Specifically it states that the "government objectives are best achieved when all sectors include health and well-being as a key component of policy development. This is because the causes of health and well-being lie outside the health sector and are socially and economically formed. Although many sectors already contribute to better health, significant gaps still exist". Further the Statement notes that the need to address "health" from a broad perspective and reducing inequities in the population is seen as key to a healthy society.

They note that "good health enhances quality of life, improves workforce productivity, increases the capacity for learning, strengthens families and communities, supports sustainable habitats and environments, and contributes to security, poverty reduction and social inclusion. Yet escalating costs for treatment and care are placing unsustainable burdens on national and local resources such that broader development may be held back. This interface between health, well-being and economic development has been propelled up the political agenda of all countries. Increasingly, communities, employers and industries are expecting and demanding strong coordinated government action to tackle the determinants of health and well-being and avoid duplication and fragmentation of actions".

In achieving this goal the WHO calls for joint government action which they refer to as "joined-up" government. This recognizes the interdependence of public policy and having all areas work together to address health. Examples of "joined-up" government include:

- Work and stable employment opportunities improve health for all people across different social groups (ECONOMY & EMPLOYMENT)
- The prevalence of mental illness (and associated drug and alcohol problems) is associated with violence, crime and imprisonment (SECURITY & JUSTICE)
- Poor health of children or family members impede educational attainment, reducing educational potential and ability to solve life challenges and pursue opportunities in life (EDUCATION & EARLY LIFE)
- Globally, a quarter of all preventable illnesses are the result of the environmental conditions in which people live (ENVIRONMENTS AND SUSTAINABLITY)
- Well-designed, accessible housing and adequate community services address some of the most fundamental determinants of health for disadvantaged individuals and communities (HOUSING AND COMMUNITY SERVICES)
- Improvements in indigenous health can strengthen communities and cultural identity, improve citizen participation and support the maintenance of biodiversity (LAND & CULTURE)

These examples emphasize the value of addressing issues such as mental health and addictions from a broader perspective and one that involves other government departments and programs and services and the wider community.

In implementing a population health approach, consideration must be given to the vast expanse of examining and addressing all factors at once. As such, the ***Transformational Process*** presented here provides an opportunity to use mental health and addictions as a focal point in applying this approach. Using mental health and addictions issues as an entry point allows for a more manageable ***Transformational Process***.

In summary, the population health approach is clearly linked to examination of health determinants, has similarities in principles with Aboriginal healing practices and requires a multi-sector collaborative approach. In this ***Transformational Process***, bringing health and non-health care sectors together to address specific mental health and addictions issues is critical. A joint overall goal of developing healthy communities and therefore healthier individuals is likely

to result in a decrease in mental health and addictions issues. An unintended benefit of addressing mental health and addictions issues in this way will be overall improvements in general health for the whole population.

Determinants of Health

The determinants of health flow from a population health approach and provide the detail for addressing health and specifically mental health and addictions on a broader level. The determinants also serve to illustrate which departments may contribute to the health of the population and how they may contribute. The determinants of health as defined by Health Canada include:

Income and social status	Health status is known to improve with each step up the income and social status ladder. Access to safe housing and nutritious food and opportunities for education and other activities increases with income. Large gaps in income distribution lead to increase in social problems and poor health among population as a whole
Social support network	People with the support of family and friends have better health overall. People who feel excluded often suffer poor health
Education	Health status improves with level of education as income, job security and a sense of control over one's life is linked to level of education
Employment & working conditions	People who have stressful working conditions or are unemployed are less likely to be healthy. High levels of unemployment and economic instability cause significant mental health problems and adverse effects on physical health of individuals, families and communities
Social environments	Risks to health are reduced when there is social stability, recognition of diversity, safety and cohesive communities.
Physical environments	Having a safe and secure place to live is critical to overall health, in addition factors in the natural environment such as water and air quality and access to nature also impact health
Culture	Culture and ethnicity influence health in complex ways. Loss of culture has an influence on health
Personal health practices and coping styles	Supportive environments for healthy lifestyle and coping skills are key influences on health
Healthy child development	Prenatal and early childhood experiences have a major influence on a person's subsequent health and well being
Biology & genetic endowment	A person's biological make-up and inherited predisposition to a health problem has an influence on health status
Health services	Availability and quality of health services in particular those that focus on health promotion and disease prevention can influence health status
Gender	Gendered norms and expected roles of society can influence health system practice and impact health of individuals

Each of these areas of concern has an impact on health and more specifically on mental health and addictions within the population.

The WHO has also defined the social determinants of health which are similar to the Canadian determinants of health. They state that "we hope that by tackling some of the material and social injustices, policy will not only improve health and well-being, but may also reduce a range of other social problems that flourish alongside ill health and are rooted in some of the same socioeconomic processes.[12]"

The determinants of health highlight the need to go beyond the idea and practice of seeing health policy governance as a role of the provision and funding of medical care. Rather they underscore that health and well-being are much broader than medical care. The determinants of health are also seen as more important as attention to them can prevent people from getting ill in the first place. It is also important that public and private business and community be involved in this process. A wider responsibility for creating healthy communities is called for.

In examining the determinants of health in relation to the mental health and addictions issues in the NWT, it is evident that unemployment, poor housing options, lack of educational opportunities and break from cultural underpinnings impact the health of many communities. This has an impact on the mental health and addictions issues in these communities.

Consistent with recent efforts of the WHO in identifying the need for "the WHO and all governments to lead global action on the social determinants of health with the aim of achieving health equality" simply put they state that "social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted"[13].

The ***Transformational Process*** relies on addressing the determinants of health in a collaborative way.

[12] The Solid Facts: Social Determinant of Health, second edition WHO Europe 2003
[13] The Solid Facts: Social Determinant of Health, second edition WHO Europe 2003

Application to NWT Territorial Government Departments

Flowing from the philosophy of a population health approach and the determinants of health, the following table provides a pairing between the determinants of health and the various government departments and their programs and services within the territorial government of the NWT. This table clearly illustrates the joint responsibility for mental health and addictions across government.

Canadian Determinants of health	NWT Territorial Government Departments Programs, Strategies and Supports
Income and social status	Dept of Education, Culture and Employment: • Income security • Adult and post secondary education student financial assistance Dept. of Justice • Law Enforcement • Courts • Corrections • Probations • Youth criminal justice Dept of Health and Social Services: • Community wellness funding (with fed govt) • Seniors • Persons with Disabilities Dept of Industry, Tourism and Investment: • Harvesters Assistance (Agriculture & Hunting/Furs • Fishing Industry Support • Arts & Crafts support Housing Corporation
Social support network	Dept of Health and Social Services: • Home Care • Seniors • Persons with Disabilities • Mental Health and Addictions • FASD • Family Violence • Child Welfare Dept. of Justice • Law enforcement • Courts • Corrections • Probations • Youth criminal justice Dept of Municipal & Community affairs • Sport & recreation • Development of youth • Volunteerism Housing Corporation
Education	Dept of Education, Culture and Employment: • Early Childhood • K – Grade 12 • Adult and Post Secondary • Apprenticeship & Occupational Certification

Canadian Determinants of health	NWT Territorial Government Departments Programs, Strategies and Supports
Employment & working conditions	Dept of Education, Culture and Employment: • Career & Employment Development • Apprenticeship & Occupational Certification • Employment Standards • Occupational health and safety
Social environments	Housing Corporation Dept. of Justice • Law Enforcement • Courts • Corrections • Probations • Youth criminal justice Dept of Health and Social Services: • Environmental Health • Seniors • Persons with Disabilities Dept of Municipal & Community affairs • Sport & recreation • Development of youth • Volunteerism
Physical environments	Housing Corporation Dept of Health and Social Services: • Seniors • Environmental Health • Persons with Disabilities Dept of Environment and Natural Resources: • Air quality • Biodiversity • Climate change • Environmental assessment and monitoring • Energy conservation and alternative energy technologies • Hazardous materials/waste Dept of Municipal & Community Affairs • Safety standards
Personal health practices and coping styles	Dept of Health and Social Services: • Health Promotion • Immunization • Hepatitis C Prevention, Support & Research • Population Health Fund • FASD • Mental Health and Addictions Dept of Municipal & Community affairs • Sport & recreation • Development of youth • Volunteerism Housing Corporation

Canadian Determinants of health	NWT Territorial Government Departments Programs, Strategies and Supports

Healthy child development	Dept of Education, Culture and Employment:
	• Early Childhood Development
	
	Dept of Health and Social Services:
	• Immunization
	• Community Wellness Funding (with fed govt):
	  ○ Aboriginal Head Start
	  ○ Brighter Futures
	  ○ Canada Prenatal Nutrition Program
	  ○ Community Action Program for Children
	  ○ Health Promotion Strategy Fund
	  ○ Healthy Children Initiative
	• FASD
	• Child Welfare
	• Family Violence
	• Mental Health and Addictions
	
	Dept of Municipal & Community affairs
	• Sport & recreation
	• Development of youth
	• Volunteerism
	
	Housing Corporation

Biology & genetic endowment	Dept of Health and Social Services: • Persons with Developmental disabilities • FSD • Mental health and addictions
Health services	Dept of Health and Social Services: • Home care • Immunization • Mental Health and Addictions • Hospital services
Gender	Dept of Health and Social Services: • Family Violence • FASD
Culture	Dept of Education, Culture and Employment: • Culture, Heritage and Languages Dept. of Justice • Law enforcement • Courts • Corrections • Probations • Youth criminal justice Dept of Industry, Tourism and Investment • Harvesters Assistance • Fishing Industry Support • Arts & Crafts support for traditional economy Dept of Municipal & Community affairs • Sport & recreation • Development of youth • Volunteerism

Traditional Aboriginal Healing Practices

The ***Transformational Process*** recognizes the Aboriginal issues related to historic trauma transmission. Integration of traditional Aboriginal healing practice is critical to the success of the ***Transformational Process*** for mental health and addictions within the NWT. Key to the successful integration of these values and practices is the reliance on the wisdom of the elders to guide this integration. Although some of the key values and principles related to traditional Aboriginal healing practices are presented here, we defer to Aboriginal leaders as the experts and depend on their involvement in the ***Transformational Process*** to ensure inclusion of these values.

Values key to traditional Aboriginal healing practices include: balance; inter-connectedness, intra-connectedness and transcendence. Maintaining balance between physical, mental, emotional & spiritual health are key to the holistic approach of traditional Aboriginal healing approaches.

It is clearly recognized that identification and gathering knowledge about specific traditional Aboriginal healing practices is beyond the scope of this project and a project in and of itself. However, it is also acknowledged that traditional Aboriginal healing practices include a wide variety of practices and that the options available and appropriate are dependent on the individual, their circumstances and the specific communities or specific bands. The ***Transformational Process*** presented in this document endorses and encourages these practices but does not prescribe the types of practice to be used to address mental health and addictions. As outlined in *Honoring the Medicine*[14] the common practices are outlined to include: ceremonies such as sweat lodge and sacred pipe; vision seeking; smudging with sage, sweetgrass and other herbs; prayer and chant; music, counselling or talking; energy therapies including massage and laying on of hands and use of herbs. It is expected that these practices will be integrated into the process of healing encouraged through the ***Transformational Process.*** It is also expected that the traditional Aboriginal healing practices and approach and mainstream practice to address mental health and addictions will work together towards the common goal of healthy individuals, healthy communities and healthy society.

In recognizing the historic trauma or generational grief, the reintegration of past, present & future to facilitate healing is practiced. Groups like the Aboriginal Healing Foundation (AHF) provide relevant information about these practices as do elders in the various communities in the NWT. Long term goals of the Aboriginal Healing Foundation logic model include: broken cycle of physical and sexual abuse and sustainable well-being. The model also acknowledges efforts to integrate traditional healing with contemporary life.

A focus of Aboriginal healing as defined by the AHF is on reconciliation in response to the recognized impacts of residential schools. A holistic approach presented by the AHF identified four steps of residential school resolution:

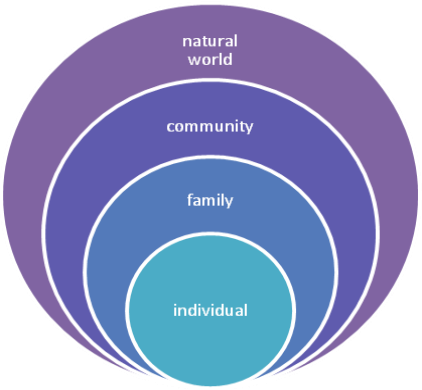
- acknowledgement;
- redress;
- healing and
- reconciliation

Acknowledgement refers to naming the harmful acts and admitting that they were wrong; redress refers to taking action to compensate for harms inflicted; healing refers to restoring physical, mental, social/emotional and spiritual balance in individuals, families, communities and

[14] Honoring the Medicine:…..

nations and reconciliation refers to accepting one another following injurious acts or periods of conflict and developing mutual trust.

Balance and inter and intra-connectedness are key to Aboriginal wisdom and translates into healing practices. Balance includes balancing the body, mind, feelings and spirit. Inherent in this approach is the need to look at the healing of individuals as well as the healing of communities. It is recognized that individuals do not exist as separate beings but that they are interconnected within complex relationships with ever broadening groups. This includes: families; communities; nations and finally the natural world. Therefore although individual healing is important, it is critical to focus on this healing within the broader context. Specifically, any efforts at healing must consider the healing of families, communities and societies as a whole and not be solely focused on healing individuals. In addition, isolating individuals and their particular symptoms does not fit with the Aboriginal healing approaches.



Given this relationship, it is clear that the mental health and addictions need to be addressed through a collaborative process that actively involves the community and works to address the mental health and addictions issues of individuals within this broader context.

The AHF identifies that healing addressed at the commnity level involves four stages. These mirror the four stages related to residential school resolution: acknowledgement; redress; healing and reconciliation. The stages for community healing include: crisis or paralysis; gathering momentum; “hitting the wall” and finally, healthy individuals and vibrant communities.

In stage one: crisis, it is recognized that the majority of people in the community are involved in destructive behaviours and there may be a group denial of this behaviour or a sense that this is the way things are and that this is normal. The healing process begins when a core group of individuals recognize that they need health with their mental health and addictions and become involved in personal healing. This group gets the ball rolling on the healing process. Stage two involves gathering momentum and increasing the participation of individuals in the community in the healing process. A sense of enthusiasm develops as community-based healing and mainstream groups work together. Although progress has been made, stage three “hitting the wall” sees the community reaching a plateau and concerns for the value of the process waning. Accomplishing the final stage with healthy individuals and communities requires a broadening of the focus beyond personal healing to include efforts to improve education opportunities, employment and economic development, in other words looking at the overall health of the population and the full range of the determinants of health.

Harm reduction

The NWT Framework for Action – Mental Health and Addictions Services notes that "addictions services in the NWT mostly aim for total abstinence from alcohol and drugs. Many people have not been able to achieve or maintain total abstinence, and experience a sense of failure when relapse occurs. The harm-reduction approach aims to reduce harmful behaviours as much as possible rather than to eliminate them completely".

Key to a harm reduction approach is the flexibility in how it is applied. The approach aims to broaden the focus beyond an abstinence model and meet people where they are at in terms of their substance use. Working with individuals and being realistic in what can be expected depending on their particular situation and level of motivation is fundamental. Celebrating small successes and reduced harms helps to move individuals forward. This approach can be delivered in a number of ways including working with individuals, changing the environment to affect change or change the environment to reduce harms. Working directly with individuals focuses on helping them change behaviour by providing education, skill building or group or individual treatment. Changing environmental factors that impact the individual's ability to change behaviour may include developing public policy, enhancing social support, addressing cultural issues. Reducing harm focuses on changing contextual factors that create harm in themselves such as providing safe injection sites.

The Canadian Centre on Substance Abuse states that harm reduction refers to "any program, policy or intervention that seeks to reduce or minimize the adverse health and social consequence associated with drug use" They describe the key principles of harm reduction as outlined by the CCSA National Policy Working Group (1996) as follows

Pragmatism	Some level of drug use in society is to be expected. Containment and amelioration of the drug-related harms may be a more pragmatic and feasible option, at least in the short term, than efforts to eliminate drug use entirely.
Humane values	No moralistic judgement is made about an individual's decision to use substances, regardless of level of use or mode of intake. This does not imply approval of drug use. Rather it acknowledges respect for the dignity and rights of the individual
Focus on harms	The extent of a person's drug use is of secondary importance to the risk of harms resulting from use. The first priority is to reduce the risk of negative consequences of drug use to the individual and others. Harm reduction neither excludes nor presumes the long-term treatment goal of abstinence. In some cases, reduction of level of use may be one of the most effective forms of harm reduction, In others, alteration to the mode of use may be more practical and effective
Balancing costs & benefits	Some pragmatic process of assessing the relative importance of drug-related problems, their associated harms, and costs/benefits of interventions carried out in order to focus resources on priority issues. This analysis extends beyond the immediate interest of users to include broader community and societal concerns. This rational approach allows the impacts of harm reduction to be measured and compared with other intervention, or no interventions at all. In practice, such evaluations are complicated by the number of variables to be examined in both the short and long term.

[15] A Foundation for Change NWT Department of Health and Social Services
[16] Harm Reduction: What's in a name? Canadian Centre on Substance Abuse May 20,2008

Priority of immediate goals

The most immediate needs are given priority. Achieving the most pressing and realistic goals is usually viewed as first steps towards risk-free drug-use or discontinued use.

The Canadian Centre on Substance Abuse identifies the following key features of harm reduction:

- Harm reduction focuses attention on the consequence of substance use, not on use itself. This inevitably involves deciding which harms need to be addressed and in what order of priority. These decisions must be made in an environment of accountability based on what we know about individual patient welfare, public health and the severity of the problem.
- Some substance users cannot or will not stop use in the short-term. Harm reduction approaches focus on the pragmatic and effective minimization of use-related harms.
- Harms related to substance use are not caused by user behaviour in isolation, but are influenced by distinct social and environmental factors. Meaningful and realistic efforts must be made to actively understand and consider this social and environmental context in order to reduce harms.
- Education, knowledge and informed decision-making by substance users and potential users are key pillars of the harm reduction approach.
- Misinformed or ineffective intervention or policy can be as important as user behaviour and the contexts of use as the source of substance-related harms, and therefore must also be targeted for "harm reduction" interventions.

Although harm reduction may seem to be in conflict with abstinence based efforts to support substance users, the two approaches can be compatible and together offer a wider range of options for individuals with mental health and addictions issues. Both approaches aim to assist substance users to address their issues.

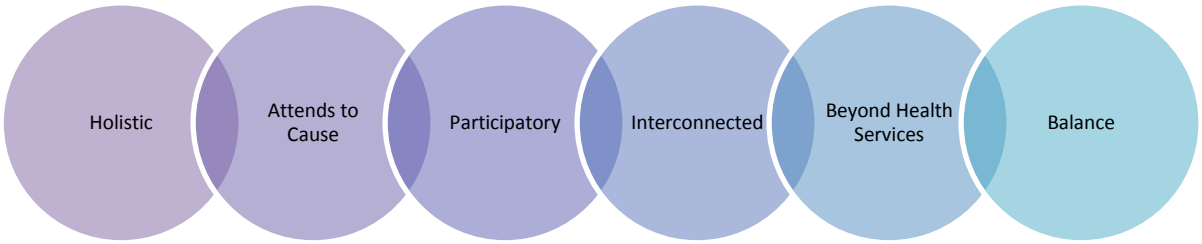
There are similarities between harm reduction and holistic Aboriginal approaches to substance abuse treatment including the importance of links between the community and individuals and the role of the community in addressing the issues.

Another element connected to the harm reduction strategy is moving towards modeling and supporting the responsible use of substances. In particular the prevalent use of alcohol and societal acceptance and promotion of its use does not easily allow for abstinence as an option. Reaching a level of reasonable and responsible use of alcohol may be more easily achieved. Modelling the responsible use of alcohol with and for children and youth may promote and support healthy behaviours and reduce substance misuse.

In summary, harm reduction goes beyond a focus on abstinence to meet people where they are and work with them there rather than requiring them to achieve the unachievable before they are assisted through programs or services. The approach also allows for small steps in the progress towards a more long term goal. In this way it is realistic in its approach. Being realistic and celebrating small successes also serves to motivate individuals to continue their efforts towards recovery and to modify their long term goals as they move forward.

Commonalities

Each of the philosophical approaches shares a number of common features. These include but are not limited to the elements highlighted below:



Holistic refers to considering the whole and the interactions between the parts. In looking at an individual with mental health and addictions it means looking at all the parts of their life and how each impacts their mental health and addictions issues. It also means examining the physical, emotional, mental and spiritual health of the individual. The goal of any attempt to alleviate the mental health and addictions issues is to achieve balance across all four of these areas of health. Holistic beyond the individual also refers to how we attend to the mental health and addictions issues of individuals within the context that they live, that is their families, peers, communities, and society. Holistic is characteristic of the population health approach by addressing the broad range of factors and conditions that have a strong influence on health of individuals and health of the overall population. A focus on all of the determinants of health provides a holistic framework for examining mental health and addictions issues. Holistic approaches are fundamental within traditional Aboriginal healing practices with the attention to balance, inter-connectedness, intra-connectedness and transcendence while considering physical, emotional, mental and spiritual health. Harm reduction approaches are holistic in meeting people where they are and working with them within their particular context.

All four of the philosophical approaches identified for the transformational process pay attention to cause of the issues in this case, mental health and addictions. Each of these approaches is naturally broad in scope and within that scope makes the effort to attend to cause and address the same.

The population health approach and attention to the determinants of health require wide participatory involvement in addressing the range of activities that impact health and assume the interconnectedness of the various determinants. The inter-connectedness and intra-connectedness of individuals, families and communities are natural elements of traditional Aboriginal approaches.

The philosophical foundation for the ***Transformational Process*** requires that the process goes beyond the traditional health services and the formal mental health and addictions systems.

All four philosophical approaches encourage and move towards balance. Balance in addressing all determinants of health, balance between the physical, emotional, mental and spiritual health of individuals and communities.

COMMUNITY COLLABORATIVE PRACTICE

Community collaborative practice in the ***Transformational Process*** refers to the necessity of undertaking a multi-level and multi-participant process with the overall goal of committing to a vision for healthy communities and taking joint responsibility for mental health and addictions. Within the philosophical foundation of the ***Transformational Process*** this means collaboration across government departments as well as between governments and communities, public, business and industry.

The collaborative process that supports a population health and determinants of health approach is named "mobilization"[17] whereby mobilization refers to "intersectoral collaboration on population health activities initiated cross sectors (e.g. business, labour, social and health) and levels of government (e.g. local, provincial). It is seen as critical to the success of these approaches as it puts theory into practices and builds support for the philosophical approach "from the ground up".

The WHO's statement about Health in All Policies, highlights some of the elements of success of achieving health improvements through strategies such as the ***Transformational Process*** proposed for the NWT. In particular they note that collaborate efforts work best when:

- A clear mandate makes joined-up government an imperative;
- Systematic processes take account of interactions across sectors;
- Mediation occurs across common interests;
- Accountability, transparency and participatory processes are present
- Engagement occurs with stakeholders outside of government
- Practical cross-sector initiatives build partnerships and trust

The WHO also identifies that in pursuing collaborative processes that take the responsibility for health beyond the typical boundaries of health, the Departments of Health must work in partnership with other sectors and explore new ways of conducting business including policy development, program design and delivery. These new responsibilities need to include;

- Understanding the political agendas and administrative imperatives of other sectors
- Building the knowledge and evidence base of policy options and strategies
- Assessing comparative health consequences of options within the policy development process
- Creating regular platforms for dialogue and problem solving with other sectors
- Building capacity through better mechanisms, resources, agency support and skilled and dedicated staff
- Working with other arms of government to achieve their goals and in so doing so advance health and well-being

In initiating a collaborative process it is critical to think about, talk about and develop principles to guide the process. These principles must consider elements such as how people will be encouraged to participate, how they will be included, and mechanisms for hearing everyone's voice and so on. Consideration of respect, relationship, recognition, effective communication, opportunity, honesty, would all be important to include. The process must be founded in a

[17] Population Health : Mobilization: A Regional Strategy; Public Health Agency of Canada

relationship of mutual trust and respect. The process must enhance connectedness and be inclusive in practice rather than be divisive or revert to sectoral focus.

As outlined in an inter-sectoral project by Health Canada, four elements of a collaborative process include: picture results; empower the team; ensure success; and build continuity.[18] Other projects named three similar steps: plan; action and evaluate.

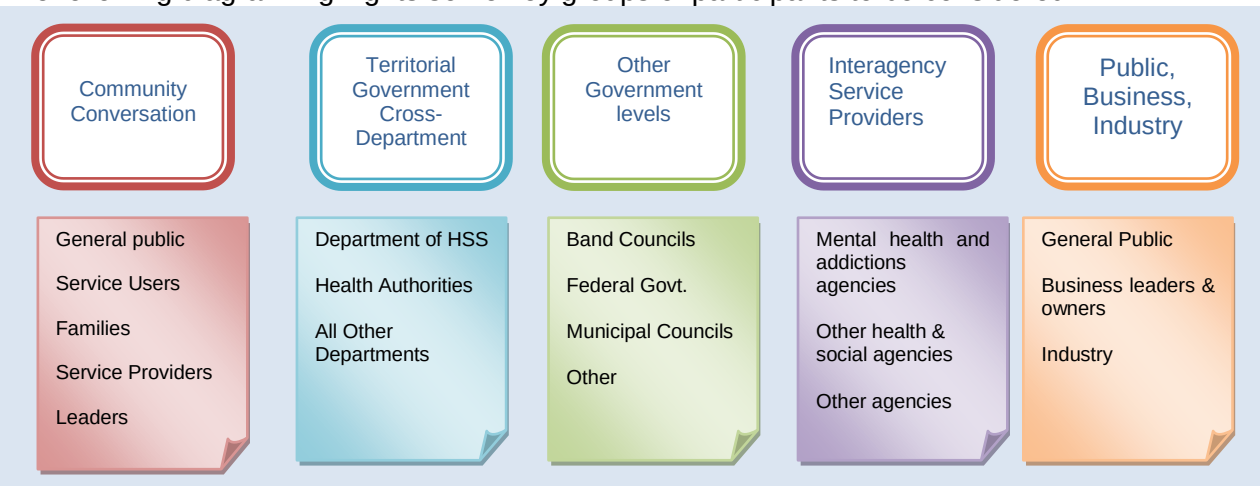
Community development through the collaborative process will be cyclical and will happen at multiple levels or in various contexts. For example, within the ***Transformational Process*** the cross sector teams within the territorial government can be operating at the same time that cross government teams can be established and all this can happen at the same time that community forums and discussions are occurring.

Of note is that the process will take time, effort and there must be room for failure and mistakes along with successes and missteps without abandoning the project.

In the ***Transformational Process*** for the NWT it is critical to include a broad range of participants and to ask the leaders in the communities, the governments, service providers and business and industry to help to identify participants. Key to the community conversation is the open invitation to all members of the community to participate in the dialogue, discussion and finding solutions. Their contributions must fit with their interest and willingness to participate and all contributions are considered valid. The ***Transformational Process*** is an inclusive process and as such may include individuals and groups who may not have been involved in these types of discussion before.

The ***Transformational Process*** supports a grassroots proactive process that moves away from a reactive "fix-it" approach to a healing and building healthy communities approach and that addresses uniqueness of communities across the NWT. It encourages change from a "grass roots" level and ensures that a "whole community" is working to support the healing of mental health and addiction issues. This will allow communities to work towards addressing issues and build healthy communities.

The following diagram highlights some key groups of participants to be considered.

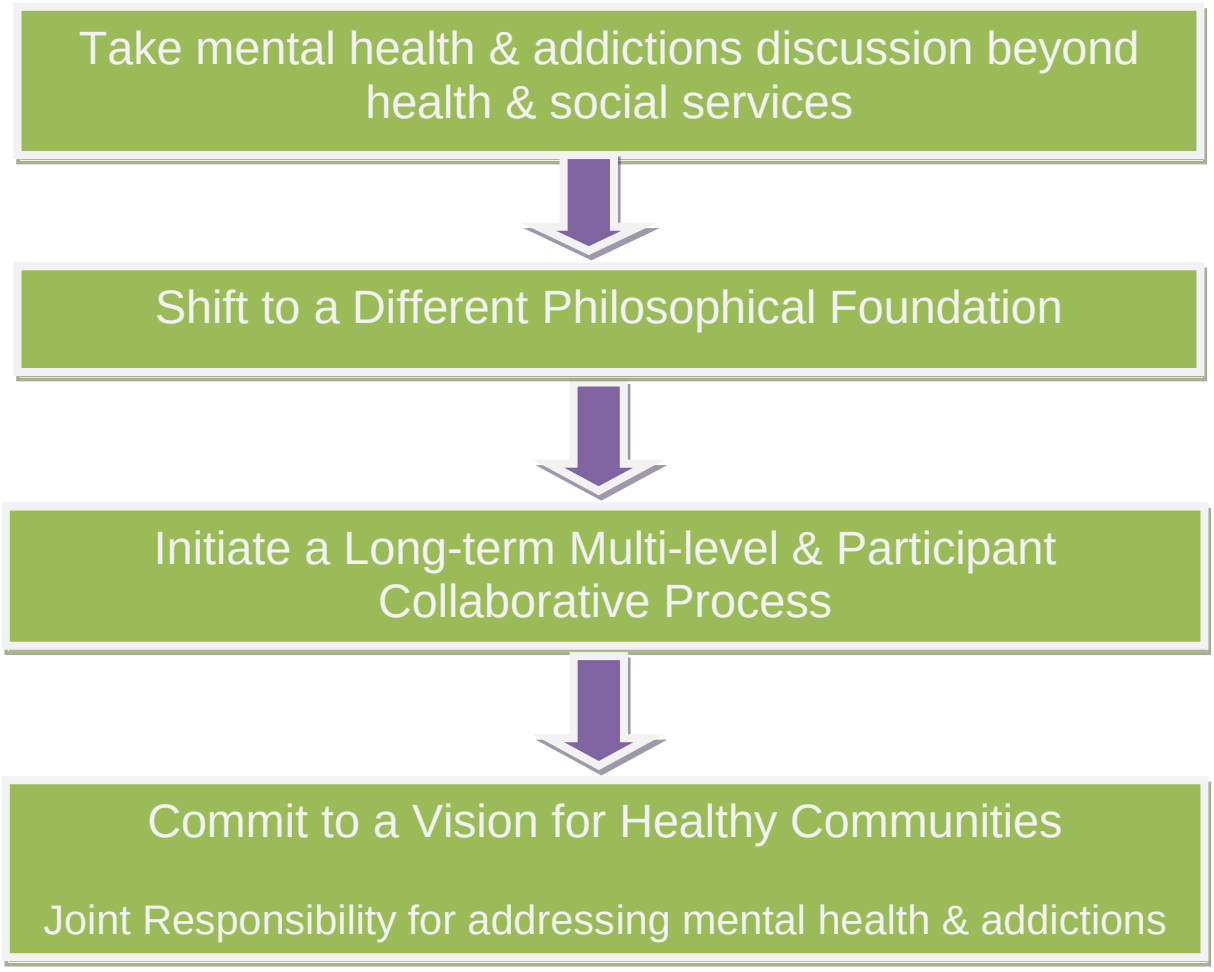


[18] Inter-sectoral Action Toolkit, Health Canada 2000

SECTION 6 *TRANSFORMATIONAL PROCESS* ACTIONS

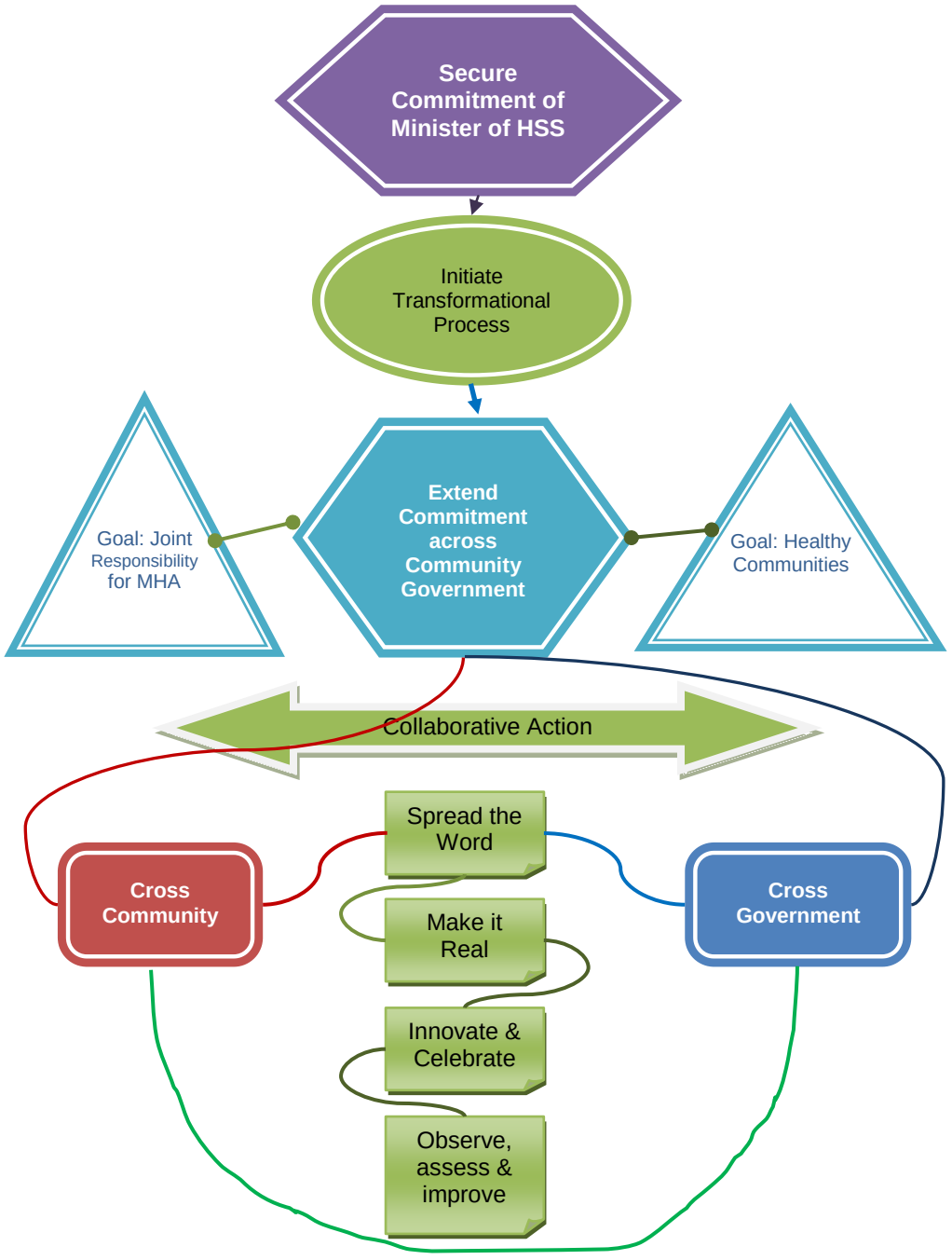
Within the context of the ***Transformational Process*** *for Mental Health and Addictions*: *Future Directions & Promising Practices* a number of actions and recommendations are offered to get the ***Transformational Process*** underway and to keep it alive*. These actions are posed within and are dependent upon taking the discussion about mental health and addictions beyond health and social services, the shift in philosophical direction, a long term community collaborative process, joint responsibility for mental health and addictions issues and an ultimate goal of healthy communities*. *Adopting and enacting the philosophical shift inherent in the* ***Transformational Process*** *is critical to the success and impact of the recommended actions*. The collaborative action within communities and government as well as between community and governments is also critical.

The ***Transformational Process*** and all associated actions are dependent upon the following priority actions:



ACTION STEPS AND PROGRESSION

The following chart highlights the key steps in the process and is followed by more details about the actions.



Action Steps Described

The action steps outlined here provide a starting point for discussion. It is known that more detail about these steps is required but it is also believed that this detail needs to arise out of the ***Transformational Process***. Inherent within the process is the collaborative approach and true involvement of communities. So although the basic process and steps can be outlined they are presented as a "straw man" rather than as a firm plan.

Action Steps	*Specific Steps*	*Details and Considerations*
Secure commitment of Minister of HSS	DM to work with Minister to secure commitment to ***Transformational Process***	• Department of HSS take the lead in shifting the philosophical direction and initiating the collaborative process

Initiate the Transformational Process	• Set up project management structure	• Establish Project Management team (neutral facilitators)
		• Establish consultative bodies:
		  • Aboriginal Wisdom Group
		  • Cross Department groups

	• Develop guiding principles	Consider principles of dialogue, relationship, trust, community driven, not government driven and process expectations such as progressive, inclusive, evolutionary, long term
	• Develop education and awareness materials of foundational philosophical shift and community collaborative process	Build the educational materials to include a focus on: • What the ***Transformational Process*** & philosophy is • Why it is important • Why (participants) should care
	• Develop mechanisms to track the story of the ***Transformational Process***	Track the progress, the activities and thus be able to contribute to replicating the process.

Extend commitment across governments & community	• Commit to:
	  • ***Transformational Process***
	  • healthy public policy
	• Commit to a common vision for healthy communities
		• Within HSS
		• Cross Territorial Government
		• Link to other Governments including Band Councils
		• Community

	• Establish statement of joint responsibility for addressing mental health and addictions	
	• Establish relationships between and among groups	

Action Steps	*Specific Steps*	*Details and Considerations*
Collaborative Action: Spread the Word	• Provide Information about Foundations of Philosophical shift through Open Community Forums; meetings in government • Conversation about impacts of applying ***Transformational Process*** through Open Community Forums; meetings in government; • Create ownership within departments and within communities • Educate and dialogue about application of ***Transformational Process***	Participants in process HSS: • MHA staff • All HSS sectors • Regional Authorities CEO's and staff • Agency Other Territorial Government Departments • Leadership • Staff • Agency/Service Providers Other Governments/Band Councils Community General public Business and industry
Collaborative Action: Making it real	• Identify readiness of communities • Establish Geographic Action Teams based on RHAs or communities • Establish Cross – Department mechanisms • Utilize Wisdom Committee(s)	• Start in communities that are most ready • Work with communities that need more help • Initiate cross department activities that have been identified in review process • Include community and government representatives • Continue the process • Monitor and report on progress
	• Dialogue about how to make it real through Open Community Forums; meetings in government • Create action groups: Focussed groups identified by community/group	Include a focus on: • What the ***Transformational Process*** & philosophy is • Why it is important • Why (participants) should care • What solutions can be found

Action Steps	*Specific Steps*	*Details and Considerations*
Collaborative Action: Innovate & celebrate	• Select initiatives to focus on and implement • Encourage innovative ideas • Celebrate small successes both in process and activity	Include sharing the word and dissemination of successes
Collaborative Action: Observe, assess & improve	• Develop evaluation and monitoring framework • Develop indicators and measures of program inputs, outputs and outcomes as a basis to analyze and understand the impacts and effects of process and activities • Implement framework	• Acknowledge missteps and process for moving past • Dissemination of results

SECTION 7: PROGRAM AND SERVICE DELIVERY RECOMMENDATIONS

Within the context of the ***Transformational Process*** *Future Direction & Promising Practice Strategies* a number of program and service delivery recommendations are offered for consideration. These recommendations are organized by the four key areas identified by the Department of Health and Social Services. They are further organized by issue and flow from issues confirmed in the project process. Many of the recommendations will be informed through the ***Transformational Process***.

It is recognized that there is overlap between and among the four key areas and the issues and effort has been made to organize the recommendations according to the most relevant area. It is also recognized that there is overlap between the ***Transformational Process*** and the recommendations outlined here.

As noted in the full report it is expected that Department of Health and Social Services will take the lead and work collaboratively in undertaking the following recommendations.

Rationale & Relevance

Philosophical Views	**RECOMMENDATIONS:** ➢ Department of HSS take the lead in shifting the philosophical direction and initiating the collaborative process ➢ Seek commitment and input from, but not limited to, areas such as education, housing, justice, employment/income, social services and supporting agencies/organizations ➢ Support change from a “grass roots” level and ensure that a “whole community” is working to support the healing of mental health and addiction issues ➢ The HSSA’s across the NWT review the practice of delivery for mental health and addiction services across the NWT to ensure that these services are being provided in as flexible a way as possible to best meet the needs and requirements of the clients they are serving. This would include areas such as location of professional visits and office hours.

Rationale & Relevance

Cultural Concerns	**RECOMMENDATIONS:** ➢ Support communities to work towards addressing issues to build healthy communities ➢ Work with communities to re-establish the roles and values of "Elder" input in the delivery of Mental Health and Addiction Services across the NWT. ➢ The Department of HSS develop/revise policies and work with all HSSA's to strengthen the practice of delivering traditional healing approaches versus western methods wherever appropriate across the NWT. ➢ In order to achieve a reality of "Healthy Communities" the Department of HSS and the HSSA's should form "Aboriginal Wisdom Committees" across the NWT [at least one in each HSSA] for the purpose of receiving wisdom, advice and input from the Aboriginal communities across the NWT regarding the delivery of mental health and addiction services and the overall approach to achieving "Health Community" status. ➢ The Department of HSS review practices in regards to supporting Aboriginal communities across the NWT to be able to expand "back to the land" activities that enable communities to come closer to traditional lifestyles, healing practices and a healthy community status. ➢ Give priority to community initiatives that support and address cultural issues
Policy Direction	**RECOMMENDATIONS:** ➢ All levels of government commit to work towards a comprehensive and consistent approach to providing stronger leadership and direction in the delivery of mental health and addiction services and to ensure that these services are inclusive of community involvement from all sectors required to achieve "healthy community" status for all communities across the NWT. ➢ The Department of HSS and the HSSA's review policies to move the integration of mental health and addiction services further towards a "true merger" of services rather than one that "appears" to be a merger of services ➢ Different levels of government, including Local Governments, Band Councils, Territorial and Federal Governments need to work in support of and collaboratively with each other to ensure that the delivery of mental health and addiction services provide for a supportive community approach in dealing with mental health and addiction issues. ➢ Support a grassroots proactive process that moves away from a reactive "fix-it" approach to a healing and healthy communities approach while recognizing unique features of individual communities ➢ Acknowledge the need for a long-term approach

Rationale & Relevance

Geographic Characteristics	**RECOMMENDATIONS:** ➢ Acknowledge that the geographic pressures on staffing and resources require a modified approach to service delivery which may differ from a southern mental health and addictions systems approach ➢ Review policies and practice to ensure that, in as much as possible, individuals living in communities have a choice of whether their "therapist" will be a local individual or someone who does not originate from the local community ➢ Acknowledge the uniqueness of each community when developing approaches for dealing with mental health and addictions issues
Professionalization	**RECOMMENDATIONS:** ➢ Move the discussion into the community and with communities ➢ HSSA's need to ensure that the mental health and addictions system is delivered in a fashion that is understood and agreed to by all service providers and stakeholders in each community of service. ➢ Professional mental health and addiction program staff develop methods of working with all stakeholders to develop delivery alternatives that best meet the needs of populations across the NWT including those living in remote locations and those having unique cultural orientation.
Legislation	**RECOMMDENDATION:** ➢ While it is clear that the NWT is in the process of reviewing the Mental Health Act it is imperative that the proposed revisions to the Act are inclusive of a "community" or "population" approach to ensuring a "healthy community" outcome following the implementation of this legislation.

Program and Service Delivery

Service Fragmentation	**RECOMMENDATIONS:** ➢ The HSSA's across the NWT develop stronger and clearer methods of communicating the operation and delivery of mental health and addiction services in the communities and ensure that all stakeholders working towards the recovery of an individual are informed and involved in the services being provided to an individual. ➢ Policies and procedures to be reviewed and clearly communicated around the cross-regional movement of individuals with mental health and addiction issues who are accessing services from one health authority to another.
Lack of Case Management	**RECOMMENDATIONS:** ➢ The Department of HSS and the HSSA's revisit the recommendations for "Case Management" mechanisms in previous mental health and addictions reviews within the context of broader focus ➢ Develop mechanisms to infuse a case management philosophy within the practice of delivering mental health and addictions services

Program and Service Delivery

Access to services and supports	**RECOMMENDATIONS:** ➢ The Department of HSS in collaboration with the HSSA's need to review the availability of dedicated mental health hospital beds in the NWT and strategies for more timely access to these beds. ➢ Methods of streamlining the process for Out of Territory referrals need to be developed in order to ensure appropriate and timely access to services. ➢ Improvements to the overall availability to the telephone Help-Line in the NWT must be made in order to ensure that this service is more accessible in a consistently reliable fashion to residents across the NWT. ➢ As part of an overall continuum of care the Department of HSS and all other relevant stakeholders need to review the need, availability and future development of shelter services in the NWT particularly for youth and women
Lack of full continuum	**RECOMMENDATIONS:** ➢ The Department of HSS in conjunction with the HSSA's review resources to determine ways to expand mental health and addiction services for children and youth across the NWT. ➢ Services for children and youth to span across full continuum of care and support with strategies and approaches that include prevention of mental health and addiction issues. ➢ Explore the feasibility of establishing a Tele-mental health system across the NWT. ➢ More emphasis on Harm Reduction strategies must be inclusive in the development of improved mental health and addiction services across the NWT.
Integration of services	**RECOMMENDATIONS:** ➢ Department of HSS take lead role in undertaking dialogue necessary to effect the true integration of mental health and addictions services; this requires service user consideration, philosophical consideration as well as system practice considerations ➢ The HSSA's need to form "Interagency Frameworks" for communities in their respective authorities that will allow for all relevant stakeholders to meet, discuss issues and work toward a common goal of recovery for individuals suffering from mental health and addiction issues. ➢ Department of HSS initiate discussion with Justice to jointly address mental health and addictions issues of individuals within the correctional system
Service Gaps:	**RECOMMENDATIONS:** ➢ The Department of HSS, in partnership with the HSSA's, review the need for medically supervised Detox services in the NWT and take appropriate action to address the outcome of this review. ➢ The Department of HSS, in collaboration with the Stanton Health Authority, examine the feasibility of establishing a Day Treatment Program in conjunction with other mental health and addiction programs connected to the Stanton Territorial Hospital. ➢ The continuum of services for people in the NWT, who are living with mental health and addictions issues, must ensure the provision of aftercare services, independent living support services and assertive community treatment services.

Program and Service Delivery

Role of supplementary personnel	**RECOMMENDATIONS:** ➢ The HSSA's to develop and implement methods of ensuring that individuals who are responding, and providing day to day support for individuals with mental health and addictions issues, have basic knowledge and support to carry out an effective role in this regard ➢ Consider expansion of Mental Health First Aid as a tool for increasing mental health knowledge amongst supplementary personnel
Housing Concerns	**RECOMMENDATIONS:** ➢ The Department of HSS along with the HSSA's must begin to work collaboratively with the NWT Housing Corporation to ensure that policies are developed that ensure individuals living with mental health and addictions, regardless of where they live in the NWT, will have access to affordable, safe and appropriate housing. ➢ The Department of HSS must ensure that housing is a clear component of supportive care across a full continuum of services for individuals with mental health and addiction issues in the NWT ➢ Examine the need for specific types of housing and or shelter options ie: shelter options for youth, for women ➢ Develop housing and shelter options that employ a harm reduction approach
Other Issues	**RECOMMENDATION:** ➢ The Stanton Territorial Health Authority review criteria for prioritizing services in the Stanton Territorial Hospital to ensure that individuals with mental health and addiction issues receive service in a timely fashion [this is particularly critical pertaining to services in the Emergency Department]

Administration & Operation

Governance	**RECOMMENDATION:** ➢ The Department of HSS needs to take a stronger leadership role for planning, development and delivery of mental health and addiction programs in the NWT. This role will include working in collaboration, and taking the lead, with other Government Departments, the HSSA's, Band Councils, Local Governments and Federal Government.
Staffing	**RECOMMENDATIONS:** ➢ Review hiring and recruitment practices to ensure that individuals being hired into the mental health and addictions programs have equal benefits as all other professionals who are recruited and hired into other areas of the health system. ➢ Review recruitment and retention policies to ensure that these are applied in a fair and equitable fashion across the NWT and that they will provide, to the greatest extent possible, for longer retention of staff. ➢ Provision of Psychiatric services across the NWT needs to be increased. Innovative ways of recruiting and retaining both resident and visiting psychiatrists to the NWT need to be examined and implemented where possible. ➢ The Department of HSS needs to review availability of training and education resources/programs for staff working in the mental health and addictions program across the NWT to ensure that these are more accessible, efficient and appropriate

Administration & Operation

Info sharing

RECOMMENDATION:

- Sharing of information across program areas, both internal and external to the health and social services sector must be facilitated through the establishment of something similar to "informed consent to share" practices which involve client input.

Funding

RECOMMENDATION:

- A review of funding guidelines must be undertaken to address the issue of inequities between staff salaries in agencies and non-government organizations, as compared to salaries paid in similar positions across government and other organizations, in order to allow these service providers to be competitive in the recruitment and retention of staff.

Mandate gaps

RECOMMENDATIONS:

- The Department of HSS needs to examine ways, in collaboration with other funding sources ie: the Federal Government, to attain more sustainable funding mechanisms for mental health and addictions programs across the NWT.
- The Department of HSS needs to work in collaboration with the Federal Government as well as with other funding sources, such as private industry, to ensure that funding for programs related to mental health and addictions is coordinated and appropriately linked to the overall continuum of care for mental health and addictions programs and services across the NWT.

Planning

RECOMMENDATION:

- Initiate and maintain ongoing mechanisms to ensure cross government and interagency collaboration in service planning

Effectiveness & Impacts

Standards

RECOMMENDATIONS:

- Use the determinants of health as the basis for standards development and as the context for quality and systems' accountability.
- The Department of HSS take the lead in establishing a mechanism for the review of program standards that currently exist for the Community Counseling Program and for the development of additional program standards that are deemed to be required to ensure the ongoing safety and effectiveness of all mental health and addictions programs across the NWT
- Examine standards from the Canadian Centre for Substance Abuse to inform standards for addictions services

Data Collection

RECOMMENDATIONS:

- The Department of HSS undertake a process to develop a method of efficiently and effectively collecting data from all mental health and addictions service delivery areas across the NWT in a regular monthly fashion.
- The Department of HSS establish ways to improve efficiencies of data collection through improved and increased use of electronic resources.

Effectiveness & Impacts

Outcomes	**RECOMMENDATIONS:** ➢ The Department of HSS take the lead in developing outcome indicators and measurement tools for the mental health and addictions programs across the NWT ➢ Develop and implement measurement strategies to monitor outcomes
Satisfaction with service	**RECOMMENDATION:** ➢ The Department of HSS and the HSSA's work collaboratively to develop a method of collecting "Client Satisfaction" information on a regular basis and of reporting this to funding bodies, service providers and clients
Quality control & Accountability	**RECOMMENDATIONS:** ➢ The Department of HSS examine the feasibility of having the mental health and addictions program accredited through an appropriate body of Canadian accreditation practice.. ➢ Use compliance to standards as one catalyst for action to improve quality

APPENDIX A: MENTAL HEALTH AND ADDICTIONS ISSUES

Rationale & Relevance	
Cultural Issues	➢ Aboriginal and non-Aboriginal communities ➢ Nine Aboriginal groups ➢ Inconsistencies regarding how MHA are viewed and thus responded to within the Aboriginal communities as well as between different Aboriginal groups and between Aboriginal and non-Aboriginal groups ➢ Tensions and need for attention to differences in traditional versus Western methods ➢ Lack of cross-community cohesiveness ➢ Language is a big issue…most individuals are ok with interpreters however this is not always available to individuals ➢ Stakeholders expressed need for the formation of "Wisdom Committees" of elders across the NWT. These committees would be focused on Healthy Communities. ➢ Elder safety and well being is an issue in that "elder abuse" is prevalent in the NWT ➢ Cultural disconnect from residential school impact are significant for individuals with MH&A issues and in providing intervention services for these folks. People are trying to return to traditional family values ➢ Generally felt that "back to the land" and traditional healing approaches are key elements in providing MH&A services across the NWT. ➢ Involvement of elders has been greatly diminished or lost. Re-introduction of "elder" input and influence to MH&A interventions is seen to be critical. ➢ Need to find ways to decrease the attitude that one should be "resigned to trauma". This attitude is felt to be inherent from the residential school experience, high suicide incidents and high rate of accidents in the NWT.
Geographic Issues	➢ Small, isolated communities in a harsh environment involving vast distances across a very large geographical area ➢ Travel issues include challenges of cost and availability of services ➢ Weather impeding access to services ➢ Industry influence on geography and use of the land (MacKenzie Pipeline) ➢ Concerns about use of the land; native land claims, environmental concerns ➢ Due to small size of most communities there is a mix of attitudes as to whether individuals want to work with counselor from "away" or a "local" person. The majority wishes to have counselors from "away" but there seems to be a need for individuals to have "choice" on this matter. ➢ Issues related to staffing are influenced by geography
Philosophical Issues	➢ Stakeholders expressed need for more leadership from Government level ➢ Different levels of government present different philosophical base ➢ Philosophy of government not well communicated to the population ➢ Overlap with cultural issues (e.g. MI seen as a gift rather than as an illness in some communities) ➢ Programs and change in services and support has to come from the "grass roots" or local level. In this regard community needs increased strength in areas such as education, housing, employment, income. ➢ Community capacity needs to be strengthened and included in the development

Rationale & Relevance	
	and delivery of MH&A services across the NWT. ➢ Stakeholders generally feel that more of a "Community Drop-in" facility approach would be effective for communities. ➢ Mental health and addictions counselors work under philosophy of "office visits" only. Many stakeholders would like to see this shifted to a more flexible model of "home and office visits" based on what is most appropriate for individual clients. ➢ Philosophy expressed that "it takes a community to support a MH&A client". It was stated that this philosophy is not being exercised in the NWT on a consistent or predictable fashion
Professionalization	➢ Conflict between the North American medical approach and the more indigenous approach ➢ Professionals not taking the time to ask or to listen to the people especially in the more remote locations and unique cultures. In some instances it was felt that MH&A professionals were perhaps uncomfortable to ask and follow-up on what would be described as more indigenous approaches to MH&A interventions. ➢ Urban (Yellowknife) approach seen as the way ➢ The mental health and addictions system representatives make decisions about the system in isolation from other stakeholders ➢ Communities want to have more say in how and what service are developed
Policy Direction	➢ It was generally felt that there is no evidence of a "true merger" of mental health and addiction services across the HSSA's and the Territorial Health Authority. ➢ Differing direction and application of direction in the various levels of government and between government and the health authorities and further between the HSSA and the communities. ➢ Funding does not always go to the programs it is intended for ➢ Stakeholders generally expressed a need for the MH&A system to move towards a "shared care model" ➢ Stakeholders expressed concern that more "leadership and direction" is required from the Department of HSS. Likewise it was stated that local Governments and Band Councils need to take more of a lead in addressing issues around prevention, education and intervention into MH&A
Legislation	➢ MH Act review underway ➢ How legislation is drafted will impact service delivery and expectations ➢ Issues related to culture, geographic isolation and resources availability need to be considered in drafting the legislation
Program and Service Delivery	
Service Fragmentation	➢ Communication across CCP staff, related service providers and care givers [including physicians and NGO's] is seen to have significant gaps. ➢ Communication across program areas within the Health and Social Services sector is seen as "weak" and often non-existent. ➢ Full continuum of services not in place in many parts of the HSSA's and the continuum is more fragmented in the more remote communities ➢ Lack of cross sector collaboration, cooperation and involvement in program needs identification, planning, development and funding ➢ Poverty is a major issue for residents of the NWT. Stakeholders advised that often individuals/families are not getting enough food/healthy food. ➢ Employment is major issue in that there is not enough to sustain the population and there is a lack of skills for jobs that are available

Rationale & Relevance	
	➢ Incentives to work conflict with cost of housing that is available through Housing Corporation ➢ Communication and coordination across HSSA's is weak when cases are moving back and forth from one authority to another or when someone is transferred OOT
Lack of Case Management	➢ Clear need to facilitate coordination and integration of fragmented services to include decentralized intake, urgent response , outreach and ACT ➢ Although recommended in many reviews a case management mechanism has not yet been established ➢ Sectors are not coming together at Gov't levels, Department levels or community levels to ensure delivery of a comprehensive and coordinated service model for individuals encountering MH&A issues ➢ Communication across sectors needs to be strengthened and an inherent function in a Cross Sector Case Management model of practice.
Access Issues	➢ Accessing MH&A services is a major issue. Factors can be lack of staffing, not enough overall resources or lack of appropriate intervention services based on individual's need. ➢ Overall access to programs for children and youth is seen as very limited and very difficult across all part of the service continuum including access to residential treatment programs. ➢ Many stakeholders expressed concern around availability and difficult access to residential programs for concurrent disorders. ➢ Shelter services are limited and hard to access for youth and elderly people ➢ Authorities indicated that it is very often very difficult to access mental health treatment beds in hospital. The Stanton Territorial Hospital Psychiatric Unit is only ten beds and the demand for these beds is very heavy. ➢ If Out of Territory referral is needed this process is very cumbersome, time consuming and very expensive ➢ Stakeholders feel that MH&A system should have more flexible hours for better access to service ➢ Stakeholders want to see better access to "telephone Help-Line" ➢ Stakeholders would like to see the option of individuals being able to receive substance abuse treatment in their own community rather than have to go "away" to a residential treatment facility. This would allow one to be able to receive treatment in their own language and customs as opposed to going to a treatment facility in another location where they may very well not understand the language or the customs and subsequently lose the value of the treatment process.
Lack of full continuum	➢ Clear shortage of MH&A services for children and youth ➢ Stakeholders felt that youth programs must start with interventions aimed at prevention of MH&A issues. One authority indicated that they have combined the roles and responsibilities for the MH&A Counsellors and the Wellness Workers into one position and that this is working effectively in having these individuals be more MH&A generalists. ➢ Strong need evident from several HSSA's for more integration of service delivery between social service staff and MH&A staff across child and youth services. ➢ Harm reduction strategies need more emphasis and support in communities across the NWT. One such example where it was felt by stakeholders that this would be effective was in the area of teaching people how to drink responsibly as opposed to teaching abstinence. This was seen to be a particularly effective intervention for youth.

Rationale & Relevance	
	➢ Strong need expressed for more local supports for individuals with MH&A issues. Examples of this support was cited as having someone organize AA groups in communities and to have more "drop-in" facilities located in communities that would serve youth and adult service users in a social support fashion ➢ Many stakeholders expressed the need for "medical detox" programs to be developed in the NWT while others felt that this was not a high priority. ➢ Both staff and community stakeholders indicated a strong need for the implementation of Tele-mental health across the NWT. NOTE: Caution was expressed in how this service would be implemented. It was felt that this needed to be a gradual process of implementation with careful attention being paid to education for individuals using the system, appropriate individuals providing the service and adequate follow-up to support this service. It was also stated that at a minimum a face to face encounter would be needed between the client and therapist prior to tele-mental health sessions being undertaken. This would of course add to costs of providing this service as travel in the NWT is very expensive. ➢ Stakeholders would like to see a "Centralized Intake Worker" system in each authority
Integration Issues	➢ More discussion and development work is required to take the merger of mental health and addictions beyond a name change ➢ Concurrent disorders not well understood across the MH&A system. Interventions involving concurrent disorders are, for the most part, being done separately in either the mental health or addictions area rather than in an integrated fashion of MH&A interventions. ➢ The focus on integration of MH&A services for children and youth needs considerable attention and enhancement. ➢ Stakeholders expressed concern over lack of Interagency Framework across the authorities that would enable the coming together of services to meet and discuss common issues concerning clients who are encountering MH&A issues
Service Gaps:	➢ There are gaps in the availability of a "Helpline" which was a clearly identified need as was the need for Tele-mental health service availability across the NWT. ➢ Psychiatric coverage is limited and sporadic at best and often times missing completely in many communities. This situation exists for adults and especially for child and youth ➢ Lack of medically supervised detox services. There is mixed opinion on this service gap with some feeling this is not required and is handled in other ways in the NWT while others felt this was clearly a needed service ➢ Stakeholders expressed concern over insufficient Independent Living Support [ILS] resources as well as Assertive Community Treatment [ACT] services across the NWT ➢ Aftercare follow-up services for individuals coming out of hospital treatment and residential treatment for addictions is seen as a void ➢ Yellowknife requires a Psychiatric Out-Patient services connected to the Stanton Territorial Psychiatric Hospital service. ➢ Coordination of planning for individuals coming out of jail is a significant issue. Most often these individuals have issues with addictions and mental health. The opportunity for individuals to succeed is badly compromised when the coordination of services to support them back into the community does not take place or they have to wait inordinate amounts of time to connect with supports such as income support and housing. All too often these individuals end up back on the path of substance abuse or deteriorated mental health due to this lack of support.

Rationale & Relevance	
Role of supplementary personnel ;	➢ RCMP often first and sometimes only responders. Mechanisms need to be developed to ensure these support service providers, and others of a similar nature, are involved in setting system directions and in implementing that direction into practice. ➢ Several stakeholders indicated a clear need to train local people to provide additional support to individuals with MH&A issues
Housing Issues	➢ Housing is a major issue for people with mental health and addictions in the NWT. Affordability, access, safety and Housing Corp Policies create major barriers in prevention and interventions of MH&A issues ➢ Housing models for remote communities based on unique community needs/issues do not seem to be evident. ➢ Funding for housing is an ongoing issue ➢ In larger centers housing for women and children is in short supply. ➢ Housing is not often considered in the discharge and case planning when individuals are being discharged form hospital or treatment centre, released from correction facilities or returned to the Territories after an OOT placement ➢ Indications are that in some HSSA's there are houses which are "boarded up" and not occupied while there are many individuals in the community who need housing. Lack of coordination of services and conflicting policies across the NWT Housing Corporation and the Health and Social Services sector are cited as reasons for this situation to continue to be an issue.
Other Issues	➢ There is a lack of collaborative involvement and policy direction across income support, justice, health and social services to support the most vulnerable individuals with MH&A issues. ➢ Due to the high demand for service in the Emergency Room at the Stanton Territorial Hospital patients presenting with mental health and addictions issues are often left waiting for inordinate amounts of time before they are seen and assessed.

Administration & Operation	
Governance	➢ Leadership from the Department of Health and Social Services is seen as inconsistent and not strong. ➢ Mandates across HSSA's seem to differ with services available in one HSSA not being available in another. ➢ Communication across the Department and the HSSA's/Territorial Health Authority is seen as inconsistent/not strong as is communication between Authorities.
Staffing	➢ Classification, training & education require attention and enhancement. ➢ Staff recruitment and retention is an ongoing and serious issue across the NWT [this includes psychiatrists]. ➢ Job re-definition and education requires attention in regards to the practice model (Integrated Service model) ➢ Conflict with the indigenous approach to MH&A interventions ➢ Staff turnover in the region and in particular in the remote regions ➢ Stakeholders felt that Department of HSS should create a position solely responsible for implementing and overseeing a "Case Management" model. ➢ Difficult to access education for local individuals working in MH&A is seen as a barrier to more effective services. ➢ The inability to retain staff is seen as part of the issue around the lack of

Administration & Operation	
	integration and coordination of services across all relevant sectors. As HSSA's are very often running on skeleton staff due to staff turnover it is not possible to focus attention and priority on developing working partnerships with other sectors such as housing, income supports, justice and others.
Info sharing	➢ Major lack of cooperation in sharing of information. Services work in silos and make little effort to resolve barriers around info sharing across sectors. This becomes an issue/barrier in instances when related case management information would clearly benefit integrated service delivery for individuals across sectors within health as well as across the social service sector and health. ➢ Ability to communicate electronically is limited in availability and education around it's application
Funding	➢ Funding and therefore expectations come from a variety of levels of government ➢ Funding is accessed mainly from the Gov't of the NWT however industry is being looked at more and more as a source of program funding in many HSSA's ➢ Federal Government has a large influence and presence in MH&A program funding across the HSSA's. ➢ Agencies/Non-Government Organizations find it extremely difficult to attract staff as they are not funded adequately to compete with the health authorities and government staff recruitment capacity.
Mandate gaps	➢ Confusion exists in many locales as to the role of the Federal Government in program planning, development and funding allocation and the connectedness of these programs to MH&A services. ➢ Frustration over the issue of Federal funding being "time limited" resulting in programs being suspended with no other funding mechanisms in place. Would like to see core funding for these federal programs.
Planning	➢ Ongoing planning mechanisms are not in place ➢ Planning appears to be done in silos and on an inconsistent basis. ➢ Indigenous people are not involved or adequately consulted around initiatives involving MH&A planning. ➢ Cross sector involvement in planning for MH&A programs is lacking thus creating greater barriers towards a true integrated model of service delivery.

Effectiveness and Impacts	
Standards	➢ Generally agreed that program standards [for CCP] are outdated and require updating
Data Collection	➢ The Department has not taken clear and strong leadership in providing direction and requirements to the HSSA's/Territorial Health Authority for the provision of monthly Statistical Information in relation to MH&A activity and outcomes. *[Currently no data of this nature is available from the Department.]* ➢ Forms for data collection are seen as cumbersome and lengthy. ➢ Data is collected sporadically, if at all, and does not allow for a consistent and comprehensive examination of service activity ➢ Electronic capacity for managing and reporting data is seen is as weak and requiring significant updating. ➢ General consensus that there is a clear need for electronic health records across the NWT.
Outcomes	➢ No indication of outcomes indicators or measurements being in place. ➢ No system is in place to effectively track outcomes of people who use the system

Effectiveness and Impacts	
	and go from one facet of care to another across the system ➢ Community Counseling Program had an evaluation component built into the implementation of the program however there is no evidence of this being active at this time.
Satisfaction with service	➢ Very little, if any evidence, that service users are canvassed on a regular or routine basis to determine their satisfaction with service.
Quality control	➢ A need for an accreditation model for the MH&A service across the NWT was cited. It was felt that this would ensure that services are being delivered at a minimal and consistent standard across all aspects of the system.
Accountability	➢ The Department's accountability requirements for the MH&A's programs are not evident or at best not comprehensive and consistently applied.

APPENDIX B: REFERENCES

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