Aboriginal Integrated Plan of Care Process

A GUIDE FOR SERVICE PROVIDERS

ACKNOWLEDGEMENTS

The Aboriginal Integrated Plan of Care process and all supporting documents are the result of tremendous efforts and work by the Aboriginal Working Group, a committee of the Ottawa Service Collaborative. We would like to acknowledge these individuals who came together with the Centre for Addiction and Mental Health (CAMH) Ottawa Regional Implementation Team to make the Aboriginal Integrated Plan of Care process a reality:

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Artist's note:

This traditional motif depicts the ancestral metaphors of mother earth, the swirling waves of the seas and the flowing winds of the sky spirits. These spirit guides have been brought together into a healing circle – its four cardinal points representing Emotional, Mental, Physical and Spiritual health. Traditional motif by EarthLore Communications.

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About this Guide

The Integrated Plan of Care (IPC) process was created by the Ottawa Service Collaborative to address the need for continuity of care for children and youth ages 6 to 18 and their families. Building on Ottawa's historically good foundation of agency collaboration, Ottawa Service Collaborative members made an explicit agreement to expedite and/or provide additional services by remaining flexible in their service delivery models and mandates in order to respond effectively to the needs of children and youth entering the IPC process.

The IPC process is for children and youth with multiple severe and complex needs who are accessing two or more services but are having minimal success. A child/youth may be referred to the IPC process by a service provider who believes that a more collaborative approach is necessary to respond to the needs of the child/youth and their family. Once the IPC process is determined to be an appropriate intervention for the child/youth and family, a team of service providers from partnering agencies come together with the child/youth and family to discuss needs, strengths and design a plan of care. Ongoing monthly meetings are held to ensure that the child/youth and family are progressing towards the goals outlined in the plan of care.

During the development of the Integrated Plan of Care process, it was recognized that a parallel culturally-based process was needed for **First Nations, Inuit** and **Métis** children and youth with complex needs and their families.

Who is this Guide for?

This guide is for service providers to understand the role of culture within the Aboriginal Integrated Plan of Care (IPC) process. In addition to providing the steps service providers should take within the Aboriginal IPC process, this guide is an opportunity to further understand the critical role that culture plays in the healing journey for First Nations, Inuit and Métis people.

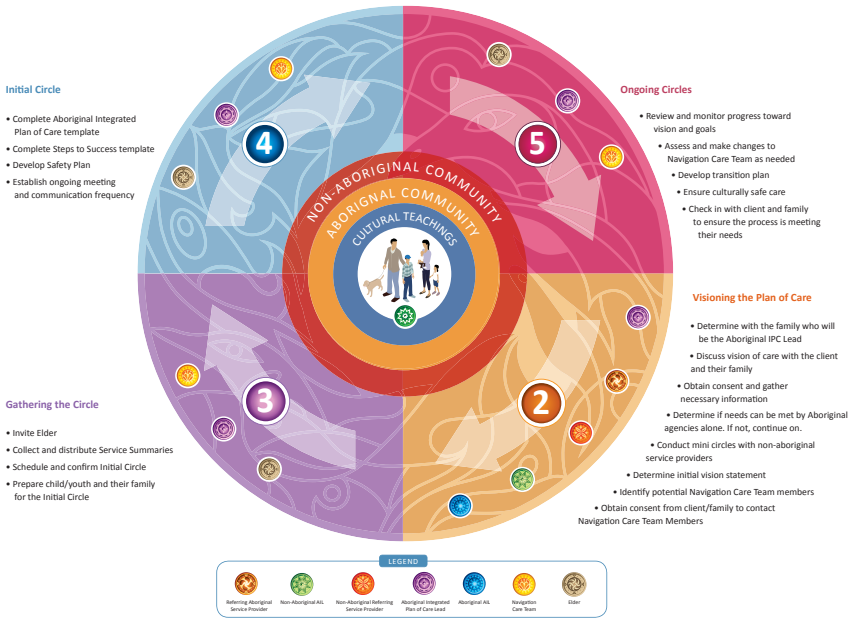
About this Guide

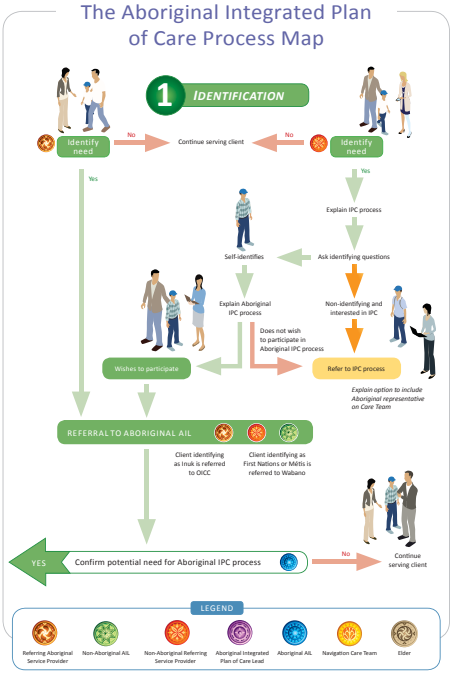
How to use this Guide?

First Nations, Inuit and Métis cultures have long passed on knowledge from generation to generation through oral traditions, including storytelling. Storytelling is a traditional method used to teach cultural beliefs, values, customs, rituals, history, practices, relationships, and ways of life for cultural continuity across generations. In this guide, the Aboriginal IPC process is woven through the story of a young man named Charlie and his family/caregivers. Charlie's story is based on true events, and his story was written in collaboration with his family.

There are important ***Teachings*** located throughout the guide. Teachings are intended to help develop a clearer understanding of cultural elements such as the significance of circles, Elders, and the impact of intergenerational trauma.

You will see icons located throughout the guide. Each person involved in the Aboriginal IPC process has a designated icon. Look for your icon in the Aboriginal IPC process map and throughout the five stages of the process: Identification, Visioning the Plan of Care, Gathering the Circle, Initial Circle and Ongoing Circles. A full list of roles and responsibilities is on page 5.





What is the Aboriginal Integrated Plan of Care Process?

The Aboriginal Integrated Plan of Care (IPC) process recognizes that Aboriginal ways of knowing and cultural values, beliefs, practices are core to providing appropriate services for First Nations, Inuit and Métis children, youth and their families. The Aboriginal IPC process involves collaborative practice in planning, decision making and service delivery for First Nations, Inuit and Métis children, youth and their families. Aboriginal service providers lead the Aboriginal IPC process.

The Aboriginal IPC process is linked to the Integrated Plan of Care process. Service providers who identify children and youth who might benefit from the IPC process will use identifying questions to determine if the child or youth self-identifies as First Nations, Inuit or Métis and if so, service providers can make an active offer to the Aboriginal IPC process.

The Aboriginal IPC process is unique in that:

- It recognizes that Aboriginal knowledge and culture is core to providing appropriate services for First Nations, Inuit and Métis children, youth and their families
- It involves collaborative practice in planning, decision making and service delivery for First Nations, Inuit and Métis children, youth and their families
- Aboriginal service providers lead the Aboriginal IPC process

Aboriginal:
For the purposes of this guide "Aboriginal" is used as a legal term defined by the Canadian Constitution to talk about First Nations, Inuit and Métis peoples. It is understood that there are distinct and unique differences in cultures and histories between these Aboriginal peoples.

First Nation(s):
This term replaces band and Indian, which are considered by some to be outdated and offensive, and signifies the earliest cultures in Canada (Ottawa Aboriginal Coalition, 2013).

Inuit:
In Canada, Inuit are the culturally distinct Aboriginal peoples who lived primarily in the Northwest Territories, Nunavut, northern parts of Quebec, and throughout most of Labrador (Ottawa Aboriginal Coalition, 2013).

Métis:
Historically, the term Métis applied to the children of Cree women in the Prairies and French fur traders; and Dené women in the North and English and Scottish traders. Today, the term is broadly used to describe people with mixed First Nations and European ancestry (Ottawa Aboriginal Coalition, 2013).

Guiding Principles

The Aboriginal Integrated Plan of Care (IPC) process acknowledges and respects First Nations, Métis and Inuit cultural values, beliefs and practices.

Child/youth- and family-centered

The child/youth and their family is the expert and is most knowledgeable in their needs, wants, and motivations for care. The child/youth and their families will lead the development of their IPC.

Culture

The Aboriginal perspective on health and well-being is a collective and inter-related one, meaning that to maintain the highest quality of health and well-being, a client requires a cohesive and multi-pronged approach to care. To provide the best possible service, service providers *(whether Aboriginal or non-Aboriginal)* must consistently evaluate their care plans to ensure they do not act in isolation and to integrate culture, knowledge and skills in the healing journey for a First Nation, Inuit or Métis person to achieve holistic well-being.

Teachings

The Aboriginal IPC process acknowledges that Aboriginal service providers are responsible for connecting clients with those who can provide cultural teachings.

Relationships

Fostering and maintaining respectful relationships and partnerships amongst Aboriginal and non-Aboriginal services in Ottawa is critical. The Ottawa Aboriginal Coalition's Collaboration Model *(see Appendix A)* is designed as a circle to represent the process of collaboration for the Aboriginal and non-Aboriginal community of service providers, provides a framework to begin this process of relationship-building. It describes a strengthening of relationships between non-Aboriginal and Aboriginal service providers with the focus on providing the best possible service to the child/youth. The time and investment that may be required to build trusting relationships that bridge historic and existing attitudinal and systemic discrimination cannot be underestimated.

Holistic

The Aboriginal IPC process utilizes a holistic framework that acknowledges the physical, mental, emotional and spiritual aspects of the life cycle.

Unique

The Aboriginal IPC process recognizes that there is rich diversity of cultures among First Nation, Inuit and Métis groups in Canada and that one approach does not meet the needs of all.

Who is involved in the Aboriginal Integrated Plan of Care process?

Non-Aboriginal Referring Service Provider

A non-Aboriginal Referring Service Provider is the person in a non-Aboriginal agency who identifies the potential benefit for the child/youth and family to participate in the Aboriginal IPC process by asking the First Nations, Inuit and Métis identifying questions. This person connects the child/youth to the Aboriginal Agency Implementation Lead.

Aboriginal Referring Service Provider

The Aboriginal Referring Service Provider is the person who identifies the potential benefit for the child/youth and family to participate in the Aboriginal IPC process and begins the referral process.

Aboriginal Agency Implementation Lead (Aboriginal AIL)

The Aboriginal AIL is the point of contact for non-Aboriginal and Aboriginal Referring Service Providers to discuss potential referrals into the Aboriginal IPC process. This person is responsible for fostering communication and collaboration between all agencies involved in the Aboriginal IPC process, and supporting the Aboriginal IPC Lead to plan and facilitate the meetings of the Navigation Care Team. In some cases, the Aboriginal IPC Lead and the Aboriginal AIL roles may be assumed by the same person.

Non-Aboriginal Agency Implementation Lead (AIL)

The non-Aboriginal AIL is the point of contact for the Aboriginal Agency Implementation Lead to discuss potential referrals from their agency into the Aboriginal IPC process. This person is responsible for fostering communication and collaboration between their agency and the other agencies involved in the Aboriginal IPC process, and fostering cultural awareness within their agency.

The child or youth and their family are at the centre of Aboriginal IPC process and are actively involved throughout all stages and key decision-making.

Aboriginal Integrated Plan of Care (IPC) Lead

The Aboriginal IPC Lead is the central point of contact for the Aboriginal IPC process for the child/youth and their families and the other partnering service providers. The Aboriginal IPC Lead assumes a leadership role for the implementation of the Aboriginal IPC process. In some cases, the Aboriginal IPC Lead and the Aboriginal AIL roles may be assumed by the same person.

Navigation Care Team

The Aboriginal IPC process is about connecting service providers from different sectors with children/youth and their families/caregivers as equal partners to create a coordinated care plan that remains focused on the understood strengths and needs of the child/youth and their family, and acknowledges and respects Aboriginal culture and values. Together, this group is known as the Navigation Care Team.

Elder

The decision to include an Elder of choice in the Aboriginal IPC is led by the family. The Elder may open and close the Circle to ensure participants speak with open hearts and good minds. Throughout the process, the Elder's role is to support the family and offer input by sharing teachings, stories and wisdom. The Elder is informed about the Circle in the same way as all participants.

Coordinated Access Mental Health Committee

The Mental Health Committee at Coordinated Access is experienced in making recommendations and/or service plans for children and youth with complex mental health needs. They are also experienced in determining a child/youth's eligibility to access the mental health flex funds and multiple complex special needs funds.

Charlie's Story

This is the story of Charlie, which we have come to know through conversations with him, his community, supports and family. Charlie is now a teenager living in Ottawa, Ontario. People who know him would describe him as a charming and likeable young man. These days, he has a strong connection to his Aboriginal culture and enjoys working with his hands and outdoors with Mother Earth.

Charlie's maternal grandmother is a residential school survivor, and, as a direct result of her traumatic lived experiences, she has learned unhealthy coping strategies. The impacts of the residential school experiences have impacted the family on an intergenerational level, which may have caused Charlie's birth mother to suffer from mental health and addictions issues. Both her mental health and addictions issues impacted her ability to feel safe enough to disclose her pregnancy to those around her, and to engage in prenatal care. Two years after Charlie was born, his birth mother made the difficult decision that she could no longer care for him. Charlie's aunt and uncle were involved from his birth and sought to provide support. Charlie had created a healthy attachment with his uncle from an early age, and it was decided he would be raised by his aunt and uncle.

Like many Aboriginal youth in Canada, Charlie's life has been impacted by the intergenerational trauma caused by residential schools and effects of colonization.

Charlie met his early milestones with some delays. Around three years of age, his parents suspected that he had Fetal Alcohol Spectrum Disorder. He started preschool and certain behaviors led educators to believe that therapy would be a good option for Charlie. A psychologist noted Charlie's attachment issues, impulsiveness, and inability to understand consequences.

The challenges persisted throughout Charlie's childhood and into adolescence. As Charlie got older he became violent, assaulting teachers, classmates and his adoptive parents. Charlie struggled academically due to learning disabilities and his mental health concerns. Around 7 years of age, Charlie was officially diagnosed with FASD.

Despite challenges with school, Charlie's strengths are evident. He is inquisitive, thoughtful, loves to help others, and is often heard sharing traditional teachings with peers. In addition, his great mechanical skills allow him to take things apart and put them back together with ease.

Charlie's Story

Unfortunately, maintaining friendships has always been challenging for Charlie, as he was often referred to as a "bully" growing up due to his aggressive and impulsive behaviour. Nowadays, he runs away from home on a regular basis, and is involved with negative peer groups and the police.

Charlie's difficulties impact his adoptive family, including his younger siblings who have witnessed his violent outbursts on a number of occasions and worry when Charlie disappears from home. Charlie's adoptive father is unable to work full-time and has to remain at home to look after Charlie.

There have been many people involved in Charlie's care from childhood into adolescence, such as the school, social workers, police, psychologists, and the Children's Aid Society; but the challenges persist. The service providers try to meet on a regular basis to support Charlie's needs but without a streamlined approach, it has been very difficult to coordinate his care delivery and maintain open communication between all parties involved.

There are two ways Charlie could enter into the Aboriginal Integrated Plan of Care (IPC) process. The first way is through services he is already receiving with Aboriginal service providers, and the second is through non-Aboriginal service providers.

Culture and healing:

Today, healing initiatives are taking place in every region of the country, in cities and small towns, on reserves and in rural, remote and isolated communities. Sharing circles, healing circles, smudging, Sundances, the Potlatch, Pow-wows, and many other ceremonies have been revived in the last few decades, providing a multiplicity of positive models not only for healing, but for people to reconnect with their cultural roots. Reconnecting with culture provides an empowering focus in life. People who have a strong sense of their culture have a strong sense of self.

– Legacy of Hope Foundation, 2015

Intergenerational impacts:

First Nations, Inuit, and Métis children were often away from their parents for long periods of time and this prevented the discovering and learning of valuable parenting skills. The removal of children from their homes also prevented the transmission of language and culture, resulting in many Aboriginal people who do not speak their traditional language and/or who are not familiar with their culture. Adaptation of abusive behaviours learned from residential school has also occurred and caused intergenerational trauma – the cycle of abuse and trauma from one generation to the next. Research on intergenerational transmission of trauma makes it clear that individuals who have suffered the effects of traumatic stress pass it on to those close to them and generate vulnerability in their children. The children in turn experience their own trauma. The system of forced assimilation has had consequences which are with Aboriginal people today.

The need for healing does not stop with the school Survivors - intergenerational effects of trauma are real and pervasive and must also be addressed.

1. Identification – for Aboriginal Service Providers

Referring Aboriginal Service Provider

Aboriginal AIL

This stage requires making an informed decision about whether the Aboriginal Integrated Plan of Care (IPC) process could meet the needs of the child/youth.

As the **Aboriginal Referring Service Provider,** you may have already been working with Charlie. It is great there are so many people involved in his healing, but you need a more coordinated approach.

1. **Use the Aboriginal IPC Inclusion Considerations:** This will help to determine if the Aboriginal IPC process is a good option for Charlie.

Inclusion Considerations for Aboriginal IPC process

- Child/youth or family self identifies as First Nation, Inuit, Métis or Aboriginal
- The child or youth is at least six years of age and under 18[1] years of age
- The child or youth is experiencing multiple intersecting complex needs that are severe and broad that lead to major challenges for the child/youth to participate meaningfully in society
- Child or youth requires non-Aboriginal service provision to meet their needs and a collaborative response between Aboriginal and non-Aboriginal services is required
- Child or youth is currently (or in the past) accessing two or more services from across sectors
- Child or youth is experiencing minimal success with current services and the rationale for lack of progress or improvement is unclear and worrisome
- Child or youth is presenting behaviours that, if left unattended, places them, their family and/or community at serious risk
- Child or youth is at serious risk of harm to self and/or others, and is exhibiting behaviours such as cutting, suicidal ideation, serious physical assault of another, etc.
- A collaborative response is required to respond to the needs of the child or youth

2. **Connect with the Aboriginal Agency Implementation Lead (AIL)*:**
   Connect and discuss a potential referral into the Aboriginal IPC.

   a. If the Aboriginal AIL thinks Charlie doesn't meet the inclusion criteria or would not benefit, discuss ways to improve services and continue serving him.

   b. If he is a potential candidate, start the next phase: Visioning the Plan of Care.

*** Note:**

IF Charlie or the family/ guardian self-identifies as Inuit, connect with the Aboriginal Agency Implementation Lead at the Ottawa Inuit Children's Centre (OICC).

IF Charlie or the family/ guardian self-identifies as First Nations or Métis, connect with the Aboriginal Agency Implementation Lead at Wabano Centre for Aboriginal Health.

[1] It is understood that a youth who becomes 18 years of age while engaged in the formalized care plan process will continue to be served until an appropriate transition can be made – a transition plan would become part of the care plan process

1. Identification – for non-Aboriginal Service Providers


Non-Aboriginal AIL


Aboriginal AIL


Non-Aboriginal Referring Service Provider

This stage requires making an informed decision about whether the Aboriginal Integrated Plan of Care (IPC) process could meet the needs of the child/youth.

In the course of providing care to Charlie, the **non-Aboriginal Referring Service Provider** thinks he could benefit from the IPC process. While reviewing the inclusion criteria, the Aboriginal identifying questions are asked.

What are the Aboriginal identifying questions to ask?

Please indicate which cultural group best represents your identity or portion of your identity *(please select all that apply):*

- ☐ First Nations – Community: _____
  - ○ Cree
  - ○ Algonquin
  - ○ Mohawk
  - ○ Mi'kmaq
  - ○ Ojibway
- ☐ Other (please specify): _____
- ☐ Métis – Community: _____
- ☐ Inuit - Region/Community: _____
- ☐ Other (please specify): _____

Teaching

Identity for First Nations, Inuit and Métis people can be incredibly complex. They could consider themselves as "traditional", "bi-cultural" or perhaps even "assimilated". They could identify based on where they reside; urban Aboriginal, rural, reserve or other. Language may also play a significant role in identity. When service providers ask about identity, it is important to allow the child or youth to determine how they choose to self-identify. There may also be hesitation to self-identify for fear of racism, discrimination, inadequate access to care because of a perception that an Aboriginal person cannot use non-Aboriginal services, etc. There has to be safety in asking the question, so be sure to explain why you are asking these questions. You could say, for example, "I want to make sure that you are connected to everything that may help. Are you comfortable to share if you would like to be provided with supports that are culturally-relevant for you?"

1. Identification – for non-Aboriginal Service Providers

Charlie self-identifies as First Nations, Inuit or Métis.

As the **non-Aboriginal Referring Service Provider,** your responsibilities are as follows:

1. **Explain to Charlie the Aboriginal IPC process.**
2. **Give choices:**
   a. He can choose not to participate in either process.
   b. He can choose to participate in the Aboriginal IPC process.
   c. He can choose not to participate in Aboriginal IPC process and continue in IPC process.
   d. He can choose to stay in the IPC and have Aboriginal services as a part of his team. If Charlie and his family agree to this option, the Referring Service Provider will make an explicit request to Coordinated Access to have the Aboriginal AIL at Wabano or OICC participate on the Coordinated Access Mental Health committee for this IPC application.

Charlie has always been connected with his culture and really likes the idea of engaging in the Aboriginal IPC process.

3. Connect to the **AIL:** Speak with the AIL within in your agency to discuss the plan to connect Charlie and his family to the Aboriginal AIL.*

*** Note:**

IF Charlie or the family/ guardian self-identifies as Inuit, connect with the Aboriginal Agency Implementation Lead at the Ottawa Inuit Children's Centre (OICC).

IF Charlie or the family/ guardian self-identifies as First Nations or Métis, connect with the Aboriginal Agency Implementation Lead at Wabano Centre for Aboriginal Health.

2.Visioning the plan of care


Aboriginal AIL


Non-Aboriginal AIL


Aboriginal Integrated Plan of Care Lead

After receiving the initial referral and speaking to the family, the Aboriginal AIL should determine, with the client and family, whether he/she will be the Lead on the IPC. If yes, the process will continue as outlined below. However, if the answer is "no", and there will be another Lead on the process, the internal referral should happen immediately, prior to gathering information and opening the file. In this case, the new Aboriginal IPC Lead, not the Aboriginal AIL, will assume all roles outlined below in Visioning the Plan of Care.

As the **Aboriginal AIL,** your responsibilities are as follows:

1. **Sign new client documentation:** Any required new client paperwork for your organization can be signed by Charlie at this time. If Charlie is under the age of consent, it is signed by his family/ guardian.

2. **Obtain informed consent, gather and complete assessments:** Obtain informed consent *(see Appendix B)* and gather Charlie's story, including assessments provided by him and his family, as well as complete any needed assessments.

3. **Assess if continuing in Aboriginal IPC process is appropriate:** You, Charlie and his family, and the involved service providers and their supervisors (if applicable) determine:

   a. Charlie and his family require support from agencies outside of the Aboriginal service system; therefore, he will continue with the Aboriginal IPC process.

   OR

   b. Charlie and his family's needs can be met by Aboriginal agencies; therefore, he will not proceed with the Aboriginal IPC process. In this case, you will support the necessary navigation to appropriate programs within the Aboriginal service system. You will ensure that all involved are clear on what services are involved going forward.

In this case, it is determined that Charlie still needs support from some non-Aboriginal services and that he would benefit from the Aboriginal IPC process, and so, he will continue the Aboriginal IPC process.

4. **Conduct mini circles*:** If Charlie was already receiving non-Aboriginal services, gather information from Charlie and his family about their perception of the services. Are there any barriers? If there are barriers, contact the non-Aboriginal Service Providers involved and conduct mini circles to facilitate a clarification of the perceived barrier.

*** Note:**

A mini circle is…

The goal of the mini circles is to strengthen relationships, educate on the Aboriginal IPC process, share information, and identify and resolve any challenges or mend any broken relationships that might exist to move forward between Charlie and his family, and non-Aboriginal service providers. If the youth/family does not participate in the mini circle, the Aboriginal AIL will share with the youth/family the discussions from the mini circle. The youth and/or family may choose whether or not to participate in these mini circles.

2. Visioning the plan of care

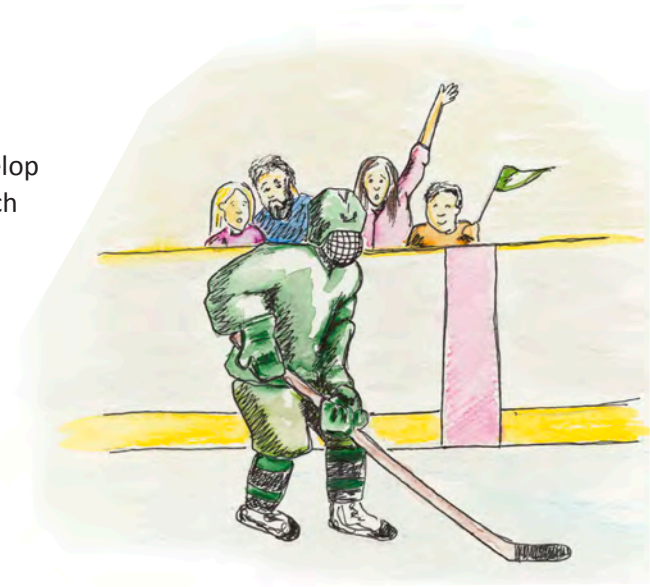
The Aboriginal IPC Lead

The Lead should be from an Aboriginal agency, Aboriginal-focused program or Aboriginal staff linked to Aboriginal network unless explicitly stated by Charlie and family that this is not the case. The Aboriginal IPC Lead:

- Should have established a positive client relationship and have ready access to the client and family and/or supporters
- Should have the confidence of the client, family and/or supporters
- Can facilitate group collaboration and guide resolution of conflicting priorities/goals

As the **Aboriginal IPC Lead,** your responsibilities are as follows:

1. **Meet with Charlie and his family:** Establish priorities, and develop and document an initial vision statement *(see Appendix C)*, which will provide a common focus for the Navigation Care Team.
2. **Identify potential team members:** Working together with Charlie and family, identify the Aboriginal and non-Aboriginal service providers who could potentially be members of the Navigation Care Team.
3. **Obtain informed consent:** Obtain informed consent from Charlie and family to contact these individuals. These members might include agencies not yet involved, but may help to provide insight or services to sustain a seamless care plan.
4. **Consider inviting an Elder:** Ask Charlie and his family if they would prefer to have an Elder join the Navigation Care Team. If the family already has a relationship with an Elder, they can ask the Elder to join. If the Elder consents to be a part of the Navigation Care Team, the Aboriginal IPC Lead will contact that Elder and explain the overall process and invite any questions.



Vision Statement:

"Charlie will be supported by his immediate and extended family throughout the IPC process to have better successes at home and school."

5. **Confirm team members:** Now that potential members have been identified and consent acquired, the Aboriginal IPC Lead contacts the non-Aboriginal AILs from the agencies to clarify Charlie's needs/goals, explain the purpose and steps of the Aboriginal IPC process, and solicits each service provider's agreement to be involved. The non-Aboriginal AILs will provide a name and contact information for potential Navigation Care Team members within their agency.

As the **non-Aboriginal AIL,** your responsibilities are as follows:

1. **Discuss potential team members:** Working with the Aboriginal IPC Lead, determine which agency staff members might be a part of the Navigation Care Team and provide their name and contact information.

Teaching

An Elder is a person who can be a source of cultural knowledge in Aboriginal communities. Maintaining strong oral traditions, storytelling, and knowledge keeping is part of everyone's responsibility as part of an Aboriginal community; however, an Elder has cumulative life experiences in sharing and keeping this knowledge as part of their life's work. Not all older persons may be Elders; however, their knowledge is also valuable. Respect for Elders is shown through gifting, and asking or receiving knowledge from them. It is important to involve them in the process, not only to open and close with ceremonies but to ask for their knowledge.

3.Gathering the Circle

Aboriginal Integrated Plan of Care Lead | Navigation Care Team | Elder

Now it is time to gather the Circle. In this part of the process, there is sharing of information among all the members of Navigation Care Team and a date is set for the Initial Circle.

Before the Circle

As the **Aboriginal IPC Lead,** your responsibilities are as follows:

1. **Distribute Service Summary templates:** Distribute Service Summary templates *(see Appendix D)* to all Navigation Care Team members with a previous relationship to Charle and his family. They should complete and return these summaries to you.

2. **Share the Service Summaries with Navigation Care Team:** Compile and condense these stories and circulate them to all Navigation Care Team members.

3. **Invite the Elder:** You will invite the Elder to the Initial Circle to ensure that cultural values are respected throughout the process *(e.g. lighting of Qulliq, providing tobacco).*

4. **Schedule and confirm:** Schedule the Initial Circle and confirm the date, location, agencies/ service providers invited, time and estimated amount of time expected for the Initial Circle *(the more service providers involved generally the longer amount of time is required).*

5. **Prepare the child/youth and family for the Circle:** It is a good idea to share some information with Charlie and his family as to what they will expect in the Initial Circle.

As the **Navigation Care Team,** your responsibilities include:

1. **Share information:** Populate the Service Summaries and return to the Aboriginal IPC Lead.

2. **Provide logistics support:** Support the Aboriginal IPC Lead in organization the date, time and location of the Initial Circle.

3. **Prepare for the Initial Circle:** Review the circulated Service Summaries.

Teaching

Every Aboriginal culture recognizes the circle and its sacredness. Original ancestral cultural practices are founded on the principles and philosophies of the circle teachings. All are equal in a circle and no one is more or less important than the other. All are given a chance to speak and express themselves in a safe and confidential environment. Within Aboriginal traditions, it is understood that what is shared, particularly of a sensitive or personal nature, is held in the strictest of confidence. Circles can be used as therapeutic tools, but also as tools for conflict resolution, consultation, and decision making.

4. Initial Circle

Aboriginal Integrated Plan of Care Lead | Navigation Care Team | Elder

Charlie and his family are looking forward to the Initial Circle, but are a bit nervous and hesitant about having all these people together to talk about them. They are worried about feeling judged or being criticized. Charlie and his family trust that their cultural needs will be met and the Initial Circle will be conducted in a culturally safe manner.

The purpose of this initial meeting is to **develop the Aboriginal Integrated Plan of Care grounded in traditional ways of knowing and approaches to healing and well-being.** Depending on the complexity of the situation, it might take one to three meetings to complete.

The Aboriginal IPC Lead is the lead facilitator at the Circle; however, may defer occasionally throughout to the Elder when appropriate or needed.

During the Circle

The **Aboriginal IPC Lead, Elder, Navigation Care Team and Charlie and his family all have** responsibilities in the Initial Circle:

1. **Explain the purpose of the meeting:** The Aboriginal IPC Lead explains the purpose of the Initial Circle and that everyone is there to help. At some point, the Aboriginal AIL may also have connected with the non-Aboriginal service providers to ensure they understand and are comfortable with the cultural values and practices involved in the Aboriginal IPC process.

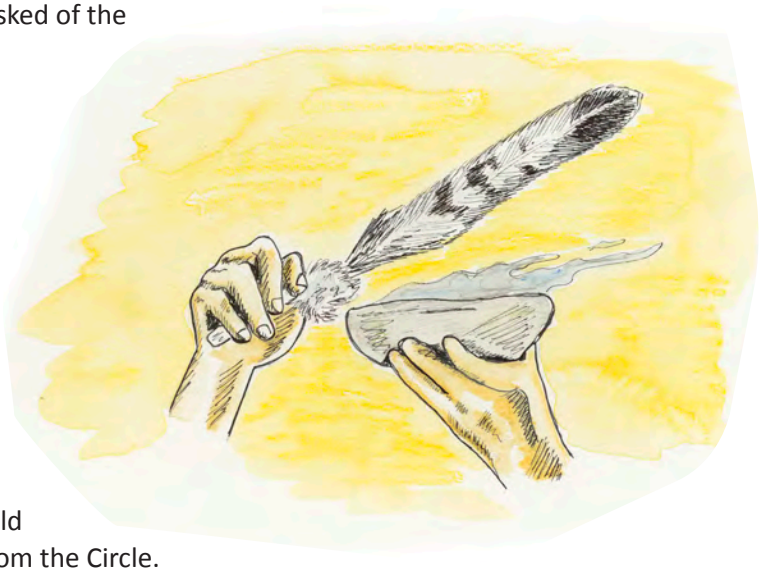
2. **Open the Circle:** If an Elder is present, they open the Aboriginal IPC Circle. The Elder may introduce the use of a talking item or feather for use during the Circle. If an Elder is not present, the Aboriginal IPC Lead will open the Circle.

3. **Meet the team:** Introductions are to be made by each of the Circle's participants.

4. **Expectations:** The Aboriginal IPC Lead explains how the Circle will be completed, such as the protocol and what will be asked of the participant. All participants have an equal voice.

5. **Roles and responsibilities:** The Aboriginal IPC Lead summarizes each Circle participant's roles and responsibilities in the Aboriginal Integrated Plan of Care, seeks clarification and obtains verbal confirmation from everyone involved.

6. **Sharing:** Ideally, Charlie begins the Circle. This is his Circle and he must be given the opportunity to speak first by sharing his vision for healing and moving forward, and what he wants from the Circle process. Alternatively, Charlie and family, or someone they have entrusted responsibility to, could begin by sharing their vision and what they want from the Circle.



a. Each member of the Circle has an opportunity to share key significant events and experiences with Charlie and how they can support the vision shared by Charlie and family speaking in strengths-based facts.

7. **Make the plan:** The Aboriginal IPC Lead facilitates the comprehensive Aboriginal Integrated Plan of Care *(see Appendix E*), Steps to Success Template *(see Appendix F),* and Safety Plan *(see Appendix G*). He/she ensures that each goal in the Aboriginal Integrated Plan of Care as an associated Navigation Care Team member who will take responsibility for that goal, with other identified members involved in supporting activities.

8. **Set meetings:** Charlie, his family and the Navigation Care Team establish the frequency of meetings, progress checks, regular communications, and responsibility for the child/youth file.

9. **Close the Circle:** The Elder or Aboriginal IPC Lead complete a closing of the Circle.

After the Circle

1. **Summarize and share:** The **Aboriginal IPC Lead** creates a summary of the Circle, describing the comprehensive Aboriginal Integrated Plan of Care, everyone's roles and responsibilities, and the next steps. Send to all parties involved, including Charlie and family.

5. Ongoing Circles


Aboriginal Integrated Plan of Care Lead


Navigation Care Team


Elder

Charlie has been in the Aboriginal IPC process for about two months now and it's time for his first Ongoing Circle. These meetings are important to ensure that Charlie is still progressing towards the vision and goals outlined in his Plan of Care, and to remain responsive to his needs. Not all Navigation Care Team members need to attend all meetings. Frequency and who should attend is determined by the priority being addressed.

As the **Aboriginal IPC Lead,** your responsibilities are as follows:

1. **Facilitate the meetings:** Ensure the Navigation Care Team is helping Charlie in the way he needs. Here are some **considerations** and **actions:**

- Are cultural values, beliefs and practices evident in the Aboriginal IPC process?
- Have barriers to progress been identified and resolved?
- Has progress been made toward goals?
- Has new information emerged that change the original plan of care direction?
- Are goals, strategies and activities realistic and working for the child/youth and their family?
- Is there a need to consider alterations or additions to the Navigation Care Team?

2. **Revise Integrated Plan of Care:** With input and consent from Charlie and his family, revise the plan as needed based on continuous process of assessment.
3. **Review and revise the Safety Plan.**
4. **Ensure culturally safe care:** Ensure care and service provided is guided by an integrated, shared plan rooted in Aboriginal culture and values.

As the **Navigation Care Team,** your responsibilities are as follows:

1. **Participate and support progress:** Attend the Ongoing Circles, review the Aboriginal Integrated Plan of Care and make changes as needed.

Next Steps

After six months in the Aboriginal IPC process, Charlie is doing much better. He does continue to struggle with controlling his violent outbursts, attending school regularly, and choosing a positive social circle. However, now when crises happen, his Navigation Care Team works together to problem solve and support Charlie. They are able to respond earlier, collaborate their efforts more effectively, and ensure that everyone is working towards the same goals. For the first time in a long time, Charlie and his family are able to negotiate and have conversations about the future because he is not always being disciplined.

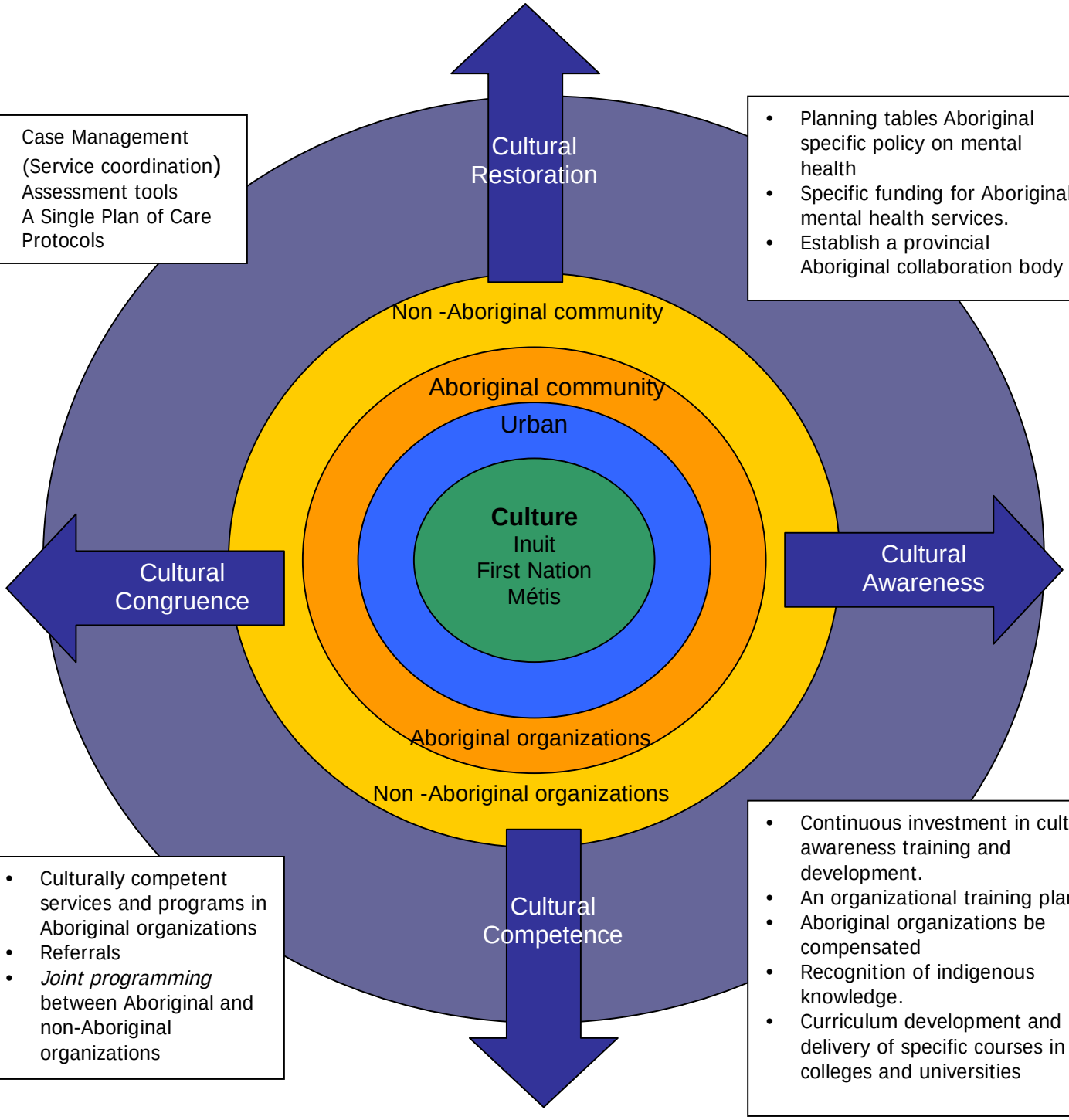
Charlie's connection to his culture continues to be a strength, and as a cultural leader, he often shares his knowledge with others while asking questions and learning about their culture in return.

When Charlie and his family agree that involvement in the Aboriginal IPC process is no longer required, Charlie and family and the Navigation Care team will develop a sustainable, youth-directed transition plan outlining ongoing activity.

Appendix A: The Ottawa Aboriginal Coalition's Collaboration Model

The Collaboration model is designed as a wheel to represent the process that Aboriginal and non-Aboriginal service providers will have to go through together. The middle four circles represent what all service providers need to know in order to effectively serve Aboriginal people.

The OAC Collaboration Model



- Case Management (Service coordination)
- Assessment tools
- A Single Plan of Care
- Protocols

- Planning tables Aboriginal specific policy on mental health
- Specific funding for Aboriginal mental health services.
- Establish a provincial Aboriginal collaboration body

- Culturally competent services and programs in Aboriginal organizations
- Referrals
- *Joint programming* between Aboriginal and non-Aboriginal organizations

- Continuous investment in cultural awareness training and development.
- An organizational training plan
- Aboriginal organizations be compensated
- Recognition of indigenous knowledge.
- Curriculum development and delivery of specific courses in colleges and universities

The Collaboration Model Explained

The Collaboration model is designed as a wheel to represent the process that the Aboriginal and non-Aboriginal community of service providers will have to go through together. The middle four circles represent what all service providers need to know in order to be effective in serving Aboriginal people.

Culture (the middle circle)

Culture is at the centre of all the work done. Each Aboriginal person has unique cultural traditions and teachings including how healing is addressed.

Ottawa service providers are working with a diverse Aboriginal community made up of First Nation, Inuit and Métis people.

There are approximately 35,000 Aboriginal people in Ottawa. The largest groups of First Nation people in Ottawa are Algonquin, Cree, Ojibway and Mohawk.

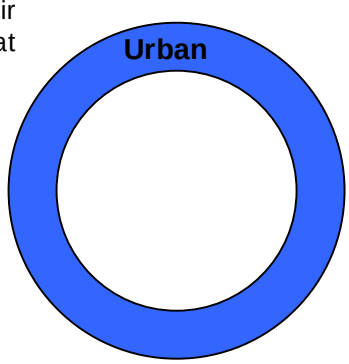
Most Inuit in Ottawa are from Nunavut, however Ottawa is also a health and education location for Inuit from Nunavik.

The Métis population in Ottawa are primarily from Ontario settlements as far as Sudbury and as close as Bancroft.

An urban context

The second circle recognizes that Aboriginal people are living in an urban environment and there are a number of implications that service providers need to consider:

- Many Aboriginal people in Ottawa are living away from their home community and may not have the same supports that they would have in their home community.
- They may have significant ties to the community and be affected by what is happening in their home community. We have seen youth suicide clusters jumped between communities because of the close connections.
- Many people are here for employment or education and may not have any supportive community.
- Aboriginal people raised in the city may not have been exposed to their culture and have a hunger to know about who they are and develop a stronger sense of identity.



Aboriginal organizations

There are ten Aboriginal service organizations in Ottawa with only two funded to provide direct clinical mental health services, Wabano Aboriginal Health Centre and Tungasuvvingat Inuit. Other Aboriginal organizations provide a wide range of protective programs and counseling for specific mental health supports.

Gignual Housing	Addressing a social determinant (housing) Life skills for tenants
Kagita Mikam	Addressing a social determinant (employment)
Madawan Development Corporation	Addressing a social determinant (housing) Has a focus on seniors
Makonsag Aboriginal Head Start	Protective programs
Minwaashin Lodge	Counselling for women Protective programs
Odawa Native Friendship Centre	Protective programs
Ottawa Inuit Children's Centre	Protective programs
Tewegan Transition House	Addressing a social determinant (housing) Life skills, counseling for young women
Tungasuvvingat Inuit/ Mamisarvick Healing Centre	Mental Health services and an Addiction treatment program
Wabano Centre for Aboriginal Health	Health Services Mental Health services

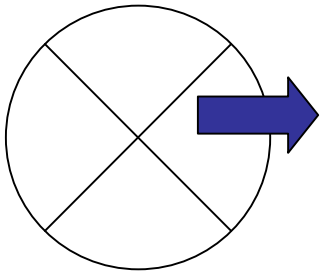
Non-Aboriginal organizations

There are numerous non-Aboriginal organizations that provide mental health services to Aboriginal people in the Ottawa community. As part of the research on Aboriginal Youth done by the Aboriginal Health Circle in 2012, 72 non-Aboriginal organizations were identified. Twenty-eight (28) mental health providers described the range of services they provide to Aboriginal people from assessment to interventions.

The Four Directions

The medicine wheel recognizes that collaboration is a process. It describes the strengthening of a relationship between non-Aboriginal and Aboriginal service providers with the focus on providing the best possible service to the client.

East – Cultural Awareness



The medicine wheel starts in the east where knowledge is acquired in order to move on to the next step in the relationship. The intent of this knowledge exchange is that every mental health service provider that works with Aboriginal people will have an awareness of:

a) The diversity of the Aboriginal population in Ottawa;
b) The specific Aboriginal service organizations and what they do;
c) The impact of living in an urban environment on Aboriginal people;
d) The impact of colonization and, more specifically, the residential school legacy;
e) How colonization and intergenerational trauma impacts the social determinants of health
f) What are protective factors for Aboriginal mental health;
g) Culturally based tools and interventions; and
h) Trauma informed practice.

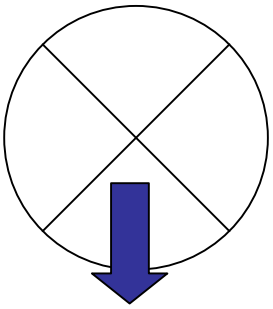
Over the last ten years the Aboriginal community has made a consistent commitment to the Ottawa service provider community to increase cultural awareness. A few things that the community has one to support cultural awareness includes:

- The annual Wabano cultural symposium for professionals;
- The Mental Health conference planned by Minwaashin Lodge for March 2013;
- The training provided to the school boards on the legacy of residential schools and the purchase of the Legacy of Hope kits for the schools;
- Specific training provided by different Aboriginal organizations to specific non-Aboriginal service providers including the Ottawa Children's Aid Society.
- Ongoing education and awareness training through committee work.

To ensure sustained cultural awareness there needs to be:

- Continuous investment in cultural awareness training and development in every organization that is working with Aboriginal people.
- An organizational training plan that reflects the nature of the workplace (e.g. the degree of turnover in staff; the orientation practice of the organization)
- Aboriginal organizations cannot be relied on, without compensation, to provide continuous cultural awareness.
- Recognition that indigenous knowledge, including awareness of mental distress and healing methods are equally credible to other professional knowledge.
- Curriculum development and delivery of specific courses in colleges and universities for mental health professionals, thus recognizing that the Aboriginal population is a vulnerable population.

South – Cultural Competence



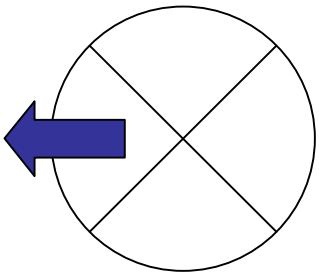
Cultural competent service providers working with Aboriginal people would be able to respond respectfully and effectively to an Aboriginal person in a manner that recognizes, affirms and values the person, their family, community and indigenous background. Cultural competency is the commitment to incorporate cultural knowledge into practice.

A cultural competent person has the ability to assess what is most appropriate for the client with respect to service delivery. It relies on three key elements:

- *Culturally competent services and programs in Aboriginal organizations*: At this time, all culturally based mental health programming and services needs to be delivered by Aboriginal organizations.
- *Referrals* to Aboriginal organizations when Aboriginal people want to receive culturally based services. The referral system needs to be simple and accessible to the greatest number of workers in each organization: know the Aboriginal service organizations and know the person to call in the organization.
- *Joint programming* between Aboriginal and non-Aboriginal organizations is an effective way to bridge the lack of cultural knowledge and capacity in organizations. Examples of successful joint programming in Ottawa includes the CAS Circle of Care program which provides Aboriginal families working with CAS an Aboriginal process through an Aboriginal organization.

System reform is required to support culturally competent practice. Service organizations that are client focused and are doing appropriate referrals to Aboriginal organizations need to not be penalized because they do not have the client numbers.

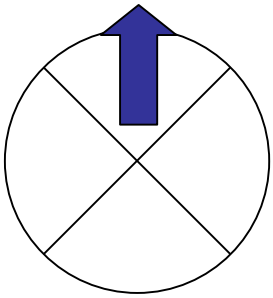
West – Cultural Congruence



Cultural congruence ensures that all mental health organizations will be able to accurately assess the needs of an Aboriginal person and provide an appropriate set of interventions. Key elements of cultural congruence is:

- *Case Management (Service coordination*) would be based in an Aboriginal organization if it is an Aboriginal person.
- *Assessment tools* will be culturally based and developed by Aboriginal people to ensure that a holistic model is applied in doing assessments. Asking Aboriginal service providers to adapt or provide input into non-Aboriginal assessment tools would not be done.
- *A Single Plan of Care* would support the system changes to ensure that case management for Aboriginal people is done in Aboriginal organizations.
- *Protocols* would be developed that would support a seamless process between organizations in order to support effective case management.

North – Cultural Restoration



Cultural restoration is when the entire system recognizes the impact of the loss of culture on Aboriginal people in Ottawa and works to support cultural restoration. Planning and funding tables would all have a capacity to be able to consider the specific needs of the Ottawa Aboriginal population and ensure that strategic investments are made to support a vulnerable population. Specific elements that would exist would include:

- Planning tables would have an informed approach to serving the Aboriginal community and sufficient representation of Aboriginal people.
- Aboriginal specific policy on mental health
- Specific funding for Aboriginal mental health services.
- Establish a provincial Aboriginal collaboration body that can support the development of curriculum for mental health professionals; develop culturally based assessment tools and describe specific culturally based interventions.

Appendix B: Aboriginal IPC process Consent Form

Available for download:

http://coordinatedaccess.ca/wp-content/uploads/2016/09/Mental-Health-Application-Form.pdf

Appendix C: Developing an Initial Vision Statement

The client and family's visions are the common framework that all Navigation Care Team members use to formulate their goals. This approach creates an integrated, client centered plan that respects the client and family's wishes. Visioning the Plan of Care assists the client and family to determine the focus of the Aboriginal Integrated Plan of Care for the next 6 to 12 months, based on the identified strengths and needs of the client and family. The client and family are assisted to frame vision statements around this focus and these visions are documented for all Navigation Care Team members to review.

Visioning the Plan of Care is conducted by the Aboriginal Integrated Plan of Care Lead who engages in dialogue with the client and family to assist them to develop their visions. Visions are captured in the client and family's words, documented and identified as the client and family's priorities for their child. Visions may be documented as follows:

Initial Client and Family Vision #1:

Charlie will be supported by his immediate and extended family throughout the IPC process to have better successes at home and school.

Initial Client and Family Vision #2:

Debbie would like to regain emotional stability in order to promote learning.

Initial Client and Family Vision #3:

Gary envisions moving from mental illness to mental wellness.

Initial Client and Family Vision #4:

My vision is to reach a point where I can function in society with some autonomy and independence.

Appendix D: Service Summary Template

Having a complete view of all Navigation Care Team members' current work with the client provides everyone with the knowledge they need to build a comprehensive integrated plan of care. A service summary from each service provider should be shared with all Navigation Care Team members and the client and/or family and/or supporter ahead of the Initial Circle. This prepares everyone at the meeting to focus efforts on working together to write goals vs. updating each other on their own isolated work with the client and family.

The summary should be brief and can be in point form, highlighting key information relevant to integrated goal writing aligned with the client/family's vision.

The Service Summary should include the following information:

- Navigation Care Team Member Name
- Agency/Organization
- Summary of current involvement
- Goals currently working on with client

Service Summary Template Example:

Service Summary	
Navigation Care Team member:	
Agency or Organization:	
Summary of Current Involvement:	
Goals currently working on with client:	

Service Summary

Client:

Navigation Care Team member:	
Agency or Organization:	
Summary of Current Involvement:	
Goals currently working on with client:	

Appendix E: Aboriginal Integrated Plan of Care Template

Aboriginal Integrated Plan of Care

Initial & Ongoing Circles

Client Name: _____ **Date Plan of Care created/reviewed:** _____

[Last name, First name] [MM-DD-YYYY]

AIPC Lead: _____

Client's Vision Statement:

Goals Identified by Client:

1 _____

2 _____

3 _____

4 _____

Goals Recommended by Supports:

1 _____

2 _____

3 _____

4 _____

Integrated Short Term Goals:	Person Responsible to Support:	Review Date: [MM-DD-YYYY]
1	1	
2	2	
3	3	
4	4	

Integrated Long Term Goals:	Person Responsible to Support:	Review Date: [MM-DD-YYYY]
1	1	
2	2	
3	3	
4	4	

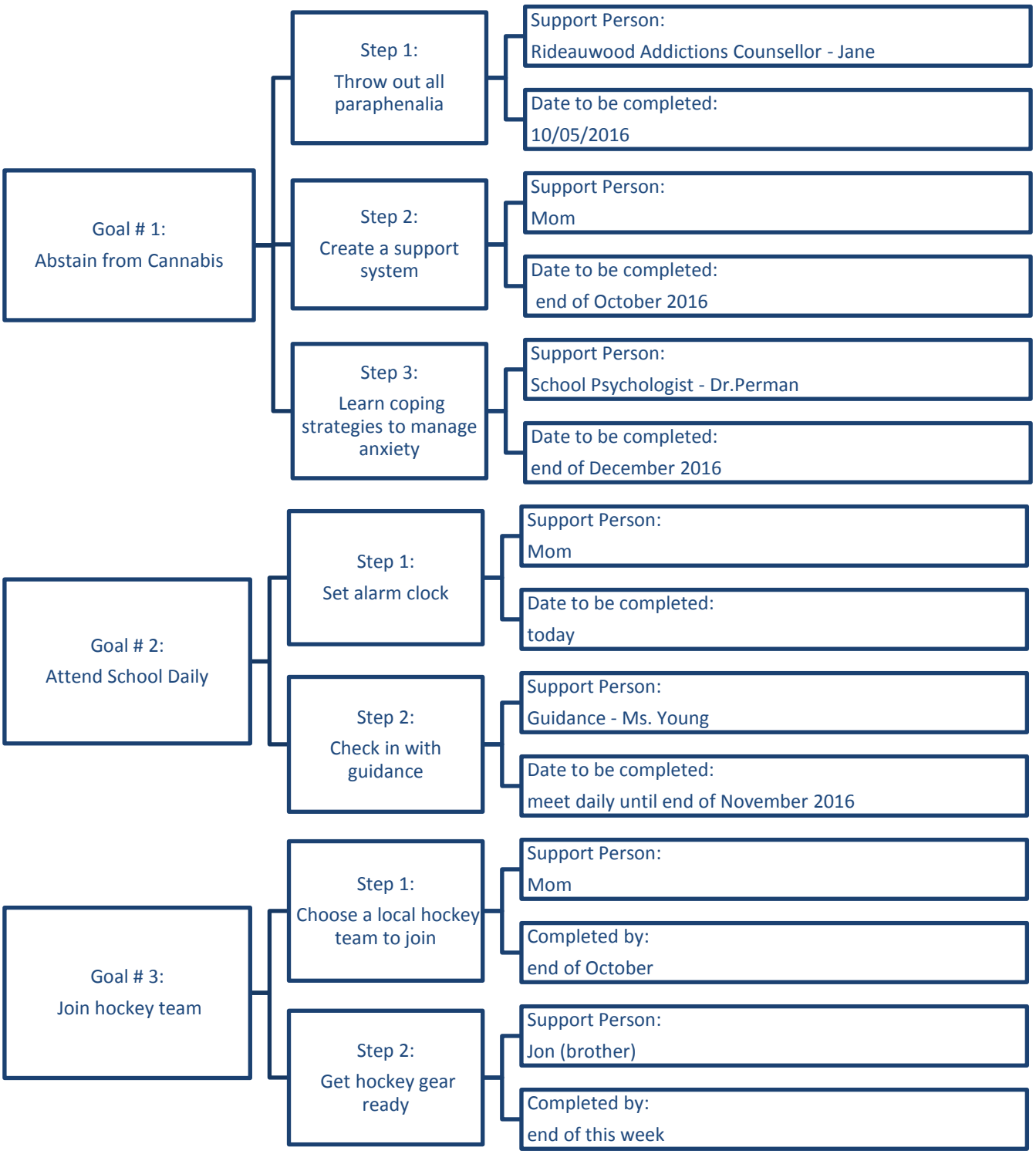
Next Ongoing Circle: _____

Notes:

Appendix F: Goals - Steps to Success Template

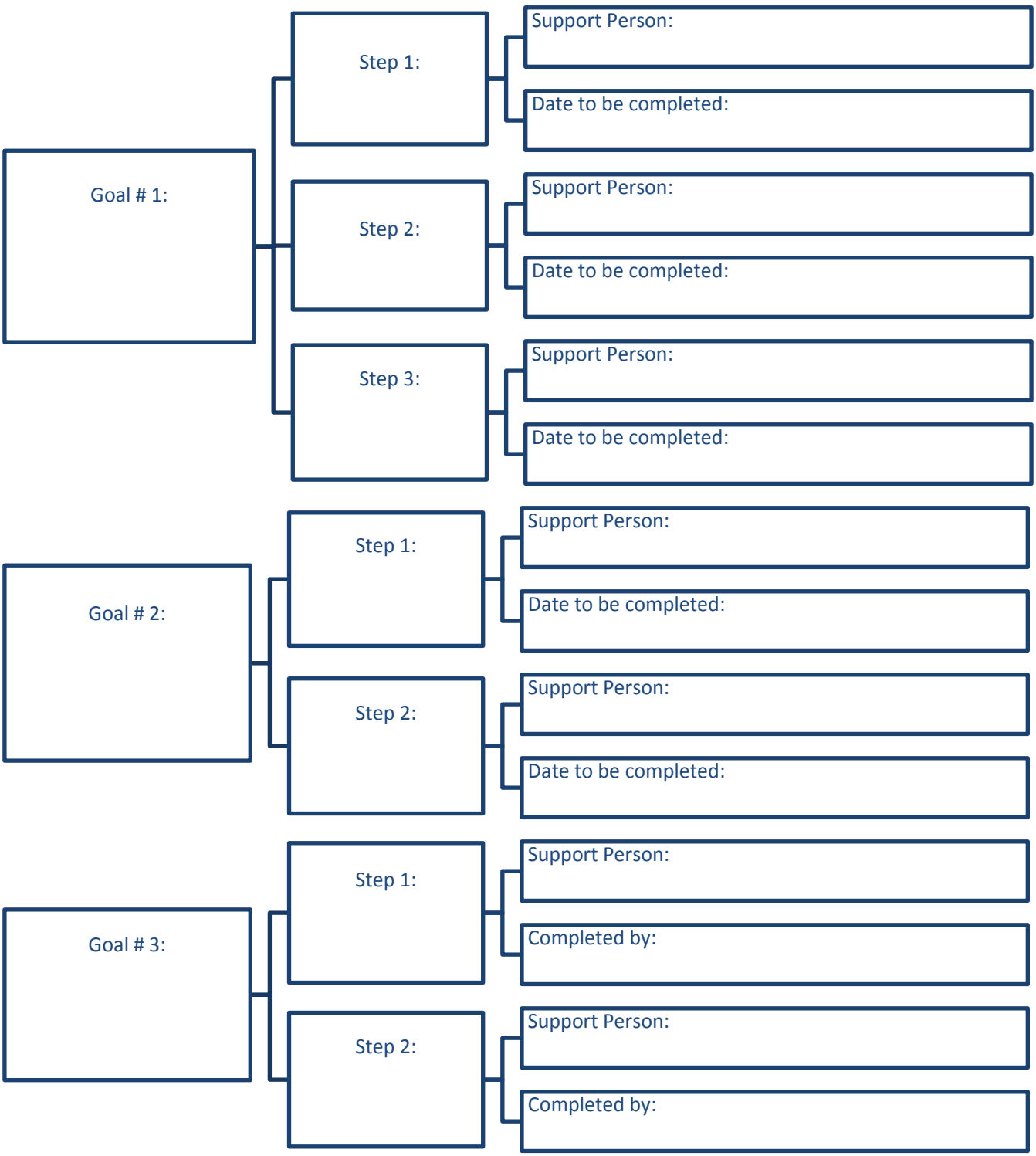
Aboriginal Integrated Plan of Care (AIPC) *Goals - Steps to Success*

Example:



Aboriginal Integrated Plan of Care (AIPC) ***Goals - Steps to Success***

Name: _____ **Date:** _____



Appendix G: Safety Plan

Preparing a Safety Plan reduces the risk, surprise and short decision time that make crises stressful and worrisome for both the client, family and the Navigation Care Team. Preparation will enable timely action to help respond to the crisis by outlining the coping strategies and supports that clients can use preceding or during a crisis. The Safety Plan is also meant to help communicate the client's wishes in the event that they are unable to do so.

The Safety Plan could include the following information:

- Warning signs that the client isn't feeling well: Help the client and family to think about and describe what it means to feel well and unwell in an age appropriate manner. Consider language used to describe how they feel, emotions that tend to present themselves, physical descriptions etc.
- Internal coping strategies: Things that the client can do to take their minds off their problems without contacting another person, i.e. relaxation techniques, physical activity, etc.)
- People and social settings that provide distractions to the client
- At what point the client wants support: As soon as warning signs appear, once the symptoms can no longer be managed on their own, etc.
- Where to go for help or who to contact in the case of an emergency: Discuss what services the client has used before and would utilize again
- What treatment options they prefer: Discuss what treatment options they have undergone in the past and would repeat
- List of current medication and any allergies
- Contact information of the Navigation Care Team, nearest emergency department and family or supporters that should be notified

The plan could also include steps that the client's family or supporters will take to offer support (i.e. calling the Aboriginal IPC Lead, paying bills if there is an extended hospital stay, looking after any dependents of the client, etc). Once contacted, Aboriginal IPC Leads are responsible for reaching out to individuals listed in a Safety Plan.

The client and family or supporters should review the plan and confirm that it reflects their needs, concerns and wishes. A copy should be given to the client and family or supporters, each member of the Navigation Care Team and placed in each agency/organization client file.

APPENDIX X: Safety Plan Template

Purpose: to reduce the risk, surprise and short decision time that makes crises stressful and worrisome for the client, family and Navigation Care team. By having a safety plan it will help to communicate the client's wishes in the event they are unable to do so and to speed up the response time to a crisis.

Signs that_____ is not feeling well. *Insert Name* What does unwell look, feel and sound like for you? How do you express that you aren't feeling well?
Coping strategies that _____ already finds helpful? What do you or others do, that helps when you aren't feeling well?
At what point does _____ want support? How might others know that you are ready for support? When signs first appear, once the symptoms can no longer be managed on their own, etc.?
Who would _____ like to have contacted in case of an emergency? Who would be the most important people to reach out to if you were in an emergency?
Which services would _____ like to access for help? What services/organizations have you used in the past that have helped? Which, if any, agencies are you willing to try for the first time?

Are there other children in the home who may need care or support?			
Name	**School**	**Emergency Contact**	**Plan**

List of current medications/allergies for _____ .			
Medication Name	**Prescription**	**Reason**	**Prescribing Doctor**
Allergies:			

Contacts for _____ 's Safety Plan			
Name	**Agency or Connection to Client**	**Role During Emergency**	**Phone Number**
Please include the Navigation Care Team Lead, Client's preferred emergency contact, Informal and Formal Supports, Guardians			
Nearest Emergency Department Name	**Address**		

Appendix H: Overview of Aboriginal Agencies in Ottawa

Gignul Non-Profit Housing Corporation

Gignul Non-Profit Housing Corporation works in partnership with other Aboriginal organizations to focus on both short- and long-term housing solutions, including supportive shelters to affordable, independent living.

396 MacLaren Street
Ottawa, ON K2P 0M8
Tel: (613) 232-0016
www.gignulhousing.org

Inuit Non-Profit Housing Corporation

Inuit Non-Profit Housing Corporation owns and operates 79 rent-geared-to-income family housing units in Ottawa and in the north; units range from 1-3 bedrooms in size.

311 McArthur Avenue, Suite 102
Ottawa, ON K1L 8M3
Tel: 613-741-1449

Kagita Mikam

Kagita Mikam provides training and employment support services to Aboriginal clients, including resume writing, employment counselling, labour market information, referral to employment and training opportunities.

456 McArthur Avenue, Box 5
Ottawa, ON K1K 4B5
Tel: 613-565-8333
www.kagitamikam.org

Makonsag Aboriginal Head Start

Makonsag Aboriginal Head Start delivers a licensed preschool program that integrates early childhood education with traditional Aboriginal culture and practices.

Tel: 613-724-5844
www.makonsag.ca

Appendix H: Overview of Aboriginal Agencies in Ottawa

Métis Nation of Ontario

Métis Nation of Ontario provides a range of employment training programs and supports for the educational success of all Métis across Ontario beginning in early childhood, continuing through K to 12 to post-secondary education and into adulthood.

500 Old St. Patrick St, Unit 3
Ottawa, ON K1N 9G4
Tel: 613-798-1488
http://www.metisnation.org/home

Miinwaashin Lodge

Miinwaashin Lodge provides violence prevention and intervention services for Aboriginal women, youth, children and elders, including traditional healing, employment, counseling, shelter, youth and cultural programs, community development initiatives, and social support.

100-1155 Lola Street
Ottawa, ON K1K 4C1
Tel: 613-741-5590
http://minlodge.com/

Odawa Native Friendship Centre

Odawa Native Friendship Centre enhances quality of life for Aboriginal people in the National Capital by offering programs to maintain a tradition of community, an ethic of self-help and traditional teachings from our Elders. Operates an alternative high school.

250 City Centre Avenue
Ottawa, ON K1R 6K7
Tel: 613-722-3811
http://www.odawa.on.ca/

Appendix H: Overview of Aboriginal Agencies in Ottawa

Ottawa Inuit Children's Centre

Ottawa Inuit Children's Centre provides cultural, educational, recreational and social support services to children, youth and families in Ottawa's Inuit community. The OICC operates an Inuit Kindergarten program and does classroom presentations on Inuit culture.

224 & 230 McArthur Ave.
Ottawa, ON K1L 6P5
Tel: 613-744-3133
www.ottawainuitchildrens.com

76 Queen Mary Street
Ottawa, ON KIK 1X4
Tel: 613-746-5400

Tewegan Transition House

Tewegan Transition House operates a 12-bed home for young First Nations, Inuit and Métis women between 16-29 years who are homeless or at risk of becoming homeless.

65 Harvey Street
Ottawa, ON K1S 0A8
Tel: 613-233-0672
www.urbanaboriginal.ca/tewegan

Tungasuvvingat Inuit

Tungasuvvingat Inuit provides a comprehensive range of Inuit specific services in housing, trauma and addictions counseling, culture, children, youth and families, employment and education, health promotion, primary health care, and community support.

604 Laurier Avenue West
Ottawa, ON K1R 6L1
Tel: 613-565-5885
www.tungasuvvingatinuit.ca

Akausivik Inuit Family Health Team

Akausivik is an Inuit health centre focused on family and community health.

24 Selkirk St, Ste 300
Vanier, ON K1L 0A4
Tel: 613-740-0999

Appendix H: Overview of Aboriginal Agencies in Ottawa

Wabano Centre for Aboriginal Health

Wabano Centre for Aboriginal Health provides a combination of traditional healing, primary health care, cultural programs, health promotion, community development initiatives, and social support services to more than 10,000 First Nations, Inuit and Métis people each year.

299 Montreal Road
Ottawa ON, K1L 6B8
Tel: 613-748-0657
www.wabano.com

Ottawa Aboriginal Coalition

The Ottawa Aboriginal Coalition represents an alliance of Aboriginal organizations that advocates at all levels to raise awareness on the issues and unique circumstances of Ottawa's Aboriginal community, while increasing positive and healthy choices for them.

www.ottawaaboriginalcoalition.ca

Appendix I: Integrated Plan of Care Partner Agencies

List of participating agencies in Ottawa (IPC and Aboriginal IPC)

- Centre psychosocial
- Children's Aid Society of Ottawa
- Children's Hospital of Eastern Ontario
- Community Care Access Centre
- Conseil des écoles catholiques du Centre-Est
- Conseil des écoles publiques de l'Est de l'Ontario
- Crossroads Children's Centre
- Family Services Ottawa
- Maison Fraternité
- Ottawa Carleton District School Board
- Ottawa Catholic School Board
- Ottawa Children's Access and Referral to Services
- Ottawa Inuit Children's Centre
- Parents' Lifelines of Eastern Ontario
- Rideauwood Addiction and Family Services
- Roberts Smart Centre
- Royal Ottawa Mental Health Centre
- St. Mary's Home
- Wabano Centre for Aboriginal Health
- Youth Services Bureau
- youturn Youth Support Services

Appendix J: Definition of Complex Needs

Complex Needs are understood to mean:

Multiple intersecting needs that span health, mental health and social issues, leading to major challenges participating in society. Categories of complex needs and contributing social factors include concurrent disorders, complex trauma, suicide and self-harm, inter-generational trauma, residential school trauma, homelessness. There is no generic complex needs case. Each individual with complex needs has a unique interaction between their health and social care needs and requires a personalized response from services.

Considerations of complex needs include (but are not limited to):

- Rather than use the term 'complex needs' to describe an individual's characteristics, it is defined in terms of an active framework for response.
- Fits with the tiered framework[2]
- Essence of complex needs implies both:
    - Breadth of need – multiple needs (more than one) that are interrelated or interconnected across multiple domains of health, mental health and social circumstances
    - Depth of need – reflects the overall severity of the person's situation and ability to manage

[2] Rush, B. (2010) Tiered frameworks for planning substance use service delivery systems: Origins and key principles. Nordic Studies on Alcohol and Drugs, 27(6), 617-636.

Appendix K: Child/Youth Family Pamphlet

Who is helping you and what do they do?

Your Service Providers

One of your service providers will talk to you about the AIPC process. With your OK, a team of people from different organizations is brought together. With their help, you will decide on what things to work on.

You

You get to make all the decisions about your plan of care with the help of your team and your family. You can choose which service provider will be in charge of making sure your plan of care is working for you.

Your Family and Supporters

Your family is important in the AIPC process. They help you talk about your vision and goals for your plan of care. They can also help you get some of these goals done. Family can also make decisions for you, if you can't do it on your own.

For more information, visit www.coordinatedaccess.ca or speak to your service provider.

Your life. Your plan.

The Aboriginal Integrated Plan of Care, or AIPC for short, is your plan.

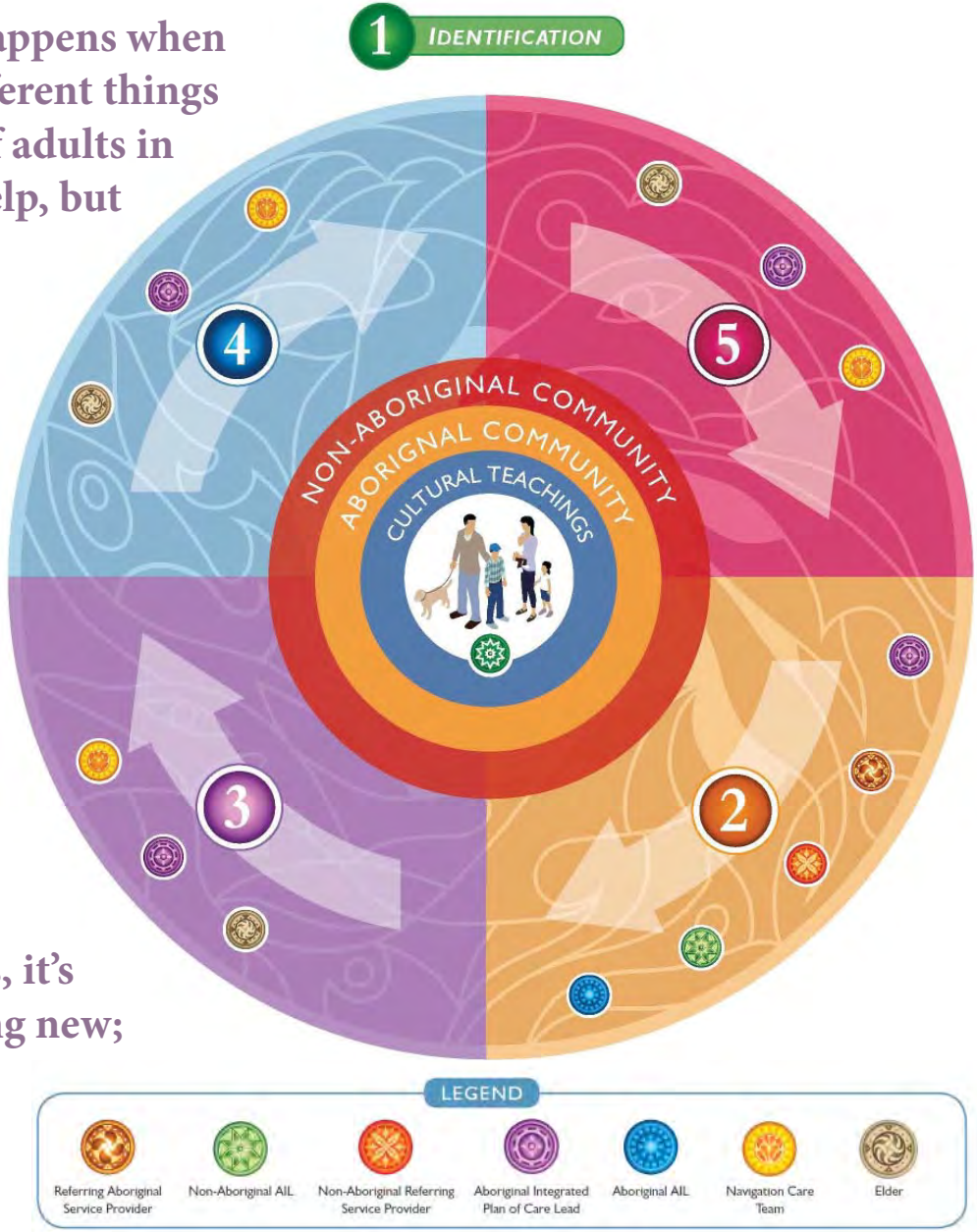
That means you and your family or helpers work together with a team of people from different agencies to create a plan that will work for you.

The AIPC process happens when there are a lot of different things going on and a lot of adults in your life trying to help, but things aren't getting better.

What do we mean by "a lot of things going on"?

- A lot of different issues
- A lot of people are trying to help
- Someone is going to get hurt, or has already

Because of all of this, it's time to try something new; the AIPC.



How does the AIPC process work?

1 When the help you're getting isn't working, a service provider may suggest AIPC.

2 If AIPC feels right for you, you get to choose any service providers who you think should be part of your team.

3 The team of helpers from different organizations get together for a meeting with you and your family to create your plan of care.

4 You will keep meeting with your team to work on your plan of care and complete your goals.

Appendix L: Team Commitment

All Navigation Care Team members are committed to the guiding principles of the IPC process. This includes promoting inter-agency and inter-professional collaboration within a healthy working environment. The goal is team-informed decision making that strives for consensus and ensures a client-centered approach.

We, as the Navigation Care Team, commit to the following:

- We will acknowledge and respect First Nations, Métis and Inuit cultural values, beliefs and practices.
- We will acknowledge that Aboriginal service providers are responsible for connecting clients with those who can provide cultural teachings.
- We will recognize that children/youth and families are the experts and most knowledgeable in their needs, wants and motivations for care.
- We will support the child/youth and family to lead the development of their IPC.
- We will engage the family in a meaningful way that is considerate of supporting families and equipping them with the knowledge required to ensure a better care experience for clients.
- We will all take part in deciding how work should be allocated.
- We will help each other learn.
- We will use the Ottawa Aboriginal Coalition's Collaboration Model to begin the process of fostering and maintaining respectful relationships and partnerships.
- We will actively participate in meetings.
- We will not act in isolation.
- We will support each other to outsiders.
- We will discuss collectively any changes related to our own agency involvement being contemplated.
- We will remain flexible and open-minded.
- We will be respectful of skills, knowledge and strengths of other team members.
- We will have open and transparent communication in order to promote trust-building and collaboration.

Appendix M: Tips for an Effective Meeting

Phase/Task	Issue/Role	Comment
Teammate	• Determining who is on the team • Everyone has an equal voice	
Working Out Team Function	• Forming – Exploration of team skills & attitudes • Storming – Working out differences – disputes • Norming – Establishing responsibilities and routines • Performing – Getting the job done	• As you become more experienced the time necessary to go through these steps decreases. Recognizing the progression can increase your efficiency.
Exploring & Accepting Teamwork Roles	• Roles: Meeting Recorder – Meeting Visualizer – Analyst – Writer – Facilitator – Leader – Task Tracker	• Remember that they can rotate.
Record Keeping	• Documents: Meeting agenda – Meeting Summary and Action Items – IPC	• Preparing and using documents effectively can help you greatly.
Meetings	• To be Effective: Regular time; everyone comes; end on time; use an agenda; do summary notes and action items; recognize everyone	• Make good use of meeting time
Decisions	• Tools: Differentiate between major and minor decisions; allow time; use criteria; hear everyone's opinion	• Making wise decisions has rules that can help.
Disputes	• Tools: Act calmly; classify the dispute; look for compromise	• Make them productive, or at least limit their duration and magnitude

Mistakes Teams Have Made:

- Assuming it's "natural" – it isn't. Working at teamwork can make a real difference.
- Assuming someone else will do it – usually they'll assume you're doing it – be explicit.
- Going too fast at the beginning – skipping

Appendix N: Conflict Resolution Pathways for Navigation Care Teams

Conflict is a normal experience and a part of working collaboratively. Most conflict situations are caused by miscommunication or a lack of clear expectations or agreements between team members and/or agencies. Conflict may also emerge when an unforeseen or unexpected situation presents itself to the team. Regardless of how it emerges, conflict provides a "team learning" opportunity to clarify team member roles, responsibilities and expectations when faced with a new challenge. In this view, conflict is viewed as a strength building opportunity for the Navigation Care Team. Below is one suggested process pathway that might assist a Navigation Care Team to better understand and resolve a particular conflict experience.

Step 1: The Aboriginal IPC Lead organizes a team meeting with all members of the Navigation Care Team to discuss the conflict situation.

Step 2: The Aboriginal IPC Lead or designated Navigation Care Team member facilitates the team meeting. Key aspects of the meeting are to ensure a safe place for people with different views or experiences, to make the intent of the meeting clear, and to create ground rules for the meeting.

Step 3: The Aboriginal IPC Lead should make a brief presentation to "normalize conflict". The main talking points to communicate are listed:

- Develop an attitude of resolution
- Most conflict is structural in nature (not from bad intention); different needs and lack of clear explicit agreement
    - no matter how good a plan may be at the beginning, conflict will arise because of unforeseen circumstances
- Skills that are useful to engage in a conflict resolution dialogue are
    - basic communications skills (respectful dialogue, self-awareness, listening, emotional intelligence)
    - desire to embrace principles of "attitude of resolution"
    - knowledge of the conversational steps

Step 4: The Aboriginal IPC Lead facilitates a team dialogue by hearing each Aboriginal IPC team member's personal perspective on the issue related to the conflict. Suggested questions are:

- What is your understanding of what occurred?
- How has this issue affected you?
- How does this issue affect you on the Navigation Care Team?

The Aboriginal IPC Lead encourages the expression of divergent perspectives and views on the issue.

Appendix N: Conflict Resolution Pathways for Navigation Care Teams

Step 5: The Aboriginal IPC Lead facilitates another round of dialogue, focused on the lessons learned, actions and solutions that can strengthen the Navigation Care Team. Suggested questions are:

- What are the lessons for us as a Navigation Care Team from this experience?
- What do you think should be done about this issue to strengthen our collaboration as a Navigation Care Team?

Step 6: The Aboriginal IPC Lead guides a discussion with the team to solicit the advantages and disadvantages for each of the suggestions proposed.

Step 7: The Aboriginal IPC Lead guides and facilitates the decision making process. Once each solution has been reviewed, the Navigation Care Team selects which option(s) they would like to implement.

In the unlikely event that the Navigation Care Team is unable to arrive at a team-based resolution, each Integrated Care Team member should inform their own individual Agency Implementation Lead (AIL) and/or internal program director of their current inability to resolve the conflict at hand. Once all AILs have been informed, they will convene a meeting in order to identify some constructive recommendations to enable and assist the Navigation Care Team to overcome the challenges.

Step 8: The Aboriginal IPC Lead solicits feedback from each team member regarding their perception of the conflict resolution meeting and their degree of satisfaction that the issue is resolved.

Appendix O: Perception of Care Measure - Initial Meeting

Perception of Care Measure - Initial Meeting

Completing this questionnaire is important to the evaluation of the IPC process. There are no right or wrong answers. We are interested in your thoughts and experiences within the IPC process.

Please answer the following questions based on **your experience in the IPC process**. Indicate if you **Strongly Disagree, Disagree, Agree,** or **Strongly Agree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply.

Your answers are confidential and will not influence current or future services you will receive. Some of the questions are very personal. We appreciate your completion of them. Please answer each question honestly and accurately.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable	Comments
1. I chose the Navigation Care Team Lead.	1	2	3	4	NA	
2. I was involved in the selection of the Navigation Care Team.	1	2	3	4	NA	
3. My cultural values were respected by the team.	1	2	3	4	NA	
4. My linguistic needs were respected by the team.	1	2	3	4	NA	
5. The team worked well together.	1	2	3	4	NA	
6. The team met often enough to provide appropriate support.	1	2	3	4	NA	
7. I was able to choose my Plan of Care goals.	1	2	3	4	NA	
8. I was involved in the creation of my Safety Plan.	1	2	3	4	NA	
9. I have made progress achieving the set goals.	1	2	3	4	NA	
10. The team encourages me to have hope.	1	2	3	4	NA	
11. The IPC process has been more beneficial than my usual treatment planning.	1	2	3	4	NA	

12. Were there any agencies/individuals who should have been involved that were not? Yes □ No □

    If yes, who was missing? _____

13. Is there anything else you would like to share about your experience in the IPC process?

14. Please indicate how you are participating in the IPC process:
    - □ as the primary client OR
    - □ as a family member or supporter.

    a. If you are the primary client, please respond to the following question:

	excellent	very good	good	fair	poor	Comments
In general, would you say your health is:	1	2	3	4	5	

    b. If you are a family member or supporter, please respond to the following question:

	excellent	very good	good	fair	poor	Comments
In general, would you say your child's health is:	1	2	3	4	5	

Appendix P: Perception of Care - Ongoing Meetings

Perception of Care Measure – Ongoing Meetings

Completing this questionnaire is important to the evaluation of the IPC process. There are no right or wrong answers. We are interested in your thoughts and experiences within the IPC process.

Please answer the following questions based on **your experience in the IPC process**. Indicate if you **Strongly Disagree, Disagree, Agree,** or **Strongly Agree** with each of the statements below. If the question is about something you have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply.

Your answers are confidential and will not influence current or future services you will receive. Some of the questions are very personal. We appreciate your completion of them. Please answer each question honestly and accurately.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Not applicable	Comments
1. My cultural values were respected by the Navigation Care Team.	1	2	3	4	NA	
2. My linguistic needs were respected by the team.	1	2	3	4	NA	
3. The team worked well together.	1	2	3	4	NA	
4. The team met often enough to provide appropriate support.	1	2	3	4	NA	
5. I have made progress achieving the set goals.	1	2	3	4	NA	
6. The team encourages me to have hope.	1	2	3	4	NA	
7. The IPC process has been more beneficial than my usual treatment planning.	1	2	3	4	NA	

8. Were there any agencies/individuals who should have been involved that were not? Yes □ No □

   If yes, who was missing? _____

9. Is there anything else you would like to share about your experience in the IPC process?

10. Please indicate how you are participating in the IPC process:
    - □ as the primary client OR
    - □ as a family member or supporter.

    a. If you are the primary client, please respond to the following question:

	excellent	**very good**	**good**	**fair**	**poor**	**Comments**
In general, would you say your health is:	1	2	3	4	5	

    b. If you are a family member or supporter, please respond to the following question:

	excellent	**very good**	**good**	**fair**	**poor**	**Comments**
In general, would you say your child's health is:	1	2	3	4	5	

Appendix Q: Consistency to Practice Checklist

Consistency to Practice Checklist

Aboriginal Agency Implementation Lead

Aboriginal Integrated Plan of Care Lead

Client: _____ **AIPC Lead:** _____

Name *Name*

Aboriginal Agency Implementation Lead

IDENTIFICATION	
Referring Service Provider and Agency Implementation Lead review potential referral and confirms criteria eligibility	
VISIONING THE CARE	
Determine, with the child and family, whether the AIL will be the Lead on the IPC	
• If the AIL will **not** be the Lead on the IPC: o Determine who will be the Lead on the IPC **Name:**_____	
o Complete the internal referral to the chosen Lead	
Complete any paperwork required by your organization with client	
Complete Aboriginal IPC process Consent Form	
Gather client's story	
Gather and complete any existing or required assessments	
Assess continuation of AIPC process	
• If client will not be supported by the AIPC process: o Support the necessary navigation to appropriate programs within Aboriginal service system	
o Ensure that all involved are clear on what services are involved going forward	
Conduct Mini Circles • If client is already receiving non-Aboriginal services: o Gather client and family's perception of the services. Are there any barriers?	
o If there are barriers, contact non-Aboriginal Service Providers involved and conduct mini circles	

Aboriginal Integrated Plan of Care Lead

VISIONING THE CARE	
Create vision statement with client and family	

Identify potential Navigation Care Team members	
Obtain any additional informed consent to contact potential Navigation Care Team members	
Explore inviting an Elder with client and family	
Contact each non-Aboriginal AIL from the agencies selected to be a part of the Navigation Care Team	
Gather the name and contact information of each service provider for each non-Aboriginal organization	
GATHERING THE CIRCLE	
Distribute Service Summary templates to Navigation Care Team for completion	
Share Service Summaries with Navigation Care Team and client/family	
If an Elder was selected, contact the Elder to invite them to join the Navigation Care Team	
Schedule Initial Circle	
Prepare child and family for the Initial Circle	
INITIAL CIRCLE	
Explain the purpose of the Initial Circle	
If an Elder is **not** present, open the Circle	
Elicit Navigation Care Team introductions	
Explain the expectations of the Circle and confirm everyone's roles and responsibilities	
Elicit sharing from the team, beginning with client	
Develop Integrated Plan of Care	
Develop Steps to Success	
Develop Safety Plan	
Set ongoing Circles	
If an Elder is **not** present, close the Circle	
Create and send a summary of the Circle to all Navigation Care Team members	
Ensure that the Perception of Care Measure for the Initial Meeting is completed	
ONGOING CIRCLES	
Revise Integrated Plan of Care	
Revise Steps to Success	
Review and revise Safety Plan	
Ensure care is culturally-safe	
NEXT STEPS	
Ensure that the Perception of Care Measure for Ongoing Meetings is completed	
When Navigation Care Team agrees that the AIPC process is no longer required, develop a sustainable, youth-directed transition plan outlining ongoing activities	