

FINAL RESEARCH REPORT

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An Integration Model for Shared Mental Health Care in Northern Ontario:

The Aboriginal Mental Health Services Research Project on Manitoulin Island

A report prepared by

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Collaborating Aboriginal Partner Agencies:

**Mnaamodzawin Health Services Inc.
Noojmowin Teg Health Access Centre**

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Main Messages

- Previous research shows that the human and service costs due to lack of mental health services can be tremendous, and are connected to health and social crisis situations, emergency use, hospitalization, and CAS involvement. Aboriginal and rural communities are particularly affected by lack of continuity of mental health care and specialized service providers.
- The Mnaamodzawin Health Services Inc and Noojmowin Teg Aboriginal Health Access Centre have developed a model of Aboriginal community-based shared mental health care that maximizes the use of local mental health resources, and facilitates a continuum of care in a region of North Central Ontario.
- In this model, providers have made exceptional progress integrating clinical services such as counselling, psychology, psychiatry and long-term care, with traditional Aboriginal healing approaches.
- Pilot research indicates that the service model is supported by very high levels of client and provider satisfaction.
- The level of cultural competence of providers as perceived by clients is very high.
- Qualitative data shows that there are significant positive client and family, as well as, service outcomes.
- Analysis of program data shows that the provision of integrated Traditional medicine services is associated with a dramatic decline in utilization of clinical mental health services.
- Lack of core funding for clinical counselling is a threat to continuity of care and client outcomes.
- Further research is required to further document, analyse and refine this model.
- Further research should:
 - Track and quantify client and service outcomes associated with various services
 - Examine the integration of clinical and traditional services in greater depth
 - Further examine the utilization trends associated with traditional healing services in relationship to other mental health services
 - Research the role that telehealth and related ICT applications might have in improving access to clinical services and continuing professional mental health education and access to reliable health information
 - Develop best practices in community-based Aboriginal shared mental health care

Executive Summary

Mental health service provision in Aboriginal communities in Ontario is a significant challenge due to many factors -including scarcity of specialist providers in the North, high burden of mental health problems, poorly understood cross cultural service environment, determinants of health, the lack of an Aboriginal mental health strategy, as well as, core funding for Aboriginal mental health services.

A multi-disciplinary mental health team on Manitoulin Island has developed a very promising approach for an Aboriginal community-driven shared care model for mental health services. With this service model the agencies have overcome service barriers - typically associated with multiple jurisdictions and piece meal funding - to create valued culturally competent services that incorporate traditional Aboriginal, as well as, clinical approaches to mental health. The model provides a continuum of care by maximizing a return on scarce resources through a regional approach and integrated service provision.

This project focused on pilot research and a formative evaluation of this model. This research shows high levels of consumer and provider satisfaction as well as positive self-reported and provider-reported health outcomes. Further research is necessary to track this model over time, and to rigorously collect quantitative and qualitative client outcome data.

This model is specifically tailored to applications in Aboriginal communities, however, many of the collaborative approaches between local and visiting professionals can be adapted to other rural or Northern service environments.

Data showed evidence of two important client outcomes related to this model:

- 1. Aboriginal Community-based shared care has excellent potential to improve client outcomes and reduce use of acute care utilization due to serious mental illness.**
- 2. Aboriginal Community-based shared care has excellent potential to improve the mental health and wellbeing of Aboriginal clients, families and communities.**

Program data showed evidence of two important service outcomes related to this model:

- 1. The provision of integrated Traditional medicine services is associated with a dramatic decline in utilization rates of clinical mental health services.**
- 2. The case management model for serious mentally ill clients and geriatric care is associated with an approximately 90% drop in readmissions to hospital based acute care.**

Recommendations for Policy Development

- Aboriginal mental health policy remains a priority need
- Core funding for core mental health services are necessary and need to replace the short term piece meal approaches
- Create opportunities for pilot funding for new and promising approaches to Aboriginal community-based shared care
- Create opportunities for funding to research new and promising approaches to Aboriginal community-based shared care

Recommendations for the Mnaamodzawin Noojmowin Teg Mental Health Team

Mental health program recommendations:

- Initiate a rigorous data collection process with all service providers to ensure evidence-based decision making is possible, including
 - Unique client identifiers, service data, presenting concerns, referral data and readmission data
 - Client outcomes
- Implement select components of clinical supervision, focused on maintaining high quality service and on-going development of the team, including:
 - yearly random case reviews/ file audits
 - implement case reviews for community level workers who provide counselling
 - audit indicators that include clinical, traditional healing, as well as cultural components
 - implementation of formal clinical supervision for new team members
 - implementation of regularly scheduled team case reviews
- Expand case management, beginning with clients at high risk, with multiple needs and/or with frequent re-admissions
- Increase opportunities for providers to enhance and shape their understanding of traditional and clinical integration; research should be a key component
- Educate mental health services clients about traditional healing services and how this can complement clinical services during initial sessions

Contract Services

- Expand services in traditional medicine
- Expand services in psychiatry, especially child psychiatry
- Create linkages and integrate all contract services (focus on third party agreements)
- Track concise program and client outcome data for all contract services (i.e. third party agreements with psychologist, psychiatrists etc.)
- Offer formal and informal opportunities to educate new staff as well as contract staff on the integration of Traditional healing and clinical mental health services

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Shared Supervisory Relationship with Community Workers

- Develop an effective communication strategy, that includes regular face to face meetings involving the case manager, band managers, and community workers, to manage expectations and report on progress of the shared supervision model
- Assess long-term mental health goals in each community
- Assess information and support requirements of workers in each community
- Implement case reviews with workers who provide counselling
- Implement a plan to achieve community goals with a particular focus on continuing education needs, clinical supervision of community workers, and community appropriate prevention services
- Track milestones achieved as part of the shared supervisory agreement

System-wide

- Continue to focus on building local community capacity for mental health care, including counselling, provision of follow up and supportive services and prevention programming
- Link this report to the regional strategic plan

Recommendations for Future Research

- Further investigate the effective integration between clinical and traditional Aboriginal services
- Study identified topics related to the integration of clinical and traditional services in-depth
- Further examine the utilization trends associated with traditional healing services in relationship to other mental health services
- Rigorously collect Aboriginal mental health, service, program, and general health status data related to Aboriginal community-based shared care
- Quantify client and service outcomes associated with various services
- Qualitative research on client, community, and health systems outcomes related to Aboriginal community-based shared care, including case studies
- Strategies for continued capacity building and local health empowerment related to Aboriginal community-based shared care
- Research the role that telehealth applications might have in improving access to services and continuing professional education
- Develop best practices in community-based Aboriginal shared mental health care

Full Report

1. Context: Aboriginal mental health and mental health care in Northern Ontario

Mental health problems are a significant health concern in Northern Ontario. Mental health diagnoses are more common when compared with the whole province (134.3 for males and 133.9 for females per 100,000 in Ontario vs. 207.9 for males and 218.1 for females respectively per 10,000 in Northern Ontario)ⁱ. Mortality due to suicide is also significantly higher (8.0 per 10,000 in Ontario versus 11.5 per 10,000 in Northern Ontario)ⁱⁱ. This has a significant impact on the health care system. Suicide hospitalizations in Northern Ontario are occurring at more than double the Ontario rate (8.3 per 10,000 in Ontario vs. 19.2 per 10,000 in Northern Ontario)ⁱⁱⁱ. During the 2004/2005 fiscal year, acute mental health diagnoses represented 7.6% of hospital separation data^{iv} from North East Ontario hospitals and 11.4% of total hospital days, both proportionately higher when compared to data from Ontario hospitals (5.8% and 10.9%, respectively)^v. The average length of stay while awaiting transfer to a psychiatric facility in alternate level care, is the longest wait in any care in the North Eastern LHIN. It is almost double in North Eastern Ontario compared with Ontario (40 days versus 23.9 days)^{vi}.

Aboriginal people represent a higher proportion of Northern Ontario residents compared with Ontario, and there is evidence that Aboriginal communities are significantly affected by high rates of mental health issues. Aboriginal populations are not adequately captured in most health surveys. Aboriginal specific data is also poorly captured in health system utilization data. Despite the short fall of population level data, there is evidence to suggest that mental health issues in Aboriginal communities in Northern Ontario are more severe than the rest of the population. The 2003 Regional Health Survey focused on First Nations people living on reserve

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and found significantly higher levels of depression and suicide among surveyed First Nations populations compared with the general population (24 per 10,000 vs 12 per 10,000). Statistics show that Aboriginal people are twice as likely to seek help for mental health problems than the general Canadian population (8% versus 17%) and it is estimated that these rates would be even higher if services were more accessible^{vii}.

Shortages in health human resources in Northern Ontario result in reduced accessibility of specialized services such as psychiatric care and mental health counseling, and continuity of care is often compromised. For Aboriginal clients, culturally competent care constitutes a further dimension of service requirements. Providers need to understand the mental health concerns of importance to many Aboriginal communities, such as multigenerational trauma, and the consequences of residential school. Providers should also be aware of, and support clients in treatment choices which incorporate cultural and traditional Aboriginal healing. Despite these gaps, there is currently no federal or provincial Aboriginal mental health strategy to address these needs.

Deinstitutionalization and the closing of psychiatric facilities has shifted the emphasis of mental health care to the community level. There is an increased need to understand how this care can be facilitated in mainstream, as well as, Aboriginal communities^{viii}. Past research has primarily focused on how collaborations between family physicians and psychiatrists can improve care at the mainstream community level, particularly in rural areas. In contrast, this research project examines the impact of collaborative approach to care facilitated by a core team of community-based mental health professionals and traditional Aboriginal providers in Aboriginal communities on Manitoulin Island. The research examines who this team is approaching continuity of care and cultural competent service provision in the absence of an

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Aboriginal mental health strategy, and lack of core funding for many of the services required for their service population.

Purpose of this research:

This project was designed to achieve two main goals:

1. To conduct formative evaluation research on the shared care services at Mnaamodzawin Noojmowin Teg, including an evaluability assessment and documentation of the current service model and client satisfaction levels.
2. To conduct pilot research, including an assessment of client recruitment strategies, and quality of existing data sources, as well as, to refine research questions for a larger study of these services.

Overview of location and client population:

Manitoulin Island is a large fresh water Island located within Lake Huron and Georgian Bay in Northern Ontario, and is accessible by swing bridge and seasonally ferry boat. The closest urban centre, Sudbury, is about 160 kilometers from the bridge to the Island. Most communities are dispersed within a 100 km approximate radius of this bridge. According to the 2006 census, the Manitoulin District is home to about 13,090 residents. The population includes approximately 5,100 Aboriginal people living in a total of 7 First Nations and off-reserve communities.

The mental health team mainly serves a client population who reside in one of five reserves in the Manitoulin District, the First Nations of Aundeck Omni Kaning, Sheguiandah, Sheshegwaning, Whitefish River, and Zhiibaahaasing, but some clients also reside off-reserve or in one of the two larger communities of M'Chigeeng or Wikemikong. The total population is comprised of approximately 1044 people living on reserve and an estimated 800+ individuals who reside off reserve. See Table 1 for detailed population counts. Geographically, the

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communities are located within about a 100 km radius from the main Mnaamodzwin/Noojmowin Teg office in Aundek Omni Kaning.

Table 1: Client population

First Nation Community	Population residing on reserve^{ix}
Aundeck Omni Kaning	346
Sheguiandah	160
Sheshegwaning	107
Whitefish River	379
Zhiibaahaasing	52
Total population on reserve	1044
Off reserve	842 (estimate ^x)
Potential Aboriginal client population	1886

Service overview:

The five First Nations have transferred health services under a single collective agreement with Health Canada in 1995. This has resulted in the creation of one regional provider, Mnaamodzawin Health Services Inc. (MHS), as well as five First Nations level clinics. Additional services are provided by Noojmowin Teg Health Access Centre (NT), an Aboriginal health access centre provincially funded under the Aboriginal Healing and Wellness Strategy (NT provides services to other Aboriginal communities in the area as well). MHS and NT provide regional Aboriginal mental health services including mental health counseling and Traditional Aboriginal medicine. In the area of mental health, the First Nations based services generally have a focus on prevention activities and support services, but some also offer mental health counseling.

For acute care, a general hospital is located in the district, with site locations in Little Current and Mindemoya, including 24 hour emergency service, and approximately 15 acute care beds at each site. Psychiatric acute care in-patient beds are available at the Sudbury Regional

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Hospital. Approximately 120 km east of Sudbury, The North Bay Psychiatric Hospital provides over 300 psychiatric bed with almost half allocated to long-term rehabilitation^{xi}.

Research questions:

The formative evaluation and pilot research was designed to address a range of research questions which are presented in Table 2.

Table 2: Research questions

Question No.	Research Question (RQ) addressed in this report
RQ 1	What are the key features of the interdisciplinary model of shared care for mental health developed at Mnaamodzawin and Noojmowin Teg?
RQ 2	What strategies have providers developed to facilitate a continuum of mental health services for clients in a northern and rural context?
RQ 3	Are there specific service gaps that exist?
RQ 4	How is the team facilitating shared care that includes both Western and Aboriginal mental health care approaches, specifically in terms of: a) policy development b) definition of scopes of practice c) liability and risk management d) interprofessional education e) case management process d) health centre policies for traditional Aboriginal healing services
RQ 5	Are there measurable health outcomes that relate to this model of care?
RQ 6	Are there measurable service, community or health human resources outcomes?
RQ 7	Are there additional indicators that could be collected to document client (or other) outcomes?

2. Research Approach:

Mnaamodzawin Health Services Inc. representatives (Executive Director, Douglas Graham, and the Board of Directors) identified this project as a priority, initiated a partnership with the Principal Investigator and assisted in the planning of the project. The research process took a participatory action approach; as such, the project was designed to be highly collaborative, involving academic researchers, community-based researchers, and local stakeholders in all

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phases of the research. Adherence to local Aboriginal research protocols was particularly important due to the sensitive nature of mental health research. In agreement with the local research guidelines (GEAR), ethics review was sought from the Manitoulin Aboriginal Research Review Committee, and a local Steering Committee was formed to oversee the research process.^{xii} The Steering Committee consisted of local Aboriginal Elders, community members and decision makers, individuals who had insight into local community circumstances and an understanding of the mental health services. The Steering Committee collaborated on research questions and advised on culturally appropriate implementation of the research project. The Mnaamodzawin-Noojmowin Teg Mental Health Team (referred to hereafter as the Team), was engaged as a technical advisory team to the researchers and provided invaluable assistance on key informant information, recruitment of clients, and access to background documentation. During the interview client phase, the Team was made aware of times and dates of client contact with the researches to ensure preparedness for follow up counseling services if necessary. Clients were interviewed by experienced community-based Aboriginal researchers.

Since the primary goals of this project were to describe the service delivery model, and to assess program data, a mixed methods approach was employed, which combined qualitative and quantitative sources of information. The data collection took a multi-pronged approach and included the following sources:

1. Program document review: A review of annual program and evaluation reports, program plans and proposals.

2. In-house data, hospital emergency data and inpatient data: Available data sets were identified, assessed and analyzed where appropriate. Service statistics directly provided by the

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Team were included, as well as utilization rates of other mental health related services including hospital and emergency room use.

3. In-depth interviews with mental health and social service providers: A key informant list was developed to recruit key stakeholders. Those interviewed included members of the Team, local (off-reserve) therapists, regional service providers, CAS workers and tribal police. Response rate was 100%, however, due to restrictions in time and resources, not all providers identified could be interviewed. A total of 15 providers were interviewed. Three focus groups were conducted with a total of 16 individuals participating.

4. In-depth interviews with clients of the services: Clients who had received services were contacted by the Mnaamodzawin intake worker. The participants were current clients who were mentally competent. A total of 67 clients were contacted and 23 clients were interviewed. The response rate was 34 %.

5. Mailed client satisfaction questionnaires

Since no client satisfaction data existed, a client satisfaction survey was implemented. Clients were provided with a short questionnaire and a stamped envelope addressed to the principal researcher. Fifty questionnaires were distributed by providers to their clients during a one month period. Nine completed questionnaires were received.

3. Results and Recommendations:

In this section we address findings related to the seven research questions identified in Table 2. Each question is addressed in a separate section, however clearly there is overlap: Often results apply to several research questions. We also provide recommendations based on the results.

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RQ1: Key features of the Mnaamodzawin Noojmowin Teg interdisciplinary model of shared care

Key organizational and service features associated with this model are outlined in this section.

1. Regional integration of federal and provincial services: Two organizations have integrated their services and staff to form a multi-disciplinary mental health team:

- Mnaamodzawin Health Services Inc., a regional provider of First Nations health services for five communities funded through a federal transfer agreement; and
- Noojmowin Teg Health Access Centre, a regional service provider of specialized services for all Aboriginal people in the Manitoulin District, provincially funded under the Aboriginal Healing and Wellness Strategy. (See Table 3 for current complement of staff and contract services.)

Table 3: Composition of the core team and contract consultants

Position	FTE or contract	Employer	Funding stream
Mental health program manager	1	Mnaa	Health transfer
Psychologist	1	Nooj	AHAC
Traditional coordinator	1	Nooj	AHAC
Mental health workers	2	Mnaa	Aboriginal Healing Foundation
Mental health nurse/ case manager SMI	1	Mnaa	Health Transfer
Psychiatrist	1 day per month	Contract services	Health transfer
Visiting Psychologist	Every two weeks	Contract services	AHAC
Traditional Healer	4-5 days per month	Contract services	AHAC

Integration of the regional team was enhanced by the following:

- Shared space in a common office environment
- Long-term staff retention of key personnel
- Formal collaboration opportunities and processes such as yearly planning retreats and weekly intake meetings
- Shared policies and procedures
- Involvement in collaborative efforts at a broader level such as the district wide mental health network
- Services and activities to build capacity with clinical staff related to Aboriginal teachings, ceremonies, language, history and other aspects of culture.

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2. Integration of Aboriginal healing and clinical mental health services: Clients are able to access traditional healing services as well as clinical mental health services by experienced providers, either in combination or separately.

3. Interdisciplinary community outreach model: Over the last 10 years, mental health service providers in the two organizations have developed a team of diverse providers with expertise in psychology, mental health nursing, long-term care, social work, traditional Aboriginal medicine and healing. The Team's main office is located in Aundek Omni Kaning, however, regularly scheduled out-reach services in each of the five communities are provided by visiting professionals. Specifically, the team members visit clients at the local community health clinic, the Mnaamodzawin Noojmowin Teg main office or at the client's home. This model of service provision makes mental health services much more accessible than a single location model where clients travel to a central location to receive services, and allows for greater confidentiality in small communities^{xiii}.

The core team collaborates and coordinates services to varying degrees with:

- Specialist service providers (eg.: psychiatrist) under contract with the organization(s).
The relationship between the certain Team members and the psychiatrist, as well as the traditional healer, is highly collaborative.
- Community-based professionals and para-professionals who provide prevention and support services at the First Nations level. Greater level of integration and service coordination is desired from the community-based organizations.
- Off-reserve providers, including family physicians and private practice therapists. There is some collaboration with physicians, mainly through the psychiatrist and the case

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manager for clients with chronic mental illnesses; collaboration is more limited with other service providers, often based on established relationships between providers.

4. Regional planning and networking: The regional organizations are coordinating their efforts in the procurement of necessary specialized services through some core funding and by “cutting and pasting” various short term funding sources. They fulfill a regional advocacy role and have established formal networks (such as the Manitoulin Mental Health Networking Group), with other agencies and providers to advance Aboriginal health services and coordination of care. Regional strategic planning is also occurring between the regional providers MHS, NT, and the five community clinics.

5. Focus on comprehensive capacity building: Regional workers, community workers, clients and their family and community have all been targeted for capacity building. Areas of capacity building have included: cultural competency, advanced clinical services, traditional healing services, as well as support of workers at the community level and building capacity with clients to manage their illness and/or adopt healthy behaviours.

RQ 2: What strategies have providers developed to facilitate a continuum of mental health services?

Several operational strategies have been developed to create a continuum of care including intake meetings, informal case consultations, and local management of specialized contract services. Other strategies are currently in the developmental stages and include shared supervision agreement with community-based organizations and workers, as well as, increasing case management and case conferencing opportunities,

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1. Weekly intake meetings

The Team reviews new referrals at weekly intake meetings. The providers review intake and referral information before clients are assigned to the most suitable mental health provider or to several providers. Services may include mental health counseling, chronic illness care, psychiatry services, and/or traditional healing services. Other service needs (e.g: primary care), may also be identified, and clients are commonly referred to other service providers in the organizations (e.g.: long-term care nursing). This team approach facilitates a high level of continuity of care for mental health clients as well as a fast response to urgent cases. The weekly intake meetings have further benefits. It creates an environment for new staff members to learn more about the local Aboriginal communities and culture, as well as common mental health issues, and accepted treatment approaches. All team members are encouraged to exchange information, receive feedback from their peers, and provide support. The Team's goal is to implement a regular review of select client cases on monthly basis.

As the demand for mental health services continues to increase^{xiv} and surpass the resource capacity of the Team, clients are referred out to private service providers who provide counseling sessions under a FNIHB Non Insured Health Benefits fee for service agreement. In fact, in the 2004/2005 fiscal year, 40% of intakes were referred out. There is no follow up once clients are referred out. It is unclear if clients who are referred to private providers receive a similar level of continuity of care and culturally competent care as those clients who are supported by the Team. Similarly, some contract providers have no apparent linkage or collaborative practice with the Team, and continuity of care and quality of service is unknown.

2. Informal case consultation and team supervision

Clinical supervision is a key component of mental health practice. It provides support, promotes continued learning, and ensures protection for clients^{xv}. Research shows that clinical supervision poses challenges in a multi-disciplinary environment. A formal case review process and supervision process has therefore not been implemented by the Team. Instead, a peer supervision process has been employed by the workers, including *ad hoc* informal case reviews and informal case consultations with colleagues. Providers share a main office location and maintain an open door policy. Hallway consultations are common amongst members of the Team, and enables peer supervision. Providers generally report high levels of satisfaction with the peer supervision model. Consistent with this Team's approach, peer supervision is often used in multi-disciplinary teams with experienced providers, however, it is necessary to caution that the peer supervision model is usually supportive of established, site-specific norms and might not challenge workers sufficiently^{xvi}. Implementation of case audits for all provider and more direct supervision of new workers should be considered.

Recommendation:

Implement some components of clinical supervision, focused at maintaining high quality service and on-going development of the team, including:

- yearly random case reviews/file audits
- audit indicators that include clinical as well as cultural components
- implementation of formal clinical supervision for new team members
- implementation of regularly scheduled team case reviews

3. Continuum of care related to contract services

The following services are provided under contract through a third party agreement with the regional providers:

Psychiatry: Psychiatric services are purchased by the regional provider and services are offered at the main office location on a monthly basis. All clients who receive psychiatric services are also monitored by a Team member to ensure continuity of care and follow up. The Team member may also attend sessions with the client. Appointments fill up quickly and a waiting list is maintained by the intake worker in the event of cancellations. Regional providers often consult in-person with the psychiatrist during regularly scheduled visit regarding clients. Notes to family physicians are written to ensure continuity of care. This time is used very efficiently.

Psychology: Contract services in this area appear less collaborative at the time of this research and there are times when client information is not accessible at the agency level when necessary.

Traditional Healing Services: The services of a traditional Aboriginal healer are also purchased under a consultant contract. The traditional coordinator normally attends all traditional healing sessions with the traditional healer and client. She also maintains client charts and coordinates necessary follow up including traditional health, clinical mental health, and primary care. The traditional coordinator, in collaboration with the traditional healer, determines if clinical mental health services are required and refers when necessary. These services are in high demand by community members, and appointments fill up quickly. Consequently, there is not sufficient time for the healer to review cases with mental health workers or increase collaboration; however, the traditional coordinator provides the important link back to the Team.

Recommendations:

Expand services in traditional medicine

Expand services in psychiatry, especially child psychiatry

**Create linkages and integrate all contract services (including contract psychology)
Keep program and client outcome data for all contract services**

4. Shared supervision model for community-based mental health workers

At the time of this research, the shared supervision existed mainly on paper in the form of a signed agreement between individual First Nations communities and Mnaamodzawin Health Services for joint management of the First Nations level employees by the mental health program manager and band managers. These positions include mental health related community positions funded through NNADAP, and Brighter Futures Initiative and Building Healthy Communities, with an emphasis on primary and secondary prevention. These positions are paraprofessional positions, although some workers have advanced qualifications. In the past, the job descriptions for these positions have varied from community to community, and at times, even from year to year. Some of the workers engage in counseling clients and others focus on community mental health promotion, primary prevention and community development. Differences in these positions are influenced by perceived community needs, community leadership and the worker's level of experience. A longstanding expectation of many community workers and leaders has been that the specialized regional providers at Mnaamodzawin Noojmowin Teg would focus part of their efforts on (1) building local capacity for direct service provision such as individual counseling, and (2) support strategic directions and good practices in the area of primary prevention and health promotion. Yet due to the high demand for services, the focus of the regional provider has been direct service provision in the form of clinical services, but a few additional services are provided in collaboration with community-based staff, such as parenting programs, or group sessions. In addition, MHS has been instrumental in increasing local access

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to education opportunities, such as the Native Community Care Diploma (NCCD) program which is designed to allow community-based workers to keep their positions while improving their skills. This year, there were 12 NCCD graduates from Manitoulin Island.

These initiatives are excellent first steps towards on-going capacity building. More are needed. For example, some community workers are in need of a more profound skill set than that provided by the NCCD program. Supporting local workers to increase their skills to support their community will take a concentrated effort and additional resource allocation. Long-term strategies to improve mental health counseling skills for those community workers who provide this service is are required. Some workers are interested (or enrolled) in degree programs, while others require ongoing professional development. Some workers who already have counseling skills need mentoring and clinical supervision. The new supervisory role of the mental health program manager is an opportunity to shift the focus to mental health services capacity building at the community level, however, ongoing awareness of several important community issues is essential:

- a) **Negotiate expectations of community administrators, community workers and regional managers:** For the shared supervisory model to be successful, clear role definition is essential in terms of clinical supervision, strategic planning, development of primary prevention community programs and enhancing the professional Aboriginal working environment. Visibility of the mental health program manager as the new supervisor is perceived as very desirable by community staff, and is essential for effective change management, particularly during the transition phase.
- b) **Some community members will not seek out counseling or education sessions by community workers:** This is generally due to past relationships and/or shared histories

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or family relationships with workers. Respecting client choices concerning access to their health information, and continued access to regional workers, will be important.

- c) **Some community workers feel disconnected.** There appear to be several reasons for this: (1) Clinical providers have exceeded capacity for services and are not able to support community workers sufficiently; (2) Some community workers are interested in using community level aggregate service data from the regional providers, but do not have access to that information (eg.: top presenting concerns). (3) clinical service providers often do not have permission to discuss their case with local workers; (4) some community workers would like to offer support services, but are not aware which clients have provided consent for them to be involved in their care.
- d) **Differences between regional and community workers:** Some people perceive a power differential between the community workers and the regional workers because of inherent differences in the positions. Typically, the regional workers have professional positions, in contrast to the many community-based para-professional positions; regional workers tend to have more advanced qualifications and skills in clinical mental health, and consequently, they tend to have higher salaries and greater professional autonomy. These perceived differences can have a divisive effect and appears to be compounded by the fact that most community workers are community members, whereas regional workers are rarely members of the target communities. This issue needs to be addressed through a clear, positive and empowering process of supervision and team building. This is an important consideration in the implementation of shared supervision model.

Recommendation:

Develop an effective communication strategy that includes regular face to face meetings involving the mental health program manager, band managers, and community workers, to manage expectations and report on progress of the shared supervision model.

Assess long-term mental health goals in each community based on strategic plans as well as collaborations with band managers and workers.

Implement a plan to achieve these goals with a particular focus on continuing education needs, clinical supervision of community counseling staff, and coordination of services.

RQ 3: Are there specific service gaps or needs that exist?

This project was not designed as a needs assessment, however, several needs were identified during interviews with clients and providers. The following needs were identified:

- Increase in primary prevention and early intervention programs
- Some need for weekend availability, particularly for urgent care or crisis management
- More access to traditional healers
- Access to Aboriginal spiritual leaders and teachers
- More psychiatric services, including child psychiatry
- Increased support for local workers to increase their skills and capacity for counseling and primary prevention programming
- Need for service geared to male victims of spousal abuse
- concurrent addictions/substance abuse services incl. supportive services, rehab/aftercare
- Childcare for clients is sometimes an issue, particularly for those who have to travel

QR 4: How is the Team facilitating shared care that includes both Western and Aboriginal mental health care approaches?

Traditional healing as a holistic medical system has been practiced by Aboriginal people for thousands of years and is still practiced today outside of the mainstream health system by many Aboriginal people. However, providing these services in a health centre setting, and in co-operation with western treatment modalities requires much groundwork to ensure clients, providers, and organizations are protected. The traditional coordinator has made significant progress, over the past 10 years, to facilitate this integration at MHS and NT.

1. Traditional healing protocols: Traditional healing protocols are established and implemented to ensure healers and clients are protected. Healers are very effectively screened for both their area of expertise and their community recognition as an Aboriginal healer. The healers work with the traditional coordinator to ensure continuity of care for clients, including follow up, and monitoring of herbal medicines. This protocol is an essential component for the successful integration of Traditional healing and clinical services, as well as risk management and safety for clients, the healer, and the organization.

2. Inter-professional education: The core team is established and works within a practice setting where traditional healing approaches are accepted and respected. Team members have had opportunities to learn about traditional healing through workshops, informal discussions, and experiential opportunities like participating in Aboriginal ceremonies or attending traditional healing sessions. New staff members and contract providers are not necessarily at the same level of inter-professional education. Ongoing professional development in this area is therefore essential.

Recommendation:

Offer formal and informal opportunities to educate new staff as well as contract staff on the integration of Traditional healing and clinical mental health services

3. Client access to traditional healing approaches: Clearly, the MHS NT mental health team has made exceptional overall advancements in terms of integrating clinical and traditional approaches to mental health. During the interviews and in the client satisfaction questionnaires, almost all clients expressed the belief that their workers are supportive of Aboriginal healing approaches, and that these services are accessible to clients. Several clinical service providers inquire with each client about their interest in traditional healing services.

Interestingly, though, many clients also mentioned that they did not ask their clinical provider about traditional approaches, or that the topic just never came up during sessions. There are several possible reasons why communication about traditional approaches might not be completely free flowing. First, there is evidence that some clients are unsure how traditional approaches might be integrated into the clinical setting without the benefit of guidance from their workers. This is expressed in the following quotes.

“ I mean what could you incorporate [in terms of Traditional Medicine]? Unless you want someone to smudge you or pray with you before you speak [to your counselor] – I don’t need that to sit down and talk to somebody.” Client (2)

“I didn’t request any of that [Traditional or cultural approaches], I just went along with what the [counselor] said” Client (3)

Other clients are uncomfortable discussing traditional approaches with their workers:

“I would be uncomfortable talking about Indian spiritual needs [with my worker].” Client (5)

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It appears that, based on their previous experience with the mainstream health care system, many Aboriginal clients seem to expect a level of separation between western clinical and traditional health services. Further integration of the two approaches will require client education as well as provider education, since it is a new way of accessing, providing and understanding mental health services. Clients we spoke with who did access the traditional healing services were referred by family members or self referred; none were referred by a clinical mental health worker. (There is an indication that these referrals do occur, but none of the clients we interviewed reported to be referred by their worker). In contrast, clients who were admitted through the traditional healing services were freely and frequently referred to the clinical mental health services. One participant explained this phenomenon as follows:

Do I see a barrier, I see a barrier in the two workers working together, the traditional counselor and western counsellor. There doesn't seem to be that [collaborative] approach, but I think there's ... that respect for one another. And there's that push for us to go either traditionally or... towards the western model. But I don't think there's that push to go to the western model and then over to the traditional aspect. I don't think or feel that a western counselor feels inclined - whoever you go and see - to throw as an option for a person to go and see a traditional healer... Like we're more inclined to [send] someone towards a traditional person and they might lead into western type counseling but I don't think it's going the other way! I don't think it's ...a recognition of that being as worthy as what they're doing. Whereas the traditional one sees it worthy as giving both options to them, that's what it is. (participant)

Important further development is necessary in this area for clinical providers to gain a common understanding how to integrate these two approaches at a more profound level and then how to educate the clients who are unsure how the integration might work.

Recommendation:

Create opportunities for providers to enhance and shape their understanding of traditional and clinical integration; research should be a key component
Educate mental health services clients about traditional healing services and how this can complement clinical services

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4. Culturally competent care: Culturally competent care goes beyond offering traditional healing services, in fact some Aboriginal clients prefer clinical services because traditional practices are not part of their way of life. Clients and providers spoke about accepting people's beliefs, religions (eg.: Christian clients), their background and history or presenting concern without judgment and providing services that are right for them. During the in depth interviews, clients repeatedly expressed the belief that their workers were culturally competent. Many saw this as a feature of the MHS NT services which are clearly different from mainstream approaches.

Living on the reserve is a different way of life...a different way of thinking. Maybe some needs are different. A lot of people I talked to in the past who were counselors that hadn't worked for Mnaamodzawin or Nooj. – they didn't understand certain things that seems like it's a part of your life when you're on the rez. It's a different way of thinking. A different way the whole community deals with things. These two counselors understand that; it's not even an issue." Client (2)

5. Case management: Ongoing case management is currently provided for geriatric clients and clients with serious mental illness. For other cases, collaboration opportunities consist of the intake meeting, informal case consultations, and occasional case conferencing.

Case management model for SMI and geriatric clients: In this model, a mental health nurse case manager monitors clients at least once per month, but some as often as once per week. The communication between the case manager and the psychiatrist is reported to be excellent, and includes consults during monthly visits as well as fax communication as necessary for the remainder of the month. Medications are continuously monitored by one worker which helps to ensure that medications are not prescribed by various physicians. The psychiatrist keeps local

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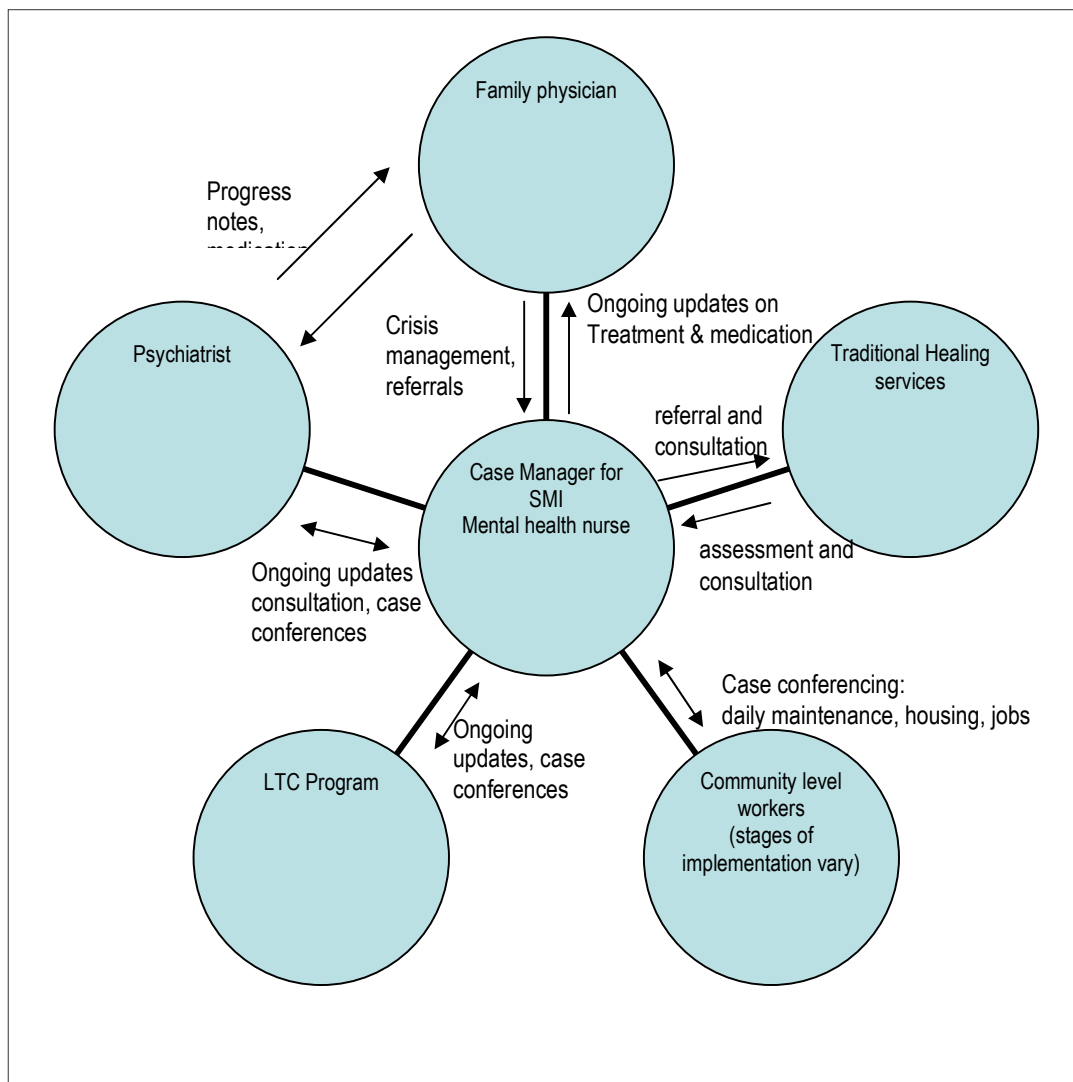
family physicians informed through progress notes, and several family physicians provide notes back however this is not consistent for all physicians.

During the initial visits, the case manager discusses services and inquires about clients' interest in a referral for traditional services. An estimated 30% to 40% of who receive case management services under this model request traditional healing services. Workers report that information about Aboriginal herbal medicines is openly shared in this service environment. Based on in-house program statistics, there is a 90% reduction in acute care hospital admission with clients in this program^{xvii}.

The case manager also works with several local community mental health workers to ensure monitoring, enhance acceptance of the mentally ill in the small communities and coordinate other essential services such as housing or job searching. There are some barriers to working with the local team, since only about half of the clients agree to have their health information shared with local providers. A diagram of the model is depicted in Figure 1.

Case management for other mental health clients: Further case management has not been formally implemented due to lack of provider time. Case management involving the client, the Team, contract providers, primary care providers and other providers as necessary for clients who are at high risk or have multiple re-admissions to the program is desirable. Case management is particularly desirable because of the unique service environment, which includes a variety of providers, agencies, funding streams, high staff turn over, clients with multiple needs, cross cultural providers etc. The case management process also has excellent potential to facilitate further integration of clinical and traditional approaches.

Figure 1: MHS NT Case Management and communication model for clients with SMI and geriatric care



Recommendation:
 Expand case management, beginning with clients at risk and/or clients with multiple re-admissions and including the client, appropriate mental health providers as well as primary care providers when necessary.

RQ5: Are there measurable health outcomes related to this model of care?

This research produced much qualitative data that supports the notion that most clients are receiving high quality care and improving their mental health or are well supported in

Grant 05160/2006/C - An Integration Model for Shared Mental Health h Care in Northern Ontario.

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managing chronic conditions. Some comments that are representative of many clients' opinions are provided below:

"It definitely helped me, even just having someone to talk to, that you could be confident with; that you could speak out and say what you really felt and know it wasn't going anywhere." Client (3)

"if I ever needed to talk to anybody or needed help... we have the resources there that I can phone...I would phone Irene (the intake worker) right away if it ever came to that. But right now everything is good." Client (13)

"I think everything was done really well. I was really comfortable talking with the counselor, and when my husband went to talk to the counselor too, he thought: "I don't think I'm going to take this!", But then at the end of it all he was the one who did most of the talking, he said, he found it really good and it was helpful to him because there was a lot of things that he had to work out and he didn't know how to deal with it. So I think that he really liked the counselor and so does my daughter." Client (12)

Unfortunately, *quantitative* data to directly measure or infer health outcomes is almost completely lacking. There is also no data on clients who did not improve, thus it is difficult to address areas for improvement, and consequently the Team is missing important learning opportunities. While most clients are very satisfied with their outcomes, the following quote shows that there is room for ongoing evaluation and monitoring of client services:

"Certain people have had great help. I've had good experiences and bad." Client 7

The available quantitative data sets and their usefulness in evaluating Aboriginal mental health services in the Manitoulin district are discussed in the following sections.

1. Local hospital use data

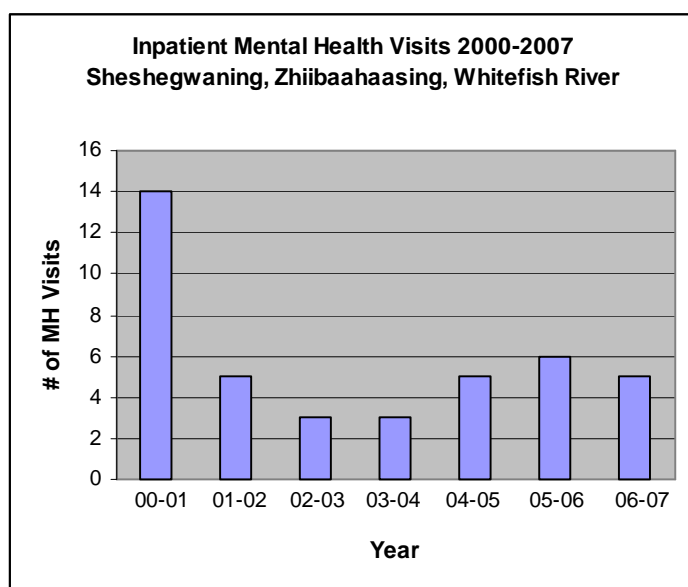
Emergency room use data and in-patient data by members of the five communities were provided to the researchers from the local hospitals sites in Little Current and Mindemoya.

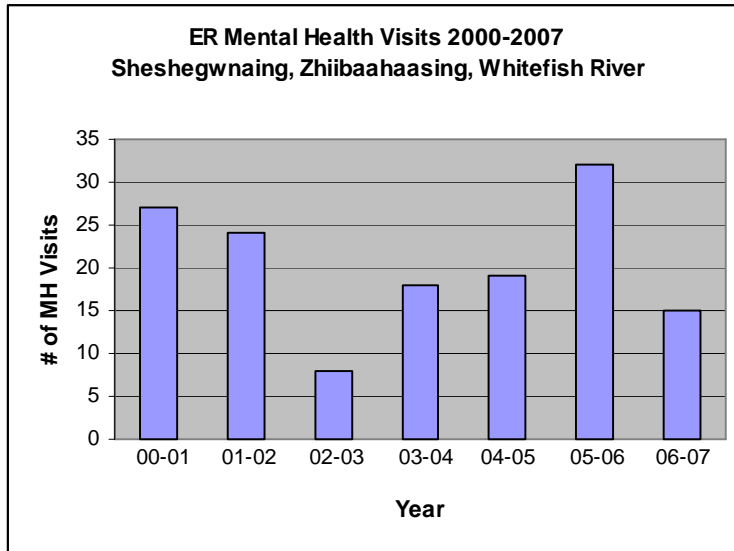
Clients were only identified by a hospital numbering code. The researchers did not have access to Grant 05160/2006/C - An Integration Model for Shared Mental Health h Care in Northern Ontario.

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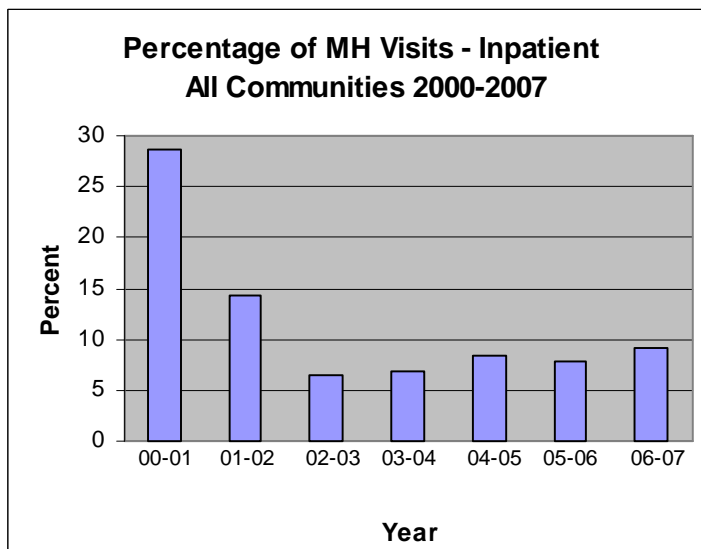
individual client records or the names of clients. The interpretation of the hospital data presented in this report is limited by several factors: 1) the coding of diagnoses at separation from the hospital was changed from the standard ICD9 to ICD10 in 2005; 2) Two reserve communities (Aundek Omni Kaning and Sheguiandah) appear to be lumped with their respective neighboring non-reserve community (Little Current and Sheguiandah village). This makes it impossible to distinguish mental health clients from the two reserve communities from the surrounding area; 3) The data for Sheshegwaning and Zhibaahsing are combined in the hospital data set; and 4) a switch to a new data entry system software system at the hospital occurred in October 2006 and the impact on the collected information is at this point unclear. **These limitations underscore the importance of Aboriginal organizations administrating and maintaining their own data sets to support the development and evaluation of services.** Clear cut trends over time are not discernable from an analysis of the number of visits to ER and inpatient hospital stays presented in Graphs 1 and 2.

Graph 1: Yearly Inpatient Totals for Mental Health Reasons Three Communities Combined

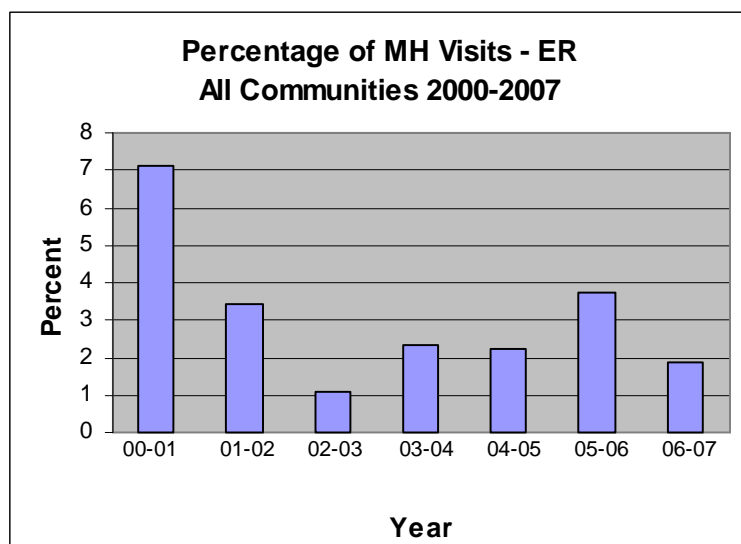


Graph 2: Yearly Emergency Room Totals for Mental Health Reasons Three Communities Combined


Graphs 3 and 4 show mental health visits as a percentage of total visits. A slight trend for decrease in these percentage is apparent. Additional analyses will be conducted to determine if the variation in the number of visits across the time period is statistically significant.

Graph 3: Yearly Percentage of Inpatient Mental Health Visits as Compared to Total Inpatient Intake


Graph 4: Yearly Percentage of ER Mental Health Visits as Compared to Total ER Intake



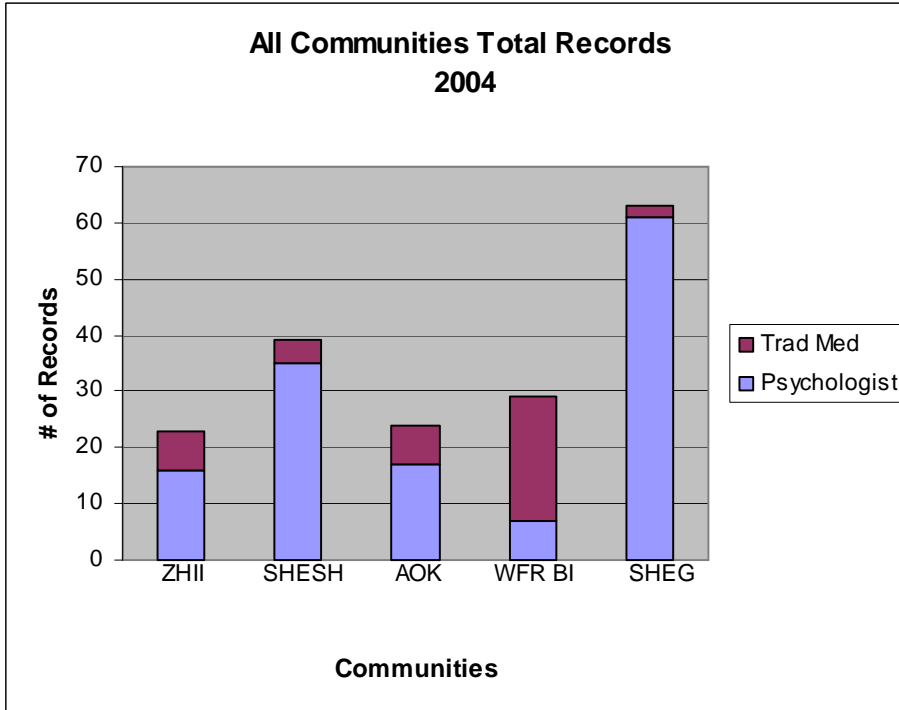
2. In-house data:

The psychologist and the traditional healing coordinator are Noojmowin Teg staff members.

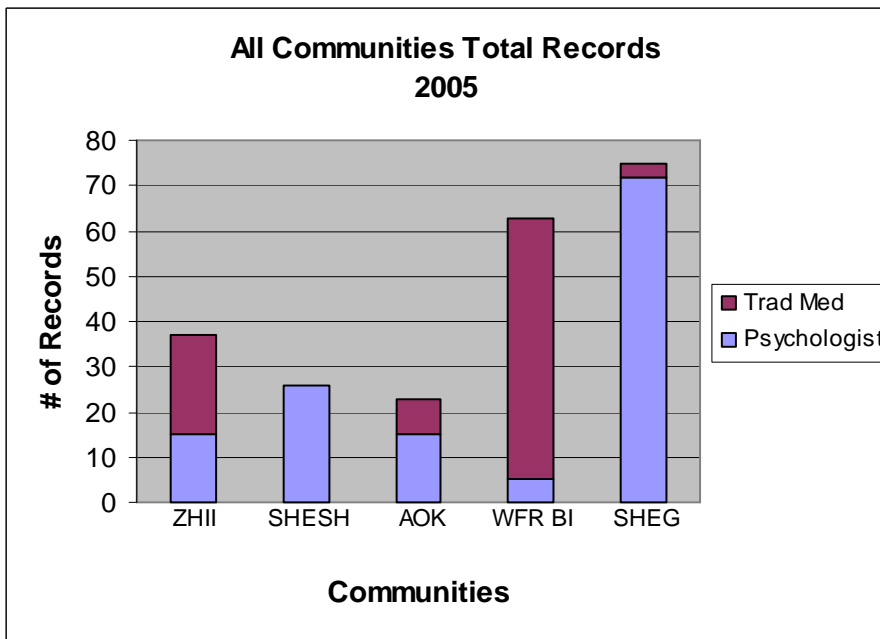
Their client service data is entered into a client database which includes unique identifiers for each client, basic demographic information, presenting concerns, services received, and referral information for the time span from April 1999 to December 2006. Mnaamodzawin mental health staff do not enter information about their clients and services into a database. Service information is therefore much more difficult to aggregate and data elements that can be studied are limited. Combined statistics for the Team are not available and can only be calculated by hand at the most basic level. Graphs 5, 6 and 7 therefore do only show an analysis of traditional healing services and psychology service. The graphs show consistently that increased traditional healing services are associated with proportionally decreased psychology services.

Graph 5: Total Number of Services Provided in 2004 All Five Communities Combined

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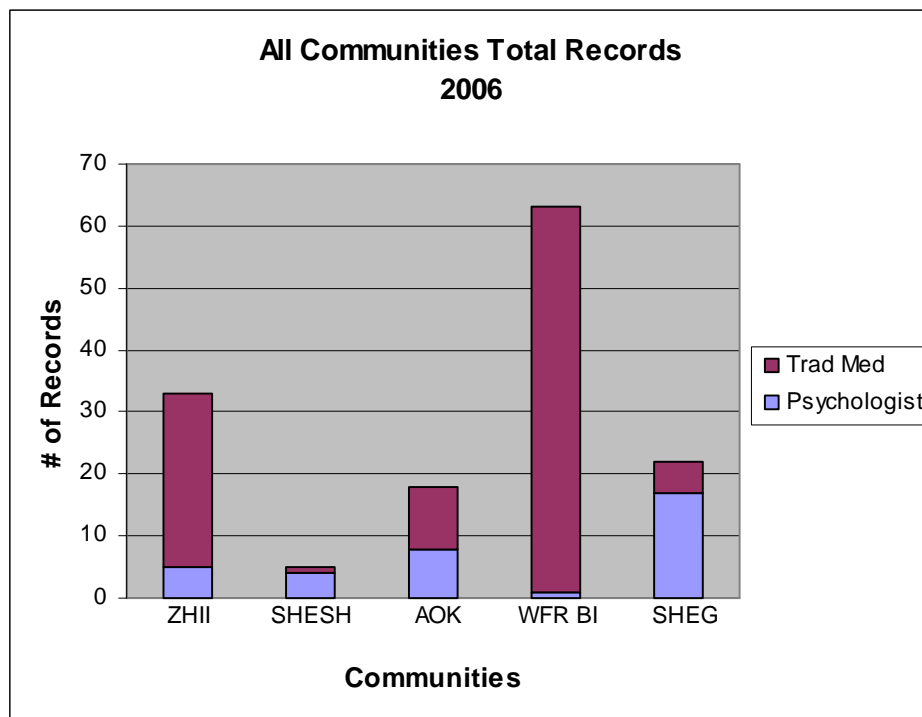


Graph 6: Total Number of Services Provided in 2005 All Five Communities Combined



Graph 7: Total Number of Services Provided in 2006 All Five Communities Provided

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Further research and data analysis is necessary regarding the relationship between traditional healing and psychology services.

The full Team statistics show that intake continues to be on the rise as seen in Table 4.

Table 4: Intake statistics for 2005 to 2007

	Intakes 2005/2006	Intakes 2006/2007	Increase
TOTAL Intake all FIRST NATIONS	125	136	9%

3. Client perspectives based on the mailed client satisfaction questionnaires

Response rates to mailed questionnaires are typically low and in this case the questionnaire had a response rate of 18 percent. The ratio of male to female respondents was 33.3 to 66.7 percent.

The age of participants ranged from 17 to 69 years of age with a mean age of 40 and a median of 42. Table 5 shows the results.

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Table 5 : Response Summary to Client Satisfaction Questionnaire

Interaction with worker	agree completely 5	agree mostly 4	partly agree partly disagree 3	disagree somewhat 2	disagree completely 1
My worker(s) listen to me	100%				
My worker(s) take enough time with me	89%	11%			
My worker(s) share information in a way that's easy to understand	78%	22%			
I feel comfortable asking my worker(s) questions about my treatment and available services	100%				
My worker(s) are sensitive to my cultural background	78%	22%			
My worker(s) respect me as an Aboriginal person	100%				
My worker(s) treat me with kindness and respect	100%				
I feel my worker(s) are/would be supportive of traditional healing approaches	89%	11%			
Service environment and accessibility					
I received services shortly after I requested them	67%	22%	11%		
My appointments are scheduled at a time that is good for me	89%	11%			
My appointments are scheduled in a safe setting that meets my service needs	89%	-	-	-	-
Result of Services:					
The services I am receiving are helping me	89%	11%			
I feel I am receiving the help I needed	78%	22%			
Confidentiality:					
I feel that I have sufficient privacy when I see my worker(s)	89%	11%			
I feel my worker(s) are keeping my personal information confidential	89%	11%			
Overall:					
I would recommend the services to anyone who needs help with their problems	89%	11%			
I would rate the quality of service(s) as	Excellent 100%	Good	Fair	Poor	Very poor

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Clients who returned the surveys were generally very satisfied with their services they had received. Due to the low response rate it is not possible to determine if this group is truly representative of the client population as a whole, yet it speaks to the fact that there are many satisfied clients.

4. Client Perspectives on health outcomes based on interview data

“One of the counselors told me to start keeping a journal of my thoughts, of my feelings so I did that for about a year. When I looked back on it I could see my attitude changing day to day in my writings.” Client (7)

“They helped me control myself in that sense, I guess. Because back then I couldn’t talk to anybody. I was pretty messed up. I guess when I first started coming out of my shell and that was a while ago. So now I’m just open and honest. I tell it the way it is and that’s just the way I am now. Have my self-esteem, courage. I was scared to do anything, go anywhere, talk to anybody. Be me. So they taught me lots.” Client (11)

Participants identified many positive outcomes which could be collected in a systematic way in the future. Thematic analysis shows that self reported outcome fell into various categories:

- Improved parenting skills
- Improved family relationships with children
- Improved communication skills
- Improved coping skills and anger management
- Improved self image
- Improved access to culturally appropriate and effective services
- Cultural safety is maintained: services are in contrast to off reserve services where some clients feel that they are stereotyped and discriminated against

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5. Client concerns and suggested solutions

While clients had generally positive experiences overall, some clients mentioned glitches, particularly with contract providers, and with new workers. One client suggested that his/her calls were not returned for over a week when s/he needed urgent services, and then had to play phone tag with his/her worker. Several clients also mentioned that some contract providers did not understand their issues and did not feel comfortable with the approach taken by their workers. Another client mentioned that s/he had good and bad experiences with his/her workers. These anecdotes indicate that there is a need for ongoing evaluation, outcome data collection and more widespread case management. Implementation of these procedures would ensure that clients do not fall through the cracks.

Several clients identified frequent staff turn over as barrier to develop a trusting relationship with their workers. Several clients spoke about feeling extremely abandoned when they were referred to a new worker due to staff turn over or changes in positions.

We got along so well. I just felt so comfortable with [my worker] and I've never really felt comfortable with a worker since. There's always something that I'm hiding – I don't know if the word hiding is right but there's always something I'm holding back instead of being 100% honest. For me it takes a lot to get my trust after everything that's happened to me in my life. The emotional things I've been through in my life. It's very hard for me to trust somebody, to 100% tell them how I really feel, and [my worker] was that one person I could do that with." Client (3)

RQ 6: Are there measurable service, community or health human resources outcomes?

At the present time there is no systematic data collection in the areas of service, community or human resources outcomes. This section therefore contains observed trends and results from the thematic analysis of the interview data.

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1. Wait times for mental health services

While there is no specific data set on wait-times, keeping wait-times for counseling to a minimum seems to have been a priority for the Team. Based on the interviews, normal response time for urgent care seems to be less than a week, whereas less urgent counseling seems to be provided within 3 to 4 weeks. Since we only spoke to clients who were receiving services from the Team and not non-clients, it is unclear if there are individuals who are trying to access services but are unsuccessful. Wait times for traditional healing appears longer, often 4 weeks or more, access to psychiatric services may be several months. Again, it is unclear whether or not clients who are not high priority for psychiatry receive any psychiatric services at all.

**Recommendation:
Collect data on wait times**

2. Client perspectives on accessibility of mental health services

Clients spoke highly of the accessibility to services both in the anonymous questionnaire, and the in depth interviews. For example:

“If you need mental health services you know who to call – even if it is not their day to be here [in this community] they make time to see you.” Client (1)

“They do a good job. They do what they can. And if they don't know about Anishinabek ways well they just ask. I know they ask because they asked my dad when I was sitting there a couple of times. I know they're not scared to ask.” Client (11)

All of the interviewed clients were satisfied that their workers were knowledgeable enough about Aboriginal culture and local circumstances to provide effective care. Clients were also satisfied that their workers were respectful of traditional approaches when requested, but clients did not see their workers as a conduit for referral to these services. It is important to stress

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that many clients who access the clinical mental health services appear not to have an expectation that their workers would or could provide referrals to traditional Aboriginal healing services. Some clients are independently seeking traditional services from the traditional coordinator or from Elders or traditional healers not formally connected to the clinical Team.

Clients also felt that the services provided by members of the Team were completely confidential, which is an important consideration for many clients when accessing community-based care. Still, several clients were concerned about the stigma of seeing their worker at the health centre, and expressed further concern regarding the potential of community staff overhearing their conversations in the health centre. One client stated:

“I always felt like walking in the building its like ‘Oh, I wonder what’s she in here for.’”

Clients we spoke to who decided to stop accessing services before they completed their treatment, did so usually because of staff turn over or because they did not like the approach taken by a worker. For example, some felt uncomfortable with a newly assigned worker because the new worker was not the same gender as their previous worker. Clients valued experienced workers. Several clients made reference to service providers they had dealt with in the past who were book smart about Aboriginal people, but had little real life experience related to Aboriginal people, culture and traditions; this is seen as a divide and does not promote a therapeutic environment. Many clients also valued the option of home visits for their counseling appointments, and stated they felt more comfortable at home than at the clinic.

3. Cultural competence and Aboriginal health human resources

At the time of this research, two of three clinical providers on the Team were Aboriginal. Aboriginal participants consistently regarded cultural competence of services provided by the

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core Team as quite high (including past workers), regardless of the ethnicity of their service providers. Many participants explained that all of the providers understand Aboriginal issues and local circumstances and are open to Aboriginal world views and healing practices. However there was concern about the larger network of service providers where some providers are perceived as respecting the right of the client to make choices, yet do not appear to take traditional approaches seriously. Consequently, an issue identified repeatedly was the need for more Aboriginal workers at all tiers of service provision who have the skills to provide clinical mental health services. In addition, it is clear that while the non-Aboriginal core Team members are seen as highly culturally competent, there are nevertheless some Aboriginal clients who feel significantly less comfortable with non-Aboriginal service providers than Aboriginal providers. **Based on the data we collected, this is an issue for a small minority of clients.** The clients' personal experiences with racism and discrimination appear to be an important factor in this issue. The following quote illustrates this sentiment.

By sending someone to a counselor who is non-native that puts the playing field where one person is an expert and one is below that – it creates that idea of when you were in school, teachers were non-native, doctors are non-native, everybody is non-native. I don't see that as a way to bring back personal power to a person. Participant

In contrast, many clients are not comfortable seeking help for mental health issues from community members, and therefore welcome a provider who is not from the local community and feel quite comfortable with their non-Aboriginal providers.

**Recommendation:
Continue efforts to recruit Aboriginal mental health professionals at all levels of service
Continue to recruit mental health professionals with necessary skills and training to work with Aboriginal clients**

4. Community Outcomes

Many of those we interviewed reported that access to services had greatly improved over the last decade and they felt that there were many signs of an increasingly healthy community. We were also cautioned though that increased services were still needed to support long-term positive outcomes. Another positive outcome noted was that the stigma in the community about using mental health services seems to be decreasing.

The shift to the shared supervisory model between MHS and the First Nations clinic staff will be an important opportunity to observe and track community outcomes.

Recommendation:
Track milestones achieved as part of the shared supervisory agreement

RQ 7: Are there indicators that could be collected to document client outcomes?

1. Recommendations for data collection:

The lack of consistent data formatted in an accessible electronic database prevents an evaluation of outcomes at this point. However, there are many important opportunities to collect client outcome data.

Client data should be collected in a *meaningful, consistent* manner for all clients who are provided with services by MHS or NT, and the data should be *accessible* to program planners and providers. As services are integrated, client information and service data collection must be integrated as well, in order to enable evidence-based decision making.

What kind of client data is necessary?

- Unique identifier for each client for in-house data and acute care

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- Client demographic information, including separation of Non-Aboriginal information from acute care data sets
- Service and referral information
- Outcome measures such as severity of mental illness, symptom scale, function scale implemented at first visit, and predetermined future visit^{xviii}.
- Client satisfaction data

Who should provide data?

Data are (at minimum) required from the following providers:

- all Mental Health Team members at MHS and NT
- all service providers under contract with MHS or NT
- community mental health workers (once integrated into existing services at a more mature stage of implementation)

2. How should the data be administrated?

- Data needs to be in electronic format to be useful for planning and evaluation
- Use existing data collection process as a starting point to plan and implement this process
- Identify data collection tools, database and process as a team in collaboration with administration

3. Secondary data

Data collected by other service providers, such as hospital emergency use and inpatient data, are secondary sources and the relationship between fluctuation in these as well as MHS and NT services might allow inferences to be drawn, but it is of course difficult to determine a direct (causal) relationship. Several data sources are of interest and require collaboration with other agencies.

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Data set	Organization	Items for discussion and follow up
Local emergency use	Manitoulin Health Centre	Require an agreement with MHC to track Aboriginal clients since the current data collection procedure lumps the following communities: - Little Current and AOK - Sheguiandah village and Sheguiandah First Nation - Sheshegwaning and Zhibaahasing
Local Inpatient	Manitoulin Health Centre	Same as above
Regional/provincial utilization data	MOHLTC, LHIN North East, CIHI (need to determine appropriate level)	- to track multiple institutions used by local population use databases such as the standardized Discharge Abstract Database (DAD) that holds data for all acute facilities in Canada - takes commitment to access
CAS program data	CAS	Client outcomes after referral to MHS and NT
Police statistics	UCCM Tribal Police	Police response statistics to incidence frequencies related to domestic violence and mental health issues

4. Milestones related to service provision and service integration should be developed and collected.

4. Additional Resources:

Websites:

1. **Shared Mental Health Care in Canada:** This website aims to provide up-to-date information on collaborative activities between mental health and primary care providers taking place in Canada and in other countries. The site has a list of resources. Website: <http://www.shared-care.ca>.
2. **The Canadian Collaborative Mental Health Initiative (CCMHI)** aims to improve the mental health and well-being of Canadians by increasing collaboration among health care

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providers, consumers, families and caregivers. This initiative has completed Phase 1 of a Primary Health Transition Fund project. Website: www.ccmhi.ca

3. Manitoulin websites that describe the health care system:

http://www.centralmanitoulin.ca/health_care.html,

<http://www.manitoulinliving.com/healthcare.htm>, www.noojmowin-teg.ca,

5. Further Research:

1. Exploring the integration between clinical and traditional Aboriginal services

The Team has made great progress over the past decade in the development a multi-disciplinary team approach that includes both clinical and traditional Aboriginal approaches, with a particular focus on client choices. Research is necessary to better understand how this service model can be furthered into a true inter-disciplinary approach that draws upon both approaches in an integrated fashion. Research on the relationship between traditional service use and clinical service use should be explored in more detail using service data and other methods.

2. Aboriginal mental health status and service data

Access to Aboriginal health status data and service data are required to move from anecdotal evidence and to establish baseline data and track outcomes. Ongoing research on in-house and external data is necessary. These include data on (1) client service data from all providers, including client satisfaction questionnaires (2) client outcome data, including changes in client behaviours, symptoms and family situation, from all providers, including contract providers (3) local emergency use and hospitalization in the Manitoulin district (4) provincial emergency use and hospitalization in Ontario, (5) health status data.

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3. Chronic mental health problems

One area of research to be explored more is the area of shared care for chronically ill clients, including perspectives of client, family, community, physicians and long-term care workers.

4. Qualitative Client, community and health systems outcomes

Case studies involving clients, worker and agencies perspectives, and development of milestones. Analysis of impact on various sectors, e.g.: social service sector – CAS; changes in the community services.

5. Telehealth applications

Research the role that telehealth and ICT applications can play in improving access to services reliable health information and continuing professional education and facilitating video conferencing.

6. Continued capacity building and local health empowerment

The quality of Aboriginal mental health services have improved dramatically over the past decade in the communities involved in this project. New research should address effective ways to further build local and regional capacity to provide community-based Aboriginal mental health services. The shift to the shared supervision model is a perfect opportunity.

6. References and Bibliography:

ⁱ 2005. Mary Ward. Mental Health in Northern Ontario (Northern Health Information Partnership, Short Report #5). Retrieved December 1, 2006,

<http://www.healthinformation.on.ca/Reports/Northern%20HIU/2005/Mental%20Health.pdf>

ⁱⁱ Ibid.

ⁱⁱⁱ Ibid.

^{iv} Hospital separation records provide data on the relative frequency of the principal causes of hospitalization for those who leave hospital.

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^v 2006. Linda Baigent, Stephanie Loomer, Jennifer Sarkella, Dave Zago. Acute Care Utilization Report. North East LHIN. Health System Intelligence Project. Access on July 10, 2007 at

http://www.health.gov.on.ca/transformation/providers/information/resources/utilization/acute_northeast.pdf

^{vi} Ibid.

^{vii} 2006. Government of Canada. *The Human Face of Mental Health and Mental Illness in Canada 2006*. Retrieved December 12, 2006, from http://www.phac-aspc.gc.ca/publicat/human-humain06/pdf/human_face_e.pdf, page 164-166.

^{viii} 1995. Raymond W. Pong, Duncan Saunders, John Church, Margaret Wanke, Paul Cappon, Health human resources in Community-based Health care: a review of the literature. Ottawa: Health Promotion and Programs Branch Health Canada.

^{ix} www12.statcan.ca/english/census06/data/profiles/community

^x This estimate is based on 2001 census data. Total Aboriginal population in the district of Manitoulin was at that time 4640 with 3977 living on reserve. Total of reserve population can therefore be estimated to be 663 in 2001. The on reserve population has increased in these five communities from 821 to 1044 from 2001 to 2006., a 27 percent increase. Assuming a similar increase as occurred off reserve, $663 * 1.27$ is 842.

^{xi} NOMECS sites accessed on August 1st, 2007 at <http://aix1.uottawa.ca/~fammed/nomsites.htm>.

^{xii} Manitoulin Aboriginal Research Review Committee. 2003. *Guidelines for Ethical Aboriginal Health Research*. Accessed on October 24, 2006 at <http://www.noojmowin-teq.ca/default5.aspx?l=1,613>.

^{xiii} See M. Maar. 2004. Clearing the Path for Community Health Empowerment: Integrating Health Care Services at an Aboriginal Health Access Centre in Rural North Central Ontario. *Journal of Aboriginal Health* 1:54-64.

^{xiv} There was a 9% increase from 2005/2006 to 2006/2007 fiscal years.

^{xv} Mullarkey K, Keeley P, Playle JF. 2001. *Multiprofessional clinical supervision: challenges for mental health nurses*. *J Psychiatr Ment Health Nurs* Jun;8(3):205-11.

^{xvi} See North Queensland Sub-Branch of the ACMHN. 2006. Clinical supervision in psychiatric mental health nursing <http://www.nq-anzcmhn.org/superv.html>

^{xvii} Previous to implementation of this model the admission rate was between 3 to 4 per year, now down to between 0 to 1 per year. Actual admissions over the past 2.5 years since implementation is 1 client.

^{xviii} For a starting point to selecting outcomes measures appropriate for the MHS/NT setting see the clearinghouse for shared mental health outcomes measures webpage at http://www.shared-care.ca/common_tools.shtml