LEGISLATIVE ASSEMBLY OF THE

NORTHWEST TERRITORIES

10TH ASSEMBLY, 2nd SESSION

TABLED DOCUMENT NO. 24-84(2)

TABLED ON JUNE 28, 1984

Tabled Document No. 24/84 (2)Ltr
Tabled June 28 1984

The Northwest Territories' Alcohol and Drug Coordinating Council and Regional Advisory Board to N.N.A.D.A.P.: A review of their structure and functioning and suggestions for their future operation.

March 30, 1984

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GNWT Service Contract No. SC 201026

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ACKNOWLEDGEMENT

The contribution of W. J. (Wilf) Totten in the production of this report is gratefully acknowledged. Chapter 3 in particular is based on material gathered and prepared by him. Its application in the final product, however, is the responsibility of the author.

Prior to his retirement in May 1981 Mr. Totten was Executive Director of the Alberta Alcohol and Drug Abuse Commission. Before coming to Alberta he was Executive Director of the Saskatchewan Alcoholism Commission.

1. The Development of Alcohol and Drug Services in the Northwest Territories

In addressing the question of type of structure which might be developed for the future delivery of alcohol and drug services in the Northwest Territories it is important to understand what is in place now and how that structure has developed.

1.1 The Territorial Initiatives

When the Government of the Northwest Territories (GNWT) moved its headquarters from Ottawa to Yellowknife in 1967 it brought with it three Territorial programs: the Alcohol Education Program and Corrections Program (both of which were created in 1966 - 67) and the Territorial Liquor System. Within the next three years the Territorial administration had responsibility for several other program areas transferred to it from the Department of Indian Affairs and Northern Development (DIAND). When the Territorial Department of Social Development was created in late 1968 the Alcohol Education Program and the Corrections Program became part of that Department. In 1969 the new Department was given responsibility for the administration of all of the other social services programs in

the District of Mackenzie (the area that now encompasses the Fort Smith, Kitikmeot and Inuvik Regions) and in 1970 the Eastern Arctic (the present Keewatin and Baffins Regions) social services were transferred to the Department. At that point in time social services staff were located only in the major population centres with the result that the smaller centres received services on a 'fly-in' basis (apart from social assistance, which was administered by the local area administrator or someone on his staff).

1.1.1 The Alcohol Education Program 1966 - 1973

Even before the GNWT moved from Ottawa to Yellowknife there was recognition of the negative impact of alcohol misue on the lifestyle of northerners. The Alcohol Education Program's primary purpose was to create public awareness of the problems of alcohol misuse. The hope was that through having a better understanding of the problems that alcohol can create, individuals and communities would develop a sensitive and responsible attitude toward

alcohol use.

In addition to providing books and printed materials to libraries and interested individuals, providing materials for use by doctors and other helping professions, providing films and other visual aids for educational programs, learning and training opportunities were provided for a variety of people. Efforts were also made to develop local committees of citizens who were interested in taking action to deal with local problems or to take political action to see that funds were provided for those services.

1.1.2 Community Alcohol Problems Grants Program 1972 - 1974

Although the results were not spectacular public concern was increasing, so much so that the Territorial Council insisted that the Alcohol Education Program budget be increased to $172,800 in 1972-73 (it had been about $64,800).

This additional $100,000 plus became the Territorial Community Alcohol Problems

Grants Program - a local initiatives-type of program designed to encourage groups or communities to mobilize their own resources to deal with the alcohol problem(s) in their area "as they saw it (them)". The total funds were allocated to the (then) four administrative regions roughly on a per capita basis with the Regional Superintendents of Social Development being responsible for the approval of projects and the allocation of funds within their regions.

This program produced some very significant results. For example, local/regional alcohol workshops were organized and in several instances the result was that, by local option plebiscite, communities expressed their strong opposition to any further outlets for the sale and consumption of beverage alcohol in their areas. Other communities used grants to develop activities which provided a positive outlet for leisure time. Three of the native associations used grant funds to do some initial work in improving the understanding of their members about what could be done to

forestall or cope with alcohol problems.

The Yellowknife Committee of Concern on Alcohol Problems used a combination of an alcohol grant and L.I.P. grant to mobilize the north's first detoxication centre. This program was subsequently expanded to include rehabilitation and follow-up services with the name of the agency becoming Northern Addiction Services.

1.1.3 Use of Film and Print Media

The Alcohol Education Program also sought other ways of getting the alcohol message across to the people of the Territories.

In 1973, the film "Alcoholism in My Land" was produced in Frobisher Bay using local Inuit and white residents as actors. The original voice track was in Inuktitut; the English version was secondary. The film proved to be an effective tool to stimulate discussion in community meetings.

A comic book series, "Captain Al Cohol" was also produced (in English) to assist in getting the message across. Although this publication (there were four issues) had its

critics it certainly achieved the goal set for it - to get people talking freely about alcohol misuse. (One of the Fathers on the Arctic Coast had promoted the idea of using a comic book format, but he had proposed using Inuit stories to give young people a positive feeling about their culture. The stories never came so the Department of Social Development enlisted the Department of Information to produce the series.)

1.1.4 The Wacko Report, August 1973

During 1973, the late Mr. William J. Wacko, a former Executive Director of the Alberta Alcoholism and Drug Abuse Commission, was contracted by the Department of Social Development to consult widely throughout the Territories with persons and organizations who had an interest in alcohol and drug problems and to recommend a comprehensive plan for dealing with the problems. His report was reviewed by Territorial Council at its 50th Session in Inuvik in October, 1973. The report, including its ten recommendations, was given unanimous approval by Council. Several significant

actions resulted.

The first of these involved changes in the Liquor Ordinance to permit communities greater latitude in deciding about the availability (or unavailability) of alcohol. The amendments enabled the Commissioner to act quickly in response to requests from communities for the control of liquor, as provided in the Ordinance.

The second significant change as that an Alcohol and Drug Coordinating Council was organized. Its structure, which differed from that recommended by Wacko, was decided by Territorial Council. As of April 1, 1974 responsibility for the Community Alcohol Problems Grants Program passed to the Coordinating Council.

The third change was that what had been the "Alcohol Education Program" became the "Alcohol and Drug Program". Wacko suggested that the range of activities and services be comprehensive but, to the greatest extent possible, local groups, communities, or native organizations should develop and

operate these services.

A fourth change was in the price structure of alcohol. The changes that were put into effect in November 1973 related price to the "contained" alcohol in each product. This resulted in lower prices for those products which contained a lower percentage of alcohol.

1.1.5 The Alcohol and Drug Coordinating Council

In his report, "Observations and Recommendations Respecting Alcohol in the Northwest Territories", Mr. Wacko recommended that the Government of the Northwest Territories establish an Alcohol and Drug Coordinating Council. He suggested its purpose would be:

- to promote coordination of Governmental services which relate to alcohol distribution and problems pertaining thereto;
- to promote communication and cooperation between the Territorial Government and the Federal Government agencies such as Justice, R.C.M.P., and National Health and Welfare, which provides nursing services throughout the North;
- to serve as an Advisory Body and a "sounding board" to the Alcohol and Drug Program in respect to program, grants, etc.;
- to act as an advisory body to the

Commissioner.

Mr. Wacko suggested that the Council should be comprised of representatives of:

- the Territorial Government (including the heads of Social Development, Education, Local Government, Industry and Development)
- Justice and law enforcement (R.C.M.P.)
- native organizations of the Northwest Territories
- the Liquor Control Board and the Liquor Licensing System
- private industry and of the alcohol beverage industry
- National Health and Welfare
- a represenative of A.A.

Although the Council of the Northwest Territories unanimously adopted the concept of an Alcohol and Drug Coordinating Council they modified the membership of it by deleting the representatives of the (four) named Territorial departments (because they did not want the Council to become dominated by senior civil servants). Two representatives from the NWT Youth Council were added, as was one from the RCMP. The Chief Magistrate was also added to the list of members. Therefore, when the Coordinating Council met first on May 14, 1974 it was

comprised of thirteen members plus a chairman, who was to be a non-government person. The Executive Secrtary of the Coordinating Council was to be the Chief, Alcohol and Drug Program. (Please refer to Table 3, page 27 for an outline of the changing structure of this Council).

"...(the) rationale for establishing a Coordinating Council is obvious, given the many facets of life that are touched by alcohol abuse. Those responsible for licensing establishments would probably benefit by direct communication with those responsible for picking up the pieces and for the prevention of abuse problems and vice versa. Such high level communication and coordination would have positive results both at the administrative and community levels where there is a crying need for more teamwork." Wacko, p. 32

1.1.6 Alcohol and Drug Program

Wacko also recommended that the GNWT establish an Alcohol and Drug Program (to replace the Alcohol Education Program) the purpose of which would be the provision of:

(a) treatment and treatment demonstration services,

(b) public information and professional training,

(c) community resource development (agency coordination and community level involvement),

(d) evaluation and research.

Wacko also suggested that the main components of this program would be:

(i) grants-in-aid to allow for the greatest possible decentralization and diversification of programming at local levels,

(ii) specialized task forces at Yellowknife and Frobisher Bay for treatment (out-patient and correctional centre), professional training, information dissemination, program assessment and fact finding,

(iii) a built-in intern training program to ascertain that people from smaller communities have opportunities for training.

Wacko did not comment on how a federal program could be coordinated with the Territorial program because when he was preparing his report there was no indication of possible federal alcohol and drug initiatives in the NWT.

1.1.7 Program Funding

Although the GNWT endorsed Wacko's recommendations concerning the establishment of an Alcohol and Drug Coordinating Council and the structuring of a Territorial Alcohol and Drug Program it made no commitment concerning the level of funding it would provide from year to year.

Table 1, which follows, identifies the extent to which change (or absence of it) has taken place in the matter of funding and staffing the program by the GNWT.

Table 1. GNWT Alcohol and Drug Program Expenditures

$'000s 1972 - 1985

Year	Salaries	Grants & Contrib.	O & M	TOTALS	Man Years
72-73	0*	100	39	181**	3
73-74	17	188	23	238	3
74-75	40	361	0*	401	3
75-76	39	376	3*	418	3
76-77	44	489	49	582	3
77-78	0*	900	0*	900	3
78-79	0*	800	0*	800	3
79-80	89	798	51	938	3
80-81	96	1,001	20	1,117	3
81-82	116	1,175	17	1,308	3
82-83	124	937	59	1,120	3
83-84	195	1,007	207	1,399	4
84-85***	197	1,158	209	1,564	4

Source - Department of Social Services

*Budgetting procedures have varied over the years: where an asterisk (*) appears these items were budgetted for in the Department's "administration" appropriation.

**In 72-73 the grants budget was exceeded with the excess being covered by transferred funds.

***Approved Estimates.

1.2 The Federal Government Initiatives

The Federal Government's mandate for its involvement in alcohol and drug programs lies in the over-riding responsibility of the Minister of National Health and Welfare for the health of all Canadians and, more specifically, for the health of status Indians and Inuit. To have "status" an Indian must be "registered", be living on a "reserve", or have been living away from his reserve for less than twelve months.

In late 1973 the Departments of Indian Affairs and Northern Development and National Health and Welfare jointly planned a program which was focused on the problems of alcohol abuse in the "status" Indian population (and, by definition this would include Inuit). Before putting their proposal forward for approval the Departments consulted with the provinces and territories to get their inputs and observations.

The GNWT suggested that, given the special circumstances that existed in the Northwest Territories: the population distribution, the fact that the GNWT already had an alcohol grants program that was available to everyone regardless of status, and that the trend was for

the GNWT to assume more and more responsibility for provincial-type services, rather than complicate the situation by putting in place a program that would tend to divide the population of communities on the basis of status (it should be remembered that only five of the sixty or so communities have over 2000 residents), it would make more sense to put the additional funds into the GNWT program (which was being administered by a coordinating council representative of the various interests groups in the NWT).

Because of its residual responsibility for Indians and Inuit the Federal Government felt it could not make a special case of the Northwest Territories and when the new program was announced it was to be for "status" Indians and Inuit throughout all of Canada.

1.2.1 The National Native Alcohol Abuse Program (NNAAP) Implemented April 1, 1975

The National Native Alcohol Abuse Program (NNAAP), a program jointly funded by the Ministers of Indian Affairs and Northern Development and National Health and Welfare, commenced on April 1, 1975 on a three-year trial basis. The funding level in year one

was $3,000,000. (nationally). The program was intended to support community-designed and operated projects "...in the areas of native (i.e. registered Indian and Inuit) health and social services for alcohol abuse prevention, treatment and rehabilitation, in order to disrupt and reverse the present destructive physical, mental, social and economic trends."

A National Advisory Board was established and one of its functions was to review grants applications that were recommended to it by the Regional Advisory Boards that were established in each province and territory. The Minister of National Health and Welfare made all announcements re grants approvals under NNAAP at this time.

Obviously the Regional Advisory Board (RAB) had a key role in reviewing project proposals and in recommending the level of funding each should receive (if any) and in suggesting appropriate controls or conditions re program operation. The RAB under NNAAP was to consist of: representatives from native groups, DINA,

HWC and the provincial or territorial government depending on the region involved.

ADCC Designated as RAB for NWT

Because the GNWT Community Alcohol Problems Grants Program had been in place since April 1, 1972 and the NWT Alcohol and Drug Coordinating Council since April 1, 1974 the GNWT proposed to the Minister of National Health and Welfare that, given the special conditions that existed in the NWT (e.g. no reserves, status and non-status population in varying proportions scattered across the Territories in small communities), it would simplify the process for community groups seeking funding from either the Federal or GNWT grants programs if the ADCC were to act as the Regional Advisory Board for the Territories. The Minister gave his approval to this proposal early in 1975 with the stipulation that HWC and DINA be represented on the ADCC/RAB (in fact, HWC was already represented on the ADCC).

Regional Alcoholism Consultant

The program structure for NNAAP also called

for the appointment of regional (i.e. one for each province and territory) alcoholism consultants to provide staff support to the regional advisory board and to the Regional Directors (of Medical Services Branch). The regional consultant was also seen as a resource to local groups in the preparation of program proposals or in the operation of approved projects. He was also called upon to evaluate requests for the continued funding of projects that extended into a new fiscal year. In the NWT the regional consultant was, and continues to be, accountable to the Regional Director, Northwest Territories Region, Medical Services Branch. He may receive suggestions and advice from the RAB re projects and their operation but he isn't obligated to accept this advice because he isn't directly accountable to the RAB.

NNAAP Extended to 1980-81

In 1978-79 the NNAAP was extended for a further three-year period, with the national funding level for that year set at $6,179,000. Funding increases in subsequent

years were to be based on the facts of the Indian and Northern Services Formula of the Department of National Health and Welfare.

NNAAP Extended to 1981-81

In March 1980 the program was given a further one year's extension on the understanding that a proposal for a permanent program would be presented in 1981-82 to the Social Development Committee (of the Federal Government), complete with a plan for measuring the ongoing effectiveness of projects in future years.

Grants Approval Process

Initially the funding process under NNAAP involved the submission of applications by local groups to the RAB who, after reviewing the applications, forwarded their recommendations to the National Advisory Board. That Board made its recommendations to the Minister, whose approval was needed before payment could be made.

In 1983 this process was modified so that the Regional Directors could authorize project funding of up to $100,000. per year.

Projects with budgets over that amount would still require approval in Ottawa.

1.2.2 The National Native Alcohol and Drug Abuse Program (NNADAP) Implemented 1983-84

The program recommended to the government was the National Native Alcohol and Drug Abuse Program (NNADAP) and it was approved for implementation in 1983-84. As with the NNAAP the administrative responsibility for program implementation remained with Medical Services Branch of Health and Welfare Canada.

Under NNADAP the Regional Advisory Boards continue to review project applications and to recommend approval for funding (by the Regional Director).

As a measure of the progress of the NNADAP has made in arresting and offsetting high levels of alcohol, drug and solvent abuse among Indians and Inuit in its first five years, the following standards have been set (nationally) for the program:

(a) increase coverage of prevention

services to 90% of on reserve population.

(b) increase number of treatment beds from 140 to 730.

(c) provide training to 800 community project and program support staff.

(d) provide developmental and remedial capital investment for up to 30 proposed facilities and 20 existing facilities.

In late January 1984 NNADAP contracted for a study "...to provide a strategic but detailed overview of the native alcohol/drug abuse problem in the Northwest Territories (Problem Statement), and in consultation with a Steering Committee, identify the approach required to satisfy the determined need for prevention, treatment and maintenance programs (Needs Assessment)." The problem statement was scheduled for completion by March 31, 1984.

1.2.3 NMUDD's Innovative Grants Program

During the period the Innovative Grants Program of HWC's Non-Medical Use of Drugs Directorate (NMUDD) was active, from 1975

through 1978, by arrangement with the Minister of National Health and Welfare, the ADCC also served as the NMUDD Regional Advisory Board for the Northwest Territories.

1.2.4 Funding

Table 2, which follows, identifies the federal expenditures in alcohol and drug services in the Northwest Territories during the period 1984 to 1987.

Table 2. Estimated Contribution Allocation

Northwest Territories Region

National Native Alcohol and Drug Abuse Program

Three Year Development Plan

Program Element	1984/85 (84/85 approved estimates)	1985/86	1986/87	Total
Treatment	740,128 (192,628)	952,628	1,165,223	2,857,979
Prevention/ Maintenance	1,117,776 (1,296,776)	1,311,336	1,504,897	3,934,009
Training	99,500 (468,000)	99,546	99.546	298,592
TOTAL	1,957,404	2,363,510	2,769,666	7,090,580

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Note: The bottom line, i.e. proposed total yearly expenditure, is the significant figure in that it is not likely to change. However, the distribution of funds between program elements is subject to change as evidenced in the 1984/85 approved estimates (the amounts in brackets).
Program administration costs are additional to the above and in 1984/85 will amount to approximately $185,000.

2. The Coordination Mechanism for Alcohol and Drug Services in the Northwest Territories - 1974-1984

2.1 The ADCC/RAB

The Alcohol and Drug Coordinating Council/Regional Advisory Board (ADCC/RAB) is the body which is primarily responsible for the coordination of alcohol and drug services in the NWT. As noted in Chapter 1., the ADCC/RAB is the clearinghouse for all applications for funding of local alcohol and drug programs/services from either the GNWT's Community Resource Development Grants Program or the Federal Government's NNADAP Program. Because it can approve grants from either source it (the ADCC/RAB) exerts considerable influence over the nature of alcohol and drug services developed in the Territories. The ADCC/RAB is limited in what it can do by the funds available to it annually, and, of course, by the nature of program proposals that are submitted by local groups; it has no authority to operate programs itself.

2.2 Compatibility of Territorial and Federal Program Objectives

The general objectives of the GNWT's Community Resource Development Grants Program and the

Federal NNADAP Program have been similar enough in intent, up to the present, not to create difficulty for the ADCC/RAB in its decision-making role. Depending on the outcome of the NNADAP's "Regional Needs Assessment" and what goals NNADAP sets for itself in the Northwest Territories, the two levels of government may wind up with differing goals and priorities.

For example, applying the NNAADAP national "standard" for treatment beds (please see page 21) to the population of the Territories, the target by 1988-89 would be 52 beds (compared to the 29 beds that presently exist: 15 in Yellowknife and 14 in Inuvik). Although it is recognized that treatment beds should be available in the Eastern Arctic it is questionable if a cost-effective program could be developed if the number of beds required isn't in the order of 10-12 (applying the NNADAP "standard" to the Baffin Region 6 beds would be the goal).

The ADCC/RAB certainly should be wary of developing more treatment beds than are really needed because of the heavy on-going financial cost of maintaining such facilities. For example, the GNWT contribution to the programs

of Northern Addiction Services in Yellowknife and Delta House in Inuvik (both of which are heavily oriented to residential treatment) amounted to approximately 50% of the total GNWT contributions funds available in 1983-84.

Obviously the ADCC/RAB, or whatever structure (if any) replaces it, will have to address the matter of long-range planning, so that its future decisions are related to and consistent with a broad, made-in-the-Territories plan for the development and continuance of alcohol and drug services. Although individual members of the ADCC/RAB undoubtedly have their own views on how programs/services should develop, there has been no long-range planning by the ADCC/RAB.

2.3 ADCC/RAB Structure

2.3.1 Membership (Organizations/Bodies Represented)

As will be seen from Table 3, which follows, although there have been modifications to the ADCC membership list approved by the Territorial Council in 1974, the current list continues to recognize the importance of having all of the native organizations represented.

Table 3. Alcohol and Drug Coordinating Council/Regional Advisory Board: Membership Structure, 1974 - present (1984)

	1974	1977	1980	1984
ADCC	Chairman	Chairman	(Steering Comm.) Chairman Vice Chairman	Chairman
	Indian Brotherhood (Dene Nation)	Dene Nation (3)	Dene Nation (1)	Dene Nation (1) (2 votes)
	Metis Assn.	Metis Assn. (3)	Metis Assn. (1)	Metis Assn. (1) (2 votes)
	COPE	COPE	COPE (1)	COPE (1)
	I.T.C.	(Inuit Assns.) BRIA (Baffin) KIA (Keewatin) KIA (Kitikmeot)	I.T.C. (1) Nominee from funded projects	BRIA KIA (Keewatin) KIA (Kitikmeot)
	A.A.	Member-at-large (2) A.A.		Member-at-large (AA) Member-at-large
	HWC	HWC		
	NWT Youth Council (2)	NWT Youth Council (1)		
	NWT Chamber of Commerce	NWT C of C		
	NWT Hotels Assn.			
	NWT Liquor System	NWT Liquor System		
	RCMP	RCMP		
	Chief Magistrate			
RAB	DINA	DINA		
Totals	15	20	7	9

The change that was proposed in 1977 resulted from Inuit Tapirisat of Canada having to withdraw from membership, because of other demands on its members at that time. The result was that representation from the regional Inuit asociations was sought, to ensure that the Inuit interests of those regions were adequately represented; and representation from the Dene Nation and Metis Association was increased to three each to equalize the voting power between the three native groups.

The revised membership structure remained in place only for a few meetings because of the relatively high cost of holding meetings. In its place a "steering committee" emerged: the plan was that the steering committee would meet as needed to deal with urgent matters and the total council would meet in March to make decisions concerning the bulk of the funding applications for the coming year.

Subsequently a new ADCC/RAB membership structure emerged - the one which is in place today.

It would appear from the minutes of the ADCC/RAB that there has been a lack of continuity in the seated members and there is general acknowledgment that this has limited the effectiveness of the ADCC/RAB. It is certainly difficult for a long-range point-of-view to emerge if the participants at the quarterly meetings are not the same for several meetings in a row.

Concern has also been expressed that those representing the various native organizations are from the organization's office rather than from the community or grass-roots level - the inference being that their point of view may not reflect the "community" point of view. In some instances non-native staff of organizations have represented their employers at ADCC/RAB meetings (which is odd given the fact that the ADCC/RAB is particularly desirous of obtaining the viewpoint of native residents concerning matters that are being considered).

2.3.2 Staff Support Services

From the inception of the ADCC the expectation was that the senior person in

the GNWT's Alcohol and Drug Program would serve as its Executive Secretary and that, as required, the other staff in that program would assist the Chief in helping the ADCC to fulfill its mandate.

The Executive Secretary's role was primarily to facilitate the work of the ADCC:

1. assist groups in preparing grants applications,
2. analyze and interpret applications for Council consideration,
3. organize and handle all follow-up activities for the Council,
4. provide consultation to local groups in their project implementation (on request,)
5. carry out all of the administrative arrangements necessary for the holding of meetings, including the preparation and production of minutes.

As a member of the staff of the Department of Social Services he/she is accountable to the head of that Department for the operation of the program.

The absence of staff input from the regional social services offices of the GNWT has been identified to the writer as a serious shortcoming of the present application for funding process. The need for regional involvement and for adequate alcohol and

drug staff resources at that level needs to be recognized and action taken to correct that situation.

With the advent of the NNAAP Program in 1975, the ADCC/RAB obtained some further staff support through the Regional Alcohol Consultant (who was a member of the staff of the Northwest Territories Region, Medicial Services Branch). The Regional Consultant was really only concerned with applications for funding under the NNAAP (or, since 1983-84, under NNADAP) and in providing follow-up support to projects that were funded by that program. Naturally, the Regional Consultant assisted groups in their preparation of applications, and aided the RAB in deciding which applications to support. The Regional Consultant now has two Assistant Regional Consultants on his staff to help service projects that are applying for or have received funding. The Regional Consultant is administratively responsible to the Assistant Regional Director, NWT Region, Medical Services Branch.

2.3.3 Management Committee

As a result of concerns expressed by the

ADCC/RAB about the lack of coordination between the two staff suppport groups, i.e. staff of the GNWT Alcohol and Drug Program and the HWC staff involved in the NNADAP, the two departments involved agreed to establish a Management Committee in August 1983.

This Committee was to consist of:

Chairman of the ADCC/RAB

Assistant Regional Director, NWT Region and Chief, Social Service Programs, Dept. of Social Services

Its purposes were:

(i) to provide greater coordination of alcohol and drug programs being delivered in the Northwest Territories,

(ii) to ensure maximal utilization of financial and personnel resources available from each level of government,

(iii) to ensure that staff activities are compatible with ADCC goals and priorities.

The Committee's activities were to:

(a) monitor alcohol and drug activities undertaken by both Federal and Territorial staff,

(b) coordinate project supervision undertaken by both governments,

(c) review work plans of program

staff (to be submitted by Coordinators) and to make recommendations.

It was planned to have the Management Committee meet bi-weekly (changed to monthly in September 1983) to review work plans of the two governments and coordinate activities. It was to report to each meeting of the ADCC.

In 1983 the Committee met in August, September, November and December. A review of the minutes of the Committee suggests that the overall coordination of departmental programs and financing of services improved as a result of its meetings, but there was no real indication that the coordination of the efforts of the program staff of the two departments was addressed or improved upon.

3. Alcohol and Drug Program Structures in the Provinces and Territories

3.1 Comparison of Administrative Models for the Delivery of Alcohol and Drug Services in Canada

The information which follows is based on responses to a questionnaire (see Appendix) sent to provinces and territories in Canada. Newfoundland did not respond to our request. No information was sought from Quebec because, in a major reorganization in that province several years ago, their separately identified addictions agency (OPTAT) was melded into other government departments.

1. Of the nine provinces and one territory surveyed, six had commissions or foundations. This is one less than was the case one year ago because British Columbia recently scrapped their Commission and returned the program to the Department of Health.

2. In every case where the Commission model operates, members of the Board are appointed by the Lieutenant Governor in Council (i.e. Cabinet).

3. The number of members on Boards ranged from a maximum of 11 in New Brunswick to a maximum of 20 in Ontario. The most common maximum was 15.

4. The frequency of Board meetings varied from 4 per year in Ontario to 15 per year in Manitoba.

5. All Boards had executive authority i.e. they are empowered to directly carry out programs. The director of the New Brunswick program indicated a heavy emphasis on their advisory role.

6. While the information on the returned questionnaires left some room for interpretation, of those provinces that had commission or foundation models, only two (Alberta and Manitoba) recruited their own staff. The remainder used the central service agency of their governments (Public Service Commission, etc.). Since the pattern for non-commission models in government programs is to use the facilities of a central recruiting and hiring agency, it can be safely assumed that the remaining jurisdictions operated in that manner.

7. The general pattern of those jurisdictions

reporting was to be organized on a hierarchical pattern with one Chief Executive Officer bearing overall responsibility for the agency's operation.

8. All Provincial and Territorial jurisdictions surveyed indicated that their Provincial or Territorial governments were a source of their operational funds. Ontario indicated External Research Grants and business-oriented profits as additional sources. Prince Edward Island stated that 50% of their funds came from the Federal Government. New Brunswick also indicated the Federal Government as a source of some of their funds and mentioned other sources such as donations, bequests, etc. This latter feature is not unique to the commission or foundation model. Generally speaking, however, this source does not represent a major part of the total requirement.

9. As would be expected, there is a wide variation in the size of various agency budgets. The following table also gives the budget in per capita terms.

Table 4. Provincial/Territorial Expenditures on Alcohol and Drug Programs 1983-84

Jurisdiction	Budget for Period ending in 1983	Per Capita Budget	Population est. 1-1-83
B.C.	$18,000,000	$6.43	2,800,000
*Alberta	$21,274,718	$9.09	2,340,600
*Saskatchewan	$6,500,900	$6.56	991,000
*Manitoba	$7,722,000	$8.41	1,042,500
*Ontario	$28,900,000	$3.30	8,753,600
*New Brunswick	$5,000,000	$7.08	706,300
*Nova Scotia	$5,500,000	$6.42	857,100
P.E.I.	$2,890,300	$23.38	123,600
Newfoundland	no response		575,900
Yukon	$1,101,000	$47.46	23,200
Northwest Territories	$1,399,000	$29.51	47,400

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*Commission form of Administration

Note: When interpreting these figures, the following factors should be borne in mind:

1. Population data are estimates and unofficial. Source: World Almanac 1984
2. In some cases budget figures were rounded to nearest $1000 or $100,000 by the reporting agency.
3. Different jurisdictions may quote their budget figures differently. For example, P.E.I. stated their budget was 50% from federal sources. Their budget may therefore not provide a valid comparison with other jurisdictions.

10. Capital funding needs are generally provided in all jurisdictions by the Provincial or Territorial government through a central government service department i.e. Public Works or equivalent. New Brunswick indicated that where operational funds are allocated to local groups to administer programs (i.e. a funded agency) those local groups were encouraged to arrange their own capital funding through CMHC mortgage or something similar to that. This method is fairly common in those programs that use the Funded Agency Model of delivering services.

11. In general, operational funds acquired from the public treasury are handled in a more or less standard manner. That is - deficits are not permitted. Where a program overspends its estimate, a request for additional funds (supplementary estimates) must be made. Similarly, funds unexpended at the end of the fiscal year are returned to the public treasury. The legislation setting up some Commissions or Foundations authorize corporate borrowing but this authority is rarely if ever used.

12. All jurisdictions allocate a portion of

their available funds to community groups to conduct programs. The proportion allocated to this system of service delivery varies widely from 100% in Prince Edward Island to 3% in Nova Scotia. The following table shows the percentage breakdown by jurisdiction.

British Columbia	50%
Alberta	24%
Saskatchewan	47%
Manitoba	22%
Ontario	5%
New Brunswick	5%
Nova Scotia	3%
Prince Edward Island	100%
Newfoundland	
Yukon	37%
Northwest Territories (exclusive of NNADAP)	72%

It should be noted that the percentage allocation fluctuates from year to year depending on local circumstances. The figures quoted in the above table are for 1983.

13. As criteria for eligibility for funding most jurisdictions require that the fundee (i.e. the agency seeking funding) have a legal status

(incorporation) and that they enter into a contractual arrangement of some sort in which the obligations and requirements of each of the signatories are documented.

14. All jurisdictions replying to the questionnaire reported that their mandate included the provision of services to native persons - except Prince Edward Island. Of those whose mandate included native programming, Alberta and Manitoba used the Funded Agency as a service delivery mechanism, Ontario, New Brunswick, Nova Scotia, and Yukon used direct line services and British Columbia and Saskatchewan used both. Similarly all jurisdictions reporting indicated that the NNADAP operated in their areas - except Prince Edward Island. Where the NNADAP operated, British Columbia, Alberta, Manitoba, Nova Scotia and Yukon indicated they coordinated their programs with NNADAP by having representation on the respective Regional Boards. Other jurisdictions indicated program coordination by informal liaison - except New Brunswick which indicated no coordination but some informal

liaison.

3.2 The Commission Model of Addictions Administration: Factors for Consideration Relative to Its Use

In discussing the commission model, it is important to select another possible model with which to compare it. In terms of government programs, perhaps the most useful model for this comparison is the standard government model either as a department or as a part of a department for which an elected official (i.e. a minister) assumes responsibility. While this is perhaps somewhat oversimplistic, the commission and foundation models can generally be treated as similar if not the same.

In the field of addiction programs, the trend toward the commission model began in the mid to late 1960's. Admittedly, such currently successful programs as the Addiction Research Foundation in Ontario, the Alcoholism Foundations in Manitoba, Nova Scotia and British Columbia had existed before that.

Usually the rationale for establishing a

commission is that such model removes the program sufficiently far from the normal government apparatus that decisions can be made and implemented more quickly and with less outside interference. This characteristic is usually referred to by the use of the term "autonomy". Therein, lies a potential problem and a source of conflict. When one speaks of autonomy, it is tempting to think of it in absolute terms. To act on that kind of impulse, however, is to ensure that one will ultimately be brought back to reality in a rude fashion. When one peruses the statutes (or other instruments) creating commissions and foundations in Canada, it is clear that in some cases, the legislators drafted these "terms of reference" without giving serious thought to the likely or possible consequences. In some cases the autonomy spectrum was so broad as to confer carte blanche autonomy. When it came to applying the provisions, the governments frequently were reluctant to cut the umbilical cord. This can (and does) create confusion as to who is in charge. (It is interesting to note that the present director of the British

Columbia program cites this factor as one of the reasons for that jurisdiction having repealed the Act setting up their Commission. It is his opinion that the change to a line operation within the Department of Health clarified that situation leading to a better environment within which to administer a program.)

Partial removal from the normal government apparatus does confer some benefits. To the extent that a commission has authority to make decisions, there is little doubt that those decisions can be made and implemented more quickly and with greater ease. This enables a commission to respond in a more acceptable way to local needs. Furthermore, with a commission model, it is possible to focus on the issues involved in addictions and thus raise the public profile of the programs. When it comes time to seek funding support from government this can lead to a more favorable response. When the program is an integral part of a department of government (especially a large department), its needs can be diluted in the large milieu.

In setting up a commission model, it is

important to avoid, if possible, the establishment of separate support services which are a necessary part of any operation. If care is not taken to avoid this, the proportion of available funds committed to these activities will detract from the ability to deliver useful services. Where the commission is small, the best approach is to use, wherever possible, those support services that already exist in government e.g. personnel, financial services, public works, etc. Of course, the economies of scale make it possible and - perhaps advantageous - for large agencies like the Addiction Research Foundation and AADAC to set up their own support services.

A commission model with a board of policymakers can, if the choice of board members is appropriate, provide a helpful means of getting local input in to program decisions. This is an important factor in successful administration and is more difficult to achieve when the program is an integral part of the government apparatus. Board members can be encouraged to communicate closely with interested people in their local communities and in turn articulate

their community's thinking at Board meetings when decisions are being made. Another technique that is helpful in this regard is to hold Board meetings in different communities to enable local people to learn about the commission and its programs and, if they wish, to make presentations to the Board.

Ideally, a board of a commission model should be selected with a number of factors in mind:

(a) Representation based on geography.

(b) Representation based on interest addictions.
Note: It is sometimes counter-productive to select board members on the basis that they represent an organized group because their independance can be put in jeopardy.)

(c) Representation based on major funding source. For example, if the NNADAP is a major funder, its representation on the Board may be critical.

(d) Representation based on "interested others". That is to say, it might be helpful to have representation from government departments such as Social Services, Health - and the liquor control agency.

(e) The Board could conceivably function as a Regional Advisory Board for the NNADAP.

(f) Many people feel that alcohol and drug abuse has an ethical, spiritual connotation and so a clergyman can

bring a valuable perspective.

In establishing a commission it is important to establish as clearly as possible and as early as possible, the lines of authority and the roles of the senior players. If the commission is established by a statute or similar instrument, ideally an elected member of the Executive Council or equivalent should be designated as responsible. The statute should indicate clearly where the responsibility lies for appointing members to the board, the number there shall be (frequently a minimum and maximum are indicated) and what powers the commission has to act. It is usual practice to delineate the limits of those powers sometimes by requiring such things as approval for certain actions.

Usually the board is its own master insofar as that is deemed appropriate. For example, the frequency of board meetings is usually a board prerogative. Boards may be empowered (permissive) to set up bylaws for their own internal purposes.

Boards usually have the power to engage staff to administer their affairs. The line between

policy making and executive functions should be defined as clearly as possible. The respective roles of the Board Chairman and the Chief Executive Officers must be defined. Suggested broad roles could be as follows.

Chairman

1. Provide an interface with government.
2. Guide the policy making decisions of the Board.
3. Act as the primary (but not exclusive) public spokesman for the Board.

Chief Executive Officer

1. Recommend policy initiatives to the Chairman and the Board for approval, rejection or modification.
2. Execute or implement policy approved by the Board.
3. Report regularly to the Chairman and the Board on the success or failure of policy implementation.

3.3 Other Possible Related Structures -
The Alberta Indian Health Care Commission

The Indian Health Policy, 1979 (as announced by the (then) Minister of National Health and

Welfare, The Hon. David Crombie) redefined the Federal policy with regard to Indian health. The new policy encouraged the participation of Indian Bands in health care delivery and provided for close consultation at Band, Provincial and National levels on health programs, finance and allocation of resources.

As a direct result of this change in policy, The Alberta Indian Health Care Commission was incorporated on October 30, 1981, under Part II of the Canadian Corporations Act. The Commission functions under the direction of Chiefs and Councils in Alberta.

The A.I.H.C.C. receives its operational core funding under a contribution agreement with Medical Services Branch, Health and Welfare Canada. The Commission has described its relationship with M.S.B. as: "That the A.I.H.C.C. would [illegible] education objectives and priorities for Indian health care in Alberta and would [illegible] the Federal Government on Indian [illegible] issues; and would offer direct [illegible] administrative and [illegible]".

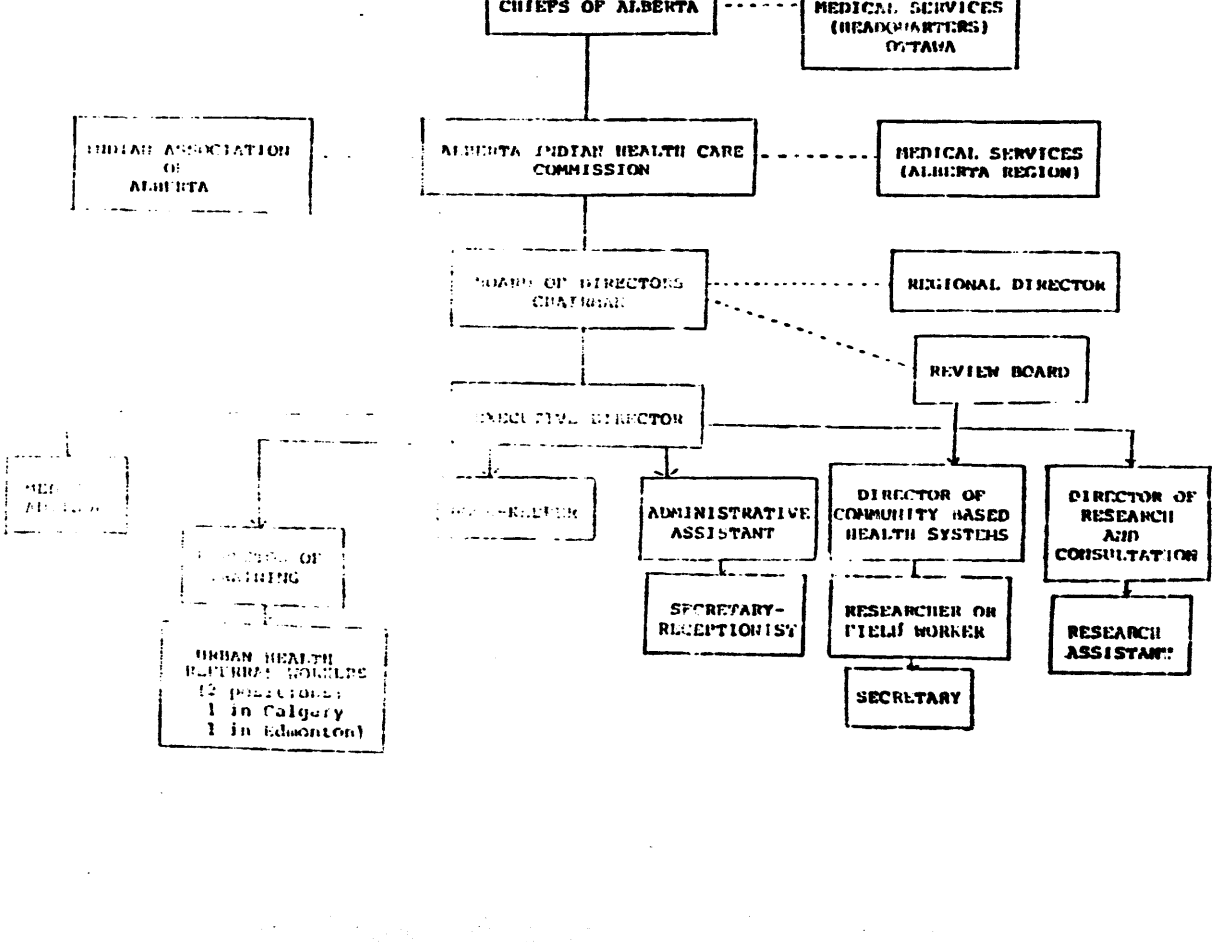
The objectives of the Commission appear in Appendix A. The Commission's concern about alcohol and drug abuse appears in clause (a): "To conceptualize and implement an Indian type of health care that emphasizes mental and physical health and more particularly prevention and treatment of alcohol and drug abuse." This interest also appears in clause (h): "To monitor and assist the full range of physical facilities, both on and off the reserves, (hospital, clinics, nursing stations, residence, alcohol and drug abuse training and rehabilitation centres, etc.)".

The organizational chart of the Commission outlines the internal relationship between staff as well as the broader relationship the Commission has with the Indian community at large. (Please see page 50 for this organizational chart.)

Although the A.I.H.C.C. has an interest in the NNADAP Program, because of the impact of alcohol and drugs on the health of Indians, the A.I.H.C.C. is not directly involved with, nor does it have a representative on the NNADAP

ALBERTA INDIAN HEALTH CARE
CONVENTION

ORGANIZATIONAL CHART



Regional Advisory Board (for Alberta Region). (Please see page 52 for the NNADAP (Alberta Region) Regional Advisory Board Organization Structure.)

3.4 Acquisition and Allocation of Financial Resources

It is a well-recognized fact that in the addictions field, even in the most generously endowed programs, there is rarely, if ever, sufficient financial resources to deal adequately with the virtually limitless range of issues that are part and parcel of the addictions phenomenon. At the same time it is not always possible to guarantee positive results proportionate to the amount of money that is put into the program. The major challenge is how to get the greatest return for the dollars invested.

How can this be achieved? There are several alternatives that can be considered and applied according to local circumstances.

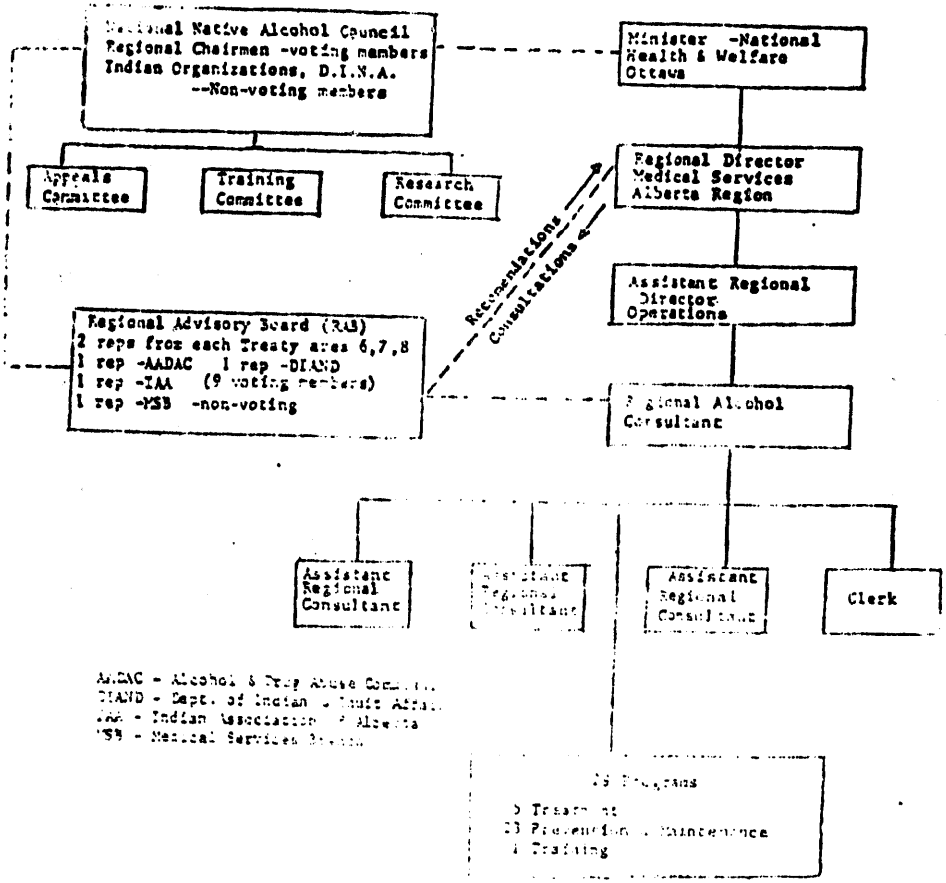
3.4.1 Limit the Program Objective and Focus

Because of the nature of the addiction

NATIONAL NATIVE ALCOHOL AND DRUG ABUSE PROGRAM (NNADAP)

ORGANIZATION STRUCTURE

ALBERTA REGION



phenomenon, the consequences of it tend to show up across a very wide range of human endeavors. For example, it can be identified as occuring in common with such other things as health problems (e.g. liver cirrhosis, cardiovascular disease, etc.), welfare rolls, marriage breakdown, traffic accidents, suicides, absenteeism in the work place, low productivity - and the list goes on. It is tempting - indeed there appears at times to be a public expectation - to address all these problems. Similarly, the conventional wisdom in the 1960's and 1970's was that program mandates should address three separate but related areas namely treatment, research and prevention. It is questionable that even with unlimited resources, any one agency can develop competence and strategies across such a broad front.

It is clear that Alcoholics Anonymous has a record of success that compares favorably with most programs. It is reasonable to conclude that a significant factor contributing to that success is the

program's single mindedness of purpose. It's concern is with the suffering alcoholic.

The Addiction Research Foundation of Ontario is universally regarded as one of the finest research agencies in the world in the field of addictions. As a matter of fact, it is one of the few agencies "accredited" by the World Health Organization. Once again, its primary focus is research and to the extent that it is involved in other areas, it does so to serve its research function. It is rare that one can be all things to all persons. It is important, however, when defining the limits of the focus, to do what is possible to encourage other areas of expertise and competence to become active in other areas. This implies liaison and coordination which are both important factors. However, by limiting the focus, one has a better chance to apply the available resources in an intense way.

3.4.2 Use of Local Resources

In the post-war period in particular, there has been a dramatic trend toward centralizing

government to do things on a broader and broader scale on behalf of the citizenry. In many respects this has produced positive results. However, while collective action through government is useful, one must remember that government has limitations on what it can do on our behalf. In many cases, more satisfactory outcomes can occur through local initiatives and the use of local resources. Frequently such initiatives minimize or perhaps eliminate the demands on program financial resources. In the field of alcoholism, the fellowship of Alcoholics Anonymous is perhaps an outstanding example of this dynamic at work. The A.A. program is credited with helping thousands - indeed millions of people throughout the world - to achieve sobriety and stability in their own lives and it has achieved this without any demand on the public treasury. Formal addictions programs can help their own cause by encouraging, promoting and assisting such local self-help initiatives. In this respect, it is appropriate to speculate on whether or not Bill and Bob (the gentlemen

credited with starting the A.A. fellowship) would have been inclined to conceive of and develop their program if they had been able at that time to use the facilities of the extensive network of publicly funded programs now available throughout the land.

An important parameter of the concept of making use of local resources is related to the method of service delivery. In general terms, it is possible to conceive of services delivery taking one or both of two forms:

(a) Direct line, where the agency employs the staff in a traditional hierarchical, authoritarian relationship, and

(b) a grant-in-aid system whereby funds are made available to local groups provided that certain requirements are met and a contractual arrangement is entered into.

Experience in most jurisdictions has shown that the grant-in-aid (Funded Agencies) system is the least expensive. In addition, it gives the local community a stake in its own program and enhances the possibilities of making use of local resources. This

system presents unique administrative issues that require close attention especially in communities that are not well developed.

3.4.3 Choices of Treatment Services Facilities

As treatment programs developed in the field of Addictions, they tended to follow some of the patterns in the health field. This was likely to be expected considering the acceptance of the disease concept of alcoholism. As one would expect both positive and negative consequences resulted.

One questionable development was the tendency to be pre-occupied with the availability of beds. This, of course, carried with it the connotation of so-called residential, in-patient services. While there is no doubt that residential, in-patient facilities are required as a part of the mix, there is also little doubt that residential services are expensive to maintain. This raises the question of how and where limited resources should be committed. One need look no further than the debate going on in the health industry about

hospital beds and the cost of maintaining such a system. Not every candidate for treatment needs to be admitted to a residential facility. In fact, some candidates do better in an out-patient setting. In the interests of accommodating limited financial resources administrators must insist proof of their need before approving in-patient facilities and once approved, insist on proper use of them.

4. The Future Administration of Alcohol and Drug Programs in the Northwest Territories

4.1 Basic Considerations

In addressing the question of how alcohol and drug services should be administered in the future there are a number of factors peculiar to the Territories which must be considered. Regardless of which administrative option is chosen these basic considerations will have to be addressed.

4.1.1 The Need to Integrate Territorial and Federal Initiatives in Alcohol and Drug Programming

It will be evident from the preceding chapters that, in reality, there are two alcohol and drug programs in the Territories - one funded by the GNWT and the other, NNADAP, funded by the Federal Government.

The Territorial program is accountable to the Legislative Assembly; NNADAP is accountable (ultimately) to Parliament. The

Territorial program is available to all residents of the Territories; NNADAP is directed toward status Indians and Inuit (as one of the Federal Government's residual obligations to status natives). (It is acknowledged that in the Territories NNADAP has funded community projects without requiring that the services funded be available only to persons of status - because that distinction simply is not relevant in most Territorial communities.)

Although the ADCC/RAB has been able to effect a degree of coordination and integration between the two programs over the years, its mandate continues to be to provide advice rather than give administrative direction. It remains with the Territorial Government and the Federal Government to decide whether this mandate should be changed and, if so, in what ways.

Before the Federal Government could consider moving out of program administration it would have to determine whether status Indians and Inuit were agreeable to such action. Possibly the situation could arise

where some regions of the Territories might request the Federal Government to integrate NNADAP with the Territorial Alcohol and Drug Program and have it administered Territorially, where other regions might prefer some other arrangement.

Where program integration is concerned, it would not be logical to have the Territorial Government transfer its Alcohol and Drug Program to the Federal Government because that would be inconsistent with what has happened since the late 60's with respect to the Territories' involvement in the delivery of "provincial-type" program responsibilities.

4.1.2. Level of Program Funding and Degree of Flexibility in Using the Funds Available

Program funding has been a continuing concern of the ADCC/RAB, particularly in trying to ensure that there will always be some funds available to respond to 'first-time' community requests. The ADCC/RAB has always felt constrained in the use of program dollars, both Territorial and Federal, because funds that have been

approved for 'contributions' (i.e. accountable funds for community projects) cannot readily be used to meet other needs within a given fiscal year, e.g. training.

Because of its initial time-frame, NNADAP funding was established for a three-year period (please see Table 2, page 23). (1) The GNWT, on the other hand, has never made a long-term commitment on the funding of the Territorial Alcohol and Drug Program. Table 5, page 73, provides an historical perspective on the funding of this program. This table also provides an historical perspective on net profits in the NWT Liquor System during the same period (1972-1984). It will be seen that alcohol and drug program costs, as a percentage of net liquor profits, have ranged from 2.7% to 20.3%, with the average being 13.1%.

If the GNWT decided it wanted to dedicate a percentage of its annual liquor profits to

.....

(1) Prior to 1983-84 the Federal budget for native alcohol and drug programs was prepared on a national rather than provincial/territorial basis.

fund its alcohol and drug program, it could only do so if it received concurrence from the Federal Government in the course of negotiating the amount of its annual deficit grant from the Federal Government.

The GNWT can decide its own priorities for program expenditures, but the Federal Government plays a major role in determining how much money the Territorial Government will have available to operate ALL of its programs.

If the Federal Government were to integrate NNADAP with the Territorial Alcohol and Drug Program, logically the funds now in the Federal program should be transferred to the Territorial Government, perhaps with the condition that the Territorial Government's financial input into that program not diminish from its present level.

4.1.3 Staff Support Systems for the ADCC/RAB

The ADCC/RAB has always had the expectation that the role of its Executive Secretary would be filled by the senior person in the Territorial Alcohol and Drug Program. It

also has expected that when new program funding requests were received staff from either the Territorial or Federal programs would meet with the people involved to ensure that their request was well-documented and precise concerning what it might achieve. There was also an expectation that projects-in-progress would be visited during the year so that the project staff could receive the kind of help they needed with administrative and program requirements and so that recommendations could be made on any requests for continuing funding. There was also an expectation that the training needs of project staff would be arranged for. For several reasons these expectations have never been fully met.

Where the Executive Secretary and the ADCC/RAB are concerned, there is a need to clarify what is expected of the Executive Secretary - in the day-to-day affairs of the ADCC/RAB and in assisting the ADCC/RAB to address some of the broader issues that interface with the alcohol and drug program.

The Executive Secretary has had limited

staff support capabilities over the years: two, and now three positions in headquarters, and usually a limited travel budget. Although the NNADAP staff (a regional consultant and two assistants) try to meet the administrative and support needs of the projects funded by that program, they are in no way accountable to the Executive Secretary nor are they expected to accept direction from that person.

One of the most serious deficiencies is the non-availability of support staff at the regional level - to provide readily-accessible administrative, program and training support to project boards and staff. Although some of these needs have been met by the staff of the Territorial Alcohol and Drug Program or of NNADAP the fact that these staff are headquartered in Yellowknife means that their effectiveness is hampered. There is a well-recognized need for knowledgeable, well-qualified staff at the regional level to ensure that projects get the kind of help they need and that the ADCC/RAB gets the kind of feedback or

information it needs to make decisions.

If regional 'boards' are ever established these regional positions could possibly be adapted to fill the executive secretarial requirements of those 'boards'.

Some of these regional positions possibly could be created using existing positions within the GNWT program or the NNADAP (if that program's administration were transferred to the GNWT), but the actual number of new positions required could only be determined after decisions are taken about the future scope of the program.

4.1.4 Representation on the ADCC/RAB

Any board that is to be responsible for developing alcohol and drug program policies must be representative of the people it serves. The present structure, with representation from the three Inuit Regional Associations, C.O.P.E., the Dene Nation (2 votes), the Metis Association (2 votes) and two members-at-large, plus the chairman, seems to be an optimum number. Although some other groups would like to be seated (such

as the NWT Native Women's Association) it is difficult to rationalize expanding the membership list beyond the present organizations represented without the board becoming unwieldly in size (as it was in 1977).

Organizational representatives should be selected on the basis of the contribution they can make to the ADCC/RAB. The goal has been to have a good ethnic mix on the ADCC/RAB, but this has not always been the case because non-native staff have represented native associations from time to time.

The ADCC/RAB should consider developing a 'conflict of interest' code, recognizing that persons who are seated on it may be connected with projects which are requesting funding (either as paid staff or board members) and they should hardly be voting on or influencing decisions respecting the funding of their own projects.

4.1.5 Establishment of Program Priorities

The "problem statement" and "needs

assessment" which are currently in progress are intended to establish priorities for NNADAP in the N.W.T. Because the NNADAP has divided its expenditures into three major categories, prevention, treatment and training (each of which has been assigned specific national objectives, (see page 21) the needs assessment will undoubtedly reflect those categories and standards. Whether the ADCC/RAB will see these as valid for the Northwest Territories has yet to be determined,

4.1.6 Linkage Between Community Projects and Municipal Government

Given the problems some projects have had in the past managing their financial affairs there would be merit in encouraging project committees to contract with their municipal council for bookeeping and administrative support services in order to draw on the skills/knowledge available in the municipal office. This would be particularly valid in the smaller communities where these specialized administrative skills are often at a premium.

In the smaller communities having a direct linkage between the alcohol and drug project and the municipal council might help to focus community attention on improving community lifestyles and counteracting the negative impact of alcohol and drug misuse. It might also help communities to give better focus to their use of grants that they receive for recreational purposes (and thereby eliminate or minimize the need for "diversionary" types of alcohol projects, freeing up dollars for counselling and other treatment-oriented projects).

Local government is much more sophisticated and responsible than it was when the Territorial alcohol grants program began in 1972 and the current programs should take advantage of that situation. In 1972 there were only 13 incorporated municipalities in the NWT (9 hamlets, 3 towns and 1 city); today there are 36 incorporated municipalities (29 hamlets, 1 village, 5 towns and 1 city).

4.1.7 Compatability of Proposed Administrative Structure With Current Trends in the

Delegation of Responsibility for Program Delivery

It is essential that any proposed structure for the administration of alcohol and drug services in the Territories recognize the fact that there is a trend in place to delegate responsibility to regional or local levels for the operation of programs. Indeed, the use of local funded agencies has been an integral part of alcohol and drug services in the Territories for many years.

Another example is the contractual arrangements between the Department of Social Services and the Town of Frobisher Bay whereby the town has delivered social services in that community for several years now.

In December 1982 Health and Welfare Canada contracted with the GNWT for the Territories to operate the Frobisher Bay General Hospital. The hospital is being operated by a Regional Board of Management. Recently discussions were begun concerning a similar contractual arrangement for the operation of

the nursing stations in Baffin Region.

The Territories' Regional and Tribal Council Ordinance, which was given Assent on September 10, 1983, gives these councils the power to "...establish a regional board of management to administer those programs in or about the region delegated from time to time by the government of the Northwest Territories".

A recent alcohol and drug training seminar in Churchill, which involved board and staff representatives from all of the funded projects in the Territories, by resolution, pressed for a greater recognition of the regions in the future administration of alcohol and drug programs in the Territories.

4.1.8 Mandate

The mandate of the NWT Alcohol and Drug Coordinating Council/Regional Advisory Board over the years can be summarized as follows:

(i) to serve in an advisory capacity to the Legislative Assembly in policy and program matters related to alcohol and drug concerns, and,

(ii) to carefully assess all funding

requests for alcohol and drug projects received for its consideration and

(a) to decide which projects will be funded (and in what amount) from Territorial sources, and

(b) to recommend to the Regional Director, NWT Region, Medical Services Branch, which projects should be funded (and in what amount) from NNADAP.

These terms of reference still appear to be valid. However if a decision is taken to change the Coordinating Council to a commission-type of operation significant changes will be required to this mandate.

In the event that regional councils or other regional bodies are given responsibilities in the alcohol and drug area modifications will also be needed in the mandate of the Territorial Coordinating Council (if it continues to function).

Table 5. NWT Liquor System Net Income and GNWT Alcohol and Drug Program Expenditures 1971 - 1984

Year	(1) NWT Liquor System Net Income	% Inc.	(2) Alcohol and Drug Program Expenditure	% Inc.	(2) as % of (1
[illegible]	2,401,000	...	64,800	...	2.7
1972	2,817,000	17.3	181,000	279.	6.4
[illegible]73	3,295,000	17	238,000	31.5	7.2
19[illegible]4	3,752,000	13.9	401,000	68.5	10.7
[illegible]5	4,298,000	14.6	418,000	4.2	9.7
1976	4,478,000	4.2	582,000	39.2	13.0
1977	4,428,000	(1.1)	900,000	54.6	20.3
[illegible]78	4,419,000	(.2)	800,000	(11.1)	18.1
1979	5,426,000	22.8	938,000	17.3	17.3
1980	6,029,000	11.1	1,117,000	19.1	18.5
1981	7,398,000	22.7	1,308,000	17.1	17.7
1982	8,304,000	12.2	1,120,000	(14.4)	13.5
1983	9,083,000	9.4	1,399,000	24.9	15.4
1984			1,564,000 (3)	11.8	

.....

Sources: (1) GNWT Annual Reports
(2) Department of Social Services
(3) 1984/85 Approved Estimates

4.2 Alternatives for Consideration

4.2.1 Integration of the Administrative Staffs of the Two Alcohol and Drug Programs in the Territories

It is unfortunate that when the NNAAP was introduced in the Territories in 1975 and the ADCC became the Regional Advisory Board for it that a contractual arrangement was not made to have the GNWT provide all of the program staff support services (the GNWT undertook to provide the Executive Secretary for the ADCC/RAB). Had this been done it would not have been necessary for Northwest Territories Region, Medical Services Branch, to hire its own staff and thereby set up the dual program administration that exists today.

On the basis of our review of the current situation, this dual administration is the problem which needs most to be resolved if alcohol and drug services are to develop more effectively in the Territories and have the confidence of the funded projects.

In our view, the logical arrangement at this time would be for the GNWT to:

(a) undertake to provide all of the kinds of staff support the ADCC/RAB requires, and

(b) provide the kind of program, administrative and training support the local projects require.

It is proposed that the GNWT do this on behalf of its own program and, by contractual arrangement, on behalf of NNADAP. If NNADAP had other specific requirements that it wanted fulfilled these could also be covered in the contract.

This type of contractual arrangement would be similar in many respects to the one now in place for the operation of the Baffin Regional Hospital.

Under this type of arranagement HWC would retain control of the funds in its NNADAP budget and the Regional Director, Northwest Territories Region would still be the person to approve expenditures under that program that were recommended by the ADCC/RAB.

4.2.2 Restructuring the GNWT's Alcohol and Drug Program Administration

As a corollary to the proposed integration of program administration it is our view that the Department of Social Services should be given the resources necessary to augment its staff. It is particularly desirable that positions be established within the DSS in each of the five regions because it is at that level the greatest gap in service exists.

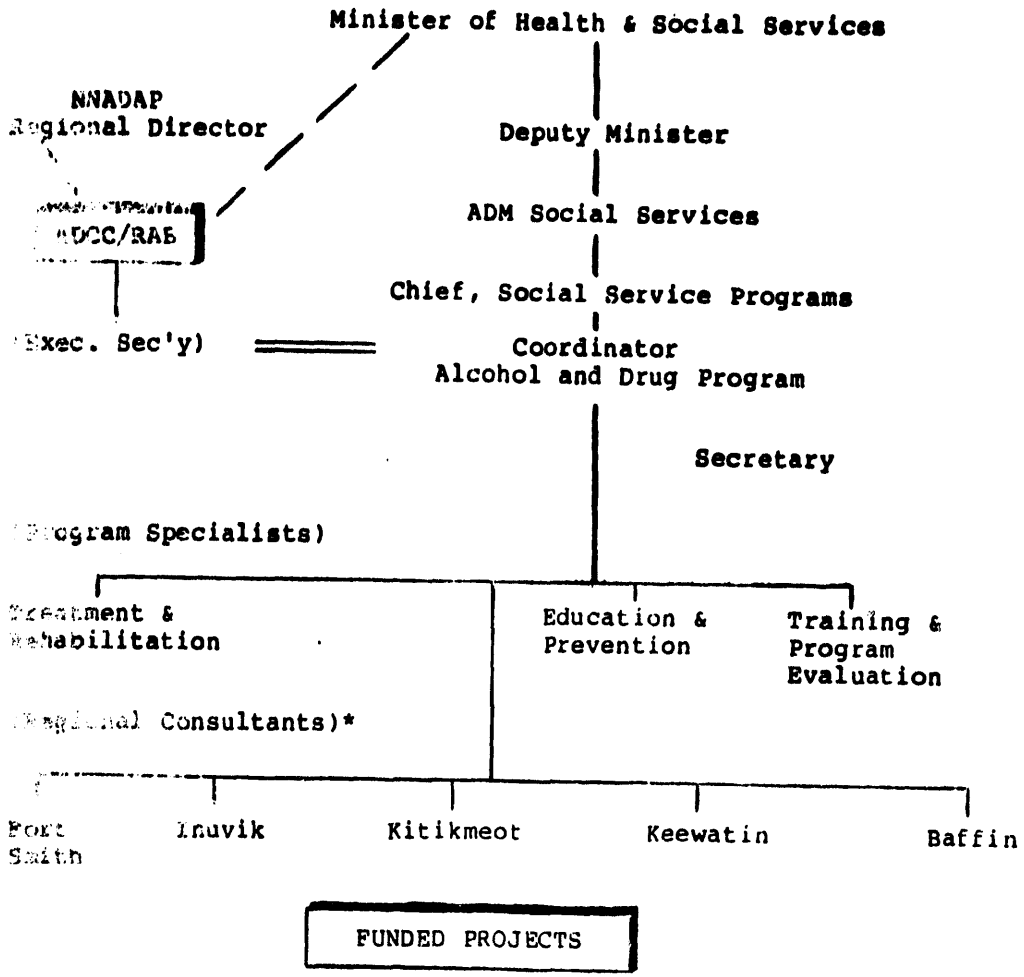
Figure 1, which appears on page 78, provides a suggested organization for the Alcohol and Drug Program. It should be noted that this type of administrative structure will be needed regardless of whether any changes are made to the mandate of the ADCC/RAB (such as it becoming an independent commission). Of course, the Department would need to examine the competencies of its present staff to see where they could most effectively function in this revised structure.

4.2.3 Broad Agreement Between HWC and GNWT to Integrate NNADAP with the Territorial Alcohol and Drug Program

As acknowledged elsewhere, HWC could only consider entering into a broad umbrella-type agreement with the GNWT for the total operation of NNADAP in the Territories if HWC had a clear indication from status Indians and Inuit that it should do so. It would appear that there are an increasing number of status persons who feel it would be in the best interests of everyone to have NNADAP combined with the GNWT Alcohol and Drug Program for their more effective operation in the Territories.

In developing such an agreement both parties could consider incorporating such special requirements as they felt were necessary (for example, the standards which should be used in trying to measure the effectiveness of the services funded).

Figure 1. Proposed Administrative Structure for the GNWT Alcohol and Drug Program



* regional consultants would be an integral part of DSS regional staff in this administrative structure

In the event that not all regions were in agreement with HWC contracting-out the operation of NNADAP, then the agreement between the HWC and the GNWT could cover only those regions that had indicated their desire to have this happen. In that event, NNADAP funds could be reserved for the regions on a per capita or some other equitable basis.

4.2.4 Establishing an 'Autonomous' Commission

When ths study was contracted, the ADCC/RAB members indicated that one of the options they wanted to examine specifically was that of an 'autonomous' commission (such as exists in several of the provinces).

In Chapter 3 a summation has been given of how alcohol and drug programs are delivered in most provinces and territories. However, the question of whether a commission-type structure would be appropriate for the Northwest Territories was not addressed.

The steps necessary to achieving an autonomous commission-type of operation would be:

1. As implied in Section 4.1.1, the Federal Government would likely only consider making a change if there was strong indication that status Indians and Inuit wanted this to happen.

2. Assuming that such a request was made and accepted, the Federal Government would then have to decide:

   (a) what kind of financial committment it would make, i.e. dollars annually and for how many years,

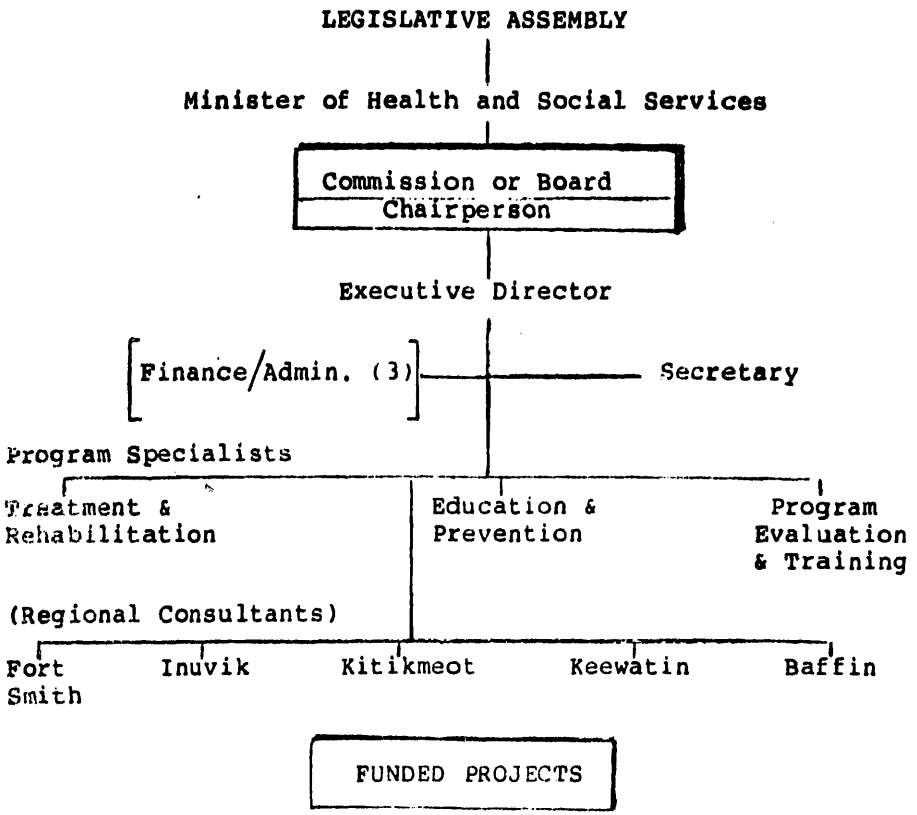
   (b) what conditions it would expect to be met (in return for this financial commitment).

3. The Legislative Assembly would have to decide whether it agreed with the Commission model of program administration and

   (a) what its financial commitment to the program would be, and for how many years, and

   (b) what conditions it would expect to be met (in return for its financial

Figure 2. Proposed Organization for an NWT Alcohol and Drug Abuse Commission



chairperson's position is much like that of a deputy minister in that he/she reports directly to a minister.

4.2.5 Financial Implications

The financial implications of setting up such a commission would depend largely on what assumptions are made concerning such things as board size, number of meetings annually, the amount of honoraria to be paid and the amount of time the chairperson would have to devote to commission affairs beyond board meetings.

It it is assumed that the commission will have the same number of board members as at present, that it will meet quarterly, that the per diem rates for members will not change, the only additional board-related costs would be the additional per diem payments to the chairperson because of the additional time he/she devotes to commission business (assuming this to be in the order of ten days per month, the additional requirement would be 10 x 12 x $150 =

$18,000).

The additional administration costs incurred by the commission would depend on a couple of factors:

(a) whether Social Services finance and administration services would be available to it at headquarters (if not it could cost in the order of $100,000 to provide these services), and

(b) whether clerical services for the regional consultants could be arranged at the regional office level at no cost to the program (if not the additional cost could be in the order of $100,000.)

4.2.6 Absence of linkage between the Commission and Regional Administration

The greatest shortcoming in the application of the commission model in the Territories is that it would create a program entity at the regional level which is administratively unrelated to anything else at that level. In

Figure 2 the 'regional consultants' are not linked with any of the existing programs at the regional level, even though they will be dealing with most of the same people in the same communities. On the other hand, Figure 1, because a departmental-type structure is outlined, the regional consultant would be an integral part of DSS regional staff and could expect to receive administrative, secretarial and financial support services from those offices. Because they are part of the DSS there should be greater likelihood of their efforts being coordinated with the efforts of other DSS staff. Alcohol misuse impacts on most other DSS programs so this intra-departmental coordination is particularly critical.

APPENDIX A

ALBERTA INDIAN HEALTH CARE COMMISSION

REVISED OBJECTS OF THE COMMISSION

Indian Health Care is a treaty right and the sole responsibility of the Federal Government to fund and deliver. Without prejudice to any treaty or aboriginal rights of Indians, the Indian Chiefs in Alberta have instructed us as a means to improve the health of the Indian people of Alberta that the Alberta Indian Health Care Commission be incorporated as a non-profit, non-political corporation.

THE OBJECTIVES OF THE COMMISSION ARE:

a. To conceptualize and implement an Indian type of health care that emphasizes mental and physical health and more particularly prevention and treatment of alcohol and drug abuse.

b. To carry on research and planning activities aimed at:

   i. Helping local Indian Health authorities to effectively deliver and improve health services.

ii. Develop a system of health care program evaluation that is appropriate to both the Alberta Indian Health Care Commission and local Indian Health authorities.

c. To collaborate with Alberta Professional Health Care Association and Societies to improve Indian Health standards.

d. To promote and assist in the establishment of local reserve, district or regional Indian Health Care Council or Boards: to provide technical support and staff training.

e. To develop a year to year financial plan as required by Bands by:

i. Monitoring the needed operational and capital requirements of Bands.

ii. Negotiating funding agreements as required between Alberta Indian Health Care Commission and the Federal and Provincial Governments and private Health Care organizations.

f. To monitor, plan, develop health care programs, policy and services focusing on:

i. Phase I - Education (in school and adult educational)and developmental and;

ii. Phase II - Community health programs aimed at improving the quality of Indian

environments for living.

g. To monitor, plan and make recommendations where necessary for a full range of Indian health care including:

   i. Universal Programs:
      - Full medical care
      - Hospitalization of all types

   ii. Special Needs
      - Ambulance and other medical transport
      - Dental
      - Optometric
      - Prescription Drugs
      - Home Care

   iii. Compensatory/Treaty Rights:
      - Any other needed or specialized health services

h. To monitor and assist the full range of physical facilities, both on and off the reserves, (hospital, clinics, nursing stations, residence, alcohol and drug abuse training and rehabilitation centres, etc.)

i. Develop and administer health care appeal procedure that meets the needs of all Indian clients both on and off Reserves.

j. To act as a resource centre for information relating to Indian Health Care in Alberta.

Rec'd Apr. 2/84.

#204 - 4559 - 32 Avenue
EDMONTON, Alberta
T6L 5N6

March 26, 1984

Winnie Fraser-McKie
Director
Government of the Northwest Territories
Department of Social Services
YELLOWKNIFE, N.W.T.

Enclosed is my personal resume, please accept it as an application for employment.

I am interested in obtaining employment in the north. I have spent considerable time working with various oil exploration companies in many areas of the N.W.T. and the Yukon and I am very interested in returning.

References available upon request.

Thank you in advance for considering my application.

Sincerely

W.A. Geddes

W.A. Geddes

encl

GEDDES WILLIAM ALTON

#204 - 4559 - 32 Avenue
EDMONTON, Alberta
T6L 5N6
Phone:461-58[illegible]

CAREER OBJECTIVE

Social Services Technician - I would like to work in the Social Services field.

EDUCATION

Social Services Worker Diploma - Grant MacEwan Community College - April 1984

RELATED EXPERIENCE

Practicum (1982-84)

Student Counsellor for day parolees two days a week from September 1982 to April 1983 at Grierson Centre - 9542 - 101 A Avenue, Edmonton, Alberta (420-3361)

Summer employment as a student counsellor for day parolees from May 1983 to August 1983 at Grierson Centre.

[illegible] participation in group sessions two days a week from September 1983 to April 1984 at Life Skills Training School - #203 - 11751 - 95 Street, Edmonton, Alberta (477-9174)

EMPLOYMENT HISTORY

Journeyman Automotive Mechanic - Norwest Automotive Services Ltd., 15935 - 118 Avenue, Edmonton, Alberta [illegible]-1398) - from 07-12-77 to 27-08-82

...2

Journeyman Automotive Mechanic - V.S. Automotive Ltd., 12530 - 128 Street, Edmonton, Alberta - 1977

Journeyman Automotive Mechanic - Northlands Service Stations Ltd., 11808 - 66 Street, Edmonton, Alberta - 1976

L.A.C. Royal Canadian Air Force for five years - 1959 - 1965

OTHERS

C.P.R. course last summer while working at Grierson Centre.

Volunteered to drive young men to Alcoholics Anonymous meetings while at Grierson Centre.

Automotive Air Conditioning and Air Brake Course at Northern Alberta Technical School - 1980

1. Under what authority does your agency operate?

- ☐ A special statute (Act) of your provincial legislature.
- ☐ Incorporation under an "omnibus" statute (Act) of your provincial legislature (e.g. A Societies Act).
- ☐ By authority of a Minister of the Crown who has been empowered to exercise such authority.
- ☐ Other (Describe briefly)

Further Comments:

Note: A copy of your authorization document would be helpful and appreciated.

2. Does your agency receive policy direction from

- ☐ A Minister of the Crown or
- ☐ A Board of Directors (commissioners, etc.) or
- ☐ Other (Describe briefly)

Further Comments:

3. If the answer to question 2 is "A Board of Directors"

- How many members are on such Board?
- By whom are the members appointed?
- How often does the Board meet?
- Does the Board have "Executive Authority"? i.e. Does it have authority to conduct programs on its own or is it primarily advisory.

☐ Executive

☐ Advisory

☐ Both Executive and Advisory

Further Comments:

4. If your agency has a Board of Directors and if that Board has Executive authority

- Does it recruit and employ the agency's staff

  ☐ Yes

  ☐ No

- If "yes" how does the staff relate to the policy maker(s)?

  ☐ In a hierarchical pattern through a Chief Executive Officer (President, Executive Director, etc.)

  ☐ To a Committee of policy makers?

  ☐ Other (Describe briefly)

Further Comments:

5. From what source(s) do you acquire your operational funds?

- ☐ Provincial Government allocation
- ☐ Federal Government allocation
- ☐ Other sources (Describe briefly)

Further Comments:

6. What was the size of your operating budget for the fiscal period ending in 1982

1983

7. Do you require capital funds? (e.g. buildings, etc.) If so, what is the source of such funds?

8. How are surpluses and/or deficits handled at the end of your fiscal period?

9. In general terms there are two ways of allocating funds to program activities. One is to deliver the services as a "straight line" function employing agency staff. The other is to provide funds for other groups to conduct programs. Please indicate which of these are used by your agency.

- ☐ Direct line delivery
- ☐ Funded agency delivery
- ☐ Both
- ☐ Other (Describe briefly)

Further Comments:

10. If both methods of service delivery are used by your agency, please indicate in percentage terms the proportion of your budget allocated to each.

1982 - Direct line delivery ___%
- Funded agency delivery ___%

1983 - Direct line delivery ___%
- Funded agency delivery ___%

Further Comments:

11. Where funds are allocated both to Direct line delivery and to Funded agency delivery what criteria are used in deciding the relative allocations?

- [ ] A percentage of total funds available
- [ ] A priority on Funded agency delivery with Direct line delivery receiving the residue
- [ ] A priority on Direct line delivery with Funded agency delivery receiving the residue
- [ ] Other (Describe briefly)

Further Comments:

12. What criteria is an agency required to meet in order to qualify for funding from you?

- ☐ Incorporation as a legal entity
- ☐ Enter into a contract (If so please include copy)
- ☐ Other (Describe briefly)

Further Comments:

13. Does your agency's mandate include programming for persons of "Native Ancestry"?

☐ Yes

☐ No

Further Comments:

If the answer to question 13 is "yes", how is the mandate met?

- ☐ Special emphasis within a "direct line delivery"
- ☐ Provision of funding to groups of persons of "Native Ancestry" to conduct and staff their own programs.
- ☐ Both of the above
- ☐ Other (Describe briefly)

Further Comments:

15. Does the National Native Alcohol and Drug Addiction Program operate in your jurisdiction?

- [ ] Yes
- [ ] No

16. If the answer to question 15 is "yes", do you co-ordinate your planning and program development with the N.N.A.D.A.P.?

- [ ] Yes
- [ ] No

17. If the answer to question 16 is "yes", how is such co-ordination achieved.

- ☐ Use of a liaison or co-ordinating committee.
- ☐ Representation on the Regional Board of N.N.A.D.A.P.
- ☐ Other (Describe briefly)

Further Comments: