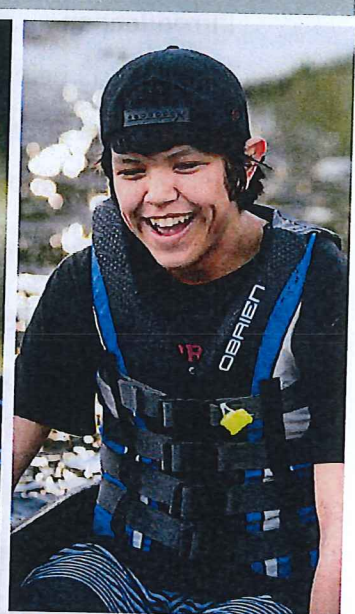




First Nations Health Authority  
Health through wellness

# Community-Based Reporting Template 2015-2016



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## General Instructions

### Introduction

This Community-based Reporting Template was designed to support the work of Health Funding Agreement recipients in meeting the reporting requirements of their Agreements.

**As you complete each section of this template, be sure to use the supporting resource, *Community-based Reporting: A Guide for BC First Nations Health Service Providers*. The Guide provides detailed instructions, definitions, examples of answers, and lists of acronyms to assist you in completing the Reporting Template. For assistance, please contact us at [fnha.reports@fnha.ca](mailto:fnha.reports@fnha.ca).**

### Before You Begin...

- This template is for reporting on performance of health programs and services. This template is **not** for reporting financial and audit information. For information on financial and audit reporting requirements, refer to your Health Funding Agreement.
- Collection and analysis of program performance information should be on-going to support your program management and reviews, and in order to submit the completed Community-based Reporting Template by the due date specified in your Health Funding Agreement.
- Performance reporting using this Community-based Reporting Template is required for all types of funding models.
- For a multi-community Agreement, the recipient will complete a separate Community-based Reporting Template for each community under its Agreement.
- This template consists of three parts. You must complete all three parts:
  - 1) Identification Information
  - 2) Common Information, and
  - 3) Program Component Reporting.
- When completing questions that require numbers as answers, be sure to enter "0" when the answer is none. Do not leave any answers blank. In cases where the response for all questions in a table is "0", write "All entries are zero" once at the top of the table.
- Your responses to certain questions will require more space than provided in the template. **Where necessary, use another sheet of paper.** Be sure to label them with the question number and submit them as part of your completed template.
- Submit your completed template to the First Nations Health Authority by the due date stated in your Health Funding Agreement.

## Other Types of Program Reporting

Programs that currently report to First Nations Health Authority using other tools, processes and/or electronic systems such as the HCC e-SDRT and e-HRTT, and COHI dental database are required to continue to input into these processes and systems within the agreed upon time frames, in addition to answering the related questions in this template.

The programs listed below are not reported through this template. If you deliver any of the following programs, refer to your Health Funding Agreement for the reporting requirements.

- Mandatory reporting on Public Health
- First Nations Health Benefits Program
- Indian Residential Schools Resolution Health Support Program
- Environmental Health Research projects
- Aboriginal Health Human Resource Initiative
- National Native Alcohol and Drug Abuse Program - Residential Treatment
- Youth Solvent Abuse Treatment Centre Program
- e-Health Infostructure
- Health Services Integration Fund, and
- Health Facilities and Capital Program.

**If you would like more information, please contact the First Nations Health Authority: [fnha.reports@fnha.ca](mailto:fnha.reports@fnha.ca).**

## Part 1 – Identification Information

**Part 1 is mandatory.** Provide the Health Funding Agreement number as indicated in your Health Funding Agreement. For items 4 and 5 below, include the contact name and information and have the report authorized and signed *prior* to submitting the completed report to the First Nations Health Authority.

Health Funding Agreement Number PA1600094-BL

Highest type of funding model in the Health Funding Agreement  
Block /Set funding

Are the services delivered in the Agreement for multiple communities? Yes ☒ No ☐

If yes, for how many communities? 3

**Note: A separate Community-based Reporting Template should be completed and submitted for each community.**

1) Community name: Tk'emlups te Secwepemc

2) a) Organization/recipient name(s): Q'wemtsin Health Society

b) Health facility name: Q'wemtsin Health Society

3) Reporting period covered by this report: April 2015- to March 31 2016

4) Submitted by:

Colleen Lessmann Health Director

Contact Name (please print)

Position

Signature

Date (day/month/year)

5) Authorized by (recipient):

Name (please print)

Position

Signature

Date (day/month/year)

## Part 2 – Common Information

**Part 2 is mandatory.**

### 1. Programs and Services Delivered

Communities are required to complete all sections of this template that apply to all health programs and services they deliver. Refer to the FNHA Program Compendium for more details about the programs listed below, which you may be delivering under different names. In the table, indicate the programs and services provided in your community during the reporting year by putting a check mark (✓) in the boxes for all that apply. See the Guide for a list of acronyms.

<p><b>A. Healthy Child Development</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Healthy Pregnancy and Early Infancy (Prenatal Nutrition, Maternal and Child Health, Fetal Alcohol Spectrum Disorder)</li> <li><input type="checkbox"/> Early Childhood Development (Aboriginal Head Start on Reserve)</li> <li><input type="checkbox"/> Oral Health (Children's Oral Health Initiative)</li> </ul> <p><b>B. Mental Wellness</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Mental Health and Suicide Prevention (National Aboriginal Youth Suicide Prevention Strategy, Brighter Futures, Building Healthy Communities)</li> <li><input type="checkbox"/> Substance Abuse Prevention (National Native Alcohol and Drug Abuse Program, Youth Solvent Abuse Program)</li> </ul> <p><b>C. Healthy Living</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Disease Prevention and Management (Aboriginal Diabetes Initiative)</li> <li><input type="checkbox"/> Injury Prevention</li> </ul>	<p><b>D. Communicable Disease Control and Management</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Vaccine-preventable Diseases and Immunization</li> <li><input type="checkbox"/> Blood-borne Disease and Sexually Transmitted Infections</li> <li><input type="checkbox"/> Respiratory Infections</li> <li><input type="checkbox"/> Communicable Disease Emergencies</li> </ul> <p><b>E. <input type="checkbox"/> Home and Community Care</b></p> <p><b>F. <input type="checkbox"/> Clinical and Client Care</b> (to be completed only by communities with a nursing station or Health Centre with Treatment providing clinical and treatment services 24 hours a day either 5 or 7 days per week)</p> <p>Are the clinical and client care services provided by First Nations Health Authority (FNHA)?</p> <p><b>Yes <input type="checkbox"/> No <input type="checkbox"/></b></p> <p>If <b>No</b>, please complete <b>section F</b>. If <b>Yes</b>, this section is to be completed by the First Nations Health Authority.</p>
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## 2. Health Team

Indicate the number of Health Care Workers in your community for each category, full-time and part-time, at the end of the reporting year.

Category of Health Care Workers	Number of Full-Time	Number of Part-Time and Visiting	Total Number in Category
Health Manager	1		1
Community-based, Band employed Registered Nurses including nurse practitioners (NP), registered nurses (RN), and licensed practical nurses (LPN)	NP #	NP#	NP#
	RN# 1	RN# 3	RN# 4
	LPN#	LPN#	LPN#
First Nations Health Authority employed Registered Nurses including nurse practitioners, registered nurses, and licensed practical nurses	NP# 1 posted	NP#	NP# 1 posted
	RN#	RN#	RN#
	LPN#	LPN#	LPN#
Other licensed or regulated health professionals	1	5	6
Community-based health workers (e.g., CHR, NNADAP, ADI, AHSOR, CPNP, MCH Home Visitors, FASD Community Coordinators and Mentors, HCC Personal Care Workers, Youth Worker, Mental Health Worker)	1 CHR 1 NNADAP 1 youth worker 2 HCC	1 COHI aid	6
Administrative, janitorial staff and housekeeping staff working in health facilities and for health programs	4	3 janitors	7
<b>Totals</b>	13	12	25

## Part 3 – Program Component Reporting

**Part 3 is mandatory.**

In Part 3, complete the information for the program components that apply to the programs and services managed in your community **under your Health Funding Agreement** with the First Nations Health Authority, and as indicated in Part 2 of this reporting template.



# Healthy Child Development



## A. Healthy Child Development

**Question 1. Pre and Postnatal Nutrition Activities:** Indicate with a check mark (✓) the pre and postnatal nutrition activities and services that were delivered in your community. If an activity you provide could fit under more than one category provided below, choose its 'best fit', and account for it only once.

Nutrition Screening, Education and Counselling	Activity Offered Check (✓)
Nutrition or dietary screening	<input checked="" type="checkbox"/>
One-on-one nutrition counselling/education	<input checked="" type="checkbox"/>
Group nutrition counselling/education	<input type="checkbox"/>
Baby food making workshops/classes	<input type="checkbox"/>
Grocery store tours	<input type="checkbox"/>
<b>Maternal Nourishment</b>	<b>Check (✓)</b>
Food vouchers distributed	<input checked="" type="checkbox"/>
Community kitchens/community cooking classes	<input type="checkbox"/>
Food boxes or groceries distributed	<input checked="" type="checkbox"/>
Community gardens	<input checked="" type="checkbox"/>
Traditional food gathering/distribution/preparation	<input type="checkbox"/>
<b>Breastfeeding Promotion, Education, and Support</b>	<b>Check (✓)</b>
Education workshops	<input type="checkbox"/>
One-on-one breastfeeding support	<input checked="" type="checkbox"/>
Group breastfeeding support	<input type="checkbox"/>
Peer support program	<input type="checkbox"/>
<b>Supportive Elements that address specific needs of at-risk clients (e.g., transportation, child care, etc.)</b>	<b>Check (✓)</b>
Yes	<input checked="" type="checkbox"/>
No	<input type="checkbox"/>

**Question 2. Reach of Pre and Postnatal Nutrition Programming:** Of the total number of women served by pre and postnatal nutrition programming during the reporting year, indicate the number of participants who **first** received services in their 1<sup>st</sup> trimester, 2<sup>nd</sup> trimester, or 3<sup>rd</sup> trimester, and the number of participants who first received services after giving birth (postnatal).

Enrolment Timeframe	Number
Pregnant women who <u>first</u> received services in their 1 <sup>st</sup> trimester (0-12 weeks)	13
Pregnant women who <u>first</u> received services in their 2 <sup>nd</sup> trimester (13-26 weeks)	8
Pregnant women who <u>first</u> received services in their 3 <sup>rd</sup> trimester (27-40 weeks)	2

Women who <u>first</u> received services after they had given birth (with an infant or infants 0-12 months of age)	3
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**Question 4. Breastfeeding:** For participants with infants six months or older, indicate the duration of breastfeeding rates for the time periods below. Time periods are consistent with the Pre and Post Natal Outcome Tracking Tool provided with the CBRT.

Breastfeeding Duration	Number
Total number of participating mothers with babies who turned six months during the reporting year	8
Mothers who breastfed for less than 3 months (less than 15 weeks)	3
Mothers who breast fed for longer than 3 months and shorter than 6 months (15 weeks to 23 weeks)	0
Mothers who breast fed for 6 months (24 weeks to 27 weeks)	1
Mothers who breast fed for longer than 6 months (28 weeks or more)	3
Mothers who did not initiate breastfeeding	0
Unknown whether breastfeeding was initiated	0

**Question 5. Risk Factors:** For all pregnancies **concluding** in the reporting year, indicate the number where the following risk factors were present among participants. If necessary, refer to the Pre- and Post Natal Outcome Tracking Tool provided with CBRT, or other tracking tools for this information.

Risk Factors	Number
Total number of participants whose pregnancies concluded during the reporting year	4
Maternal age less than 20	0
Maternal age 35 or higher	0
Smoking by mother during pregnancy	0
Drug or solvent use by mother during pregnancy	0
Alcohol use by mother during pregnancy	0
Diabetes diagnosed before pregnancy	0
Diabetes diagnosed during pregnancy (gestational diabetes)	0
Post partum mood disorders (previous diagnosis)	0

**Question 6. Total Number of Births:** Indicate the number of babies born to mothers who live in the community during the reporting year. This information may not be available from your program sources. You may have to use another source in your community to obtain this information. See Guide for details.

Total Births	Number
Total number of babies born to mothers who live in the community	4

**Question 7. Birth Weight:** Indicate the number of babies who were full term, pre-term, and unknown term for each of the birth weight categories provided in the table. Count only babies born to program participants during the reporting year. Refer to the Pre- and Post Natal Outcome Tracking Tool provided with the CBRT, or other tracking tools, for this information.

Birth Weight Category	Number		
	Full term	Pre-term	Unknown Term
Less than 5lb 9oz (less than 2500g)			
Between 5lb 9oz and 8lb 11oz (2500g – 4000g)	1		
More than 8lb 11oz (more than 4000g)	3		
Birth weight unknown			

**Question 8. Solid Food Initiation:** For infants who turned 6 months old during the reporting year, indicate the numbers who initiated solid food in each of the time periods in the table below. Refer to the Pre- and Post Natal Outcome Tracking Tool provided with the CBRT, or other tracking tools, for this information.

Solid Food Initiation	Number
Solid food initiated before 6 months	0
Solid food initiated at 6 months	7
Solid food initiated after 6 months	0
Unknown when solid food was initiated	0

**Question 9. Maternal and Child Health Screening and Assessment:** Indicate with a check mark (✓) which types of screening and assessment services were delivered in the reporting year. If an activity you provide could fit under more than one category provided below, choose its 'best fit', and account for it only once.

Screening and Assessment for:	Check (✓)
Risk factors for pregnant women and new mothers such as post partum depression, chronic conditions such as Type 2 diabetes, gestational diabetes, and tobacco/alcohol/drug/solvent use	<input checked="" type="checkbox"/>
Risk factors for developmental milestones for infants and children	<input checked="" type="checkbox"/>
Vision/hearing/dental screenings or assessments for referral	<input checked="" type="checkbox"/>

**Question 10. Maternal and Child Health Home Visiting and Case Management**

**Programming Reach:** Indicate in the fields provided, the number of participants who received home visits and/or case management services. ('participant' is defined as the primary contact for services, including their family and dependants). See Guide for details.

Home Visits and Case Management	Number
Total Number who received home visits	27
Total Number who received case management	3

**Question 11. First Home Visit:** Of all the pregnant women and new mothers receiving home visits through maternal and child health programming during the reporting year, indicate the number who received their FIRST home visit in their 1<sup>st</sup> trimester, 2<sup>nd</sup> trimester, or 3<sup>rd</sup> trimester, and the number of participants who first received services after giving birth (postnatal).

First Home Visits	Number
Pregnant women who received their <u>first</u> Maternal and Child Health home visit in their 1 <sup>st</sup> trimester	13 + 1 preconception
Pregnant women who received their <u>first</u> Maternal and Child Health home visit in their 2 <sup>nd</sup> trimester	8
Pregnant women who received their <u>first</u> Maternal and Child Health home visit in their 3 <sup>rd</sup> trimester	2
Women who received their <u>first</u> Maternal and Child Health home visit within 6 months of giving birth (postnatal)	3

**Question 12. Fetal Alcohol Spectrum Disorder (FASD):** Use a check mark (✓) to indicate which services were delivered. Then provide the number of families receiving FASD community coordination services or FASD case management services, and the total number of clients receiving FASD mentoring services. See Guide for details.

FASD Activities	Activity Offered Check (✓)	Number of Participants
FASD Community capacity building activities (e.g., awareness and prevention activities, and development of action plans)	<input checked="" type="checkbox"/>	
FASD Community coordination/FASD case management	<input type="checkbox"/>	
FASD Mentoring	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

**Question 13. Aboriginal Head Start On Reserve (AHSOR):** Provide information on AHSOR program delivery in your community by completing the table below and checking all that applies. See Guide for details.

13A) How many communities are served by your AHSOR program?		
13B) Does your AHSOR program offer Outreach/Home-visiting?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13C) Is your AHSOR site Centre-based? (if <b>NO</b> , please proceed to Question 14 below. If <b>YES</b> , please continue completing this table)	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13D) Is your AHSOR program licensed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13E) How many full/half days <b>per week</b> does your Centre-based AHSOR program operate?	# of Full days:	# of Half days:
13F) Is your AHSOR program co-located?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
13G) If <b>YES</b> , is your AHSOR program co-located with a school or daycare facility?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**Question 14. AHSOR Activities:** Indicate with a check mark (✓) which activities were provided.

Activity Type	Activity Offered Check (✓)
Teaching children their First Nation language(s) (e.g., reading a story, teaching letters or numbers, etc.)	<input type="checkbox"/>
Traditional ceremonies and activities (e.g., smudging, gathering traditional foods, visits from Elders, etc.)	<input type="checkbox"/>
Early literacy skills (e.g., reading to children, singing songs, etc.)	<input type="checkbox"/>
Fine and gross motor development activities (e.g., catching a ball, holding a pencil, etc.)	<input type="checkbox"/>
Providing healthy foods (snacks and/or lunches)	<input type="checkbox"/>
Healthy personal hygiene and dental habits (e.g., teeth brushing, hand washing, etc.)	<input type="checkbox"/>
Physical activity (e.g., outdoor play, games, dance, etc.)	<input type="checkbox"/>
Linkages (including referrals and collaborations) to professionals and community supports and providers (e.g., housing, education, specialists, etc.)	<input type="checkbox"/>
Parent and family support activities (e.g., workshops for new mothers and young parents, support groups, etc.)	<input type="checkbox"/>
Visits from health professionals (e.g., nurses, dental hygienists, others)	<input type="checkbox"/>
Safety education and awareness activities, (e.g., play ground safety, car seat technician training, car seat use, seat belt use, bike safety, etc.)	<input type="checkbox"/>

**Question 15. Number of Children in AHSOR Programming:** Indicate total participation in AHSOR programming by age and program delivery type (centre-based and/or outreach/home visiting) and the number of children on a waiting list, if applicable. See Guide for details.

Age	Number of Participants by Program Delivery Type		Does the program keep a waiting list. Indicate Yes or No.	If Yes, how many children are on the waiting list?
	Centre-Based	Outreach/Home Visiting		
Number of children younger than 3 years old				
Number of children 3 to 6 years old				
<b>Total</b>				

**Question 16. AHSOR Children and Special Needs:** For each program type, indicate the number of children in the AHSOR program who have been diagnosed, screened/assessed, or referred for special needs during the reporting year, as well as the number of children on a waiting list at the end of the reporting year. A single child may be counted in more than one category if it applies. See Guide for details.

Special Needs Diagnosis, Screening/Assessment, Referrals, Wait List	Number of Children by Program Type	
	Centre-based	Outreach/Home Visiting
Number of AHSOR children who have been <i>diagnosed</i> with special needs		
Number of AHSOR children <i>screened/assessed</i> for special needs		
Number of AHSOR children <i>referred</i> to other community resources (e.g., nurses, doctors, specialists, etc.) for special needs support or diagnosis		
Number of AHSOR children on a wait list for special needs diagnostic assessment		

**Question 17. Frequency of Parent/Family Participation:** For **centre-based** AHSOR programs only, indicate the total number of adult parent and family participants involved and the frequency of their involvement (e.g., daily, weekly, monthly or special occasions). Count each person only once under the appropriate heading.

	Daily	Weekly	Monthly/Special Occasions	Total
Number of Parent/Family Participants				

**Question 18. Children's Oral Health Initiative (COHI):** All communities delivering COHI, regardless of agreement type, are expected to continue to use the Dental Service Daily Record and Dental Screening Forms according to the frequency and terms outlined in their Health Funding Agreement program plan.

**In addition, please answer the following question:**

Indicate the total number of children living in the community by age group, and the number participating in COHI activities.

Age	Total Number Living in the Community (If necessary, obtain data from a non-program source)	Number Participating in Children's Oral Health Activities
Children less than 5 years	103	116
Children 5 to 7 years	101	75

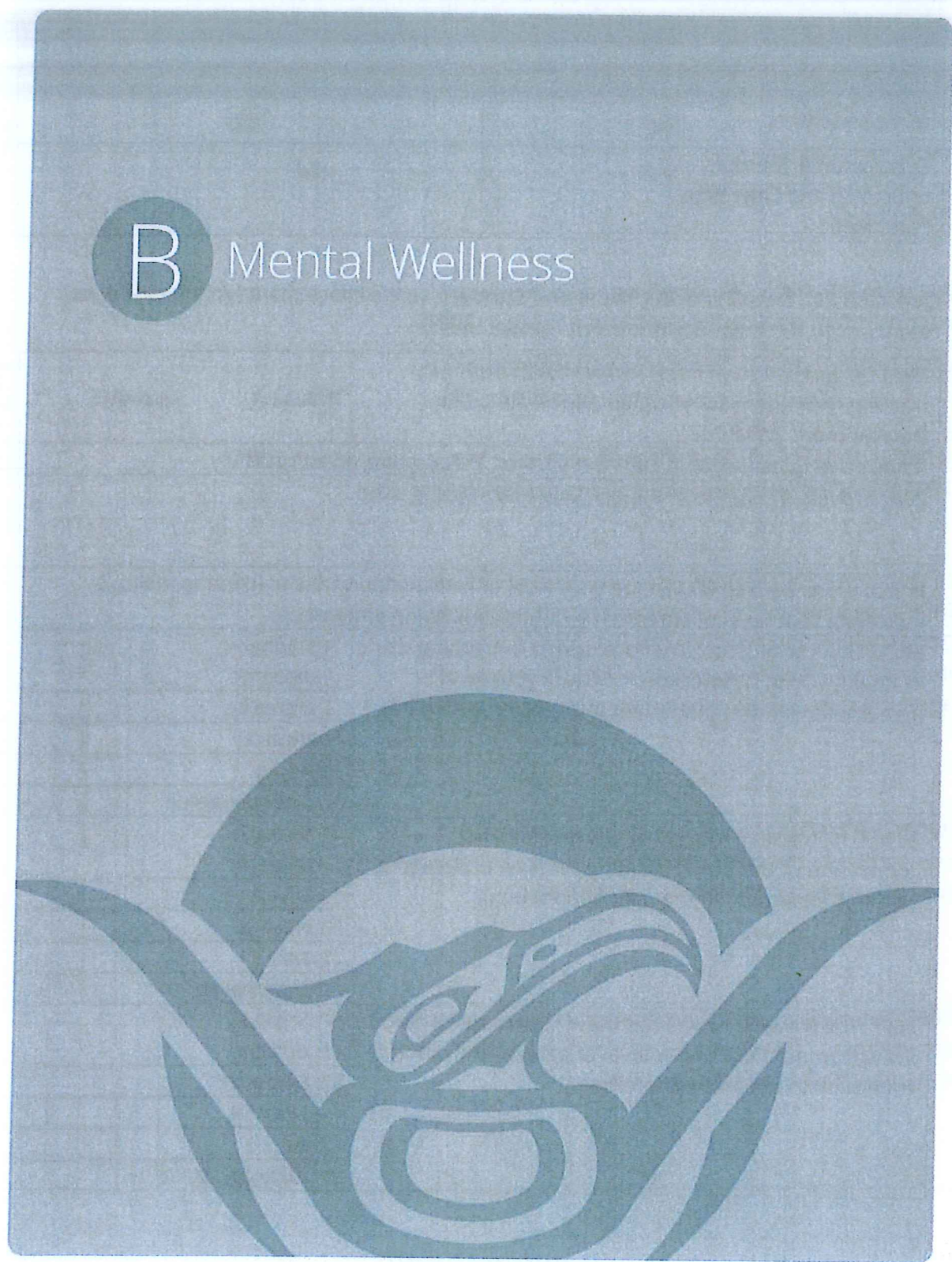
**Question 19. Healthy Child Development Service Linkages:** Use a check mark (✓) to indicate where service linkages occurred between community health staff and external organizations and agencies during the reporting year. Service linkages can be formal or informal arrangements, collaborations, or processes with external individuals and organizations to facilitate the delivery of health services. See Guide for details and examples.

Type of Service/Service Linkage	Regional Health Authority/ Health Service Zone	Educational Organization	Non-profit Organization	Provincial Services
Nutritionist/dietician	✓			
Physical activity/recreation	✓			
Specialist care	✓			
Treatment/management	✓		✓	
Diagnostics/screening	✓		✓	
Drug/alcohol treatment				
Dental	✓			
Child and family social	✓		✓	

Type of Service/Service Linkage	Regional Health Authority/ Health Service Zone	Educational Organization	Non-profit Organization	Provincial Services
service supports	✓		✓	
Occupational Therapist or Speech and Language Pathologist	✓		✓	

**Question 20. Data Tracking Tools and Support:** Use a check mark (✓) to indicate your responses to the following questions (except in **20B**).

<b>20A)</b> Do you use any First Nations Health Authority tracking tool(s) to track your work in Healthy Child Development activities?		Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If <b>No</b> , go to question <b>21</b> in the next section. If <b>Yes</b> , go to question <b>20B</b> .			
<b>20B)</b> Provide the name of the tracking tool(s) being used.			
In questions <b>20C) to 20 E)</b> , rate your level of satisfaction with the tracking tool(s) by indicating your level of agreement with the following statements:			
<b>20C)</b> "The tracking tool(s) is (are) useful in tracking work in Healthy Child Development." (Mark your level of agreement with this statement in the appropriate box.)	Strongly disagree	<input type="checkbox"/>	
	Disagree	<input type="checkbox"/>	
	Neutral	<input type="checkbox"/>	
	Agree	<input type="checkbox"/>	
	Strongly agree	<input type="checkbox"/>	
<b>20D)</b> "The tracking tool(s) has (have) aided in the completion of the CBRT." (Mark your level of agreement with this statement in the appropriate box.)	Strongly disagree	<input type="checkbox"/>	
	Disagree	<input type="checkbox"/>	
	Neutral	<input type="checkbox"/>	
	Agree	<input type="checkbox"/>	
	Strongly agree	<input type="checkbox"/>	
<b>20E)</b> "The tracking tool(s) has (have) been useful across activity areas." (Mark your level of agreement with this statement in the appropriate box.)	Strongly disagree	<input type="checkbox"/>	
	Disagree	<input type="checkbox"/>	
	Neutral	<input type="checkbox"/>	
	Agree	<input type="checkbox"/>	
	Strongly agree	<input type="checkbox"/>	



## B. Mental Wellness

**Question 21. Mental Wellness Activities:** Indicate with a check mark (✓) which activities and services were offered in your community. If an activity or service you provided could fit under more than one category below, choose the category that is its 'best fit', and account for it only once.

21A) Suicide Prevention Activities	Activity Offered Check (✓)
Awareness activities (e.g., increasing knowledge of suicide rates and contributing factors, addressing suicide myths and pre-conceptions, increasing communication about suicide, and decreasing stigma)	<input checked="" type="checkbox"/>
Sport, recreation and other activities to engage youth	<input checked="" type="checkbox"/>
Traditional activities to engage youth (e.g., land-based activities, cultural practices, skill development)	<input checked="" type="checkbox"/>
Life skills activities for youth (e.g., leadership, relationships, problem solving, developing positive coping skills)	<input checked="" type="checkbox"/>
Training on signs and symptoms and responding to suicidal behaviour (e.g., ASIST, SafeTalk, Mental Health First Aid, train-the-trainer sessions, CISM)	<input checked="" type="checkbox"/>
Crisis intervention (e.g., mobilizing to prevent spread of suicide)	<input checked="" type="checkbox"/>
21B) Mental Wellness Promotion and Support: Wellness activities teach and promote ways to increase well being, focusing on positive choices for all, regardless of risk for mental health issues and addictions.	Activity Offered Check (✓)
Wellness activities promoting mental health (e.g., parenting skills, self-care, managing stress, positive relationships, emotional and spiritual well being). Activities may include community celebrations and recreation activities, including physical and social activities.	<input checked="" type="checkbox"/>
21C) Substance Abuse, Addictions and Mental Health Activities	Activity Offered Check (✓)
Presentations and workshops aimed at preventing substance abuse	<input checked="" type="checkbox"/>
Cultural events to support the prevention of addictions and substance abuse, as well as the awareness of mental health issues	<input checked="" type="checkbox"/>
Addictions recovery support groups	<input checked="" type="checkbox"/>
School-based programs to support awareness of substance abuse and addictions	<input checked="" type="checkbox"/>
21D) Crisis Intervention	Activity Offered Check (✓)

Mental health crisis intervention activities (other than those specific to youth suicide prevention)	<input checked="" type="checkbox"/>
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**Question 22. Suicide Interventions:** For each type of suicide intervention in the table, indicate the number of interventions, clients, and clients where family was involved. The "total number of interventions" should be the number of events and not the number of individuals (e.g., multiple interventions might occur for a single individual). The "number of clients where the family was involved" should be understood as a sub-set of the total number of clients.

Suicide Interventions	Total Number of Interventions	Total Number of Clients	Number of Clients Where Family was Involved in the Intervention
Interventions with youth at risk for suicide (e.g., counselling, assessments)	21	9	5
Interventions with individuals or those affected after an attempted suicide (e.g., support, counselling, treatment planning)	25	15	7
Interventions after a death by suicide with those affected	3	3	2

**Question 23. Interventions for Substance Abuse, Addictions and Mental Health:** For each type of intervention in the table below, indicate for each age group the number of clients who received interventions and the number where the family was involved. Use the number of clients, **not** the number of interventions. The number for "where the family was involved" should be understood as a sub-set of the number of clients.

Interventions for Substance Abuse, Addictions, and Mental Health	Number of clients			
	Youths (under 18)	Where family was involved in Intervention	Adults (18 and over)	Where family was involved in Intervention
Screening and Basic Assessment (e.g., CAGE, MAST or DAST)	3	2	56	0
Brief Intervention (e.g., supportive discussions including personalized feedback, identification of supportive networks/resources, and goal setting on substance use behaviours)	2	2	26	0
Comprehensive Assessment (provided	2	2	21	0

Interventions for Substance Abuse, Addictions, and Mental Health	Number of clients			
	Youths (under 18)	Where family was involved in Intervention	Adults (18 and over)	Where family was involved in Intervention
or referred) such as specialized addiction or mental health assessment	0	0	5	0
Direct Counselling (e.g., pre-treatment, day or evening programming or aftercare)	3	2	56	0
Community-based Supports (e.g., support groups such as AA and NA, counselling, day or evening programming). <b>Note:</b> Do <b>not</b> include NNADAP or NYSAP residential services.	1	0	35	0
Cultural supports including community based Elders and traditional healers.	16	0	18	0
Referral to Specialized Supports (e.g., psychiatric services, intensive concurrent disorder treatment, or medically based withdrawal management)	0	0	10	1

**Question 24. Referrals to Treatment Centres:** For each client category in the table, indicate the number of clients who were referred to a treatment centre in the National Native Alcohol and Drug Abuse Program (NNADAP) or a treatment centre in the Youth Solvent Abuse Program (YSAP). **Note:** A client should be counted only once. A family should be counted only once and only in the category "Family referrals", not as an individual referral in another category.

Client Category	Number of Clients referred to			
	NNADAP Treatment Centre	YSAP Treatment Centre	Provincial Treatment Centre	Other Treatment Centre
Males under 12 years				
Females under 12 years				
Males 12-17 years				
Females 12-17 years				
Males 18 years and over	3		1	
Females 18 years and over	5		1	1
Family referrals	1			

**Question 25. Service Linkages for Mental Health and Addictions:** Use a check mark (✓) to indicate where service linkages occurred between community health staff and external organizations and agencies during the reporting year. Service linkages can be formal or informal arrangements, collaborations, or processes with external individuals and organizations to facilitate the delivery of health services. See Guide for details and examples.

Type of Service/ Service Linkage	Regional Health Authority/ Health Service Zone	Educational Org's	Non-profit Org's	Police (Band, RCMP, Local/ Provincial)	Provincial Services
Mental wellness promotion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Detoxification services	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction treatment and aftercare	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Suicide prevention	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental health treatment and aftercare	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Client case management	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crisis response	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

**Question 26. Data Tracking Tools and Support:** Use a check mark (✓) to indicate your responses to the following questions (except in **26B**).

<b>26A)</b> Do you use any First Nations Health Authority tracking tool(s) to track your work in Mental Wellness activities?		Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
If <b>No</b> , go to question <b>27</b> in the next section. If <b>Yes</b> , go to question <b>26B</b> .			
<b>26B)</b> Provide the name of the tracking tool(s) being used.			
In questions <b>26C) to 26E)</b> , rate your level of satisfaction with the tracking tool(s) by indicating your level of agreement with the following statements:			
<b>26C)</b> "The tracking tool(s) is (are) useful in tracking work in Mental Wellness." (Mark your level of agreement with this statement in the appropriate box.)	Strongly disagree	<input type="checkbox"/>	
	Disagree	<input type="checkbox"/>	
	Neutral	<input type="checkbox"/>	
	Agree	<input type="checkbox"/>	
	Strongly agree	<input type="checkbox"/>	
<b>26D)</b> "The tracking tool(s) has (have) aided in the	Strongly disagree	<input type="checkbox"/>	