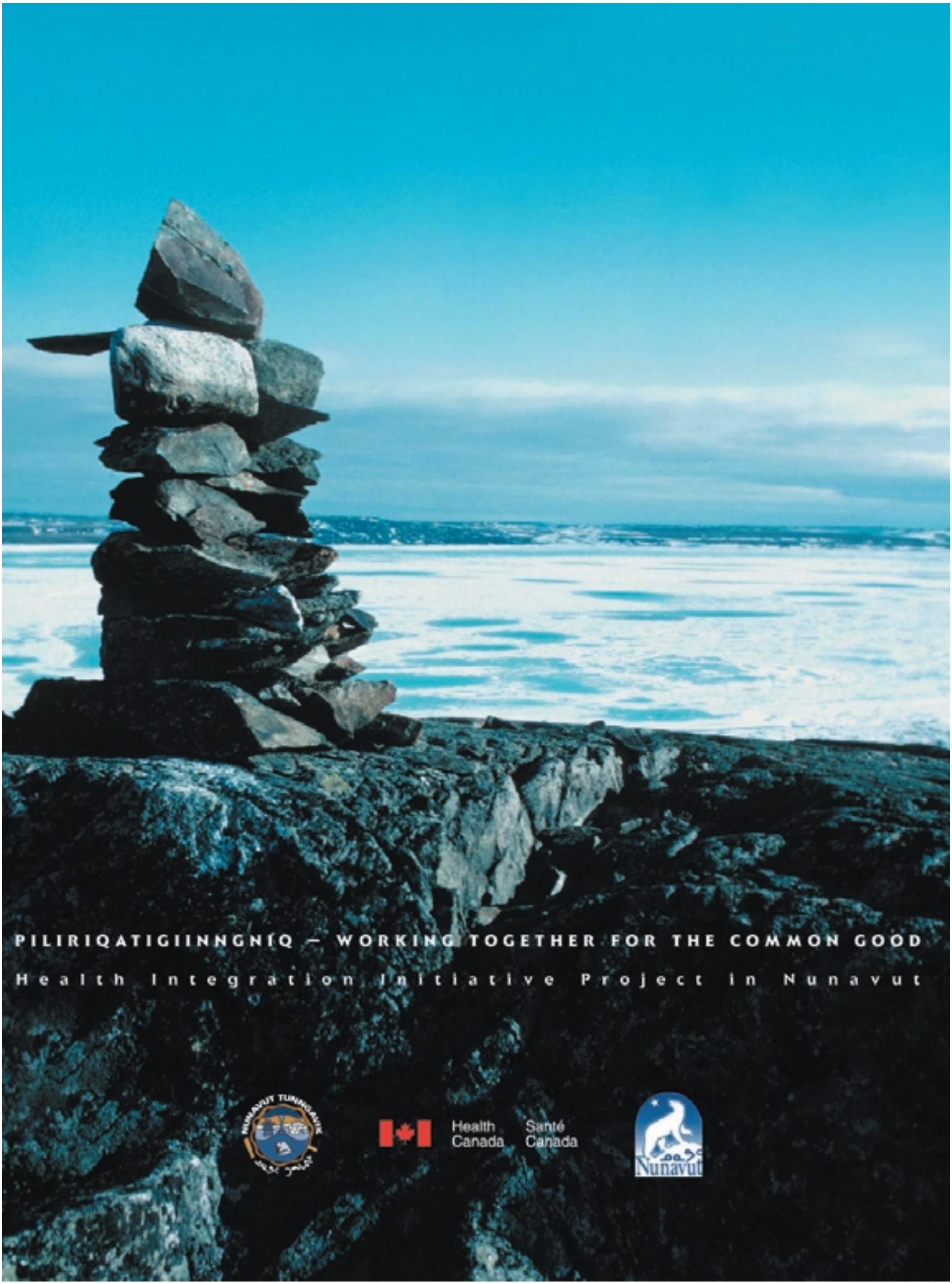
PILIRIQATIGIINNGNÍQ – WORKING TOGETHER FOR THE COMMON GOOD
Health Integration Initiative Project in Nunavut
Health Canada
Santé Canada
Nunavut

Acknowledgments

Many individual people and organizations throughout Nunavut and across Canada must be thanked for their participation in this project and their contributions to this report. We thank them for their time and for their honesty in responding to questions about maternal and child health services, oral health and addictions and mental health services in Nunavut.

Thank you to all those people in Iqaluit and the Hamlets who took the time to attend interviews and community discussions.

We also thank everyone who helped to arrange interviews and community discussions and, the people who responded to the call for reports and documents early in the project.

The work of the Steering Committee, which included members from Nunavut Tunngavik Incorporated (NTI), the Government of Nunavut Department of Health and Social Services and Health Canada's Northern Secretariat, was integral to the success of the project.

Pierre Lecomte, the project co-ordinator from NTI deserves special thanks for his efforts throughout the duration of the project.

This report was prepared by the New Economy Development Group, Ottawa, Ontario for the Health Integration Initiative.

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Executive Summary

The Health Integration Initiative (HII) in Nunavut involved the Government of Nunavut Department of Health and Social Services, Nunavut Tunngavik Incorporated and Health Canada's Northern Secretariat working in partnership to develop an action plan for Nunavut focusing on increased integration of federal and territorial health promotion and illness prevention programs in the areas of maternal and child health, mental health and addictions treatment and oral health.

During the project's 6 months of data collection, interviews and community discussions, there emerged a powerful overarching theme for increasing integration within Nunavut: the development and implementation of a Community-Wellness Strategy for Nunavut which would take a holistic, integrated and community-centric approach to health care and social services delivery in the Territory. This strategy is perhaps the logical extension of the cultural dynamic at play in the Territory for thousands of years, a dynamic firmly focused on the family and the community rather than the individual.

Part 2 of this report outlines the rationale and the strategic activities required to develop, put in place, and support such a Community-Wellness Strategy, to help combat the consistently poor health and social issue outcomes which, for numerous historical, geographic and socio-economic reasons, the people of Nunavut people have experienced when compared to the rest of Canada.

Actions to increase integration in the areas of maternal and child health, oral health and the development of a Culturally Appropriate Continuum of Mental Health and Addictions are included as necessary elements of a Community-Wellness Strategy and are also outlined separately in more depth. Part 3 of this report focuses on Findings with regard to a Culturally Appropriate Continuum of Mental Health and Addictions Services; and in Part 4 — Findings on Maternal and Child Health Services and Oral Health for Children are provided.

Information on the Approach and Methodology for the data collection is contained in Appendix 1.

Summary of Proposed Actions

The following actions have been identified as necessary steps on the road to implementing a proposed Community-Wellness Strategy. They are designed to increase integration, both at the community level and between federal and territorial initiatives.

Overall community-wellness comes from a population health approach which considers all facets of community life. As such, the proposed Community-Wellness Strategy for Nunavut is meant to bring communities together by taking an inclusive, interrelated approach to maternal and child health, oral health, addictions and mental health, education, justice, recreation and employment.

To effectively develop integrated community plans, gaps have been identified that, if addressed, will support the Community-Centred Strategy.

As well, there are specific Findings and Recommended Actions with regard to Maternal and Child Health and Mental Health and Addictions. Many of the actions build on one another or are linked in some way and have to proceed concurrently. Some of the recommendations have time frames that are more critical then others—in other words nothing can proceed without the recommendation moving forward. Those recommendations have been identified as Short Term (in the next 18 months); other recommendations fall out directly from the short term recommendations and have been identified as Medium Term (in the next 24 months) and lastly some recommendations require more extensive strategic planning and have been identified as Long Term (24 months to 5 years).

1.0 Develop Community-Wellness Strategies to Plan and Meet Health and Social Service Needs in the Hamlets

Short Term

1.1 Development and adoption by The Government of Nunavut (GN) of a policy framework and funding model to support a Community-Wellness Strategy. The foundation of a Community-Wellness Strategy should include the adoption of coordinated and complementary arrangements which support a comprehensive approach by the key government stakeholders. A Community-Wellness Strategy builds upon the former Community Health Councils but needs to take into consideration other key GN stakeholders including the departments of education, culture (recreation) and housing.

1.2 Provide support for Community-Wellness Councils to identify and plan for health and social service needs at the hamlet level.

1.3 Identify selected communities in terms of their readiness for action and change.

- Work with selected communities in Coordination, Priority Setting and Planning with regards to a Community-Wellness Plan focused on health and social services.

- Provide selected communities with strategic community development support and manage the implementation of the development of Community-Wellness Plans as a group with regular conference calls and face-to-face meetings in order to maximize learning and outcomes.

- Strategic support to the communities would also include joint development and use of tools for Community Asset Mapping, Community Needs Assessment, Community-Wellness Indicators, Human Resources and Training Plans, and Community-Wellness Plans.

Short-Long Term

1.4 Establish Selected Community-Wellness Councils by reactivating existing Community Health Councils at the Hamlet level, and re-orienting them to a community-wellness focus that includes health, social services, recreation, justice (Justice Committee and RCMP), housing, education and representatives from community-based social service organizations.

2.0 Integrate Existing Federal and Territorial Initiatives into Community-Wellness Strategy

Short term

2.1 Integrate existing GN grief and loss initiative into the overall Community-Wellness Strategy with dedicated/continuous funding to support grief and loss workshops. Integrate other initiatives such as those funded through the Aboriginal Healing Foundation.

2.2 Integrate suicide prevention work such as Embrace Life Council into overall Community-Wellness Strategy with dedicated/continuous funding to support suicide prevention.

2.3 Integrate existing Public Health Agency of Canada (PHAC) Health Promotion Programs and Health Canada, First Nations and Inuit Health Branch (FNIHB) Health Promotion Programs into Community-Wellness Strategies.

Medium term

2.4 Identify and utilize existing infrastructure (schools, recreation and community centers, youth and elder centers) and their activities into the Community-Wellness Strategy.

2.5 Integrate recreation services as key part of creating healthy communities and preventing social and health problems.

2.6 Ensure community access to schools during off-hours for recreational activities, and provide necessary resources.

3.0 Develop Information and Data Management Requirements to Meet Nunavut Planning Needs.

Medium Term

3.1 Develop both process and outcome evaluation frameworks for the Community Wellness Strategy Initiative.

3.2 Develop and appropriately fund Nunavut-appropriate health and social indicators development. Consider using the indicators developed from the selected (pilot) communities as a basis to build upon.

Long Term

3.3 Utilize the learning from the evaluations to adjust/make changes and strengthen the Community-Wellness Strategies in the Hamlets.

3.4 Develop regular data collection and periodic evaluation timetable using revised health and social indicators from pilot evaluations.

4.0 Assess and Support Human Resources and Training Needs

Long Term

4.1 Re-examine and redefine key community roles and responsibilities, reporting relationships, training needs and linkages between the roles; specifically the Community Health Representatives and Community Liaison Officers and where they exist, Wellness Workers and addictions and mental health counselors.

5.0 Review of Funding Models by All Funding Partners

Short Term

5.1 Examine ways to provide multiple year funding for health promotion and prevention activities in Nunavut.

5.2 Health Canada and the Government of Nunavut to jointly examine and assess the issue of accessibility of funding programs and the resources available to apply for those programs at the Hamlet level. The use of traditional languages and alternative applications/communication processes (e.g. the use of adjunct video and oral application processes) could be explored.

5.3 Funding partners to establish processes and communication mechanisms that foster a joint planning process. Support a process that ensures planning for grants and contribution agreements is completed at the operational level (Hamlets) then rolls up into an overall Community-Wellness Strategy for Nunavut. GN regional managers to play a key role.

5.4 Examine the concept of a "basket" of core health promotion /prevention programs under a Community-Wellness framework and develop the needed funding and reporting tools which support this approach. Coordination of community-wellness programs to be designed to foster both collaboration and communication of the framework amongst staff and community members.

6.0 Implement a Mental Health and Addictions Core Continuum of Services under the Guidance of a Territorial Steering Committee.

Short Term

6.1 Integrate all mental health and addictions, suicide prevention and grief and loss policy and program work in the GN Department of Health and Social Services into one unit with dedicated staff. Any Mental Health and Addictions (MH&A) work would need to be coordinated with and be integral to the development of Community-Wellness Strategy.

6.2 Establish a Steering Committee comprised of a Territorial Mental Health and Addictions Coordinator, Regional Mental Health Coordinators, Addiction Coordinators, Directors of Treatment facilities and other key stakeholders with expertise in cultural issues for Nunavut and addictions, mental health, grief and loss and post-traumatic stress disorder. This Committee would oversee the development and implementation of a Mental Health and Addictions Continuum of Core Services and a Workplan/Timetable.

6.3 Assign a minimum of two dedicated staff to the development and implementation of the Continuum for at least two years.

Training

Short Term

6.4 Connect the Addictions and Mental Health Continuum Implementation to the Addictions and Mental Health Worker Program at Arctic College. Ensure that a representative of the Program sits on the Territorial Steering Committee.

Cultural Elements

Short-Long Term

6.5 Incorporate and explore more fully culturally appropriate programs and service elements including connection to the land, harm reduction, cognitive based interventions, teaching of Inuktitut, teachings from the Elders and a holistic approach that links personal and community healing to personal and community experiences of trauma and loss.

Prevention

Short Term

6.6 Integrate prevention programs with Community-Wellness Framework and link with existing health promotion programs and with organizations such as Embrace Life Council.

6.7 Incorporate culturally appropriate community activities in safe places (e.g. recreation, community centre and educational facilities).

6.8 A mix of professionals is needed; ensure that recreation workers get some training in addictions/mental health intervention or that addictions workers are linked to or working out of recreation programming facilities for some of their time.

6.9 Develop and offer teacher training in suicide prevention and addictions avoidance.

Self-Help

Short Term

6.10 Ensure that self-help is an integral part of all Hamlet Community-Wellness Plans through dedicated support to the development of self-help mechanisms by Community Health Representatives (CHR) MH&A/community wellness workers.

6.11 Incorporate and support outreach by addictions/mental health workers with community members who have overcome addictions and/or mental health problems and who would be willing to act as mentors to those currently dealing with these kinds of problems.

6.12 Examine Elder circle and observation approaches and consider adapting/developing to facilitating group self-help.

6.13 Promote and provide access to materials and information in Inuktitut and access to websites on self-help (e.g. AA).

Crisis Response

Short term

6.14 In the area of crisis response, support the Kamatsiaqtut Help line with adequate paid staff and volunteer training. Integrate the 1-800 Territorial Youth Help Line to ensure adequacy/continuity of training and standardization of protocols and procedures. Link with the Distress Centre in Ottawa (a Best Practice Distress Centre) or another southern city to develop crisis response/assessment training.

6.15 Develop and provide training to Hamlet-based mental health and addictions workers which include a triage approach to in-person crisis response.

6.16 Ensure that professionals and para-professionals have access to the on-call system for assessment support from professionals.

6.17 Conduct a needs assessment with regard to implementation of an Assertive Community Treatment (ACT) Team for Iqaluit for identified at-risk persons with mental health, addictions and dual diagnosis problems.

6.18 Set up a network of safe houses within Hamlets to support individuals and families dealing with addictions, mental health problems, and family violence.

Community-Based, Non-Residential Services

Short-Medium Term

6.19 Short term development and implementation of in-service assessment training for health centre nurses, and mental health and addictions workers currently working in Nunavut.

6.20 Develop an on-call system for assessment support. That on-call support could be provided regionally (East and West) or centrally in Iqaluit through a toll-free number.

6.21 Access expertise through the Mamisarviq Healing Centre in Ottawa or other centres in the South with experience in dealing with the multidimensional grief and loss issues confronting Nunavut.

6.22 Ensure that all those hired from the South to work in addictions and mental health have experience/training in trauma and loss and post-traumatic stress disorder.

Assessment and Follow Up

Medium Term

6.23 Explore the establishment of a Residential Treatment Centre in Iqaluit that could be attached to the hospital, and used to treat clients with mental health problems and addictions from Iqaluit and the hardest to serve clients from the whole Territory who need long-term treatment (e.g. detox; forensic psychiatry; dual diagnosis). The on-call service expertise should be co-located with the residential treatment centre(s). Any development of a Residential Treatment Facility for Nunavut needs to take into account the issues around confidentiality and choice when determining residential treatment options (leaving the Territory should be an option).

6.24 Integral to any treatment plan, an individual within the community of return must be identified who has the skills and time to provide follow-up treatment to individuals returning from residential treatment. Support the development and implementation of discharge plans for all individuals returning from treatment and include the cost of executing the follow-up/discharge plan in budgets for residential treatment.

6.25 Examine ways to provide follow-up support at the community level that uses all available resources (including community members with training from Aboriginal Healing Foundation) in a case management approach that has outreach as a critical component.

Facility-Based Treatment

Long Term

6.26 Explore options for facility-based treatment. The current Wellness Centre Program in Cambridge Bay could be adapted and built upon to form a foundation in the West. Existing buildings should be used where possible (there are, for example, DND and GOC buildings that are underused in the larger communities) to house short-term, non-medically based residential treatment programs.

7.0 Maternal and Child Health and Oral Health

Medium Term

7.1 Develop/adapt culturally relevant parenting program in cooperation with existing programs/initiatives (e.g. Great Kids).

7.2 Develop and deliver age specific sexual health programs to all schools in Nunavut on a consistent and ongoing basis.

7.3 Explore the development of a self-esteem program for young women (workshops; mentoring).

7.4 Systematically assess FASD in the schools: develop programs to address behavioral and cognitive development.

7.5 Enhance training in FASD assessment for nurses and teachers (Best Practice Models in Saskatchewan and Manitoba).

PART 1

Introduction to the Report

1.1 Introduction and Purpose

The following document is the culmination of several months of data collection and community discussions concerning health promotion and illness prevention programs in the areas of mental health and addictions treatment, maternal and child health and, oral health in Nunavut. This report integrates findings from numerous data collection phases, and includes proposed actions concerning the development and implementation of a Community-Wellness Strategy for Nunavut.

The purpose of this document is to present the strategic activities required to develop, implement, and support the proposed Community-Wellness Strategy which is outlined in Part 2. Part 3 presents findings and recommendations regarding a Culturally Appropriate Continuum of Mental Health and Addictions Services. This is followed by findings and recommendations on Maternal and Child Health and Oral Health for Children in Part 4.

Information on the Approach and Methodology for the data collection is contained in Appendix 1. Before moving into the proposed Community-Wellness Strategy, this first part (Part 1) presents a brief description of the project, and outlines Nunavut's social and health context within which this project sits.

1.2 Background to the Project

The Health Integration Initiative in Nunavut involved Health Canada's Northern Secretariat (NS), the Government of Nunavut (GN) Department of Health and Social Services, and Nunavut Tunngavik Incorporated (NTI) working in partnership to increase integration between Health Canada and the Government of Nunavut's illness prevention and health promotion program activities.

It is firmly believed that greater integration will help to achieve better health outcomes in the North by maximizing effectiveness of health promotion and illness prevention investments, and minimizing the threats of continued excessive pressure on the curative system.

Addictions and mental health treatment, maternal and child health, and oral health are priority areas for each of the partners and there are gains to be made by developing mechanisms to integrate the programs and services currently offered.

As defined in Article 32 of the Nunavut Lands Claim Agreement, NTI's role is to ensure that Inuit have an opportunity to participate in the development of social and cultural policies and programs. Throughout the project, NTI has provided expertise to assure that the action plan for Nunavut is socially responsive and culturally sensitive.

The HII project was also intended to support the GN's strategic plan to bring care "Closer to Home". The Closer to Home framework is intended to both ensure more appropriate and better access to health and social services to Nunavummiut; as well as more effective and efficient use of existing health and social service resources. As articulated in background documentation, "The GN now spends over $70 million, or roughly 9% of our total government expenditure, to provide health services (including medical travel, treatment and residential care) outside of Nunavut. We are committed to a series of transforming initiatives that will repatriate those services wherever patient and provider safety permit and service quality can be assured".[1]

This vision for health and social services delivery is part of a broader framework to bring not only health care, but also jobs and learning opportunities, closer to home as articulated within the "Pinasuaqtavut" (Bathurst Mandate). The Bathurst Mandate lays out four themes that serve as an important context to this HII project from the perspective of Nunavummiut: Healthy Communities, Simplicity and Unity, Self-Reliance, and Continuous Learning. Specifically, within these four priority areas it articulates the need to:

- Improve our well-being, where we define what well-being means to us;
- Support the development, delivery and continuous improvement of Nunavut-based programs and services, comparable to those enjoyed by Canadians everywhere else, and which respond directly to our own health needs;
- Contribute to other sectors of Nunavut's economy, so that health expenditures are an engine of our economic health, not a drain on our resources; and
- Help to build capacity in Nunavut and representative participation of Inuit in our workforce in every community, by investing in continuous, accredited education, training and mentoring initiatives.

The key elements contained in these documents have been important to the approach taken to collecting and analyzing the data, and in crafting proposed actions for this project.

1.3 Population Health Approach to Understanding Health Challenges in Nunavut

Population health is an approach to health care delivery which has gained near universal acceptance as the most effective and inclusive means to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, the population health approach looks at and acts upon the broad range of factors and conditions

[1] *Closer to Home, Department of Health and Social Services, Government of Nunavut, 2004.*

that have a strong influence on our health. It is for these reasons that a population health approach guided this project as well as the conclusions of this report.

In January 1997, the Federal, Provincial and Territorial Advisory Committee on Population Health (ACPH) defined population health as follows:

Population health refers to the health of a population as measured by health status indicators and as influenced by social, economic and physical environments, person health practices, individual capacity and coping skills, human biology, early childhood development, and health services. As an approach, population health focuses on the interrelated conditions and factors that influence the health of populations over the life course, identifies systematic variations in their patterns of occurrence, and applies the resulting knowledge to development and implement policies and actions to improve the health and well-being of those populations. The population health framework recognizes that environmental issues, social problems, economic factors, and personal habits and behaviors are all important determinants of the health and well being of the population.

A population health approach recognizes that any analysis of the health of the population must extend beyond an assessment of traditional health status indicators like death, disease and disability. A population health approach establishes indicators related to mental and social well-being, quality of life, life satisfaction, income, employment and working conditions, education and other factors known to influence health.

These factors are also called the "determinants of health", and include income and social status, social support networks, education, employment and working conditions, physical environments, social environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender and culture.[2]

It is well understood by governments that non-medical determinants of health-issues such as unemployment, income levels, the changing family, education and literacy affect the health and well-being of a population. As such, Nunavut communities with high unemployment rates, low education levels, low income levels, a large number of single-parent families and poor housing conditions are at high risk for poor health. In addition, other factors such the trauma left from the experience of residential schools, cultural dislocation, forced gathering of families into communities, and other historical events must be taken into account when assessing the health of Nunavut's Inuit population.

[2] *Evaluation of Health Care Models in Inuit Regions, Inuit Tapirit Kanatami, September 2000.*

A broader discussion of these well-understood factors is contained in Appendix 2. While the term "population health" may be new to Inuit, the concept is certainly familiar, and is consistent with the holistic approach to health traditionally practiced by Inuit.[3] Addressing these underlying health determinants is, as important for population health as are good medical care, primary prevention, and health promotion and sound public policy initiatives.

[3] *Ibid*

PART 2

Piliriqatigiinngniq: The Need for a Community-Wellness Strategy that Promotes Integration

2.1 Why A Strategy?

By taking a population health approach as described above, and by examining the determinants of health, it is clear that the health care and service delivery problems in Nunavut are complex, multi-layered and interconnected to Nunavut's broader socio-economic, historical and cultural context.

It follows then that any solution to such broad and diverse challenges must be rooted in the determination to integrate the activities and the resources—both human and capital—at the community level.

By bringing representatives of all aspects of community life—health, education, justice, recreation and so one—to the same community table, the effectiveness of such resources will be maximized as the community focuses on its wellness as a whole.

By extension, this holistic view adopted by all participants in the health and social services sectors will break through program silos and funding structures, the mechanisms which exist to support the delivery of health and social services.

Figure 1: Community-Wellness Strategy: Piliriqatigiinngniq

Figure 1 depicts the range of stakeholders, the multidimensional aspects of wellness, and the implementation strategy required to achieve the goal of community wellness. At the heart of the success of such a strategy is the participation of the Inuit community, at both the level of the hamlets, as well as at the level of the whole community of Inuit living in the north. At the same time, it is within communities that the experience of wellness and healing must take place, for individual Nunavummiut as well as for Inuit as a collective. The community is therefore the means, and the ends, of the proposed community-wellness strategy.

Moving outward from the community in the centre, numerous stakeholder groups that are critical to the success of the community wellness strategy are listed. These stakeholder groups are depicted as blue bubbles surrounding the community in the centre: Inuit Organizations; Businesses; Community Leaders; Youth; Government representatives (federal, territorial, hamlet); Elders; and Health and Social Services Organizations. It is important to note that while these stakeholder groups appear to be outside of the community, they are in fact also a fundamental part of the community. The purpose in listing them is to indicate the importance of all stakeholders working together in a collaborative way on a shared project.

Encircling the community and its stakeholders are the issue areas that must be addressed as part of the integrated community wellness strategy (these are on a green background). These encompass a multitude of health-related areas—mental health, oral health, maternal and child health, addictions—but go beyond to include other factors that determine population health and wellness. The determinants of health listed include employment, education, justice, housing, and recreation because these areas are all intricately connected to the ways in which Nunavummiut find meaning in their lives; interact with one another and the broader social structural systems around themselves; and define their communities as both physical spaces, and as moral spaces. Finally, although grief and loss issues are not one of the identified determinants of health, addressing those issues at both the individual and community levels is critical to the success of the strategy. If these issues of grief and loss remain buried or are not adequately addressed, they will continue to impede the healing process that is required for Nunavut to move forward to supporting a holistic wellness approach.

Finally, the dynamic wellness strategy is depicted as an ongoing, iterative process. Beginning with "Establish Community Council" (top right) and proceeding clockwise, these action-oriented stages lay out how the community-wellness strategy will be implemented. Although depicted as a linear process, once the strategy is underway it will be possible for steps to be shortened or skipped. However, the steps as indicated serve as touchstones for the Community-Wellness Councils as they work to fulfill the community-wellness strategy on a ongoing basis. For example, results from a Community-Wellness Strategy Evaluation could be used to make adjustments to the Community Council membership; to identify whether the assets mapped previously have changed; to assess whether community needs have changed; to revised community priorities; adjust the community-wellness plan, and the associated funding plan; and to implement revised initiatives.

2.2 Key Components of the Community-Wellness Strategy

Years of community development practice and a focus on public health has shown that comprehensive collaborative approaches to addressing community issues are necessary for communities to overcome long histories of poverty, isolation, buried culture and history, and other social problems.

However, in less advantaged and isolated communities, it is rare for such initiatives to happen without external funding support, technical assistance provided on a sustained, longer term basis, and within the context of an overall integrated policy and program framework.

In order to begin the process of developing a Community-Wellness Strategy, it will be necessary for the Government of Nunavut and Health Canada to support a community planning process that is based in community development best practices, draws on the collective experience of people at the local level and is designed to empower Nunavummiut and build upon the Inuit culture.

At the outset, selected communities require targeted funding and support, to plan and implement strategies which can then be evaluated and adjusted prior to a full-scale roll-out of the process across Nunavut.

Experience indicates that this process needs to include the following four key elements, along with their supporting components:

1. GN development of a policy framework and funding models to support a

Community-Wellness Strategy. This framework would spring from a collaborative effort with the federal government to review existing funding models and health promotion and illness prevention programs to preserve and integrate current programs into the wellness strategy.

2. Community-Wellness Council with broad stakeholder representation, working from Principles and Values developed by the Council.

3. Technical Assistance, using Community Development Teams.

4. A Community-Wellness Planning Process which includes:

    - Community Asset Mapping;
    - Community Needs Assessment With Priority Identification;
    - Community-Wellness Indicator Development; and
    - Community-Wellness Plans and Human Resources Planning.

2.2.1 GN Development of a Policy Framework and Funding Models to Support a Community-Wellness Strategy

The foundation of a Community-Wellness Strategy should include the adoption of coordinated and complementary arrangements which support a comprehensive approach by the key government stakeholders.

In order to get underway, the establishment of a coherent framework in Nunavut will require timely action by both levels of government and the support of the relevant Inuit organizations. Within the federal government, efforts to promote horizontal action could be strategically focused on the health and wellness file across a number of departments, perhaps building on the experience of the Nunavut Federal Council.

Ideally, within the Government of Nunavut, a designated lead department should establish a horizontal initiative, or build on a relevant current one, to create a framework for joint and coordinated delivery of resources, as well as to link up with the parallel federal effort. Where possible, new multi-year joint funding and support mechanisms (e.g. funding platforms) should be negotiated and launched in preparation for moving resources cost-effectively to communities on a sustained basis.

Essential Supports to the Wellness Strategy

The following elements would be part of the policy framework and would be addressed within that framework. This links with the previous section regarding the need for the development of a horizontal initiative

(integrated systems approach) and the review of funding models etc.

- Integrated Systems Approach and Effective Working Relationships.
- Clarification and examination of Community Health Representative (CHR) and Community Liaison Officer (CLO) Roles and Training Needs.
- Multiple Year/Flexible Funding Models.

Each of these elements is described below.

2.2.2 Integrated Systems Approach and Effective Working Relationships

An essential element of a community-wellness approach is the requirement to take an integrated systems approach. This means that the approach must integrate with existing initiatives rather than existing in parallel; it must be supported and delivered using existing services wherever possible; and it must be supported with sustainable funding.

While it is neither possible nor desirable to re-invent health and social services systems from the ground up, it is necessary to fundamentally alter how many of these work together in order to bring a holistic perspective to supporting and developing community wellness.

The requirement to work across jurisdictional boundaries for common purpose has become as necessary in Nunavut as it is in the South. In order to take an integrated systems approach to achieving community wellness, critical resources must be allocated to fostering and supporting horizontal and vertical working relationships. Collaboration does not simply happen; it must be adequately resourced and supported. These relationships will be necessary to ensure system efficiencies, but also to ensure coherence at the level of service goals and objectives, and in the implementation of these.

Relationships with the full range of health and social service providers must be developed and supported, including the following: Health and social services, community and government services, education, and justice. It is preferable to use existing initiatives and mechanisms to foster the collaboration and horizontal and vertical working relationships needed to develop, implement and support the proposed community-centred wellness approach.

2.2.3 Roles and Training Needs to Support the Community-Wellness Strategy; Community Liaison Officers and Community Health Representatives.

In keeping with the notion of utilizing existing resources, it is recommended that the responsibilities of the Community Liaison Officers and Community Health Representatives be more clearly defined and enhanced by having them play key roles in the imple-

mentation and maintenance of community-wellness plans.

Community Health Representatives, (CHRs), are typically Inuit from the community who have taken the 10 week CHR certificate from Arctic College. They usually work out of the local community health centres and assist with delivering culturally appropriate health promotion activities. Generally, the CHRs report to the Head Nurse in the Community Health Centres. Each CHR works independently and the environment and working relationship differs from community to community. Moreover, while there is funding for CHRs in all communities, there are currently upwards of 10 vacant CHR positions in the Territory.

There is no central coordination or functional guidance of CHR's from the Department of Health and Social Services headquarters in Iqaluit. CHRs are expected to be responsive to the needs identified by their communities. This flexibility allows for the CHR to focus his or her attention in a variety of different areas. In addition to daily diversions from their work, the CHR work in the Hamlets responds to health promotion "days and weeks" recognized by the professional health care community such as Aids Awareness Week, FASD Day, Weedless Wednesday etc.

However, there is concern over the growing number of tasks and priority areas they are being asked to take on, including all aspects of sexual, maternal, and child health. This indicates a need for increased training to ensure competency and/or a review of their workloads.

Another position that bears further scrutiny in relation to community-centred wellness plans is that of the Community Liaison Officer. That position, where it exists in Nunavut, is funded by the GN and reports to the Hamlet Office and Council.

The CLO role could be expanded with training to act as the secretariat to a Community-Wellness Council or coordinating the various committees active in the Hamlets and acting as a bridge between health and social services.

Both the CLO and CHR positions could be valuable assets to a Community-Wellness Strategy and their staffing, training, development and management would need to be reexamined by the GN in that light.

In addition to the CHR and CLO roles, there are several other positions including the mental health and addictions workers who could be utilized in the delivery of a Community-Wellness Strategy.

(more specific details on those positions can be found in the section on mental health and addictions and in Appendix 3)

2.2.4 Multiple Year/Flexible Funding Models

A third essential support to the proposed community wellness approach is the requirement for multiple and more flexible funding models. There are a number of issues currently at play in Nunavut that demonstrate the need for flexible funding; these are discussed below.

Short-term Proposal Based Funding

Funding available to the Hamlets through both the Government of Nunavut and through Health Canada and the Public Health Agency of Canada are, for the most part, project-based and time-limited. This model sometimes works somewhat more effectively in the South due to the existence of philanthropic and community-based funding sources which can be utilized to complement and extend the federal funding. However, the use of these models in the North often creates a number of barriers to success.

Additionally, community organizations that apply for and receive the funding often have limited capacity to write grant applications and do not have the same capacity from year to year to write applications. The result is that programs, for example for FASD or STDs awareness and prevention, are "available to the community one year and gone the next" as one person interviewed put it.

Moreover, there is a fundamental inequity of access to funds based on the ability of application writers as opposed to the actual needs of the community.

> *"(There are) strings attached that make it difficult. (It) takes months to do the paperwork to get the money. (They) can't afford to fund a program once the money dries up".*
>
> ***—Hamlet Community Worker***

> *"There is no program now for HIV/Aids education in the schools and little understanding as to the seriousness (of this issue)".*
>
> ***—Hamlet Teacher***

> *"There is no funding available to hire Elders for the schools as there was in the past."*
>
> ***—Hamlet Council Member***

Accessibility of the Applications Process

As with health promotional materials, the language and medium of the project application and reporting process was an issue for many communities. The application and reporting processes for most programs are exclusively in English, but also only available in a written format. Lower literacy levels for English, and, in particular, for the written language means that many communities are not able to apply for funding or successfully

report on the activities completed with the grants and/or contributions received.

There is, therefore, the need to investigate alternate methods for proposal and report writing for funding proposals including: translating application processes into traditional languages, or adopting audio or videotaping of both application and reporting requirements for projects. Both approaches would respect the Inuit culture and likely increase the number of people who could participate in the planning and development process for project funding.

The Need for Multiple Year Funding for a Basket of Programs and Services

There are a number of very good programs available in the Hamlets funded through the Government of Canada. However their availability varies from year to year. In addition, as described earlier and will be seen in the next section on maternal and child health, the health indicators in Nunavut are much below that for the rest of Canada. If health promotion and prevention activities, in particular those aimed at children, youth and young mothers, are available one year and gone the next it does not send a clear or consistent message as to the on-going importance of the issue to healthy mothers, youth and the community in general.

Project funding and resource levels allocated by fiscal year may provide some ability for governments to manage their budgets. However, the application of these practices in Nunavut does not provide communities with the ability to develop skills and establish more long-term partnerships and funding strategies. Multiple year funding is a requirement to ensure stability and continuity of staffing and program presence in a community.

Community capacity to develop proposals and lack of communication between levels of government contribute to regional and local inequities in funding allocation. Mechanisms for joint planning and ongoing communication between levels of government need to be established and maintained.

2.2.5 Working with Selected Communities to Establish Community-Wellness Councils with Broad Stakeholder Representation, guided by Principles and Values

Understandably, addressing broad social problems requires participation from a broad group of people. The development of community-based plans means that all parts of the community must be involved. As a part of the initial phase of a Community-Wellness Initiative, it will be necessary for the community leads to identify all relevant players and the actions to meaningfully involve a broad cross-section of community stakeholders in the process. To ensure this broad representation, an exercise in social network mapping will need to be done in each selected community.

This process is being suggested because it looks at the broadest range of community members from all levels of government, institutions (i.e. churches, schools etc.), community organizations (both advocacy and service oriented) as well as the economic/business links in a community's overall make-up.

In Nunavut, it will be vital to include representation on the Community-Wellness Council from a number of groups that historically may not be involved. These groups would include Inuit organizations, Elders and youth and the business sector where it exists. Where there are no such formal organizations which represent these groups, strong members from these segments of the community will need to be identified. Once the potential players have been identified, the work can begin to bring these people together in a planning process.

It is understood that each Hamlet used to have a Community Health and Social Services Committee or Community Health Committee. These Committees have become largely defunct, although during the community discussions, several mayors and Senior Administrative Officers (SAOs) spoke about bringing the Committees back into existence and, in fact, in Cambridge Bay, the Committee has begun to meet again. While more broadly based than the original Committees, the Wellness Councils will need to be mindful of building on work already accomplished by the previous or existing Committees.

- **Values and Principles**

The Community-Wellness Councils should be guided by a set of agreed-upon values and principles, as identified by the Councils themselves. Several key principles and values provide a framework for the design and implementation of the community-wellness strategy, and reflect previous work including the Addictions and Mental Health Framework.[4] These are presented below as a way to begin the process of Values and Principles identification, and are not intended to be seen as definitive or exhaustive.

- **Community-Centred**

At the heart of the proposed community wellness strategy is a holistic group focus, as opposed to a focus on the individual. This approach acknowledges the critical importance of the family and of the community unit within Inuit society, and focuses on promoting and supporting wellness at all levels of Inuit society.

[4] *Law, 2001.*

- **Closer to Home**

Wherever possible, people need to receive services within their communities. This principle reinforces the policy direction of the GN and will require the support and development of infrastructure that provides Inuit with opportunities to access an increased number of programs and services in their communities.

- **Culturally-Based Language and Materials**

There is a need to develop and provide information materials to Inuit in all Inuktitut dialects as a cornerstone to supporting the survival of Inuit culture.

- **Development of a Basket of Services Available to Communities**

A basket of services must be made available to all communities, and clients need access to a consistent range of services across Nunavut.[5] This means that services will look different in each region, depending on a number of factors including the level of need, as well as the resources available. Despite being organized or delivered differently from region to region, services identified as "core" will need to meet benchmarked standards of delivery to ensure equitable access across the North.[6]

In keeping with the principles of Closer to Home and Core Services, programs and services need to be flexible and offer choice to clients where possible. This may be easier to accomplish in the larger centres, where there is greater concentration of resources and service providers. However, there are ways to support flexibility and choice that incorporate distance delivery techniques (e.g. video conferencing) to those communities that are more isolated. These techniques need to be fully explored.

2.2.6 Technical Assistance from Community Development Teams

Experience in launching and sustaining comprehensive community initiatives demonstrates the vital importance of access to appropriate technical assistance and support, both resident in the community and obtained from external sources. Technical assistance from Community Development Teams will be necessary to support the work of the proposed Community-Wellness Councils.

It is clear that communities in Nunavut often find themselves attempting community development without much experience in planning, writing proposals, facilitating meetings, exploiting leadership skills and so on. Equally, it is apparent that the reliance on the goodwill of local volunteers has reached its limit in a growing number of places.

Internally within the communities, the creation of the multi-disciplinary community development teams is one way to bring

[5] *Access to a consistent range of core services may not always mean that services are present in each community—especially where services are highly specialized, or when a local population is widely dispersed. Those services, however, should be made available to each community, through appropriate support.*

[6] *This principle has been well-articulated by Law, 2001, p.15, for addictions and mental health services specifically.*

together and build up the available community-oriented human resources and expertise. The literature on comprehensive community initiatives also stresses the key role that outside technical assistance can play in disadvantaged communities.

Please see Appendix 3 for a discussion on possible models for community development.

The first step towards implementing the development of community wellness plans, is to engage accomplished community developers to assist selected communities in getting integrated initiatives off the ground. Together with government representatives, this group would:

- Develop a resource package from existing community collaboration materials such as community planning and organizing and consultation techniques—including the translation of materials into Inuktitut, where necessary. Arctic College could be engaged to integrate this information into the existing courses for community worker programs.

- Identify selected communities to begin the process of developing wellness plans—including the development of criteria for selecting communities and supporting an equitable distribution across Nunavut which would include pre-qualifying communities on the basis of their demonstrated interest and commitment to the establishment of multi-stakeholder lead local organization and joint community-based development teams.

- Set up mentor/coaching opportunities (twinning)—Each community will have a lead local person(s) or organization who will be partnered with a community developer coach/mentor.

- Establish a virtual knowledge network of people involved in the project to ensure that people are able to share their experiences and develop a knowledge base that is unique to Nunavut and Inuit communities.

2.2.7 A Community-Wellness Planning Process

Having developed a Community-Wellness Framework which identifies the key players and supports for the implementation of the strategies, the actual community wellness planning process would include several related activities:

- Asset Mapping;

- Priority Identification;

- Community-Wellness Indicator Development and Evaluation; and

- Community-Wellness Plans and Human Resources Planning.

Each of these activities is described below.

Asset Mapping

Part of the community-wellness planning would include asset mapping which involves the documentation of human and other resources within a community. This approach is different from other processes because it focuses on the community as a place with assets to be preserved and enhanced, not one with deficits (problems) that have to be remedied.

Asset-based community development is most often attributed to Kretzmann and McKnight.[7] It is based on the recognition of social capital and participatory approaches to collaboration which facilitate empowerment and ownership and enhance civil society.[8]

It is important to note that Asset Mapping does not overlook the significant challenges that exist in communities, but recognizes that it is the development of strategies to support community assets which leads to sustainable community change. Community mobilization and engagement is an essential part of this process of asset mapping.

The most common exercise to capitalize on assets is known as SWOT, an examination of strengths, weaknesses, opportunities and threats (challenges). Each selected community would be supported by the Community Development Team to complete a collective process of asset mapping, and a SWOT analysis, which would form the basis for a community-wellness plan.

Priority Identification

Subsequent to the asset mapping and SWOT exercises, the selected communities would engage in a decision making process to identify priorities that would best strengthen their community. These priorities and plans would then be used to develop an action-oriented community-wellness plan.

The plan could be used to help both the Government of Nunavut and the Government of Canada to make strategic funding decisions related to the priorities in each community. A local community organization involving a cross-section of community stakeholders would lead the process, provide direction and oversight to the work, and determine future priorities and action plans.

Community-Wellness Indicator Development and Evaluation

Because an important piece of the community wellness planning process is the incorporation of an accountability and evaluation process, there needs to be baseline information available against which progress can be measured. This requires the development of culturally appropriate outcomes and indicators that will be used to measure the extent

[7] *Kretzmann, J. P. and McKnight, J. L. Building Communities from the Inside Out. Evanston, IL: Asset-Based Community Development Institute, Northwestern University, 1993.*

[8] *See www.cete.org/acve/docgen.asp?tbl=tia&ID=170 for a good collection of resources on asset mapping strategies.*

to which the strategy is effective in meeting its goals. Citizens and policy makers alike need to know the impact of public efforts and thus be in a position to modify the programs and services governments offer.

From the perspective of communities, there is a growing need for a "community information infrastructure" to enable them to acquire, create and use information. "The general product of an information infrastructure in any given community should be a body of information, quantitative as well as qualitative, in a form which supports public discussion and decision-making on issues of importance."[9]

This is not a new requirement. The Annual Report on the State of Inuit Culture and Society clearly articulated the need for a series of indicators, and provides a well-thought, comprehensive framework for their development.[10] Without adequate information collection and management tools and mechanisms in place for an assessment of progress towards identified goals and outcomes, there is in effect no accountability mechanism to ensure that progress is made towards these goals.

Community-Wellness Plans and Financial and Human Resources Planning

The Community-Wellness Plans themselves would take into consideration, the resources available in the community, (both people and infrastructure) and the needs and priorities going forward, as identified by the Community. It would set out goals and objectives and a time frame in which to accomplish those objectives. The Plan would be accompanied by a Financial and Human Resource plan over 5 years.

[9] *Reed, Paul, Smarter Communities, Developing Strategic Information Infrastructure for Urban Canada, in "Making Waves, volume 14, number 4.*
[10] *Nunavut Social Development Council 2004, p. 52*

PART 3

Culturally Appropriate Approaches to a Continuum of Mental Health and Addictions Services

Part 3 of this Report provides recommendations on a culturally appropriate approach to a continuum of mental health and addictions services. This section of the Report highlights some of the best practices found in the literature and in interviews with regard to culturally appropriate approaches, and ends with some specific recommendations and priorities for action. For an overview of the extent and complexity of mental health and addictions challenges facing Nunavut, as well as the current services delivery situation, please see Appendix 4.

This section builds upon the extensive and well-researched Government of Nunavut, Mental Health and Addictions Framework developed by Dr. Sam Law in 2002. The Framework was developed based on best practices but did not deal to any great extent with cultural approaches specific to Nunavut. Some of the recommendations from that Report have been implemented; namely the hiring of several mental health and addictions specialists (psychiatric nurses) and the development of a two-year Nunavut Mental Health Diploma. However, the Territorial Director of Mental Health position has not been filled for several years.

One of the central recommendations of 2002 Framework was to combine the management of mental health and addictions. This has not been done to date. The complex interrelated problems of mental health and addictions can only be addressed with a coordinated, comprehensive and strategic approach that embraces some priority areas for action for all of Nunavut. Such an integrated approach would work well in the communities within the Community-Wellness Framework as described in Part 2 of this Report.

Strategy for a Nunavut Addictions and Mental Health Services Continuum

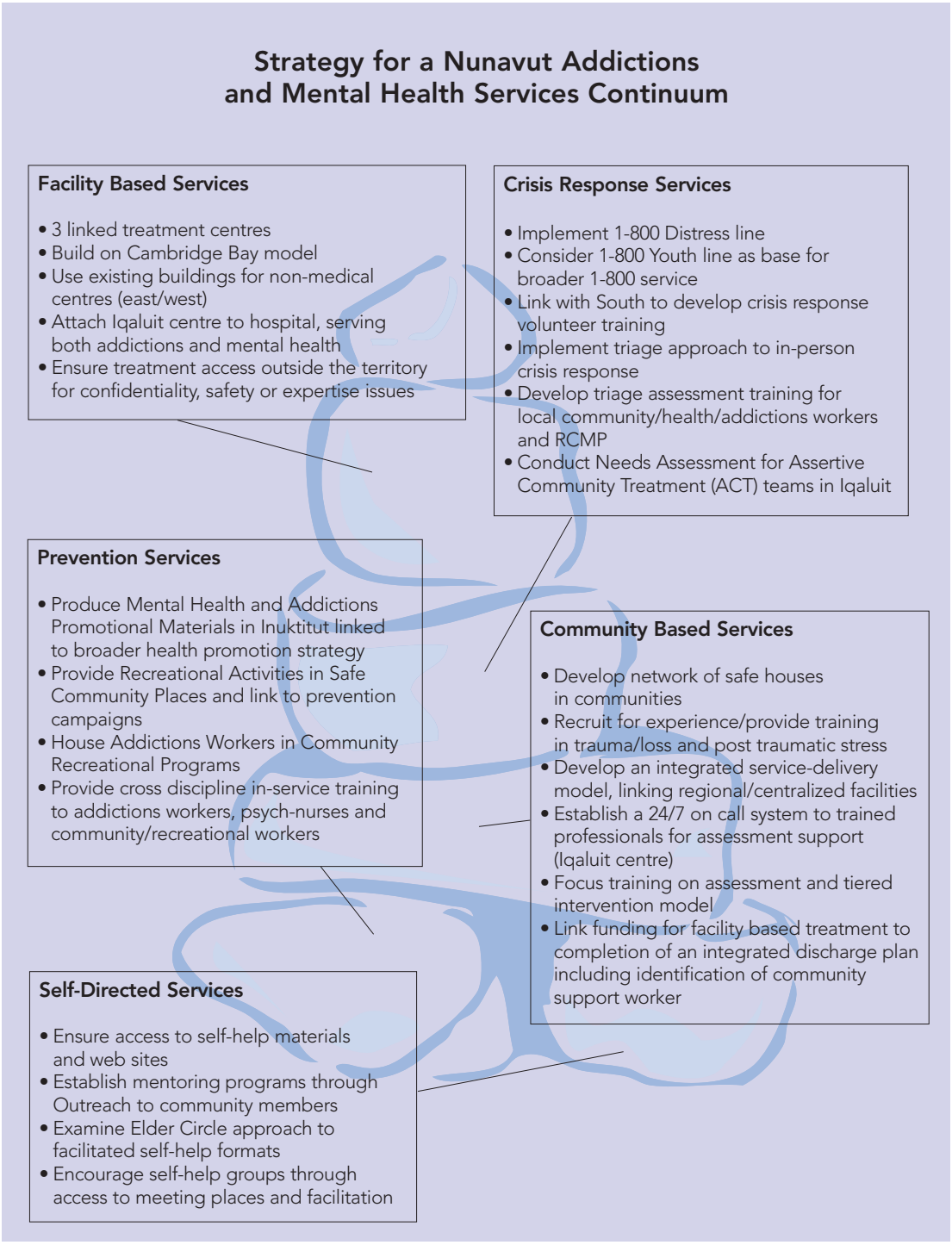


Figure 2: Strategy for a Nunavut Addictions and Mental Health Services Continuum

Figure 2 *is a graphic representation of the proposed strategic actions required to achieve a Nunavummiut-centred addictions and mental health services continuum. The Inuksuk symbol was chosen because of the important role played by these stone figures in Inuit culture, and in the north. Inuksuit are used as markers for a variety of purposes; in this current context, the Inuksuk diagram acts as a guide for those travellers working within and on behalf of the addictions and mental health services system. The use of an Inuksuk in the form of a human being—or an Inunnguaq—reflects the fact that the addictions and mental health services system exists to support individuals.*

Each block of the Inuksuk represents an essential component of the overall system. Working from the ground up, the identified services are most community-centred and under individual control at the base of the Inuksuk (prevention and self-directed) and less so towards the top (facility based). This does not mean that that the services are not client-centred, but rather refers to the fact that services become progressively more intense in terms of the types of interventions being used.

Two essential "legs" or building blocks are the foundation for the rest of the system: prevention services and self-directed services. Without these essential elements that support individuals to be agents in working toward their own well-being and care, the formal system risks being overwhelmed and unable to meet the level of need. This foundation is important for services anywhere in the world, but particularly so in the north where service availability is considerably lower than in higher population centres in the south. Moreover, this foundation works with Inuit cultural traditions which value self-reliance within a supportive community.

The next layer of the Inuksuk contains community based services, and includes a range of options that must be available and interconnected to the extent possible in every community. The intensity of services offered by this tier is increased from those in the prevention and self-directed blocks, but the emphasis remains on supporting the individual within their community. Community and family are of paramount importance within Inuit culture. Therefore, even where an individual needs to leave their immediate family situation for a time, the provision of safe places within the local community acts to enable the individual to draw on those personal network resources that continue to offer positive support. The maintenance of positive personal supports is seen as critical to the overall success of the services.

The third layer refers to a cluster of crisis-response services that is required in order to meet the needs of clients approaching, or in, crisis. Though also community based, crisis response services are more intensive and intrusive than those in the two tiers below. Crisis response services require timely response and the active collaboration of numerous professionals, including law enforcement, in order to achieve crisis resolution and maintain the individual within the community based services continuum. However, where necessary individuals can be referred from crisis response services to the facility based part of the service continuum. As a result, the triage function is central to the success of this cluster of services.

The top layer of the Inuksuk, facility based services, refers to the most intensive and least locally-based cluster of services. Currently, these kinds of services are not widely available in Nunavut: many individuals must travel out of territory for facility-based treatment. The proposed system must expand the within-territory, facility-based options, so that Nunavummiut are provided with the most culturally-appropriate services that, while perhaps not locally-available, are at least available within the more broadly-defined Inuit community.

Three key success factors have been identified in relation to the implementation of the continuum: first, all of the services along the continuum must be delivered in a holistic and client-centred way. Second, all of the identified core services will need to be implemented in stages over time, particularly in communities where more of the proposed services are currently unavailable. Third, the planning for the implementation of the additions and mental health services continuum will need to be integrated into the Community-Wellness Strategy community councils.

3.1 Gaps to Effective Service Delivery

The findings from the interviews and discussions were consistent across the regions and at the Hamlet level. In the respondents' view, lack of access to services and a lack of coordination between those services that are available have exacerbated efforts to treat people with mental health and addictions problems. Lack of access to services and the gaps surrounding provision of addiction and mental health services were key concerns and have been articulated elsewhere.[11]

Moreover, the complexity of health and social problems in Nunavut, gaps in training and personnel, and lack of data and information compound the issue.

[11] *Law, 2001.*

Perhaps most importantly, there is no culturally appropriate, Inuit-based approach to mental health and addiction counselling.

3.1.1 Service Gaps

In terms of service gaps, there are no specialized addictions and mental health services for children and youth, and little consistent delivery of suicide prevention programs. Crisis management is conducted by health and social services staff at community health centres, and there is little or no time/resources for prevention or follow-up activities. People medivaced out one day are often back the next due to lack of assessment resources; likewise, there is little follow-up for people returning from treatment out of Territory.

Communities also articulated a lack of safe spaces and supports for women, men and children subject to family violence/trauma.

There are no facility-based addiction or mental health treatment programs in any of Nunavut's regions.[12] There are inadequate or non-existent transitional or occasional housing to alleviate problems for traumatized, low-functioning and severely and persistently mentally ill clients.

For those clients who do receive residential treatment out of Nunavut, there is limited discharge planning and follow-up support; consultation participants and interview respondents indicated the need for dedicated discharge planning funds.

3.1.2 Lack of Service and System Integration and Coordination

Presently, there is no coordinated mental health and addictions strategy that incorporates early intervention strategies and supports and strengthens family and individual coping skills.

Beyond the mental health and addictions service system, there is a further lack of coordination between health and social services, education, day-care providers, schools, education, recreation, justice, and family resource centres, resulting in fragmented delivery of services without a coherent approach at the community level. Those initiatives that have been developed by the GN (e.g. addictions/mental health training/addictions strategy) are often not connected to previous or related initiatives. This is likely due to the fact that there is little coordinated, strategic dialogue or discussion among current service providers, government responsibility centres and departments, and NGOs to address the issues.

This lack of integrated addiction and mental health service provision has led to the use of a variety of addictions/mental health treatment approaches brought from the South, many of which ignore the complex conditions that lead to alcohol misuse in Nunavut, of the different types of misuse (alcoholism vs. dependence), and which are generally lacking cultural sensitivity or appropriateness.

[12] *Cambridge Bay has recently completed a two-week facility-based treatment program for women.*

Evidence from community discussions and interviews also suggest a lack of shared understanding among mental health and addictions counsellors concerning modern theories underlying alcohol and drug misuse, therefore limiting the range of potentially appropriate treatment approaches and methods offered.

3.1.3 Lack of Data and Information

Largely underpinning the consultation and interview process was the significant challenge in accurately identifying and describing the extent of the health and social problems in Nunavut because of a lack of credible data and information. This critical information gap ranged from understanding the exact nature, extent and severity of the problems of alcohol and drug abuse, to much more generalized health and social problems.

Consultation participants indicated that this lack of shared understanding perpetuates differences in perception about problems (e.g. between Inuit/white people living in Nunavut, or between professionals and community members).

There was a common concern in communities about the increase of social problems and a strong desire to do something about them, and about coordination problems. There was also a frustration with "where to start". Lack of clarity concerning the role of non-government, community-based organizations in service delivery also makes it difficult for communities to begin to address their social problems.

There was an expressed wish by community members to incorporate more traditional Inuit values and teachings into parenting, addictions and mental health treatment, and to use these teachings in the development of informal and formal community resources to address suicide, addictions and mental health issues (such as Elders' circles and time out on the land).

3.1.4 Gaps in Training and Personnel

The most significant human resource challenge in Nunavut is a lack of personnel. Among the available wellness, addictions and mental health workers in Nunavut, the wide variation in training, expertise and knowledge also presents a challenge. Further, where people have the training and expertise they are often not able to provide service in Inuktitut, or in a manner that respects cultural traditions and approaches. Another challenge relates to health care provider retention, and is associated with staff burnout and staff shortages, combined with "practicing beyond competence" that occurs in rural, remote communities.[13]

These considerable challenges prevent agencies from collaborating and working together to deal with these issues.[14] During the community discussions, it became apparent that health and social services were not

[13] *Zamparo and Spraggon, 2004, p. 39.*
[14] *Law, 2002*

working together very closely, even in communities of less than 1,000 residents and with fewer then a dozen staff.

A survey of community needs conducted in 2004 observed that individuals providing services in Nunavut communities that have not resided in the North for long may be particularly susceptible to workplace stress caused by cultural dissonance. Staff turnover is the result.[15] The need to encourage people who live in the communities to be trained to fill the range of positions emerged clearly from those consulted. As stated in the report, "Such a human resource strategy has the potential to create a sustainable workforce that understands the nuances of rural, remote community life while respecting the culture."[16]

This situation has begun to be addressed with the rollout of the two-year Mental Health Worker Program at Arctic College in Iqaluit which began in January 2006. The Program will include cultural components, but it is unclear at the time of writing the exact nature of those components, nor is it clear from the course overview[17] the extent to which the Diploma Program incorporates mental health and addictions training within an overall framework that is explicitly linked to issues associated with cultural dislocation and grief and loss.

In addition, because the development of the Diploma started before the development and implementation of the work on a Culturally Relevant Continuum of Mental Health and Addictions Services (MH&A), the two are not at this time aligned. It would, therefore, be important to ensure membership of a representative from Arctic College on the Steering Committee overseeing the implementation of the MH&A Continuum. This would enable the Diploma Program to evolve and incorporate new training modules as required.

3.2 Elements of a Culturally Appropriate Approach

During the interviews and discussions, there was a repeatedly expressed desire to incorporate traditional practices and Elders in mental health and addictions treatment. No one was proposing solutions that take Inuit back in time; however, it was suggested that those skills of the past and the values embedded in them be brought forth to inform the modern ways of community life.[18] For the most part, according to respondents, this desire has yet to manifest itself in a significant way within the Territory.

In addition, the literature search found no services or approaches that have been specifically designed for Inuit populations, but did find examples of services and treatments that incorporate culturally-appropriate elements. Culturally-appropriate refers to the application of Inuit Qaujimajatuqangit (IQ) to modern Inuit problems must be done in an

[15] *Zamparo and Spraggon, 2004, p. 39.*
[16] *Ibid, p. 39.*
[17] *Mental Health Diploma Program Year One; document received, January 2006*
[18] *"Our Words Must Come Back To Us"; Inungni Sapujjijiit Task Force (2003)*

authentic and meaningful way, because it contributes to the overall objective of achieving individual and community-well-being.

This point is well-articulated in a previous study "taking time off from work to go berry picking, or to partake in other "traditional" activities like hunting are all fine and well. But the emphasis in IQ development should be to study and incorporate the operating principles behind what makes an Inuk an Inuk."[19]

These culturally appropriate program elements include connections to the land, harm reduction, inclusion of Inuktitut teaching, use of cognitive approaches, involvement of Elders/Leaders, and a holistic approach that links personal healing to personal and community experience of trauma and healing. Each is addressed in turn.

3.2.1 Connection to the Land Program Elements

Several programs have included some form of a connection to the environment, or "back to the land" approach. The purpose of this component of the program is to support the link between Inuit traditional culture, which highly values the Inuit connection to the environment, as well as to provide a "safe period" in which a person can detoxify (when necessary).

The extent to which each incorporates this "connection with the land" element varies from program to program, a comparison of which is presented in the following table:

Table #1: Connection to the Land Program Elements

Program	Connection to the Land Program Elements
Mamisarvik Healing Centre, Ottawa Ontario	One week of this eight week treatment program is spent in a camp setting. The week includes intensive clinical therapy and as such is not focused on a traditional lifestyle. Traditional foods are brought in from the North.
Saputjivik Centre North West River, Labrador	Three days of the first week are dedicated to a "back to the land" program. Participants go out hunting on the land, in the company of counsellors and Elders. All resources gathered during this trip are used as a part of the overall diet for the program.

[19] *Arnakak, 2000.*

Aniyaaqvik Spiritual Healing Camp, Moosa Akavak and Pitsula Akavak Iqualuit	This Program is run in conjunction with Corrections Canada to deal with substance abuse. It runs 1-2 weeks depending on need. Pitsula Akavak is trained in counselling and uses a traditional Inuit approach of story telling and observation to help people surface their stories and begin healing. Most are dealing with grief and loss issues related to abuse. Participants are taken onto the land to live and work in the traditional ways.
Mavsigviq Recovery Program Old Spud Farm Kotzebue, Alaska	This program is uniquely set in a rural camp. The program is an intense return to nature that includes the entire family, Elders and counsellors who reside at the camp and live a traditional lifestyle from between 6 months to 2 years. Educational services for children are included as a part of the treatment program.

3.2.2 Harm Reduction

While there continues to be debate in the literature as to whether the disease model of addictions is valid, there is a growing understanding of substance use and abuse as behavioural and habitual dependency. This understanding underpins a number of treatment modalities that focus on personal responsibility and rational behaviour, of which harm reduction is but one.[20]

This notion has, in large part, grown out of ground-breaking research by Berg and Miller who argue that the behaviour of many substance abusers who have experienced trauma is a normal reaction to abnormal circumstances, but does not constitute a physical addiction or disease.[21] These harm reduction programs, based on the notion that not all people want, or are capable of choosing lifestyles that reduce health risks, seem to have great potential for applicability in the North.

For example, harm reduction as an overall approach is central to Australia's National Drug Strategy, and the Aboriginal and Torres Straight Islander Peoples Complementary Action Plan 2003-2006.[22] Australia is working with its First Nations to address similar issues to those affecting Inuit in the Canadian North, including the need for a broad socio-economic and cultural healing strategy to

[20] *Berg and Miller 1992.*
[21] *Psychology Today, 31(1), 10.*
[22] *Commonwealth of Australia 2003.*

address the numerous risk factors associated with being an aboriginal person in Australia.

Australia has developed a program call "Controlled Drinking through Correspondence." This innovative program introduces the practice of identifying drinking patterns, self-recording, developing strategies for high-risk situations and cognitive restructuring as a part of its design. It has been specifically designed for use in isolated areas and may have some applicability to the north. According to one report, since its start in January 2004 this program "has, to date, recruited and treated over 1,000 participants from rural and urban areas all over NSW and other states, making it the biggest alcohol treatment program in Australia.

The program's 60% female participation rate also compares favourably with the traditional face-to-face treatment programs that typically attract only 7-14% of women. After completing the program, participants reported over 50% reduction in their drinking and an overwhelming majority (91%) found the program useful."[23]

Other harm reduction techniques being explored, with mixed success, include the establishment of "sobering-up shelters". Sobering-up shelters offer a safe alternative environment for temporary supervision and care of intoxicated people at risk of harming themselves or others, as well as an effective means of diverting individuals from police contact and public drunkenness.[24] A number of studies indicate successful outcomes such as reduced community violence, fewer motor vehicle accidents resulting from drinking and driving, and so on. This approach needs further exploration for Nunavut given the current choice in most Hamlets is a night in jail. The acceptance of harm reduction as a philosophical framework exists already at differing levels in Nunavut and is very much in keeping with the Inuit culture of flexible and open approaches to those at harm to themselves and others. A healthy harm reduction philosophy covers a continuum of strategies that help patients move from self-harm to a higher level of functioning, which may or may not include total abstinence.

The adoption of harm reduction principles usually results in a flexible approach to connecting with patients, the development of innovative outreach techniques and a decrease in patient anxiety regarding the use of treatment resources. The discussions concerning this philosophy also encourage workers to explore their own attitudes toward alcohol and drug abuse.

3.2.3 Cognitive-Based Interventions

The notion of cognitive therapy has been suggested as a possible culturally appropriate treatment approach because it fits with the Inuit tradition (and survival skill) of being able to rationally think through a problem.[25] All programs examined in the literature review included some form of cognitive therapy, linking belief, thinking and consequences. Most notable is the workbook used

[23] *Australian Centre for Addiction Research, http://www.acar.net.au/cdcp01.html.*
[24] *Ibid: 25.*
[25] *Marja Korhonen of the Ajunnginiq Centre, September 13 2005.*

in the Community-Wellness Program delivered through the Churchill Regional Health Authority. Based on work conducted by the Phoenix Education Society, this workbook moves through a series of 55 exercises designed to help people identify and change thought and behaviour patterns that reinforce addictive behaviours.

3.2.4 Incorporation of Inuktitut Language

Another element which connects Inuit to their culture is the Inuktitut language. Several of the treatment programs have some elements that support the use of traditional languages. For the Masigvik and Mamisarviq programs, participants are encouraged to use the language of their choice. The presence of bilingual staff members can provide support for those people who require it. At the Saputivik Centre, all staff and clients are required to attend a weekly language training session where together, they learn or improve their traditional language.

3.2.5 Teachings from Elders

All programs include Elders as a part of the residential experience. At the Mamisarviq Healing Centre, Elders are brought in for one of the eight-week periods. In addition, the program model includes one day a week of Inuit History. The Saputivik Centre in Alaska includes Elders in the "land-based" portion of the program. Saputivik also develops client outings which assist individuals in getting back in touch with the land, their heritage and culture.

3.2.6 Holistic Approach Linking Personal and Community Healing to Personal and Community Experiences of Trauma

Trauma is an important contributing factor in understanding patterns of substance use and abuse, and is not limited to the Inuit Culture. Due to Inuit collective experience of social-cultural trauma over the course of the past fifty years or so, any treatment program must understand the link between cultural and community experiences of trauma, and how these have been transmitted to subsequent generations at the individual level. It is a holistic understanding of this link between individual and community experiences of trauma that a treatment approach can begin to support individuals to heal their personal traumas, and so, over time, heal communities.

The program at Mamisarviq Healing Centre is the most overt in its identification of the co-existence of substance abuse problems and post-traumatic symptoms. Their stated goal is "to help clients reduce the fear, pain and suffering caused by addictions and trauma."[26] The Saputjivik Centre presents trauma-based elements in a section of the program titled "Barriers to Personal Recovery."[27] Connected to a holistic approach that links personal and community experiences of trauma is the personal observation techniques traditionally used by Elders to address problematic behaviour among

[26] *Taken from the Mamisarvik Healing Centre pamphlet, distributed by Tungasuvvingat Inuit*
[27] *Taken from the Saputjivik Treatment Centre pamphlet, distributed by the Labrador Inuit Health Commission, December 2001.*

community members. Using these techniques, Elders would take note of the state of the individual's eyes and of body movements. When an infraction occurred, the offending individuals were addressed by Elders, and were required to make close eye contact with the Elders during a questioning period. Individuals were asked to acknowledge their infraction, and were offered different options in order to "make amends" for their behaviour. Although adapted to suit modern circumstances, this technique of keen observation is also being used by some of the Inuit women in conjunction with southern-based training techniques. This technique needs to be explored further and used in conjunction with a holistic approach to treatment.

3.3 A Continuum of Core Services to be Made Available

In keeping with the Principles and Values articulated in Part 2, the system should be comprised of a set of core services. This section uses the five categories of service described in the Nunavut Addictions and Mental Health Framework as a way to organize the recommended continuum of services.[28] These elements are illness prevention, health enhancement and community development programming, self-help based programs and services, community-based programs and services, crisis response, and facility-based programs and services.

3.3.1 Illness Prevention, Health Enhancement and Community Development Programming

Illness prevention and health promotion programs are critical to making the best use of limited resources in both health and social services. The high priority on programs that heighten public awareness and knowledge has been repeatedly supported by domestic and international experience.

However, there is no prescriptive approach to the design and delivery of prevention programs. Those that have been most successful have included direction and delivery by the community. Often, prevention programs and community-based programming are a part of a larger program base. For instance, in Labrador, a series of Youth and Adult groups have been established as a part of the overall aftercare program for addictions. While these groups provide a safe environment for recovering addicts, they also provide an opportunity to have speakers or films that can educate all community members.[29]

At the Maniilaq Association in Kotzebe, Alaska[30] and in Labrador, for example, social gatherings are a part of both the Adult and Youth counselling programs. In Labrador, the activities are supported through two funded aftercare programs. The activities offered are not restricted to people in the program, and the involvement of family and friends is

[28] *Law, 2001.*
[29] *Interview with Marjorie Flowers, Labrador Inuit Health Commission. James Hicks, September, 13th 2005*
[30] *Interview with Ray Koppock, Behavioural Health Services, Maniilaq Association, Kotzebue Alaska. James Hicks November 22, 2005*

encouraged. Outings are used as a time to replace unhealthy behaviours with positive ones and provide a safe place for those who are currently trying to change their use of substances.

Key components of developing community-based programs are the need to strengthen community knowledge, and support community ownership. "Peer leadership" may be a welcomed model for introducing preventative programs into communities, but these programs should not be based solely on Southern models, but, rather, should rely on local community leaders in their development.[31]

In terms of alcohol prevention programs, a number of types of public information materials are required and have been successfully used, including:[32]

- Safe drinking guidelines;
- Public information and role model campaigns for social learning;
- Information about the different kinds of drinking;
- Self-help ideas for assessing and changing drinking;
- Early identification of risky drinking coupled with programs such as relationship/life/coping skills; and
- Programs that strengthen families.

The research indicates that there will likely not be a single model for prevention and community development practices for Nunavut. The emphasis should be on building capacity and opportunities for community members to design and develop solutions that fit their community. The first step using a community-based development approach is a series of community planning meetings to reach a common understanding of the problem, and to collectively identify solutions. This reinforces the Inuit culture of taking responsibility for the individual's, and the community's welfare.

3.3.2 Develop and Support Self-Help and Self-Directed Programs and Services

On some levels, it is difficult to distinguish between prevention and community-based programming, and self-help based programs. The major difference is that the participants in the self-help based programs often have some form of health issue, or have dealt with some form of trauma or substance use/abuse in the past. By comparison, prevention and community-based programs are offered to participants prior to the onset of an addiction or dependency. Four Directions Recovery, a program in British Columbia, is a good example of self-help based programming that uses an integrated, holistic approach. This program for aboriginal persons is based on the teachings of the medicine wheel and includes esteem building, communication, self-help groups, guest speakers and an outreach component. The program also includes both volunteering and employment components.[33]

[31] *Interview with Samuel Law, Ph.D. St. Christopher's' Hospital, James Hicks, September 16, 2005*
[32] *Korhonen 2004.*
[33] *http://www.vnhs.net/programs/directions.htm September 2005*

Harm Avoidance

A number of self-help supports are available both on-line and in northern communities.[34] The most common of these is Alcoholics Anonymous (AA). The AA program has been extremely successful for a portion of the population. However, given the geographical constraints in connecting to other AA members, this model is somewhat limited in its application in the North.

In addition, AA only recognizes abstinence as a solution to problem drinking. This is also true of other self-help programs such as Rational Recovery and SMART Recovery. Both of these programs are based on cognitive restructuring, instead of the more spiritual nature of the traditional AA program.

Given the high recidivism rate of people returning to isolated communities, models other then AA need to be explored.[35] The consultations and interviews revealed that there are few AA or self-help programs in Nunavut although several of the mental health professionals interviewed indicated that starting up such a group was something they wished to support.

Moderation Management at the Community Level

Moderation Management is a program that offers self-help materials and group meetings in order for people to reduce their drinking. This program was developed as a fit for nondependent problem drinkers.[36] It holds that such drinkers can learn to manage their substance use as a habit disorder through social support and cognitive-behavioural principles.

Unlike AA, it is not based on a spiritual approach, but rather on taking self-reliance and personal responsibility. According to one study, it attracts well-educated individuals with significant economic and social resources; as such it is unclear to what extent it would be appropriate to the population of Nunavut.[37] According to the Moderation Management website:[38]

- Moderation programs are less costly, shorter in duration, less intensive, and have higher success rates than traditional abstinence-only approaches.

- Approximately 30% of MM members go on to abstinence-based programs.

For many, the ability to self-select into an abstinence treatment model is empowering, particularly among populations who already feel dis-empowered such as women and visible minorities.

The use of harm reduction or moderated use strategies requires quick and effective identification and/or screening of risky drinking behaviours. A number of tools exist to assist counsellors in the detection of alcohol

[34] *Korhonen 2004*
[35] *Korhonen 2004.*
[36] *Elena Klaw et al 2003.*
[37] *Ibid.*
[38] *http://www.moderation.org/whatisMM.shtml*

problems. These include Cut down, Annoyed, Guitly, Early-morning (CAGE is one of the oldest brief screening instruments for alcohol use); the 5-Ps (a simple screening tool for Fetal Alcohol Syndrome); and The Net (a tool used in prenatal care but addressing substance use overall).

All of these tools are easy to administer and can be used by support workers with a variety of different professional backgrounds, levels and types of training.[39]

Respondents felt strongly that harm reduction services need to be delivered from within the community. However, the level of expertise required to counsel a person in harm reduction is extremely high. Harm reduction strategies need to take into account an in-depth knowledge of the general use and impacts of specific substances being abused, as well as the understanding of an individual's specific environment, patterns and secondary illnesses. For instance, understanding the types of solvents being used is imperative to helping someone reduce the permanent damage of some solvents.

Likewise, knowing the methods for smoking crack and the increase of risk to Hepatitis C transmission from sharing pipes is vital when working with crack cocaine users, and the interactions of alcohol and medications for mental health issues is absolutely essential in developing strategies to reduce harm for those with dual diagnoses.

Having access to up-to-date information about new substances and regular access to clients is a must in this type of service.[40]

Emerging Community-Based Responses to Self-Help

The community discussions revealed that, not only were community members very concerned about what was happening, many had begun to do something about it. Several communities, notably Cape Dorset, Cambridge Bay and Pangnirtung, have applied for and received grants from the Aboriginal Healing Foundation to receive training, largely in relation to suicide prevention, and in turn deliver training to community members. The programs vary from community to community and some include a "back to the land" component aimed at developing better relationships between Elders and youth and increasing youth self esteem.

In some communities these initiatives were well known and integrated into the larger health and social services delivery system; in other communities the fact they existed seemed to be largely unknown to the health care professionals. It would be important to identify the extent to which similar initiatives exist in all communities in Nunavut in order to draw on the resources and begin to learn from the experiences of the communities themselves.

One way to do this is by enlisting, educating and empowering natural helpers (e.g., care-

[39] *Korhonen 2004.*
[40] *Karen White-Jones Sandy Hill Community Centre, Addictions Counsellor. September 15, 2005*

givers, other community members), to assist in providing services. Natural helpers would have a larger investment in the community and would be able to provide culturally appropriate services as indigenous close-knit relationships provide an informal infrastructure of social support for transferring traditional knowledge and skills.[41]

Additional resource people were also identified during the consultations who "had come back from the brink." These were people who self identified as former alcoholics/addicts and who expressed remorse at the harm they had done their families. In many cases, their behaviors had created a second generation of substance abusers and violent family members. In some cases they had gone on to get training in counseling and all expressed a desire to help their communities but indicated that they were as yet not being used as a resource to their community.

The literature search did not identify any self-help programs that were based in Inuit culture. In a follow-up email to an interview with Marja Korhonen, she provides the following suggestion about self-help and Inuit culture[42]:

> *One of the things I always emphasize is that we need to talk to people who have managed to change unhealthy drinking patterns. In my almost 2 decades up north, I have met countless people who at one time binge-drank destructively... public intoxication, black-outs, drunk tank, violence, neglect of children, etc. but who changed those patterns on their own, without "professional" help… We need to start talking to these people. How did they manage the change? What did they do, and what do they continue to do? There is much to be learned.... and all of it is Inuit-specific. We talk of "culturally appropriate strategies", yet as I mentioned, what does that mean? To me, if something works for an Inuk, then it's culturally appropriate.*

Again, an attempt should be made to identify as many of these people as possible and begin to draw them into a larger scale process of community healing. This could be done as part of the Community Asset Mapping exercise of Community-Wellness Planning.

3.3.3 Community-Based Programs and Services

Traditionally, community programs and services have been out-patient and facility-based. That is, they are housed in the community, tend to be tied to an office and are dependent on clients coming into a specific location, but do not include a residential program.

The most common community-based program in substance abuse is typically delivered on an out-patient basis. This service allows people to remain in their own homes, either waiting for more intense services, or integrating treatment into their existing social and/or employment structures. All of the service

[41] *Echoes and Reflections: A Discussion of Best Practices in Mental Health JoAnne Zamparo Donna I. M. Spraggon, 2004*
[42] *Marja Krohonen, e-mail September 13, 2005*

providers interviewed identified some form of outpatient service.

At the Mamisarvik Healing Centre in Ottawa, the in-patient (residential services) and out-patient programs are merged for some of the counselling and social activities, allowing participants to expand their social support network, while beginning their recovery process.[43]

By contrast, following a short-term stay at the Churchill Health Centre, a hospital, people are moved to the TC Centre, a boarding house paid for and staffed by Government of Nunavut employees. The Churchill Program is included in the outpatient section because the program consists of one-on-one counselling with residents through the hospital Community-Wellness program. This program is based on the idea of co-occurrence of substance, physical and/or mental health problems, and provides a holistic approach to counselling. Through a Life Skills workbook approach, clients are assisted 55 different exercises that help them to learn both behavioural and cognitive changes that can be implemented upon return to their own communities.[44]

Best practice research reveals that an outreach oriented, case management approach is the most effective.[45] However, experience in the North has shown that outpatient, community-based services are not as effective in the small communities as they have been in the South. Confidentiality issues, lack of access to follow-up services and possible stigma of accessing services have all contributed to the under-utilization of this type of service.

3.3.4 Assessment and Follow-Up

Through the course of the interviews, and data gathering, the issues of assessment and follow-up came up continually as integral to any program of support either associated with community or facility-based treatment and care. There is limited assessment capability in the Territory, in particular with regard to assessing the mix of post-traumatic stress disorder, family violence, drug and alcohol induced hallucinations and suicide threats[46] that are seen on a regular basis by health centre staff and, in many cases, the RCMP. As articulated in the "Framework"[47], a combination of home visits, assertive follow-up, assistance in obtaining services and care, close monitoring, on-going assessment and treatment planning needs to be included in a community based programming mix.[48] In addition, it is necessary to explore the notion of virtual teams, allowing for generalists to provide outreach services in the community, with easy access and support from experts in a variety of different fields. This approach would go a long way to reducing stigma, and reducing the need for highly specialized professionals in every isolated community.

Distinguishing between a night of poor coping from genuine suicide attempts and alcohol and drug addiction from dependency requires very skilled intervention based on years of experience and training. Medivacing

[43] *Pam Stellick, Director, Counselling Program, Tungasuvvingat Inuit, Ottawa, Ontario, December 2005*
[44] *Michel Petit, Manager of Community Services, Churchill Regional Health Authority, January 2006*
[45] *Law 2001.*
[46] *Some communities estimate that 50% of medivacs are related to suicide attempts.*
[47] *Law, 2001*
[48] *Law 2001.*

people out who are back the next day, at a cost of $10-$15,000 per person, is a highly costly proposition for the Territory.

The hiring of a half dozen psychiatric nurses has added to the pool of skilled people who can do assessment but there are not enough of them and, in interviews, they felt that they are already stretched to the limit. Innovative ways of providing assessment through video conferencing and over the phone need to be explored for Nunavut. A similar situation exists with regard to follow-up supports.

The Treatment Centres in the South do their best to provide transition support to Hamlet-based mental health and addictions counsellors but those counsellors are not, in many cases, adequately trained nor do they have time to do the outreach required[49] for follow-up. Without adequate follow-up, much of the progress following costly facility based treatment is lost.

In most northern communities, there is a mixture of community wellness counsellors, mental health workers, Registered Psychiatric Nurses, and alcohol and drug workers and community people who could be used in a case management mode to provide outreach based follow-up in a more systematic way. A multi-disciplinary approach to outreach based community services, may be possible by combining the available resources. These resources should be part of any asset mapping exercise as part of a Community-Wellness Strategy.

3.3.5 Crisis Response

Crisis response services are those that need to be mobilized quickly at the time of a crisis. In the current context, crisis response services refer to those required to address crises resulting from a mental health or substance problem, though crisis response services are also required to deal with personal safety issues within domestic situations within the broader community.

Proper crisis response can contribute to stabilizing and resolving emerging dangerous or distressing situations and limit the need for people to be removed from their communities into a more intensive facility-based service. Ensuring that individuals are stabilized in their local communities means also taking into consideration the total needs of the family. In some cases that may mean that families are given shelter in a home or setting in the community specifically set aside for that purpose.

It became apparent during the consultations that such shelters are limited in the Hamlets. In some cases, community members make their homes available but this is problematic in a situation where most homes are already overcrowded. The absence of safe spaces is a contributing factor in a decision to medivac someone in crisis out of the community. A systematic inventory of possible safe houses needs to be undertaken at the community level as part of the Community Asset Mapping exercise.

[49] *Anecdotal evidence from the interviews suggests that some 50% of appointments booked for counselling are no shows.*

In the particular example of a crisis involving an attempted suicide, research demonstrates that crisis response services can have an important deterrent effect. Specifically, suicide response services provided before, during and after a suicide attempt can reduce subsequent suicide attempts and deaths.[50] Crisis response systems support individuals, families and the front line staff. For example, a coalition of individuals and agencies in Nunavut came together in the last two years to address the need to respond to the growing epidemic of suicide in Nunavut. The Embrace Life Council[51] was set up in 2004 as a result of a conference on suicide prevention. Since then, in addition to suicide prevention work Embrace Life representatives have provided counselling and workshops. For example in Cape Dorset in the summer of 2005 after several suicides among young women. Any overall crisis response in Nunavut would need to integrate the work of the Embrace Life Council.

Centrally Managed Crisis Response

There is a volunteer run distress line called the Kamatsiaqtut Help line that is managed from Iqaluit but that serves the territory and beyond. Created by the NWT several years ago, it is open 7 days a week, 7 pm to midnight. Interviews indicate that one of the major issues with maintaining the help line is finding Inuktitut speaking volunteers and providing them with adequate training. The adequacy of the hours would also need to be addressed as part of an overall plan for crisis response.

Providing adequate resources for training of volunteers with access to a database of referrals to community or facility based services and well developed protocols for interventions and support would be vital to ensuring the success of this service. In addition, it may be possible to work with other existing hotlines (i.e. the Nunavut Territory for youth) to integrate local counsellors and volunteers who can provide service in traditional languages.

Further exploration will be required to determine the best approach to ensuring that people served by crisis response teams receive adequate follow-up. Centralized crisis response teams need to be connected to local community-based counsellors and trained concerning the prevention of future crisis situations, as well as for individual client follow-up.

3.3.6 Facility-Based Programs and Services

Facility based services include programs that provide service outside of the client's home, and include some form of residential service. As there is currently no facility-based GN funded program for substance abuse in Nunavut, clients who require this type of support are sent out of Nunavut for services.

The "Framework"[52] identifies a need for Nunavut to develop more specialized residential care, which is in keeping with the philosophy of self-reliance or "Closer to Home".[53] Closer to Home recommends that referral out of the Territory be avoided wherever possible.

[50] *Law 2001.*
[51] *Annual Report Isaksimagit Inuusirmi Katujjiqatigiit Embrace Life Council 2004-2005*
[52] *Ibid.*
[53] *Ministry of Health and Social Services 2004.*

However, the only Nunavut-based residential treatment centre closed in 1998 after four years of operation. Issues associated with the level of staff training and its capability to diagnose, assess, and treat meant that not enough clients entered the program to warrant the costs of staff and program operation. Clients were then sent to the centre in Kuujjuaq (since closed), other residential programs in various provinces such as the Churchill Health Centre in Manitoba, High River, and High Level in Alberta, and Tungasuvvingat Inuit's (TI) Mamisarvik Healing Centre in Ottawa.

The Wellness Centre in Cambridge Bay has recently used a GN building to deliver a 28-day out-patient program which they use also as an initial treatment program to determine whether people need to be sent out of the Territory. In addition, they have completed a facility-based treatment program for women that was funded largely through support from the Aboriginal Healing Foundation and Health Canada. The Programs are co-delivered by an addictions and mental health specialist from Alberta with many years of experience in the field with First Nations people.

This program is based to some extent on the teachings of the medicine wheel and includes esteem building, communication and self-help groups. The counsellor/facilitator comes in as required to deliver the programs. The Wellness Centre Program could be built upon with some strategic support. There are a number of issues associated with going out of Nunavut for treatment. Interviews and research[54] have identified, for example, that participants from North who are sent out of their communities for treatment often do not get the full benefit of the programs (both residential and out-patient). They are often overburdened with cultural acclimatization issues and do not participate fully as a result.

On the other hand, anecdotal evidence and interviews suggest that some people would not accept treatment if that had to go to a facility within their home community due to issues of confidentiality and stigma.

In addition to this type of intervention-based residential program, it is necessary to explore the development of multi-function facilities that can run a variety of programs for specific populations. This may reduce the risk of under-utilization of facilities. There is also the need for other facility-based services such as crises and short-term care. Dealing with acute addiction or mental health symptoms can increase stress levels and contribute to family breakdown. The availability of short-term respite care options may contribute to the maintenance of people in their home communities and families.

From a program design perspective, many of the facilities for alcohol and drug abuse programs are based on the disease model of addiction. This means that the goal for treatment includes abstinence. As described earlier, some new models of treatment are based on harm reduction and/or moderation, particularly outside of North America, and are not based on a 12-step program or even abstinence. These will need to be further explored for Nunavut.

[54] *Interview with Karen White Jones, Sandy Hill Community Centre, Addictions Counsellor, July, 2005.*

PART 4

Maternal and Child Health and Oral Health for Children

The term Maternal and Child Health is used inclusively to describe the range of health care needs and services required by women during their childbearing years including sexual and reproductive health, prenatal, labor and delivery care, post-partum and healthy parenting, as well as all the health needs of all infants and children under the age of six. This section primarily concerns itself with the identified gaps in services delivery to these areas and the possible actions to fill those gaps.

For an overview of health indicators and a brief synopsis of the maternal and child health and dental services available in Nunavut, please see Appendix 4.

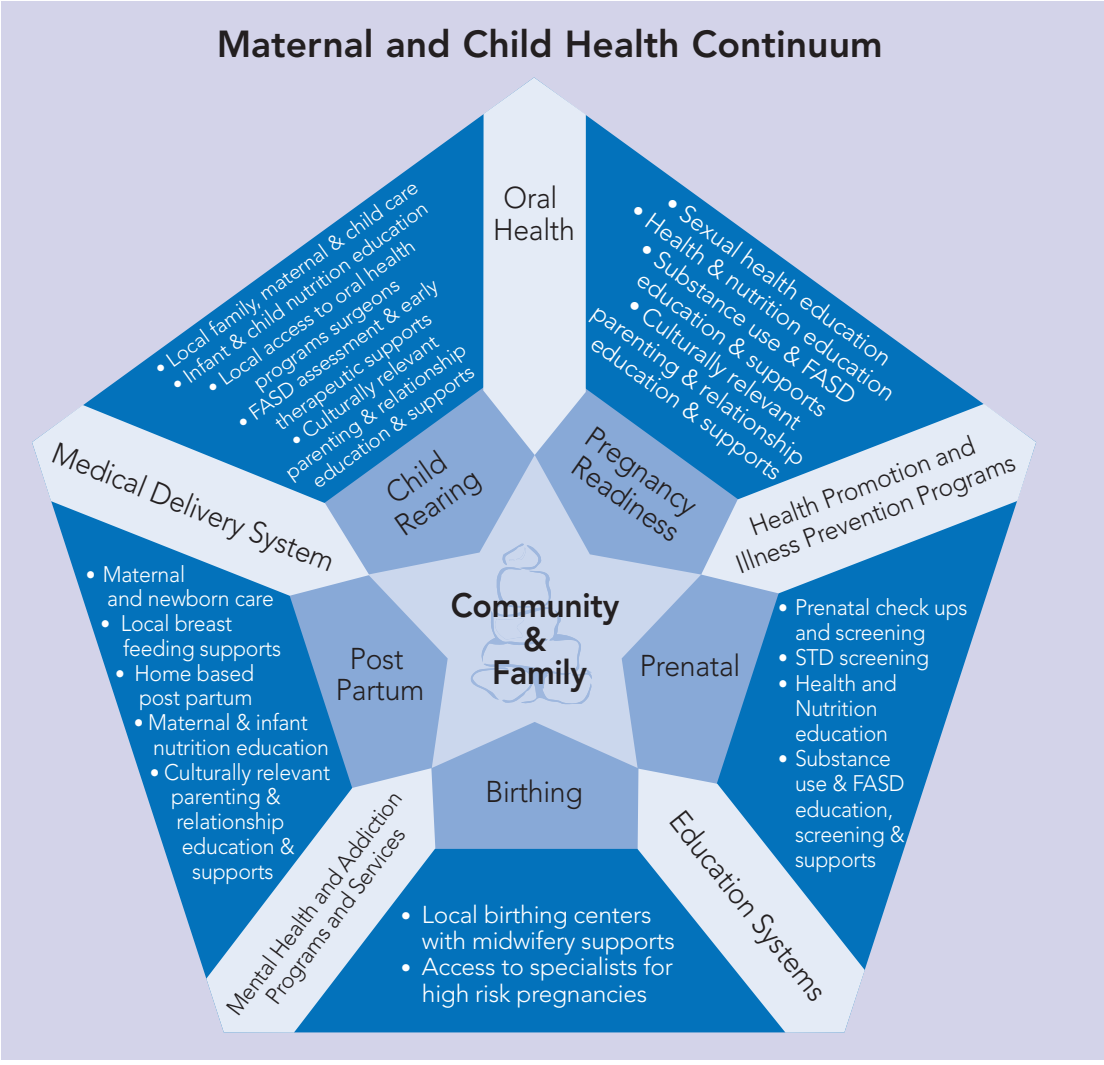


Figure 3, Maternal and Child Health Continuum *depicts the main physical stages of maternal health from pregnancy readiness to child rearing. Under each heading, a basket of core health, education, social and community supports is outlined. Feeding the system are the government and community structures and programs that are used to deliver services. At the core of the model, recognizing their central importance and function, are the communities and families that support mothers and children.*

Each of the stages of the continuum builds on the efforts and benefits injected at the previous stage. Beginning with Pregnancy Readiness, core services include appropriate sexual health education that empowers women to plan their pregnancies. In this wellness model, there are also specific preventative efforts focused on nutrition, mental health, substance use and FASD education and supports so that women are in good physical and emotional health before they become pregnant.This also includes interventions for young women that include motivational opportunities and skill building. When a woman becomes pregnant, her prenatal care continues to include general information on nutrition, mental health, substance use and means to prevent FASD, as well as the medical aspects of pregnancy. At the community level there is a need for programs and services that provide information on nutrition/food support programs, labour and delivery and parenting programs and substance use reduction programs If a woman is generally healthy prior to becoming pregnant, experiences a healthier pregnancy and has had access to appropriate prenatal, nutritional education and social supports, then her chances of a safe delivery of a healthier baby are increased. Access to local birthing facilities where women can be accompanied by their partners, family members or community midwives can also decrease the stress of delivery and lessen the post-partum recovery period and contribute to the strengthening of the family bond. Community programs that support new mothers to breastfeed serve to increase the health and well-being of the babies and can lead to a decrease in dental decay as well as future childhood illnesses. On-going access to culturally relevant parenting and relationship education and supports that reconnect and reinforce the importance of childrearing within a community-wellness approach will assist families at all maternal and child health stages. Healthier, happier children grow into healthier, happier adults who are better equipped to become healthier, happier parents in turn.

Elements of this integrated Maternal and Child Health System are in place in Nunavut communities to varying degrees through existing programs and services. The continuum also identifies needs that are not currently being widely addressed such as a parenting program. Within the development of a policy framework to support a Community Centred Wellness Strategy, the Government of Nunavut can work with communities to examine what services are currently being provided and which services and supports remain to be developed. The strength of the Maternal and Child Health Continuum is that it can be responsive to the priorities that local hamlets identify through Community-Wellness Plans. The communities can choose to emphasize a component in its planning and prioritizing activities to address their particular needs.

4.1 Maternal and Child Health Service Needs

4.1.1 Need for Prenatal, Labour and Delivery and Post Partum Maternal Care Services in Communities

There was a general recognition in the interviews and community discussions that the need for pregnant mothers to leave their home communities and give birth in one of the two birthing centres was a source of distress for many mothers. Contributing to this distress was the lack of options available to them including where to deliver their babies and their inability to have their partners or a birthing coach with them.

Another consistent theme expressed in the discussions was the dissatisfaction with the Boarding Home in Iqaluit where pregnant women resided pre and post delivery including limited pre-natal resources or supports provided. Women reported feeling isolated from their families and communities, uncomfortable being surrounded by strangers and sharing the space with other patients including sick and mentally ill people.

Postpartum services varied by region and proximity to a larger community. Recognizing the success with the childhood immunization program within the territory, there are few other coordinated or formal health programs operating for new mothers or young children.

4.1.2 Sexual Health Education

A consistent theme discovered throughout the community discussions and interviews was the lack of adequate sexual health education. According to the Nunavut Department of Health and Social Services in 2002, Nunavut has the highest rate of chlamydia infection in Canada. In 2000, 17 times more women and almost 18 times more men were diagnosed with chlamydia in Nunavut than in the whole of Canada.

In Nunavut, women are more than twice as likely to be reported with chlamydia infection as men. On the whole, the chlamydia infection rate appears to be climbing since 1991.[55] Nunavut also has the highest Canadian rates of gonorrhea.[56] Infection rates for syphilis and viral Hepatitis B were not known.

The need for more sexual health education is also reflected in the relatively high rates of teenage pregnancy. In 2000, Nunavut reported the highest teenage pregnancy rate in the country, 161.3 per thousand births, compared to the national average of 38.2, or four times the Canadian average. An effective sexual health education program would also include the concept of "pregnancy-readiness" or "maternal health" for women of reproductive age. This includes education about maternal nutrition, weight, smoking, alcohol and drug use, diabetes and hypertension as well as the social and mental health conditions such as stress, depression, anger management and conflict resolution.

There are significant maternal and child health implications relating directly to maternal age. The 2003 Canadian Perinatal Report concluded that younger mothers are more likely to smoke, binge drink and less likely to breastfeed or breastfeed for shorter periods of time than older mothers. The report states that a higher percentage of teenager mothers are victims of physical and sexual abuse during pregnancy. Mothers 17 years or younger have been found to have an increased risk of delivering babies who are pre-term or growth restricted. Research has documented that low maternal education levels have been found to be consistently related to poor perinatal health outcomes.

4.1.3 Parenting and Relationships

Reoccurring throughout the interviews was the expressed need for more parenting education and support. Parents were often found to experience difficulty balancing traditional and modern parenting practices in response to new social and economic realities. While formal or structured parenting education opportunities were identified as needs, it was equally important that familial parenting supports should be strengthened. Stress management, healthy relationships and conflict resolution were identified as key education priorities.

The increased role of and importance of men in parenting should also be addressed as a part of the Maternal and Child Health Continuum. Respondents felt that men should play a more vital role as active contributors to sexual health of a relationship, providing support to pregnant and new mothers as well as taking on shared responsibility for the health of young children.

4.1.4 Food and Housing

Adequate housing for pregnant women with small children was identified as an ongoing concern in the Territory. In over-crowded living conditions, mothers experienced a lack

[55] *Nunavut Department of Health and Social Services, Report on Comparable Health Indicators for Nunavut and Canada, September 2002, p. 36. http://www.gov.nu.ca/Nunavut/English/news/2002/sept/pirceng.pdf*
[56] *http://www.phac-aspc.gc.ca/std-mts/stdcases-casmts*

of control over the physical space to advocate for healthier environments such no smoking, drinking or drug use.

Food security was brought forward as a parallel issue. There is a recognized difficulty in accessing quality and nutritious food and an appropriate quantity of food sources. Pregnant mothers receiving food supplements often end up sharing the food supplements with the extended household, as there is a traditional expectation that food is communal. An underlying concern that affects women of all reproductive ages is abuse and trauma.

4.1.5 Substance, Tobacco, Drug and Alcohol Use

A report done by the RCMP in 2001 suggests 30 per cent of Nunavut's expectant mothers may drink significant amounts of alcohol while pregnant, and a frighteningly high 85 per cent of their children will show symptoms of FAS.[57] In their 2004 report on teenage pregnancy, the Pauktuutit Inuit Women's Association documents that over 45% of respondents reported that substance abuse was one of the leading reasons teenage Inuit women become pregnant.[58]

Early identification and treatment is an important component of caring for children with FASD. Currently within Nunavut, at risk women and children have limited access to resources, screening and preventative help such as occupational therapy, hearing tests due to long waiting lists or the unavailability of professionals in the communities. Strengthened public health screening and parental education would improve the awareness of FAS signs and symptoms las well as increase the opportunity for intervention.[59]

4.1.6 Oral Health

Health officials have estimated that up to half of all children in Nunavut suffer from preventable tooth decay. There were 592 children approved for travel for dental services in 2004-05. The cost of dental treatment only (travel, accommodation and anesthetist not included) for the numbers of children approved for dental travel for extractions, 2004-05 was:

Baffin Region	177 x $1,400 =	$247,800
+ Iqaluit	54 x $1,400 =	$ 75,000
Kivalliq Region	163 x $1,400 =	$228,200
Kitikmeot Region	198 x $1,400 =	$277,200
	Total	$828,200[60]

Tooth decay causes pain and suffering for young children, can lead to misaligned adult teeth, poor jaw development and speech impediments. Poor dental hygiene and esthetics is also a cause for social embarrassment for older children and adults contributing to lower self-esteem.

[57] *http://www.nunatsiaq.com/archives/nunavut030328/news/nunavut/30328_06.html*
[58] *Teenage Pregnancy in Inuit Communities: Issues and Perspectives, Pauktuutit Inuit Women's Association, 2004, p. 11.*
[59] *http://www.cps.ca/english/statements/II/ii02-01.htm*
[60] *DHSS, Community Profile: Education and Development Planning, August 2005, Unpublished.*

4.1.7 Preventable Injuries

Injuries are the leading cause of death in children under the age of 10 years. While there is no specific data on Nunavut at present, in the mid-1990s the Canadian Institute of Child Health reports that the injury death rate for First Nations infants was almost 4 times higher than the national average and more than 5 times higher for preschoolers.[61]

During the interviews, it was suggested that there should be increased education given to preventable children's accidents and injuries. Specifically mentioned were accidents involving ATVs. Also mentioned were accidents involving dog bites and maulings, burns, poisonings, drownings, or food contamination.

Preventable injuries can be addressed through parental education programs as well as addressing underlying social and economic conditions in which women and young children live.

4.2 Gaps in Service

According to respondents, there was no significant duplication of sexual health and maternal and child health services found in the Territory. However, service could potentially be delivered more efficiently and effectively through increased standardization throughout the Territory as well as an increased level of coordination and communication.

Regionalization was found to be a barrier to efficiency when similar efforts were being duplicated in each of the regions. Formal linkages and coordination could be developed and strengthened between professional counterparts across Nunavut.

In general, most sexual, maternal and child health prevention and promotion services were not as accessible in Nunavut as could be found in southern Canada.That being the reality of Northern lifestyle, there were also significant differences in levels of service between urban centres including Iqaluit, Rankin Inlet and Cambridge Bay and the outlying communities. While there are more professional services, resources and programs available in the larger Nunavut centres, some participants believed that the smaller communities were often able to give more personalized service. It was felt that some mothers, babies and families in larger communities were overlooked or became lost in the "system" while in the smaller communities, the medical and social service personnel knew all the women and children who required care.

It was also noted that the Health Centres predominantly operated in a "crisis management mode" resulting in little time or energy for additional proactive sexual, maternal and child health promotion or prevention programs. It was noted that prevention and promotion programs are often the first programs cut when making difficult budget

[61] *Unintentional and Intentional Injury Profile for Aboriginal People in Canada, http://www.hc-sc.gc.ca/fnih-spni/pubs/injury-bless/2001_trauma/5_dimension-aspect_e.html#injuries_first_nations*

decisions or are incorporated after core medical services have been established.

As noted earlier, there are differences in service delivery in the Hamlets due to a number of factors including availability of personnel, the capacity to write and manage grant applications and the availability of facilities to run programs in schools, community centres and recreation centres.

4.2.1 Sexual Health Services

Also as noted earlier, there is no developed, culturally appropriate sexual health promotion program or strategy within Nunavut. There was overwhelming consensus that a culturally and age-appropriate birth control and sexual health program specifically aimed at young women should be a priority. A community or school based program for both young men and would focus on the development of healthy sexuality and relationships. Topics should include basic physiology, fertility, pregnancy, pregnancy testing, options & referral, emergency contraception, as well as STD/ HIV testing, treatment & prevention.

4.2.2 Maternal Prenatal Care

The most pressing service gap identified for pregnant women was and the general absence of obstetricians, obstetrical nurses, midwives, doulas, maternal care workers and lactation consultants. This lack of staff contributed to the inability of local delivery for expecting mothers outside the larger centres and to a weakened maternal and child health prevention and promotion environment.

The Kivalliq region benefits from a more developed maternal health system than the other two regions. At present, there are 3 dedicated maternal and child care workers serving the communities of Arviat and Rankin Inlet. These professionals are Inuit women who are fluent in the language and culture of the communities they serve. The Maternal Care Workers perform home visits, which is often easier and more comfortable for the new mother. In the other communities and other regions, maternal and newborn health services are performed by the CHRs and the nursing staff.

To expand this model to all communities would require a significant influx of resources.

4.2.3 Parenting

The most important service gap identified was the general absence of developed culturally appropriate parenting programs. In the interviews and group discussions, parents and community members expressed concern with the decline in respect by youth in their interactions with Elders and other community members. This also included a lack of culturally appropriate parenting education for teens concerning the roles and responsibilities of parents. One respondent indicated that parenting materials she had found would require modifications and

translation, which was beyond the abilities and resources of her staff and office.

While there are a number of different activities being undertaken throughout the Territory, there is not a territorial, integrated and culturally appropriate parenting program. There was universal agreement that parenting skills programs were of the utmost priority.

One model is The Great Kids Initiative. This program is used across Canada, including NWT, and Yukon. Great Kids offers a 2-week workshop for community members such as CHRs, daycare workers, early childhood workers, Canada Prenatal Nutrition Program (CPNP) workers, as well as parents themselves who could then return to mentor their community. This course teaches service providers how to work with parents in their homes and how to use the developed lesson plans and activities with their clients.

Intended to start prenatally, this program is designed to work with children up to age 6. The Great Kids program is a home visitation program individually based, which complements other community programs such as CPNP, Aboriginal Headstart and Moms and Tots.

Two recent workshops have been held one in Cambridge Bay with participants from the 5 communities of the Kitikmeot, and Hall Beach. The participants included Home and Community Care Workers, Community Health Representatives, and Daycare Workers. Through videos, story telling and group work, participants learned how to conduct strength-based home visits.

Since these 2 workshops, Home and Community Care Workers in 3 communities are now doing home visits using the Great Kids Curriculum. The communities are very supportive and other communities are asking for these workshops.

The program currently is for prenatal care to 36 months, but will be extended to 5 years of age. It was felt that prenatal visits would help with learning about nutrition and the effects of drugs and alcohol on the unborn. It is hoped that building self-esteem might also help with decreasing the suicide rate. Another example of a parenting program is "Nobody's Perfect" developed by Health Canada. This is a parenting education and support program for parents of children from birth to age five. It is designed to meet the needs of parents who are young, single, socially or geographically isolated or who have low income or limited formal education. This is a short-term program offered as a series of six to eight weekly group sessions. The program is built around five colourful, easy-to-read books which are given to the parents free of charge.

During the meetings, trained facilitators support participants as they work together to discover positive ways of parenting. Participation is voluntary and free. It includes

components of mentoring, self-esteem, employment counselling, relationships, recreation and sexual health.[62]

In the Yukon, the Healthy Families Program is a volunteer service which delivers a culturally appropriate intensive home-based family support service to overburdened families, pre-natally and/or at birth through school age. The early service delivery reaches families when parents are eager to learn how to care for their children and links parents and infants to early preventative medical care. It also provides support for families with children under the age of two, a time which many parents find stressful. The program assists families in developing appropriate expectations for their children's development and helps in fostering that development.[63]

4.2.4 FASD Awareness and Training

The exact percentage of children and adults with FASD in Nunavut is not known at this time. However there was an acknowledgement during the interviews that FASD is a growing health and social problem. In order to address this at a functional level, there needs to be education done in the communities in order for residents to understand the causes, prevention and treatment of FASD.

Education, health and social service partnerships should be in place to deal with long-term implications of a FASD diagnosis. Communities themselves must be ready and knowledgeable in order to cope with the broader implications of FASD diagnosis. In addition to supporting the individual child and their family, it is important to support the community in which these people reside.

At present, there is little standardized FASD diagnosis being done on Nunavut children due to the lack of multi-disciplinary teams required for accurate diagnosis.

The FASD Breaking the Cycle conference held in Toronto in 2004 outlined several considerations for working with pregnant women at risk.[64] Important factors of engaging and working with women in programs included being non-judgmental, the importance of building trust with health care and social service providers, involvement of other service and social supports and the focus on setting goals to reducing harmful behaviours and replacing them with helpful behaviours. It was also noted that successful programs included components of community outreach, liaison with other agencies, and provision of information and resources, food vouchers, and transportation.

4.2.5 Oral Health

It was routinely noted that oral health of young children is a key challenge in all communities causing considerable pain for children and major expense for health services. There was also consensus that meaningful prevention efforts should be a high priority. The lack of dental therapists was routinely

[62] *http://www.phac-aspc.gc.ca/dca-dea/family_famille/nobody_e.html*
[63] *http://www.hss.gov.yk.ca/programs/family_children/early_childhood/healthy_families/*
[64] *Breaking the Cycle, http://www.naho.ca/inuit/english/documents/BreakingtheCycleFASD.pdf*

cited as a chronic service issue for Nunavut as a whole. For example, in the Kivalliq there was funding available for 7 dental therapists but only 2 positions were filled.

According to the 2003 Report on Nursing Perceptions of Public Health Programming in Nunavut, less than half of the schools have meaningful access to a dental therapist. When there is not a dental therapist available, the Community Health Representative may or may not provide a fluoride rinse program in the schools. While there is some dental health education done in the schools through the health curriculum and other initiatives, it was observed to be inconsistently delivered and one of many health education priorities.

It was also noted that few Nunavut communities, Iqaluit, Rankin Inlet, Arviat, fluorinate their water and a specific recommendation was made to investigate (with the Department of Community Government) if communities could implement fluorination programs. There has been some resistance to developing fluorination programs in the communities because of a belief that there is a change in taste of the water and misinformation about fluoride programs. Cost was not identified as a barrier to developing these programs nor was expertise as the water system manager would also easily implement fluorination treatments.

4.3 Gaps in Training and Personnel

In general, the lack of personnel is a systemic issue for most communities. While all communities have trained nursing staff, these personnel were usually trained as generalists and usually do not have the expertise in maternal care that would allow for women to give birth in their home communities. Nurses are almost exclusively non-Inuit and the lack of cultural sensitivity and the cultural divide continued to emerge among respondents as a service barrier.

Staff recruitment and retention was listed as a primary obstacle to the delivery of effective sexual, maternal and child health programs. There are only 3 communities with 2 CHR positions at present, Iqaluit, Cambridge Bay and Gjoa Haven, while upwards of 10 other communities did not have any CHRs in their community. According to the Report on Nursing Perceptions[65], while 35% of nursing respondents reported that they visited schools on a regular basis, 45% of respondents stated that they did not.

While there was an overwhelming agreement that a presence in the schools would be bene-ficial, the limited school presence was largely attributed to the lack of available time and staff.

[65] *Report on Nursing Perceptions of Public Health Programming in Nunavut, 2003, P.39*

While more public and registered nurses with more formal training are a definite requirement, it was also felt that more training for CHRs who provide direct connections to the public health nurses would be a successful intermediate solution.

Another theme emerged around the perception and understanding of an integrated public health or community wellness approach. Many people trained in traditional medical models tended to look at treatment first and not appreciate the important role for prevention. Many people expressed the need to provide personnel support to health and social service providers. The demands on staff are very high and may become increasingly difficult when local people are trained and they must also meet the needs of their own families and communities.

To date, there have been a few focused attempts to provide training for the Community Health Representatives around select key areas including immunization, smoking cessation and breastfeeding. Training for CPNP workers is provided by Health Canada.

4.3.1 Maternal Care Workers

Similar to the model being developed in Kivalliq, it is anticipated that there will eventually be Maternal Care Workers working alongside the CHRs in most communities. To reach this goal, more students will have to complete the one-year Maternal Care program through the Arctic College. An alternative to increasing this student population would be to offer it through long-distance learning.

Maternal Care Workers would be able to provide a range of prenatal and post natal resources and support to expecting mothers and fathers. Maternal Care Workers would also perform home visits which would enable more effective one-on-one communication and problem solving. Home visits would also allow the Maternal Care Worker to work with the entire extended family, reflecting the multigenerational nature of many Inuit families.

4.3.2 Integration of Elders and Youth in all Programming

Many people interviewed expressed the desire to incorporate respected Elders into community programs. In some communities, Elders are already active participants in breakfast programs, cooking classes, and sewing classes. Creating positive multigenerational events allows for opportunities for the youth and Elders to interact and learn from and about each other in respectful ways.

Discussion groups could emerge that reflect on how traditional wisdoms could be applied to new social realities as well as how traditions could change with new social realities.

4.3.3 Oral Health

There is chronic understaffing of all dental positions in the Territory. There are no permanent government funded dentists or dental assistants living and working in the Territory, a situation that is not expected to change in the foreseeable future. Most dental therapist positions are currently vacant; resulting is an extremely high level of need in the community. At present, there are no education opportunities available in the Territory in any area of dental health and all personnel must be trained out of the Territory.

It was mentioned that an impediment to attracting and retaining dentists was the extremely out-of-date tools and equipment provided for dentists to use. It was also felt that competitive salary increases were not a solution to the human resources issues in the long term. Respondents consistently reported that the solution was to educate local people who have a long-term connection to the communities and the Territory and who could become key community members and role models.

A Community Dental Health and Nutrition Promotion Specialist program is in the process of being developed and approved through the Arctic College. The CDHNPS would conduct active preventive dental health and nutrition education programs in schools and community health centres to promote health and reduce the incidence of dental problems and poor nutrition. It is anticipated that graduates could eventually be hired into a position in every community in the Territory to work in conjunction with the CHRs.

This position would perform an integral networking role with health and social service partners including the Health Promotion Team, community program staff, nurses, dental therapists, CHRs, social workers, schools and pre-natal classes (i.e. CPNP) to develop and deliver integrated dental health and nutrition solutions.

APPENDIX 1

Information Collection Approach and Consultation Methods

Document Review

The information resources provided for analysis for this Project consisted of over 60 documents, some in paper form, some in electronic form, and some collected from web pages of various organizations. Some of the documents provided a significant amount of useful information; others provided background and contextual background The methodology used to collect and consolidate the information was as follows

1. Each document was reviewed at a high level to determine its relevance to the areas of study—(Maternal and Child, Dental, and Addictions). Other documents were classified as of general interest; that is, they provided general information about availability of professional resources, deployment of spell out HCPs in communities, social conditions and health issues in Nunavut.

2. Each document was assigned a document number of the form Axx where A is one of the major classifications (General, Maternal and Child, Dental, Addictions) and xx is a sequential number.

3. A document database was created, which included the document name, dates, a brief description of the contents, its scope (i.e. is it relevant to Nunavut only, all Inuit, First Nations and Inuit, etc.)

4. Each document was then reviewed in detail, and a database of specific information created. This information was classified in a number of ways, including:

    - Fact or Comment;
    - Relevance to Service Delivery, Resources, or Other;
    - The Organization which Authored the Document;
    - The Relevant Service or Program; and,
    - The Major Classifications (see above).

Literature Review

Following the document review of current services and practices, this project reviewed literature examining approaches to addictions and mental health treatment, including specific treatment models, for Northern communities in general, and Inuit communities in particular. More specifically, this project focused on the identification of service models that are currently being used in other parts of Canada, Nunavik, North West Territories, Yukon, Labrador, and in international locations such as Greenland and Alaska.

The role that Inuit culture and beliefs play in delivering community-based services for children, youth and adults in the fields of

mental health and addictions was a central component of this review. The data collection approach consisted of two methods: a primarily internet-based literature search and follow-up interviews with people responsible for approaches or delivery models as identified through the literature.

The literature search was completed almost exclusively on the Internet. Searches were conducted using multiple search engines including Yahoo, Google, MSN and Ask Jeeves (via dogpile.com). The overall result of the search highlighted the limited information available concerning culturally appropriate interventions for alcohol problems and misuse in Inuit communities around the world.

Additional material was also obtained directly from NTI.

Community Discussions

To this report's authors—and, hopefully, to the reader—the most important research component in compiling this report were the in-person and telephone discussions with the key players in the delivery of health and social services to Nunavut and the many community members who attended the community discussions. Whether in a group or individually, the opinions expressed were brave, candid and well intentioned. We attach the utmost validity to these views as they come to us directly from the people on the front lines, the people who grapple every day with the physical, emotional and spiritual problems of their clientele, and the community leaders who have committed themselves to finding solutions which are both immediately effective and enduring.

Indeed, it was really through the community discussion process that the requirement for a holistic approach solidified. Time and time again, discussion participants articulated a complex understanding of, and sense of responsibility for the multiple health and social challenges in Nunavut, as well as a desire and capacity to address the problems. Despite considerable challenges, there was expressed tremendous hope for the future, and the understanding that, while the challenges were community-based, so too were the solutions.

Community discussions were arranged in 7 communities: Iqaluit, Hall Beach, Pangnirtung, Cape Dorset, Whale Cove, Rankin Inlet and Cambridge Bay. Bad weather forced the cancellation of the trip to Whale Cove and to changes in the dates and times for the subsequent community meetings.

The group discussions were designed to obtain information directly from the perspective of the communities and community members and were seen as complimenting the research, document review and interviews that had previously been conducted with staff of the GN.

The HII Project has two distinct themes: maternal and child health promotion and prevention and a mental health and addictions treatment approach. As such it was necessary to organize two to three separate consultations in each community, with service providers, Elders, service users and other key stakeholders including mayors, SROs, RCMP, educators, religious leaders and other community leaders. In each community the Community Liaison Officers (CLOs) and Community Health Officers (CHRs) provided excellent support and guidance in setting up the required meetings. In each community, in addition to the consultations organized by the CLOs and CHRs, interviews were conducted with a significant number of other community people (approximately 40 other key people in all) who were either unable to attend the formal meetings or were identified at the meetings as important people to talk to. Interviews were held with numerous health and social services staff, mayors, Elders and key community leaders who were identified by people in the meetings.

Key Informant Interviews

Following the literature search, a number of people were identified as expert resources in the areas of Inuit Culture, Addictions, or service delivery to Inuit persons in Canada and around the world. Interviews were conducted with a total of 50 people representing Inuit organizations, health institutions, and community service delivery agencies.

APPENDIX 2

Health Challenges and their Determinants in Nunavut: The Extent of the Problem

As articulated by the population health approach, health is a multidimensional concept, with each of the dimensions related to the others. In order to understand the extent of health problems and health and social service in the specific areas of mental health and addictions, maternal and child health, and dental health, the broader context of health in Nunavut must also be understood. In trying to obtain data at the Hamlet level in particular, it became apparent that there are large gaps in the available information; what is available is of questionable reliability and accuracy.

What is clear from the information collected is that Inuit health is significantly poorer than that of other Canadians, particularly with respect to life expectancy and suicide rates.[66] Consider the following selected health indicators:[67]

- Life expectancy in Nunavut is ten years lower than the Canadian average: For Males, 66 years compared to 75.7; for Females, 71 compared to 81.4.

- Nunavut has a tuberculosis rate that is 25 times the national average in all age groups, the highest rate of tuberculosis in Canada.

- The suicide rate is 6 times the national average in Nunavut, at 77.4/1000 compared to 13/1000 for all of Canada. Substance abuse is a factor in 90% of suicides.

- Nunavut has a high rate of infant mortality. From 1991 to 1999, Canada saw its rate decline from 5.6 to 4.6 per 1,000 live births, while the rate in Nunavut declined from 18.3 to 16.3.

As stated above, many factors contribute to overall health status. All likely can be traced to a period of rapid socio-economic and cultural change as Nunavut has been "modernized" and has taken on many "Southern" characteristics. The collapse of the fur trade in the 1960s forced Inuit to give up their traditional nomadic ways and were encouraged by the federal government to establish settlements that changed their way of being in the world. Men and women were encouraged to adopt very Southern gender roles; children were taught Southern ways and ideas in schools, including replacing Inuktitut with English. This phase of life in the North saw Inuit losing their culture, their language, and their connection to the environment—in essence, their way of life.[68]

Changes in social structure focus—from the group to the individual; cultural reference points; diet; availability of quality housing; levels of smoking and substance abuse; levels of education and employment; the use and availability of Inuktitut in Nunavut; and the health care system's ability to attract and retain health care resources within communities have all resulted from this period of

[66] *Evaluation of Health Care Models in Inuit Regions, Inuit Tapiriit Kanatami, September 2000*
[67] *Data quoted is taken from Government of Nunavut Department of Health and Social Services, 2004*
[68] *http://collections.ic.gc.ca/heirloom_series/volume2/section6/69-75.htm*

rapid change.[69] These selected determinants of health are briefly discussed below.

Social Structure Focus on the Individual, not the Family or Group Structure

The primacy and centrality of the family and of the group, as opposed to the individual, has undeniably been eroded in the North. Communal living has given way to more Southern "nuclear family-based" housing arrangements, which has had further implications for how Inuit deal with each other. For example, in the past Elders were central to Inuit ways of "making amends".

This community-based discipline has been replaced by an objective enforcement and legal system that distances the offender from the consequences of their actions. Some believe that this fact has also contributed to the further erosion of authority and respect of Elders within Inuit society.[70]

Fall-out from residential school experiences and removal of children from their homes and families, high rates of teenage pregnancy, and the prevalence of female led, single-parent families have altered parenting patterns and contributed to a profound loss of confidence among many Inuit concerning their ability to discipline, parent effectively, and provide a structured family environment for their children.[71,72]

Finally, the diffusion of more Southern-based values through multi-media and introduction of economic and educational structures that focus on individualism and individual achievement further erode the traditional collective social structure.

Cultural Reference Points

A belief in surroundings and an environment that is "alive" or "conscious" has been replaced among many Inuit with Christianity. Where once the shaman would have held a place of priority and respect within an Inuit community, this role and the traditional beliefs attached to it have been pushed aside, which has contributed to a larger sense of cultural dislocation.

Diet

While the traditional Inuit diet of caribou, seal, whale, char, goose and ptarmigan is still a significant part of the diet, the high cost of hunting equipment and changing northern economies have led to traditional foods being less available than in the past. The high cost of store-bought foods and their availability is a major problem in the North, with 12.7 percent of Inuit people over the age of 15 reporting food availability problems, compared to 7.5 percent of the Canadian population.[73] Increasingly Inuit are consuming foods associated with a southern/western diet, though the adverse affects of that diet as manifested

[69] *Based on the key informant interviews conducted as part of this study, health care workers and managers are equally aware of the need to address the non-medical determinants of health in efforts to improve overall health status. In fact, those on the front lines of health care delivery are probably most acutely aware of the limitations of putting band-aids on problems that have historical and systemic roots.*

[70] *Oosten and Laugran 2002.*

[71] *Dion Stout and Kipling, 1999.*

[72] *FAS/FAE Technical Working Group 1997.*

[73] *2004 Annual Report, Government of Nunavut Department of Health and Social Services.*

in high rates of diabetes in the south have as yet to assert themselves in Nunavut.

Availability of Adequate Housing[74]

Overcrowded and inadequate housing contributes to the spread of infectious diseases, stress related ailments, and the high rate of respiratory diseases among children. It also makes the delivery of home care services difficult. Data indicate that while housing affordability for the general Canadian population is 26%, it is less the 8% in Nunavut. Given demographic realities, 3,500 new units in the Territory are required to meet demand over the next five years, at a capital cost of at least $640 million.[75]

Over half of Inuit in Nunavut live in social housing, and ninety-eight per cent of social housing tenants are Inuit. The waiting time for a social housing unit in Iqaluit averages two years, but can be as high as seven years in Clyde River. Approximately 4,000 people in 1,100 families (15 per cent of the population) are on the waiting list.[76] Anecdotal evidence from interviews suggests that in some communities, as many as 18 persons to a household suitable for 6-8 persons means that people eat and sleep in shifts.

Levels of Smoking and Substance Abuse

Despite efforts of some communities to remain "dry", high rates of alcohol, solvent and substance abuse are major problems. The rates of heavy drinking are reported at 4 times that of the rest of Canada. Teenage smoking rates are much more than double those for the rest of the Canadian youth population, at 77.9% compared to 32.4%. In all the interviews and consultations the use of marijuana was seen as endemic in Nunavut, among all age groups.

Levels of Education and Employment

Inuit society has traditionally valued logical thinking, intelligence and knowledge acquired through life experience, because of the importance of this intelligence and experience for survival. According to data provided by the GN's Bureau of Statistics, residents of Nunavut have less formal education compared with the rest of Canada.

While high levels of education are typically associated with higher levels of health, longer life expectancy and other positive health outcomes, the emphasis on formal education does not take into account the importance of informal education in the lives of Inuit, or how their experiential knowledge might contribute to improved well-being and higher health levels within the Inuit context.

Low levels of formal education may also be related to the history of residential schools; parents and Elders who have had a traumatic residential school experience may not view formal education as a healthy process with positive outcomes, and have doubtlessly passed this perception on to the younger generation.

[74] *The federal 2006 Budget included new investments for housing in Nunavut. As part of the Northern Housing Trust, Nunavut will receive $50 million over 3 years similar to the other three territories and an additional $150 million for "urgent needs".*

[75] *Nunavut Tunngavik Timinga/Nunavumi Inuligiyiit, 2003-2004.*

[76] *Ibid.*

Closely connected to levels of education are employment levels. Population health approaches consider "meaningful" work a key element in the social and economic environment that affects the health and self-esteem of individuals. Unemployed people tend to have a reduced life expectancy and to suffer more health problems than those who are gainfully employed.

Real unemployment levels in Nunavut are unknown, as many people do not consider themselves part of the traditional workforce; suffice it to say that unemployment levels are high in the territory.

The replacement of subsistence hunting and gathering activities with those supported by the wage economy ignores the fact that many young Inuit men and women aspire to continue Inuit traditional lifestyles, skills and culture, and derive significant personal meaning, self-worth, accomplishment and pride from these traditional activities. This is particularly true for men in a society where the traditional male role has greatly changed, and is a key factor in the emergence of depression, anomie and cultural dislocation experienced by many Inuit.[77]

Use and Availability of Inuktitut

The GN is trying to deliver health and social services (H&SS) services that are culturally appropriate and sensitive to the needs of Nunavut's majority Inuit population. However, the majority of H&SS clients are either uni-lingual Inuktitut or Inuit who prefer services in their first language, while most of its professional service providers (nurses, doctors, and front line staff) are English speakers. This language barrier can often lead to misinformation and misunderstanding between practitioners and clients.

The perspective shared by many is that H&SS must support enhanced community-based initiatives that use and integrate Inuit Qaujimajituquangit (IQ), modern science, community wisdom and local solutions, and make professional training available in Inuktitut.

Health Care System's Ability to Attract and Retain Resources in Nunavut

Isolation limits access to many services at the community and regional levels. For example, emergency medical evacuations to southern hospitals are standard in all regions. Isolation also affects recruitment of southern medical professionals. There are few Inuit health professionals: thus, people from outside the North fill the majority of professional and medical positions. Attracting, acculturating and retaining medical professionals in each community is a challenge. Evidence from the interviews and the lists of unfilled positions[78] for qualified personnel in the North suggest that attracting and retaining staff for any length of time has become substantially more difficult then it has been in the past.

[77] *Ibid.*
[78] *Ibid.*

APPENDIX 3

Building on Experience: Potential Models for Community Development

Collaborative and/or horizontally managed initiatives have been used to address broad social problems in the environmental, social, health and economic fields for the past 10-15 years, initiatives with which NEDG has extensive experience. The abundance of "healthy community" programs that have sprung up in the last two decades has helped to reinforce the conviction that addressing health issues is far more than just the introduction of health programs. They make the case for a much more holistic and integrated approach. Indeed, when taking a population health approach, the broad determinants of health must be taken into account. As such, there is a concomitant requirement for not only the health care system, but those systems supporting the other determinants of health such as education, housing, social well being, and economic well-being, to be woven into the Strategy.

At a policy level, the notion of community developed and driven solutions is reflected in the "Closer to Home vision for health care in Nunavut. This approach is not new. It has been used in many different contexts to address a number of complex social issues. Two Canadian examples are presented here:

- The first of these is the Vibrant Communities Initiative of the Tamarack Institute. This initiative provides a national framework which supports is a community driven, multi-stakeholder exercise to reduce poverty. It links up to 15 communities across Canada and focuses on six pilot communities.[79] Vibrant Communities concentrates on four key approaches to reducing poverty: comprehensive place-based development; collaboration among all sectors of the community; a focus on building community assets; and a commitment to shared learning amongst communities. Crucially, it brings dedicated resources and outside coaching and technical assistance into the community.

- The second example of multi-sectoral community based planning is the Supporting Communities Partnership Initiative (SCPI). This case is one of the cornerstones of the Government of Canada's National Homelessness Initiative. This unique initiative, launched in 1999, supports the view that "local solutions address local needs and issues best".[80] SCPI has supported the development of integrated community plans in 61 communities across Canada. The model requires involvement from a broad group of stakeholders, including all levels of government, the business sector, the voluntary sector, and key groups of people who are at risk. Facilitators are made available to assist the community to complete an analysis of their assets and identification of gaps; followed by a priority setting exercise and the development of a plan of action. Funding is contingent on a plan being in place, which guides the community to develop local solutions and multi-stakeholder commitment.

[79] *http://tamarackcommunity.ca/g2s1.html*
[80] *http://www.homelessness.gc.ca/initiative/scpi_e.asp*

These examples and others stress that in order for communities to become and stay healthy, they need to be directly engaged in planning and delivering the programs that serve their communities. Local participation and decision-making are key factors in the development of sustainable community change strategies which respond concretely to community priorities.

In summary, while these experiences can be used as a guide, they do not completely fit the reality of the North and Nunavut. Each of the models relies heavily on the involvement and engagement of the business community, as well as the support of community organizations that have community development expertise and networking skills. In remote and sparsely populated communities, the community business sector is often quite small, its management capacity and its ability to leverage resources is limited, and its entrepreneurial pool is shallow.

Many of these communities are multiply disadvantaged by language barriers, a lack of community members with the necessary confidence and writing skills, and with limited outside contacts and few network connections. Just a few of these barriers prevent the traditional models from being applied directly. The consultations and interviews identified a number of local initiatives that have been successful despite the multiple disadvantages of the North noted above. One such initiative was focused on the reduction of new FASD cases in a particular community. The strategy was not centred on health promotional materials but was designed to build capacity in the community.

The project began with a community "asset mapping", which is the development of an inventory of community resources and barriers. This step was followed by the identification of stakeholders and the development of a community-based plan of action. When asked why this project was so successful, the respondent highlighted two characteristics as defining factors: the process engendered community awareness of the issues, and ownership of a plan of action.

Another example, again in the area of maternal and child health, was a project cited by a respondent in which the success of the program was attributed to the strategy of assessing the strengths and needs of the community. That project brought people together and gained the support of the Hamlet council in the process. It tracked progress and kept the partners in the project focused on finding solutions, not just preoccupied on problems.

These "made in Nunavut" success stories point to the tremendous capacity within the north that is available to be tapped. In order to move towards a change in the status quo and a new vision, it will be necessary for the Government of Nunavut to establish a process that supports the meaningful

involvement of communities in the development and delivery of their own health strategies.

However, this approach cannot be the responsibility of the Government of Nunavut alone. In order for a comprehensive community-driven approach to work, it will take the collaboration of all levels of government, and within each level of government, greater horizontality amongst departments. As such, it will be necessary for the Government of Canada and the Government of Nunavut to develop a unique and fresh approach for the creation of a Community-Centred Wellness strategy in Nunavut.

An instructive model for building technical assistance teams is the Canadian Economic Development Technical Assistance Program (CEDTAP). It is a national technical assistance (TA) provider, funded initially by a major Canadian Foundation and based at Carleton University, which makes available external TA advisors for a defined period of time to communities requiring development and planning expertise.

Similarly, the Vibrant Communities Initiative mentioned earlier also provides outside coaches who assist designated communities in the development of multi-stakeholder, place-based planning and action-oriented initiatives aimed at measurably reducing poverty. Through a group called the Pan-Canadian Learning Community (PCLC), the Vibrant Communities Initiative has also linked other interested communities into their developing knowledge base compiled by their six pilot communities.

The PCLC is made up of leaders of the community teams and forms a national knowledge and information sharing network of local communities involved in tackling local poverty. It shares best practices and lessons learned while the work is ongoing in their communities.

The Vibrant Communities' office at the Tamarack Institute provides the overall national strategic and conceptual framework with a small staff team and some part time coaches, the distance learning approach, and evaluation approach and expertise.

A further example can be found within the Supporting Communities Partnership Initiative (SCPI) program at the National Homelessness Secretariat, where community facilitators are engaged to convene the necessary local players and assist the community to complete is planning and implementation processes.

APPENDIX 4

Mental Health and Addictions in Nunavut

Complexity of Health and Social Problems in Nunavut

There are wide ranging concerns related to the complexity of treating addictions and mental health across the regions. There was a common concern in all communities about increased levels of, and the often interconnections between, alcohol and drug abuse, suicide incidents, family violence, child and generalized sexual abuse, depression and anxiety. In addition, there is a growing awareness that trauma and loss issues related to residential schools, cultural and community dislocation are resulting in increased social problems, and that these social problems are being passed on to subsequent generations.

Across the consultations, there were common concerns around teen-age pregnancy, parenting skills, and an apparent growing lack of respect for Elders and other adults in general.

For some, this lack of respect or trust, seems to compound the generation gap between those raised in a more traditional way and younger generations who have been much more influenced by southern culture and influences.

In terms of service delivery, lack of trust also plays a role in many communities who expressed concerns about confidentiality, resulting in a reluctance to reach out to community wellness/ addictions workers from the same community for fear of loss of privacy.

Implications of Social and Cultural Dislocation: Mental Health and Substance Abuse Problems

According to the Canadian Centre on Substance Abuse (CCSA), there is little data on substance abuse among Canadian Inuit. In general, the following general statements can be made:[81]

- The substances most often abused are alcohol and marijuana.
- Binge drinking is the most common pattern—due to several factors including historical causes related to food insecurities and the intermittent availability of alcohol dating back to 19th century whalers, as well as differing current policies related to the availability and distribution of alcohol in the territories (i.e. some communities are dry and alcohol is not available except through bootlegging and Canada Post).
- Marijuana is often cheaper and easier to bring into the Territory than alcohol.
- Street drugs such as cocaine or heroin are seen in Iqaluit, the most urban of all the population centres. The use of this type of drug may increase if mining and subsequent prosperity becomes more prevalent.
- Pockets of solvent abuse appear and disappear within the communities, and are more prevalent among youth and children.

[81] *http://www.ccsa.ca/CCSA/EN/Partnerships/Territories/Nunavut.htm*

- Cigarettes are the most commonly used drug, as approximately 70% of the population smokes.

Existing research suggests that the use and misuse of alcohol among Inuit is a complex process linking many factors including the genetic and biological characteristics of Inuit, a lack of historical responsible use in day-to-day activities, socio-economic determinants such as poverty and a lack of opportunities and of meaning in daily activities, rapid cultural change, as outlined in the first section of this report.[82] Indeed, Korhonen states that:

> *...the connections are complex between alcohol abuse and [social determinants of health]... But it is likely that when individuals do not have the tools to make a meaningful life, feel a lack of secure rootedness in family and society, and/or do not have a sense of direction for a positive future, they may learn to use alcohol as a coping tool. This alcohol misuse then creates even more problems.*[83]

For example, current anecdotal evidence from counsellors in the substance abuse recovery program at the Mamisarvik Healing Centre in Ottawa indicates that the majority of clients are actually dealing with differing forms of post-traumatic stress syndrome. The effects of residential schools, forced relocation from traditional lands, physical, emotional and sexual abuse from family and community members are underlying the their use — and abuse — of substances. The use of substances is one of the coping mechanisms to deal with the effects of multiple traumas.[84]

This combination of personal psychological coping factors and environmental stressors results in a significant problem for many individual Inuit, and certainly for Inuit communities on the whole. In particular, "Inuit communities and regional governments/organizations have identified alcohol abuse as a priority problem. Binge drinking, the predominant pattern in Inuit areas, is a major factor in violence, accidents and injury, employment and family problems, unwanted sexual contacts, etc."[85]

A number of social, economic and health problems now permeate communities in Nunavut, and have become cyclical and multi-generational. While the problems themselves are not unique to the region, their pervasiveness is.

Brief Overview of Service Delivery for Mental Health and Addictions

In the western half of Nunavut, HSS provides limited funding for Alcohol and Drug programs. These programs, usually run by Hamlet councils, have Alcohol and Drug (A&D) Workers who are intended to be able to assess patients for treatment and to support them (and their families) during and after treatment. In the Baffin, most communi-

[82] *Korhonen, Marja. Alcohol Problems and Approaches: Theories, Evidence, and Northern Practice. Ajunnginiq Centre, National Aboriginal Health Organization, 2004.*
[83] *Ibid: 11.*
[84] *Interview with Pam Stellick, December 5, 2005, by James Hicks.*
[85] *Kohornen 2004: ii.*

ties opted to convert the A&D programs to GN wellness workers, most of who can perform the same function.

Most often, these local workers—virtually all Inuit—have received minimal training, and stability of the programs is a problem. In addition, workers have little or no clinical supervision, particularly within Hamlet programs.

Counselling, assessment and referral services are also provided by a variety of other health professionals including Mental Health Workers and Social Workers. However, these practitioners are often understaffed, have received little training in addictions and/or stay only a short time in the Territory.

Some communities have specialized resources such as addictions counsellors, and, as well, Nunavut has recently hired 5 psychiatric nurses (of a total of 7 planned) who divide their time between one or two communities. The psychiatric nurses are trained in assessment as well as providing some counselling and follow-up support for those who have gone away for treatment. Some communities have psychiatrists who visit on a rotational basis. A few communities have established or are in the process of establishing AA groups. Where AA exists, it often is large component of any community-based support and/or follow-up to treatment.

In addition, the Community Health Centres provide emergency care and stabilization, medical consultation, short-term acute care and support for people awaiting medical evacuations. Laboratory and Pharmacy services are also available in the health centres.

APPENDIX 5

Maternal and Child Health and Oral Health Indicators: The Extent of the Problem

With the highest pregnancy rate in the country, (100.1), Nunavut almost doubles the Canadian average of 54.9.[86] Nunavut's population continues to grow with 14 communities reporting population increases of 30% or more in the last 20 years.[87] A high birth rate requires a high level of government focus and resources to ensure appropriate maternal and child health services and social supports are offered to individual women and families as well as the communities in which they live.

The health and well-being of mothers and their young children are important because they directly reflect the current health status of the people themselves, as well the community as a whole. It is generally understood that maternal and child health is a key predictor of the health and capacity of the next generation.

While Canada as a whole enjoys one of the lowest maternal and infant morbidity rates in the world, there are marked variations within the country. The national neonatal mortality rate is 1.7 per 1000 live births while Nunavut rate currently stands at three times that (5.5). In contrast, the Northwest Territories has a neonatal mortality rate of 1.5.

Pre-term delivery is an important indicator of infant heath and is associated with several long-term health issues. Nunavut has the highest rate of pre-term delivery in Canada at 10.4%. Known risk factors for pre-term birth include single marital status, age of the mother, smoking, low or high weight gain, infection, drug and alcohol use as well as stress, all indicators of broader social conditions affecting well-being.

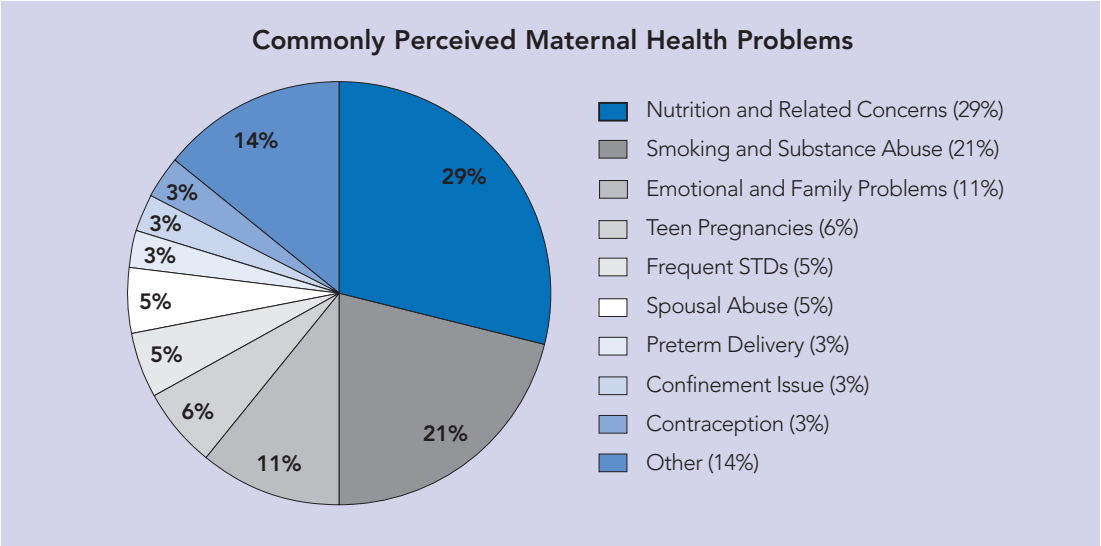
Another significant indicator of maternal and child health is the hospital readmission rate. In 2003, the neonatal readmission rate in Nunavut was 9.3%, compared to a national average of 3.2%. The newborn neonatal read mission rate can be used as evaluation criteria to determine the quality of maternal and child health care including community support.

In 2003, the Department of Health and Social Services conducted an audit on the public health programs. They identified that nutrition and food, smoking and substance abuse and family and emotional problems were the top 3 perceived maternal health problems.[88]

[86] *Statistics Canada, http://www40.statcan.ca/l01/cst01/hlth64a.htm*

[87] *Community Profiles: Education and Development Planning, Department of Health and Social Services, August 2005.*

[88] *Report on Nursing Perceptions of Public Health Programming in Nunavut, 2003, P.26. http://www.gov.nu.ca/hsssite/Report%20on%20Nursing%20Perspectives%20on%20Public%20Heatlh%20Programming%20in%20Nunavut.pdf*



Service Delivery Overview

Prenatal and Maternal Health Services

Across the territory, most prenatal and postnatal care is provided through the community health centres. There are community health centres in every community. Prenatal, postnatal and well-baby visits are generally standardized throughout the territory. The midwifery and maternal care program in Rankin Inlet enjoys Public Health Nurses (PHNs) who perform prenatal check-ups while in Iqaluit prenatal check ups are performed by Public Health Nurses in the clinic. In the other outlying communities, prenatal check-ups are performed by Community Health Nurses.

During the early visits, pregnant mothers are screened for drug and alcohol use, as well as smoking. Women receive initial nutrition counseling and vitamins, as well as information regarding the food supplement program. STD testing is performed as a part of the regular pre-natal visit and women are encouraged to get tested for HIV at this time.

Prenatal visits are typically done every 4 weeks up to 28 weeks of pregnancy, then visits increase to biweekly until 34 weeks of pregnancy. At 36 weeks, pregnant women are transported to the birthing centre closest to them. According to the Nursing Perspectives on Public Health Programming in Nunavut report, "virtually every woman in their community receives some prenatal care."[89] At present, the only pre-natal education classes being offered are in Iqaluit.

Most women deliver their babies at one of two birthing facilities in the territory, Iqaluit Hospital (Baffin Region), Rankin Birthing

[89] *Nursing Perceptions of Public Health Programming in Nunavut Sue: a document? Year?*

Centre (Kivalliq Region) or Yellowknife Hospital in NWT (Kitikmeot Region), depending on their proximity. Expecting mothers who must travel out of their communities stay in the Boarding Houses pre and post-delivery, if they are not able to make other housing arrangements. High-risk pregnancies such as twins are delivered in urban centres outside of the territory such as Edmonton, Winnipeg or Ottawa depending on the proximity.

Infant and Child Health Services

Post-partum home visits are only performed by PHNs in Iqaluit. The Kivalliq region has 3 maternal and child health workers who provide home visits to new mothers. In all other communities, new mothers and their babies must visit the community health centres for their post-partum well-baby visits.

All immunizations are done through the community health centres and the public health nurses. Well-baby check-ups are arranged through the public health offices or the community health centres. Community health centre visits allow time to discuss issues with mothers regarding developmental changes, nutrition, and address any areas of concern.

Access to other health professionals including pediatricians, occupational therapists, audiologists, speech therapists are requested as needed, but access is limited due to geographic isolation and long waiting times. Children and families who are seen to be at risk are referred to the social service system.

The Territorial FASD Initiative, operating under a steering committee, works in conjunction with various components of the health, education and social service spectrum. Under this initiative, presentations and training are given to CHRs, CPNP staff, community leaders, and community justice workers. Presentations have also been given to students and parents. There has been 1 FASD diagnosis pilot program in Kuglukuk.

The Paukuuit Inuit Women's Association has been an active participant in FASD education in Nunavut. They have developed bilingual information packages including posters, radio play, CD ROM, Video and a video viewing guide.

Sexual Health Services

At present, there is no comprehensive sexual health promotion program or strategy within Nunavut. Most sexual health services are performed within the community health centres, in established well-women clinics or by physicians in the larger centres. While some sexual health education is delivered through the high schools, respondents felt it is inconsistently delivered, available to only a selection of the student population and still only a small component of a broader physical and health curriculum. Some CHRs also deliver some forms of sexual health information in the communities.

The Pauktuutit Inuit Women's Society have been involved in AIDS/HIV education since the 1990s. In addition to workshops, Pauktuutit has created 6 publications, available in printed versions and on their website. This material addresses different AIDS topics including HIV protection and HIV and other STD and it has been translated into English, Labrador Orthography and Inuktitut.

Oral Health Services

The actual number of dentists operating in Nunavut varies throughout the year. On average, there are 10-12 "locum" dentists operating in the Territory. Of the 17 positions available at the time of the interviews, there were 9 vacancies. Due to the changing roster of dentists, there are few opportunities for continuity of care. In the Baffin region, there are 4-6 dentists who travel to the communities. In the Kivalliq region, there is an average of 4 circulating dentists and there are 2 dentists working throughout the Kitikmeot region. The only permanent dental facilities are located in Iqaluit and Rankin Inlet but neither of these facilities have permanent dentists. Dental Assistants will fly in with the dentist. There are 2 private and independently run dental clinics in Iqaluit.

There are Orthodontists who come into the main centres of each of the regions, Iqaluit, Rankin and Cambridge Bay. These visits are scheduled on average every 7 weeks. Oral surgeons make on average 2-3 trips a year to each region based on the volume of need and requests made. Dental surgery that requires hospitalization, for example complicated procedures or children who are unmanageable at the dentist facilities, is currently only being performed in the Territory in Iqaluit at the Baffin Regional Hospital. Patients in the Kivalliq region are sent to Churchill, Manitoba while dental surgery patients in the Kitikmeot region are sent to the Stanton Regional Hospital in Yellowknife, NWT.

There are 8 dental therapists operating independently in the Territory focused on school age children. These dental therapists are trained and equipped to do tooth extractions, fillings and crowns in addition to delivering dental health promotion and prevention programs. At present, there are 3 traveling dental therapists in the Baffin region, 2 in Kivalliq and 3 in Kitikmeot. The dental therapists can do emergency procedures for adults if necessary.

The Dental Health office in HSS has developed a number of successful promotional products. They include the "Smiles for Life" pamphlet that provides bilingual information on dental health as well as pictures that illustrate healthy and decayed teeth. The "Drop the Pop" initiative was developed by the health and nutrition promotion offices in conjunction with the dental health office.

This bilingual program is run once a year in schools and offers contests and incentives to increase the choice of healthy beverage

choices. There are school lesson plans developed and there has been excellent participation of schools and teachers. Last year there were over 10,000 bottles of water that were distributed to schools.

Another successful program are the dental "kits" that contain orthodontic pacifiers, baby tooth brushes and brushing supplies that are distributed at prenatal, postnatal and well-baby clinics at community health clinics. There is a well-developed school tooth-brushing program that enjoys an estimated 90% compliance rate. Schools are sent all supplies and the teachers organize and facilitate brushing times during the day.

In addition, the Dental Health Specialist for Nunavut has identified pilot projects in the works for the Territory. One project will see the development of a training course and train individuals in all communities for health prevention of fluoride varnishes for children aged 0–5. A second will look at a training course for local dental and nutrition workers. The third is centred on the use of "denturists" in two communities. Currently, it can take up to 6 months to produce dentures, out of the community. These para-professional specialists can produce dentures in 24 hours.

Canada Prenatal Nutrition Program

The Canada Prenatal Nutrition Program is administered by the First Nations and Inuit Health Branch of Health Canada. This program currently serves 22 communities in Nunavut, 16 through FNHIB and 6 PHAC sites. The program primarily targets pregnant women and women with infants up to 12 months of age. It is delivered by community health and social service providers with additional services being provided by dieticians/nutritionists, and others where available.

The overall goal is to improve maternal and infant nutritional health. The flexible framework of CPNP ensures that evidence-based approaches are taken to address maternal and infant nutritional health issues, while also allowing community workers to tailor their program activities to the priorities and culture of their communities. In general, the CPNP supports activities related to: 1) nutritional screening, education and counselling, 2) maternal nourishment, 3) breastfeeding promotion, education and support. Activities include cooking classes, sewing classes, nutrition support to promote healthy food choices and lifestyle, activities around breastfeeding, tobacco cessation and support for maternal and child health and nutrition.

Aboriginal Head Start Program

The Aboriginal Head Start Program in Urban and Northern Communities is an early childhood development program for the children and families of off-reserve First Nations and Inuit and Métis living in urban and northern communities. It currently serves 7 Nunavut communities with a potential reach of 345 children. AHS projects are intended for

children ages 0–6 with a primary emphasis on children three to five. AHS supports strategies designed and controlled by first Nations and Inuit people.

Community Action Program for Children

Currently in 6 communities, the Community Action Program for Children provides long-term funding to community coalitions to establish and deliver services that respond to the health and developmental needs of children from birth to six years of age, who are living in conditions of risk. CAPC projects provide parents with the benefits of support, information and skills that promote healthy child development. Activities include weekly pre-school sessions in Inuktitut and English to develop school readiness, group activities, literacy, parenting, father involvement, and attachment, knowledge through oral history, traditional arts and crafts, and Elder involvement.

APPENDIX 6

Selected Summary of Community Discussions and Interviews

Community frustration with government's perceived inability to coordinate actions and collaborate across departments and jurisdictions was evident in each community visited. In order to improve the current community health and wellness situations, a community-wellness strategy will only have credibility and a potential to succeed if governments demonstrate a willingness to act horizontally and in a manner responsive to community needs and priorities.

Interviews with community health workers, community-wellness counsellors and community liaison officers and others identified the untapped potential of those resource people to work in teams.

The current unfilled positions, undefined roles, unsupervised work and unconnected activities were a source of frustration to the incumbents and represented an underused resource. The gathering of these individuals into teams, which are tasked to activate the Community-Centred Wellness Strategy, its planning and execution, would provide a focal point for action and innovation. The creation of these community development teams would also represent a cost-effective method of responding to each unique set of community priorities.

The interviews and discussions revealed a number of initiatives working to address, in a holistic way, the issues that confront Nunavut. In some cases these initiatives have been led by the GN (e.g. Grief and Loss Workshops for GN employees), and in other cases by grassroots groups of concerned citizens, such as the gathering on suicide which led to creation of the Embrace Life Council.[90] In some Hamlets, notably Pangnirtung, Dorset and Cambridge Bay, community members have applied for and received funding from the Aboriginal Healing Foundation for multiple year initiatives focused largely on suicide prevention.

Some projects also incorporate traditional practices on the land with a view to building bridges between youth and Elders. These initiatives have included extensive training in dealing with grief and loss and which have resulted in trained people available to the community. The consultations revealed however, that in many cases these people were not being utilized to the fullest extent as part of a team of health and social service providers in their communities.

A meeting with CHRs in Iqaluit and subsequent discussions revealed that, depending on the health centre, CHRs may be asked to take on additional tasks including acting as interpreters, translators and clerks. Some of the participants in the interviews and consultations felt that the organization of activities into health promotion campaigns was a good way of assisting staff to organize community events as they provide an opportunity for staff with less training and limited resources to focus community activities on specific health issues.

[90] *Annual Report Isaksimagit Inuusirmi Katujjiqatigiit Embrace Life Council.2004-2005*

While the promotional campaigns do provide a framework within which the CHRs can organize their energies, other respondents indicated that the activities do not necessarily reflect the priorities of either the communities or indeed of Nunavut.

Additionally, not every community needs to focus on every national day/week/month as some have already raised awareness of specific health problems.

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