



# *Anishnawbe Health Toronto*

## **Aboriginal Mental Health Strategy**

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# **ABORIGINAL MENTAL HEALTH SERVICES**

## **Strategic Directions and Service Model**

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**Anishnawbe Health Toronto**

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## *“Living a Good Life...Promoting Good Health*

*When we refer to living a good life, we are talking about our way of life, a healthy life. The Aboriginal way of life promotes good health throughout life’s journey. Through the Traditional Healers, Elders and Medicine People, our songs, dances, stories, prayers and ceremonies, we are introduced to many dimensions of healing, growth and development.*

*As we pursue our Aboriginal way of life, to live in balance and harmony with all of creation, we reclaim who we are – our Aboriginality. Our sacred path becomes one of healing, reconnecting us to the wisdom and traditions of the past and the generations of the future.*

*Guided by the teachings of our Traditional Healers, Elders and Medicine People, the programs and services at Anishnawbe Health Toronto promote living a good life.”*

*(Circle of Care Manual, Anishnawbe Health Toronto)*

## INTRODUCTION

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A Multidisciplinary Mental Health Committee (MMHC) was established and began meeting in October 2004 completing its work in May 2005. The Committee developed its terms of reference on the basis of needs assessment and model development research completed on behalf of Anishnawbe Health Toronto by Native Management Services.

This detailed report represents and concludes the work of the MMHC.

### Report Structure

The MMHC Report (Report) begins with a brief discussion of the background and rationale for establishing and mandating the MMHC. Its Terms of Reference are in this section.

The Report continues with a short description of the Committee's course of action. This section lists the MMHC's membership; describes the Model Development Framework; identifies two central tasks; and presents a brief summary of the findings.

The main section of the Report contains a detailed presentation of the MMHC's work. The main section includes a working definition of mental health (Task 1) and a detailed explanation of the types of services needed to address mental health needs in the Aboriginal community of the GTA (Task 2). For the purpose of model development, the MMHC presents an analysis of the following components of service delivery:

- Types of Disorders
- Prevalence in the Aboriginal Community
- Priority Populations
- Service Capacity
- Challenges and Opportunities

The MMHC concludes on the basis of its analysis that the present delivery structure is inadequate. Specifically the present service capacity is described as being deficient in the following ways:

- Under-resourced
- Focused on short-term interventions
- Lacking in coordination and integrated case management
- Under resourced to address stigmatization as a barrier to service access

- Includes minimal opportunities for health promotion, after care, and follow-up
- Does not address underlying issues, focusing instead on symptoms

The Report continues with a cursory description of the existing service components at Anishnawbe Health Toronto. On the basis of identified deficiencies in service availability to address the mental health needs of the Aboriginal community in the GTA, the MMHC recommends an alternative model.

The MMHC presents, in narrative and graphical formats, a detailed description of a proposed client and family centred, interdisciplinary Mental Health Service Delivery and Program Model. An alternative model would build upon existing programs, services and staffing. An alternative model would include professional expertise, case management and crisis management capacities specific to a new focus on mental health, addiction and concurrent disorders.

## BACKGROUND

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Anishnawbe Health Toronto (AHT) is an accredited community health centre funded by the Ministry of Health and Long Term Care (MOHLTC). AHT is mandated by the Aboriginal community of Toronto to provide health programs and services through a model that integrates western health care methods with culture-based and traditional approaches.

In 2004, AHT along with Native Child and Family Services of Toronto (NCFST), Native Men's Residence (NAMERES) and Council Fire (CF) met to discuss the increasing challenges they have in responding to the mental health issues and needs of the Aboriginal community. The front-line service of these agencies felt that the community was facing a mental health crisis. A partnership of these agencies was formed which commissioned a study to assess the mental health needs of the community. The final report "*Needs Assessment and Delivery Models to address Mental Health Needs of the Aboriginal Community of Toronto, September 2004*" was used as a backdrop and guide for the MMHC and will be further referenced as *Mental Health Needs Report* in this document.

In October 2004 the Executive Director established a multi-disciplinary mental health committee (MMHC) with the following terms of reference.

## TERMS OF REFERENCE

<p><b>Description</b></p> <p>The Multi-disciplinary Mental Health Committee (MMHC) is an interdisciplinary group with the mandate to develop a strategy and service model that addresses the mental health needs of the Aboriginal community in the GTA.</p>
<p><b>Purpose</b></p> <ul style="list-style-type: none"><li>• To develop a definition of mental health from an Aboriginal perspective to be a basis for long term planning of service delivery and evaluation.</li><li>• To examine different components of existing mental health services and how they would relate to strategic direction.</li><li>• To develop a mental health continuum of service system that is collaborative, comprehensive and reflects the “circle of care” holistic approach to service delivery and values.</li></ul>
<p><b>Functions</b></p> <p>To utilize the final Mental Health Needs Assessment Report as a backdrop:</p> <ul style="list-style-type: none"><li>• To develop a strategic plan for mental health services at Anishnawbe Health Toronto.</li><li>• To examine different components of existing mental health services and how they would relate to strategic direction.</li></ul>
<p><b>Membership</b></p> <p>The Committee shall be comprised of:</p> <ul style="list-style-type: none"><li>• Psychiatrist</li><li>• Physician</li><li>• Four Circle of Care Workers</li><li>• Traditional Counselors and</li><li>• Osh-Ka-be-Wis</li></ul>
<p><b>Meetings</b></p> <p>Initially, meetings shall be held bi-weekly. Once parameters for the group have been established, meeting times may be revised. Notes and agendas shall be available to members at scheduled meetings.</p>
<p><b>Accountability</b></p> <p>The MMHC is accountable to the Executive Director and work in progress will be reported to the Board through the Executive Director.</p>
<p><b>Evaluation</b></p> <p>The Chairperson shall submit a written report to the Executive Director at the completion of the MMHC’s mandate who will forward the report to the Board with appropriate recommendations.</p>

## MULTI-DISCIPLINARY MENTAL HEALTH COMMITTEE

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The MMHC consisted of eight (8) health care practitioners employed with AHT. The MMHC adopted a Model Development Framework to guide its activities and structure its recommendations.

### MMHC Membership

- Dr. Chandrakant P. Shah, Physician (Chair)
- Dr. Adam Quastel, Psychiatrist
- Doreen LaRiviere, Traditional Counselor
- Wanda Whitebird, Traditional Counselor
- Theresa Shilling, Traditional Counselor
- Andy Mark, Circle of Care Worker
- Dwayne Boyer, Osh-Ka-be-Wis
- Dolores Esquimaux, Circle of Care Worker

The MMHC made decisions by consensus and presents in this report its recommendations for Mental Health Program Planning and Service Delivery.

### MMHC Model Development Framework

In developing a mental health strategy, the MMHC adopts the following framework:

- a. Needs Assessment:** Examine existing programs, services and resources (e.g. information management, staffing, training, technology, partnerships), to determine what is needed to initially improve and subsequently optimize AHT's capacity for addressing the identified prevalence of mental health care needs of the Aboriginal community living and working in GTA.
- b. Strategic Planning Guidelines:** Use prevalence data and information about organizational capacity to generate and prioritize a set of feasible goals, objectives and an action plan, which reflect AHT's mission, values and principles and can mobilize more adequate service delivery capacity.
- c. Service Model Development:** Develop a Mental Health Service Delivery Model to include western and culture based approaches and which reflects the findings and recommendations of the *Mental Health Needs Report*.

- d. **Implementation Strategy:** Establish and populate a Mental Health Project Steering Committee with a mandate to further research, develop, coordinate and promote the needed structures and processes including policies and protocols for AHT and its partnerships. Structures and processes would be equipped to effectively, efficiently and sensitively mobilize a progressive implementation of a Mental Health Unit. Implementation would be in accordance with identified priority needs (i.e. mental health crisis and case management including after care) and target groups (i.e. homeless population; families affected by FASD/E; people with severe mental illness or Residential School Syndrome).
  
- e. **Evaluation Planning:** Use information about prevalence and service capacity as a base line for monitoring progress toward a long term initiative which provides improved access to a continuity of collaborative, coordinated, managed and culturally appropriate care by qualified AHT staff and intra-agency partnerships.

### **MMHC Activities**

The MMHC applied the above Model Development Framework to accomplish two tasks:

**TASK I:** Adopting a working definition of mental health and

**TASK II:** Examining current services, presenting prevalence data, documenting service gaps and reviewing best practices.

The MMHC deemed these two tasks as key to designing a capacity building strategy and service delivery system that would address the urban Aboriginal community's need for improved mental health programs, services and resources.

The MMHC began its work in October 2004 and held 17 meetings. The final report of the MMHC was submitted for review on May 29, 2005.

### **MMHC Findings in Brief**

#### **A Community in Mental Health Crisis**

Drawing on research and clinical experience, the MMHC noted the numerous descriptions of the Aboriginal community of Toronto as a community in mental health crisis.

The MMHC documented that Aboriginal people throughout the life cycle present to health professionals and agencies, with a range of mental health diagnoses. Mental health professionals attribute mental health problems in the Aboriginal community as frequently resulting from the effects of colonization and residential schooling (*Mental Health Needs Report*). The effects of colonization and residential schooling include:

- Alienation
- Isolation
- Marginalization
- Cultural Dislocation

The MMHC also noted the co-occurrence of addiction and mental health problems, especially but not exclusively among the Aboriginal homeless population. Mental health diagnoses typical to the Aboriginal population include:

- Substance Use Disorder
- Post-traumatic Stress Disorder
- Organic Developmental Disorders related to alcohol consumption during fetal development (e.g. FASD/E)
- Major Psychiatric Disorders (e.g. Schizophrenia, Obsessive Compulsive Disorder, Manic Depression, Borderline Personality Disorder)
- Depression including AIDS/HIV-related depression and dysthymic disorder
- Self harming behaviour (e.g. suicidal tendencies)

Finally, the MMHC reviewed evidence that mental health issues are more prevalent and more complex when clients in need are poor, transient, homeless, lack adequate social supports or have been exposed to interpersonal violence.

### **Inadequate Service Capacity to Address Mental Health Needs**

The MMHC further noted resources are inadequate for addressing the continuum of mental health needs in the urban Aboriginal community living and working in the GTA.

Drawing upon evidence documented in the *Mental Health Needs Report*, the MMHC identified that Aboriginal people with mental health issues are falling through the cracks every day and the situation grows worse. Mainstream service providers often lack the sensitivity and understanding necessary to detect and appropriately respond to the mental health needs of Aboriginal people. Aboriginal service providers often feel disempowered within a

mainstream partnership. This is due to credentialism and a devaluation of traditional and experience-based knowledge and skills.

The MMHC gleaned evidence from clinical encounters and the *Mental Health Needs Report* indicating that Aboriginal agencies are a preferred access point for Aboriginal clients but that agencies lack the capacity in terms of both human and financial resources, to adequately address mental health needs. Additionally, the closing of the Aboriginal Crisis Intervention Program at Anduhyuan and its transfer to AHT has created a significant strain on AHT.

The MMHC reviewed evidence showing additional resources are required to begin managing mental health symptoms in a coordinated system of planned and integrated multi-disciplinary care. An appropriate mental health service model would include a capacity to identify and address root causes.

## **Acknowledgements**

The MMHC acknowledges the firm of Native Management Services which was commissioned by the partnership of AHT, NCFST, NAMERES and CF. Their final document Mental Health Needs Report was utilized to guide in our deliberations.

The MMHC expresses their thanks and appreciation for comments and guidance provided by the Executive Director, Joe Hester.

The MMHC also acknowledges the general and technical editing, which was completed by the Mental Health Project Manager, Brenda Sedgwick and Executive Director, Joe Hester. We also extend our appreciation to the Executive Assistant, Nancy Jocko for the final presentation and formatting of this document.

## TASK I: DEFINITION OF MENTAL HEALTH

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The MMHC recommends adopting the following definition of mental health (a) and one of the 14 values and principles of appropriate service delivery (b), as expressed in the *Mental Health Needs Report*:

- a) “Feeling vital, full of energy, having good social relationships, feeling in control over life and living conditions, being able to do things which one enjoys, having a sense of purpose in life, having a sense of connected-ness to the community and generally feeling happy with one’s self.” \*
- b) “Recognize that good ‘mental health’ is more than the absence of illness but a state of well-being which includes appropriate housing, education, employment, childcare, food, supportive family, peer and community relationships.” \*\*

\* Dr. Nel Wieman, Aboriginal psychiatrist with a mental health clinic at Six Nations of the Grand River, and on U of T Medicine’s teaching staff

\*\* from Page 25, Item 2 in of the Mental Health Needs Report

The above quoted principle of appropriate service delivery identifies a set of social determinants (e.g. housing, education), which can be used in conjunction with the components of mental health (e.g. vitality, purpose, connected-ness) to identify clients’ base line measure of mental health and to track progress toward benchmarks of individual, family and community mental health well-being.

## TASK II: TYPES OF SERVICES NEEDED

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### Introduction

In order to understand the types and extent of services needed, it is first necessary to present a profile of mental health and addiction disorders in the Aboriginal community. Secondly, it is necessary to identify what is currently not working effectively for the Aboriginal community. Before proceeding with this discussion of the burden of mental health and current capacity to respond to that burden, a brief outline of this section is presented.

The MMHC reviewed literature and considered their collective clinical experience to gain an understanding of the types and extent of mental health and addiction disorders in the Aboriginal community. The MMHC refers to the prevalence of mental health and addiction disorders as a ***burden of mental health***.

The Aboriginal community's mental health burden is described later in this section on the basis of varied published data sources. Prevalence of mental health and addiction specific to the GTA Aboriginal population is estimated using conservative multipliers. These multipliers are derived on the basis of the committee's collective viewpoint, as it reflects both their clinical experience and their stock of knowledge obtained from academic literature, government reports, workshops, seminars, community consultations and informal networks.

Prevalence data is represented in narrative format and in two tables. The findings of the MMHC show that mental health and addiction disorders are more prevalent among Aboriginal people of all ages in comparison with their counterparts in the mainstream population.

On the basis of both published reports and clinical experience, the Aboriginal homeless population is identified as being particularly over represented among people affected by a burden of mental health.

Data from the Aboriginal Healing Foundation is used to demonstrate the strong relationship between residential schooling experiences and the burden of mental health and addiction disorders among Aboriginal people.

Following a discussion of the burden of mental health, the MMHC introduces the current framework of programs at AHT and concludes that the present service delivery capacity is deficient.

The MMHC discusses deficiencies resulting from an insufficient allocation of resources for the following:

- Training and recruiting Aboriginal mental health professionals
- Addressing credentialism, which discredits and devalues Aboriginal knowledge and training
- Consistent data management across programs/agencies
- Optimal ways of delivering services to Aboriginal clients by Aboriginal providers (e.g. Crisis Management, Case Management, Stronger Outreach)
- Core Aboriginal Mental Health Program
- Effective, balanced partnerships and collaboration between Aboriginal and non-Aboriginal providers
- Emphasis on long term mental health recovery needs
- Respond to short-term crisis intervention as appropriate
- A focus on quality of life issues for the seriously mentally ill
- Prevention of mental health stress through health promotion
- Provide more services, especially culture-based services

Finally in this section, an alternative delivery model is described in detail and depicted graphically. The MMHC lists the values and principles which would be characteristic of an appropriate service delivery model. A three-tiered service delivery model is described which would consist of:

- 1) Primary Services
- 2) Secondary (Specialized) Services
- 3) Support Structures

# BURDEN OF MENTAL HEALTH OF ABORIGINAL PEOPLE IN GREATER TORONTO AREA (GTA)

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## Common Mental Health Issues

Experience in the Primary Health Care Clinic at Anishnawbe Health Toronto indicates that Aboriginal clients present with one or more of 16 common mental health and addiction issues.<sup>1</sup> The most common disorders are listed below (in no particular order):

- Fetal Alcohol Syndrome, Alcohol related neuro-developmental disorders
- Post-traumatic Stress Disorder
- Depression
- Anxiety
- Schizophrenia
- Bipolar Disorder
- Dementia
- HIV/AIDS-related Depression
- Self Harming Behaviour
- Suicidal Tendencies
- Family Violence
- Substance Abuse
- Unresolved Grief Reactions
- Anger Issues
- Dual Diagnosis (e.g. Bipolar Disorder and Down's Syndrome)
- Concurrent Disorders (e.g. Schizophrenia and Alcoholism)
- Problem Gambling

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<sup>1</sup> Drawing from a discussion paper, *Aboriginal Mental Health: What Works Best* (July 2001, Vicki Smye & Bill Mussell: Mental Health Evaluation & Community Consultation Unit), the MMHC recommends that both serious mental illness and prioritization for service be categorized using the terms of reference adopted by British Columbia's Ministry of Health. Specifically, both serious mental illness and prioritization for service delivery are no longer based on mental health diagnosis (i.e. DSM-IV major psychiatric disorders, i.e. schizophrenia, panic disorder, major affective disorders, anxiety disorder, substance abuse disorder). Classification is made instead on the basis of degree of disability or functional impairment associated with a mental disorder; and this can include post traumatic stress and residential school survivor disorders, prevalent in the Aboriginal population (<http://www.mheccu.ubc.ca/documents/publications/discussion-paper.pdf>). The MMHC adopts this perspective on categorizing and prioritizing mental health illness as a base assumption throughout this Report.

## ESTIMATE OF NUMBER OF INDIVIDUALS REQUIRING MENTAL HEALTH SERVICES

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The Senate Standing Committee on Mental Health, Mental Illness and Addiction<sup>2</sup> estimated the number of Canadians who could be suffering from mental health and addiction disorders. The Senate Standing Committee generated its estimates using the prevalence data on certain common mental health problems.

Using the Senate Standing Committee data as a base, the MMHC makes projections for the Aboriginal population of Metropolitan Toronto. According to the 2001 Census, there were 24,910 people who identified themselves as Aboriginal in Toronto.<sup>3</sup> The *Mental Health Needs Report* identifies that more accurate estimates indicate that there are between 40,000 and 60,000 Aboriginal people in Metropolitan Toronto. For the purpose of this Report, the MMHC uses a base of 40,000 Aboriginal people.

Estimates of mental health problems are presented in Tables 1 and 2, below. Literature reviewed for the *Mental Health Needs Report* indicates that rates of many mental health conditions including addiction are at least 2-3 times higher for the Aboriginal population. In developing projections, the MMHC utilizes a conservative estimate of 1.5 times the rate of mental health/addiction problems of the general population.

Using the above assumptions, the MMHC calculates an estimated occurrence of mental health and addiction problems in the Aboriginal population in Metro Toronto (see Tables 1 and 2):

- 1900 children and adolescents
- 3000 – 4500 adults
- 550 homeless people<sup>4</sup>

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<sup>2</sup> Mental Health, Mental Illness and Addiction: Issues and Options for Canada – Interim Report of The Standing Senate Committee on Social Affairs, Science and Technology, Report 3: The Honourable Michael J. L. Kirby, Chair & The Honourable Wilbert Joseph Keon, Deputy Chair (November 2004)

<sup>3</sup> According to the *Mental Health Needs Report*, two factors suggest Census data underestimate the number of Aboriginal people living, working and needing health services in Toronto: 1. Census data is considered to underreport people of Aboriginal ancestry; 2. Many people of Aboriginal ancestry commute between Toronto and their home communities for work or health services.

<sup>4</sup> Further discussion about estimates for the homeless population is presented in the next section of this Report: Burden of Mental Health for Homeless Aboriginal Peoples.

**TABLE 1**

<b>PROJECTED ONE-YEAR PREVALENCE OF MENTAL DISORDERS AMONG CANADIANS AND ABORIGINALS IN METRO TORONTO, AGED 15 YEARS AND OLDER (2002)</b>				
	<b>Total Canadians</b>		<b>Total Aboriginals in Metro Toronto*</b>	
	<b>Number (000's)</b>	<b>Rate (%)</b>	<b>Projected Number</b>	<b>Projected Number by 1.5 times</b>
Unipolar Depression	1,120	4.5	1296	1944
Bipolar Depression	190	0.8	230	345
<b>Any Mood</b>	<b>1,210</b>	<b>4.9</b>	<b>1411</b>	<b>2116</b>
Panic Disorder	400	1.6	460	690
Agoraphobia	180	0.7	201	301
Social Phobia	750	3.0	864	1296
<b>Any Anxiety</b>	<b>1,180</b>	<b>4.7</b>	<b>1353</b>	<b>2029</b>
Alcohol Dependence	640	2.6	748	1122
Illicit Drug Dependence	170	0.7	201	301
<b>Any Substance Use</b>	<b>740</b>	<b>3.0</b>	<b>864</b>	<b>1295</b>
<b>Total – Any Disorder</b>	<b>2,600</b>	<b>10.4</b>	<b>2995</b>	<b>4492</b>

Statistics Canada, "Canadian Community Health Survey: Mental Health and Well-Being", [The Daily](#), 3 September 2003. \*Toronto Aboriginal population estimated to be 40,000.

**TABLE 2**

<b>PROJECTED PREVALENCE OF MENTAL DISORDERS IN CHILDREN AND ADOLESCENTS<sup>(a)</sup> IN CANADA &amp; FOR ABORIGINAL CHILDREN IN METRO TORONTO</b>			
<b>MENTAL DISORDER</b>	<b>CANADA: PREVALENCE RATE (%)</b>	<b>CANADA: APPROXIMATE NUMBER</b>	<b>APPROXIMATE NUMBER OF ABORIGINAL CHILDREN IN METRO TORONTO*</b>
Anxiety Disorder	6.5	513,780	780
Conduct Disorder	3.3	260,842	396
ADHD	3.3	260,842	396
Depressive Disorder	2.1	165,990	252
Substance Abuse	0.8	63,234	96
Pervasive Developmental Disorder	0.3	23,713	36
Obsessive-Compulsive Disorder	0.2	15,809	24
Schizophrenia	0.1	7,904	12
Tourette's Disorder	0.1	7,904	12
Eating Disorder	0.1	7,904	12
Bipolar Disorder	less than 0.1	less than 7,904	Less than 12
<b>ANY DISORDER</b>	<b>15</b>	<b>1,185,645</b>	<b>1900</b>

(a) Based on a population estimate by Statistics Canada of 7,904,300 children and adolescents (aged 0 to 19 years) in July 2002. **\*Estimated children for 40,000 Metro Toronto Aboriginal population to be 12,000 (30%)**

### **Burden of Mental Health for Homeless Aboriginal Peoples<sup>5</sup>**

The *Mental Health Needs Report* captures data from varied reports showing that poverty, lack of adequate housing, and absolute homelessness are strongly predictive of a higher prevalence of mental health and addiction disorders. In this section, the MMHC presents published data from the 1999 *Mayor's Task Force Report* on homelessness in the City of Toronto, showing homeless Aboriginal people are at a particularly high risk of presenting with significant mental health, substance abuse and concurrent disorders.

<sup>5</sup> *Taking Responsibility for Homelessness: An Action Plan for Toronto, City of Toronto Mayor's Task Force on Homelessness (February 1999)*. The report is referred to as the Mayor's Task Force Report.

## Aboriginal Homeless Population in Toronto

The *Mayor's Task Force Report* indicates that within the homeless population, Aboriginal people are overrepresented. While Aboriginal people constitutes 1.9% of the Metro Toronto population, it is estimated that Aboriginal People make up 15% of the homeless.

- Estimated number of homeless in Toronto: 4,000
- 15% of homeless are estimated to be Aboriginals: 600

## Mental Health & Addiction Disorders of Aboriginal Homeless

The MMHC explains that demographic variability, transience and morbidity in the homeless population makes it particularly challenging to measure the prevalence of homelessness, the personal characteristics of people who are homeless, and the health profile of homeless persons.<sup>6</sup> However, collective practitioner experience at AHT identifies that major health problems among homeless Aboriginal clients include both mental health disorders and addiction.

The MMHC estimates the number of homeless Aboriginal people with mental health and/or addiction problems in Metro Toronto, using data published in workshop proceedings presented by the Mental Health Policy Research Group.<sup>7</sup> The *Pathways to Homelessness* workshop proceedings involve research over an 18-month period to estimate the prevalence of mental illness and addiction among people who are homeless.

The MMHC's estimates based on the *Pathways to Homelessness* workshop proceedings are further supported by the following research which identifies the rates of Aboriginal homeless with substance abuse issues:

- National Aboriginal Health Organization (NAHO)
- Hamilton, ON report
- Government of Canada

NAHO presents information about homeless Aboriginal people surviving in urban areas. The higher prevalence of morbidity experienced by Aboriginal homeless in comparison with their

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<sup>6</sup> To this day, Canada has no official data on homelessness, a situation that has come in for comment from the United Nations Committee on Economic, Social and Cultural Rights (Patricia Begin *et al.*, Reference 9 in this Report).

<sup>7</sup> Mental Health Policy & Research Group (CMHA Ontario Division, Clarke Institute of Psychiatry, Ontario Mental Health Foundation) *Mental Illness & Pathways into Homelessness: Findings and Implications -- Proceedings and Recommendations* (January 16, 1998) [http://www.camh.net/hsrhc/html\\_documents/pathways\\_proceedings.html](http://www.camh.net/hsrhc/html_documents/pathways_proceedings.html)

mainstream cohort is relevant to understanding the extreme burden of mental health in this population segment:

*“Aboriginal Peoples are disproportionately represented among the urban homeless. It is estimated that they accounted for 41 percent of all deaths among the homeless [even though Aboriginal people comprise only 2% of the population].”<sup>8</sup>*

The Government of Canada’s Parliamentary Information and Research Service’s report, “Homelessness” (1999)<sup>9</sup> estimates that 20-30% of homeless people have a mental illness. Using a 2-3 times prevalence rate, the Government of Canada’s estimates would suggest agreement with the MMHC’s estimate that 360-540 of Toronto’s Aboriginal homeless population survives on the streets with mental illness and/or addiction.

*The Homeless Trail: The Voice of the People -- An Introductory Report on Aboriginal Homelessness within Hamilton, Ontario* (March 2001)<sup>10</sup> presents findings that 36% of people who experience homelessness have a mental illness and 41% experience substance abuse, homelessness and mental illness combined.

An estimated mental health profile of 600 Aboriginal homeless peoples in Toronto would exhibit the following profile:

- Approximately 66% of homeless persons had a lifetime diagnosis of mental illness, 2-3 times the rate in the general population: **Aboriginal 396 persons.**
- About 66% of homeless persons had a lifetime diagnosis of substance abuse (of alcohol, marijuana and cocaine in particular), 4-5 times the rate in the general population: **Aboriginal 396 persons.**
- Some 86% of homeless persons had either a lifetime diagnosis of mental illness or substance abuse, 2-3 times the rate in the general population: **Aboriginal 516 persons.**

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<sup>8</sup> *Journal of Aboriginal Health*, NAHO: 2004 reported in Native Management Services (September 2004) Needs Assessment and Delivery Models to Address Mental Health Needs of the Aboriginal Community of Toronto – Final Report (p. 18).

<sup>9</sup> Patricia Begin, Lyne Casavant, Nancy Miller Chenier (Political and Social Affairs Division) and Jean Dupuis (Economics Division), Parliamentary Information and Research Service January 1999: Homelessness [http://www.parl.gc.ca/information/library/PRBpubs/prb991-e.htm#At%20the%20Heart-txt]

<sup>10</sup> <http://www.sprc.hamilton.on.ca/reports/The%20Homelessness%20Trail.pdf> (Hamilton Executive Directors’ Aboriginal Coalition / Native Home Providers in Ontario).

- In other words, only 14% of homeless persons exhibited no symptoms of either mental illness or substance abuse: **Aboriginal 84 persons.**
- Some 75% of homeless persons in every diagnostic category of mental illness also had substance abuse disorders.
- The lifetime prevalence rate of severe mental illness (psychotic disorders, including schizophrenia) was 5.7%: **Aboriginal 34 persons.** And that of mood disorder was 38%: **Aboriginal 228 persons.**
- Some 22% of homeless persons stated that either mental illness (4%) or substance abuse (18%) was the reason for their becoming homeless.
- In the year immediately prior to becoming homeless, 6% of homeless persons had been in a psychiatric institution, 20% had received services for substance abuse, 25% had received psychiatric outpatient services, and 30% had spent time in police stations or jails.

Table 3 below charts the above description of the mental health and addiction profile of Aboriginal homeless people.

**TABLE 3**

<b>Mental Health &amp; Substance Abuse Disorders Profile of 600 Aboriginal Homeless People Living in Toronto<sup>11</sup></b>		
<b>Mental Health/Substance Abuse Issue</b>	<b>Percentage Aboriginal Homeless with Mental Health/Substance Abuse Problems</b>	<b>Number Aboriginal Homeless with Mental Health/Substance Abuse Among 600 Homeless Aboriginal Peoples</b>
Mental Illness, Lifetime Diagnosis	66.0%	396
Substance Abuse, Lifetime Diagnosis (alcohol, cocaine, marijuana especially)	66.0%	396
Mental Illness or Substance Abuse, Lifetime Diagnosis	86.0%	516
<b>Exhibit NO Symptoms/History</b> of Mental Illness or Substance Abuse Across Life Cycle	14.0%	84
Substance Abuse Disorders <b>Concurrent</b> with Mental Illness (for every diagnostic category of mental illness), Lifetime Diagnosis	75.0%	450
Lifetime prevalence rate <b>severe mental illness</b> (psychotic disorders, including schizophrenia)	5.7%	34
Lifetime prevalence rate <b>mood disorder</b>	38.0%	228
Homeless person states mental illness or substance abuse was a <b>reason for becoming homeless</b>	18.0%	108
<b>Lived in psychiatric institution</b> during year prior to becoming homeless	6.0%	36
<b>Received services for substance abuse</b> during year prior to becoming homeless	20.0%	120
<b>Received psychiatric outpatient services</b> during year prior to becoming homeless	25.0%	150
<b>Spent time in police stations or jails</b> during year prior to becoming homeless	30.0%	180

<sup>11</sup> The Mental Health Needs Report (Native Management Services) reports that Anishnawbe Health Toronto currently provides services to 300 homeless Aboriginal people the majority of whom are male between the ages of 25 and 40; and that most homeless cases have mental health needs (p. 15).

## OTHER OBSERVATIONS ON THE PREVALENCE OF MENTAL ILLNESS IN ABORIGINAL POPULATION

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### Residential School Survivor Syndrome

The MMHC provides no estimate on the number of Aboriginal persons in the GTA suffering from the impact of residential schools but draws its conclusions from a published study of residential school survivors. Published data from British Columbia is presented here which demonstrates mental health and addiction disorders can be coexistent with having experienced residential schooling.

The Aboriginal Healing Foundation reported in 2003 on the mental health profiles of residential school survivors in British Columbia. Mental illness was indicated in all but two of the 127 case files examined. The most common mental health problems among Residential School Survivors were as follows:

- Post-traumatic stress disorder (64.2%)
- Substance abuse disorder (26.3%)
- Major depression (21.1%)

The Aboriginal Healing Foundation reports further that half of Residential School survivors presenting with post-traumatic stress disorder also had concurrent mental health disorders. Concurrent disorders among Residential School survivors included the following:

- Substance use disorder (34.8%)
- Major depression (30.4%)
- Dysthymic disorder, a chronic form of depression (26.1%)

Prevalence data reported by the Aboriginal Healing Foundation is presented below in Table 4. While this data is not specific to the Aboriginal population living or working in the Toronto area, the MMHC makes the assumption that Residential School survivors would present with similar mental health and addiction issues irrespective of geographic location of residence.

**TABLE 4**

<b>BURDEN OF MENTAL HEALTH FOR URBAN ABORIGINAL PEOPLE SURVIVING RESIDENTIAL SCHOOLS</b>		
<b>Mental Health/Addiction Issue</b>	<b>Percentage Residential School Survivors</b>	<b>Number Among 127 Residential School Survivors</b>
Indication of Mental Illness Among Residential School Survivors	98.0%	125.0
Post Traumatic Stress Disorder (PTSD)	64.2%	81.5
Substance Use Disorder	26.3%	33.0
Major Depression	21.1%	27.0
PTSD Concurrent with Other Mental Health Disorder(s)	50.0%	63.5
PTSD with Substance Use Disorder	34.8%	44.0
PTSD with Major Depression	30.4%	39.0
Dysthymic Disorder, a chronic form of depression	26.1%	33.0

*Aboriginal Healing Foundation reported in 2003 on the mental health profiles of 127 residential school survivors in British Columbia.*

### **Depression and Suicide: Prevalence for Urban Aboriginals**

The MMHC extrapolates data from two published sources to estimate the prevalence of depression and suicide for urban Aboriginal people in the GTA. Statistics Canada (2002) reports on depression among off-reserve (urban) Aboriginals. The Royal Commission on Aboriginal Peoples (1996) presents statistics describing prevalence of suicide among Aboriginal people. Prevalence of depression and suicidal tendencies suggest Aboriginal people living in urban areas may experience feelings of alienation, isolation, marginalization and cultural dislocation.

A 2002 report by Statistics Canada,<sup>12</sup> examining the health of the off-reserve Aboriginal population, found that Aboriginal people who live off-reserve were 1.5 times more likely than the non-Aboriginal population to have experienced a major depressive episode in the previous year. About 13% of the off-reserve Aboriginal population had experienced a major depressive episode in the year before the survey. In comparison, only 7% of the non-Aboriginal population

<sup>12</sup> Health of the Off-Reserve Aboriginal Population, 2000/2001 (2002) Jackie Godfrey *The Daily* Statistics Canada

had experienced a major depressive episode during the same time frame.

Statistics Canada (2002) reports further that low income was shown to increase the likelihood of depression. Twenty-one percent (21%) of low income Aboriginal people reported a major depressive episode. In comparison, 13% of Aboriginals in middle income households and only 8% of those living in high income households reported experiencing a major depressive episode.

The 1996 Report of the Royal Commission on Aboriginal Peoples<sup>13</sup> found that the suicide rate for Aboriginal Canadians was 3-4 times (3-4x) that of the general population. Among Aboriginal adolescents, suicide occurred roughly five to six times (5-6x) more frequently than for their non-Aboriginal counterparts. The Commission reported that suicide was the leading cause of death among Aboriginal males aged 10 years to 49 years.

The Canadian Institute for Health Information (CIHI) reports data non-specific to the Aboriginal population that suicide is the leading cause of injury-related death in Ontario, accounting for 1/3 of all injury-related deaths.<sup>14</sup> The CIHI reports further that there is now a greater proportion of deaths due to suicide and self-inflicted injuries compared to five years ago (24% compared to 20%). CIHI reports that experts, with the High Risk Consultation Clinic at Toronto's Centre for Addiction and Mental Health, as stating that we are not doing quite as good a job with suicide as with other injuries that cause death and that we need to work harder on removing fundamental causes of suicide.

Glen Coulthard of the University of Alberta states that 60% of all Aboriginals who commit suicide are acutely intoxicated at the time. This compares to 24% for non-Aboriginal suicides.<sup>15</sup>

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<sup>13</sup> Royal Commission on Aboriginal Peoples (RCAP), (1995). **Choosing Life: Special Report on suicide among Aboriginal people.** Ottawa (Ontario): Canada Communication Group.

<sup>14</sup> [http://secure.cihi.ca/cihiweb/dispPage.jsp?cw\\_page=media\\_28nov2001\\_e](http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_28nov2001_e) Suicide Leading Cause of Injury-Related Deaths (Canadian Institute for Health Information) 2001

<sup>15</sup> [http://www.religioustolerance.org/sui\\_nati.htm](http://www.religioustolerance.org/sui_nati.htm)

Estimated rates of depression and suicide in the Aboriginal population are presented in Table 5 below.

**TABLE 5**

<b>DEPRESSION AND SUICIDE RATES FOR ABORIGINAL PEOPLE</b>	
<b>Mental Health/Addiction Issue</b>	<b>Prevalence Compared with General Population</b>
Rate of Depression*	1.5 Times
Suicide Rate**	3-6 Times
Experienced Major Depressive Disorder During Last Year*	2 Times

\* A 2002 report by Statistics Canada, examining the health of the off-reserve Aboriginal population.

\*\* 1996 Report of the Royal Commission on Aboriginal Peoples

### **Concurrent Disorders: Estimated Prevalence in Aboriginal Population**

The *Mental Health Needs Report* includes some reference to concurrent disorders (coexisting mental health and substance abuse disorders). Specifically, Aboriginal service providers in Toronto stressed that many of their clients experience ‘concurrent disorders’ and/or ‘dual/multiple diagnosis’ problems. The *Mental Health Needs Report* indicates a level of concurrent disorders approaching 75-90%.

Referring to published data, the BC Ministry of Health report *Every Door is the Right Door* estimates that “it is likely that forty to fifty-five percent of people with substance abuse disorders also have concurrent mental disorders” (p. 20). Data from the *1990 Ontario Mental Health Supplement* shows that 18.6% of respondents aged 15-64 presented with one or more current alcohol, drug or mental health problem. A more recent Ontario sample found that 55% of those with a lifetime alcohol diagnosis also qualified for a lifetime mental health diagnosis.<sup>16</sup>

<sup>16</sup> <http://www.hc-sc.gc.ca/hecs-sesc/cds/pdf/concurrentbestpractice.pdf> “Best Practices: Concurrent Mental Health and Substance Use Disorders” Health Canada (2002)

## ESTIMATED PREVALENCE OF ABORIGINAL MENTAL HEALTH AND RELATED NEEDS IN GTA

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The analysis presented above using conservative estimates and a base population of 40,000 indicates that there are approximately 7,000 (17.5%) Aboriginal persons in the Metro Toronto area needing varied degrees of mental health services.<sup>17</sup> That is, the MMHC estimates that about 4500 adults, 1900 children, and 550 homeless people require mental health and/or addiction services.

### Service Access Points and Estimates of Service Access

This section reports estimates of current service utilization by Aboriginal clients living and working in the GTA. The MMHC cautions that these statistics must not be taken to represent the extent of need. The Standing Senate Committee's Mental Health, Mental Illness and Addiction Report presents a key finding that only 32% of individuals with mental illness and addiction saw or talked to a health professional during a 12-month period (p. 11). *The Mental Health Needs Report* prepared on behalf of Anishnawbe Health Toronto by Native Management Services identifies that many Aboriginal clients are aware of having a mental health problem but do not seek a diagnosis because of fear and other barriers:

- Fear loss of children
- Shame
- No one to talk to
- Language Barriers
- Denial
- Need to be accompanied to seek help
- Homophobia/AIDS Phobia
- Obsessive-Compulsive Behaviour
- Eating Disorders
- Agoraphobia
- Preferring to access services from Aboriginal people
- Experience of racial backlash from mainstream
- Mainstream services lacking any cultural component that reflects Aboriginal people and our beliefs

Aboriginal People who need mental health services are known to seek their care from mainstream organizations, private clinics and Anishnawbe Health Toronto. The *Mental Health Needs Report* reports statistics describing Aboriginal client case loads for the following agencies:

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<sup>17</sup> Please refer to Tables 1, 2 and 3 in this Report.

- Native Child and Family Services of Toronto (NCFST)
- Council Fire Native Cultural Centre
- 2-Spirited People of the 1<sup>st</sup> Nations
- Anduhyuan Aboriginal Mental Health Crisis Service<sup>18</sup>
- CAM-H Aboriginal Services Unit
- Gerstein Centre<sup>19</sup>
- Anishnawbe Health Toronto

Information obtained about client loads is presented below for each of the agencies listed above. Readers are advised that due to a lack of a coordinated information management system across programs and agencies, it is not possible to conclude with accuracy the percentage of clients who receive services from more than one of the listed Aboriginal or non-Aboriginal agencies. However, the following statistics present some indication of the number of Aboriginal people in Toronto who present with mental health issues at agencies which may or may not have the necessary staff expertise and other resources to accommodate their reported or inferred needs.

***Native Child and Family Services of Toronto (NCFST)*** reports 80 to 90% of their clients have mental health needs. In 2003/2004, NCFST served 308 adults in groups; 150 children and youth in circles; 17,000 meals at youth drop-in; and offers 96 licensed child care (Aboriginal Head Start) spaces. At minimum, this would suggest that between 360 and 400 of NCFS clients need mental health services.

***Council Fire Native Cultural Centre (NCF)*** reports that 90% of their clients need spiritual help and well over 50% of their clients have mental health needs. Written records are kept based on specific incidences only.

***Two-Spirited People of the 1<sup>st</sup> Nations and the Ontario Aboriginal HIV/AIDS Strategy*** workers report that anywhere from 50-90% of their clients have mental health needs but written records are not kept because their clients fear disclosure related to their sexuality and their HIV status.

***Anduhyuan***, in 2002-2003 had 187 Aboriginal clients, of whom 27 were new clients. This would suggest an annual increase of 17%.

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<sup>18</sup> As of June 2004, Anduhyuan no longer provides mental health crisis intervention service for Aboriginal people and this service component is in process of being transferred to Anishnawbe Health Toronto.

<sup>19</sup> Gerstein Centre's service for Aboriginal clients is being transferred to Anishnawbe Health Toronto during 2005.

Additionally, Anduhyuan responded to 2,821 crisis calls, had 270 drop-in visits and 324 mobile visits.

***The Centre for Addiction and Mental Health's (CAMH's) Aboriginal Services Unit*** (working out of Parliament Street at King) saw 200 Aboriginal clients from August 1, 2003 to March 31, 2004. CAMH notes that less than five percent (5%) of its total clientele (25,000 patients) are Aboriginal, amounting to an Aboriginal case load of about 1,250 per year.

***The Gerstein Centre*** is a non-medical, community mental health service providing telephone support, community visits and a ten-bed short-stay residence. Gerstein provides crisis intervention but not crisis management to adults with mental health problems living in the City of Toronto. Gerstein sees about 60 to 70 Aboriginal clients out of a total client base of 7,000. The Gerstein Centres' 1,500 mobile visits annually include 30-40 Aboriginal clients. This would suggest that Aboriginal people constitute 1% of the Gerstein Centre's in-house client load and 2% of its outreach client load.

***Anishnawbe Health Toronto (AHT)'s*** clinical files located at 225 Queen Street number 10,000 clients. These files include those clients accessing services at the Gerrard Street location either through the Babishkhan (Homeless Initiatives) Unit or with traditional counselors and Traditional Healers, Elders and Medicine People. AHT does not offer a specific Program or Unit for addressing mental health, addiction and concurrent disorders in a focused way; although AHT offers diagnostic services and interventions for Fetal Alcohol Spectrum Disorder. Currently mental health services are ad-hoc and no formalized structure exists to address this need.<sup>20</sup>

AHT is located in the inner city area where the prevalence of mental health and addiction problems is higher than in suburban areas. The Mental Health Needs Report identifies that significant differences exist between the clients in the inner city and the outlying suburbs. Specifically, in the suburbs crisis teams tend to see families who have no access to residential facilities for treatment. Suburban need and service profiles contrast sharply with the inner city core where clients tend to be single people, homeless or living in group homes or supportive housing and with greater access to residential facilities.

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<sup>20</sup> In June 2005 a Mental Health Project Manager was hired to implement a Mental Health Crisis Management Unit. In August 2005 a Mental Health Project Steering Committee was established to guide a Mental Health Strategy. A Mental Health Worker was hired in September 2005 and the recruitment of a Mental Health Nurse is pending.

AHT health practitioners and counseling professionals see many homeless people in the inner city and suburban areas, among whom prevalence rates for mental health and concurrent disorders are shown to be among the highest. AHT's clinical files currently include files for 300 homeless people. The clinical opinion of a psychiatrist working on contract with AHT is that 100% of the homeless Aboriginal population would benefit from more focused mental health interventions. Homeless mentally ill clients need a continuum of services including mental health promotion; suicide prevention;<sup>21</sup> crisis management; and case management of varying degrees of intensity. An AHT staff physician offers his clinical opinion that 85% of AHT's clients present with mental health and addiction disorders. The MMHC's collective clinical opinion is that at least 1% of current clients present with severe mental illness.

### **Summary: Prevalence, Need and Service Delivery Capacity**

Approximately 40,000 Aboriginal people live or work in the GTA. On the basis of published data, a profile on the burden of mental health is presented earlier in this report. The profile estimates 7,000 Aboriginal people need mental health or addiction services. Published reports identify that about 32% of people needing mental health services actually seek or receive such services due to barriers to access.<sup>22</sup>

Currently in Toronto, no agency offers a continuum of mental health services designed for delivery specific to the Aboriginal population. Also, no agency offers a mental health service framework which features an Aboriginal human resource and information management system. The current piece-meal service delivery framework is being accessed by up to 3,000 Aboriginal clients across the life cycle. The *Mental Health Needs Report* documents that many Aboriginal mental health clients would prefer to access services from Aboriginal people and agencies because of cultural barriers and racism.

Key deficiencies in mental health service capacity for Aboriginal people in the GTA are discussed below.

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<sup>21</sup> Studies indicate that more than 90 percent of suicide victims (all age categories) have a diagnosable psychiatric illness and that suicide is the most common cause of death for people with schizophrenia ([http://www.ontchild.ca/files/gates\\_exec.pdf](http://www.ontchild.ca/files/gates_exec.pdf)).

<sup>22</sup> *Op.cit* (Footnote No. 2).

## MAJOR CONCERNS ABOUT MENTAL HEALTH SERVICE DELIVERY CAPACITY IN GTA

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***Aboriginal Mental Health: What Works Best – A Discussion Paper*** prepared by Bill Mussell and Vicki Smye in July 2001, University of British Columbia (UBC), resulted from the work of the BC Government's Aboriginal Mental Health Committee that began in 1999.

The UBC discussion paper mirrors some of the concerns expressed in the *Mental Health Needs Report* by key informants in Toronto. These deficiencies are presented below.

### **Key Deficiencies in Mental Health Service Capacity for Aboriginal People in Greater Toronto Area (GTA)**

- Many agencies/organizations offer components of mental health services with **minimal coordination** between them.
- **No core** Aboriginal Mental Health Program exists federally or provincially.
- **No formalized systems of case coordination** are available.
- There is a **lack of protocols re: information sharing** across agencies. Client/patient confidentiality is highly valued by providers as is seamless, coordinated care.
- No coordinated service exists for the **mental health well-being of children** including programs to address bullying and peer-group exclusion.
- **No education, training and support** are available for mental health workers and volunteers on the front line. Aboriginal service providers often feel **disempowered within a mainstream 'partnership' due to credentialism** and racism.
- **Aboriginal knowledge tends to be devalued, discredited and marginalized.** The traditions, values and health belief systems of First Nations and other Aboriginal People are poorly understood by many providers and often are not respected or considered.
- **Data management is not done consistently** across programs or agencies.

- Information systems regarding available resources are missing.
- There is a **lack of timely, coordinated treatment and support** for individuals with alcohol and substance use issues.
- Although there is some follow-up provided for individuals returning from withdrawal-management treatment, there are **few rehabilitation programs**.
- **Housing** is considered to be one of the most pressing social issues affecting mental health.
- Mainstream agencies are not directly accountable to the Aboriginal population and therefore are **not obligated to reach Aboriginal objectives**.

### **CONCLUSION: Assessing AHT's Capacity to Address the Prevalence of Mental Health and Addiction Problems**

The MMHC concludes that AHT's current service framework and capacity are inadequate to address the mental health needs of the Aboriginal population in the GTA. As stated above, while practitioners do address mental health issues as they arise and are reported by clients, there is no focused mental health program, services or Unit at Anishnawbe Health Toronto.

At present, limited mental health services are provided *ad hoc* by five different programs within Anishnawbe Health Toronto. It is essential to note that these programs are not designed, staffed or equipped to specifically address mental health needs of Aboriginal clients. The programs are listed below:

- Babishkhan Unit
- Primary Health Care Unit
- Traditional Healers, Elders and Medicine People
- Traditional Counseling
- Addiction Services
- Psychiatric Consultation Services

Clients accessing care do so either directly to these services or through self, outside or internal referrals. Services are limited in nature and scope; and they lack coordination, case conferencing and case management capacities. Current infrastructure does not provide formally for mental health promotion and mental illness prevention activities. AHT lacks a coordinated mental health and

suicide crisis management service. Some staff are experienced in mental health and addiction but lack specialty training in this area, and so frequently refer clients to outside agencies.

Currently AHT lacks the needed infrastructure, human and information resources to adequately manage and monitor progress on mental health, addiction and concurrent disorders. However, AHT through its outreach activity does have an existing and well-established rapport with many homeless and mentally ill clients. Further, AHT's Babishkhan Unit has been operating for a period of time developing a Case Management approach (Circle of Care Model), which meets the expectations of Aboriginal people who are homeless. This case management model could be adopted by the Mental Health Unit.

The cultural component of AHT's current service delivery model reflects Aboriginal people and their beliefs. The integration of Traditional and Western healing methods, approaches and practitioners is identified as a best practice in the British Columbia Discussion Paper: *Aboriginal Mental Health: What Works Best*. The integration of Traditional and Western health care methods and approaches indicates that AHT is at the leading edge of shifting from the "institutional-medical approach" and the "community treatment-rehabilitation approach" to the "empowerment-community integration approach."<sup>23</sup>

Further development and integration of the cultural/traditional approaches with clinical-medical methods in the areas of mental health, addiction and concurrent disorders will be necessary.

The MMHC concludes however that AHT is at an appropriate stage of readiness to implement a mental health service delivery framework involving the following indicators of effectiveness:

- Stakeholder participation and empowerment: ***Citizen engagement***
- Community support and integration: ***Meaningful partnerships***
- Social justice and access to valued resources: ***Capacity Building***
- Focus on the whole person: ***Holistic mental health care***

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<sup>23</sup> For more about this paradigm shift away from an Institutional-Medical Model, see Geoffrey Nelson, John Lord and Joanna Ochocka *Shifting the Paradigm in Community Mental Health: Towards Empowerment of Community* (Toronto, University of Toronto Press, 2001).

- Addresses the crucial determinants of health: **Population based**
- **Promotes systemic change** (e.g. social policy) as fundamental to individual, family and community mental health promotion

Finally, AHT has direct linkages with the Inner City Program at St. Michael's Hospital; good working relationships with the Centre for Addiction and Mental Health and other Toronto providers seeing Aboriginal mental health clients; and an effective relationship with consulting medical professionals (e.g. psychiatrist, psychologist).

## AHT'S MENTAL HEALTH SERVICE DELIVERY MODEL

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### **Mental Health Service Delivery: Building On Existing AHT Capacity**

Currently, mental health, addiction and concurrent disorders are to some extent addressed by the following service portals at AHT:

- Primary Health Care Unit
- FASD Diagnostic Clinic
- Addiction Services
- Babishkhan Unit
- Mental Health Crisis Management Unit

The MMHC considers the following features of current service delivery to be innovations of AHT's service delivery model, which contribute to client wellbeing:

- Circle of Care Model
- Mobile Case Management
- Aboriginal Human Resources
- Integrating Aboriginal and Western Health Care Approaches and Practitioners
- Integrated, Multi-disciplinary Approach to Health Care

The MMHC concludes that the establishment of a Mental Health Unit would improve AHT's capacity to address the mental health needs of the Aboriginal community. The MMHC therefore recommends that an integrated, multi-disciplinary, continuum of care, culture-based Mental Health Unit be established at Anishnawbe Health Toronto.

### **Mental Health Service Delivery: Mobilizing AHT's Strategic Plan**

A Mental Health Unit would broaden the strategic directions, which form the basis of the recently established Mental Health Crisis Management Unit at AHT.<sup>24</sup> A Mental Health Unit would also

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<sup>24</sup> The March 2005 AHT Report, '*Mental Health Crisis Management for Aboriginal People in Toronto*,' elaborates 4 strategic directions for delivering mental health crisis management services. These are: 1. Crisis Management; 2. Traditional and Western Based Health Support Services; 3. Family & Individual Mental Health Counseling; and 4. Community Outreach and Training. AHT's Mental Health Crisis Management Unit was established in July 2005: Direct service delivery is expected to begin by mid-November 2005.

advance the short-term and long-term objectives of AHT's Strategic Plan.<sup>25</sup> As represented in Table 6, a Mental Health Unit would be established on the basis of 5 strategic directions with 23 objectives:

**TABLE 6**

<b>AHT'S MENTAL HEALTH SERVICE DELIVERY STRATEGY for ABORIGINAL PEOPLE LIVING &amp; WORKING IN GTA</b>	
<b>Strategic Direction</b>	<b>Objectives</b>
<b>Holistic Health Care:</b> Go beyond mental health crisis management to deliver a continuum of mental health services across the life cycle	<ul style="list-style-type: none"> <li>• To become a Mental Health Care service provider</li> <li>• To provide 24/7 coordinated access to managed, culture-based mental health care services</li> <li>• To develop addiction services</li> <li>• To develop a Rural Healing Lodge</li> <li>• To develop chronic care services for seniors and people with disabilities</li> </ul>
<b>Holistic Health Care:</b> Integrate emerging mental health programs and services with existing Traditional and Western based health support services	<ul style="list-style-type: none"> <li>• To develop a multi-disciplinary mental health strategy</li> <li>• To expand scope of mental health services to include other disciplines</li> <li>• To implement Mental Health Worker; Mental Health Nurse; and Mental Health Unit / Case Manager positions</li> <li>• To provide access to Traditional mental health practitioners and approaches</li> <li>• To develop and integrate a Mental Health Care Data Base</li> </ul>
<b>Generations &amp; Growth:</b> Provide individual, family and group counseling and psychosocial supports with the expertise of specially trained mental health staff from varied disciplines	<ul style="list-style-type: none"> <li>• To go beyond treating symptoms to actually identify and address underlying issues related to presenting mental health symptoms</li> <li>• To establish, promote and evaluate appropriate</li> </ul>

<sup>25</sup> The *Circle of Care Manual*, which is AHT's Policy & Procedures Manual, lists the agency's strategic directions and related short-term and long-term objectives (pages 10 to 13 of 84).

**AHT'S MENTAL HEALTH SERVICE DELIVERY STRATEGY for ABORIGINAL PEOPLE LIVING & WORKING IN GTA**

Strategic Direction	Objectives
	<p>programs for meeting mental health needs</p> <ul style="list-style-type: none"> <li>• To consider the establishment of an Employee Assistance Program either within the organization or in the community to meet mental health needs of AHT staff</li> </ul>
<p><b>Community Outreach:</b> Promote and establish community outreach and training on the basis of appropriate mental health system partnerships and linkages</p>	<ul style="list-style-type: none"> <li>• To inform the public, organizations, partners, linkages and donors including the private sector of the Circle of Care model</li> <li>• To develop strategies and plans that promote Anishnawbe Health Toronto as a learning organization, potentially developing as a Centre of Excellence in Aboriginal Mental Health Human Resource Development</li> <li>• To provide staff training specific to mental health and related to the Circle of Care model</li> <li>• To develop and implement training programs for the homeless</li> <li>• To increase youth participation and training opportunities in all areas of Anishnawbe Health Toronto</li> </ul>
<p><b>Infrastructure Renewal:</b> Develop the administrative and management functions in response to emerging mental health capacity building</p>	<ul style="list-style-type: none"> <li>• To establish support services as a component of the Mental Health Unit and consisting of information management, evaluation, research and training</li> <li>• To measure progress toward improved individual, family and community mental health outcomes</li> <li>• To promote exchange of human resources across programs, Units and external partners</li> </ul>

<b>AHT'S MENTAL HEALTH SERVICE DELIVERY STRATEGY for ABORIGINAL PEOPLE LIVING &amp; WORKING IN GTA</b>	
<b>Strategic Direction</b>	<b>Objectives</b>
	<ul style="list-style-type: none"> <li>• To train and promote Aboriginal mental health professionals</li> <li>• To continue developing, advancing and promoting a best practice mental health delivery model</li> </ul>

\* This table was developed using information from two sources: *The Circle of Care Manual* (pp. 10-13) and AHT's funding submission *Mental Health Crisis Management for Aboriginal People in Toronto*.

### **Mental Health Service Delivery: Building Mental Health Capacity of Priority Populations**

A Mental Health Unit would consist of a comprehensive service delivery model for addressing urban Aboriginal mental health needs across the life cycle, and targeting the burden of mental health discussed earlier in this report. A Mental Health Unit would respond to identified gaps and deficiencies for addressing Aboriginal mental health, substance abuse and concurrent disorders.

On the basis of its findings, the MMHC recommends that a Mental Health Unit be established which offers a continuum of services accessible to the priority populations as represented in Table 7.

**TABLE 7**

<b>IMPLEMENTATION OF THE MENTAL HEALTH UNIT</b>	
<b>CONTINUUM OF SERVICES</b>	<b>PRIORITY POPULATIONS: Those who are ...</b>
<ul style="list-style-type: none"> <li>• Mental Health<sup>26</sup> Promotion</li> <li>• Mental Health Crisis Management</li> <li>• Mental Health Case Management</li> <li>• Mental Health Referrals</li> </ul>	<ul style="list-style-type: none"> <li>• Homeless</li> <li>• At risk of self-harm</li> <li>• At risk of harming others</li> <li>• Diagnosed with Severe Mental Illness<sup>27</sup></li> </ul>

<sup>26</sup> For the purposes of this table, mental health here includes concurrent disorders. Concurrent disorders is defined as the co-occurrence of symptoms of cognitive and emotional disease with a substance abuse problem.

<sup>27</sup> See Footnote 1.

IMPLEMENTATION OF THE MENTAL HEALTH UNIT	
CONTINUUM OF SERVICES	PRIORITY POPULATIONS: Those who are ...
<ul style="list-style-type: none"> <li>• Mental Health Follow-Up</li> <li>• Mental Health After Care</li> </ul>	<ul style="list-style-type: none"> <li>• FASD/E and their families</li> <li>• Challenged by historical trauma</li> <li>• Challenged by Residential School Syndrome</li> <li>• Having problems of Identity</li> </ul>

### Mental Health Service Delivery: Values and Principles

A Mental Health Unit would incorporate the same values and principles reflecting Traditional and Western approaches that are the basis for promoting, implementing and evaluating progress in existing AHT Units and Programs.

- 1) Recognize that Aboriginal People have **inter-generational stress** resulting from the Residential School legacy; colonialism; marginalization; loss of resources, culture, language, self-esteem; and from family and community dislocation.
- 2) Recognize that **good "mental health" is** more than the absence of illness but a state of well-being which includes appropriate housing, education, employment, childcare, food, supportive family, peer and community relationships.
- 3) Respect and support **Traditional Healers, Elders and Medicine People** and Aboriginal healing practices.
- 4) Ensure **synergy of Traditional and Western Medicine and Practices** through a continuum of care from traditional to western-based.
- 5) Respect an **individual's right to choose** his or her own healing path and support a client-centered approach.
- 6) Support community **empowerment and build capacity** within Aboriginal service agencies to serve the needs of Aboriginal people.
- 7) Support on-going **"action-oriented" research**, driven and controlled by the Aboriginal community.

- 8) **Respect diversity** within the Aboriginal community including the needs of women, children, men, youth, elders, the disabled, sex trade workers, 2 spirited people, HIV+ people, and transgendered people.
- 9) Support **mental health promotion** and work to **remove the stigma** associated with mental health issues.
- 10) Ensure better **integration and coordination** of mental health services among Aboriginal and non-Aboriginal service providers.
- 11) Aboriginal individuals with mental/emotional difficulties need to continue to be **part of a healthy and active community**.
- 12) **Culturally relevant and sensitive** services to Aboriginal individuals will increase accessibility to mental health care and will ensure that individuals and their families are treated with **respect and dignity**.
- 13) Services need to be accessible **24 hours a day and 7 days a week**.
- 14) **Services need to be provided in the community** as much as possible; that is, at home, in places of employment, and in neighborhoods.

### **Mental Health Service Delivery: Integrated System of Care**

A Mental Health Unit would begin with the Crisis Management Unit and later integrate the following components:

- **Primary Services**
  - Clinical Health Care Services
  - Babishkhan Unit
  - Traditional Healers
  - Counseling Services
  - Addiction Services
  - Crisis Intervention/Crisis Management
- **Secondary/Specialized Services**
  - FASD Diagnostic Clinic
  - Chronic Care Unit
  - Psychiatric Consultation Program
  - Group Process Circles
  - Healing Lodge/Addiction Management Unit
  - Child, Youth & Family Wellness Team
  - Withdrawal Management Facility

- **Support Services**
  - Information Management
  - Research & Evaluation
  - Training & Capacity Building
  - Reception
  - Maintenance

**Mental Health Service Delivery: Staffing**

The MMHC recommends hiring 32.2 new staff and transferring or sharing 12.1 existing staff to meet the projected staffing requirements for a Mental Health Unit. (See Table 8)

**TABLE 8**

<b>STAFFING REQUIREMENTS FOR MENTAL HEALTH UNIT</b>	
<b>NEW STAFF TO BE HIRED (32.2)</b>	<b>EXISTING STAFF TO BE TRANSFERRED or SHARED (12.1)</b>
<ul style="list-style-type: none"> <li>• Mental Health Unit/Case Manager (1)</li> <li>• Traditional Healer (2)</li> <li>• Elder (2)</li> <li>• Osh-ka-be-wis (1)</li> <li>• Assistant Osh-ka-be-wis (1)</li> <li>• Traditional Counselor (1)</li> <li>• Addiction Counselor (3)</li> <li>• Psychiatrist (1.4)</li> <li>• Mental Health Worker (1)</li> <li>• Mental Health Nurse (2)</li> <li>• Nurse Practitioner (2)</li> <li>• Physician (.2)</li> <li>• Circle of Care Worker (2)</li> <li>• Psychologist (0.6)</li> <li>• Family Care Worker (3)</li> <li>• Occupational/Recreational Therapist (1)</li> <li>• Health Promoter (1)</li> <li>• Social Worker (1)</li> <li>• Associate Coordinator (2)</li> <li>• Family Counselor (3)</li> <li>• IT Specialist (1)</li> </ul>	<ul style="list-style-type: none"> <li>• Traditional Healer (1)</li> <li>• Osh-ka-be-wis (1)</li> <li>• Assistant Osh-ka-be-wis (1)</li> <li>• Traditional Counselor (3) - transferred</li> <li>• Psychiatrist (.1) - transferred</li> <li>• Circle of Care Worker (4)</li> <li>• Coordinator (2)</li> </ul>

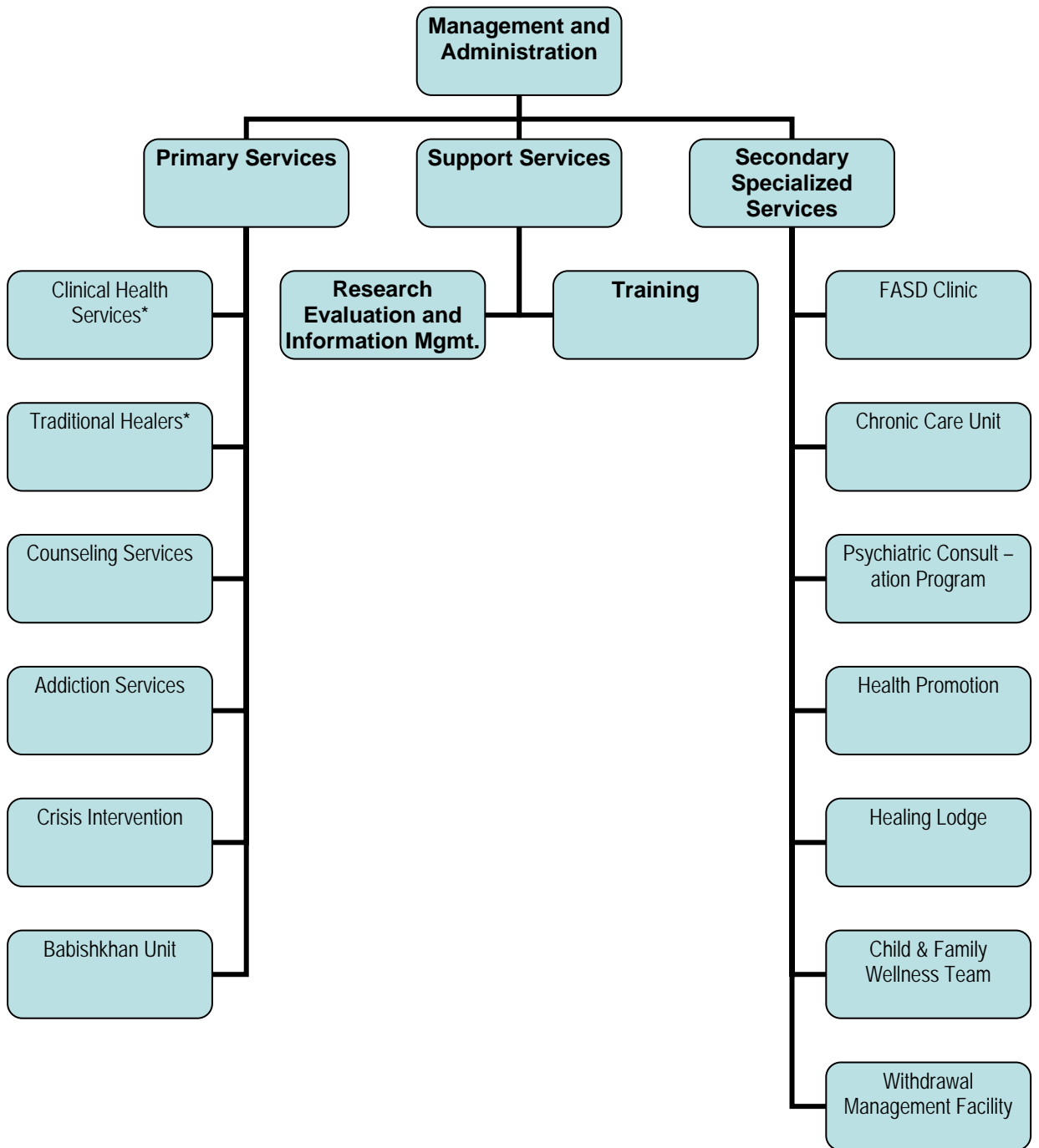
## **Mental Health Service Delivery: Space Allocation**

The MMHC recommends that the Mental Health Unit be centrally located, that mental health services and programs are integrated with other AHT Units in structure, process and function. Client information management (i.e. electronic charting using current software) ought to be integrated with other Units and meet the minimum reporting requirements of government and other stakeholders.

The MMHC refers readers to Figures 1, which graphically represents the components of the Mental Health Unit.

**FIGURE 1**

**Mental Health Unit: Proposed Structure**



\* While these are not primary mental health services, many clients seeking primary medical/traditional care also have mental health issues.

## DETAILED DESCRIPTION OF SERVICE DELIVERY MODEL

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### Introduction

A Mental Health Unit would be a specialized portal of service delivery. It would be equipped to prevent and address identified mental health, substance abuse and concurrent disorders in the Aboriginal population of the GTA. AHT's current service delivery framework would be specialized, expanded and diversified to meet the community's mental health needs.

An integrated, interdisciplinary team of qualified mental health professionals would staff the Mental Health Unit. Staff would collaborate and consult with community based Aboriginal and non-Aboriginal service providers. Staff would develop, promote and implement services and programs and coordinate referrals consistent with the needs and preferences of clients.

The Mental Health Unit would involve a three-tiered Service Delivery Framework as described earlier in this report:

- Primary Services
- Secondary (Specialized) Services
- Support Services

In addition to appropriate staffing and a human resource strategy (e.g. training, specialist job descriptions, performance evaluation), the MMHC recommends that the Mental Health Unit include the following five (5) components:

- 1) Intake Process** which includes an assessment tool and protocols for gathering, exchanging and tracking client information
- 2) Coordinated Case Management**, including mobile case management for crisis and ongoing mental health issues; multidisciplinary care plans; and case management logs
- 3) Collaborative Decision-Making**, consisting of multi-disciplinary team meetings; case conferencing; and ethical reviews
- 4) Formalized Referrals Process** with appropriate protocols and a communications strategy to sensitively address mental health issues
- 5) Integrated and comprehensive Continuum Of Care** including follow-up and after care to maintain seamless delivery

## 1) Intake Process

The MMHC recommends that mental health service delivery utilize the Medicine Wheel concept to design an intake process (See Figure 2). The Medicine Wheel is a simple but effective tool for completing and tracking intake assessments. The Medicine Wheel represents a circle of care. It reflects the four aspects of self (emotional, physical, mental-cognitive, and spiritual); the life cycle (infancy & childhood, youth, adulthood, and senior); intensity of case management (assertive/sustained; intensive; monitored; self-directed); level of need (e.g. in-crisis; at-risk; stable; self-sufficient); and progress toward mental wellness (entering; learning; integrating; healing). This approach to intake considers the whole person and expands the identification of mental health determinants.

Employing the Medicine Wheel to complete intake assessments entails using the narrative interview technique over a period of time to gather information from the client describing their mental health history, issues (e.g. service barriers; discrimination), needs/goals and resources (e.g. family support, community participation).

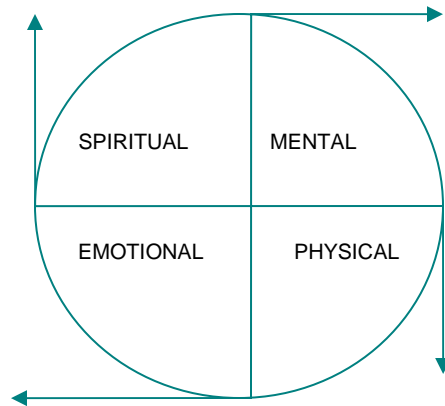
The MMHC recommends that Intake would reflect a solutions-focused model, which recognizes that recovery is a viable goal for people with mental health problems. A recovery approach involves using empowerment (e.g. client-directed care plans) and community integration (e.g. involving family or individual's circle of trust in care delivery).

Intake staff in consultation with the Unit/Case Manager and with the client as an active participant would assess clients and make referrals on the basis of:

- a. Identified needs & preferences
- b. Client readiness
- c. Collateral resources available to the client (e.g. family supports, housing, goal successes)
- d. A Client-focused care plan

**FIGURE 2**

**Medicine Wheel Approach to Service Delivery**



**2) Coordinated Case Management**

The Mental Health Unit would utilize the Circle of Care Model developed and implemented by AHT’s Babishkhan Unit. The Circle of Care Model includes mobile case management, care plans and case management logs, which would be adapted for use within the Mental Health Unit.

In order to promote and establish a basis for mental health service access by existing clients, the mental health team would interface with the Babishkhan Unit and other Units, programs and services.

**3) Collaborative Decision Making: Mental Health Team**

The MMHC recommends that the Mental Health Unit staff meet regularly as a multi-disciplinary team and periodically for case conferences, ethical reviews, specialized training, and cultural development.

In addition the MMHC recommends the establishment of a Mental Health Project Steering Committee to provide input to the planning and implementing of a Mental Health Unit.

#### **4) Formalized Referral Process & Protocols**

The MMHC recommends that clients would be referred to different services both internally between AHT's two locations and externally, depending on clients' unique and changing needs (See Figures 1 and 2). The MMHC recommends that intake would be on the basis of self, internal/external referrals. Internal referrals would be either from Primary Services or Secondary (Specialized) Services (see Figures 1 and 2).

Clients would give consent to mental health interventions and referrals on the basis of full disclosure about the different service modalities (e.g. Traditional, psychiatric, psychosocial).

#### **5) Integrated, Comprehensive Continuum of Care**

The MMHC recommends that services would be available to Aboriginal people across the life cycle from conception and infancy through childhood, youth, maturity, to old age, and through chronic and palliative care. In order to ensure a continuum of community-involved care is available to Aboriginal people of all ages and from all walks of life, the MMHC recommends that client intake and ongoing care would involve as and when necessary one or more of the following client support networks:

- Family members
- Informal circle of trust (i.e. when family is unavailable)
- Client-requested community agencies

In addition, the MMHC recommends that as needed, services would be provided in collaboration with AHT's other Units and programs (e.g. Prenatal Program, Primary Health Unit; Massage Therapy Services, Primary Health Unit).

## FUNCTIONS AND ACTIVITIES OF THE MENTAL HEALTH UNIT

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A series of charts are presented below, which list the recommended functions and activities of each component of the Mental Health Unit.

In consideration of currently established delivery portals at AHT (e.g. Babishkhan Unit), the MMHC lists recommended *additional* functions and activities. The MMHC believes that the mental health service capacity of existing Units and programs can be improved by adding the suggested functions and activities.

- A. Primary Services
- B. Secondary Mental Health Services
- C. Support Structures

### A. Primary Services

Primary Services include:

- 1) Babishkhan Unit
- 2) Primary (Clinical) Health Care Services
- 3) Traditional Healers, Elders and Medicine People
- 4) Addiction Services
- 5) Traditional Counseling Services
- 6) Crisis Management Services

Clients would self-refer or be referred by external Aboriginal and non-Aboriginal agencies. Clients making initial contact to any of the above portals for service entry would participate in an initial assessment, treatment and possible referral to one or more of the six specialized services either at Anishnawbe Health Toronto or other community based services (e.g. for harm reduction). The timing and location of consultations and referrals would depend on factors such as the following:

- Client's needs
- Client's readiness
- Client's comfort
- Client's capacity
- Practitioner's case load
- Practitioner's expertise
- Practitioner's standards of practice

The recommended functions and activities of each of these Primary Service portals are presented in a series of tables below.

## 1. Babishkhan Unit

Functions	Activities
<ul style="list-style-type: none"> <li>• Provide outreach and long-term support to clients who are homeless with mental health issues.</li> <li>• Implement mental health case management for clients dealing with issues in addiction, homelessness, employment, education and reconnection with culture and tradition.</li> <li>• Assist clients to develop a supportive mental health network.</li> <li>• Facilitate access to needed AHT mental health services, resources and supports.</li> <li>• Develop and maintain collaborative relationships with key mental health supports and resources in the community.</li> <li>• Develop and maintain collaborative relationships with traditional and cultural supports and resources in the community.</li> <li>• To reintegrate homeless mental health clients back to community.</li> </ul>	<ul style="list-style-type: none"> <li>• Babishkhan Unit staff will design and implement strategies for homeless clients assisting them to meet their basic needs and to identify and realize their personal goals in their issues such as addiction, housing, employment/education and culture/tradition.</li> <li>• Provide support and information to clients and to their family to enable them to overcome homelessness. Programs will provide education and/or skill development for labour market re-entry including referrals and advocacy for vocational rehabilitation supports from ODSP, CPP, etc.</li> <li>• Advocacy on behalf of clients as appropriate.</li> <li>• Liaise with other nongovernmental and government agencies.</li> </ul>

## 2. Primary Health Care Services

Functions	Activities
<ul style="list-style-type: none"> <li>• To provide assessment, treatment, counseling and referral to appropriate mental health and social services to clients visiting various services including medical clinic, chiropractors, naturopaths, chiropodist and dental services, for health problems within a framework that is culture based utilizing a mixture of Western intervention/treatment and Traditional teaching/healing ways.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment, diagnosis and management of mental health and addiction issues as presented at the primary health care stage.</li> <li>• Treatment where appropriate and/or referral to other resources internally or externally.</li> <li>• Provision of continuity of care for individuals with chronic mental health problems.</li> <li>• Advocacy on behalf of client to health, welfare, educational and social services.</li> </ul>

### 3. Traditional Healers, Elders and Medicine People

Functions	Activities
<ul style="list-style-type: none"> <li>• Assess/diagnose mental health issues and provide medicines and counseling services.</li> <li>• Education for extended family/relatives.</li> <li>• Early detection of possible mental health symptoms.</li> <li>• Educate to build community awareness in regards to mental health, to reduce myths &amp; misunderstandings that lead to stigmatization.</li> <li>• Promote healthy/balanced traditional roles &amp; responsibilities.</li> <li>• Address underlying mental/emotional issues which contribute to violence &amp; dysfunction.</li> <li>• Education based on medicine wheel, holistic approach.</li> <li>• Positive proactive 'can do' attitude in the hopes of rebuilding healthy relationships between families and communities.</li> <li>• Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment of mental health issues and provision of traditional medicine and counseling services.</li> <li>• Teaching circles, sharing circles, storytelling and ceremonies.</li> <li>• Provide support &amp; learning through sharing in group experiences.</li> <li>• Training and education of other workers.</li> <li>• Promote awareness of existing resources and advocate for gaps in services.</li> <li>• Provide community outreach.</li> <li>• Add to the existing body of knowledge, identifying strategies that people need to model.</li> <li>• Encourage community empowerment.</li> <li>• Collective/collaborative problem solving in community.</li> <li>• Nurture grassroots involvement and the development of local leadership (elders, youth reps, traditional elder).</li> <li>• Improve awareness among leadership about how they may be helpful to the healing process.</li> <li>• Training and joint program planning, development and delivery.</li> <li>• Provide traditional remedies to clients.</li> <li>• Through workshops, seminars, teachings and ceremonies contribute to addressing identity issues associated with mental health.</li> </ul>

### 4. Addiction Services

Functions	Activities
<ul style="list-style-type: none"> <li>• Provide assessment, treatment, relapse prevention, aftercare and referrals.</li> <li>• Provide follow-up care on return from treatment centre and ceremonies.</li> <li>• Support to individuals with addiction problems including their family.</li> <li>• Support services to primary care practitioner.</li> <li>• Prevention and education.</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment and treatment of individuals with addiction issues.</li> <li>• Counseling and psychosocial supports to individuals, families and groups.</li> <li>• Advocacy on behalf of clients.</li> <li>• Education to communities about addiction issues by different means such as posters, open meetings, circles etc.</li> </ul>

## 5. Traditional Counseling Services

Functions	Activities
<ul style="list-style-type: none"> <li>To provide counseling services within a framework that is culture based, utilizing a mix of traditional healing ways and western approaches.</li> <li>Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>Provide counseling services for individuals, couples, families and groups (i.e. ceremonies/circles) independently and in collaboration with other health care practitioners.</li> <li>Counseling services for mental, emotional, spiritual, social and cultural issues.</li> <li>Intake, advocacy, education and referral on behalf of the client in the community.</li> </ul>

## 6. Crisis Management Services

Functions	Activities
<ul style="list-style-type: none"> <li>To deal effectively and efficiently with crisis situations related to mental/emotional health.</li> <li>Provide traditional and western based health support services.</li> <li>Provide family and individual mental health counseling.</li> <li>Be a Centre of Excellence for training mental health professionals in crisis intervention and management.</li> </ul>	<ul style="list-style-type: none"> <li>Provide a crisis telephone line available 24 hours a day and 7 days a week to community members and agencies.</li> <li>Provide a mobile unit to assist in crisis situations on a 24-hour a day basis.</li> <li>Develop protocols with the Aboriginal Peacekeeping unit of the Metropolitan Police force and others.</li> <li>Provide diagnostic and other medical services in order to deal with the presenting health symptoms.</li> <li>Provide access to elder and traditional healers for counseling services when needed or appropriate.</li> </ul>

## B. Secondary Mental Health Services

Secondary Mental Health Services would be specialized and would complement and extend the mental health service capacity available through expanded Primary Services as detailed above. Secondary Services include:

- 1) Psychiatric Consultation Services
- 2) Health Promotion--Circles, Support Groups, Ceremonies & Teachings
- 3) FASD Diagnostic Clinic and Program Team
- 4) Child and Family Wellness Team
- 5) Chronic Care Services
- 6) Healing Lodge

Existing secondary services would be expanded and specialized to address the mental health and related needs of clients.

A Prenatal Program exists and it would be expanded to encompass a program framework for a Child and Family Wellness Team. In consideration of early investigations into the chronic care needs of seniors, youth and children;<sup>28</sup> the MMHC recommends the inclusion of a new Chronic Care Services portal within the rubric of a Mental Health Strategy. Additionally, the MMHC's findings support the inclusion of a rural Healing Lodge within the fabric of a Mental Health Unit.

Clients would access secondary (specialized) services in one of the following ways:

- Directly by self-referral
- Subsequent to an in-house referral from Primary Services
- Through an external referral from community based Aboriginal or non-Aboriginal service providers

The next series of charts list the recommended functions and activities of the secondary (specialized) service areas.

### 1. Psychiatric Consultation Services

Functions	Activities
<ul style="list-style-type: none"> <li>• Psychiatric support to AHT staff.</li> <li>• Liaison with AHT staff: provision of indirect client management supports.</li> <li>• Mental health education.</li> <li>• Mental health assessment.</li> <li>• Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• Psychiatric assessment of clients for AHT staff, to enable more comprehensive client care.</li> <li>• Work with client's primary support at AHT to develop comprehensive treatment plan.</li> <li>• Short term client follow-up for complex or acute cases.</li> <li>• Liaison and indirect consultation services for AHT staff regarding client care.</li> <li>• In-service rounds, education sessions.</li> </ul>

### 2. Health Promotion--Circles, Support Groups, Ceremonies & Teachings

Functions	Activities
<ul style="list-style-type: none"> <li>• Support individuals and families with mental/emotional/spiritual/physical</li> </ul>	<ul style="list-style-type: none"> <li>• Conduct different types of circles/ceremonies/teaching, such as:</li> </ul>

<sup>28</sup> See Pre-feasibility Study: A Profile of the Needs and Opportunities for Toronto's Aboriginal Community in the Area of Long-Term Care (Dr. Margaret MacAdam, Ph.D: The Age Advantage, Inc., April 13, 2005).

Functions	Activities
<p>issues.</p> <ul style="list-style-type: none"> <li>• Promote spiritual/emotional/mental/physical wellness at individual, family and community level.</li> <li>• Education for extended families and relatives about mental health issues for early detection of mental health symptoms.</li> <li>• Education to build community awareness about mental health, to reduce myths that lead to stigmatization.</li> <li>• Promote healthy/balance traditional roles and responsibilities within families and communities.</li> <li>• Address mental/ emotional/ spiritual issues that contribute to violence and dysfunction.</li> <li>• Education based on medicine wheel using holistic approach.</li> <li>• Build strong interpersonal skills and connections to larger community.</li> <li>• Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>- Teaching Circles</li> <li>- Healing Circles</li> <li>- Support Circles</li> <li>- Sharing Circles</li> <li>- Gender specific Circles</li> <li>- Issue specific Circles (e.g. healthy relationships, grieving process, mutual support, or problem gambling)</li> <li>- Traditional Ceremonies: <ul style="list-style-type: none"> <li>➢ Pipe</li> <li>➢ Naming</li> <li>➢ Clan</li> <li>➢ Vision Quest</li> <li>➢ Full Moon</li> <li>➢ Sweat Lodge</li> <li>➢ Shake Tent</li> <li>➢ Night Lodge</li> <li>➢ Yuipi</li> <li>➢ Community Gatherings i.e. Feasts</li> </ul> </li> </ul>

### 3. FASD Evaluation Team

Functions	Activities
<ul style="list-style-type: none"> <li>• Provide FASD assessment and support to affected individuals and families using traditional and contemporary healing methods.</li> <li>• Provide prevention and education around alcohol use during pregnancy.</li> <li>• Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• Multidisciplinary team assessment.</li> <li>• Referral to appropriate services.</li> <li>• Advocacy on behalf of clients for needed services.</li> <li>• General education at individual, group and community level about FASD and substance abuse.</li> </ul>

### 4. Child and Family Wellness Team

Functions	Activities
<ul style="list-style-type: none"> <li>• Support families in crisis.</li> <li>• Educate and support families of patients with mental health issues.</li> <li>• Support families where there is domestic violence.</li> <li>• Support adult children/care-givers of elders with mental health issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Educational workshop re: mental health issues, including both western and traditional care.</li> <li>• Home visits as needed.</li> <li>• Individual/Family group counseling and circles.</li> <li>• Mediation and conflict resolution.</li> </ul>

Functions	Activities
<ul style="list-style-type: none"> <li>• Support families whose children and adolescents are suffering with mental health issues.</li> <li>• Support families whose relative is homeless.</li> <li>• Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• Liaison with FASD/E Evaluation Team</li> </ul>

## 5. Chronic Care

Functions	Activities
<ul style="list-style-type: none"> <li>• Maintenance of individuals with chronic mental illness in communities.</li> <li>• Become a Centre of Excellence for education and training for Aboriginal professionals.</li> </ul>	<ul style="list-style-type: none"> <li>• <b>Continuum of Inter-disciplinary and Coordinated Care:</b> Various levels of intervention depending on clients' community need as determined using intake and assessment tool.</li> <li>• <b>Level Four:</b> Ongoing, continuous and sustained community-based intervention at a high level of intensity and involving for example home visits by a nurse for supporting medication compliance or a mental health worker for addressing psycho-social isolation;</li> <li>• <b>Level Three:</b> Case management involving intense services but less monitoring and an improved capacity to seek services within the agency;</li> <li>• <b>Level Two:</b> Case management involving reduced intensity, improved capacity for establishing rapport; infrequent monitoring and significant improvement in capacity to participate in agency-based services;</li> <li>• <b>Level One:</b> Primarily self-directed mental health maintenance with minimal case manager/practitioner interventions such as providing long term monitoring and follow up for chronic but mostly stable clients.</li> </ul>

## 6. Healing Lodge

Functions	Activities
<ul style="list-style-type: none"> <li>• To provide intensive healing services to youth and their families in a specialized and dedicated setting.</li> <li>• To use a collaborative service delivery model in partnership with Native Child &amp; Family Services of Toronto and</li> </ul>	<ul style="list-style-type: none"> <li>• Healing and health services will be culturally based, using Aboriginal specific approaches such as the use of Elders; Yuwipi Ceremony; Shaking Tent; Full Moon Ceremony; Sweat Lodge; Naming Ceremonies; and other</li> </ul>

Functions	Activities
<p>within a framework that is culture based utilizing a mixture of western intervention/treatment and Traditional teaching/healing ways.</p>	<p>Sacred Ceremonies independently and in collaboration with other health care professionals.</p> <ul style="list-style-type: none"> <li>• In addition, western counseling services for youth and their families may include: Play therapy; Individual, family and group therapy.</li> <li>• Counseling services for mental, emotional, spiritual, social and cultural issues.</li> <li>• Intake, advocacy, education and referral on behalf of the client in the community.</li> </ul>

**C. Support Services: Training, Information Management, Evaluation and Research**

The MMHC recommends including support structures within the Mental Health Unit. Support Structures would include training, capacity development, information management, evaluation and research.

The MMHC recommends that these support structures be coordinated at the administrative and management level. All staff would be provided training to build their capacity to contribute to training, information management, evaluation and research.

The MMHC recommends that AHT include in its strategic planning framework, a goal and related strategy for AHT to become a Centre of Excellence for education and training of Aboriginal mental health professionals. This long term goal recognizes a significant human resource gap, which has been identified in the *Mental Health Needs Report*, Roy Romanow’s Report<sup>29</sup> and in reports developed by Local Health Integration Networks (LHINs).

The functions and activities of the Support Services component (Training, Information Management and Research Services) are presented below:

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<sup>29</sup> The *Mental Health Needs Report* restates Commissioner Roy Romanow’s consideration that there is an urgent need to train more Aboriginal health care providers and his recommendation that measures be undertaken to increase the number of qualified Aboriginal health professionals, and to encourage their employment in service agencies, through such initiatives as support for clinical placements (Romanow, 2002: Building on Values – the Future of Health Care in Canada (p. 220).

## Support Services: Training, Information Management and Research Framework

Functions	Activities
<ul style="list-style-type: none"> <li>• Innovation and Development of mental health program and addiction services.</li> <li>• Data management of both clients and staff.</li> <li>• Training and apprentice program for homeless and mentally ill clients.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop teaching programs with in-class training and appropriate field placement.</li> <li>• Develop continuing education program and appropriate field practicum.</li> <li>• Develop alliance with educational institutes for training.</li> <li>• Develop mechanism of knowledge translation.</li> <li>• Develop mechanism of formal evaluation of program.</li> <li>• Standardized intake instruments.</li> <li>• Implementing Mental Health Information System.</li> <li>• Patient and family education centre.</li> <li>• Development of best practices as related to Aboriginal programs.</li> <li>• Develop relationships with Aboriginal and non-Aboriginal organizations and mainstream organizations.</li> <li>• Develop curriculum for training in Traditional methods and approaches.</li> </ul>

## CONCLUSION AND NEXT STEPS

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The MMHC uses a Model Development Framework involving Needs Assessment, Strategic Planning Guidelines, Service Delivery Design, Implementation and Evaluation Planning. On the basis of its projections about need and its analysis of current capacity to address needs for mental health and related services, the MMHC recommends a structure, delivery system and program objectives for developing a focused, comprehensive, continuum of mental health service delivery framework be established at AHT.

In consideration of funding constraints and time lines, the MMHC recommends a progressive implementation of recommended components of a Mental Health Unit. As a first step toward efficient, effective and collaborative implementation of the proposed Mental Health Strategy, the MMHC recommends the establishment of a Mental Health Project Steering Committee and the hiring of a Mental Health Project Manager.

The MMHC utilizes the findings of Native Management Services' *Mental Health Needs Report* that the Aboriginal community in the GTA is a community in mental health crisis. The MMHC recommends the alternative service delivery framework described above be housed at Anishnawbe Health Toronto, to address the mental health crisis being experienced by Aboriginal people living and working in the GTA. At the same time, the MMHC recognizes that the diversity and extent of need for mental health and related services requires that progress be measured incrementally, using a carefully crafted Evaluation Framework.

The MMHC recommends that the Mental Health Project Steering Committee include developing appropriate evaluation tools, within its mandate. Evaluation would measure progress on projected outcomes and would advise about next steps for maintaining best practice services for addressing mental health, addiction and concurrent disorders in GTA's Aboriginal population.

The MMHC recommends the following next steps:

- Recruit a Mental Health Strategy Manager
- Establish a Mental Health Strategy Steering Committee
- Develop and Monitor a Work Plan for Implementing the Strategy
- Cultivate needed financial, information and human resources

## LIST OF RECOMMENDATIONS

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1. **A Mental Health Service Delivery Model:** The MMHC recommends a model be developed which is culture-based and includes a capacity building strategy.
2. **An Appropriate Definition of Mental Health:** The MMHC recommends adopting the following definition of mental health:

*“Feeling vital, full of energy, having good social relationships, feeling in control over life and living conditions, being able to do things which one enjoys, having a sense of purpose in life, having a sense of connected-ness to the community and generally feeling happy with one’s self.”*  
(Dr. Nel Wieman, Aboriginal psychiatrist with a mental health clinic at Six Nations of the Grand River, and on U of T Medicine’s teaching staff)
3. **Additional Criteria for Good Mental Health:** The MMHC recommends that a working definition of mental health includes the following principle:

*Recognize that good ‘mental health’ is more than the absence of illness but a state of well-being which includes appropriate housing, education, employment, childcare, food, supportive family, peer and community relationships. (One of 14 Values & Principles, from Page 25, Item 2 The Mental Needs Report).*
4. **Expand & Diversify Current Service Delivery Capacity:** The MMHC recommends that AHT’s current culture-based service framework would be specialized, diversified and expanded to adequately address the identified types and extent of client, agency and system-level needs related to mental health, substance abuse and concurrent disorders of Aboriginal peoples in the GTA.
5. **Monitoring of Implementation and Outcomes:** The MMHC recommends that the strategy includes a yearly review of progress toward meeting objectives within projected time frames.
6. **Components of an Urban Aboriginal (AHT) Continuum of Service Mental Health Strategy:** The MMHC recommends that AHT’s Urban Mental Health Strategy include the following service components:
  - 1) Mental Health Crisis Management
  - 2) Mental Health Case Management

- 3) Crisis and Case Management for Substance Abuse and Concurrent Disorders or Dual Diagnosis
- 4) Chronic and Long Term Care Services (e.g. Dementia, Alzheimer's)
- 5) Child/Family Mental Health Wellness/Quality of Life Services
- 6) Crisis and Case Management Services and Programs for People Affected by FASD/E; PTSD; Severe Clinical Psychosis and Affective Disorders; Residential School Survivor Syndrome; and other issues of historical trauma
- 7) Aboriginal Mental Health Promotion
- 8) Aboriginal Human Resource Strategy for Increasing and Networking the Supply of Aboriginal Mental Health Professionals
- 9) Aboriginal Information Management System for Monitoring the Implementation and Outcomes of AHT's Urban Aboriginal Mental Health Strategy
- 10) Other components as identified during Implementation and Evaluation.

**7. Service Delivery Framework of the Mental Health Strategy:**

The MMHC recommends that the Mental Health Unit would include the following components requisite to a culture-based recovery model:

- Aboriginal Human Resource Strategy (e.g. training, performance evaluation, specialist job descriptions)
- Medicine Wheel Intake Process including Assessment Tool and Protocols
- Coordinated Crisis and Case Management including Care Planning and Tracking Care Progression
- Collaborative Decision Making consisting of Multi-Disciplinary Team Meetings to Mobilize Effective Strategies and Resources for Client-Focused Mental Health and Substance Abuse Services and Supports
- Formalized Referral Process including Protocols and Communications Strategy to Address Social and Environmental Determinants of Mental Health, Substance Abuse and Concurrent Disorders

- Integrated and Comprehensive Continuum of Care including Follow-up or after care to maintain the momentum of mental health care for individuals and families
8. **Establishing A Mental Health Unit:** The MMHC makes the recommendation that a new Mental Health Unit be established at Anishnawbe Health Toronto to coordinate and integrate components of an Urban Mental Health Strategy and to address gaps and deficiencies in mental health and substance abuse prevention and case/crisis management for Aboriginal peoples and families with mental health issues living or working in the GTA.
9. **Components of Proposed Mental Health Unit:** A Mental Health Unit would be a comprehensive, holistic, culture-based mental health service delivery model with the following components:
- Primary (Clinical) Health Services
    - Primary Health Unit
    - Babishkhan Unit
    - Traditional Healers
    - Counseling Services
    - Addiction Services
    - Crisis Intervention/Crisis Management
  - Secondary/Specialized Services
    - FASD Diagnostic Clinic
    - Chronic Care Unit
    - Psychiatric Consultation Program
    - Group Process Circles
    - Healing Lodge
    - Child & Family Wellness Team
    - Withdrawal Management Facility
  - Support Services
    - Information Management
    - Research
    - Training
10. **12 Service Portals For Clients To Participate In Mental Health Services And Programs:** The MMHC recommends that each of 12 recommended service delivery 'windows' of opportunity are coordinated and integrated to become an operational model for the overall Mental Health Unit:
- a) **Primary Service Portal**  
(See pp. 46-49 for Recommended Functions & Activities):

- 1) Babishkhan Unit
- 2) Primary Health Care Services
- 3) Traditional Healer Services
- 4) Addiction Services
- 5) Traditional Counseling Services
- 6) Crisis Management Services

b) **Secondary Mental Health Services**

(See pp. 49-53 for Recommended Functions & Activities)

- 7) Psychiatric Consultation Services
- 8) Circles, Support Groups, Ceremonies & Teachings
- 9) FASD Diagnostic Clinic and Program Team
- 10) Child & Family Wellness Team
- 11) Chronic Care Services
- 12) Healing Lodge

**11. Focused Portal of Service Delivery to Prevent And Address Mental Health Problems:** A proposed Mental Health Unit would augment the current limited capacity of AHT to address mental health and substance abuse disorders using prevention, health promotion, crisis management, case management, treatment, after care, follow-up and capacity building.

**12. Three-Tiered Service Delivery Model:** The MMHC recommends that a proposed Mental Health Unit would feature a three-tiered Service Delivery Model:

- Primary Services
- Secondary (Specialized) Services
- Support Services

**13. Increase, Diversify and Specialize Mental Health Service Capacity:** The MMHC recommends adding 4 service areas to AHT's current service framework to mobilize the overall initiative:

- Crisis Management
- Chronic Care Unit
- Child & Family Wellness Team
- Healing Lodge/Addiction Unit

**14. Begin with Priority Needs:** The MMHC recommends that implementation begins with the following priority needs as identified in the *Mental Health Needs Report*.

- 1) Mental health crisis management
- 2) Mental health case management

15. **Begin with Priority Groups:** The MMHC recommends that implementation of services begin with the following priority populations:
- 1) Homeless people
  - 2) People in mental health crisis including suicidal, high anxiety, rapid decompensation, high risk of injury to self/others
  - 3) People with severe mental illness as defined by DSM-III and in consideration of historical trauma issues
  - 4) Families affected by FASD/E or other conditions resulting from exposure to alcohol during pregnancy and lactation
  - 5) People with issues related to historical trauma, identity and stress including Residential Schooling Syndrome
16. **Recovery Model:** The MMHC recommends that service delivery extend beyond Harm Reduction to a Recovery Model. A Recovery Model acknowledges that people diagnosed with severe mental illness as clinically defined in the DSM-IV can recover and lead high quality, productive lives unmarred by cognitive, emotional, social and spiritual isolation and diminishment.
17. **Empowerment-Community Integration:** In addition to basing service delivery in a unique combination of Traditional and Western approaches, the MMHC recommends that service delivery (e.g. intake, case management, referrals, protocols, reporting, monitoring) reflect an Empowerment-Community Integration framework.
18. **Service Continuum across the Life Cycle:** The MMHC recommends that services would be available to Aboriginal people across the life cycle from conception and infancy through childhood, youth, maturity, to old age and through chronic and palliative care.
19. **Service Integration:** The MMHC recommends that as needed, services would be provided in collaboration with AHT's other Units and programs (e.g. Prenatal Program, Primary Health Unit; Massage Therapy Services, Primary Health Unit) as well as in partnership with external Aboriginal and (as deemed relevant) non-Aboriginal providers.
20. **24-Hr and 365-Day Service Delivery Capacity:** The MMHC recommends that the new Mental Health Unit collaborate with the Board and Administration of AHT to generate financial

resources to support staffing and other infrastructure needs for a 24 hour a day, 7-day a week service delivery capacity.

21. **Resources and Technology:** As detailed in the AHT submission, *Mental Health Crisis Management for Aboriginal People in Toronto*, the MMHC recommends that the new Mental Health Unit include appropriate resources and technology for advancing best practice service delivery.
22. **Interdisciplinary and Team-Based Approach to Service Delivery:** The MMHC recommends that a proposed Mental Health Unit would utilize an integrated, interdisciplinary team of qualified mental health professionals working in collaboration with community members to provide high quality mental health services and programs at the most appropriate time and by the most appropriate person using methods and approaches consistent with the needs and preferences of the client.
23. **Begin with Crisis Management Services:** The MMHC recommends that implementation begins with the introduction and evaluation of efficacy, efficiency and outcomes of Crisis Management Services using a Case Management approach involving integration with other AHT Units, Services and Programs and partnerships with external Aboriginal and (as deemed appropriate) non-Aboriginal partnership/referral network.
24. **Expansion of Prenatal Program:** A Prenatal Program exists currently at AHT and the MMHC recommends that it would be expanded later (Second Phase Implementation) to encompass a program framework for Child and Family Mental Wellness and Quality of Life Management.
25. **Long Term and Chronic Care Services with Mental Health Focus:** In consideration of the chronic care needs of seniors, children and youth with addiction issues concurrent with mental health or behavioural disorders, the MMHC recommends including chronic care services and a rural healing lodge within the rubric of a Mental Health Strategy.
26. **Integrated Support Structures:** The MMHC recommends that an immediate goal of a Support Structure component of the Service Delivery Model would be to assure the inclusion of training, information management, evaluation and research activities across all other functions and activities listed for Primary and Specialized Health Services.

- a) **Operating a Support Structure Component:** The MMHC recommends that Support Structures would be integrated to the Unit.
- b) **Mental Health Staff Trained to Mobilize Support Structures:** The MMHC recommends optimally that all staff would be provided opportunities to acquire and utilize knowledge and skills related to evaluation, training, information management and research.
- c) **Establishing a Centre of Excellence:** The MMHC recommends that AHT include in its long term planning framework that AHT would become a Centre of Excellence for training Aboriginal mental health professionals.

**27. Policies, Procedures and Protocol:** The MMHC recommends that the Circle of Care Manual be reviewed and updated where necessary to:

- a) Include guidelines specific to mental health for confidentiality, privacy and sensitivity in client-related communications; minimum reporting; adequate risk identification, risk management and accountability to the community in regards to all aspects of client information exchange as well as exchange of services between agencies; client advocacy; and supporting client capacity building.
- b) Identify specialized guidelines for storage and use of vehicles, cell phones, computers, software, security devices and other technology needed to advance the goals, objectives and work plan of the Mental Health Unit.
- c) Present guidelines for developing and monitoring appropriate, timely and targeted mental health care plans.

**28. Traditional Aboriginal Values and Principles:** The MMHC recommends that the components of a proposed Mental Health Unit would be guided by 14 recommended values and principles (pp. 34-36 this Report).

**29. Medicine Wheel Intake and Assessment Framework:** The MMHC recommends that the Medicine Wheel is used as a framework for client assessments, client case management logs and other aspects of client participation in the Circle of Care.

- 30. Intake Process is Family-Inclusive:** The MMHC recommends that the intake process would involve family members as and when necessary. Where family is unavailable a circle of trust can be substituted. Where the client receiving residential or intensive services in a partner organization (e.g. corrections), a community agency can be substituted.
- 31. Immediate Staffing Goals:** The MMHC recommends the following new staff be hired immediately and work in collaboration with a Project Steering Committee to: (1) Develop, manage, operate, evaluate and sustain Crisis Management Services and Programs and to continue planning and (2) Continue building toward a comprehensive continuum of service delivery model that would be called a Mental Health Unit.
- 32. New Staff for Mental Health Strategy:** The MMHC recommends the hiring of 32.2 staff including three (3) immediate staff for the Crisis Management Unit.
- 33. Transfer or Sharing of Existing Staff:** Total transfer or sharing of existing staff totals 13.1 including six (6) staff slated for immediate transfer [Traditional Counselors (3); 2 FASD Program Staff; 1 Psychiatrist].
- 34. Space Allocation for Mental Health Unit:** The MMHC recommends that the new Mental Health Unit be situated on the 3<sup>rd</sup> Floor of the 179 Gerrard Street East location.
- 35. Implementation of Steering Committee:** The MMHC recommends that a Project Steering Committee be established to provide direction and guidance to develop and monitor implementation and evaluation strategies and work plans for AHT's Urban Aboriginal Mental Health Strategy.