2. Aboriginal Integrated Plan of Care Process

2.1 Commitment of Purpose

The Aboriginal Integrated Plan of Care process recognizes that Aboriginal knowledge and culture is core to providing appropriate services for First Nations[1], Inuit[2] and Métis[3] children, youth and their families. The Aboriginal Integrated Plan of Care 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.

2.2 Guiding Principles

The Aboriginal Integrated Plan of Care process respects and acknowledges Aboriginal cultural values and practices.

The Aboriginal Integrated Plan of Care process acknowledges that Aboriginal service providers hold the sole responsibility of providing cultural teachings. Their knowledge, history and culture will be respected and recognized as their responsibility back to the children.

The Aboriginal Integrated Plan of Care process recognizes that non-Aboriginal informed services working in isolation may have minimal impact on the health and well being of First Nations, Inuit and Métis children youth and their families. Underestimating and/or underutilizing the culture, knowledge and skills in the Aboriginal community is detrimental to providing the best possible service to First Nations, Inuit and Métis children, youth and their families.

The Aboriginal Integrated Plan of Care process recognizes that there are clear distinctions between First Nations, Inuit and Métis culture and needs and that one approach is not appropriate for all.

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

The Aboriginal Integrated Plan of Care process is committed to fostering and maintaining respectful relationships and partnerships amongst both Aboriginal and non-Aboriginal services in Ottawa. The Ottawa Aboriginal Coalition's Collaboration Model, designed as a wheel to represent the process of collaboration that the Aboriginal and non-Aboriginal community of service providers will have to go through together, provides a framework to begin this process

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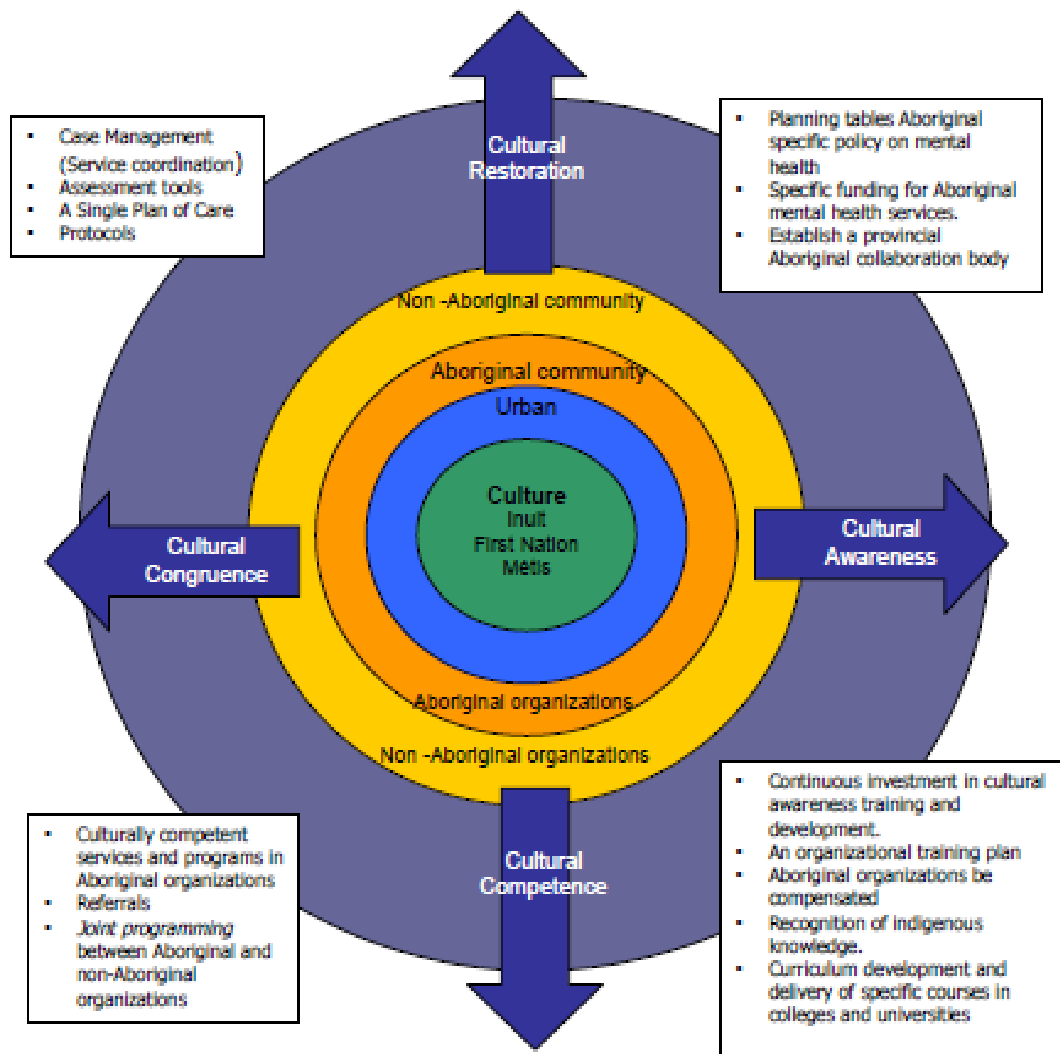
[1] First Nation(s): this term replaces band and Indian, which are considered by some to be outdated and offensive, and signifies the earliest cultures in Canada. (Ottawa Aboriginal Coalition 2013)

[2] 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)

[3] 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)

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 and family. The time and investment that may be required to build trusting relationships that bridge historic and existing attitudinal and systemic discrimination can not be underestimated.

The OAC Collaboration Model



Ottawa Aboriginal Coalition, 2013

2.3 Outcomes / Deliverables

Through the Aboriginal IPC process, First Nations, Inuit and Metis children, youth and families achieve social, emotional, physical, mental and cultural well being and are able to achieve their full potential, thereby bringing about the total well being of themselves, their families and their community.

Development of an Integrated Plan of Care for First Nations, Inuit and Métis children and youth that is grounded in Aboriginal knowledge, culture and approaches to mental wellness.

Provision of care and service based on the Aboriginal Integrated Plan of Care process by cross-sectoral service providers for First Nations, Inuit and Métis children and youth.

First Nations, Inuit and Métis children, youth and their families are actively involved and perceive their care and service to be coordinated, seamless and grounded in their Aboriginal knowledge and culture.

Effective engagement of Aboriginal and non-Aboriginal services to implement the Aboriginal Integrated Plan of Care process.

Expand culturally-based care by Aboriginal service providers and increase culturally competent care by other key non-Aboriginal service providers.

Strengthen the relationship between non-Aboriginal and Aboriginal service providers with a focus on providing the best possible service to the child/youth and family.

Ensure that service coordination for First Nations, Inuit and Métis children and youth is based in and led by an Aboriginal organization whenever possible in consultation with family.

Support a seamless referral process between Aboriginal and non-Aboriginal services.

2.4 Criteria for Consideration

- 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[4] 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 2 or more services from across sectors

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[4] 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 – transition plan would become part of care plan process

- 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, 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

2.5 Aboriginal Integrated Plan of Care process

2.5.1 Identification

For non-Aboriginal Service Providers

When the ***First Nations, Inuit and Métis identifying questions*** are asked by the Referring Service Provider and the child or youth self-identifies as Aboriginal, the choice and opportunity to participate in the Aboriginal Integrated Plan of Care process is explained by the Referring Service Provider. If the Aboriginal child or youth chooses to continue with the Aboriginal Integrated Plan of Care process, the Referring Service Provider communicates with their own Agency Implementation Lead to discuss the plan and to designate someone to connect the child/youth to the Aboriginal Agency Implementation Lead designated by the Wabano Centre for Aboriginal Health.

- The designated person communicates with the Aboriginal Agency Implementation Lead at the Wabano Centre for Aboriginal Health to discuss making a potential referral into the Aboriginal Integrated Plan of Care process.
- If the child or youth has self-identified as Inuit, the Aboriginal Agency Implementation Lead at Wabano makes no decision on the referral and directs the referral over to the Aboriginal Agency Implementation Lead at the Ottawa Inuit Children's Centre (OICC).

If the child/youth and family chooses not to participate in the Aboriginal Integrated Plan of Care process, the option of involving an Aboriginal service in the Integrated Plan of Care process is offered. If the child/youth and family agree, the Referring Service Provider connects with the Aboriginal Agency Implementation Lead at the Wabano Centre for Aboriginal Health or OICC and includes the request to have a Wabano or OICC representative on the Coordinated Access Mental Health Committee in their application to Coordinated Access (i.e. the Referring Service Provider will make an explicit request to Coordinated Access to have the Aboriginal Agency Implementation Lead at Wabano or OICC participate on the Coordinated Access Mental Health committee for this IPC application).

For Aboriginal Service Providers

When a service provider within an Aboriginal agency identifies a child or youth who could potentially benefit from involvement in the Aboriginal IPC process, the service provider communicates with the Aboriginal Agency Implementation Lead at the Wabano Centre for Aboriginal Health to discuss making a potential referral into the Aboriginal Integrated Plan of Care process.

If the child/youth self-identifies as Inuit, the Aboriginal Agency Implementation Lead at Wabano makes no decision on the referral and directs the referral over to the Aboriginal Agency Implementation Lead at the Ottawa Inuit Children's Centre (OICC).

2.5.2 Visioning the Plan of Care

If the family is new to Wabano or OICC, the Service Agreement must be explained and signed by the family either on behalf of the child/youth or if the youth is of age of consent, signed by the youth.

The Aboriginal Agency Implementation Lead at Wabano or the OICC will have an initial discussion with the child/youth and/or family about their vision for treatment and the strengths and needs of the child/youth and their family.

The Aboriginal Agency Implementation Lead at Wabano or the OICC will meet with the child/youth and/or family to obtain informed consent, gather the necessary information including existing assessments as agreed to by the youth and/or the parent, and complete any assessments as needed.

If non-Aboriginal agencies are currently providing services, the Aboriginal Agency Implementation Lead will discuss with the family their perception of the services. If there are any perceived barriers, the Aboriginal Agency Implementation Lead will contact the non-Aboriginal service to conduct a mini circle to facilitate a clarification of the perceived barrier. The youth and/or family may choose whether or not to participate in these mini circles. The goal of the mini circles is to strengthen relationships, educate on the Aboriginal Integrated Plan of Care process, share information and identify and resolve any challenges or mend any broken relationships that might exist to move forward. If the youth/family does not participate in the mini circle, Aboriginal Agency Implementation Lead will share with the youth/family the discussions from the mini circle.

If the Aboriginal Agency Implementation Lead at Wabano or the OICC assesses in collaboration with the child/youth and family, involved service providers, and their supervisor (if applicable) that their needs can be met by Aboriginal agencies, they will not proceed with the Integrated Plan of Care process and will make necessary navigation to appropriate programs within the Aboriginal service system. The Aboriginal Agency Implementation Lead will ensure that all involved are clear on what services are involved going forward.

If, the Aboriginal Agency Implementation Lead at Wabano or the OICC assesses in collaboration with the child/youth and family, involved service providers and their supervisor (if applicable) that the child/youth meets the criteria for the Aboriginal Integrated Plan of Care process, the Aboriginal Agency Implementation Lead at Wabano or OICC and their supervisor will identify and appoint the staff member best suited to take on the role of the Aboriginal Integrated Plan of Care Lead.

The Aboriginal Agency Implementation Lead or the supervisor will connect with the appointed Aboriginal Integrated Plan of Care Lead, the youth and/or family and other involved service providers to inform them of who is the Aboriginal Integrated Plan of Care Lead.

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC supports the child/youth and/or family to establish priorities and to develop an initial vision statement(s) which will provide a common focus for the Navigation Circle Team.

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC identifies with the child/youth and/or families the Aboriginal and non-Aboriginal service providers who could potentially be members of the Navigation Circle Team. The Navigation Circle Team may include agencies that have not yet had involvement with the child/youth and family however may provide insight or services to help sustain a seamless plan of care.

Inviting an Elder (subject to resource availability) to be part of the Navigation Circle Team and to ensure that cultural values are respected are discussed with the child/youth and family. If the family already utilizes an Elder, with the family's recommendation the family will ask the Elder to be a part of the Circle and provide tobacco (or other respectful custom). If the Elder consents to be a part of the Navigation Circle Team, the Aboriginal Integrated Plan of Care Lead will contact that Elder and explain the overall process and invite any questions.

The Aboriginal Integrated Plan of Care Lead obtains informed consent from the youth and/or family to contact identified potential Navigation Circle Team on behalf of the youth and/or family.

The Aboriginal Integrated Plan of Care Lead will contact the Agency Implementation Leads of identified agencies, including those organizations and/or other service providers who might not have been part of the Service Collaborative, to clarify the needs/goals of the child/youth, explain the purpose and steps of the Aboriginal IPC process and elicit each service provider's agreement to be involved. The AILs in the non-Aboriginal agencies will provide the Aboriginal Integrated Plan of Care Lead at Wabano or the OICC with the name and contact information for potential Navigation Circle Team members within their agency.

2.5.3 Gathering the Circle's Participants

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC invites an Elder (if a child/youth and family requests and subject to resource availability) and ensures that cultural values are respected throughout the process (e.g. lighting of the Qulliq, providing tobacco). Prior to involvement, the correct protocol will be engaged with the Elder's assistance.

The Aboriginal Integrated Plan of Care Lead schedules the Aboriginal IPC Initial Circle.

If there was a prior relationship with the child/youth and family, the Navigation Circle Team members provide Service Summaries to the Aboriginal Integrated Plan of Care Lead at Wabano or the OICC for distribution.

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC distributes Service Summaries to youth and/or family and other Navigation Circle Team members requesting the service summaries be completed and sent back to the Aboriginal Integrated Plan of Care Lead prior to the Circle. The Aboriginal Integrated Plan of Care Lead will compile and condense those summaries and get them back to the Navigation Circle Team prior to the Aboriginal IPC Initial Circle and will communicate date, location, agencies/service providers invited, time and estimated amount of time expected for the Circle (the more service providers involved generally the longer amount of time is required).

2.5.4 Aboriginal IPC Initial Circle

If an Elder is present, he/she will open the Aboriginal IPC Circle (smudge or complete an opening or brief traditional teachings regarding the upcoming circle, lighting of the Qulliq). She/he may introduce the use of a talking stick or feather for use during the Circle.

The Aboriginal Integrated Plan of Care Lead is the lead facilitator at the Circle, however may defer occasionally throughout to the Elder for spiritual guidance.

Introductions will be made by all (including all family and personal supports and service participants) of the Circle's participants in the first round.

The Aboriginal Integrated Plan of Care Lead will explain how the Circle will be completed (protocol and what participants can expect). All participants will have an equal voice.

Service Participants are invited to explain their roles and responsibilities in the Integrated Plan of Care; the Aboriginal Integrated Plan of Care Lead seeks clarification and obtains verbal confirmation from everyone involved.

Ideally the child/youth will begin the Circle. This is their Circle and they must be given the opportunity to speak first by sharing their vision for healing and moving forward and what they want from the Circle process. Alternatively, the child/youth and family, or someone they have entrusted responsibility to, will begin by sharing their vision and what they want from the Circle.

Each member of the Circle will have an opportunity to share key significant events and experiences with the child/youth and how they can support the vision shared by the child/youth and family speaking in strengths based facts.

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC facilitates the development of individual goals, the comprehensive Aboriginal Integrated Plan of Care (use Integrated Plan of Care template) and a crisis management strategy.

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC ensures that each goal in the Integrated Plan of Care has an associated Navigation Circle Team member who will take responsibility for that goal with other identified members involved in supporting activities.

Child/youth, family and Navigation Circle Team establish the frequency of follow up meetings, progress checks, regular communications, and responsibility for the child/youth's file.

The Elder or the Aboriginal Integrated Plan of Care Lead at Wabano or the OICC will complete a closing of the Circle.

A summary of the Circle will be sent to all parties involved, including child or youth and their family.

2.5.5 Aboriginal IPC Ongoing Meetings

Ongoing meetings may be necessary when a change needs to be made to the Aboriginal Integrated Plan of Care, or when Navigation Circle Team members need to be added or changed.

Ongoing meetings are used to review and monitor progress towards the vision and the goals outlined in the Aboriginal Integrated Plan of Care.

Integrated Plan of Care is periodically reassessed for effectiveness:

- Are Aboriginal cultural values and practices present and visible in the Integrated Plan of Care process?
- Has progress been made toward goals?
- Have barriers to progress been identified and resolved?
- Has new information emerged that change the original plan of care direction?
- Are goals, strategies and activities realistic and working for the child or youth and their family?

Plan is revised as needed, based on continuous process of assessment.

Lead is checking with the youth and family to ensure their Team is a "good fit" with the original plan.

Team membership reassessed.

Goals are reviewed and revised plan agreed and consented to by child or youth and their family.

Crisis management plan is reviewed and revised as needed.

Care and service provided is guided by an integrated, shared plan rooted in Aboriginal culture and values.

When the youth/child family agrees that involvement in the Aboriginal Integrated Plan of Care process is no longer required, a sustainable, child/youth-directed transition plan outlining ongoing activity for the child or youth and their family and team is developed.

2.5.6 Service Delivery

Care, service and educational programming are provided based on the goals identified in the Aboriginal Integrated Plan of Care. Documentation (e.g., clinical or professional practice) of service providers' activities and services will be recorded in their specific organization format such as case notes, file notes, progress notes. Similarly, educational programming will be recorded in their board-specific format. Goals, supports needed and the roles and responsibilities of Navigation Circle Team members involved in achieving goals are recorded in the Integrated Plan of Care template.

Summary of care and service provided and progress toward goals documented in the Integrated Plan of Care is recorded in meeting summary notes and action items.

The Aboriginal Integrated Plan of Care Lead at Wabano or the OICC compiles and distributes information to the entire team, including the child or youth and their family.

Navigation Circle Team meets with child or youth and their family at scheduled intervals or as needed.