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The staff at Building A Nation Family Healing Centre Inc. were instrumental in allowing much needed insight into how their clients have been affected by residential schools and governmental policy. I wish to thank this project for sharing time and energy and by allowing me to visit and talk with them on how this project has supported their clients. Thank you.
1. Introduction

A series of case studies was conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case studies were intended to provide a detailed, holistic view of the projects and their ability to contribute to desired outcomes. This case study was selected to reveal the unique challenges facing urban-based projects with First Nations, Métis, homeless, and incarcerated individuals from a Western geographical perspective. All data collection, analysis, and synthesis was done by Community Support Coordinators under the facilitative guidance of Kishk Anaquot Health Research.

The project that forms the basis for this case study is entitled "Healing the Multi-generational Effects of Residential School Placement—Urban Access Program" (AHF-funded project # CT-2429-SK/1256-SK). It was described in the funding application as seeking to:

- provide clinical and traditional counselling services, as well as child custody, justice system, and social assistance program support to individuals and specific interest groups.
- Clinical services are provided by a registered counselling psychologist, a certified mental health therapist, whose practices are done in the four-directions worldview providing counselling to women, children, men and couples.
- Crises services are provided by trained crises intervention counsellors of Aboriginal descent.
- We have a traditional therapist who provides traditional ceremonies and practices, as well as counselling to our clients and survivors...
- Counselling services are provided to non-status First Nations, Métis, and non-Aboriginal family members are provided, as well as follow-up services for Treaty First Nations persons whose Health Canada counselling benefits have ended; services include Traditional healing ceremonies and practices for clients, extended family members, and community-at-large persons seeking support.

This report provides a description of the Building A Nation Family Healing Centre Inc. project (herein referred to as the project or BAN), including activities, participant characteristics, and environmental factors that may influence the project. This includes a description of the community and potential indicators of change, along with those chosen by the AHF Board to be applied to all projects (physical abuse, sexual abuse, incarceration, suicide, and children in care). The project’s best practices, successes, challenges, and lessons learned are discussed as well as impacts on individuals and the community. The methodology section provides detail on the data collection process and limitations to the methods used.

Sources of information included project files (funding proposals and quarterly reports); the AHF National Process Evaluation Survey (NPES), February 2001; key informant interviews with the project team and randomly selected community service providers; and documents and data collected by the community support coordinator (CSC) as part of the case study process. In particular, information provided by the project through its database offered important insights on client characteristics. Project files indicated use of standardized assessment tools (Myers-Briggs, Connors Scale, etc.); however, such information or analysis was not made available as the instruments were used as self-awareness tools only.

During the assessment with Myers-Briggs, after it is complete and we analyze it and transfer it to the Medicine Wheel concept, we hand them over the assessment sheet and rip up the other portion to show them we are not about keeping personal information or [that we would] use it against them later. It is an attempt to build trust.

Some conflict was noted between data sources (i.e., the National Process Evaluation Survey, internal client records, and quarterly reports); therefore, a decision was made to use internal records from Building A
Nation Family Healing Centre Inc.’s database as a first option and fourth quarter statistics for any other information required.

2. Methods

All project files were thoroughly reviewed prior to preparing the logic model and performance map. Interview questions were later developed for both internal and external agencies (see Appendix 3). Preliminary contact was made with the therapist to introduce the CSC and the case study process and to secure potential interviewees. Several unsuccessful attempts were made to secure analyzed summaries of standardized assessments consistently referenced in quarterly reports.

Over the course of four and a half days (3–7 March 2002), one-on-one interviews were conducted with seven people who primarily worked for BAN and/or served on its board. One person chose not to respond to most questions because that person did not see clients in any counselling capacity. In addition, four of these seven people were given interview questions prior to their interview. A different set of questions was delivered to external agencies that were identified from project files as having some formal or semi-formal relationship with BAN. From a list of 11 agencies, five were successfully reached and interviewed (by phone) during the visit to Saskatoon and afterwards.

Data from provincial departments of Social Services and Bureau of Statistics were also collected to provide a provincial picture of Aboriginal life in Saskatchewan. Further information was taken from Statistics Canada’s 1996 Census as well as crime-related figures and profiles from Correctional Services of Canada. The project provided a database printout of anonymous client profiles. The study relied heavily on project files, database information provided by the project, and key informant perceptions of change in participants’ knowledge, attitudes, skills, and behaviour.

2.1 Limitations

Unfortunately, no summarized analysis of the standardized assessment tools mentioned in project files were available. However, the project did maintain and share information on participant characteristics of particular interest to the AHF (e.g., history of physical abuse, sexual abuse, incarceration, suicide, and foster care). The database also provided the total number of clients and frequency of counselling sessions.

The perceptions of key informants were weighted heavily because direct assessments were kept confidential and were used primarily for client-centred purposes only (e.g., to create self-awareness). Participant feedback was primarily unsolicited and informal, and this was also not available. Still, some participant voice was gathered regarding the Circle of Voices theatre production.

Two days of training were offered to CSCs in survey development and interviewing techniques in March 2001 with a follow-up in July 2001. Work began in earnest on this case study in March 2002, and interviews were prepared based on the short-term outcomes identified in the performance map. The interviewer was independent in the field and, in this case, minor debriefing after each day of interviews took place. Field notes were reviewed and transcribed only after all interviews were conducted. There were really only two line of evidence in this case study, the project team and project files. Dissent was encouraged in at least two introductory remarks preceding interview questions:
that there are no right or wrong answers, only answers that are true from your perspective; and
the report will not be able to identify who said what, so please feel free to say things that may cause controversy.

Attempts to secure disconfirming evidence, rival explorations, or negative cases included soliciting information from five external and fiscally independent agents. Other possibilities to secure this type of information were not possible due to lack of time. The only quantitative information obtained was limited to participant characteristics, rates of participation, and provincial social indicators. The luxury of multiple evaluators was not available within the resource limitations; however, the context and data were reviewed and most responses were recorded verbatim permitting verification and re-analysis by an external evaluation facilitator. Having the analysis verified and re-analyzed by an external evaluator may have reduced bias associated with only one investigator.

The interviewer was mostly reliant on information that was readily available as only four and a half days were used to conduct one-on-one interviews and gather data from the project. In addition, phone interviews took place with all external agencies. The most important information missing was social indicator data relevant to the Aboriginal population of Saskatoon, disconfirming points of view from the participant group, as well as more long-term follow-up of individuals based on the desired outcomes identified.

3. Project Description

The BAN project applied separately for each of the two years under review. It was funded in its first year from 1 May 1999 to 30 April 2000 with a contribution of $210,229. In its second year, which operated from June 2000 to 31 May 2001, a further $222,800 was secured from the AHF. Both funding applications highlighted the need for continuous services, not just for crisis intervention. In particular, BAN wanted to offer therapy, healing activities, and continuing support. The first year included involvement with a cultural camp hosted by the Saskatoon Police Force, crisis services, and a drop-in centre. Year two continued the work started in year one with the following added or expanded goals:

• return the four-directions worldview (the Medicine Wheel and the Dene Drum) as the basis of helping and healing therapies;
• provide an urban infrastructure support system that includes advocacy services for persons involved with the justice, child custody and social welfare systems; and
• address the longer-term need for a learning model of self-directed and family-based solutions to conflict resolution and crisis intervention issues.

BAN offered both healing and training. Review of quarterly reports showed two key training programs that were offered (Aboriginal Parenting Skills and Counselling First Responders). The latter became known as A.C.C.E.S.S. (Aboriginal Counselling and Cultural Education Strategies and Systems) and offered four levels of certification. In addition to the individual and group counselling, healing activities included traditional celebrations and ceremonies, continuing support (e.g., drop-in centre, client advocacy for those involved with the justice system, child custody, etc.), and social gatherings. Training was considered as part of the continuing support to help individuals manage personal and familial crisis independently. Appendix 1 shows participation figures by year, quarter, and male-to-female participation rates. It is interesting to note that men appeared to have higher participation rates in a number of areas. 3
The logical link between BAN’s activities, what they hoped to achieve in the short term and the desired long-term outcome was summarized in Table 1 on the following page. Table 2 is a “performance map” that summarizes BAN’s activities and goals (referred to as long- and short-term outcomes) as well as the indicators that show how change was measured.

### Table 1) Logic Model—Healing the Multi-general Effects of Residential School Placement —Urban Access Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>Therapy/healing activities.</th>
<th>Continuing support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we did it</td>
<td>Ongoing individual and group counselling; powwow, cultural camp, sharing circles, sweat lodge ceremonies, cultural industries, and cultural teachings; develop an appropriate assessment and evaluation strategy; and seek avenues to ensure BAN sustainability.</td>
<td>Drop-in centre; social gatherings; crisis intervention (first responders) training; life skills; parenting skills; partnerships with early-diversion youth program and male correctional facility, adjunctive client advocacy services, life skills, and housing support; public speaking; outreach; and inter-agency partners and exposure to healthy role models.</td>
</tr>
<tr>
<td>What we did</td>
<td># of individuals counselled; # of individual counselling sessions; # of groups in counselling; # of common interest circles (e.g., family, volunteers, parolees, etc.); database design and management; drama play/video production; music/dance lessons; visual/graphic arts classes; sweat lodge, pipe, and feast ceremonies; and kick-boxing classes.</td>
<td># of training courses; # of community release plans and client support appearances (court, child custody, etc.); # of presentations; and curriculum development on residential school history and recovery.</td>
</tr>
<tr>
<td>What we wanted</td>
<td>Reduced substance abuse, risk for suicide, criminal activity, and recidivism; greater cultural identity/pride; reduced abuse; less involvement of Aboriginal clients with agencies (child custody, justice, and social assistance); increased use and understanding of traditional healing methods; increased access to culturally appropriate services; and sustainability.</td>
<td>Effective and enhanced support networks; improved interpersonal relationship skills; evidence of a greater sense of community spirit and involvement/belonging; increased use of self-directed and family-based solutions; increased ability to intervene in a crisis and resolve conflict; and increased access to advocacy services.</td>
</tr>
<tr>
<td>How we know things changed (short term)</td>
<td>Rates of participation in project activities and service access; measures of participant life satisfaction as well as that of participant family members; self-reported and observed evidence of changes in self-sufficiency, relationship/communication skills, knowledge, and use of traditional healing practices; # of agencies with formal working protocols with BAN and their ratings of the quality of interaction with BAN; self-reported and observed social and familial support; # of disclosures; # of referrals; self-reported and observed improvements in crisis management skills; and degree to which project builds sustainability (amount of ongoing committed funds toward BAN activity).</td>
<td></td>
</tr>
<tr>
<td>Why we are doing this</td>
<td>To provide ongoing effective opportunities to heal individuals and families in order for clients to have greater self-direction to manage personal and/or family crisis.</td>
<td></td>
</tr>
<tr>
<td>How we know things changed (long term)</td>
<td>Rates of lateral abuse, incarceration, children in care, sexual abuse, suicide and attempts, participation and volunteerism in community events, and dependence upon social assistance.</td>
<td></td>
</tr>
</tbody>
</table>
Case Study Report: Healing the Multi-generational Effects of Residential School Placement—Urban Access Program

Table 2) Performance Map—Building A Nation Family Healing Centre Inc.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td>activities/outputs</td>
<td>Survivors and later generations (couples, families, and incarcerated).</td>
<td>Increased use of self-directed and family-based solutions; increased # of individuals and families involved in healing; increased access to culturally appropriate services; increased understanding and use of traditional healing methods and ceremonies; increased # of effective support networks regain balance and self-directed control; and improved interpersonal relationship skills.</td>
<td>Restored balance and harmony in individuals and families; increased sense of community; reduced dysfunction; and healthier lifestyles.</td>
</tr>
<tr>
<td>Provide healing activities; and therapy, individual, and group counselling—traditional and Western-based—and crisis intervention.</td>
<td>Increased ability to intervene in a crisis and resolve conflict; increased # of effective support networks; increased use of self-directed, family-based solutions; and increased access to culturally appropriate advocacy services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide continuing support through training in crisis intervention, Aboriginal parenting skills, as well as client advocacy.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How will we know we made a difference? What changes will we see? How much change occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$433,029 over 2 years</td>
<td># of participants from Saskatoon, surrounding communities, and nearby correctional facilities.</td>
<td>Rates of participation in project activities and service access; measures of participant life satisfaction as well as that of participant family members; self-reported and observed evidence of changes in self-sufficiency, relationship/communication skills, measures of knowledge, and use of traditional healing practices; # of agencies with formal working protocols with BAN and their ratings of the quality of interaction with BAN; self-reported and observed social and familial support; # of disclosures; # of referrals; self-reported and observed improvements in crisis management skills; and degree to which project builds sustainability (amount of ongoing committed funds to BAN activity).</td>
<td>Rates of lateral abuse; incarceration; children in care; sexual abuse; suicide and attempts; participation and volunteerism in community events; and dependence upon social assistance.</td>
</tr>
</tbody>
</table>
3.1 Participant Characteristics

The project was intended to serve Survivors and their descendants primarily in the city of Saskatoon; however, some nearby First Nation communities were also served and at least one federal correctional healing lodge. Participants at the cultural camp, hosted by the Saskatoon police department with BAN involvement, were described as:

Likely multi-addicted, prone to a lifestyle of dependency and living from crisis to crisis, involvement with the criminal justice system, minimal, if any understanding of Aboriginal culture, past and current family violence and low self esteem. In short, a microcosm of Aboriginal people who suffer from the multi-generational effects of the Residential school.

The following graphic further describes participant histories for BAN participants. The vast majority (70%) have experienced physical abuse, many (slightly less than 50%) are sexual abuse victims with a history of suicide attempts and ideation, and just over 40 per cent had been wards of the province.

Figure 1) Participant Histories

<table>
<thead>
<tr>
<th>Percentage of clients (n=432)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivors</td>
</tr>
<tr>
<td>suicidal</td>
</tr>
<tr>
<td>incarcerated</td>
</tr>
<tr>
<td>physical abuse</td>
</tr>
<tr>
<td>sexual abuse</td>
</tr>
<tr>
<td>foster care</td>
</tr>
</tbody>
</table>

In most quarterly reports, the percentage of direct Survivors (i.e., those who attended residential school) remained at or near the 80 per cent mark. All participants accessed at least one of the following agencies or services or, in many cases, all three: family services, criminal justice, and social assistance.

The National Process Evaluation Survey (NPES) showed that participants involved in the healing component were: mostly male (66%); females accounted for 33 per cent; 25 per cent to 33 per cent were incarcerated; 15 per cent were homeless; youth accounted for 12 per cent; 5 per cent were Elders; and 1 per cent to 2 per cent were gay/lesbian. The vast majority were First Nations (90%) off-reserve and Métis (6%), Inuit (1%), and First Nations on-reserve (1%) accounted for the rest. For the training component, the majority of those involved in training were women (45%); men accounted for 35 per cent; 11 per cent were families; 5 per cent were Elders; 4 per cent were youth; 1 per cent were gay/lesbian; 1 per cent were homeless; and no training was delivered to incarcerated individuals.
Severe participant challenges (more than 80%) were identified as: lack of Survivor involvement in the project; history of incarceration; denial, fear, and grief; lack of parenting skills; history of suicide attempts; history of abuse as a victim; history of abuse as an abuser; history of foster care; family drug or alcohol addictions; poverty; and lack of communication skills.

The amount of time an individual participated in healing was from 80 to 100 hours from beginning to end. While the NPES showed the total number of participants was 1,100, the total number was still unclear as different sources stated different figures. In terms of completing the program, 125 people were listed with another five to six people not completing the healing component. The reason given for those who did not complete the program was said to be entrenched psychopathologically. The NPES identified 98 people who received training at 15 hours per person and only 3 per cent did not complete training because the content was too painful.

### 3.2 The Project Team—Personnel, Training, and Volunteers

The following table shows the number of project staff over the two-year period under review.

<table>
<thead>
<tr>
<th>Year One Title</th>
<th># of Positions</th>
<th>Year Two Title</th>
<th># of Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counsellor/Case Worker</td>
<td>1</td>
<td>Psychologist</td>
<td>1</td>
</tr>
<tr>
<td>Youth Worker</td>
<td>1</td>
<td>Traditional Therapist</td>
<td>1</td>
</tr>
<tr>
<td>Mental Health Therapist</td>
<td>1</td>
<td>Case Manager</td>
<td>1</td>
</tr>
<tr>
<td>Theater Project Coordinator</td>
<td>1</td>
<td>Youth Worker (1 male and 1 female)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Legal Advocate</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Executive Director</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financial Comptroller</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Receptionist</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Public Relations Officer</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office Manager</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Women’s Therapist</td>
<td>1</td>
</tr>
</tbody>
</table>

In addition to the project team, an advisory board was established with designated Survivors. According to the second-year funding application, their role was stated as follows: “Advisory Board will have direct input to the design of data gathering instruments, analysis of data, and both formative and summative evaluation phases of project management and reporting.”

The NPES showed that there were nine full-time employees (working 30 hours per week or more) and seven part-time employees (less than 30 hours per week). In addition, volunteer service was listed as 60 hours per month. During the study period, project staff were engaged in training and professional development. The basic and advanced training received by staff are outlined in Appendix 2.

The project reported several areas where further training was needed: crisis intervention, trauma awareness, counselling skills, Aboriginal language/culture, computer/Internet training, Legacy education, the
application of the Charter of Rights and Freedoms, dealing with family violence, and programs related to family functioning (e.g., child development/parenting skills).

4. The Context

Very little information was found on the selected indicators (suicide, children in care, physical and sexual abuse, and incarceration) for the Aboriginal population in Saskatoon. The follow figures for the province and for the non-Aboriginal population are intended to only provide a general context.

The project operated mainly in an urban setting; namely, Saskatoon, Saskatchewan. In the 1996 Census, Statistics Canada identified the population for Saskatoon at 193,647 people, and it also cited a figure of 219,056 for the greater metropolitan area. Saskatoon is the largest city in Saskatchewan. There are a number of Aboriginal groups in Saskatchewan, fewer are Inuit (170 persons), Métis people represent the next highest (35,655), and the First Nations population is generally made up of Cree, Ojibway, Dene, and highest is Chipewyan at 72,835. This did not suggest that other First Nations groups were not present in Saskatchewan, only that the above-mentioned groups are indigenous to the area. What can be gathered from these figures is that the proportion of Aboriginal people compared to the overall Saskatchewan population was significant. The Aboriginal population in Saskatoon was listed as being 16,160. The project, in its funding application, estimated the Aboriginal population at about twice this number (30,000).

Saskatchewan First Nations people have what are commonly called “number” treaties (or Victorian treaties) because numbers were assigned to the treaties negotiated between Canada and First Nations under the reign of Queen Victoria.

Unemployment figures show that Saskatoon had a 7.5 per cent rate, slightly higher for males (7.7%) than females (7.4%). Saskatchewan had an unemployment rate of 7.2 per cent in 1996, compared to Canada with a rate of 10 per cent for the same period. The project reported in their second year application that:

| The Saskatoon area has the full range of services expected in a major city, but access to these is severely limited compared to the need in Aboriginal families; none of these [services] has adequate Aboriginal content or cultural sensitivity to Aboriginal values; even though Aboriginal persons are hired by these service organizations and institutions, they are obligated to honor the mainstream policy environments into which they are hired; mainstream denial and de-culturation mechanisms dominate what address is given to Aboriginal issues.14 |

Regarding the economy, specifically social assistance rates, “over 4,600 families in Saskatchewan have left welfare in the past four years ... 11,829 families were living on welfare in 2001.” As to the five indicator areas the AHF Board seeks to influence (children in care, sexual abuse, physical abuse, incarceration, and suicide), what follows are data gained through various sources. All are related, in varying degrees, to the goals of the project and are issues the project could play a role in influencing. In several areas, no specific figures were available for Aboriginal people or for the city of Saskatoon.
4.1 Children in Care

In 2000 to 2001, Saskatchewan had 5,120 cases investigated by the division responsible for child protection concerns. The two main causes for child protection involvement were “physical neglect and the need for family support.” On 31 March 2001, there were 2,906 children in care for all of Saskatchewan. “Sixty-five per cent of all the children in care are First Nation and another ten per cent are Métis.” No figure was available for how many Aboriginal children were in care for the city of Saskatoon.

4.2 Sexual Abuse

Sexual assault figures for Saskatchewan were 1,525 in the year 2000. For Saskatoon, there were 347 sex offences in 1991 and 274 in 1996. It is important to note that many reported cases did not go further with charges or court trials, as a child was deemed unfit, unable to withstand a court case, or they recanted their disclosure. Another factor was that there may not have been enough evidence to proceed with a charge. Furthermore, police data represented reported rates that could have been influenced by a number of factors, including a victim's willingness to report; therefore, reported rates could differ substantially from actual rates of abuse that include children.

4.3 Physical Abuse

Common assault figures for Saskatchewan were 13,627 for the year 2000. Saskatoon had 722 major assaults and 1,523 common assaults in 1996, an increase of about 37 per cent over previous years. Not all cases of physical abuse resulted in death; however, some startling figures did exist for the Canadian population as a whole. For example, in 1998, “there were 23 victims of homicide under the age of one.” This same source goes on to state, “Parents were involved in most infant homicides ... Eighteen of the 23 victims under the age of one ... were killed by a parent ... eleven by the father, six by the mother, and in one case, both parents were involved.” Furthermore, “spousal homicides, including both husbands and wives ... accounted for 70 homicides in 1998 ... Four out of every five victims of spousal assault in 1998 were female,” and homicide accounted for 10.6 per cent of all deaths.

4.4 Incarceration

In 1999, Saskatchewan had “1,144 inmates in provincial custody,” with a clear overrepresentation of Aboriginal offenders. In Canada, as a whole, Aboriginal overrepresentation was greatest in the Prairie provinces.

On July 2, 1995, Aboriginal offenders ... comprised 11.2% (2,483) of the total [federal] offender population. Of these, 68% were in the Prairie region and within this region, Aboriginal offenders comprised 35% of the offender population.” In Saskatchewan, ... between 1993-95, an average of 73% of sentenced admissions ... were Aboriginal.

Further information showed that “Aboriginal peoples represent 2.8% of the Canadian population, but account for 18% of the federally incarcerated population.” In addition, the number of young offenders in Saskatchewan, regardless of ethnicity, have been steadily increasing annually since 1992 by about 6 per cent. For 1992–1993, there were 291 young offenders in custody in Saskatchewan, and for 1998–1999, the figure was 398.
Seventy-three percent of the children in the young offender custody programs are First Nations or Métis. First Nations and Métis children come into care more often than their non-Aboriginal counterparts and they stay in care longer.\(^{15}\)

4.5 Suicide

In Canada, suicide declined slightly from 1981 to 1997. For the overall population, 1997 saw 3,681 deaths (12.3 per 100,000 people).\(^{16}\) Although more recent figures were unavailable for how suicide compares in the Aboriginal population of Saskatchewan or Canada, some disturbing figures do exist.

The three-year national average rate of suicide for First Nations people was 38 per 100,000.\(^{17}\) Provided this rate remained fairly steady and assuming a national rate would accurately reflect a Saskatchewan reality, this would mean that First Nations people in Saskatchewan are about three times more likely to commit suicide than Canadians in general. Over a four-year period, suicide accounted for 23 per cent\(^{18}\) of injury and poisoning deaths in Saskatchewan for First Nations people. For the Saskatchewan general population in 1992, there were 140 suicides.\(^{19}\) Although indicator data did not speak directly to the Aboriginal population of Saskatoon, it was clear from participant characteristics that it is plausible to assume that they were living with the same disproportionately high rates of physical and social stress.

5. Reporting Results

Before reporting on the impact of various target groups, it is useful to recall that project activities involved both healing and training components. There were also one-time events, (e.g., cultural camp and theatre production). The following discussion deals with an overall assessment of the impact on individuals followed by impact on specific groups of individuals.

5.1 Impact on Individuals

While the more detailed impact of BAN intervention on individual lives (e.g., reduced substance use, risk for suicide, criminal activity, abuse, dependence upon social assistance, involvement with the justice system, use of self-directed family-based solutions, ability to intervene in a crisis and resolve conflict, and improved interpersonal skills) remains unclear, the project did offer opportunity for individuals to move toward reclamation of a healthy, stable, functional life without service interruption commonly associated with other short-lived interventions (e.g., counselling offered under the Non-Insured Health Benefits program). In addition, some evidence was secured to suggest that BAN had an impact upon some participants that led to an enduring commitment to engage in addictions treatment, greater cultural identity/pride and community spirit, increased understanding and use of traditional healing, and increased access to culturally effective human services. BAN’s inclusive family orientation led to a reduced risk of child apprehension, which the project attributed to their ability in providing skilled support during crisis and more general support for lone-parent households. Some participants developed sufficient leadership skills, enough so that they now manage the administrative details associated with group events (e.g., advertising, scheduling, etc.). Ideally, the evaluation plan to measure individual and family impact should be implemented. In any case, other anecdotal evidence of impact is offered for the specific target groups involved.

BAN offered client advocacy to those involved in the justice system; therefore, a key target group was young offenders. Respondents reinforced much of what was already known about this group, as many
are from homes characterized as unstable with unavailable parents (emotionally, physically). Most carry the burden of a history of physical and sexual abuse, abandonment, neglect, and foster care with some suffering from fetal alcohol syndrome (FAS) and attention deficit and hyperactive disorder (ADHD). In some cases, they represent a third or fourth generation dependent upon social assistance, and when they become teen parents, as many of them do, the cycle continues. Such a predictable pattern means comprehensive change is needed. As one informant observed, “Aboriginal people are eight times more likely to be criminalized by the time they are eighteen years old. That’s systemic injustice.”

Still, these unfortunate young people recognize positive influences when they feel them and yearn for the same emotional ties as other youth. “All they want is love, they need a comfort zone ... We have positive activities, they take it all in, absorb all of it.” Informants believed that the reasons why young offenders responded so positively was because a bond based on trust was developed with the team. Evidence of the relationship was best illustrated by the fact that “they [the young offenders] always come back, if not this month, next month.” Furthermore, a sense of belonging was created and self-discipline cultivated, for which the team credits the cultural components of the program (e.g., impulse control taught in sweats). BAN offers a new system with various layers of support not offered elsewhere (e.g., help looking for parents and apartment hunting). The team believed that psychological assessment helped before these young people attended BAN, but also recognized the limitations of counselling. After all, once the program is over for the day or for the duration, most of these young people must return to dysfunctional families.

Overall, respondents felt that BAN was able to achieve desired results reasonably well, a belief based upon the unsolicited calls received from referral agents and clients who agree. They also felt that the comprehensive and voluntary nature of their services helped (i.e., culturally appropriate healing, advocacy, support, and life skills reinforcement that emphasizes self-responsibility). The team also recognized that, beyond what they did or offered, the climate gave Survivors a venue to tell their story as well as listen to those of others. This type of connection appeared to be medicine by itself.

Young offenders were not the only group who benefitted from having BAN support them in legal affairs, as older individuals also received such services. One informant stated that, “eighty per cent of those who go to court are going for administrative violations (failure to appear or report),” which further criminalized people with criminal records. One person offered suggestions on what to do to meet these needs, including “our own police force,” while two people spoke of the Medicine Wheel teachings as a response to overcome the “systemic injustice of failed Canadian policy.”

Part of BAN activity also included a 10-week theatre program (Circle of Voices) to help youth (ages 12–26) feel safe to creatively express themselves, build self-esteem, as well as learn about theatrical productions. Over time it became clear that this group became dependent upon each other for support and encouragement. They felt a sense of responsibility to the group and grew determined to create a solid production. They eagerly anticipated the talking circles and showed respect and kindness to the volunteer and Elder support that made Circle of Voices possible. Youth became increasingly confident and more willing to take risks. In fact, one participant went to an audition for a film project and landed the part. Another was approached by a production company for a job. Family members were also influenced by increasing youth enthusiasm as evidenced by their voluntary attendance at daily workshops, involvement in talking circles and support for the production run. Some even motivated their children to continue in the performing arts industry. Two participants shared their experiences and growth with the project team.
I learned ... how to build a set and where to get light and sound equipment for the production. I also learned what it takes to be an actor and how much time and commitment is involved in being a good actor ... I want to continue working in theatre as an actor and set builder. The Circle of Voices program has allowed me to heal a part of myself that was hurting ... the program was an uplifting and thought provoking experience.

What I enjoyed about the Circle of Voices Program, is leaving it feeling confident and better about myself. I also really had fun in the actual drama part of it, although the opportunity to grow in so many ways was given to us ... I have also learned the true meaning of teamwork, discipline, punctuality, consequences and most importantly, respect. I am thankful that our ‘young’ voices were not only heard but also respected.

The Counselling First Responders (CFR) training course (intended to help individuals manage crises in their lives) was also offered to individuals who could utilize the training to assist others. Part of the rationale to develop CFR training was to establish sustainability beyond AHF funding; thus, BANTI (Building A Nation Training Institute) was born. There were 153 people who completed CFR training from the start of the project until March 2002. However, it was not clear what extent the necessary knowledge or skill participants acquired to effectively manage crises in their lives.

BAN personnel came away with a greater sense of self-responsibility, understanding of the power of forgiveness in healing, knowledge of traditional values, as well as a dream about how Canada could be a place where Aboriginal people would be recognized, respected, and accepted. Also, the need for Legacy education was consistently reinforced, not just for participants, but for a variety of human service agencies.

My Dad was a Survivor and used to beat my Mom. Sometimes, she’d be laid up for more than a week. We would see him go out on the porch in the mornings and cry really, really loud. Then he would look up in the sky, stop crying, and say something in Cree. Then, he would come back in and tell us everything was going to be ok now. But it wasn’t ok, because nobody ever talked to us about what was wrong in the first place. I couldn’t understand my Dad’s anger or why we had to suffer abuse or alcohol and drugs.

While it was unclear what extent family therapy ultimately led to desirable outcomes, respondents were clear that the challenges facing families were many (e.g., poverty and addiction). The reader is reminded that virtually all participants were dependent upon social assistance, and if they were not victimized directly, they witnessed horrific acts of violence. This meant that client needs often exceeded program capacity. One informant suggested that one or two full-time positions just for family support was required. Still, whole family treatment served as a “reality check” by helping families recognize and accept the need for change. Family sessions also helped strengthen healthy communication skills. The philosophical approach at BAN was one where healing came first and justice issues came later. This philosophy helped to establish trust that was critical in engaging families in a way that would facilitate results. Such trust was also credited to BAN being Aboriginally owned (the majority of the team being First Nations and Métis) as well as a sensitivity to Legacy issues and cultural understanding. In fact, cultural reinforcement was viewed as a way of “giving them back what residential schools took away.” At least one informant believed strongly that recognition and respect for Aboriginal culture would broadly facilitate their efforts.
5.2 Impact on Community

BAN’s team has a good reputation. They were perceived as friendly, understanding, prompt, conscientious, respectful, and easy to work with; there were always people in the sitting area. External agencies further noted that BAN training was excellent, but recommended a more balanced approach to the relationship between Aboriginal and non-Aboriginal people. One informant acknowledged that history was not always pleasant, but felt that enlisting allies might require a less threatening approach. “It’s valuable work, but it won’t get through if people get put off. Focus on positive things too.”

Referral agents noted that some clients they shared with BAN became involved (in BAN) as a result of their own initiative due to increased access to advocacy services. Sometimes, referral agents became frustrated by the lack of progress in their own approach, even with the support of various provincial departments, and have referred several clients to BAN and believe they need to refer more. Although the justice system did not follow up on inmates after release, one supportive justice official was able to maintain contact with a young ex-inmate after he was released with BAN’s help. One informant was clear that no single agency by itself can make change; rather, the collective effort is what will bring a difference to individual lives.

One of the unique challenges of working in an urban context is directly related to variety. Coming to consensus can be difficult in these scenarios; however, there may be some evidence that BAN is also building bridges in this regard.

Building A Nation’s board is comprised of First Nations, French speaking people, Metis and white. We had to learn to work out our differences and how to bridge the gap. When we formed our board, we did not see eye-to-eye, but it worked. We learned about each other. We learned about each other’s culture.

After eight weeks of intensive theatrical training and preparation combined with unique traditional healing experiences, the youth involved in Circle of Voices had the opportunity to share their production with the community. Truth Hurts was a play based on true stories of physical and sexual abuse, foster care, loss of cultural identity, language, abandonment, and racism. The stories belonged to, and were portrayed by, the young participants. Audience members for the theatrical production of Circle of Voices, Truth Hurts, had this to say:

- “Inspirational.”
- “Very realistic.”
- “Precious and wonderful.”
- “Everyone needs to see this.”
- “Fantastic play.”
- “Very emotionally captivating.”
- “That’s my life they’re talking about.”
- “The points made strike a chord in everyone’s life.”
- “I have no words to express my gratitude, thank you for bringing the truth to us all.”

The central message of the play did not end with the catharsis of sharing stories and pain but with a clear and tenacious message that young people have been empowered to change the status quo.

The story is a powerful one. A group of young people gather together a year after the suicide of a friend. They discuss his suicide and what led to it. They also discuss their lives. Truths and secrets
are revealed and their lives laid bare. The conclusion? The time for whining and blaming is over, now is the time to heal and rebuild. It's a story for everyone.45

There was an increased demand for the Counselling First Responders (CFR) course that led BAN to seek registration as a private vocational school (BANTI) with the province so that trainees could receive certification. Lastly, court referrals for community release programs managed by BAN have increased over time, and Saskatoon courts recognize BAN programming as an “alternative sentencing” program, possibly the result of more culturally sensitive staff at these agencies.

5.3 Partnerships and Sustainability

Although BAN has a plan and is hopeful about long-term funding beyond the life of the AHF, no formal agreements have been obtained. While no dollar figure was provided, the project believed that it enjoyed generous donations of goods and services, with an estimated $14,000 secured through fundraising. Figure 2 illustrates the generous funding partners of BAN (totalling $42,100).

![Figure 2) Funds Donated by Partners](image)

The Circle of Voices youth theatre production was supported by the Westmount Community School that provided the facility. Dark Horse Studio took photos of project participants and produced advertising materials. Blue Hills Productions covered the difference between actual costs and project resources to produce the Circle of Voices video and The Saskatoon Fringe provided free passes to the Saskatoon Fringe Festival to all participants.

With respect to establishing effective working partnerships, all external informants were at least aware of BAN, with the majority able to articulate the project’s goals and activities. Most commonly cited BAN features included culturally appropriate services and training for human service workers. Some external informants felt that their organization benefitted from the work done by BAN. One informant was hoping
to refer families to BAN that were long involved with child protection services and believed that the team’s ability to speak Cree was a real asset. In fact, a strong relationship appeared to exist between BAN and local service agencies, including many formal referral systems. For example, 37 clients were referred to the New Dawn Treatment Centre; of those, 28 completed the treatment cycle. From an addictions treatment perspective, BAN was valued as a partner to fill the gaps before and after treatment: “Their clients have a good show up rate which says a lot because there can be a three to four week wait before a bed opens. This must mean they keep working with the client until the opening comes up.”

Members of the Saskatoon police service were attending BAN training, and during each school year there were roughly 50 children attending an information session on the Legacy. Several other local agents have also taken BAN training, including the Aboriginal cultural coordinator within Social Services and the program coordinator at a local youth group home. Once word was out, BAN also received referrals from public schools, the courts, and even the Healthy Mothers – Healthy Babies program. Others who took the training claimed to like BAN’s work and, although unsure of the impact upon clients, did acknowledge that BAN operated in a “hard core area.” Upon release, inmates were referred to BAN, but only some actually sought services, and at least a few “really found a place there.”

Some referral agents felt that BAN facilitated bridge building among agencies with different world views and that the cultural orientation and training was definitely needed to avoid future conflicts and misunderstandings. External agents recognized the contribution BAN has made to an increased understanding of the Legacy, not just for clients but for outside institutions. “If they [BAN] didn’t exist, could turn into a little Mississippi. Need to target more agencies.” Partners and referral agents consistently recognized the potential for BAN to affect their work (e.g., family supports leading to less crime, less violence in homes, and less addiction-related charges).

5.4 Accountability

Although informants felt that BAN engaged in clear and realistic communication with the community as well as allowed for community input, they acknowledged that communication was a challenge with their target group (i.e., homeless or incarcerated individuals who can be highly transient). Their most successful strategy was to use monthly feasts as a way of gathering the community for sharing information and soliciting feedback. Informants were mindful that a balance was required between active outreach, extensive public relations campaigns, and delivering services to clients who find themselves in a constant state of crisis—when priorities have to be set, client needs came first. Still, BAN did manage to engage in outreach with neighbouring communities, including Pinehouse and Sandy Bay in Saskatchewan and Pukatawagan in Manitoba.

The team believed the program has been accountable to the community through its information management strategies, strategic planning at the board level, and meeting of AHF reporting requirements. Although they believe some improvements could be made, none were offered. There was also no indication that community meetings occurred or whether board meetings were open to the public.
5.5 Addressing the Need

All felt the program addressed the needs very or reasonably well, although some felt there was room for improvement. Remarkably, all who attended (and this included five to seven new people each week) have continued their attendance, even if only sporadically. In other words, no client was “lost”; informants believed their efforts to cultivate trust and offer client-centred support with counsellors sensitive to Legacy issues were the reasons for program popularity. The improvements suggested were related to the time and support required to move through the healing phases, most notably reclamation where the individual moves toward forgiveness and seeks to establish stability in his/her newly formed healthy pattern. One informant believed that restoration of an Aboriginal world view as a daily usable tool in all environments would be beneficial.

5.6 Best Practices

The team believed strongly in Medicine Wheel-based counselling, asserting that it “fits everything and works very well.” The Medicine Wheel encourages self-directed learning and growth and is all the more important if this cultural framework was removed or devalued by residential schools. Role-modelling was also cited as a best practice: “practitioners (professionals) delivering direct services should practice traditional healing ceremonies and practices as part of their lives in order to have the credibility that residential school survivor look for.” In fact, there was a general consensus about “walking the talk.” In other words, all those in the helping professions, whether they were part of BAN’s team or a referral agent, recognized that you had to live the life you were trying to help create for your client.

Being a client advocate, first and foremost, without feeling the obligation to adhere to governmental agency-based policy was also a highly regarded philosophical foundation. An Aboriginal team, some of whom speak an Aboriginal language, also contributed to desired outcomes. Aboriginal control of Aboriginal programming in an urban area where few other similar services exist was also cited as a best practice.

BAN attempted to offer clarity in the therapeutic process by helping individuals identify their strengths and weaknesses. This was done by blending Western tools (i.e., Myers-Briggs) within a culturally appropriate framework for analysis (i.e., the Medicine Wheel). This exercise was done solely for the expressed purpose of offering client insight, and this apparently worked very well to create self-awareness, establish trust, and integrate Western and traditional approaches.

5.7 Challenges

Many participants came from harsh circumstances, oftentimes experiencing several layers of difficulties. In addition, quarterly reports identified several barriers, generally falling within these three key areas: cultural insensitivity of mainstream agencies, simultaneous training and service delivery, and service demand.

During the first year, mainstream agencies kept referring Aboriginal clients to non-Aboriginal service providers who were, “not familiar with any traditional Aboriginal world view,” but some improvement was noted in the second year as referrals did increase. In one public presentation, tension was created when a Catholic high school principal asked, “Where is Jesus in the Medicine Wheel?” Other cultural tensions included the fact that mainstream agencies were mandate-centred while BAN was client-centred.
[O]ur first ethical consideration is ‘the good of the client’, and thereafter, professional currency and public safety receive consideration as ethical priorities. The opposite is true of persons under contract of the crown for whom the crown is their primary client and Aboriginal persons the ‘subjects’ on whom services are performed; public safety becomes the first priority, current practices, the second and the good for the individual person the lowest priority.\textsuperscript{50}

Merging with provincial agencies to provide seamless service was a challenge because of the lack of understanding about the Legacy, dis-empowering nature of mainstream services, and cultural dominance.

The Medicine Wheel allows Aboriginal persons to function as their own authority (priest or minister) whereas mainstream cultures usually place teaching and practicing authority in “special” hands; this posture dis-invites self-selected and self-directed learning and growth, which most of our clients need and appreciate.\textsuperscript{51}

[W]e are free to use the Medicine Wheel in everything we do and this is the most “threatening” feature of our operation to mainstream service providers; Aboriginal people feel at home in our shop and our programs and they do not have that same sense of belonging in other mainstream or government agencies.\textsuperscript{52}

Some external agencies were resistant to the restorative nature of BAN’s clinical and adjunctive programming, as well as unable or unwilling to recognize the impact of the Legacy on the individual: “Healing the abusive experiences of the past has to happen ‘in the background’ while dealing with the current issues of engagement with the Justice systems of Saskatchewan and Canada.”\textsuperscript{53}

There were unique challenges related to professional development: “we would move away from using training grants as job opportunities for untrained people in key jobs within our clinic (office manager, receptionist) and hire fully trained people.”\textsuperscript{54}

Service demand, burnout, over-scheduling, and double-duty (e.g., management and service delivery) also stressed the team. Managing caseloads became problematic as the client base grew and the amount of time involved in meeting requests for individual and couple counselling was overwhelming. Furthermore, community release plans increased pressure for more adjunctive activities (e.g., support related to housing, employment, life-skills development), and the team learned not to schedule the same team members for day and evening sessions in the same week. Team members faced challenges trying to meet the demands of their emotionally draining jobs that require them to be role models: “You have to be a strong person to work here. Know who you are, walk your talk. Home life has to be good or I’ll crash.” Not being familiar with the justice system posed a barrier earlier in the project’s mandate, and administrative costs (i.e., accountant and lawyer’s fees) became burdensome.

Programming issues listed as barriers include: transportation during daytime hours, “some clients cannot afford it [transportation] or daycare”; tuition fees for training provided by BAN; and the unique challenges that come with servicing a homeless population. Structured schedules clearly did not work; however, demand-driven service availability did engage even the “hard to reach” groups who fell through the service gaps.

Solvent abusers have no direction in life. I used to work at the front desk and would open at eight-thirty a.m. all the time. People would be standing outside, as smelly and reeking as they were, they’d want to pray with me. They had no belonging, their belonging was coming here. They’re harmless, have nothing, no place, no programs.
Informants reinforced the importance of having a devoted Aboriginal team motivated by their desire to inspire others toward healing, most particularly Elders, together with an immediate need for more Aboriginal people trained in both standard-recognized and traditional therapies. The project also struggled with evaluation skills and requirements, as the planned evaluation appeared to have been used only for the Circles of Voices theater production.

5.8 Lessons Learned

It became clear to team members of the extent to which Cree and Euro-Christian world views were fundamentally different. They gained clarity about their identity as well as the extent to which systemic racism and forced cultural assimilation affected not only their lives but the undercurrent of rage in their communities. Some had no idea of the extent of abuse, family breakdown, and level of hurt. Personnel came away with a greater sense of self-responsibility, understanding of the power of forgiveness in healing, knowledge of traditional values, as well as a dream about how Canada could be a place where Aboriginal people would be recognized, respected, and accepted.

For one team member, the learning was up close and personal. The context of BAN finally offered a social explanation for the impact of the Legacy that other individual and symptom-focused treatment programs had not.

I went to Residential School when I was quite young. Three years ago, I dissociated - had a breakdown at a Catholic conference. I saw them in their robes and just lost it. I don't remember anything for awhile but afterwards, I ended up with thirteen charges. I went into some sort of blackout ... I knew something was wrong, so went into a detoxification unit. Then I went on to a twenty-eight day treatment program. I also went to Alcoholics Anonymous. One day I stopped in here, at BAN and I've been coming in every week for close to two years. Everything began to make sense to me, my whole life.

When asked what improvements could be made to the project, some worried about the stability of funding. While they believed the therapeutic parts of the program were essentially working well, they felt there was insufficient attention to establish ongoing funding commitments. Others felt that the strength of partnerships needed to extend beyond financial support to include a service network. They believed that BAN and other programs were insufficiently integrated and that program- and jurisdiction-specific funding failed to recognize the need for community services to support one another: “There are kids out there, eleven year old drug addicts ... we need a shelter ... kids are homeless, have no food ... we need a network otherwise we too are a stand alone agency.”

One informant believed a more traditionally based and internally accountable form of Aboriginal government would help their efforts, while another recommended changes to promotional items and training outlines. Two respondents spoke more from a client-centred perspective, describing the underlying need for community development: “I see a lot of people, families who have lost their language, culture, basic things have been lost ... We need to create our own community.”

It was recommended that broader healing efforts focus upon resurrecting and strengthening traditional family values, gender relationships, as well as teaching the language. By itself, BAN did not have the resources to guard Aboriginal cultural integrity, but would be well-serviced by other institutional efforts
to do so. The experiences of this project also warned against simultaneous training and program delivery. Training cannot occur when you need a team that must deliver services immediately.

BAN repeatedly reported using several standardized tools that fit well with Aboriginal culture and the residential school experience. It was unfortunate that any analysis from these tools was not available. However, when Western techniques were blended with traditional healing, several widely recognized tools were cited (e.g., Myers-Briggs Personality Type Indicator, Conference Board of Canada Employability Skills Profile, Behavioural Assessment Scale for Children, Connor’s Scale). BAN also felt that the combination of having skilled traditional and clinical therapists working together meant prompt movement from assessment and planning to healing. Furthermore, important and practical instrument development was planned, but the extent of development and the detailed use was unclear.

6. Conclusions

Although young, BAN proved to be a resource for a significant number of Aboriginal people living in Saskatoon. Referrals and client numbers have increased steadily, and most return for ongoing counselling and support. The project was clearly able to create an environment where participants felt they belonged and were respected, which was an important factor since the project asserted that many of their clientele felt lost. Some team members also speak Cree; a welcomed skill.

Positive results were most often attributed to the culturally appropriate services offered. Cultural reinforcement offered participants a sense of belonging, self-awareness, and group identity that had been stifled by colonial institutions and society: “It’s the medicinal wheel concept, has a life of its own. You get your head wrapped around it then you realize who you are.”

When change was not immediately apparent, the team acknowledged that stresses of undergoing healing and training, while maintaining economic self-sufficiency, was a harsh reality and a struggle for some. Referral agents also acknowledged that the target group (especially incarcerated and homeless individuals) was a challenging group to maintain, although BAN appeared to have sufficiently established trust and comfort with them.

The project also created a better understanding of Aboriginal culture within mainstream service agencies. Offering cross-cultural sensitivity training and promoting the Medicine Wheel concept improved relationships with some external agencies so that mutual Aboriginal clients received proper support.

It can be stated that BAN was clearly filling a need by offering a continuum of services where gaps existed previously. Two clear examples stood out, one was the ongoing therapy available to status First Nations’ clients once their non-insured health benefits ran out and the other was the type of ongoing support required to keep clients who were dealing with addictions stay engaged with BAN services until openings became available at an addiction treatment centre. (Key informants have stated this could take up to six weeks.) Advocacy support at court hearings was another example of how BAN created a working relationship with the justice system, and as a result, the number of community release plans BAN manages has increased.
BAN did fill a service gap, as many who expended their use of counselling services were eligible for services with BAN (e.g., extended family members whose counselling allotment under the Non-Insured Health Benefits (NIHB) program were exhausted).

7. Recommendations

It is important to recognize that crisis intervention and drop-in services for street-involved, incarcerated, or addicted individuals means that long-term and comprehensive strategies are required (exactly what BAN offers). But, BAN is an undefined entity with varied activities and targets that may contribute to the dilemma of “overreach.” In other words, minimal impact is achieved when programs with fixed resources try to serve too many individuals. Achieving results depend on a reasonably restricted target group and adequate resources. When efforts are spread too widely they inhibit program ability to achieve desired outcomes. While some results were clear, many remain ambiguous and the client base was clearly large and ever-expanding. To that end, it was recommended that BAN focus its effort either by reducing the target or identifying more realistically attainable outcomes for such a broad-based beneficiary group.

In addition, greater investment in outlining and documenting how Western and traditional healing methods complement each other or blend together to better serve Aboriginal clients was also recommended. Following through with the plan to develop a Survivors’ assessment protocol adapted or blended from widely recognized tools and well-suited to the cultural context would be of great benefit to other agencies and, ultimately, clients.

We are designing a survivors’ assessment protocol to function as a standardized clinical technique for estimating the recovery risk condition that is culturally sensitive to Aboriginal values and preferences; this intake and treatment effectiveness instrument will reduce the intrusiveness of mainstream technologies by focussing on the key features of recovery as identified by survivors themselves.\textsuperscript{56}

Partnerships should continue to be pursued and nurtured with related service agencies, Aboriginal and non-Aboriginal, to provide the needed additional support for adjunctive services. They should be strategically selected so that efforts to raise awareness and train external agents to address the Legacy were sufficiently resourced with detailed curricula and time. Much confusion was generated when attempting to secure a complete view of program activity. To that end, it was recommended that program databases be merged to provide only one record.

There remains a need to document how individual needs were being met and how effective the project was at meeting those needs. Project files consistently stated that certain standardized techniques were being used or designed that would allow measurement of success; however, no such tools or analysis were provided. It was recommended that BAN revisit their evaluation plans to gauge the effectiveness of key program components by implementing the planned evaluation approach,\textsuperscript{57} which includes developing tools and collecting the following information:

- The measurable change in participant life satisfaction: assessment devices (list of questions, questionnaires, etc.) be developed using standard anecdotal and innovative techniques; and Aboriginal languages be incorporated into these assessment procedures.
- The measurable degree of satisfaction of participant family members: field assessments be undertaken (going out into the community of Saskatoon and the participants’ communities); assessments be
conducted in Aboriginal languages whenever possible; and assessment devices be designed specifically for this purpose.

- The **observable change in self-sufficiency**: this can be estimated from incoming, ongoing, and outgoing conditions that exist in participant lifestyles; and factors to consider might be whether or not the person lives independently or in a controlled environment (e.g., Salvation Army, etc.), whether or not they are employed and how stable their jobs are, do they have a bank account, a car, a phone, etc.

- The **effectiveness of project management**: estimated by the kinds and degrees to which the stated objectives have been attained and the sources of information that each will be asked to rate the different project objectives they are involved with; for example, the community agencies be asked to rate the quality of their interaction with BAN.

- The **degree to which the project builds longevity past AHF funding**: estimated by indicating the percentage of the overall project budget that comes from new and alternative funding sources.

**Notes**

1. Information from the Healing The Multi-Generational Effects of Residential School Treatment—Urban Access Program quarterly reports submitted to the AHF.
2. Key informant interview, internal questionnaire.
3. Traditional ceremonies, the sweat lodge, and teaching men to be doorkeepers and how to collect rocks or wood for the sacred fire and are jobs meant to be done by men. Clients, generally, tend to be men involved in court advocacy hearings or those needing psychological and emotional support as they go through residential school claims. The project has more male counsellors and men’s circles, all of which contribute to the higher number of male involvement. To some degree, homelessness and street involvement factor in as well, as more men may be coming from these life circumstances.
4. Information from the Healing The Multi-generational Effects of Residential School Treatment—Urban Access Program submitted to the AHF; initial application for project funding.
5. It should be noted that virtually all were dependent upon social assistance.
7. Information from the NPES.
8. Information from the NPES.
9. See note 4, second application for project funding, Part F.
10. Information from the NPES.
14. See note 4, second application for project funding, Part C.
23. Major assault is defined as assault causing bodily harm and generally more severe. Common assault is less intrusive and can include spitting, manhandling, or crimes that cause much less harm.
26 Canadian Centre for Justice Statistics (1999).
27 Canadian Centre for Justice Statistics (1999). Spouse is defined to include married or common-law as well as separated or divorced.
29 Statistics Canada (2002).
30 Statistics Canada (2002).
31 Statistics Canada (2002).
40 Interviews with key informants, March 2002.
41 Follow-up facsimile requesting figures, 4 July 2002.
42 Key informant interview, internal questionnaire.
43 The project described these presentations as a form of cross-cultural sensitivity training that promotes an Aboriginal case-management model (Medicine Wheel).
44 The Times Observer (2001:3). Building A Nation: Aboriginal community leader appeals to educators to build cultural bridges (September 2001).
46 This spoke to racial tensions/violence. BAN work was valued as alleviating that potential by working with Aboriginal clients to fit within mainstream society and by working with non-Aboriginal people to better understand Aboriginal issues.
47 First quarter report, section VII, General Comments.
48 First quarter report, section VII, General Comments.
49 Year one, second quarter report.
50 Year one, second quarter report.
51 Year two, First Quarter Report, p. 17.
52 Year two, First Quarter Report, p. 17.
53 Year two, First Quarter Report, p. 11.
54 Year two, First Quarter Report, p. 15.
55 Information from quarterly reports.
56 Second Application for Project Funding, Part D, General Information about the Project, Target Population, Question 3.
57 Initial application for project funding.
### Appendix 1) Project Activities and Participation Rates

<table>
<thead>
<tr>
<th>Yearly Activity</th>
<th>Participation by Quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>1. Healthier Lifestyles</td>
<td>none stated</td>
</tr>
<tr>
<td>1. Counselling</td>
<td>87/59</td>
</tr>
<tr>
<td>2. Reducing Dysfunctions: Training</td>
<td>none stated</td>
</tr>
<tr>
<td>2. Parenting Skills</td>
<td>none stated, training started</td>
</tr>
<tr>
<td>3. Program Assessment</td>
<td>none stated</td>
</tr>
<tr>
<td>3. Youth Support</td>
<td>18/15</td>
</tr>
<tr>
<td>4. Support Networks</td>
<td>none stated</td>
</tr>
<tr>
<td>4. Crisis Intervention (100 @ Cultural Camp)</td>
<td>50/50</td>
</tr>
<tr>
<td>5. Developing Community: Powwow</td>
<td>none stated</td>
</tr>
<tr>
<td>5. Financial/Program Accountability</td>
<td>none stated, dollar-based</td>
</tr>
<tr>
<td>6. Legal Rights of Clients</td>
<td>20/13</td>
</tr>
<tr>
<td>7. Relationship Skills</td>
<td>none stated</td>
</tr>
<tr>
<td>7. Special Needs: 390/270</td>
<td>none stated</td>
</tr>
<tr>
<td>8. Aboriginal Identities: (Rolled-up estimates from database. Powwow = 200)</td>
<td>none stated</td>
</tr>
<tr>
<td>9. N/A</td>
<td>none stated</td>
</tr>
</tbody>
</table>

N.B. Shaded area applies to year one.

* There is a figure stated here because the project visited several communities promoting AHF funding as a key source for their work. One project team member felt it necessary to present their work and agency in terms of accountability by promoting both their revenue source and the mandate of the AHF.

** Cultural enterprises were described in project quarterly reports as arts and crafts activities that were designed to possibly create personal income for clients.
### Appendix 2) Training Provided to Project Employees

<table>
<thead>
<tr>
<th>Training Activity</th>
<th>Basic</th>
<th>Advanced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis intervention</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Trauma awareness</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Counselling skills</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Aboriginal language/culture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer/Internet training</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Learning about the history and impact of residential schools</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Learning about the application of the Charter of Rights and Freedoms in the project</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dealing with family violence</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Professional development training</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Programs related to family functioning (e.g., child development/parenting skills)</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Appendix 3) BAN Internal Questionnaire

Building A Nation Project: Interview Questions — Project Team
[Introduce myself and case study purpose, offer tobacco or sweet grass.]

1. To start, I would like you to now think about the project participants. Have you noted changes in any of the following?

<table>
<thead>
<tr>
<th>Changes</th>
<th>Dramatic Increase (&gt;80%)</th>
<th>Moderate Increase (40–80%)</th>
<th>Slight Increase (1–40%)</th>
<th>No change</th>
<th>Don’t Know</th>
<th>Slight Decrease (1–40%)</th>
<th>Moderate Decrease (40–80%)</th>
<th>Dramatic Decrease (&gt;80%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) knowledge of crisis intervention skills</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>b) ability to intervene in a crisis</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>c) ability to resolve conflict</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>d) coping ability</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>e) self sufficiency</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>i) interpersonal communication skills</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>j) understanding of traditional healing</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>k) use of traditional healing</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>l) # of families involved in healing</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>m) # of individuals involved in healing</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>g) existence of support network</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>h) use of support network</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>f) community spirit</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

2. Why do you think things turned out the way they did? In other words, if there was no change or things got worse, how would you explain why this has happened? OR - If there was change? Why did things change? What do you believe caused things to change/remain the same/ or get worse?

3. What have you learned from your involvement with this project so far?

4. Is there anything you could suggest that might improve this project?

5. Does a formal referral system exist with any local agencies or institutions (e.g., schools, correctional facilities, governmental departments)?
   Yes  No  Don’t know

6. If yes, please provide any further insight in the effectiveness and extent of partnerships and linkages?

7. Now, thinking specifically about Young Offenders, can you tell me what you know or have observed about them in the past two years?

8. Why do you feel this project has been successful or not successful in this area?

9. For families who have been involved in the project, can you tell me what you know or have observed in the past two years?

10. Why do you feel this project has been successful or not successful in this area?

11. Do you have any final comments to share?
MANDATORY QUESTIONS:

12. How well is the project addressing the legacy of physical and sexual abuse in Residential Schools, including inter-generational impacts? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:

13. What are the previously identified needs that the project is intended to address?

14. How would you rate the project’s ability to address or meet those needs?

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:

15. How well has the project been accountable (i.e., engaged in clear and realistic communication with the community, as well as allow community input) to the community? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:

16. How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:

17. Will the project be able to operate when funding from the Foundation ends?

18. How well is the project able to monitor and evaluate its activity? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:
Appendix 4) Interview Questions — External Agencies

Building A Nation Project

Interview Questions — External Agencies

1. Are you aware of the Building a Nation Project?
   Yes No A little Not sure

2. If yes, can you tell me what you feel is the central service they are trying to deliver?

3. Do you believe that your office has benefitted by the work done by Building a Nation?
   Yes No A little Not sure
   Please explain why you feel this way?

4. What, if anything, do you feel will change in how you do your work, as a result of the BAN project activities?
   Please explain why you feel this way?

5. In the last 24 months, have you noted any changes in the mutual clients your office and BAN shares?
   Yes No A little Not sure
   Please provide, in a general way, what types of changes you are seeing?

6. Would you have any final comments to share? Something you would like to add that I may not have asked about?
Appendix 5) Application for Project Funding

Multi-generational Effects of Residential School Healing Program

Application for Project Funding

<table>
<thead>
<tr>
<th></th>
<th>H.1.1 Measurable Change</th>
<th>H.1.2 Family Effects</th>
<th>H.1.3 Self-sufficient</th>
<th>H.1.4 Effective Management</th>
<th>H.1.5 ...etc. Project Longevity</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.2.1.1 Youth Participation Subgroup 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.2.1.2 Women Participation Subgroup 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.2.2.1 FSIN Community Agency 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.2.2.2 D.S.S. Community Agency 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H.2.3.1 Circle of Voices Linkage Agency 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linkage Agency 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAN Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BAN Board</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Each cell of the grid will have specific data-gathering instruments created for the purpose of assessing that particular aspect of the project.
Big Cove First Nation

Project Number: RB-175-NB

Case Study Report

Big Cove Youth Intervention Project (Youth Initiative)

Written by:
Kevin Barlow

Under the direction from:
Linda Archibald and Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2001
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Acknowledgements

I would like to offer my appreciation to the people of Big Cove and, especially, staff of the Youth Initiative, members of the Wellness Committee, and others in the community who opened their doors and hearts to me to tell their stories and experiences, without which this study would not be possible.

Welalin, Thank you
1. Introduction

Thirteen case studies were conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case study process included data collection on selected social indicators that were to be used to measure the impact of projects over time. In particular, data was collected for the year prior to AHF-funded activity and once again in the year 2003, an approach known in the evaluation field as a within-groups repeated measures design. The case studies are intended to provide a detailed, holistic view of the projects and their outcomes. All data collection, analysis, and synthesis was done by community support coordinators under the facilitative guidance of Kishk Anaquot Health Research.

The project that forms this case study is entitled, “Our Youth, the Voice of the Future” (AHF-funded project # RB-175-NB). It is described in the application as “An integrated prevention, early intervention, and aftercare initiative which focuses on the youth at risk of Big Cove.” This report provides a holistic overview of the Big Cove Youth Intervention Project (referred to by the community as the “Youth Initiative”), including a description of important community characteristics and conditions that may influence the project.

Sources of information used in this case study include project files (funding proposal and quarterly reports); the project’s response to the AHF National Process Evaluation Survey (NPES) sent to all funded projects in February 2001; key informant interviews with the project team and selected community service providers; and documents and data collected by the community support coordinator as part of the case study process.

2. Project Overview (Thinking Holistically)

The Youth Initiative project was funded in a pilot year from 3 January 2000 to 31 December 2000 with a contribution in the amount of $189,300. Bridge funding was advanced, taking the project to 31 March 2001; a second phase was funded until the end of 31 December 2001. This study focuses on the period ending 31 December 2000. The funding application highlighted the rash of suicides that occurred in the community during the 1990s and cited the purpose of the project as follows:

[The purpose of this project is] to provide youth at risk with opportunities for self-development in the areas of self-esteem, responsibility, respect and empowerment. These skills will allow them to grow strong and proud of their self-identity and to initiate and become self-directed. In essence, it will provide youth continued support and opportunity to develop personal, social, mental and physical well being that is so needed to combat the devastating and destructive effects of unresolved trauma originating primarily from the legacy of residential schools.

The contribution agreement states that the expected results of this project are “To empower, develop diverse ongoing activities and introduce an outreach and aftercare program with and for Youth at Risk.” It also specifies the following objectives:

- organize and implement a youth council and youth advisory board;
- develop and implement ongoing activities for youth (with youth input in the planning), including personal development presentations, cultural activities, babysitting classes, a youth summer program, and Girls in the 90s program;
- organize a youth support group night;
develop a youth alcohol and drug awareness program;
- establish substance abuse workshops;
- provide youth outreach and a rehabilitative program for alcohol and drug abusers by conducting cultural and spiritual events, providing alternative activities, teaching traditional values, and making referrals; and,
- provide aftercare and follow-up for alcohol and drug abusers.

A second AHF-funded project exists in the community: the “Outreach Program for the Suicidal at Risk Clients of Big Cove.” A key aspect of this second project is a program known as “Personally Empowered People,” which deals with life skills. The community also has projects called “Nurturing our Youth” and “Restorative Justice Initiative” implemented early in 2000. These last two initiatives are not funded by AHF but have related or similar goals and have liaised with the project that is the focus of this study. Visually, the relationship between these four projects would look something like this:

![Figure 1) Relationship of Projects in the Community](image)

2.1 Participant Characteristics

The Youth Initiative is a project that targets Big Cove youth between the ages of 10 and 29. Children under the age of 10 need parental accompaniment when activities are being delivered, which allows their appropriate participation. Over half (57.4%) of Big Cove’s population is under the age of 30, and more than one (27%) fall into the category of 15 to 29 years as of 31 March 2000, according to a community demographic study. This equals roughly 642 youth. Since the project does serve as young as 10 years old, it is estimated to be serving approximately 900 youth. Moreover, most project staff are themselves youth within this age range, so it is fair to include them as part of the target audience and also in terms of benefits or impacts the project is having on youth in general.

Participant recruitment is an open-door policy (with the exception being under age 10). Events are promoted through local radio, cable TV station, a newsletter, and word-of-mouth. While the program has an open recruitment policy, priorities have been identified as youth aged 12 to 18 years, most needy, and first-come, first-served.
Participation rates based on gender were about even for most activities, with the exception of sports-oriented activities that tend to attract more males than females. As well, some activities were targeted to one gender (e.g., the Girls in the 90s Program). Others, such as the Santa Claus Parade, sought community-wide participation.

Based on the AHF national survey completed by the project and confirmed by telephone, the project held both healing and training activities that reached approximately 150 people, 69 of which were youth. However, reports for the final quarter of year 2000 estimate that the project was reaching approximately 150 youth and children on a weekly basis, while one-time events such as conferences or gatherings held in the community were attended by up to 300 people. It is unclear whether these are directly organized by the project or if they cooperate and support such events. In addition, the national survey stated 60 people participated in training activities with 38 being youth. Ten people did not complete the training and 35 did not complete the healing program.

Table 1 shows participation rates in project activities by gender and Table 2 reports the same information by age group. Data for the tables were extracted from quarterly reports submitted for the year 2000. It is likely that individuals participated in more than one activity; therefore, it is not possible to determine from these charts the total number of young people participating in the Youth Initiative. On the other hand, it is clear that a large number of various activities are being provided.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Females</th>
<th>Males</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open gym night</td>
<td>Monday evenings</td>
<td>18–25</td>
<td>46–52</td>
</tr>
<tr>
<td>Jingle dance lessons</td>
<td>Tuesday evenings</td>
<td>34</td>
<td>n/a</td>
</tr>
<tr>
<td>Jingle dance ceremony</td>
<td>once</td>
<td>48</td>
<td>28</td>
</tr>
<tr>
<td>Traditional ceremonies and spiritual support group</td>
<td>Tuesday evenings</td>
<td>26–36</td>
<td>24–31</td>
</tr>
<tr>
<td>Arts and crafts development</td>
<td>1 evening per week</td>
<td>12–31</td>
<td>13–38</td>
</tr>
<tr>
<td>Karate</td>
<td>Weds. night/Sat. morning</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Babysitting course (held January 2001)</td>
<td>9-week course/two sessions</td>
<td>14</td>
<td>6</td>
</tr>
<tr>
<td>Youth sweats</td>
<td>1 per month</td>
<td>38</td>
<td>27</td>
</tr>
<tr>
<td>Girls in the 90s</td>
<td>Thursday afternoon</td>
<td>9</td>
<td>n/a</td>
</tr>
<tr>
<td>Voices/choices (mothers/daughters)</td>
<td>1 full day</td>
<td>6–7 sets</td>
<td>n/a</td>
</tr>
<tr>
<td>Newsletter production</td>
<td>monthly</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Fundraising</td>
<td>ongoing</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Open basketball/volleyball</td>
<td>Thursday evenings</td>
<td>5–10</td>
<td>25–32</td>
</tr>
<tr>
<td>Bowling</td>
<td>Saturday morning</td>
<td>7–8</td>
<td>9–12</td>
</tr>
<tr>
<td>Movie night</td>
<td>every 2nd Friday evening</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Teen dances</td>
<td>every other 2nd Friday evening</td>
<td>19–22</td>
<td>27–32</td>
</tr>
<tr>
<td>Activity</td>
<td>Duration</td>
<td>Females</td>
<td>Males</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>---------</td>
<td>-------</td>
</tr>
<tr>
<td>a) Summer program</td>
<td>day trips, etc.</td>
<td>a) 106</td>
<td>a) 93</td>
</tr>
<tr>
<td>b) March break program: n/a</td>
<td>(March break fell in 1st quarter)</td>
<td>b) n/a</td>
<td>b) n/a</td>
</tr>
<tr>
<td>Volunteer recruitment, development and recognition</td>
<td>once</td>
<td>83</td>
<td>93</td>
</tr>
<tr>
<td>Liaise with Alternative Justice Initiative</td>
<td>as needed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth rally, youth council and youth board plus a youth centre (council or centre has not been realized)</td>
<td>13 people from agencies plus 6 Youth staff sit on the Youth Board and meet monthly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and drug awareness, outreach, rehabilitation, aftercare</td>
<td>high school presentation once per month + Alateen program</td>
<td>70</td>
<td>55</td>
</tr>
<tr>
<td>Drop-in service</td>
<td>after a completed suicide: 24/7, 1 week</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Santa Claus parade</td>
<td>once</td>
<td>530</td>
<td>530</td>
</tr>
</tbody>
</table>

**Table 2: Participants in Project Activities by Age**

<table>
<thead>
<tr>
<th>Activity</th>
<th>0–14</th>
<th>15–25</th>
<th>26–49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Open gym night</td>
<td>65–75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jingle dance lessons</td>
<td>33</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jingle dance ceremony</td>
<td>29</td>
<td>13</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>Traditional ceremonies and spiritual youth support group</td>
<td>21–32</td>
<td>8–25</td>
<td>3–17</td>
<td>2–4</td>
</tr>
<tr>
<td>Arts and crafts development</td>
<td>24–34</td>
<td>3–31</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Karate</td>
<td></td>
<td></td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Babysitting course</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth sweats</td>
<td>30</td>
<td>29</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Girls in the 90s</td>
<td></td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voices/choices (mother/daughters)</td>
<td>6–7</td>
<td></td>
<td>6–7</td>
<td></td>
</tr>
<tr>
<td>Newsletter production</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fund-raising</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open basketball/volleyball</td>
<td>21</td>
<td>16–33</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bowling</td>
<td>14–18</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Movie night</td>
<td>5</td>
<td>19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teen dances</td>
<td>8–9</td>
<td>38–43</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a) Summer program</td>
<td>a) 97</td>
<td>a) 102</td>
<td>a)</td>
<td>a)</td>
</tr>
<tr>
<td>b) March break program: n/a</td>
<td>b) n/a</td>
<td>b) n/a</td>
<td>b) n/a</td>
<td>b) n/a</td>
</tr>
<tr>
<td>Volunteer recruitment, development, recognition</td>
<td>68</td>
<td>51</td>
<td>57</td>
<td></td>
</tr>
</tbody>
</table>
### Activity Table

<table>
<thead>
<tr>
<th>Activity</th>
<th>0–14</th>
<th>15–25</th>
<th>26–49</th>
<th>50+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liaise with Alternative Justice Initiative</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth rally, youth council and youth board plus a youth centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(youth council or centre has not been realized)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and drug awareness, outreach, rehabilitation, aftercare. (High school)</td>
<td>125</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop-in service</td>
<td>400</td>
<td>200</td>
<td>400</td>
<td>60</td>
</tr>
<tr>
<td>Santa claus parade</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The project reported several severe participant challenges in the NPES: lack of parenting skills, poverty, lack of literacy skills, and lack of Survivor involvement in the project. A severe challenge was defined as one affecting 80 per cent or more of participants. Moderate challenges (impacting 40%–80% of participants) include denial, fear, and grief; history of suicide attempt; history of abuse, adoption, and foster care; family alcohol or drug addiction; and lack of communication skills. Overall, these suggest that the Youth Initiative is addressing a very high-needs group. The discussion of the project team that follows includes information on team members who participated in the training to help prepare them for this work.

### 2.2 The Project Team—Personnel, Training, and Volunteers

The project team includes the young people hired by the project as well as key individuals within select community agencies who make up the Working Group. The Working Group is a sub-committee of the Big Cove First Nation Wellness Committee, which serves as a coordinating and development mechanism for community wellness services and programs. When combined with the project staff they become known as the Youth Advisory Board. Representatives in the Working Group are the following:

- director of Health Services
- director of Lone Eagle Treatment Centre
- director of Child & Family Services
- director of Alcohol & Drug Prevention
- coordinator of Psychological and Community Development

Four of the above members are from Big Cove and fluent in their language. Some have been directors within their program for over a decade. Combined, they offer decades of experience and are a wonderful resource for the youth project staff.

The coordinator of Psychological and Community Development is also the project coordinator. He oversees all project activities, develops proposal(s), ensures short- and long-term planning, coordinates staff recruitment, meets all quarterly and financial reporting requirements, and deals with other aspects of the psychological and community development services.

There are six full-time staff members on the Youth Initiative that include one youth development worker, three youth workers, and two field workers. The youth development worker’s job description consists of “developing, planning, and implementing specific programs that are meant to enhance the quality of life of the people of Big Cove.” The position requires some knowledge and experience with community
development as well as effective communication skills, group facilitation, visioning, and short- and long-term planning, implementation, and evaluation abilities. The youth development worker oversees other positions with this project, is fluent in Mi’kmaq and holds a two-year Youth Development Certificate. She brings four years of relevant experience to the position, is slightly over the age that defines a youth, and is a member of Big Cove First Nation.

Three youth worker positions were established to build and provide community support for Big Cove youth and provide them with opportunities to acquire the skills necessary to develop self-esteem, responsibility, respect, and empowerment. Their duties include offering cultural awareness, organizing events, initiating counselling, and facilitating appropriate referrals. Volunteer recruiting and scheduling is also part of their duties. These individuals also hold between two and three years of relevant experience. Two of the individuals speak Mi’kmaq fluently and all three have completed Grade 12.

Two field workers assist in the development of prevention, follow-up, and aftercare planning for ages 13 to 20. They also offer assistance to youth undertaking treatment and conduct public education and awareness sessions at schools. In addition to this, these positions require a minimum of two years free from alcohol and/or mind- or mood-altering substances as well as a certificate or other proof of having completed a treatment program. These two people have also finished Grade 12. They have between one and two years of relevant experience, and one speaks Mi’kmaq.

All staff are female. Those initially recruited into these positions still held them at the end of the first fiscal year, with the exception of one who pursued another opportunity within the community and was replaced shortly afterwards. The project’s NPES response indicates that five of the six positions are filled by individuals of First Nations origin. The survey also reports six part-time staff members (security, arts and crafts facilitator, youth spiritual circles facilitator, jingle dance instructor, and two fundraising assistants). All are First Nations, two are both elders and Survivors, and the related experience of the group ranges from five to 25 years. The project coordinator is a registered psychologist with extensive experience and has worked in the community of Big Cove since the early 1990s.

During the period this case study focuses on, project staff were given certain types of training and professional development. These courses, as reported in quarterly reports submitted to the AHEF, are outlined below:

First quarter:
- 5-day orientation
- 5-day Suicide Intervention
- first aid

Second quarter:
- 4-day Leadership Training Workshop (Ottawa, ON)
- 3-day Work Plan Development Workshop (Fredericton, NB)
- 1-day Suicide Prevention Workshop (Saint John, NB)
- 5-day Restorative Justice Workshop (Big Cove, NB)
- 5-day Suicide Intervention Workshop (Big Cove, NB)
- 3-day Personal Empowerment Workshop (Big Cove, NB)

Third quarter:
- Restorative Justice Panel Training (one staff, Big Cove, NB)
Case Study Report: Big Cove Youth Intervention Project (Youth Initiative)

- Youth Action Network (one staff, Toronto, ON)
- Environmental Network (two staff, Truro, NS)
- Medicine Wheel Teachings (three staff, Big Cove, NB)

Fourth quarter:
- 1-day stress management workshop (all staff)
- 1-day first aid/CPR (two staff)
- 1-day suicide Intervention Workshop (three staff)
- 1-day “Stop Bullying” Workshop (three staff)

The project’s final report estimates approximately 30 hours per month of volunteer service toward project activities. Volunteers donated their time and efforts as follows: food preparation, fundraising, healing circles, transportation, and traditional activities. Table 3 shows estimates of the value of donated goods and services as reported in the community’s response to the NPES.

Table 3) Estimated Value of Donated Goods and Services

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>$5,000</td>
</tr>
<tr>
<td>Food</td>
<td>$1,000</td>
</tr>
<tr>
<td>Labour (including volunteers)</td>
<td>$10,000</td>
</tr>
<tr>
<td>Space for project</td>
<td>$12,000</td>
</tr>
<tr>
<td>Project management</td>
<td>$25,000</td>
</tr>
<tr>
<td>Human resources, capacity building</td>
<td>$40,000</td>
</tr>
</tbody>
</table>

The three most generous donors of goods and services were the community’s health services, the school, and social services. The high value of donations suggests that the project is not working in isolation of other community services. In fact, it is important to view any project in the context of the community in which it operates. The following is a description of Big Cove First Nation and the issues and events that have both shaped and influenced this particular project at this point in time.

2.3 Community Profile

Big Cove is the largest First Nation in New Brunswick. This Mi’kmaq community is located near the town of Richibucto and the Village of Rexton and is approximately 11 kilometres from the latter. The largest and nearest city is Moncton, approximately 83 kilometres south. Big Cove’s population, as stated by Indian and Northern Affairs Canada (INAC) in April 2001 was 2,458. According to a community study, the population at 31 March 2000 was 2,379, and it was listed at 2,302 in 1998. Previously, it was 2,236 in 1997, according to INAC, which suggests a growth rate averaging between 3.1 per cent (2000–2001) and 3.5 per cent (1997–1998).

Big Cove First Nation has experienced extensive media attention on several issues, including the number of suicides between 1992 and present, its housing situation, and, of late, the band’s financial situation. Furthermore, changes in political leadership occurred after the retirement of a long-serving chief (1967–1993) who was often re-elected by acclamation. In subsequent years, political leaders changed continually, which may have created some uncertainty for band staff and the community in general.
The band operates a wide range of programs and services with a budget in excess of $20 million.

- band membership
- capital/housing/infrastructure
- social assistance
- education (including their own school for Grades 1–8)
- community policing and restorative justice initiative
- alcohol and drug treatment centre (6-bed facility) and prevention services
- child and family services
- sports/recreation/culture and leisure centre
- mental health (including crisis centre/help-line)
- Youth Initiative–AHF-funded
- community service maintenance
- economic development/adult education and training
- fire/emergency/ambulance services
- health centre (one of the first in the region to undertake health transfer)
- healing lodge

In addition to this there is one other AHF-funded project in the community at present, which targets at-risk suicidal members of the community. There is also a “Nurturing Our Youth” project that shadows a group of youth and documents issues being faced by this target group for a five-year longitudinal study. The community is also seeking to undertake long-term community development and mental health plans. Also present in the community is a Roman Catholic Church, rectory, and convent as most Mi’kmaq communities are devoutly Catholic. Mi’kmaq were among one of the first to convert to Catholicism and are believed to be the only tribe to actually sign a treaty with the Vatican in 1610. In terms of privately run business, there are two medium-sized convenience stores and numerous home-based “canteen”-type operations. There are two take-out food operations and Micmac Industries, which includes a gas bar and an automotive repair shop.

The AHF national survey identified severe challenges facing the community, which included poor local economic conditions (including high unemployment and poor housing), substance abuse, suicide and suicide attempts, and fetal alcohol syndrome/fetal alcohol effects (FAS/FAE). The following is a review of four issues that have impacted the community over the period leading up to and during the course of the Youth Initiative project: suicide, the impetus for the project; housing and unemployment as factors, which may influence and possibly reduce the impact of the project; and band finances, a circumstance unique to this time and place and has repercussions in the community.

“Then there’s always the silent ones ... the ones who never say anything.” The issue of suicide in this community has created extensive media attention and an added burden on community service providers. This was especially true during 1992 that saw suicides peak in numbers. The project coordinator confirmed that during the period when the numbers peaked, all community service agencies were essentially doing crisis management. This resulted in burnout and an inability to effectively manage long-term treatment plans for many in need. Over time, with some additional resources and increased coordination within the community, they have been able to shift from crisis mode to a more proactive approach. Below reveals the pre-AHF funding situation:
It has been expressed on many occasions by the youth of Big Cove that they find themselves constantly struggling to survive, that they find little or no value and meaning in their daily lives, that they have little or no influence over decisions that affect them, that they stand alone with few people to accompany them in their journey to Wellness ... We have attempted time and time again to obtain funding for a youth initiative but we still have not been able to access any as yet.... The Big Cove Wellness Committee and the Big Cove First Nations want to go much further in youth program development and for this reason we see this project as a priority.  

Suicide is the key reason why this project was needed. As stated earlier, it is an integrated prevention, early intervention, and aftercare initiative that focuses on the youth of Big Cove who are at risk. Most of the informants, as well as a community survey conducted by this project, identified alcohol and drugs as a major problem facing youth. Informants later linked alcohol and drugs as having a major influence in the number of suicides.

A housing shortage has also brought media attention. Recently, INAC said it would stop reimbursing the community social development office for rent subsidies paid to off-reserve band members on social assistance. For the most part, these are individuals and families who had little or no choice but to reside elsewhere due to the lack of available housing on the reserve. Clearly, there are emotional and financial advantages for band members who can find residence in their own community. As most Aboriginal cultures (if not all) are family-based, this physical separation borne out of necessity not only deprives the individual of family support, but it also denies them services from their home community.

Coupled with the population growth, the need for housing continues to outstrip the ability to meet the basic human need and demand for proper shelter. A needs assessment conducted in the fall of 1997 cited 750 families in Big Cove with only 450 housing units available, plus 100 apartments and 10 mobile homes. This suggests a shortage of almost 200 units and the likelihood that many families are living in overcrowded conditions. More recent figures put the number of houses at 515.

Big Cove is located in Kent County, a part of the province with high unemployment rates that fluctuate with seasonal employment. The surrounding region is primarily French-speaking (70%), which further hinders the community of Big Cove that is largely Mi’kmaq-speaking with English as their second language. The needs assessment mentioned above cited an unemployment rate of 80 to 85 per cent. According to the 1996 Census, the unemployment rate in New Brunswick was 15.5 per cent, and in the community of Big Cove (Richibucto 15 Indian Reserve) the rate was three times greater at 46.2 per cent. It should be noted that the 1996 Census also showed Big Cove’s population at only 1,403 with a population growth at 9.4 per cent between 1991 and 1996. Statistics Canada and INAC use different methods to determine demographics. INAC maintains a registry, which influences the amount of funding a band is entitled to, and it may be fairer to say that the numbers maintained by INAC are more up-to-date because there is incentive for a band to maintain accurate data.

According to the needs assessment, unemployment rates dropped after a court ruling that allowed Native involvement in the forestry sector. The ruling was later reversed with subsequent tensions as First Nations people from this and other communities attempt to exercise what they feel are legitimate treaty and Aboriginal rights. The Aboriginal fishery has also been a more recent source of seasonal employment. Big Cove has 12 commercial fishing licenses shared by about 25 fishers.
The last key issue to make media attention was centred around the band's financial deficit, estimated to be in the millions. News reports claimed that band cheques, including social assistance, were being refused by local financial institutions and that even New Brunswick Power was threatening to shut off hydro to many residents whose power bills were in default. The current administration claims that it inherited the deficit from a previous one and feels it has been taking steps to gain control of the situation. This does not appear to have an impact on the Youth Initiative project, except perhaps in terms of fundraising for a youth centre. Some people may be reluctant to donate funds without confirmation that the situation is under control.

3. Using Common Sense: The Data Collection Process

All project files were thoroughly reviewed prior to conducting the interviews (funding application, quarterly and final reports, and the AHF national survey). Project files also contained a Youth Initiative community survey that was examined. A special education needs assessment was made available after the interview process. After the initial review of all documentation, a logic model and a performance map were designed to provide an overview of the project. Next steps included contacting the project coordinator to gain general information about the community and to negotiate a time to conduct interviews. These steps guided the design and finalization of the interview questions.

During the course of roughly one week, personal interviews were conducted with 14 people associated with the project or with community services. A shorter version of the questionnaire was delivered to staff at the Big Cove School and Big Cove Police who were not necessarily associated with the day-to-day activities of the project, while two key people associated with the project were asked additional questions (see Appendix 1). Interviews were done in private and ranged from 20 to 45 minutes in length. In all, the working group of the Big Cove Wellness Committee, all project staff, and some staff at the Big Cove School and police department were interviewed.

A presentation made by Sargeant Ross White of the Richibucto RCMP Detachment to Big Cove's Tripartite Mental Health Committee in early 2001 was also made available. This document provided statistics on assault, spousal assault, sexual assault, suicide, and property crimes. Two other organizations provided information: the Big Cove Child and Family Services provided rates of children in care and Lone Eagle Treatment Centre (based in the community) provided numbers on people seeking alcohol and drug treatment for the years between 1998 and 2001.

The following performance map (Figure 2) was used as a one-page reference guide to collecting information. It links the desired long-term outcome (youth having the support and opportunities they need to develop personal, social, mental, and physical well-being) with long-term indicators of change: reduced rates of attempted and completed suicides, alcohol and drug use, and youth crime and an increase in education and skill levels and overall community well-being (reduced rates of physical abuse, sexual abuse, incarceration, and children in care). Short-term outcomes and indicators are similarly mapped. In this way, the performance map identifies significant measures of change.
### MISSION:
To enable individuals, families, and the community to achieve optimal levels of mental, spiritual, physical and emotional wellness by supporting and guiding programs within the community of Big Cove.

<table>
<thead>
<tr>
<th>Resources</th>
<th>Who?</th>
<th>What do we want?</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>activities/outputs</td>
<td>Youth, project team, and community.</td>
<td>Increased skill levels, knowledge, self-esteem, health of youth, levels of leadership, peer support, healthy lifestyles, and communication with parents/community; build capacity and skills among youth and diversion from alcohol and drug use; reduced alcohol and drug use among youth; increased participation in alcohol and drug treatment; increased community and parental involvement in programs; youth council and youth advisory board; and progress towards establishing a youth centre.</td>
<td>Youth in the community have the support and opportunities they need to develop personal, social, mental, and physical well-being; healthy youth equals a healthy community.</td>
</tr>
</tbody>
</table>

### How will we know we made a difference? What changes will we see? How much change has occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$189,300</td>
<td># of youth participating in and impacted by programs.</td>
<td>Youth satisfaction with activities (participant feedback forms); # of youth participating in alcohol and drug services, including treatment and aftercare; level of participation in alcohol- and drug-free activities and events; rates of alcohol and drug use among youth; perceptions of key informants and self-reported changes in self-esteem, leadership skills, and attitudes of youth; evidence of peer support; steps taken towards establishing a youth centre ($ raised); family and community involvement with youth (# of volunteers and duration of service); active youth advisory board; participation rates and # of cultural and traditional activities and interactions between youth and Elders; and evidence of improved community spirit.</td>
<td>Increase in healthy youth as evidenced by reduced rates of attempted and completed suicides, alcohol and drug use, and youth crime and an increase in education and skill levels; increase in overall community well-being (reduced rates of physical abuse, sexual abuse, incarceration, and children in care); and healthier youth with a sense of belonging—evidence of changes in community's attitudes towards youth and in youth involvement in family and community affairs, cultural events, and traditional activities.</td>
</tr>
</tbody>
</table>
3.1 Thinking Logically: Activities and Outcomes

There is a logical link between the day-to-day activities a project undertakes, what they hope to achieve in the short term, and the desired long-term outcome. In this case, the community wanted to do something about the high rate of suicide among youth by providing activities that increased their skills, self-esteem, and mental, physical, spiritual, and emotional well-being and by addressing the problem of alcohol and drugs. The community survey conducted by the project in the summer of 2000 served as both a needs assessment and an evaluation tool. As outlined previously, a wide range of activities for and by youth were initiated, such as the creation of a youth advisory board and the increased capacity of the project team to carry out their jobs through participation in a variety of training initiatives. It was anticipated that project activities would lead to the following outcomes:

- increased numbers of young people with professional, personal, and leadership skills;
- empowerment and increased opportunities for youth to be involved in community planning and decision-making;
- increased personal, social, mental, and physical well-being among youth;
- improved relationships between youth, their families, and the community; and
- reduced rates of alcohol and drug use.

These would ultimately result in a healthy youth population and a healthy community. In the interviews, one person spoke about the difficulties facing this project in a changing world where Internet and the media are shaping the minds of youth: “work being done now won’t be realized until the next generation.” Similar comments were echoed by others on difficult issues like suicide, addictions, and family violence that will only be addressed through long-term prevention and intervention efforts. Some people spoke about the old ways and the need for the community to come together and share everything, good or bad.

On the day-to-day level, some of the project’s activities were ongoing, some were one-time events, and some were for specific durations. The sheer number of youth in this community requires a significant amount and variety of activities. One person noted that increased awareness of the project and the issues it seeks to address led to an increased demand for services. Until volunteer recruitment is fully realized and parental involvement increases, the burden on project staff will remain extensive. Certain staff have children and rely heavily on their parents or grandparents to watch them so that they may devote the evening and weekend hours required for these positions.

Project activities were selected based on the work plan that was youth-driven. It appears the weakest areas have been volunteer recruitment, low levels of parental involvement, and efforts toward organizing the youth that included the realization of a youth centre. According to those interviewed, the first two areas seem to be due to low interest from potential volunteers or parents. Progress towards creating a youth centre is being realized, but the amount of time and effort required was underestimated. Building costs have been estimated at approximately $250,000. The project coordinator felt that this is now a longer term goal that requires guidance and nurturing from adults working and able to offer this kind of development and support. This objective actually grew out of planning activities related to creating a youth council (an objective that has not yet materialized) and was not included in the original proposal or contribution agreement. This is an example of how the project has already grown since its inception, and it is expected that the youth centre may take on added importance as the project continues to develop and mature.
There are two main buildings used to deliver project activities: the community school for Grades 1 to 8 and the healing lodge that is part of the community health centre. Project staff work out of one large room at the Psychology/Education building next to the school. The lack of a youth centre in some ways compromises the delivery of events, largely because the school has many restrictions on its usage. This is also true to some extent for the healing lodge.

Some of those interviewed raised the possibility of losing the use of the school if it continues to be damaged or not cleaned up properly after use. Although project staff felt they were properly supervising the building during use, apparently some damage did occur. The school has also been a constant source for vandalism. Access to other resources such as a bus to transport youth on day trips or other outings is also an issue, making for less spontaneity as it requires time to book a bus and driver. The need and goal of having a youth centre were almost unanimously identified by those interviewed. Some inferred that if a youth centre was designed by youth they might have more ownership and respect for it; they may not damage or vandalize it as with the school.

The relationship between project activities and both short- and long-term benefits is set out in the following logic model (Figure 3). This model does what the name implies: it logically describes the project activities, how they were delivered, and what the community wanted to achieve. It then goes on to identify how we will know things have changed in the short term, why this work is being done, and how we will know things have changed in the long term. In this way, an outside observer can use a logic model to see how activities are expected to lead to outcomes or results. There are four activity areas outlined in the logic model: the Youth Activity Program, training, youth organization, and alcohol and drug awareness and outreach. Objectives outlined in both the contribution agreement and quarterly reports fall generally into these four categories.
### Figure 3) Logic Model—Big Cove Youth Intervention Project

<table>
<thead>
<tr>
<th>Activity</th>
<th>Youth activity program</th>
<th>Training</th>
<th>Youth organization</th>
<th>Alcohol &amp; drug awareness and outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How we did it</strong></td>
<td>Weekly arts and crafts, sports, and cultural activities; babysitting and Girls in the 90s courses; workshop for mothers and daughters; special events; youth support group; and summer program organized with youth involvement.</td>
<td>Project team participates in orientation and training programs held within and outside of the community.</td>
<td>Plan, organize, and implement a youth council; create a youth advisory board; plan annual youth rally; and plan a youth centre.</td>
<td>Presentations to schools and develop alcohol and drug curriculum; newsletter; support group, alcohol- and drug-free activities, deliver substance abuse workshop, cultural/traditional activities, inter-agency networking, and access to rehabilitation and aftercare.</td>
</tr>
<tr>
<td><strong>What we did</strong></td>
<td># and variety of daily, weekly, and special activities; # of participants; and age and sex of participants.</td>
<td>#, type, and location of training programs; and # of workers participating.</td>
<td>Composition of youth advisory board; # of meetings (youth council did not materialize); types of decision making; and # of participants in rally.</td>
<td># of presentations to schools; curriculum developed; # and type of alcohol- and drug-free and traditional activities; # of participants in activities, workshop, support circle with Elders, and # of referrals; and composition and activities of inter-agency network.</td>
</tr>
<tr>
<td><strong>What we wanted</strong></td>
<td>Increased skills, knowledge, self-esteem, physical health, responsibility, and peer support; and improved relationships with families and communities.</td>
<td>Increased professional and personal skills, knowledge, and self-esteem.</td>
<td>Youth empowerment and increased leadership skills and roles for youth; and increased level of involvement in planning and decision making.</td>
<td>Reduced alcohol and drug use among youth.</td>
</tr>
<tr>
<td><strong>How we know things changed (short term)</strong></td>
<td>Level of participation in activities; level of youth satisfaction; and views of key informants regarding changes in youth.</td>
<td>Self and key informant reports of increased levels of knowledge, skills, and confidence.</td>
<td>Level and quality of participation; and progress towards establishing youth council, youth centre, and planning youth rally.</td>
<td>Level of participation in alcohol- and drug-free activities; increased # of referrals; reduced rates of alcohol and drug abuse; and key informant views.</td>
</tr>
<tr>
<td><strong>Why we are doing this</strong></td>
<td>Create opportunities and an environment for youth in the community to develop personal, social, mental, and physical well-being; healthy youth make a healthy community.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How we know things changed (long term)</strong></td>
<td>Increased proportion of youth involved in healthy lifestyles; active, empowered youth involved in leadership and community affairs; and overall community well-being (social indicator analysis of suicide, incarceration, physical and sexual abuse, and children in care).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. **Our Hopes for Change**

It is difficult to assess change so early in the life of this project as it is designed as “an integrated prevention, early intervention, and aftercare initiative;” however, it is reasonable to present and explain the data being used to gauge impact. The social indicator data presented provide a baseline from which to measure future progress and include the social indicators identified by the AHF Board (physical abuse, sexual abuse, incarceration, children in care, and suicide) as well as one indicator particular to this project—alcohol and drug abuse. Suicide is discussed first since the prevention of suicide is the primary purpose driving this project.

4.1 **Suicide**

Suicide is defined as “an injury deliberately inflicted on oneself with the intention of ending one’s life.”

Suicides represent only a small part of all suicide attempts; therefore, it is important to report information on attempted suicides as well. As stated, this community has experienced a significant amount of suicide committed by individuals within the 16 to 34 age range. A statistical table collected by the community detailing suicides between 1975 and 2000 reports an accumulated total of 34 deaths as a result of suicide. It cites the national annual suicide rate at 13/100,000. Based on figures for Big Cove for this same time period (26 years), the suicide rate is 71/100,000. For the last eight years since 1992, Big Cove’s annual suicide rate is 116/100,000; a total of 21 completed suicides.

Suicide, which peaked in 1992 with six deaths, has been a major and ongoing issue in the community. The following years saw suicides fall to three or less per year. The ages for completed suicides have varied, clustering in early or late twenties or early thirties with the age range between 16 and 34. This is confirmed by the Tripartite Mental Health statistics given by the Richibucto RCMP detachment, which documented two deaths each year for 1998, 1999, and the first quarter of 2000, and the first quarter of 2000. The Crisis Centre in Big Cove, which staffs help-line and outreach workers, documents an average of three to five attempts per week, and this suggests there may be 150 to 200 attempted suicides each year.

Clearly, the numbers are staggering. Interestingly, in the *Youth Initiative Survey*, less than one-quarter of respondents (23%) mentioned thoughts of suicide as the greatest problem facing youth today and not suicide itself. Also, only one interviewee mentioned suicide as the biggest obstacle or challenge the project is facing. Seven of 14 people felt that suicide in the last 12 months had decreased, three said rates had increased, and four said they had stayed the same. Comparing these perceptions to RCMP statistics, there were two reported suicides in 1998, two in 1999, and a further two in the first quarter of 2000. However, there was a dramatic increase in reports of attempted suicides between 1998 and 1999, from 54 to 98. Table 4 indicates the number of suicides and attempted suicides in Big Cove in the last year. As noted above, there are differences between rates reported by the RCMP and those reported by Big Cove Mental Health. While they may, in part, be due to differences in reporting periods, the huge variance in suicide attempts must have another explanation. It is well recognized that official records often under-report suicide because forensic, social, cultural, and religious factors can influence whether or not a death is classified as a suicide. Similar classification issues come into play when reporting suicide attempts.
Table 4) Completed and Attempted Suicides 1999–2000*

<table>
<thead>
<tr>
<th>Type</th>
<th>Number of Incidents</th>
<th>Information source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide</td>
<td>3</td>
<td>Big Cove Mental Health</td>
</tr>
<tr>
<td>Suicide</td>
<td>2</td>
<td>RCMP (1999)</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>150–200</td>
<td>Big Cove Mental Health</td>
</tr>
<tr>
<td>Attempted suicide</td>
<td>98</td>
<td>RCMP (1999)</td>
</tr>
</tbody>
</table>

* RCMP figures are reported numbers only and use a calendar year. The fiscal year is used by Big Cove Mental Health. Details on age, sex of victim, relationship to accused, etc. were not available.

The suicide literature reports distinct gender differences with respect to suicide and suicide attempts. In Canada as a whole, males are four times more likely than females to commit suicide. Attempted suicides, however, are more common among women. While the data presented here do not include a gender breakdown, it has been unofficially reported (but not confirmed) that all but one of the completed suicides in Big Cove involved males. Risk factors associated with suicide include a recent family or relationship breakup, facing criminal proceedings, previous attempted suicide, affective disorders, alcohol and drug dependency, and access to firearms. Studies show that gay men, lesbians, and people who have experienced child sexual abuse may be at higher risk of suicide.

When key informants were asked how well the project will affect the issue of suicide, most comments supported the notion that an impact is being or will be seen. Half of the interviewees thought there was now an increased awareness and a greater willingness to talk about suicide. Just over one-third (35.7%) said that the project creates self-esteem while another third referred to it as a positive influence. Others mentioned the ability of the project to respond immediately to a crisis and to provide ongoing support, prevention, and outreach—a proactive rather than reactive approach. This would include the multi-agency coordination taking place in the community and the shift away from crisis management. However, one person mentioned how people may have become immune to the rash of suicides, perhaps indicating hopelessness or frustration that comes with extensive and frequent loss. In addition to examining rates of suicide and attempted suicide in the follow-up study planned for 2003, it will be important to once again canvas the views of key informants on this issue.

4.2 Physical Abuse

Table 5 provides information on the number of assaults recorded by the RCMP in 1999. Data based on police reports are limited because they can be influenced by numerous outside factors, including police charging policies and recording practices (and changes in those policies and practices over time) as well as the willingness of victims to report to police. With respect to spousal violence, it is commonly noted that reported cases may represent as little as 10 per cent of actual cases. Similar claims have been made regarding child abuse; an estimated 90 per cent of cases may not be reported to child welfare agencies. Consequently, it is expected that the numbers reported below underestimate the real extent of the problem.
In reviewing the statistics from the Richibucto RCMP detachment, level one assaults have the highest incidence over the reporting period. In 1998 and 1999, there were 183 and 179 reports, respectively, with 30 reported in the first quarter of 2000. Level two assaults are summary convictions and range from spitting on someone to spousal assault. Level two assaults are indictable offences that usually causes physical harm. Spousal assaults are listed separately, although it was reported that officers do not always capture this additional information, so some of the reported cases under levels one and two may include spousal assault.

### Table 5) Assault Cases, 1998–1999

<table>
<thead>
<tr>
<th>Type of Assault</th>
<th>Number of Incidents*</th>
<th>Details (age, sex of victim, relationship to accused, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault level I</td>
<td>179 (1999) 183 (1998)</td>
<td>n/a</td>
</tr>
<tr>
<td>Assault level II</td>
<td>41 (1999) 54 (1998)</td>
<td>n/a</td>
</tr>
</tbody>
</table>

* Information source: RCMP investigative reports.
** RCMP apply the term spouse to both common law and married couples. It is unclear whether this extends to same-sex partners.

In the absence of data from other sources, such as victimization surveys and records from women’s shelters and social services, the numbers presented above are assumed to be an underestimation of the real problem of physical abuse. In such circumstances, the views of key informants offer potential insights that may be invisible in the official statistics.

When asked whether rates of physical abuse had changed over the past year, more than three-quarters (78.6%) of those interviewed were unsure or said they had stayed the same. However, the interviews also captured observations on the most common crimes—assault—being committed by youth in the last year (64.3%). On violent youth crimes, there was no consensus on whether rates had risen, decreased, or stayed the same. Follow-up interviews in 2003, along with RCMP data for that year, should help to clarify trends regarding rates of physical abuse in Big Cove. Interpretations will have to proceed with caution; however, an increase in reported rates of abuse may reflect an increased willingness on the part of victims to report or authorities to respond rather than an increase in the actual rate of physical abuse. It is understood that the objective of reducing levels of violence and abuse within the community speaks to real or actual rates and not simply a reduction in cases reported to authorities.
4.3 Sexual Abuse

Official data under-report the extent of sexual abuse. Victimization surveys indicate that up to 90 per cent of sexual assaults are not reported to police.\textsuperscript{15} In addition, prevalence of child sexual abuse is difficult to determine, as it is a hidden crime and many victims only report the abuse after they reach adulthood. Information on sexual assault in Table 6 is based on RCMP investigative reports while the child sexual abuse disclosures were provided by staff at Big Cove Child and Family Services. According to the RCMP, child sexual abuse would be included under the charge of sexual assault. Unfortunately, the police figures available do not provide a breakdown allowing for identification of how many were sexual assaults against a minor. Also, the number of child sexual abuse disclosures recorded does not represent total cases that made it to the court system, as some children were felt to be not psychologically ready for a court trial, or some made the initial disclosure but would not repeat the allegation during a later interview.

<table>
<thead>
<tr>
<th>Type of Abuse</th>
<th>Number</th>
<th>Information Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Sexual Abuse</td>
<td>6 disclosures</td>
<td>Big Cove Child and Family Services</td>
</tr>
<tr>
<td>Sexual Assault</td>
<td>14 reports</td>
<td>RCMP investigative reports (1999)</td>
</tr>
</tbody>
</table>

Key informants did not mention sexual abuse as one of the most common crimes or as one of the reasons children are being placed in care. However, responses to the \textit{Youth Initiative Survey} included family abuse (29\%) and “other” abuse (20\%) among the greatest problems facing youth. While the survey did not list sexual abuse as a possible category, it would be reasonable to assume it has been included in the “other” responses.

The Richibucto RCMP detachment reports that their investigative procedure regarding sexual assaults and sexual abuse includes informing Big Cove Social Services when an allegation has been made involving a minor, whether or not it turns out to be true. This, however, is not reciprocated; for instance, allegations made to social services are investigated, but there may not be sufficient evidence to involve the RCMP. Therefore, the RCMP may be underestimating the number of reports or be unaware of the number of alleged assaults. RCMP investigative reports show sexual assault cases for 1998 through to the first quarter of 2000 were 19 cases for 1998, 14 cases for 1999, and 4 cases for 2000.

In the case of Big Cove there are few indications of the actual rate of sexual abuse, and reported rates must be viewed with the same caution referred to in relation to physical abuse. Reductions in the actual rate of sexual abuse can be interpreted as an indicator of progress towards healing. However, elevated reporting of sexual abuse over the course of a healing project may turn out to be a positive indicator of healing. For example, increased rates of child sexual abuse may reflect an increased awareness as well as an increased willingness to report; a trend noted nationally and believed to be the result of a changing social climate about the acceptability of child sexual abuse. Key informant interviews conducted during the next phase of this case study will be an important factor in analyzing any changes that may occur in reported rates of sexual abuse.

Key informants described how “kids confide in them” and “are responding and growing.” Many felt more youth were indicating a need or willingness to seek alcohol and drug treatment, and there was more
opportunity for families and youth to discuss alcohol and drug issues. With increased opportunities and improved levels of support, it may be that over the course of the project some youth will feel safe enough to disclose sexual abuse. This, however, is purely conjecture as currently there is neither data on actual sexual abuse rates in the community nor any concrete indications of the extent of the problem.

4.4 Incarceration

No figures are available on incarceration rates for this community. Some inference can be made by the number of reports filed with the RCMP (i.e., assault and sexual assault), but again this does not provide the number of cases that make their way through the courts that result in incarceration. RCMP investigative reports show 117 investigations of damage to property in 1999; however, it is unlikely that many of these incidents led to offenders being incarcerated. A similar trend was observed in response to the interviews, where vandalism and break-and-enters were identified as the most common crimes committed by youth. An examination of changes in reported rates of damage to property over the course of the Youth Initiative and in key informant perceptions of youth crimes may provide an indication of the emotional state of the community’s youth.

In fact, the issue of property damage was raised on several occasions during the interviews, and it was pointed out that the school itself was a constant target for vandalism. During conversations outside the interviews, two community staff members suggested that perhaps the reason the school is being targeted is due to it being a “safe” environment or a symbol of where they can express anger, albeit in an inappropriate way. One said, “I’d rather see a door or window replaced or wash off graffiti rather than bury another child.” The school is also where most of the Youth Initiative activities are being held, which may make it a target for youth who do not participate. This was stated by one respondent who felt that the hard-to-reach kids were not having access to project activities. It is unclear whether this is because of their involvement with alcohol and drugs, which would deter their participation in alcohol- and drug-free events, or feelings of isolation based on their behaviour in general, or both.

Interview questions posed around the issue of incarceration received varying responses, yet the majority (57.8%) felt that incarceration rates had decreased. When asked what measures have been taken to address youth crime, a clear majority (71.4%) cited the community’s Restorative Justice Initiative. Other measures include the fact that police were more involved in youth activities and a variety of activities associated with the Youth Initiative (healing circles, alternative alcohol- and drug-free events, alcohol and drug education and awareness, youth centre efforts, and the preventative approach). All of these activities are actually included or referred to in the project’s work plan. Measures not directly associated with the Youth Initiative include installing curfews, making parents more responsible for their children’s actions, and the availability of more parenting courses.

4.5 Children in Care

Children in care is defined broadly to include all children placed in out-of-home care by child welfare agencies, whether voluntary, involuntary, temporary, emergency, long-term, or court-mandated and including all forms of placement (foster homes, group homes, institutions, and placement in the care of relatives). In general, a decrease in the number of children in out-of-home care can be positively correlated with an increase in healthy parenting. However, an increase in the number of children in care is not
necessarily indicative of a failure to improve the level of healthy parenting. For example, at the national level, more children are coming into the care of child welfare agencies, which has been attributed to heightened awareness of child abuse and neglect, stronger legislation, and worsening conditions among the poor. Therefore, increased rates of children in care must be interpreted very carefully because it can be a positive as well as a negative indicator of healing, depending on the context. Table 7 indicates the number of Big Cove’s children in care during the 1999–2000 fiscal year.

**Table 7) Children in Care, 1999–2000**

<table>
<thead>
<tr>
<th>Care designation</th>
<th>Number of children*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent Wards</td>
<td>19</td>
</tr>
<tr>
<td>Temporary Wards</td>
<td>8–23</td>
</tr>
</tbody>
</table>

* Information source: Big Cove Child and Family Services

It was reported that permanent wards tend to be older youth and under longer periods of care. Temporary wards are usually younger and involve shorter stays. In key informant interviews, this particular issue received quite varied responses, and there was no consensus on whether the number of children in care had decreased, increased, or remained the same over the past year. One person said numbers were up because of population growth, and two people said rates were up but with shorter stays because of the involvement of family members in temporary care. When asked about reasons for children being placed in care, a clear majority (78.5%) cited parental use of alcohol and drugs as the number one reason. Other reasons included lack of parenting skills, child safety or neglect, spousal assaults or fights, parental stress (including single parent issues), and grief and loss issues. Finally, issues of poverty and the inability to provide were referred to by two respondents.

### 4.6 Alcohol and Drug Use

According to the Youth Initiative Survey, 91 per cent of respondents felt that alcohol and drug use was the greatest problem facing youth today, followed by peer pressure (45%) and unwanted pregnancy (35%). When asked about the greatest needs of youth, the majority mentioned alcohol- and drug-free events (57%), fun and safe activities (54%), and recreation and sports (50%). All of the people interviewed claimed alcohol and drugs had a major role in the high number of suicides. Examples of responses included:

- “A huge role.”
- “One hundred per cent.”
- “Permanent solution to a temporary problem.”
- “Affects reason or ability to make good choices.”
- “It [alcohol] is a depressant.”

The Lone Eagle Treatment Centre is a six-bed facility with eight intakes per year. Admissions to the facility were reported as follow: 59 for 1998–1999, 56 for 1999–2000, and 51 for 2001. This does not imply that all those admitted to treatment at this facility were Big Cove band members, nor does it detail how many were youth.
While no specific data were made available on rates of alcohol and drug use, it is highlighted here as an indicator because of its relationship with other social indicators as well as its prevalence as an issue in the Youth Initiative. The performance map contained in Section 4 includes the following measures of short-term outcomes: the number of youth participating in alcohol and drug services, including treatment and aftercare; the level of youth participation in alcohol- and drug-free activities and events; and reduced rates of alcohol and drug use among youth. There is also a recognized relationship between alcohol abuse and some of the other indicators that form part of this study. Recent research points to the following trends:

- periodic heavy drinking (defined as five or more drinks on five or more occasions within a month) is associated with elevated rates of spousal violence;
- members of families in which one or both parents abuse substances are considered to be at high risk for physically abusing and, particularly, for neglecting their children;
- persons who have experienced family violence are at greater risk for alcohol and other drug problems than those who have not;
- parental child abuse was six times more frequent among men who often drank to excess;
- ten studies reporting chronic alcohol use, alcoholism, or alcohol abuse reported that between 24 per cent and 86 per cent of battering incidents involved alcohol abuse;
- alcohol abuse has been identified as a problem among 76 per cent of the Aboriginal inmates; and
- 55 per cent of all inmates (Aboriginal and non-Aboriginal) were under the influence of alcohol, drugs, or both on the day they committed the offence for which they are incarcerated.\(^6\)

The research is clear that the relationship between alcohol abuse and other social problems is complex, multi-dimensional and not necessarily causal. However, given such evidence of relationships, it is reasonable to assume that reductions in alcohol use and abuse among Big Cove youth may have impacts in other areas, including incarceration and crime rates, children in care, and physical and sexual abuse. Moreover, as alcohol is a recognized depressant, reduced alcohol use may have an impact on suicide rates.

Despite the need for more knowledge of actual rates of alcohol and drug use and abuse in the community, there is evidence that this is a significant issue to contend with. Figures cited in a study of special educational needs\(^7\) showed that of the 157 students at Big Cove School, one-fifth had been exposed and affected by alcohol and drugs prenatally. Both parents and teachers surveyed provided almost equal observations on the extent of alcohol and drug use and abuse. Parents estimated that 71 per cent of students have educational problems related to alcohol problems and an equal portion of those surveyed noted an increase in alcohol and drug use in the community in the last 25 years, especially during pregnancy.\(^8\) Teachers estimate that 72 per cent of students have educational problems related to alcohol abuse, and 45 per cent reported an increase in alcohol and drug use.\(^9\) The Big Cove Health Centre conducted a demographic study between 1994 and 1997. Over this four-year period, 16 per cent of the pregnant women who delivered babies disclosed alcohol intake during pregnancy.

5. Reporting Results

Big Cove faces many hardships and challenges. The population growth over the past decade translates into a growing need, especially since many new parents are themselves young and inexperienced, in terms of parenting, and are likely to be among the peer group of suicide victims of the past decade. Combine this with an environment that promises a housing shortage, the likelihood of unemployment, and the ever-present appeal for some to escape through alcohol and drugs you will end up with a hurting community.
Still, there is hope in this community and a spirit or drive to meet these forces. This is evident in how respondents described not only their knowledge of the issues being faced, but also what efforts are needed to counter the negative influences. Throughout the interviews, informants stated the benefit of having the Youth Initiative project. One person said, “agencies would be in dire straits if it weren’t for the youth project.” Comments such as this provide an indication of the project’s role in the community. As the research process unfolded, it became evident that this project and the people behind it had undertaken an ambitious endeavour.

It was the Youth Initiative team and community service providers who provided much of the information that forms the heart of this study, along with the AHF project files. Demographic data found in community studies allowed the opportunity to confirm the needs behind the project, while data provided by the RCMP provided insight into many of the issues the community is facing. The special education needs assessment done for the Big Cove School, figures from the Lone Eagle Treatment Centre, and the survey done through the project itself provided a deeper understanding of the influence of alcohol and drugs. As well, suicide statistics provided by Big Cove Mental Health signal just how many people do lose hope and seek the ultimate escape. Finally, data from Statistics Canada, Indian and Northern Affairs Canada, and Human Resource Development Canada detail employment challenges that compound all other factors facing this community.

There were limitations and gaps in the data secured, most of which have been stated throughout this study. There were no clear numbers regarding alcohol and drug use and incarceration rates, nor were youth-specific or gender data available in most of the five main indicator areas. However, the observations of key informants provided a good source for understanding the problems facing youth and possible changes in youth behaviour and the community since the commencement of the project.

The people selected for interviews represented a good cross-section of key agencies with a mandate to work in the areas being influenced by this project. These informed opinions, whether from day-to-day exposure with project participants or by virtue of their positions within the community, should suffice for our purpose of gathering observations and impressions from which we can draw fair conclusions.

Ideally, more time would have allowed for a larger number of people to be interviewed about the project and opportunity to extrapolate more quantitative data, especially youth-specific data. This does not seem like a major issue in terms of making generalizations and inferences on how social problems may be affecting the youth of this community. Aside from the suicide statistics, this study must rely on the informed opinions that became the key sources of information for this study.

All people contacted for interviews or for other data offered their unconditional cooperation, demonstrating a willingness to provide as accurate a picture as possible of the situation facing the youth of their community. In several instances, repeat calls were placed to confirm details, including one to the Richibucto Detachment of the RCMP. This indicates that perhaps the situation in Big Cove is serious enough to welcome evaluation efforts, which may assist in improving programs and services and, in turn, effectively meet the needs of those the project is intended to serve.

Without a doubt, one key observation focused on the benefit the Youth Initiative has had in terms of allowing other agencies to take a pause from the crisis situation that resulted from the rash of suicides in
the community. Social and economic issues facing this community are extensive. Whatever the true figure
for unemployment rates within Big Cove, be it the one stated by Statistics Canada or from the community
itself, it is clear that low income is a reality for too many people. The missing element of time to grieve
losses from suicide simply fosters a numbness and, for some, a desire to escape through whatever means.
In essence, a vicious cycle can occur, complicating efforts to intervene and prevent further loss.

In addition to suicide, the issue most often raised in the interviews and supported by the documents
reviewed is alcohol abuse and the attending high-level needs of children born with FAS/FAE. Data collected
on physical and sexual abuse suggest that these, too, are problems to be confronted and addressed. The
housing shortage, unemployment, and poverty become other obstacles that add to the load a person may
be carrying and, thus, affect whether or not that person finds the strength and resources to reach out in
healthier ways. When you introduce youth with lesser experience in dealing with life on life’s terms, this
equals the need for a project like the Youth Initiative.

The question is: How do you intervene to prevent an escalation in the social issues facing this community?
Or do you focus on treatment issues alone? The answers are not so easy to provide, yet it seems clear
from the interviews that without the Youth Initiative, community agencies would revert back to crisis
management alone, not allowing for any long-term community development or wellness planning for
those in need. In this regard, key informants describe a number of benefits of the project:

- it provides hope for the future;
- diverts youth from alcohol, drugs, and trouble;
- provides the community’s youth with support and something to do;
- directly involves youth;
- the project team works well as a “team”;
- facilitates cooperation among community service providers;
- develops self-esteem and new skills; and
- provides a safe place for kids.

5.1 Influencing Individuals and the Community

Project staff are for the most part youth, with the exception of one who is slightly older. The training
that project staff undertook included several types of suicide prevention and intervention training. One
informant with the project attested she had learned a lot in this area. Several other project informants spoke
of gaining a better understanding on the extent of the hard times being faced by youth today. Examples of
professional development include learning how to develop work plans, organize meetings, and communicate
with youth. This type of learning helps project staff perform their jobs more efficiently while also moving
forward efforts to establish a youth council and, ultimately, a youth centre. Some project staff also spoke
of learning from their involvement with community leaders, and one person mentioned pride. Overall, it
appears that the project is having distinct and varied positive influences on the staff.

Intermediate outcomes can be seen, at least in one clear example, in how project staff took the initiative
around the location of a wake in the latest suicide to hit the community. In Mi’kmaq communities, wakes
are almost always held in the homes of the family. However, the youth took steps to hold the wake at
the drop-in centre, which they helped to staff on a 24-hour basis for about one week. This was cited as
an example of how youth are showing leadership by being assertive enough to challenge traditions. This
behaviour indicates confidence and leadership as well as assertiveness. Others pointed out that youth are being both listened to and encouraged to do so more often.

While it is still fairly early in the life of the project to notice long-term changes, a number of observations can be made at this stage. Behavioural changes may be seen in the interview statement that the youth “don’t fight and throw things” as much as they did initially. One person mentioned how project staff seem to have greater control over the youth, even more so than the teachers. Personal conduct is changing. Another noted that youth show up on time when they have activities to go to, thereby demonstrating responsibility and suggesting that the activities are relevant and of interest to youth. Some staff spoke of youth confiding in them, bonding that is taking place, and the fact that children are stopping them in the streets to say hello. Since this is relatively new behaviour, they concluded that young people and children are coming out of their shells and beginning to talk more. One teacher noted how some youth are volunteering without pay, which she said is a big thing. Project staff also noted that older youth are now helping to watch the younger ones.

As some people noticed an increased willingness to seek alcohol and drug treatment, and the opportunities were better for families and youth to deal with these issues, it can be said that some youth may be engaging in improved behavioural changes such as seeking a lifestyle free of alcohol and drugs. The youth support group has shown steady and good attendance, which backs this observation; however, there are no available statistics to support a more definitive conclusion. Follow-up interviews may shed more light on this issue.

In the interviews, members of the project team were asked to list previously identified needs that the project intended to address. Responses referred to empowering youth, creating a positive self-identity, decreasing crime, providing a wide range of cultural, social, and recreational activities, addressing the suicide issue, and creating opportunities for youth to be involved in the community. Overall, these respondents felt that the project was performing reasonably well in meeting those needs. Interestingly, as the study author drove into the community one day to conduct interviews, a boy around age 11 was riding along on his scooter. An oncoming vehicle caused a slow down and the boy ended up cutting my vehicle off as he scooted from one side of the road to the other. My window was down and I heard the boy call out, “sorry sir, didn't mean to cut you off.” As the author is intimately familiar with this community, it can be said that this politeness has never been noticed before. In fact, it was not all that long ago that children would be seen playing in the streets seemingly unconcerned about vehicular traffic.

In the interviews, respondents were asked to rate on a scale of 1 to 5 (where 1 is low, 5 is high) significant changes they had noticed in the following areas: youth self-esteem; parental involvement, mother/daughter communications; family relations; youth leadership; peer support; cultural awareness; goal setting; and social skills. The average response is shown in Table 8.
Table 8) Observed Changes during the Previous 12 Months

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<thead>
<tr>
<th></th>
<th>1</th>
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<th>3</th>
<th>4</th>
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<th># of responses</th>
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<td></td>
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<td>Mother/daughter communications</td>
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<td>3.7</td>
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<tr>
<td>Family relations</td>
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<td>Youth leadership</td>
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<td></td>
<td>3.6</td>
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<tr>
<td>Peer support</td>
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<td>14</td>
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<tr>
<td>Cultural awareness</td>
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<tr>
<td>Goal setting</td>
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<td>3.4</td>
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<td>Social skills</td>
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<td>3.3</td>
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Overall, there is an indication that changes have taken place during the course of the project: changes in knowledge and skill levels (leadership, cultural awareness, goal setting, and social skills), attitudes (self-esteem), and behaviour (parental involvement, mother/daughter communication, family relations, and peer support). Each area, except for parental involvement, had an average score of at least 3. Responses to parental involvement covered a particularly wide gamut, with ratings ranging from 1 to 5. The highest rating was given by a member of the project team, while community agencies (including the local school and police) scored low in this area. Informants from the Wellness Committee Working Group were more in agreement, offering an average score of 3. The highest overall average was for cultural awareness. This is supported by project files that show youth sweats and other cultural activities are well-attended. In terms of the project impact on youth around alcohol and drug issues, almost two-third of interviewees (64.3%) said that there were better opportunities to deal with the issue now than in the past. However, just over one-third (35.7%) had observed a greater willingness for youth to seek treatment.

These assessments support the view that the project is having some impact in shaping the lives of youth. Understandably, the Wellness Committee Working Group, which oversees the project, has a good understanding of the project and provided higher scores than the community agencies. Youth leadership had an average score of 3.6, yet there was quite a disparity among community agencies, with individual scores ranging from 1 to 5. The highest scores came from Wellness Committee members who explicitly included project staff in their assessment. This suggests that the Committee is solidly behind the project and the young people working on it. The reason for the wide disparity in scoring from other agencies was not clear, although the school had been broken into the Friday prior to these interviews, and this may have influenced some respondents.

Questions were also asked about how the community deals with suicide and what special efforts were being directed toward youth around suicide. The Youth Initiative appears to be playing a major part in closing a service gap. One informant stated, “there had been no suicide training for youth before this project, it had all been given to adults and staff.” Another referred to the crisis management approach before the project.
Half of the responses spoke about a greater awareness of suicide, a new openness to talking about it, and the fact that there is now more support available, including the capability for immediate response in a crisis. There were direct references to the Youth Initiative as well as the fact that there was a more cooperative, proactive multi-agency approach in place. When probed about youth-specific efforts, project activities such as the newsletter, school presentations, and bringing in Elders and guest speakers were mentioned along with references to the other AHF-funded project and the drop-in centre.

It appears that the community is seeing some change taking place in youth behaviour, but the impact of the project on the community is less clear. For example, there is a discrepancy on the issue of volunteers and parental involvement. The AHF national survey completed by the project identified approximately 30 hours of volunteer service per month, with volunteer efforts including food preparation, fundraising, healing circles, transportation, and traditional activities. This appears to be a substantial contribution. On the other hand, the low number of volunteers and lack of parental involvement were identified as project challenges in the personal interviews. Project staff, in particular, suggested this area was low; however, others interviewed felt it was higher. Some activities required parental involvement, such as “Voices/Choices,” which was about improving mother/daughter communications. Perhaps part of the difference in views relates to looking at specific events rather than ongoing involvement. Although there may be a low number of volunteers, those involved could be putting in long hours.

5.2 Partnerships and Sustainability

As reported earlier, there are other projects in the community with similar goals and target populations. In the interviews, the Restorative Justice Initiative was mentioned by almost three-quarters (71.4%) of the respondents when they were asked about measures taken to address youth crime. The restorative justice approach provides an avenue, other than the courts alone, to identify and resolve inappropriate expressions of anger. The Youth Initiative is linked to these efforts as a member of the community’s Justice Panel.

Perceptions of the type of youth crime most commonly committed by youth (i.e., vandalism) match the high number of damage to property investigations reported by the RCMP. Project staff almost unanimously stated that vandalism, along with break and enters, were common youth crimes. In informal conversations, references to “acting out” were made along with an observation that some vandalism to the school occurs after an event at the school. Three people felt that there may be some relationship between the vandalism and what the school represents: it is a safe way of acting out or the school was a symbol of a safe place where feelings could be expressed, even if done in a negative way. As noted earlier, many of the project’s activities are delivered in the school. Alternatively, it may be a case of anger against the school. Over half (52%) of the respondents in the Youth Initiative Survey said that the school was not helping to address the needs of youth.

In many ways, the project has partnered with the schools (both on- and off-reserve) in terms of coordinating and delivering alcohol and drug awareness by utilizing the Big Cove School to deliver activities. However, the relationship with the Big Cove School may require further work. The interviews revealed that communication between the project and the school could be better. Despite school programs being run by the other AHF-funded project and the more recent alcohol and drug programming that this project is involved in, school staff suggested that they did not have sufficient knowledge of youth activities, some of
which occurred with teachers finding out only after the fact. As school staff deal with many of the same children being served by the Youth Initiative, an enhanced partnership could result in many benefits.

As there is another AHF-funded project in the community, questions were posed to capture views on how or if they relate to each other. There appears to be a high recognition that organizations with similar goals network and work together, even if people are less clear about who specifically does what and where funding comes from. In particular, the practice of working together after a suicide was noted.

The Wellness Committee is a good example of the inter-agency partnering that benefits the Youth Initiative. Aside from the five key agencies that comprise the Working Group (Psychology, Health, Alcohol and Drugs, Lone Eagle Treatment Centre, and Child and Family Services), there is also representation from Economic Development, Education, Police, Band Administration, Band Council representation, Elders (one is a Survivor), and the Chief who sits as an ex-officio member. The Chief and Council supported the project through a band council resolution, and informants felt support from leadership was high.

5.3 Reaching Those in Greatest Need

While the exact number of youth participants in this project remains unclear, there was an estimate made of 150 youth and children per week. This would mean that the project is serving 16.7 per cent of the estimated target group of 900 youth. In fact, the AHF national survey completed by the project stated that with the proper resources, it could serve 500 youth.

Some informants specifically mentioned hard-to-reach youth, and one person said that this would be the project’s biggest challenge. Further discussion among the project team and the community may be required in order to develop effective strategies on meeting the needs of hard-to-reach youth—a clear, open discussion, as it is a complex issue and the fact that this group is hard to reach.

It remains unclear how well the project is addressing the legacy of physical and sexual abuse in residential schools, including intergenerational impacts. The residential school in Shubenacadie, Nova Scotia, where First Nations children in the Atlantic region were sent, has been closed for almost 40 years, but many of the community’s youth are intergenerational survivors. Interviewees reported that Survivors were involved in the proposal development, and some sit as Elders, teach arts and crafts to youth, or participate in fundraising. Two people involved in delivering traditional activities as volunteers—part-time members of the project team are both Elder and Survivor. Key informants did state that many Survivors are not willing to come forward in the capacity that the project was seeking, such as sitting on advisory boards or becoming staff members. However, in the project’s current structure, Elders (one of whom is a Survivor) sit on the Wellness Committee and Youth Advisory Board.

The project was not intended to address physical and sexual abuse directly, as it is “an integrated prevention, early intervention, and aftercare initiative.” Indirectly, however, there may be increased opportunities for these issues to come into the open as children and youth are reportedly bonding with staff, confiding in them, opening up, talking more, and seemingly gaining higher levels of confidence and self-esteem.
5.4 Best Practices

Four things in particular stand out as practices that appear to be working well:

- the project is youth-driven, including staff who are themselves youth;
- it is an integral part of the Community’s Wellness Committee, thereby allowing it to be guided and nurtured by people who have a wealth of experience and expertise to offer;
- coordination is at community level (Wellness Committee) and not tied to any particular agency; and
- the project consulted the community through the Youth Initiative Survey and has clearly responded by providing activities identified in the survey results as priorities (e.g., alcohol- and drug-free events).

In several areas, the Youth Initiative has undertaken far more than what was stated in their contribution agreement with the AHF. The work plan points out the project’s role in liaising with other initiatives in the community and even networking with other youth projects in the region. This supports statements from key informants who noticed a willingness on the part of Big Cove to share its experiences with other communities. A second innovation is closer to home: while not included in the original proposal, a key objective is to raise enough funds to establish a youth centre in the community. This would be a welcome change as the project is currently working out of rooms at the school, the health centre, and the mental health office. More importantly, the youth centre initiative is clearly youth-driven, and there are likely to be many side benefits associated with achieving this goal—from community development and network building to increased levels of self-esteem and leadership skills among those involved.

An interesting note on the best practice of having a youth-driven project for youth, as a program was previously introduced to the community without asking youth if they wanted it. Adults initially felt it was a good program, and they in fact got some initial participants, but slowly they dropped out. This story was retold by a key informant who praised the work of the youth involved in the Youth Initiative project and its relevance to the needs and interests of young people in the community.

When asked what they liked most about the project, four people spoke about the structured events for youth and three noted that it is youth helping youth. Other responses included the bonding between workers and youth, the goal of creating a youth centre, and meeting the challenge.

5.5 Challenges

In the interviews, people were asked about the challenges or obstacles the project faces as well as what they liked least about the project. While no one issue stood out, responses included the following:

- the need for their own building;
- the need for more activities, more diverse activities, and ongoing funding in light of the high need and size of the youth population;
- lack of parental involvement or resistance from parents;
- the effort that goes into such a high-level need and the challenges associated with maintaining momentum;
- burnout;
- alcohol and drug issues, including availability;
- too few volunteers;
- suicide;
• difficulties reaching “the hard-to-reach” ones; and
• working hours (evenings and weekends) create difficulties for staff with children.

The special education needs study cited earlier also points to the fact that the youth of Big Cove may include a large number of individuals with higher than average needs. These may include the hard-to-reach kids mentioned earlier. This suggests why some parents and community members may be hesitant to become involved with the project activities, as some parents may be worn out from their own children who may be demonstrating hyperactivity or others may be involved with alcohol or drugs. Also, potential volunteers may feel that the children are too much to handle or the needs or responsibilities too great to warrant their involvement, especially since they would be susceptible to criticism by those who are less amiable in their dealings with project staff. This is not to suggest all children are difficult or hard to reach; in fact, one person interviewed stated how project staff seemed to have greater control over youth participants than even teachers. However, it is fair to say that having hyperactive children or others with behavioural or emotional challenges can influence and disrupt other youth, as is noted in the school setting.

5.6 Lessons Learned

There appeared one major lesson learned, and that was the underestimation around what effort was actually needed to organize the youth. The proposal hoped to hold annual youth rallies, which would support the establishment of a youth council. This would be topped off with a youth advisory board. Despite the youth council not materializing, the rallies and the advisory board have provided some foundational work. Moreover, there appears to be strong support among the working group for the project and its staff, and most of the adults interviewed suggested that the project staff are becoming role models in their own right. The decision to incorporate a youth centre into the work plan speaks to the fact that the project is growing with the capacity of staff to deliver the program. However, as reported throughout this study, the project and the community are facing very real challenges, and it is not surprising that the efforts involved were underestimated.

6. Conclusion

The investment in project staff, as evidenced in the large number of training opportunities provided, was a logical and ultimately effective place to begin. As one person said, “the key to the youth will come from the youth themselves.” As the project begins slowly to raise self-esteem, confidence, and skill levels in youth, perhaps new leaders will emerge from this group. The project is having a positive impact in other ways as well. We know, for instance, that it has provided other community services with an opportunity to shift from crisis management to more effective long-term wellness planning and community development. Structured activities, bonding between staff and participants, and the guidance of adults involved in community agencies should support continued short-term changes and help build the foundation for long-term results. The proactive and coordinated approach to community issues taken by this project is also part of the capacity building among youth. Having a seat on the Wellness Committee and liaising with other initiatives can be seen as short-term changes, which can broaden the perspective of project staff and help reduce gaps in service.

In spite of this progress, many people have rightly pointed out that true impacts will not be felt for quite a while. For instance, it is unreasonable to believe that in such a short period of time youth will be less suicidal
or less entangled in legal troubles. Reaching the hard-to-reach youth will be an ongoing challenge. Issues related to the presence of alcohol and drugs, family dysfunction, abuse, and neglect simply compound the problem. The youth population demands attention, as without the intervention and prevention efforts being offered through this project, these issues will continue to outpace the ability to meet the challenges.

7. Recommendations

The following comments are offered as tentative recommendations in support of the progress the project has achieved to date:

- The six youth members of the project team are all female. Efforts to secure a male worker and young male volunteers may provide further opportunities for personal growth in two specific areas: role modelling and efforts to address emotional issues that are difficult to talk about, such as suicide and sexual abuse. The bonding between project personnel and young people in the community has been observed throughout this study, yet it has not been clear whether there are gender differences in the young people who are opening up to the workers. If this is the case, then an increased number of male staff and volunteers may be worth considering.

- A dialogue is needed to explore methods of gaining the trust and involvement of the hard-to-reach population and leading to the development of a strategic plan. A comment by the police suggests that many of the crimes in the community are being committed by the same individuals. Perhaps the youth seat on the Justice Panel can be utilized to reach young offenders and, if appropriate, to draw them into the project’s circle of activities.

- Greater efforts should be placed on working more closely with the Big Cove School, as some teachers were unaware of Youth Initiative events until after they had taken place. This may also help efforts to secure the use of the school’s facilities and increase the potential pool of volunteers.

- Strategic planning should also occur in the area of volunteer development, for without it the project team could be hard pressed to maintain the momentum they have shown to date. This could also involve discussions with parents to see how they might become more involved. Lastly, further community-based research into the specific issues facing youth may provide useful insights, especially if the entire youth population of the community was targeted. It would also be helpful in assessing progress towards healthy lifestyles if a survey included questions concerning knowledge, attitudes, and behaviours around issues such as alcohol and drug use. Furthermore, if information on the age and gender of respondents was collected, planning could include specific target audiences within the youth population.

Notes

1 Information from Youth Initiative Project submitted to the AHF, funding application, March 1999, Part F, Page 9.
2 Information from the Youth Initiative Project quarterly reports for year 2000 submitted to the AHF.
3 A grandmother speaking about the recent loss of her sixteen-year-old grandson.
4 Information from Youth Initiative Project submitted to the AHF, funding application. The first paragraph cited is from Question 3, Part F, Page 9 and the second from Question 7, Part F, Page 11.
8 This survey was delivered during the second quarter (1 April to 30 June 2000). A total of 141 community members responded to this survey.
9 Cox, Lori Vitale (1998). Special Education Needs Assessment Study [unpublished]. Dr. Cox was hired in the fall of 1997 to study the special needs of the children who attend Big Cove School. This study is grounded in the concerns of parents, Elders, teachers, administrators, and staff expressed at community meetings and workshops held in the winter and spring of 1998. The study was conducted in four parts: 1) surveys and interviews; 2) teacher–student index; 3) in-depth analysis of a sample of the special needs population; and 4) alternative classroom experiment–interview with two students.
15 See Hattem, Tina (1998). Survey of Sexual Assault Survivors: Report to Participants. Ottawa, ON: Department of Justice Canada and the Canadian Association of Sexual Assault Centres. One study found that reasons for not reporting the assault include (in order of frequency) fear of the criminal justice system; fear of record disclosure; fear of impact on family; negative experiences with the justice system; the perpetrator could not be located or was dead; fear of the perpetrator; and fear of impact on the relationship.
Appendix 1) Big Cove Interview Questions

1. On a scale of 1 to 5, (1 being low, 5 high) what level of support are community leaders currently giving to this project?

   1  2  3  4  5

2. From your perspective, what are the most common crimes being committed by youth in your community in the last 12 months?

3. In the last 12 months, please state whether you feel violent youth crimes have:

   increased  stayed the same  decreased

4. In the last 12 months, please state in your opinion, have rates for incarcerated youth:

   increased  stayed the same  decreased

5. What measures have been taken, that you are aware of, to address youth crime in your community?

6. What do you perceive the benefits are, by having this project in the community?

7. What do you see as the biggest challenges and obstacles this project will face?

8. In your view, how do you see other Aboriginal Healing Foundation projects relating to this youth project?

9. What role have Residential School Survivors had, with respect to this project’s goals and activities? Please elaborate if you can.

10. Have you noticed if more youth are indicating a need or willingness to seek alcohol and drug treatment?

    yes  no  the same  haven’t noticed

11. In your view, would you say the opportunities for families and youth to deal with alcohol & drug issues are:

    better  the same  less

12. In the last 12 months, and on a scale of 1 to 5, (1 being low, 5 high) what significant changes among youth have you noticed, for any of the following areas:

    Youth self-esteem  1  2  3  4  5
    Parental involvement  1  2  3  4  5
    Mother/daughter communications  1  2  3  4  5
    Family relations  1  2  3  4  5
    Youth leadership  1  2  3  4  5
    Peer support  1  2  3  4  5
    Cultural awareness  1  2  3  4  5
    Goal setting  1  2  3  4  5
    Social skills  1  2  3  4  5

13. What do you feel is the strongest contribution you can make in helping this project reach its goals?

14. Please define what you think “community spirit” means, as it relates to this project.

15. What do you like most about this project?

16. What do you like least?

17. What have you learned from your involvement with this project so far?

18. Is there anything you could suggest that might improve this project?
19. How well do you feel the areas being addressed through this project will affect the issue of suicide in this community?

20. In your opinion, for each of the following, which answer best describes whether rates have changed as a result of this project for:

- Physical abuse: have changed, the same, unsure
- Sexual abuse: have changed, the same, unsure
- Children in care: have changed, the same, unsure
- Incarceration: have changed, the same, unsure
- Suicide: have changed, the same, unsure

21. In the last 12 months, have the number of suicides in this community:
- increased
- stayed the same
- decreased

22. Please describe what role you feel alcohol and drug abuse contributes to the number of suicides?

23. In your opinion, what factors allow your community to now deal with suicide differently?

24. What special efforts, if any, are being directed toward youth regarding suicide?

25. In the last 12 months, from your opinion, have rates for children in care within this community:
- increased
- stayed the same
- decreased

26. To your understanding, what do you feel is the number one reason why children in this community are being placed in care?

27. Can you provide an example of how youth may have improved their social skills?

28. Can you explain, if possible, how training courses were identified for this project?

29. What changes have you seen regarding youth taking on more leadership roles, in the last 12 months?
- none
- a little
- the same
- a lot

30. Would you have any final comments to share?

**NB. The same questionnaire was delivered to staff at the Big Cove School and the Big Cove Police. However, this second questionnaire was a shortened version, removing questions 8, 9, 13, 17, 28 which may not have allowed these agencies to comment on matters more related to planning aspects or direct involvement. Also Mandatory questions were only asked to the Project Coordinator and the Youth Development Worker.**

**Mandatory questions:**

31. How well is the project addressing the legacy of physical and sexual abuse in Residential Schools, including inter-generational impacts? Please choose only one response.

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<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
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Please offer an explanation why you feel this way:

32. What are the previously identified needs that the project is intended to address?

33. How would you rate the project’s ability to address or meet those needs?
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<td>Not sure</td>
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34. How well has the project been accountable (i.e. engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

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<td>Is not addressing the Legacy at all</td>
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Please offer an explanation why you feel this way:

35. How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

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<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
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Please offer an explanation why you feel this way:

36. Will the project be able to operate when funding from the Foundation ends?

37. How well is the project able to monitor and evaluate its activity? Please choose only one response.

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Please offer an explanation why you feel this way:
George Manuel Institute/Neskonlith Indian Band

Project Number: HH-88-BC

Case Study Report

Honouring Residential School Survivors:

A Theatre Production

Every Warrior’s Song

Written by:

Kevin Barlow

Under the direction from:

Linda Archibald and Kishk Anaquot Health Research

Prepared for:

Aboriginal Healing Foundation Board of Directors

2001
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Acknowledgements

It is with great appreciation I give thanks to the people who made themselves available to be interviewed and be recognized. Without such openness and willingness to share very personal experiences, this study would not have been possible. It is this same dedication, commitment, and sharing they showed me that led the production to become what it was.
1. Introduction

A series of case studies was conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case study process included data collection on selected social indicators that will be used to measure the impact of projects over time. In particular, data was collected for the year prior to AHF-funded activity and once again in the year 2003, an approach known in the evaluation field as “within-groups repeated measures.” The case studies are intended to provide a detailed, holistic, in-depth view of the projects and their outcomes. All data was collected by community support coordinators.

The project that forms this case study is entitled, “Honouring Residential School Survivors: A Theatrical Production under the Honour and History Theme” (AHF file # HH-88-BC). The production became Every Warrior’s Song and is described in the application as, “A theatrical production that addresses the legacy of physical and sexual abuse of the Residential School impacts on First Nations families and communities.”

This report provides a holistic overview of the Neskonlith Indian Band and the George Manuel Institute’s project (herein referred to as “theatrical production” or “project”), including a description of important regional characteristics and conditions that will reflect the areas where the project unfolded. This is followed by a detailed discussion of project activities and anticipated short- and long-term outcomes and how change will be measured. It discusses the range of potential indicators of change, including those chosen by the AHF Board to be applied to all projects (physical abuse, sexual abuse, incarceration rates, suicide, and children in care) as well as indicators specific to this project. It also includes a discussion of the views of the project team and community service providers on the project and its impacts to date and provides an overview, impressions, and conclusion.

Sources of information used in this case study include: project files (funding proposal and quarterly reports); key informant interviews with the project team, cast members, and follow-up contacts in each location the project had toured; documents and data collected by the community support coordinator as part of the case study process. The AHF National Process Evaluation Survey (sent to all funded projects in February 2001) was not available.

2. Project Overview (Thinking Holistically)

The project that developed and delivered the play Every Warrior’s Song was funded from 1 January 2000 to 31 December 2000 with a contribution in the amount of $147,366. The focus of this study is for the same time period.

The project involved researching, writing, producing, and delivering a play that addressed the legacy of physical and sexual abuse and other residential school impacts on families and communities. The writing is based on the experiences of Survivors interviewed during the research phase; Survivors were also involved as advisors throughout the project. The funding application reported that the project was expected “to provide a creative process of healing for residential school Survivors and their families by putting words to their experiences of physical and sexual abuse and providing them with an opportunity to share their experiences in a safe environment.” The application for funding went on to state the play would honour
Survivors; share history; promote healing for Survivors, their families, and communities; and provide education, awareness, and understanding of what is necessary to restore balance.

One person associated with the host agency stated that the key impetus behind this theatrical production was, in part, an identified need that arose when some community members attended a play about residential schools approximately one year before they applied for funding. According to this individual, the play had many inaccuracies and impacts on the Aboriginal members of the audience. It was developed by non-Aboriginal people with little or no consultation with them. It also portrayed the central character, a nun, interpreted by some audience members as being almost seen as a martyr because she had to “educate the poor Indians.” A key shortcoming was that no debriefing for the audience was available to allow for the processing of emotions that were triggered. Out of anger and a need to tell a true story, this project became a reality.

The sponsors for the project was the Neskonlith Indian Band and the George Manuel Institute, located near Chase in the interior of British Columbia. The Institute itself has been incorporated since 21 January 1993, according to the project application, and served as the administrative body for the project. It has administered a wide range of programs and services over the years.

2.1 Participant Characteristics

The theatrical production was designed to be made available within the province of British Columbia. The majority of participants were the general public, both Aboriginal and non-Aboriginal. Also included were Survivors, their families and communities, actors, project staff, roving counsellors, volunteers, community staff members and leaders, and the rest of the members of the 12 communities that hosted the play. Indirectly, there were some people from neighbouring communities that would travel to where a performance was being held.

Participant recruitment cannot be defined in a traditional sense mainly because of the type of project and for these reasons: 1) the performance had an open-door policy (as long as the facility could hold the audience); and 2) the medium being utilized was felt to be a less threatening one that did not hold the same barriers often found when offering “individual counselling.” In this sense, participants could be there for entertainment or on a first-come, first-served basis to secure a seat in the hall; healing itself did not have to be the reason for attendance. An important aspect to participant recruitment, however, applied to those who worked on the project. During the early stages of interviews in the research phase, the playwright–director was asked by Elders, Survivors, and a treatment director to ensure those who worked on the project be “in sobriety and working on healing.”

Of the six actors, four stated they had a parent(s) who was a residential school Survivor. One confirmed not being a direct descendant, while another made no mention of being a descendant. The ages of the actors ranged from 17 to 45 years old, with a majority being under the age of 30.

Of the 12 performances, two were held at treatment centres for clients only. It is impossible to total the exact number of audience members; however, project files reported reaching an estimated 4,000 people, and many interviewees reported standing room only.
2.2 The Project Team—Personnel, Training, and Volunteers

The project team included six staff members, six actors, and 12 other support staff who received honorariums for various duties. The positions included a project coordinator (replaced once), a production manager, a playwright–director, a stage manager–sound and light person (replaced once), a dramaturge, a choreographer, and 12 support staff. These were Elders and Survivors who advised, taught songs, gave teachings, and drummed. Others did set design, soundscape, or video footage or were actors to workshop the first draft of the play, front-of-house staff, stage crew, or make-up artists.

Not all of the actors had acting experience as they were hired because they were on a healing path. Most of the actors were young. In addition to the staff and actors, quarterly reports submitted to the AHF from the project stated that there were 40 roving counsellors and 30 volunteers who supported the development and delivery of the theatrical production at 12 locations.

The roving counsellors were provided by the host community to gauge how the audience was responding to what was being presented. They would also intervene and provide counselling if someone expressed or showed a need for such. According to quarterly reports submitted to the AHF, the playwright–director met with the roving counsellors prior to each performance to share with them the counselling techniques specific to generational grief and childhood trauma. Follow-up referrals or counselling were also the responsibility of the roving counsellors, as the theatrical production was generally in the community for one performance only.

A very important function of the playwright–director was to facilitate debriefing sessions at the end of each performance. This aspect required a lot of skill and experience and was also utilized to work with actors and staff in preparing and processing the intensely emotional subject matter. Several of the actors stated that the person who provided this guidance was exceptional and that, without her, they would never have tackled this type of theater job.

Volunteers donated their time and efforts in hall set-up, food preparation, healing circles, and transportation. Project reports submitted to the AHF also indicated that the communities that held a performance took efforts in preparing feasts, promoting the event, and providing hall set-up, tear down, clean up, media contact, and protocols to secure Elders and leaders for opening prayers. They also provided staff to oversee any follow-up referrals and counselling needs. This study was unable to determine the total value of in-kind contributions; however, it is believed that contributions were received in the form of administrative support from both Neskonlith Indian Band and the George Manuel Institute, including 40 roving counsellors and 30 volunteers. It is unclear whether any or all of the 12 facilities where a performance was held donated their space free of charge.

2.3 Regional Profile

According to Statistics Canada in the 1996 Census, the Aboriginal population in British Columbia was listed at 139,655. Persons registered under the Indian Act living both on- and off-reserve were listed at 93,835. In keeping with similar Aboriginal demographics across the country, almost half of the province’s Aboriginal population (57,645) are under the age of 19. Adding the next age group (20–24), this figure rises to 69,595. Combined with the next age category (25–34), the figure rises to 93,845, which means
there is a significant number of young Aboriginal population in British Columbia. All these figures are important since the play was partially about teaching history, and the above-mentioned population would not have been old enough to attend residential schools in the province that had closed by 1965. The 1996 Census also cited 26,000 Métis in British Columbia.

According to project staff, if using language as a basis of classification, there are 10 major linguistic groups within First Nations in British Columbia. There are 193 bands, 33 tribal councils, and well over 200 umbrella political and social organizations. British Columbia has nearly 20 per cent of the total Aboriginal population in Canada, 32 per cent of the total number of bands in Canada, and has 1,634 of the 2,323 reserves in Canada. A fair number are remote, isolated communities found in the northern portion of the province. The urban Aboriginal population carries implications in terms of population size, especially in the Vancouver/Richmond area. One factor is the milder weather during winter months; many people involved in more transient lifestyles migrate to this area to escape harsher climates found on the Prairies, elsewhere in Canada, and even within British Columbia. Therefore, the Aboriginal population may fluctuate depending on the season. In terms of reach, two performances were held in Vancouver where there is a significant Aboriginal population. The following table details where performances were held and population figures for that area.

**Table 1) Population of Locations Where Performances were Held**

<table>
<thead>
<tr>
<th>Location</th>
<th>General Population**</th>
<th>Aboriginal Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vancouver (x2)</td>
<td>1,831,665 (Metropolitan)</td>
<td>31,140**</td>
</tr>
<tr>
<td>Round Lake Treatment Centre (Armstrong)</td>
<td>5,322 (Armstrong District)</td>
<td>36-bed facility</td>
</tr>
<tr>
<td>Nenqaynî Treatment Centre (Williams Lake)</td>
<td>38,552 (Williams Lake agglomeration)</td>
<td>4 family units plus 10 youth beds</td>
</tr>
<tr>
<td>Interior Indian Friendship Centre*** (Kamloops)</td>
<td>84,914 (Kamloops)</td>
<td>undetermined</td>
</tr>
<tr>
<td>Ki-Low-Na [Kelowna] Friendship Centre***</td>
<td>136,541 (Kelowna)</td>
<td>undetermined</td>
</tr>
<tr>
<td>Tillicum Haus Native Friendship Centre*** (Nanaimo)</td>
<td>85,585 (Nanaimo)</td>
<td>undetermined</td>
</tr>
<tr>
<td>Neskonlith First Nation* (near Chase, Kamloops Service Centre)</td>
<td>2,460 (Chase) 84,914 (Kamloops)</td>
<td>543</td>
</tr>
<tr>
<td>Lytton Band* (Merritt Service Centre)</td>
<td>7,631 (Merritt)</td>
<td>1,665</td>
</tr>
<tr>
<td>Bonaparte Band* (near Cache Creek, Kamloops Service Centre)</td>
<td>1,115 (Cache Creek) 84,914 (Kamloops)</td>
<td>719</td>
</tr>
<tr>
<td>Coldwater First Nation (near Merritt)</td>
<td>7,631 (Merritt)</td>
<td>282**</td>
</tr>
<tr>
<td>Bridge River Band* (near Lillooet, Kamloops Service Centre)</td>
<td>84,914 (Kamloops)</td>
<td>379</td>
</tr>
</tbody>
</table>

* First Nations Profiles, Indian and Northern Affairs Canada, July 2001  
** Statistics Canada, 1996 Census  
*** Friendship centres serve largely urban populations and satellite First Nations
3. Using Common Sense (The Data Collection Process)

In order to guide the community in measuring change, this section links the long- and short-term goals of the project with how change will be measured. Indicators of change and how they are being measured are outlined in the performance map found at the end of this section. All project files were thoroughly reviewed prior to conducting the interviews, which included the funding application and all quarterly reports. Preliminary contact was made with key informants to make introductions and begin planning for when interviews would take place. After initial review of all documentation, a logic model and a performance map were created to provide an overview of the project. These steps then guided the design and finalization of the interview questions (Appendix 1) as well as a list of who would be interviewed.

Over the course of roughly two weeks, both in-person and phone interviews were conducted with 12 of the 14 people originally identified as potential key informants associated with the project. These included the cast and crew whose names were provided by the playwright—director as well as other key contacts named in project files. The main questionnaire was delivered to these individuals soliciting their observations, lessons learned, knowledge of the purpose behind the project, as well as perceptions of the impacts in the five main indicator areas identified by the AHF Board, to name a few.

The follow-up questionnaire (Appendix 2) asked only question #17 from the main set and three other separate questions to determine the length of debriefing sessions and number of individuals or family units who had sought counselling as a direct result of the performance. Question #17 asked respondents to select the answer that best suited how they felt from a set of predetermined choices on the potential for effect or impact in the five main indicator areas. The reason for the follow-up questions was due to the project being in each location only once. Respondents to the main questionnaire were often unable to relay what, if any, follow-up efforts occurred. The follow-up questions were delivered to key contacts from each location the project toured, whose names were provided by the project team, to identify what follow-up needs were expressed and met.

Key interviews were done privately in person or by phone; facsimile transmission was used for some of the follow-up contacts. Interviews ranged from 25 minutes to one hour in length. In addition, two key people associated with the project were asked the mandatory questions set out by the research team. All actors and most of the staff were interviewed. Follow-up calls were placed to 10 of the 12 communities identified in project files.2 Of the ten people, eight completed and/or returned the follow-up questionnaires by phone or fax, and the other two had either left the agency or were unavailable due to personal schedules.

Two other sources of information came from Statistics Canada for the 1996 Census and data from the First Nations Profiles, maintained by Indian and Northern Affairs Canada, with figures updated in July 2001. Additional information was collected through phone contact with some Aboriginal agencies. Other information used was from Correctional Service Canada and various British Columbia ministries. The following performance map (Figure 1) can be used as a two-page reference guide to collecting information. It follows the key questions aimed at securing unique answers that can be verified by project files and key informants who are intimately knowledgeable about the project.
**Figure 1) Performance Map—Honouring Residential School Survivors: A Theatre Production  
*Every Warrior’s Song***

**MISSION:** A creative, interactive process of healing for Survivors, their families, and their communities that stays true to the original experiences of residential school Survivors.

<table>
<thead>
<tr>
<th>Resources</th>
<th>Results</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How?</strong></td>
<td><strong>Who?</strong></td>
<td><strong>What do we want?</strong></td>
</tr>
<tr>
<td>activities</td>
<td>reach</td>
<td>short-term outcomes</td>
</tr>
<tr>
<td>Research and write a play in consultation with Survivors; recruit staff; recruit actors through auditions based on basic skills and their familiarity with residential school issues; produce and deliver performances locally, then provincially, and possibly elsewhere in Canada; engage, debrief, and interact after each performance with the audience; and provide closure to staff and actors at project’s end.</td>
<td>Residential school Survivors; family and community members; actors, staff, and volunteers; and community staff and leaders.</td>
<td>Increased knowledge and awareness of residential school issues; involvement and input from Survivors; accurate, true portrayals of the original experiences of Survivors; honouring the resilience of Survivors at the family and community levels; appropriate, guided dialogue after each performance; and appropriate wellness/safety plans for all involved or working on the project.</td>
</tr>
</tbody>
</table>

| How will we know we made a difference? What changes will we see? How much change has occurred? |
|---|---|---|---|
| Resources | Reach | Short-term measures | Long-term measures |
| $147,366 one year only | 12 locations; 4,000 people; and 6 actors, 6 project staff, 12 support staff, 40 roving counsellors, and 30 volunteers. | Active, engaged dialogue after each performance by # of audience members staying for discussion; reports of audience reaction; length of time people would stay, discuss, and listen to issues; perceptions of actors, staff, and volunteers on what changes have been seen in Survivors, their families, and their communities; self-reported and key informant views on how the performance has impacted on those directly involved with the project; and evidence of increased awareness of residential school issues within communities. | Increase in Survivor healing, as seen through sense of belonging, validation, utilization as a resource, and family and community reconciliations; decreased physical and sexual abuse as a result of better education, awareness, and willingness to acknowledge and intervene in these areas; and increased healing as evidenced by decreased rates of suicide, children in care, and incarceration. |
3.1 Thinking Logically: Activities and Outcomes

There is a logical link between the day-to-day activities a project undertakes, what they hope to achieve in the short term, and the desired long-term outcome. Here, the theatrical production was intended to provide an opportunity for healing especially for Survivors, their families, and their communities and to raise awareness by retelling history. It was anticipated that the theatrical production would lead to the following outcomes:

- an opportunity to bring healing through a creative process;
- to honour residential school Survivors;
- to share history, specifically about residential schools;
- to promote healing for Survivors, their families, and their communities; and
- to provide education, awareness, and understanding of what is necessary to restore balance.

The relationship between the project activities and both short- and long-term benefits is set out in the following logic model (Figure 2). This model does what the name implies: it logically describes the project activities, how they were delivered, and what the community wanted to achieve. It then goes on to identify how we will know things have changed in the short term, why this work is being done, and how we will know things have changed in the long term. In this way, an outside observer can use a logic model to see how activities are expected to lead to outcomes or results.
## Figure 2) Logic Model—Honouring Residential School Survivors: A Theatre Production

*Every Warrior’s Song*

<table>
<thead>
<tr>
<th>Activity</th>
<th>How we did it</th>
<th>What we did</th>
<th>What we wanted</th>
<th>How we know things changed (short term)</th>
<th>Why we are doing this</th>
<th>How we know things changed (long term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and write a theatrical production that addresses the legacy of residential schools.</td>
<td>Worked in collaboration with Survivors in the research phase and as advisors.</td>
<td>Chose performers and stage crew based on basic skills and familiarity with residential school issues; # hired; and rehearsed 6–8 hours/day x 6 days per week x 6 weeks.</td>
<td>A creative process of healing for Survivors and stay true to the original experiences of Survivors.</td>
<td>Willingness of Survivors to give input, direction, and attend performances by # of Survivors involved and degree of involvement.</td>
<td>To provide a creative process of healing for Survivors, their families, and their communities by honouring their true experiences while creating education and awareness as well as what is needed to restore balance.</td>
<td>Evidence of increased levels of knowledge and understanding of residential school impacts and empathy towards Survivors in communities where performances took place; and increase in healing of individuals and families evidenced by decreased rates of physical and sexual abuse, incarceration, children in care, and suicide and increase in participation in healing activities/programs.</td>
</tr>
<tr>
<td>Secure production staff and actors; and hold rehearsals.</td>
<td>Recruited and guided all production staff and actors; and rent theatre for rehearsals.</td>
<td>Delivered play to 12 communities (# and location of performances).</td>
<td>Presented a play that honours the determination, courage, strength, and resilience of Survivors.</td>
<td>Self-reports and key informant views on impact of play on individuals involved as actors, staff, and stage crew.</td>
<td>Key informant and self-reported perceptions of improvements in participants’ ability to recognize and discuss the impact of the residential school legacy on their lives and emotions.</td>
<td></td>
</tr>
<tr>
<td>Produce a play and deliver it throughout the province of British Columbia.</td>
<td>Selected 12 locations to deliver the play.</td>
<td>Encouraged host communities to plan for aftercare; ensure wellness plan for actors and staff; and roving counsellors provided individual support as required.</td>
<td>Healing for the community, particularly Survivors and their families.</td>
<td>Engaged discussions after each performance by # of audience members who stayed for discussions; reviews in local media; and views of volunteers and roving counsellors on impact of the play.</td>
<td>Increased dialogue in communities on the impact of the residential school legacy and increased number of people seeking support for healing.</td>
<td></td>
</tr>
<tr>
<td>Debrief, counsel, and process with the audience after each play.</td>
<td>Skilled facilitator prepared roving counsellors and volunteers prior to performance and led discussions afterwards.</td>
<td></td>
<td>Safety and immediate and ongoing support for those who attend each performance.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide closure for actors and staff.</td>
<td>Involved actors, Elders, staff, and volunteers in a process to provide closure.</td>
<td></td>
<td>Members of the project team have an understanding of the impact of the project on themselves; and the project contributes to the individual healing process.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Our Hopes For Change

This project operated for one year only and the performance was delivered only once at each location. The question is: Can a one-time event change a life? The answer would most likely be yes. A clear example might be a near-death experience where a personal transformation might occur. Although this play was not a near-death experience, let us pose some questions for thought. What would happen if someone in the audience was feeling depressed and suicidal? Or, what might happen if an audience member had been physically or sexually abused? How might a person react who had lost custody of his/her children or was at risk of this because of his/her own self-destructive behaviour? Could the play influence a person who was coming from a troubled past that included incarceration? What if somebody attended a play and knew something was wrong in his/her life but just couldn't put a finger on it? What would happen when truth gets spoken? The answers to these questions may in fact describe, or be supported by, the observations and short-term impacts felt by those involved with the project.

During interviews with the project team, the goal that was most often described was to bring understanding, awareness, and education about residential schools to the communities and, secondly, to begin a healing process for Survivors and their families. The logic model and performance map presented earlier identify a number of desired short-term outcomes, including: increasing knowledge and awareness of residential school issues; involving Survivors; accurately portraying the experiences of Survivors and honouring their courage, strength, and resilience; providing a safe environment for discussion of issues raised by the play; and contributing to the healing of individuals, families, and communities. It can be said that the process used to achieve such increased the likelihood of an impact being felt in a positive manner. This study describes the wisdom behind, first of all, recruiting people who were working on healing for themselves. One respondent mirrored this wisdom by describing what he learned through his involvement: “I have to practice what I’m preaching, it has switched my way of thinking.” This approach is commonly described or used in 12-step-type fellowships, such as Alcoholics Anonymous, with the message being delivered by one alcoholic to another, or someone who has experienced the message, and is likely to be received more effectively.

Over the longer term, success will be gauged by evidence of increased knowledge, understanding, and awareness of residential school impacts and by increased participation in healing activities. Progress in these two areas will be supported by decreased rates of physical and sexual abuse, incarceration, children in care, and suicide and by participation rates in healing activities. It would be unrealistic to expect one performance in any given location to have a direct or measurable influence on these desired long-term outcomes. On the other hand, the performances may have acted as a catalyst for change in individual members of the audience and therefore could lead to increased levels of healing activity in their communities. It is also anticipated that members of the project team may experience changes in their lives that they can attribute to their participation in the project. These issues were explored in interviews with key informants and the project team, albeit a short time after the project’s completion. Follow-up interviews in 2003 will provide an opportunity to examine the same issues over a longer time span.

In addition to the longer term potential for change in individuals who viewed the play, there were clear opportunities to stimulate awareness and education in three key groups beyond the audience in general. The first group included the cast and crew who were recruited mainly because they were on their own healing journey. An example for potential long-term outcomes can be seen here by several members of the
cast and crew indicating they had started counselling or therapy. The second group included the clients at two treatment centres who were provided a closed performance. By virtue of their attendance at a treatment facility, the clients had the advantage of being in treatment with access to longer term follow-up or processing with trained individuals if any emotions and/or memories were triggered by the performance. The third group included the people involved in some form of training capacity. One friendship centre and other informants mentioned that trainees had attended a performance, usually in a group, so as to receive an experiential type of learning. This type of visual stimulus can be most effective when it is combined with the proper guidance, as was provided in the debriefing and the provision of roving counsellors. The fact that these individuals attended as part of a group also created opportunity to debrief among themselves with their instructor and to process the experience. In these three areas, it would appear a ripple effect was possible to influence longer term outcomes.

The case study design anticipated measuring change in five key indicators of healing—physical and sexual abuse, incarceration, suicide, and children in care—by comparing data collected one year before the project commenced and again in 2003. Attempts to secure the data on the communities that hosted performances were not successful. There were 12 performances in 11 different locations, with two being held at different venues in Vancouver. Community level data can be difficult to access from afar, and the researcher was only in British Columbia for one week. Time and cost constraints, the number of communities and the distance between them, as well as personal schedules and the residence of some key informants resulted in a number of interviews being conducted by telephone. There was only one interview that occurred in the host community. In total, four of the 12 key interviews were done in-person, and the remaining were done by phone. Table 2 presents information available from the interviews on how the project team and key informants in the communities believe the project will influence the identified social indicators.

<table>
<thead>
<tr>
<th>Social indicator</th>
<th>Significant impact</th>
<th>Little or no impact</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A lot</td>
<td>Some</td>
</tr>
<tr>
<td>Physical abuse</td>
<td>70%</td>
<td>20%</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>85%</td>
<td>10%</td>
</tr>
<tr>
<td>Incarceration</td>
<td>55%</td>
<td>20%</td>
</tr>
<tr>
<td>Suicide</td>
<td>60%</td>
<td>35%</td>
</tr>
<tr>
<td>Children in care</td>
<td>45%</td>
<td>40%</td>
</tr>
</tbody>
</table>

In all, a large majority of the key informants from the project team and the sponsoring community organizations believe that there will be an impact over the long term on the social indicators the AHF hopes to positively influence. In fact, 95 per cent of respondents believe that the project will have a lot or some impact on sexual abuse, and 90 per cent believe the same about physical abuse. This is significant in light of the project’s goal to deliver a theatrical production that addresses the legacy of physical and sexual abuse of the residential school system affecting First Nations families and communities.

As noted, longer term impacts will be addressed in the follow-up report based on data collected in 2003. While similar barriers may be encountered in obtaining community-level indicator data, key informants
within those communities can be asked to describe any observed changes in rates of abuse, incarceration, and suicide since the performance. Assuming that the performance was a catalyst for change, a general increase in levels of knowledge and awareness of residential school impacts as well as an increase in the number of people involved in healing activities can lead to a reduction in destructive behaviours represented by the five social indicators. Also, while actors and stage crew tend to be a more fluid group, members of the project team who will be available for future interviews could be asked about changes the project initiated in their personal lives. Certainly, as the following will show, the performances left a strong impact on audiences and members of the project team.

5. Reporting Results

The need for accurate portrayals of the experiences that occurred within residential schools is paramount if it is to facilitate a process that would lead to healing. In this case, the project remained clear in its goals and demonstrated an intricate knowledge of these issues as well as how to approach them when using theatre. The application itself reflected this knowledge and articulated how the project wanted to proceed. Although no direct data link may be found through the attendance or participation in the production, there is still opportunity for this project to serve as a stimulus and catalyst that could influence longer term outcomes.

Both in the project files and throughout the interview process, several people mentioned the safety or non-threatening nature of theatre, which appears to have worked well here. References were made of Aboriginal people being “visually oriented” as well as the recognition that the issues of physical and sexual abuse, children in care, suicide, and incarceration are difficult issues to tackle openly. Many barriers such as denial, addictions, shame, or depression are just some of the obstacles or barriers that would inhibit or prevent a person from coming forward to deal with these issues.

This project demonstrated a clear process involving Survivors at all stages in order for the project to stay true to the original experiences,” as stated in project files. It also seemed evident that due to the effective portrayal of the characters, these “original experiences” found an opportunity to release some of the difficult issues that otherwise may not have been disclosed. Informants made reference to witnessing many first-time disclosures and, coupled with the fact that family and community members were in attendance for many of these disclosures, a climate was supported through debriefing and by having roving counsellors to process these revelations.

Nobody seemed unrealistic by thinking or feeling that this one-time event would heal people. It was rightly presented as “an opportunity to begin healing.” There were clear examples provided on how this opportunity to begin healing translated into direct involvement in counselling or therapy. About half of the cast indicated that they had begun these forms of healing for themselves. In other cases, the benefit of enhancing training or professional development for people already working in this field or studying to be counsellors was suggested. This form of experiential learning appeared to have worked well. However, without interviewing any of these individuals (beyond the scope of this study), it is unclear as to what effect the production had.
5.1 Influencing Individuals and Communities

Due to the nature of this type of project—awareness building was the driving point behind its efforts—the following information will present how these efforts have influenced individuals and communities. Information is presented under three categories: the project team, the audience, and the community. Influences are depicted through informant responses and observations. Implicit in the discussion, and especially evident in the quotes from respondents, is the fact that the performance appears to have contributed greatly to an increased awareness and dialogue on residential school impacts.

The cast and crew of Every Warrior’s Song were asked to describe the impact on themselves regarding residential school issues as portrayed through the characters in the play. It is important to remember that four of the six actors had at least one parent who is a Survivor. One person described the impact as, “Overwhelming. Survivors had to tell their story. It wasn’t enough to hear other peoples stories, they had to tell their story.” Others spoke about more personal issues:

- “I felt like I was reliving a part of my past when I was drinking and drugging and on the skids. I’m glad I got a role and it was funny how it happened.”
- “Before the play, I stopped drinking. Going through the play and understanding the process helped me stay off of booze. I previously had problems stuffing emotions but the play allowed me to open up. I want to go back into the field of theatre. I now have more compassion, I understand and see the real reasons behind certain behaviours.”
- “My Dad is a Survivor. A lot of personal issues came up [informant becomes emotional and interview is paused]. Issues came up for me about alcoholism, suicide, feelings of self-worth all surfaced.”
- “Yes, I am aware of an example. My Mom is a Survivor and started talking more which she never did before. I saw changes emotionally with my family, like she used to have problems hugging and now she does.”

There appears to be advantages to the medium of theatre used here. Earlier, it was mentioned that this medium is a less threatening or imposing way of introducing emotional issues, such as those associated with the legacy of residential schools. The project team included actors, staff, and support staff who offered numerous examples that further supported the benefits of a positive impact that they were seeing:

- “Healing is an ongoing thing and I’m still working on my issues. Writing is like therapy, many times I was moved to tears. I needed a strong support system and I totally related to residential school Survivors.”
- “It is very important for our people to understand that all stories are relevant and real. There is a great need for our people to find all kinds of avenues to construct their story through ceremonies, plays, workshops. This definitely needs to happen.”
- “It’s only the tip of the iceberg. The AHF process is good, an alternative to what non-Native people are offering us as solutions to our problems.”
- “Felt good knowing the project was a little about prevention, little about treatment, some education, even for non-Native people.”

The non-threatening medium of theatre can be said to offer an equal set of opportunities that create an awareness and stimulate further efforts to address the needs that flow from that awareness. As the saying goes in the healing movement, “you can’t heal what you can’t feel.”

The impact on audience members, particularly Survivors, was witnessed through certain responses. According to informants, every performance honoured Survivors by recognizing their strength and resiliency. Many informants described their observations:
Case Study Report: Honouring Residential School Survivors: A Theatre Production  
Every Warrior’s Song

- “My Mom is a Survivor, she attended one performance and I acknowledged her there as a Survivor for the first time.”
- “I’m closer to my Dad who went to residential school, kind of ironic that something that separated us also brought us closer [together].”
- “I learned about their resiliency, compassion, the audience opened up and wanted to talk about things at a very personal level.”
- “They [Survivors] want to do something about it and are just waiting for the right opportunity or circumstance.”
- “A lot have never been able to tell their story and they want to.”
- “A lot of people attended with family members and are now doing things with them. Many wanted to see repeat performances and to bring other family members.”

These observations suggest that the staff and actors were given ample understanding to first hear the stories and then mirror that back through the characters.

Follow-up interviews with eight of the 12 communities that held performances show that debriefing and question/answer sessions were held after each performance and ranged from 45 minutes to 3.5 hours, with the average time being just over one hour. In follow-up telephone calls, communities were asked about the number of clients and family units who sought counselling following the performance. The following responses were from five of the performance locations. One of the respondents stated that most of the audience members at his facility were enrolled in various training programs, not only being already involved in this area, but not necessarily providing counselling yet to individuals or families. The two treatment centres are not included as all of their clients sought counselling by virtue of their participation in the centres’ programs. One treatment centre’s contact explained that their facility holds four families at any given time as well as 10 youth in their inhalant program. The performance at their facility was closed to the public. The other treatment centre is a 36-bed facility and clients must be 19 years or older. Also, some individual clients may also be members of the families who sought counselling.

Table 3) Numbers of Individuals or Families Who Sought Post-performance Counselling

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<tr>
<th>Community</th>
<th>Individual Clients</th>
<th>Families</th>
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<tr>
<td>1</td>
<td>6</td>
<td>2</td>
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<td>2</td>
<td>11–12</td>
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<td>3</td>
<td>23</td>
<td>8</td>
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<td>4</td>
<td>4 referrals</td>
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In questions aimed at determining levels of support from community leaders and community staff members, respondents from the main questionnaire (n=12) were asked to rate this support on a scale of 1 to 5 (1 low, 5 high). For both groups, the average score was 4 indicating high support. Informants provided examples of what special efforts or factors that might allow a community to deal differently with residential school issues and what services have improved:

- “I feel they can now deal with things differently because the conversation has been opened up with a lot of family members. They were all there [together], all crying, all supporting, all spoke. The healing was transpiring right before our eyes.”
Kevin Barlow

- “I saw an impact on frontline workers, development and education, even for the leadership. People feel they must now start organizing, find all avenues for our people to feel safe.”
- “I feel the play can be used as a reference. It made some people want to apply for funding, and those already with funding incorporated the play into their work.”
- “One community, Lillooet, said they were talking about starting group meetings for Survivors. People also discussed the play and the impact on them.”
- “I know many people, Bands, and places we didn’t go heard about it [the play]. More people started showing up at healing places on the reserves, one being my stepfather. I’ve also heard they want more healing.”

From these examples and information from quarterly reports, it is shown that residential school support groups have come together in many communities and that men’s and women’s healing groups have formed. It is therefore safe to say that communities have responded to this stimulus by introducing new services or by taking special efforts to improve upon what they had already offered to Survivors. “I feel they are now more informed. Talking equals solutions. Survivors did an honouring at each performance. The community now sees their strength and how Survivors can make contributions to the community.”

5.2 Engaging Survivors

Survivors had key roles from the beginning to the end of the project. In project files it clearly stated: “Residential school Survivors will be involved throughout this project, as interviewees in its research phase, and as advisors throughout the duration of this project ... Survivors will also be consulted to ensure that the story stays true to, and honors, their experiences.” The files provided information on the reasoning behind the project: “Survivors will also be honored as an important [part of] the performance. Through this honoring, they will be acknowledged for their courage and strength to survive and be welcomed back into the community. In this way, Survivors will be encouraged to acknowledge the positive qualities that they have to share with the community, and they will have their place in the community.”

It may be due to this method of engaging Survivors that encouraged and welcomed a willingness of Survivors to contribute to the process. This aspect is important in terms of how family members and the community were provided an opportunity to witness these stories and to find reconciliation and a greater sense of community. Here we see some examples of the spirit behind each performance:

- “Survivors attended rehearsals, plays, and were often crying, talking, encouraging us. They expressed how glad they were that someone was telling their story. Some helped with facilitation after the plays, some taught us songs.”
- “I heard very powerful comments and questions. They [Survivors] were looking for the truth and what this meant to our people in terms of healing and recovery.”
- “[T]he characters were exactly like their experiences and that they [Survivors] could relate.”
- “Survivors would get up in front of crowds, vocalize their anger, and you could almost see a weight lifted off their shoulders.”
- “Each night we got a real sense of community after each performance.”
- “Definitely never a lack of questions or comments, was kind of strange, like a friend telling you an amazing story.”

As can be seen by these responses, the contribution to and from Survivors helped create an accurate understanding of their experiences that benefited them both ways. By portraying real life experiences through the characters, Survivors and audience members were afforded a stimulus that resulted in emotionally charged testimonials before, during, and after the performances.
In terms of special efforts or improved services for Survivors and their families, four people were not aware of any, while another six stated that they could not provide an example or were not sure of how services were improved. As stated earlier, the cast and crew were generally only there for one performance and had little or no contact afterwards. However, some examples were provided, such as:

- “I know that Survivor support groups were started, even a theatre group in Merritt was started.”
- “After each performance, groups were held, healing circles for Survivors.”
- “I know one friendship centre is now running training for counsellors.”
- “Front-line workers at each performance got more understanding of trauma. We recognize basic alcohol and drug counselling isn’t enough.”

It appears that there was significant dialogue resulting from this project. Several examples cited family units attending and benefiting from this type of education and awareness. As stated by the project, one aspect or goal of the project was certainly to present an opportunity for healing. Figure 3 indicates perceived changes in regards to Survivors taking on more leadership roles over the last 12 months.

**Figure 3) Changes in Survivors’ Leadership Roles in Past Year (n=12)**

5.3 Establishing Partnerships

Partnerships were required in order for this project to be a success and to ensure safety needs were met. This is especially true since the performance was for one night only at each location. The following partnerships were listed as:

- Little Shuswap Indian Band;
- Adams Lake Indian Band;
- Nunalituuoait Ikai Uqatigiitut (Kuujjuaq, QC);
- Journey of Many Feet, Pauline McCrimmon;
- Whiskeyjack Treatment Centre Inc.; and,
- Na Nichimstm tine iKwi Kwekin, Voices from the generations, Squamish Nation Residential School Committee, Teresa Nahanee.

In the final quarterly report, however, several more partnerships were named. The first five were described as existing partnerships, while the rest were new:
• Round Lake Treatment Centre;
• Neskonlith Indian Band (Social Development Department);
• Little Shuswap Indian Band (Social Development Department);
• Adams Lake Indian Band (Social Development Department);
• Coldwater Indian Band (Social Development Department);
• Williams Lake Treatment Centre;
• Interior Indian Friendship Centre (Counselling Department);
• Vancouver Friendship Centre (Counselling Department);
• Vancouver Robson Square Media Centre;
• Merritt Coldwater Indian Band (Social Development Department);
• Nanaimo Tillicum House (Counselling Department);
• Kelowna [Ki-Low-Na] Friendship Centre (Social Development Department); and,
• Lillooet Bridge River Indian Band (Social Development Department).

This same report outlines what host communities were expected to provide. “All of the partners involved provided host sites, with a stage and area large enough to house their anticipated audience, marketing, transportation to the audience, the feast, a counselor pre and post action plan for participant support, and roving counsellors for during the performance.”

5.4 Best Practices

There appeared to be several best practices that would support greater opportunity to have the desired positive impacts. For example, given that the playwright–director had an excellent understanding of the needs (supported by key informant observations), there were opportunities to avoid negative experiences. These more negative consequences were seen at the earlier mentioned non-Aboriginal production that, in part, served as a catalyst for this project. Here are the best practices identified through this process:

• adequate research involving “experts” in this area—namely, Survivors;
• adequate preparation and support to cast and crew in order to navigate the emotions that would be experienced by these individuals without taking on other people’s issues;
• appropriate recruitment criteria to include those “working on themselves and being clean and sober”;
• the practice of debriefing, the use of roving counsellors and volunteers to ensure safety measures were in place, and closure at the end of the project;
• having Survivors identify themselves and acknowledging them at performances by standing allowed roving counsellors to tag people and do follow-up if required;
• the highly skilled facilitator (playwright–director) appeared to have benefited all involved; and
• the involvement of Survivors and Elders at all stages of the project allowed for sustained momentum and adequate support.

5.5 Challenges

However successful, the project was not without challenges or obstacles. Despite them, the project was able to stay on track through its use of best practices and clearly articulated goals. The following lists respondents’ observations identifying these challenges and obstacles:

• In reference to the promotional needs, five people stated “getting people to come out” was a challenge, especially since the production was about emotional subject matter.
• Two other informants mentioned “dealing with our own emotions” or “getting over or looking at our own issues and experiences.” Even months later, during the interview process, at least two informants became emotional, requiring the interviewer to pause.
• Others mentioned budgetary problems; for example, the application underestimated certain costs. Because project funds were limited, this prohibited the ability to travel to more communities.
• Four people cited various problems with the project sponsor, including, “the financial management from our host organization, we didn’t know if we would get paid at times or working with administrative bodies who aren’t all in healing themselves or are unaware of theatre work.” This included a vacuum that was created when the original contact person from the host organization had left early near the startup of the project.
• The recruitment process for the cast posed some challenge, as a key requirement became not so much their acting experience but their own commitment to personal wellness. One informant mentioned, “finding actors with a grassroots understanding on culture, spirituality, tradition, and then develop that into the play.”
• Reference was made to the subject matter itself and how certain individuals may have found it difficult to hear or talk about these issues: “My Dad is a Survivor and a really tough guy. It’s difficult to get someone like him to talk about these sensitive issues.”

Despite these challenges, there was a commitment to move forward by addressing these issues. Reference was made by some informants that, “It was like a ceremony, not just a play. A lot of what I did for this play, you wouldn’t do for your average theatre job.” This type of dedication and the feelings that the cast and crew felt from the production appears to have outweighed or compensated for any negative experiences.

5.6 Lessons Learned

It is one thing to experience normal ups and downs with any new project, but to learn from these experiences is another. People change jobs and others, for whatever reason, are required to leave their posting. One such reference was found in project files of one project position that, “had difficulty respecting the safety boundaries of the other staff. After working closely with him to work on his struggle, the [person] chose to leave the production.”

In response to some of the challenges experienced, informants offered various insights into what lessons they had learned. What follows are some of these responses:

• “I learned a lot about accountability and going slower, being better prepared.”
• “Could have talked more with admin staff before the play. Also more counselling services available for Survivors so we could refer them.”
• “Longer follow-up period, evaluation, follow-up with all counsellors. Copy the video of the play for all counsellors to use.”
• “Stay in a community longer, so more people could see the play.”
• “Someone to go beforehand and inform about the play, promote and prepare about potential impact.”
• “[M]ore conscious of the people they hire, know their backgrounds, et cetera.”

The project’s quarterly reports stated that one lesson it learned was that it did not allot enough time for the final meeting where closure took place, thereby going over-schedule with this. Final reporting requirements to the AHF was also underestimated in terms of the time and effort to get all involved in this important aspect, which was described as “information sharing.”
6. Conclusion

This project can be deemed a success. It met all of its stated requirements and managed challenges with commitment and dedication. Short-term impacts have been stated, most commonly with the number of people who sought counselling or therapy, including members of the cast. Longer term outcomes are that much closer to being felt, considering the level of short-term impacts. Examples taken from quarterly reports included, “many residential school support groups; some Survivor groups have returned to the site of the school they attended, and with support and help from counsellors and spiritual Elders, they use ritual to let go of painful memories of their past; and, men’s healing groups and women’s healing groups have formed.”

General comments from the final report included an observation for a need to “upgrade the skill level of community counsellors to a level that would allow them to work more skillfully with residential school Survivors.” Indeed, spinoff efforts have been stated. Trainees from various training courses who attended performances also benefited by guided instruction and processing of this experience. Some organizations were said to bring their entire trauma team and to also process the impact among themselves. An advanced trauma training course was subsequently initiated after the project ended. One commonly observed conclusion is the impact on the cast, most of whom were under the age of 30:

The last scene of the unveiling of the masks, brings together the journey of the Survivor. It helps the audience to feel a sense of courage in their own journey as they come to realize that this play was literally a healing journey for the actors. In order to perform this scene the actors developed their own masks, in order to do this the actors needed to express who they are under their masks. In order to unveil themselves, they needed to trust.

This impact was seen among the actors because of the actions they were taking, such as making decisions to “go back to school,” several stated “going into counselling or therapy,” two mentioned not using “alcohol and drugs,” and how this seemed to them to be part of their character building. “I feel so much better about me. I’m approachable, trustworthy, never been as involved in the Aboriginal community as I didn’t grow up on the reserve. I’m more spiritual than before.” In many instances, the value behind having a highly skilled facilitator was expressed. The playwright—director wore several hats, including the handling of some of the financial aspects, not to mention providing all aspects of the preparation, debriefing, and closure.

In closing, one informant, who is a Survivor, rightly observed that “the spirit of the play will move in the direction it wants to ... [W e] must move forward, start the real forgiveness, forgetting the memory, move on to bigger and better things, and we are contributors to society.” Another Survivor wrote a support letter after witnessing the performance held at the Kelowna [Ki-Low-Na] Friendship Centre, which depicts the emotions and thoughts that can occur when taking the courageous step of attending:

With anxiety and curiousness, I went to Kelowna to watch the play ... Not knowing what to expect — but realizing past pains — to expect the worst. I didn’t know if I would leave in devastation or what to expect. Sitting there nervously, I waited for the acting of our past to begin. Once it started, I was glued to the seat and yet willing to run out. Many feelings and emotions came over me, such as fear, anger, hate and crying out [of] self-pain. I was strong one minute and like jelly the next. All these masks of hidden secrets that residential school Survivors know too well. Masks of emotional pain that is buried so deep that the fear of time will be your enemy. Residential school theatre made me aware of the masks I carry. I started to peek around these masks of trauma,
hoping to see or find peace. Quality of this play was surprisingly light. The [director] and crew only scratched the surface. I think that because it only scratched the surface, [it] gives this play credibility. The reverse is true also, if it was too heavy, it may have cause some of Survivors to harm ourselves. This theatre on residential schools was done just right. I, as a residential school Survivor, support this theatre exposure. I strongly recommend that this theatre be shown in more native communities. I believe that from this acting that more masks will come off. Only then will other residential school Survivors begin to heal.

Notes

1 Personal communication with the playwright/director during an interview and subsequently reported by a follow-up question in an email.
2 The two that were not called for follow-up had already been interviewed with the main questionnaire.
3 Application for funding submitted to the AHF.
4 Application for funding.
5 Information from the Every Warrior’s Song project quarterly reports submitted to the AHF.
6 Information from project quarterly reports.
7 Information from project quarterly reports.
Appendix 1) Interview Questions

1. On a scale of 1 to 5, (1 being low, 5 high) what level of support did you feel community leaders gave to this project?

   1  2  3  4  5

2. On a scale of 1 to 5, (1 being low, 5 high) what level of support did you feel community staff members gave to this project?

   1  2  3  4  5

3. What was the most important goal in producing and delivering this play?

   WHAT:

4. What did you learn from Survivors as the project unfolded?

5. Please describe the willingness of Survivors to contribute to the production and/or discussions after each performance?

6. What do you perceive the benefits were by having the project in the community(s)?

7. What did you see as the biggest challenge or obstacle the project faced?

8. In your view, how did you see other Aboriginal Healing Foundation projects relating to this project?

   WHO:

9. Please describe the impact on you as residential school issues were portrayed through the characters?

10. In your view, would you say the opportunities for Survivors and families to discuss residential school issues are:

    better   the same   less   not sure

11. What was the strongest contribution you made in helping the project reach its goals?

12. What do you feel was the biggest thing you got from the project? (Deleted)

13. What did you like most about the project?

14. What do you like least?

15. What did you learn from your involvement with the project?

16. Is there anything you would suggest that might have improved the project?

   WHY:

17. How well do you feel the areas addressed through the project will have an affect or impact on the issue of:

   Physical Abuse :   a lot   some   a little   none   not sure
   Incarceration :    a lot   some   a little   none   not sure
   Suicide :          a lot   some   a little   none   not sure
   Sexual Abuse :     a lot   some   a little   none   not sure
   Children in care : a lot   some   a little   none   not sure
18. Based on the discussions after each performance, would you say the amount of education and awareness on residential school issues has:

- increased
- stayed the same
- decreased

19. Are you aware of examples of how Survivors, their families and communities have benefitted from this production? If yes, please elaborate.

20. In your opinion, what factors allow the community(s) that held a performance to now deal with residential school issues differently?

21. What special efforts, if any, are being directed toward Survivors that you are aware of as a direct or indirect result of the performances?

22. Can you provide an example of how the community(s) that held a performance may have improved services for Survivors and their families?

23. What changes have you seen regarding Survivors taking on more leadership roles, in the last 12 months?

- a lot
- some
- a little
- not sure
- none

24. What changes, if any, have you made in your life or work as a result of your involvement with this project?

25. Would you have any final comments to share?

**MANDATORY QUESTIONS:**

26. How well is the project addressing the legacy of physical and sexual abuse in residential schools, including intergenerational impacts? Please choose only one response.

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<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
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Please offer an explanation why you feel this way:

27. What are the previously identified needs that the project is intended to address?

28. How would you rate the project’s ability to address or meet those needs?

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<td>Is not addressing the Legacy at all</td>
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29. How well has the project been accountable (i.e., engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

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<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
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Please offer an explanation why you feel this way:

30. How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

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<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
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Please offer an explanation why you feel this way:

31. Will the project be able to operate when funding from the AHF ends?

32. How well is the project able to monitor and evaluate its activity? Please choose only one response.

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Please offer an explanation why you feel this way:
Appendix 2) Follow-up Questions

1. Please estimate how long the debriefing sessions lasted after the performance?

2. Please identify how many clients have sought counselling with you after the performance was held?

3. Please identify how many family units have sought counselling with you as a result of the performance?

4. How well do you feel the areas addressed through the performance will have an affect or impact on the issues of:

   - Physical Abuse: a lot, some, a little, none, not sure
   - Incarceration: a lot, some, a little, none, not sure
   - Suicide: a lot, some, a little, none, not sure
   - Sexual Abuse: a lot, some, a little, none, not sure
   - Children in care: a lot, some, a little, none, not sure
Hamlet of Cape Dorset

Project Number: CT-411-NT/32-NT

Case Study Report

Healing and Harmony in Our Families

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Prepared for:
Aboriginal Healing Foundation Board of Directors

2002
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Acknowledgements

I would like to offer my deep thanks to the people of Cape Dorset, especially to the members of the Community Healing Team and others in the community who gave me the opportunity to talk with them about this project and the issues facing the community. I would also like to thank my colleague for all her help with this case study: confirming figures, taking notes, setting up interviews several times, and especially offering the gloves, scarf, and mitts in minus-50 degree weather.

As with all those interviewed, each brought something special and, often, very personal examples of life experiences. And so I thank you all for sharing this and your community.
1. Introduction

A series of case studies was conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case studies are intended to provide a detailed, holistic view of the projects and their outcomes. All data collection, analysis, and synthesis are being done by community support coordinators under the facilitative guidance of Kishk Anaquot Health Research. The project that forms the basis for this case study is entitled “Healing and Harmony in Our Families” (AHF-funded project # CT-411-NT/32-NT). It is described in the funding application as seeking to:

- Provide healing and training to individuals who are committed to personal healing and who will support healing within their family and the community at large; develop and implement a healing strategy that will include training workshops for healers and caregivers, community awareness workshops, healing circles or gatherings for women, teens, Elders and men; and plan and deliver healing camps on the land at least once a year for targeted groups, including youth, women, men, Elders and families.

This report provides a description of the Cape Dorset project, which includes activities, participant characteristics, and environmental factors that may influence the project. It also includes a description of the community and the range of potential indicators of change, including those chosen by the AHF Board to be applied to all projects (physical abuse, sexual abuse, incarceration rates, suicide, and children in care). The project’s successes, challenges, and lessons learned are discussed as well as impacts on individuals and the community. The methodology section provides detail on the data collection process and limitations to the methods used. Sources of information include project files (funding proposal and quarterly reports); the AHF National Process Evaluation Survey (February 2001) completed by the project; key informant interviews with the community healing team (CHT) and selected community service providers; and documents and data collected by the community support coordinator as part of the case study process. In addition, the project provided summaries of participant evaluation forms for four of the workshops it held.

2. Methodology

There is a logical link between a project’s activities, what they hope to achieve in the short term, and the desired long-term outcome. In essence, a project meets its service delivery objectives when it carries out planned activities. However, further information is required to assess the actual impact of activities. This means linking desired outcomes—what the project hopes to achieve in the short and long term—to indicators of change, such as changes in participant knowledge, skills, attitude, behaviour, and, ultimately, changes in environmental or social conditions. The following summarizes the project’s goals and objectives (referred to as long- and short-term outcomes) as well as the indicators that show how change is being measured:

- **Short-term outcomes:**
  - increased skill and capacity of caregivers to support healing within their family and community;
  - increased capacity to effectively manage individual and family crisis;
  - increased capacity and effectiveness in serving hard-to-reach people, especially men;
  - community healing in areas of lateral abuse, violence, sexual abuse, and suicide;
  - overcoming powerlessness and hopelessness;
- increased sense of pride in culture and spirituality as it relates to healing; and
- strong, effective community healing team.

Short-term measures (indicators of change):
- number of participants in healing circles, workshops, counselling, and on-the-land camps (\# of participants over time for each target group);
- self-reported and key informant perceptions of changes in participants’ self-esteem, coping patterns, dealing with depression and suicidal thoughts, and understanding the effects of sexual abuse;
- self-reported and key informant perceptions of change in participants’ behaviour (not attempting suicide, getting help for violence and abuse, participating in alcohol and drug treatment, and giving to/receiving support from Elders);
- increased skills and, therefore, reach of caregivers and workers (\# of skilled caregivers; key informant and self-reported perceptions of training and skills acquired; and \# of people reached); and
- a healing strategy that focuses on hard-to-reach groups, such as men.

Long-term outcomes:
- restored balance and harmony in families and community.

Long-term measures (indicators of change):
- reduced rates of physical and sexual abuse, suicide, incarceration, and children in care; and
- evidence of active, healthy community life (\# of elders, youth, women, and men involved in community affairs; and \# of and participation in community events).

The focus of the case study is on assessing the impact of the project’s healing and training activities; in particular, weekly healing circles for women and girls, healing and training workshops, individual counselling, and on-the-land camps. To a lesser degree, the study addresses planning and evaluation activities, especially since planning meetings were routine and facilitated all other activities. Specific target groups were women, youth, Elders, men, and caregivers. In addition, the community was targeted in a community awareness session, and workshops and healing circles were advertised on local radio. Strategies to address hard-to-reach groups, particularly men, were discussed in planning meetings and two evening groups were offered to men in March. The study relies heavily on key informant perceptions of change in participants’ knowledge, attitudes, skills, and behaviour.

All project files were thoroughly reviewed prior to conducting the interviews, starting with the successful application, then all quarterly and final reports. After initial review of all documentation, a logic model and performance map (Appendix 1) were created to provide an overview of the project. These steps then guided the design and finalization of the interview questions (Appendix 2) as well as a list of who would be interviewed. The list was created from project files that provided information on CHT members and project personnel. Preliminary contact was made with key informants through my colleague (fluent in Inuktitut) to introduce us both and begin planning when the interviews would take place. The questions went through several revisions and then translated into Inuktitut. These were made available to an interpreter who was hired to assist during the interviews. Two attempts were made to fly into the community. The first could not be completed, as mild weather and fog prevented landing of the aircraft and the duration of the trip was spent in Iqaluit to secure data from various territorial government offices.

Over the course of five days (26–30 November 2001), in-person interviews were conducted with 10 people. One person opted to take the questionnaire home to complete and then returned it the next day. Two additional people were expected to be interviewed, but outside factors prevented them from being in the community when the interviews were taking place. Some informants were only contacted while in
the community. The project was in the process of reapplying for AHF funding. It was explained by the justice specialist that an AHF request for additional information was not fulfilled by the project due to lack of time or personnel. Consequently, no current project coordinator was in place to interview. The CHT members who were interviewed included the project coordinator for the year this study focuses on. Healing circle facilitators were also part of the group interviewed. The same set of questions was delivered to all informants to solicit their observations, feelings, and opinions as well as their knowledge of the issues facing the project’s target audience and of the project’s purpose.

Of those interviewed, only one was male (an Elder) as the only other male on the CHT was unavailable. The remainder were female with one being a non-Inuk. Six required interpretative services and four received the interview questions in English, including the person who self-completed the survey. In a follow-up contact with the justice specialist, three of the people interviewed were identified as Elders.

Interviews averaged approximately 45 minutes to one hour in length, with four people present: the study author, his colleague (an AHF employee from Iqaluit), an interpreter (recommended by the community), and the informant. Eight of the 10 people who participated in the planning for the project were also asked mandatory questions set out by the research team. The location for eight of the interviews was at the Justice building. One person was interviewed at the probation offices and one person was met at a school who subsequently took the survey home to self-complete.

Data from Government of Nunavut Bureau of Statistics and Health and Social Services in Iqaluit were collected. While in Cape Dorset, the RCMP detachment, Social Services office, one school, the nursing station, and one business operation were visited to secure further information. Also, informal conversations with several business owners and others who held professional roles in the community (such as a former councillor) were also sources of information used for this study. However, these individuals were not speaking in their professional role but as community members. Finally, the hamlet provided a community profile and an economic development plan mentioned earlier. Summaries of participant evaluations for four of the workshops were made available.

2.1 Limitations and Considerations

Much of the indicator data used in this report were provided orally, as only a few documents were made available. Project personnel provided other details such as children in care rates. It is unclear whether “select” information was shared or if there were more details that could have supported a more accurate assessment of the environment and context where this project operated. Some older data provided by the hamlet suggests no up-to-date population or demographic figures were available.

The interpreter was also interviewed as she held the position of project coordinator for the year in question. However, it is felt that she provided accurate interpretation of the informant responses. My colleague, also fluent in Inuktitut, was present for all interviews and took notes of informant responses that were later compared with the study author’s. This lends an increased level of confidence to the interview data. In fact, the skills of the interpreter can be said to be very high, and this case study likely benefited by having such a skilled person involved that is from the community. Translation of the questionnaire provided the interpreter familiarity prior to the interviews. Interview questions were asked in English and the interpreter used her own language and terminology. Inuktitut responses were recorded in English based on the words of the interpreter, and the analysis was done in English.
Ten people were interviewed, although experience from previous case studies recommends at least 12 to 14 interviews to allow a well-rounded perspective. However, because eight of the 10 informants played a key role in planning, they were also asked the mandatory questions set out by the research team. Thus, enough information was collected to support the analysis. The limited time available for gathering data in the community meant efforts were concentrated on interviewing CHT members and meeting with agencies to collect social indicator data. No time was available to solicit views about the project from the community at large or from particular segments of the community who may not support the project. While it appears that respondents were open and honest about the project’s challenges and shortcomings as well as its successes, it must be recognized that these are “insider” perspectives, and there may be competing or conflicting views that are not represented here. The project did provide summaries of participant evaluations from four workshops, which proved to be limited in their usefulness as they only addressed the adequacy of workshop delivery and content and contained few other details.

While the case studies are not intended to deal directly with program participants due to ethical concerns about the possibility of triggering further trauma, an exception is made for this case as CHT members were not only involved in planning and delivering programs but also participated in them. This issue was first discussed with the justice specialist to ensure that informants would have access to support people if the need arose. The second AHF employee present was also asked to be vigilant if a person was showing signs of distress. In addition, key informants were told they were being interviewed in their role as a CHT member or in their professional role in the community and not as a project participant. This was reinforced in the wording of the questionnaire.

Finally, if more time was allowed for a longer stay in the community, this would have provided greater insight into community dynamics. What did become clear during the interviews was that not all community members agree with the term “healing,” and it can be said that religious influences within the community have differing views on the matter. One other observation was that men seemed not to be as involved as desired by the project. At one point, the study author queried as to whether the Justice building, where most of the project activities are held, was a factor. The response by one informant was, “no.” This question was asked because it seemed the Probation offices located at Social Services were having men participate in its activities, such as with courses on anger management. Granted, these individuals were court ordered to participate, but we were informed that some enrolled in the courses voluntarily. This matter could have been explored further had more time prevailed.

3. Project Description

The Cape Dorset project was funded from 1 May 1999 to 30 April 2000 with an agreed-upon contribution in the amount of $121,080 and was sponsored by the Hamlet of Cape Dorset. This study focuses on the same time period. The project was in its second year of operation at the time of writing. The funding application highlighted the need to develop a healing strategy based on a “heal the healer” approach. It described a “very low moral state” and “high levels of abuse, crime and violence, especially against women and children.” In particular, it wanted to “heal and train a core group — mainly women.” The serious impact that physical and sexual abuse had on some female community members who attended southern institutions was listed as well as the impact of a male teacher who sexually abused male students in the 1980s. It went on to link why some of the victims end up in correctional institutions or commit suicide.
It also spoke of toxic shame as being intergenerational and how many victims feel powerless, useless, and suffer in silent shame and how many experienced a spiritual destruction among the Inuit.

The application further stated that during the past five years a core group (primarily women) had put into place weekly healing circles for women and, more recently, teenage girls who had been victims of sexual abuse. They expected this project to reinforce and expand upon this base:

We want to draw more men into the Healing Team and involve men in developing and supporting a healing program for men in the community. We want to deliver specific healing activities for Elders and Youth, and work towards more balanced community healing during the next five years. We would like more individuals in our community to develop their knowledge of self, and their capacity to take care of themselves and foster healthy relationships with others in their family and community. We want to strengthen the Healing Team’s capacity through more training and healing, to be able in the long term, to effectively help families in crisis and offenders returning from the correctional institutions to resolve their issues.3

The following objectives were included in the work plan:

- healing and training to enhance the CHT and other caregivers’ knowledge, skills, and capacities to support therapeutic healing for the community at large;
- weekly healing circles or gatherings for women, teens, and men;
- five on-the-land healing camps for specific groups: men, women, Elders, youth, and families;
- individual counselling; and
- ongoing evaluation and planning.

The planned workshops were mentioned in quarterly reports submitted to the AHF, but few offered participation figures. There were summaries of participant evaluations for four separate workshops, and the project’s end-of-year report provided another list with some participation figures (see Table 1). It appears that workshops were planned in the first quarter but held during the remainder. In some cases, no participation figures were available as the project did not seem to have the AHF reporting format that captures statistics per activity. Thus, the first three reports were narratives and only the final report had numbers.
Table 1) Project Activities by Category

<table>
<thead>
<tr>
<th>Activity by Category</th>
<th>Time Frame</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly healing circles:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women's healing circle</td>
<td>weekly</td>
<td>10–12 participants (average)</td>
</tr>
<tr>
<td>Girls' group</td>
<td>weekly</td>
<td>average of 10 participants</td>
</tr>
<tr>
<td>Weekly healing circles (women, teens, and 2 men's groups)</td>
<td></td>
<td>males (13), females (23)</td>
</tr>
<tr>
<td>Special circles to close the women and teen groups for Christmas</td>
<td>prior to Christmas</td>
<td>no data</td>
</tr>
<tr>
<td>On-the-Land Program:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth camp (on-the-land)</td>
<td>Aug</td>
<td>17 youth</td>
</tr>
<tr>
<td>Elders' camp (on-the-land)</td>
<td>Sept</td>
<td>no data</td>
</tr>
<tr>
<td>On-the-Land Program (women's)</td>
<td>no data</td>
<td>males (0), females (7)</td>
</tr>
<tr>
<td>Planning and evaluation</td>
<td>monthly</td>
<td>19 members of the CHT; (average 8–9 people for planning) developed mission, code of ethics, rules, etc.</td>
</tr>
<tr>
<td>Individual counselling*</td>
<td>ongoing</td>
<td>males (15), females (22)</td>
</tr>
<tr>
<td>Healing and training: (workshops)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Building</td>
<td>27 Sept–1 Oct</td>
<td>no data</td>
</tr>
<tr>
<td>Male Victims of Sexual Abuse</td>
<td>Nov 1–4</td>
<td>no data</td>
</tr>
<tr>
<td>3 days: Men's Healing &amp; Healthy Relationships; and 2 days: Community Healing Awareness</td>
<td>Nov 15–19</td>
<td>60 people (at community workshop) including 15 men (most returned for both evenings)</td>
</tr>
<tr>
<td>Grieving workshop</td>
<td>no data</td>
<td>males (1), females (10)</td>
</tr>
<tr>
<td>Women's Group Process**</td>
<td>Feb 7–11</td>
<td>males (3), females (14)</td>
</tr>
<tr>
<td>Healing for Couples</td>
<td>no data</td>
<td>males (3), females (11)</td>
</tr>
<tr>
<td>Teen Group Process</td>
<td>Dec 6–10</td>
<td>9 participants completed evaluations</td>
</tr>
</tbody>
</table>

* This was indicated as being volunteer counselling and not documented. Two men started attending healing training in the second quarter.

** This workshop was referred to as Women's Group Process in the quarterly report, but the participant evaluation summaries called it "Group Process and Sexual Abuse Training."

Now that we know what was intended by the project, we shall describe participant characteristics, including the project team, who were essentially members of the CHT. There was only one project employee. The CHT viewed the training as part of the healing process and vice versa. They also saw themselves as both participants in healing and as building their skills and capacity to support others. Moreover, some members of the CHT facilitated groups and healing circles and provided counselling while also participating in healing and training activities. In light of these dual or multiple roles, the CHT is discussed in greater detail in the following section on participant characteristics.
3.1 Participant Characteristics

The project provided healing and training to members of the CHT, and it was hoped that they in turn would use their increased knowledge, awareness, and skills to provide support to other family members and in the community. Thus, the CHT formed the core group that received healing and training. Nineteen people were listed as being members with the following agencies represented:

- Uquajjiaqtiiq Justice Committee (six members, including the chairperson and justice specialist);
- social services (Dorset);
- Tukkuvik Women's Shelter personnel;
- community school counsellors;
- Anglican Women's Auxiliary (layperson caregivers); and
- two land guides and two people listed without any affiliation.

Other activities, including larger gatherings and on-the-land camps, targeted the community as a whole or any one of these specified groups: men, women, teens/youth, Elders, or families. Membership on the CHT was open to the entire community, as were all activities stated in Table 1 (on-the-land camps, healing circles, workshops, and individual counselling). In general, recruitment was an open door policy and project activities were promoted largely over the local radio station. A person could participate in an event and not necessarily be on the CHT.

Participation rates based on gender or group varied. It is clear that although men were a priority target group and described as hard to reach, this was the only group not to become firmly established. As illustrated in Table 1, men did not attend as much as women. Although not clear, the one time most men became involved was felt to be during the community awareness session and associated workshop on men’s healing (November 1999). However, the final report for the project did list a higher figure for male involvement. This discrepancy with informant interviews, which stated men were not participating, may be that the figure in the final report referred to the one time men requested support at a trial in Iqaluit. (At least two CHT members travelled to Iqaluit to support victims of sexual abuse during the trial of an abuser—a male teacher who targeted young male students.) It is unclear whether this service was listed as part of the 15 males who received counselling sessions mentioned in their reporting to the AHF.

Based on the AHF national survey, the project held both healing and training activities, reaching approximately 107 people in individual and group healing activities. In addition, 67 people participated in training activities. Figure 1 includes breakdowns per target audience under both healing and training categories.
The AHF national survey stated three people did not complete the ongoing healing component as two had moved away and one person died, and none were identified as not completing the training component. Furthermore, the project reported no severe challenges and identified these participant characteristics as moderate challenges affecting 40 per cent to 80 per cent of participants: history of abuse as a victim, family drug or alcohol addictions, and poverty. The following slight challenges (1%–40%) were: lack of survivor involvement in the project; denial, fear, and grief; lack of parenting skills; history of suicide attempts; history of abuse as an abuser; history of adoption; and lack of communication skills. History of incarceration, history of foster care, and lack of literacy skills were issues identified as posing no problem.

Identified in the project files was the link between many victims of sexual abuse and incarceration. At least six people on the CHT are members of the Justice Committee who obviously have a role in this issue. There is a discrepancy between viewing incarceration as not being a problem for the project, yet stating it was an issue in the funding application for the community. One possible explanation is the national survey responses were describing the core group on the CHT and not the community at large where those in conflict with the law, particularly males, were an issue or target group.

### 3.2 The Project Team—Personnel, Training, and Volunteers

As noted earlier, the project team was essentially the project coordinator and the CHT, which played a dual role as both participating in the healing and training as well as planning and delivering activities. Many CHT members were also healing circle facilitators or on standby if the main facilitator was not available.
The position of the project coordinator had to be replaced several times, but it is unclear whether this was a factor for the year this study is reviewing. The national survey showed there were no full-time employees and eight part-time employees. During the period this case study focuses on, project personnel were given certain types of training and professional development. The advanced training received by project personnel over and above the workshops listed earlier and reported in the national survey are outlined below in Table 2.

**Table 2) Training Provided to Project Employees**

<table>
<thead>
<tr>
<th>Advanced Training Activity</th>
<th>Advanced</th>
<th>Was Adequate</th>
<th>Not Adequate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma awareness</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Counselling skills</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Dealing with family violence</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Programs related to family functioning (e.g., child development/parenting skills)</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Other: sexual abuse</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>

In the national survey, the project reported the need for advanced training in counselling skills and dealing with family violence, and volunteer service was identified as being 534 hours in a typical month. Volunteers donated their time and effort in two key areas: administration (planning and management) and workshops. The local government (hamlet), the Justice Committee, and one community member were identified as donating the largest amounts of goods and services. A vast majority of the project activities were situated at the Justice building, which is likely the identified in-kind contribution for space. Table 3 shows estimates of the value of donated goods and services as reported in the national survey.

**Table 3) Estimated Value of Donated Goods and Services**

<table>
<thead>
<tr>
<th>Donated Goods or Services</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food</td>
<td>$ 2,000</td>
</tr>
<tr>
<td>Space for project</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

**3.3 The Context**

Cape Dorset has a population of approximately 1,200, with a high proportion (almost 50%) under the age of 20. Projected population growth is 46 per cent over a 15-year period, which would bring the population to 1,632 in the year 2011. A 1995 community profile done by or for the hamlet broke down the population by gender, with 53 per cent male and 47 per cent female. Age distributions were as follows: 0 to 4 were 16 per cent of the population; 5 to 14 were 25 per cent; 15 to 64 made up 57 per cent; and 65 and older were 2 per cent. The community was 93 per cent Inuit, 6 per cent non-Native, and 1 per cent Dene. Languages spoken were primarily Inuktitut followed by English.

Cape Dorset (also known as Kingnait, which means “high mountains” in Inuktitut) can be found on an island nestled off the southwest coast of Baffin Island in Nunavut. It was at this location where remains
of an ancient culture who flourished between 1000 BC and 1100 AD were first found. They were known as the Dorset culture named after Cape Dorset, which in turn was named by Captain Luke Fox. Captain Fox named the place after Edward Sackville, the Earl of Dorset, in 1631 when the Northwest Passage was being sought. The Baffin Inuit of Cape Dorset are descendants of the later Thule culture, known as Tuniit in their legends.

The hamlet operates a wide range of programs and services with a budget of approximately $9.3 million, as reported in the 1999 RT & Associates’ Community Economic Development Plan. The report also suggested estimated sales from carvings were a few extra million, but this figure was not further defined.

The Hamlet of Cape Dorset is a transferred community, as confirmed in a discussion with the Department of Health and Social Services of the Government of Nunavut. This means that Cape Dorset manages its resources directly, and funds are transferred from the territorial government to Cape Dorset. The following facilities and services in the community include:

- Sam Pudlat School (K–7) and the Peter Pitseolak High School (7–12)
- health centre (with approximately 7 personnel)
- RCMP detachment
- Nunavut Arctic College adult education centre
- Anglican and Pentecostal churches
- visitors’ centre
- post office
- Hamlet office, including Social Services, Probation, Public Works, etc.
- arena
- community hall
- local radio station
- airport and daily air service (Hawker Sidley and Beach 99 aircraft)
- two large retail food stores
- three convenience stores
- one coffee shop/bakery
- two hotels each with their own restaurant/coffee shops
- fire department
- water treatment and sanitation services

Community issues are described in the following table.⁶
### Table 4) Issues Challenging the Community

<table>
<thead>
<tr>
<th>Issue</th>
<th>Severe Challenge</th>
<th>Moderate Challenge</th>
<th>Slight Challenge</th>
<th>No Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult illiteracy</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Lack of acceptance of Aboriginal language and culture by local institutions</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Apathy or lack of active Aboriginal community support</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Local community opposition</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Poor local economic conditions</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Substance abuse</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family violence</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>✔</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of transportation</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
<tr>
<td>Lack of community resources, facilities, services, etc.</td>
<td>✔</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide or attempted suicide</td>
<td></td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Fetal alcohol syndrome/fetal alcohol effects (FAS/FAE)</td>
<td></td>
<td></td>
<td></td>
<td>✔</td>
</tr>
</tbody>
</table>

3.4 Prints and Carvings

Cape Dorset is known for both its printmaking and carvings. In fact, studies have been conducted to try and determine why so many people in the community have this artistic ability. A local businessperson, who had previously served on the Hamlet Council, laughingly shrugged it off by saying, “they [researchers] couldn’t figure it out,” and suggested that over half the community members are either carving or involved in printmaking. This community is home to Kenojuak Ashevak, whose print, *The Enchanted Owl*, has become world renowned. In fact, during the visit for this case study, news reports confirmed that one of her earlier works had sold for approximately $60,000 at a New York art auction and that a carver from the same community sold a piece for about the same price range.

A West Baffin Eskimo Cooperative employee felt that most of the artists were no younger than early 40s and that many of the young people did not seem interested in establishing prestige or a name in the arts. They appeared to be more interested in making immediate money from their carvings or prints.

The *Community Economic Development Plan* by RT & Associates, as stated earlier, gave an estimated income of a few million for the arts sector, including carvings. Still, a 1995 community profile provided by the hamlet cited, “unemployment at 25%, twice the national average and slightly higher than the regional rate of 22%.” The 1999 *Nunavut Labour Force Survey* showed several methods for determining the number of people unemployed by using national criteria to identify a 22.8 per cent unemployment rate. Under the survey criteria “Want a Job,” it showed that 42.6 per cent were unemployed in 1999, and under “No Jobs Available,” the figure was 33.3 per cent for unemployed in the same period. It is clear that whatever method was used, unemployment remains a challenge for the community. Inuit women tended to have
lower unemployment rates in the 15 to 34 age group than their male counterparts. In the age group of 35 to 44, rates tended to be almost equal for both Inuit men and women. Inuit men between 45 and 64 had lower unemployment rates than their female counterparts. Lastly, Inuit males over 65 had higher unemployment than Inuit women in the same age category.\textsuperscript{10}

4. Social Indicators

The AHF Board of Directors has identified five specific areas where it hopes to see an impact over the long term: sexual abuse, physical abuse, incarceration, children in care, and suicide. In the case of the evaluation of AHF-funded activities, the five selected indicators are closely associated with the impact of the legacy of physical and sexual abuse in residential schools, including intergenerational impacts. In general, improvement in rates measured by these indicators can be viewed as evidence of sustainable healing that break this cycle of abuse. All the selected indicators are related to the goals of the Cape Dorset Healing Project and are issues the project will ideally play a role in influencing. What follows are data gained through both local and territorial government sources.\textsuperscript{11} In essence, the data provide a snapshot in time, and they may be used as a baseline for any future assessments of changing social conditions at the community level.

4.1 Sexual Abuse

Incidents of sexual abuse, one of the key areas the project is concerned with, were reported at six against minors over the 23-month period the RCMP reviewed in their computerized database.\textsuperscript{12} Of those six, five were against females and one against a male. To give some indication of what may transpire after an investigation, Probation Services estimated that only one person per year is charged for sexual abuse. It is important to note that many cases are not reported to police, and of those cases that are reported, not all proceed to charges and trials. For example, the child may be deemed unfit or unable to withstand a court case, they may recant their disclosure, or there may not be enough evidence to proceed with a charge. Also important to note is that police data represent reported rates, which can be influenced by a number of factors including a victim’s willingness to report; therefore, reported rates can differ substantially from actual rates of abuse. Some informants indicated that, initially, many of the healing circles were meant to deal with sexual abuse.

Twelve incidents of sexual assault against an adult were reported by the RCMP. Probation Services estimated sexual assault at two or three incidences per year. Again, some discrepancy exists between these two figures and with the probation figures being much lower.

4.2 Physical Abuse

Figures were secured on level one assaults (common assault) and level two assaults (indictable offences that usually cause physical harm). According to the RCMP, over a 23-month period there were 195 incidents of level one assaults and 24 level two incidents. A RCMP officer at the Cape Dorset detachment felt that these figures have remained steady over the past few years. A follow-up telephone call to another officer who elaborated that of the 195 common assaults, at least half were felt to be domestic disputes, although no hard data were provided. Further, it was estimated that in cases of domestic violence, two-thirds of
the offenders were male and one-third female. Information was not provided on the number of incidents involving child victims.

As with sexual abuse, reported rates of physical abuse are understood to represent only a portion of actual cases. Social Services stated that between 1999 and 2001, the average number of assaults against women each month ranged from five to eight (includes both reported and unreported cases). This would mean that assaults against women would be between 60 and 96 over the course of a year.

The data, along with the issues identified in the project proposal, indicate that both physical and sexual abuse are problems in the community. With respect to sexual abuse, the project has identified the need to address the needs of both male and female victims. Physical abuse, however, has been discussed primarily in terms of male violence against women. RCMP estimates that one-third of domestic disputes involve female offenders, suggesting further work is required to determine the extent to which men are victims of domestic violence and what their needs are in this area.

### 4.3 Suicide

Another key issue raised by the project in their application for funding was that of suicide. Both Justice and the RCMP noted that there were two completed suicides for year 2000. Social Services agreed by saying there were one or two per year. Some key informant responses also supported this by saying these figures have been fairly steady over the last several years. Completed suicides, however, are just the tip of the iceberg. The RCMP also stated there were 20 actual attempted suicides reported but receive many more threats of suicide. This was echoed by Social Services in which they state that for each week there are two to three attempts, averaging 10 per month, which translates into 120 attempts per year if the average holds steady.

The project's fourth quarter report made reference to having the “highest rate of suicide in the eastern Arctic.” This statement is supported by figures released in a document reporting statistics up to 1996. It states that in Canada, the annual suicide rate was 13 per 100,000 people in 1992. Nunavut has an alarming rate of 77.4 per 100,000 from an analysis of data from 1985 to 1996. The Baffin region, where Cape Dorset is situated, shows the highest male suicide rate in Nunavut at 133.9 per 100,000, close to three times the female suicide rate of 47.1 per 100,000. The suicide rate for females in Baffin is also the highest compared to other regions. For all of Nunavut, the male suicide rate (118.6/100,000) is 3.5 times the female rate (33.8/100,000).

### 4.4 Incarceration

The funding application included a letter of support from the RCMP detachment that states, “The community of Cape Dorset in the past has been well known for its reputation as having one of the highest per capita criminal statistics in the Northwest Territories.” While no data were gathered on the community’s incarceration rate, the crime rate in Nunavut is three times the national average, and the violent crime rate is seven times higher than the rest of Canada. There was a minor discrepancy between what was viewed as the number one crime in the community; for example, Justice felt it was vandalism while Probation said it was spousal assaults. Justice also echoed spousal assaults were “really high.” Figures provided by the RCMP show that there were five cases of vandalism with damages over $5,000 and 111 with damages under $5,000.
4.5 Children in Care

The Government of Nunavut Department of Health and Social Services provided figures for all of Nunavut, but do not necessarily include transferred communities. For year 2000, there were 62 permanent wards and 138 temporary wards. It also stated adoptions were at five per year for departmental adoptions, 20 per year for private adoptions, and 250 per year for custom adoptions. Health and Social Services also described a new category called “medically fragile,” where the department becomes involved when a child requires significant medical care, usually in the south, and is not in need of a social worker. The medically fragile designation is separate from temporary or permanent wards. The role of the department then becomes the timely exchange of information and decision-making ability until the need becomes no longer necessary.

Social Services indicated that there was one child in permanent care and eight to 10 children in temporary care, with one child in disability care. Providing figures over a four-month period between March and June 2001, numbers varied between four to 10 children each month in care. On average, they held three to four investigations per month. Figures provided from Social Services were confirmed in a follow-up conversation and from various sources, including client files, client visits, and referrals from RCMP and the nursing station. Table 5 compares children in care for Cape Dorset and Nunavut. It appears that these figures for Cape Dorset are half of Nunavut’s estimates.

<table>
<thead>
<tr>
<th></th>
<th>Nunavut</th>
<th>%</th>
<th>Cape Dorset</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children in care, 2000–2001</td>
<td>200/month</td>
<td>100</td>
<td>10–12/month</td>
<td>2.0</td>
</tr>
<tr>
<td>Population (projected to October 2001)</td>
<td>28,554</td>
<td>100</td>
<td>1,270</td>
<td>4.4</td>
</tr>
</tbody>
</table>

The social indicators point to a community grappling with significant issues of physical and sexual abuse, suicide, and incarceration. The number of children in care, although below the territorial average, is still noteworthy. However, the community has many strengths, including a world-class carving and printmaking economy, a vibrant culture and language, a municipal office, a hamlet council capable of administering a range of territorial programs and services, and an active commitment to addressing social problems through such groups as the CHT and the Community Justice Committee.

5. Reporting Results

The project offered a vision by identifying activities that would serve various groups and by recognizing that at least one group with significant needs—men—was not being reached. A logical place to start was to heal and train a core group of people. The project also took this a step further by wanting a healing strategy that would look at meeting the special needs of the target groups it identified.

Sexual and physical abuse were key issues raised in the application for funding. It also asserted that suicide and incarceration were by-products from unhealed trauma for some victims and described the impact on Inuit spirituality when several losses were felt over time. One of these losses was the cultural autonomy
the Inuit had prior to contact. Forced relocation and the killing of entire dog teams were some of the other devastating losses experienced and described.

CHT members were asked about the needs the project was intending to address. Responses included phrases such as “healthier families,” “healthier lifestyles,” “helping the community,” “supporting victims of sexual abuse,” “help lessen crime in the community,” and “heal the healers first.” Taken together, the impression given is a project that would support the healing of individuals and families and improve the community. When next asked how they would rate the project’s ability to meet those needs, the average score was 4.75 on a scale of 1 to 5 (1 low, 5 high).

Before more findings are presented, the reader is reminded that the CHT members played a dual role. First, they used the approach of “heal the healers first.” They further stated: “We have supported and sustained our ability to help others heal by first starting to deal with our own issues with the help of resource facilitators whom we have hired to deliver weekly healing and training workshops in our community and to provide individual counselling.”

Not only did CHT members participate in planning and healing activities, but they also considered much of these activities as training to build their capacity to support others.

Thus, there is a link between efforts to heal individuals and the healing of families and communities. For example, one informant noted that in the process of working on her own healing, her husband changed (i.e., emotionally and in how he responded to her). Likewise, as several Court Elders were actively involved in the project’s healing activities, the growth they experienced may have an impact on decisions they were making on behalf of individuals involved in the court process. One elder mentioned being “scared to do these jobs until I took healing.” Other responses focused on the home and family:

- “I really liked healing, many times I realized I’m at peace at home, towards my family.”
- “Being more open as a parent, trusting yourself more—like who is safe and who is not. You learn these things through healing ... people talk now, as I’ve learned to talk to my kids.”
- “We learned to not only deal with our own depression, once there we learned to cope ... we learn to recognize it instead of saying ‘you stupid kids’.”

The project consistently links the healing and training activities and offers no clear distinction of purpose between these two activities. A third level of integration involves the project’s use of the word “caregivers,” which appears inclusive of both paid and volunteer counsellors. In a booklet on counselling skills, Pauktuutit Inuit Women’s Association defines the term as follows:

We use the terms “caregiver” and “counsellor” throughout this handbook to refer to people who counsel. A caregiver can be anyone — a friend, family member, neighbour, teacher, elder — anyone who cares enough to listen and offer support. Also, anyone can be a counsellor, although some are paid counsellors while others are volunteers.

It is important to note that some of the CHT members also have professional roles within the community, such as working at a women’s shelter or being Court Elders, and many spoke of very personal first-hand experiences. In several areas, informants indicated that people approach them on their own time, like on the streets, to ask for help.
5.1 Impact on the Individual

The interviews began by asking people to describe their role in or relationship to the project. This question was asked for two key reasons. First, the process was not aimed at interviewing “clients” or participants directly, and this was mainly for safety reasons and an inability to offer counselling if issues triggered participants negatively. Second, the interview process wanted to identify the professional roles individuals held. Given that CHT members also viewed themselves as participants, there was a need to identify some distinction between personal and professional interests. Key informants included Court Elders, facilitators, standby facilitators, members of the CHT and planning team, and two people who had acted as the project coordinator. One person mentioned he/she began as a participant and then moved on to become a CHT member involved in planning and standby facilitation.

Nine of 10 respondents reported seeing changes in project participants. They provided examples of changes in attitude, such as "growing up emotionally," "people are happier," "healthier," and more positive in their attitude. As well, changes in behaviour were observed, such as more teens participating in groups and talking openly; people being more stable and fun to be with; and the CHT working together and supporting each other during crises. During the interviews, it was noted on at least two occasions that an informant hesitated in responding, seemingly to protect individual confidentiality. Observed changes included the following:

- “I can tell people are able to deal with issues in a way they didn't know before. Very obvious, not just crying and crying anymore.”
- “A lot of health, people are happier, more able to cope with own personal lives. Brought more light into our community, more hope.”
- “People grew up not in terms of age, but emotionally. They became stable and fun people to be with.”
- “I have seen big changes, for example, in a crisis we can work as a team and support each other.”
- “This year there were more teens participating, quite determined to take healing circles, start off with crafts, they talk while making them. When it comes time to go, they hate to leave. On average, ten girls attend.”

From these examples, it is clear that key informants saw attitudes and behaviours changing as the project progressed. Table 6 shows responses to a list of specific changes sought by the project. All respondents felt that there were improvements in areas of self-esteem, understanding sexual abuse, healthier coping patterns, and dealing with depression. A near consensus (9) also felt improved self-esteem for youth and that both talking about and not attempting suicide were areas offering notable changes for participants. The areas where less change was noted related to abusers/men getting help to stop violence and men and women getting treatment. Questions were asked specifically for each group: abusers, men, and women. Some informants were not sure because they were only involved with one particular group (e.g., teens, women). Of note is the closure of the alcohol and drug abuse treatment centre in Iqaluit that may have affected these response areas.

Overall, it appears that key informants believe the project is leading to improvements in key areas of participants' lives. Issues that can be dealt with through positive, supportive measures and provision of information (education and training) show the highest level of observed changes in individuals: healthier coping patterns, improved self-esteem, understanding the effects of sexual abuse, dealing with depression
and thoughts of suicide, community support for Elders, and a stronger CHT. In each case, either nine or all 10 respondents noted positive changes. The lowest area of observed improvement is men receiving treatment, not surprising since the alcohol and drug treatment centre in Iqaluit had closed. The fact that more people observed changes in women receiving treatment may be due to more women being involved in the healing project and dealing with these issues. Only four of 10 respondents saw improvements in abusers getting help to stop physical abuse and violence. Five saw improvements in men dealing with violent behaviour. This observation may be related to the low levels of male involvement in the project either because men are not addressing these issues or because key informants are unaware that men are seeking and getting help elsewhere.

Table 6) Observed Changes in Participants Involved in Healing Activities

<table>
<thead>
<tr>
<th>Healing Activity</th>
<th>Number of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Healthier coping patterns</td>
<td>10</td>
</tr>
<tr>
<td>Better self-esteem</td>
<td>10</td>
</tr>
<tr>
<td>Better self-esteem (youth)</td>
<td>9</td>
</tr>
<tr>
<td>Understanding sexual abuse</td>
<td>10</td>
</tr>
<tr>
<td>Dealing better with depression</td>
<td>10</td>
</tr>
<tr>
<td>Talking about suicidal thoughts</td>
<td>9</td>
</tr>
<tr>
<td>Not attempting suicide</td>
<td>8</td>
</tr>
<tr>
<td>Victims getting help for violence/abuse</td>
<td>8</td>
</tr>
<tr>
<td>Abusers getting help to stop violence</td>
<td>4</td>
</tr>
<tr>
<td>Men getting treatment*</td>
<td>3</td>
</tr>
<tr>
<td>Men dealing with violent behaviour</td>
<td>3</td>
</tr>
<tr>
<td>Support from Elders</td>
<td>2</td>
</tr>
<tr>
<td>Community supporting Elders</td>
<td>1</td>
</tr>
<tr>
<td>Women getting treatment</td>
<td>2</td>
</tr>
<tr>
<td>Stronger community healing team</td>
<td></td>
</tr>
</tbody>
</table>

* The term “treatment” was understood by most interviewees to mean alcohol/drug treatment.

In addition to the changes noted in Table 6, six respondents mentioned other changes they observed, including improvements in how the CHT is working together and in how participants see their worthiness and employment opportunities in the community:

People are becoming employed who usually were unemployed. Opened up areas to be employed in. For example, “I only speak Inuktitut therefore can only clean or cook” mentality. Now people are going after their dreams. Two Elders/land guides are writing a proposal for “On the Land” project. Women are looking for jobs and believing they can do it.
Respondents were asked how the training workshops helped and to give an example of a skill they learned that could help them support others. Responses show that a variety of changes occurred in participants’ attitudes and behaviour:

Helped me to deal with personal problems, recognize which ones I had. Helped me to make healthier choices, to not commit suicide. I’m worth something. I’m a better parent. More outgoing. I don’t know if I’d be alive today to be exact, if I didn’t look in that area ... If I didn’t have friends in the group, I don’t know where I’d be. I have healthy self-esteem, it made me grow. When you are a sexual abuse victim, it can be for years. Call yourself a survivor when you get help, I am one.

A couple of respondents mentioned that other people have seen changes in their lives and now approach them for counselling. This is the essence of the Cape Dorset approach: begin by healing the healers and then the ripple effects will reach out into families and communities.

I have benefited a lot because I am able to help. I don’t advertise it, people see changes I’ve made in my life and people come to me based on that.

I can listen to people when they talk about abuse/victimization. I’m able to support them through stages so they can better cope. I’m also aware of not feeling responsible or to be a fixer.

Before healing, people didn’t approach me. Now, out on the streets, people come up and ask for help. Big difference in my life. We also hear about men’s healing sessions on radio. In court, I advise them to attend.

Others spoke about being more confident because of the training, becoming more aware of being a role model for younger people, having increased self-awareness to make better life choices, and being able to share what they learned with others. In terms of concrete skills, listening was most often mentioned, followed by being able to recognize when another is in pain: “Recognizing what the other person’s needs are. Very hard time listening, but it’s a skill I learned. Haven’t learned to do the dishes yet.” Others mentioned learning breathing exercises and massage.

Summaries of participant evaluations were provided for four of the training workshops. All four evaluation forms used a scale of 1 to 7 (low to high). The four workshops were: Team Building, 27 September –1 October 1999 (12 completed evaluations); Healing for Men and Families, 15–19 November 1999 (12 completed evaluations); Teen Healing, 6–10 December 1999 (five of nine completed evaluations); and Group Process and Sexual Abuse, 7–11 February 2000 (14 completed evaluations). For each workshop, participants were asked to rate content, delivery, and participation. Average scores ranged from 4.2 to 6.5, with the content and delivery of three of four workshops averaging six or higher. It is clear that since the score was out of seven, most were very satisfied. The evaluation form did not address issues of participant needs and expectations, and summarized responses to questions about participant learning would have benefited from more detail.

5.2 Impact on the Community

While it may be too soon for the project to truly have an impact, there is evidence that some impact is being felt. This observation is supported by two reasons: 1) although the project has only received funding from AHF for the last two years, there were prior efforts on a smaller scale since 1995, allowing greater time for impact on individuals; and 2) many individuals in key roles within the community (i.e., Court
Elders, probation officer, school counsellor) have been involved in healing activities, allowing personal growth to perhaps also influence their professional roles.

Respondents were specifically asked to give an example of how the community has benefited from the project. Several describe an increased skill level or an increased capacity to deal with crises: “Caregivers have a big job, they are available at deaths, crisis. They now have the tools to deal effectively in these situations”; and “I can only use myself as an example. Before, I had a lot of pain but didn’t know that. Now I can identify when people are in pain, in need of help. People come to me and I can say I’ve been there.” The collective impact of having a number of individuals involved in healing who live and work in the community and are walking the walk and talking the talk is evident in the following response:

[There is] more hope. We have more capable people to make it a healthier place. This may happen just in their family but also at the community level. My family is better because of my participation. It has a domino effect. Kids will learn this stuff too. More people are like that now in our community, not in denial about problems. We can face reality, see what it is. Have better problem-solving skills. More awareness of sexual abuse, spousal abuse, and now can say that’s not okay. In the long run it will be less and less okay, people won’t just hide their heads. Even if my kid was the abuser, I’d deal with that.

At a practical level, the project increased the number of traditional activities available in the community while providing opportunities for community members to be involved in concrete supporting roles, such as transporting people and supplies to camps. In the process, understanding and support for the project may have increased:

Youth have been able to go on the land. Women’s Planning Team group have been able to go on the land too. On both these occasions, community members were offered a chance to participate directly or indirectly [e.g., transporting people/supplies using own gear, hunting for animals, etc.]. Men’s group has been started, with struggle. People in the community are leaning towards believing that workshops and gatherings are beneficial to the community as a whole, having seen and heard from those who have taken workshops. More people are beginning to open up and stating that healing needs to be done, by people who have not taken the workshops or those who have participated fully or partially.

In terms of how AHF funding has supported opportunities to create a positive and meaningful impact, this quote offers some insight:

Funding for healing has had a big positive impact on community. We gain information we otherwise wouldn’t have access to. We come to understand different types of pain. In that way, we can offer support to those in need. I’d like to see dollars come forward, only way to hold our heads up. One goal is to have all community organizations and agencies come together as one, with no barriers.

In addition to asking respondents for an example of how the community has benefited, they were asked to describe any changes they saw in rates of physical and sexual abuse, suicide, incarceration, and children in care since the project began. Based on the program logic (Appendix 1), decreases in rates over time can be viewed as indicators of the project’s success. However, Figure 2 shows that there is no clear pattern to the responses, as most did not know whether rates of sexual abuse and children in care had changed, and half the respondents felt that rates of physical abuse and suicide had decreased. Over half felt that incarceration rates (a community problem identified in the funding application) had stayed the same.
While individual perceptions of change can differ from the reported and actual rates of abuse and suicide, they can be important indicators of how safe a community feels of its inhabitants and how key informants feel about the project’s impact over the long term.

Figure 2) Perceptions of Changes in Rates Since the Project Began

The majority (8) were uncertain about how rates for sexual abuse had changed, but three people did suggest rates had gone down. When asked to further explain their reasoning, similar responses were provided, such as: “out in the open and talked about more.” The following quote from a person who felt rates had gone down further exemplifies this reasoning:

Being more open as a parent, trusting yourself more, like who is safe and who is not. You learn these things through healing. I think it’s lower. If people [abusers] hear they’d have a harder time continuing with that behaviour. More chances of getting caught. People talk now, as I’ve learned to talk to my kids.

While this quote and others suggest, openness and breaking the silence around sexual abuse leads to lower rates, which may or may not be what actually happens in the short term. For example, it may initially lead to an increase in reported rates, but over the long-term healing process along with talking about the issue more openly, this may eventually prevent actual abuses. For those who did not know, two felt that “it [sexual abuse] wasn’t talked about enough,” and one person said they were not directly involved in this area. Two respondents gave no explanations, while one said his/her reasoning was because “nobody had disclosed.”

On the issue of physical abuse, half the respondents felt rates had gone down. Of those who offered explanations, most responded similarly with, “don’t see as many women and kids with visible injuries” or “don’t see people with dark glasses and black eyes.” Three people did not offer explanations, and one person
who worked at the women’s shelter stated, “a lot of women come to the shelter.” This person felt that rates were the same. Four respondents said they did not know whether rates had changed. One person who did not know how rates had changed stated that “few people report to the RCMP.”

As with physical abuse, half the respondents felt that suicide rates had gone down and several felt that “survivors talk more openly now over the loss of a loved one” or “attempted [suicide] people share their stories.” (The term “survivor” in this quote is felt to reflect a survivor of suicide and not a residential school Survivor.) One person responded by saying, “it won’t change overnight, we won’t fix all that.” Again, three people did not offer an explanation and one person chose not to say. One person stated that “one member of the CHT had a child commit suicide,” yet felt that rates had gone down.

For children in care rates, more than half (6) said they did not know if rates had changed. However, two people spoke to reasons why children may be placed in care, such as, “I’ve seen two women who fled abusive situations” or “there’s a good and bad side to this. Good when people put their kids in care to protect them, but more kids [in care] means something is wrong.” Several respondents who were former foster care parents or grandparents who had taken in grandchildren felt that they did not know if rates had changed.

Slightly more than half (6) of the respondents felt that incarceration rates stayed the same. One person said, “people go out, others come back, just trading places,” while another said, “always the same ones in and out.” One respondent felt, “men aren’t really involved, it [rates] would go down if involved.” (Although not directly stated, based on this person’s previous responses to questions on the other indicator data, being involved appears to be in reference to being involved in healing.) Another respondent cited an observation by a MLA (member of the legislative government) who thought there were less people from Cape Dorset at the Baffin Correctional Centre. Two people gave no explanations while another stated, “one thing that contributes are court date delays. People are under stress and end up doing things that lead to incarceration. They have court hanging over their head.”

Two of several Elders on the CHT offered the following insights: one said, “I can say healing is a major thing, don’t joke about it, it’s a process, difficult thing to do, especially for new participants.” This reflects a sound understanding that shows this project was meant to address serious and difficult issues. The second Elder described behavioural changes in this way: “[the] community has benefited greatly, I see more involved, especially young people. I see them enter healing earlier. The population is growing, and would like to see the healing project carry on. I’m one of the Court Elders, [and it’s] not hard to see who needs healing.” Again, it speaks to how the needs addressed by the project are being felt and observed.

Without knowing what rates were in previous years leading up to this project, it is difficult to determine why some issues seem to bring a discrepancy between informant observations and figures provided by various other community sources. For example, with physical abuse, half the respondents felt that rates had gone down, yet the RCMP reported 195 common assault incidents over a 23-month period. Likewise, sexual assault figures from the RCMP were at 12 over the same period. Probation Services stated that there were two or three assaults against women each month and that these figures have remained steady. In this case, we are unsure whether the 12 cases cited by the RCMP involve only women or males as well. Therefore, it is difficult to say whether these two figures or if a wider variance is occurring. For suicide, half the respondents also said rates had gone down; yet again, both RCMP and Social Services report high figures, such as one to two completed suicides each year and up to 10 attempts each month.
Although half the respondents did not know if children in care rates had changed, several gave examples such as, “used to take care of them, haven’t got any lately so I don’t know” and “I’ve seen two women who fled abusive spouses, never saw them with their kids before until recently. This won’t leave here.” Two respondents actually felt that rates had gone up by stating that it was, “not the ones [children] of the participants, but it has gone up in the community” and “see a lot of foster parents, don’t have too much information.” As noted earlier, Cape Dorset rates are lower than the Nunavut average, but the data do not show how rates may have changed over the past few years. Also, without further research, it is impossible to determine the reasons for the lower rates in Cape Dorset compared to Nunavut as a whole.

5.3 Partnerships and Sustainability

The AHF national survey listed several key community agencies as being linked with the project: Social Services, Tukkuvik Women’s Shelter, and the Justice Committee. A majority of project activities occurred at the Justice Building, except for on-the-land camps and perhaps community awareness sessions. The funding application itself listed a school community counsellor, lay caregivers from Anglican and Full-Gospel churches, a community health representative, and a health centre as additional supports, partnerships, and linkages.

The application further listed the RCMP and the hamlet under linkages and partnerships. Letters of support were submitted from the RCMP, municipality of Cape Dorset Department of Social Services, the hamlet (municipality), Uqaujjiaqtiiit Justice Committee, and the health centre. Both the hamlet and the Justice Committee were the largest donators of goods and services, with community members being first.

For the year under review, the project’s final quarterly report for the year cited that 17 community caregivers had received training while listing 19 front-line workers. There is no explanation as to why there are two different figures here. In keeping with the CHT being largely the project team, this would suggest a total of 17 or 19 members. Several were affiliated with the agencies listed above along with several who had no designated affiliation. A subsequent list from the project’s second year of operations provided a list with 12 additional CHT members, which suggests a broadening of the base was occurring. Also, it was stated during informant interviews that an average of eight to 12 people participate in planning on a regular basis. One person mentioned that they liked the fact that many Justice Committee members participated in the project, thereby developing their capacity to deal with offenders.

An interesting observation of a strained relationship was noted between the Justice Committee and Probation Services. One person felt that “a lot of gossip” was coming out of the other office, while another said the relationship was “at a dead end” and that the RCMP would act as a go-between when referrals were necessary.

Another discrepancy is that both churches were listed as being a support, linkage, or partner; yet it was evident through the informant responses that one of these churches was more opposed to or divided on “healing.” A colleague, fluent in Inuktitut, suggests that perhaps the discrepancy could be caused by the interpretation of the Inuit word for healing. Mamisaq is usually meant as physical healing and, thus, some people do not apply it to mean healing from sexual abuse or other trauma. The issue of the usage of the word “healing” was echoed by a couple of informants, as one said, “if it could be changed.” Whether or not
this is the case is unclear, as informants gave examples that suggest the church’s disagreement on “healing” was based more on seeking repentance for sins committed and less on the need to gather and heal from the traumas experienced. However, there was no opportunity to interview members of this church as they were not members of the CHT. These two discrepancies indicate that some partnerships were not being realized.

From the information gathered, it is unclear whether strong partnerships were developed. If the CHT is examined strictly from a multi-agency perspective (i.e., school, church members, probation, and women’s treatment centre), then certainly the Justice Committee with several members on the CHT were strengthening ties within the community. Most of the examples provided during informant interviews seemed to depict a sense of personal growth that could assist individuals in their professional roles. It is also difficult to assess how well ties to other agencies were creating adequate partnerships. For example, no evidence was provided to identify whether referrals were being handled differently. There is, however, the aspect that the CHT seemed “stronger,” with responses like, “I’ve seen the team, they are able to work together,” reflecting a cohesiveness. Further, the core group has remained steadily involved. Those involved on the CHT through the healing and training as well as planning have developed a core group who are comfortable enough with each other that partnerships in their professional capacities can be realized. There seems to be a need to increase efforts to bring understanding and, perhaps, to increase cooperation with the opposing church and Probation Services. Without interviewing a broader sampling of community agencies, it is difficult to provide a more accurate assessment of these ties.

In terms of sustainability, there is strong evidence from informant responses that suggest the efforts behind the project could continue, with or without AHF funding. Five of eight respondents either agreed or said something like, “if there is a strong desire to continue with it on a voluntary basis and/or to seek funding elsewhere.” Of the remaining responses, most did not state outright that they would close down. Some speculated as to how they might continue without AHF funding and all seemed to indicate a desire to have the project continue in some form, such as a scaled-back level if funding ceased or with volunteers.

5.4 Addressing the Needs

Eight people answered questions about the needs the project intended to address and its ability to meet those needs. While responses varied considerably (and some of the answers did not directly address the question of need), there were two references to improving the community and three to healthier lifestyles or families. Two people spoke about working with or supporting sexual abuse victims; one of them also mentioned the need to “heal the healers first.” In addition, one person mentioned training. In rating the project’s ability to meet these needs, the average score was 4.75 out of 6, which ranks just below category 5 defined as “very well, but needs minor improvements.” In contrast, the project received an average score of only 2.8 on how well it had been accountable to the community. Reasons tended to focus on the need for more outreach to and feedback from the community.

While most respondents felt that the project’s methods, activities, and processes worked reasonably well, there was a recognizable gap in relation to men: “Not enough participation from men, especially sexual abuse victims.” “Men’s healing is struggling.” “It’s happening, I know there are men out there but not sure what will reach them.” However, project files and interviews confirm that women’s and teen girls’ groups are well-established and that Elders are represented on the CHT and have participated in healing and training activities.
5.5 Successes and Best Practices

As noted throughout this study, key informants cited the project as having a positive impact on individual participants with respect to their personal healing and by providing knowledge and skills to improve their capacity to help others. In the latter case, there was some evidence that participants’ families and the community at large benefited. One success noted in the second quarterly report was that the CHT had established a mission statement, goals, objectives, a code of ethics, guiding principles, and CHT rules. All of these show proper planning and orientation for the CHT on how they will operate. It puts into place a safety system to ensure clients and participants will have a greater chance to deal with their issues in a safe environment where everyone knows their role.

Another good practice is the training to identify unique needs for certain groups (teens and men), which demonstrates adequate planning instead of just assuming the group knows what teens or men need or want. The main difference between a good and best practice can be that best practices have approaches with proven track records as their strength. Several other successes were also noted, mostly from quarterly reports. The on-the-land camps were described as “one big family,” and an earlier reference was made as to how people and groups helped, such as with transportation. This simple activity obviously succeeded in bringing people together in the community to offer support in tangible ways. Two other successes mentioned were child care for women so they can attend healing activities and the use of local facilitators. In addition, quarterly reports mention special circles to close different components or periods, such as before Christmas. In this way, participants were offered opportunities to mark progress and not be left alone without the group acknowledging the potential stressors that could come during the Christmas holidays; for example, when offices may be closed. In general, it appears that the project carried out its programs in a well-planned and responsible manner.

The national survey responses stated the best practices were: 1) healing and training are well-attended by caregivers and team members; 2) facilitators receive training; and 3) teen group is activity-based fun (i.e., crafts). Although attendance itself is not a best practice, this may allude to the fact that steady attendance is a key element to the healing and training for this core group as opposed to an individual attending just once in awhile. This is also true of facilitators who receive training; it would not be a best practice in itself, but may demonstrate that the facilitators who are local people are being adequately prepared before delivering or facilitating circles. Having a teen group that consists of activity-based fun may in fact be a best practice, as it speaks to the need to utilize an appropriate approach that fits the target group. In this case, teens would likely require activity-based efforts as opposed to only counselling or group discussions on heavy and emotional topics. More than one informant described how teens interacted and spoke while making crafts, and their self-esteem grew when they made something.

There may be some slight variation for what a best practice is and what constitutes a success (or good practice). Best practices can be proven methods or securing ideal circumstances that, when properly done, can have the desired results. This means having adequate knowledge of the issues so that ideal services and people are in place to respond to an issue or situation. An example of a best practice could be hiring people who have stopped using alcohol and drugs and who have completed adequate healing work on themselves to work as alcohol and drug counsellors. It allows the client to know that the counsellor understands what they are going through because the counsellor went through it himself or herself. A success (or good practice), can be steps taken that may eventually lead to a desired goal and could be a by-product of
certain efforts. For example, an awareness session may only reach one or two people and could be seen as a success; however, if there are significant issues in the community, then it would not be enough to just stop there. As one informant put it, “one prevention is better than no prevention at all.”

The training workshops were provided by outside facilitators, mostly from southern Canada and one from another Nunavut community. There appeared to be a concerted and well-planned effort to bring in qualified trainers and thereby develop the capacity and skills of local caregivers. In one workshop, an Inuit couple from Pangnirtung provided training on men’s healing and healthy relationships. While in the community, the couple worked with the CHT to plan and organize a community healing awareness workshop that drew over 60 people, including 15 men. Another workshop described in the third quarterly report as “experiential training” combined healing and training activities for a core group of caregivers. Without detailed participant evaluations, not enough data exist to call this or any of the training sessions a best practice. However, experiential training as an approach is far more emotionally involved than simply presenting theory or information on a subject. It can allow participants to process their own issues and, in turn, improve their ability to understand and support others who may be experiencing similar challenges. This appears to be the thrust behind this project and, based on key informant interviews, is working well.

The most clear example of a best practice was mentioned in the fourth quarterly report. It spoke about how “modern techniques/approaches are chosen based on how they fit within Inuit culture (values, approaches and philosophy of life).” Also, Inuktitut is used as well as simultaneous translation, and many Elders are part of the team. Best practices take into consideration the environment where the work is being done. If only English was used, no Elders were present to speak about Inuit cultural and traditional ways, or approaches were being forced on participants that were not culturally inappropriate then it would be highly unlikely the project would reach anyone. The fact that the CHT includes Elders, the Inuktitut language, and Inuit culture as integral parts of the process and that “modern” techniques and approaches are incorporated to fit within the culture are all felt to be a best practice. For example, when male victims returned home from a trial in Iqaluit of a male teacher charged with sexual abuse, several key groups, including the CHT, “welcomed [them] back with a special community gathering.” This shows not only community spirit but also cultural ways of showing support. The following quote further supports this best practice:

In the training workshops our Elders share from their experience the traditional life and traditional values that emphasize a caring, sharing practices within an extended family. That the Healing Team members are Inuit; we use the modern therapeutic approaches that fit within the Inuit values and approaches. Our pair of trainers were Inuit (in the previous reporting period) and their healing approach combined imagery of the natural world of creation and the Inuit life practices to present an understanding of personal growth through life crisis. Other training facilitators from southern Canada were chosen because of their experience working with First Nations and Inuit people and their training is sensitive to and their approaches respect Inuit values and philosophy of life.

5.6 Challenges

The national survey listed a challenge of “getting men involved because of their need to appear strong.” Involving men still remains a challenge, but having said this, there are several examples that may be deemed progress because they may eventually lead to more men getting involved in healing. One example found in quarterly reports was that men attended the community sessions. If these sessions had not taken
place, then there would have been one less avenue for men to hear about the project. Support was also requested by the male sexual abuse victims of the teacher on trial mentioned earlier. Obviously, there was enough knowledge of the project to recognize that support could be found there. This was taken a bit further with the special gathering that was held upon their return. Also, an experienced male facilitator held two men’s groups that were well-attended. All of these can be seen as progress because there were opportunities to offer support.

This project may not be all that unique in their difficulties to recruit men. Reaching men was consistently raised in the documentation as an objective or target group the project wanted to address. Some responses suggest that the men’s group did start but not without a struggle. Quarterly reports outline that men have begun attending, although figures were very low.

This study cannot provide an accurate assessment of why men have only become involved under certain instances or circumstances (i.e., community workshops or request for support at Iqaluit trial). Two quotes found in quarterly reports may provide part of the answer. For example, one report stated, “men in the workshop expressed a desire to start up a men’s group, but wanted someone experienced leading them.” In another report, “more men in our community need to be involved in the healing training workshops over a period of time to gain the knowledge and skills to help counsel other men and lead a men’s group.” From these two statements it may seem like men were left unfulfilled, first by expressing their need and desire for an experienced facilitator and then to have this need denied because no qualified men were available. A downside to this may be undue pressure on a participant to eventually become qualified enough to lead a group when all he may have wanted is to heal his own personal traumas. This, however, is speculation as informant interviews and other data do not offer any more insight into this matter.

Whether male involvement in healing activities was impeded by group sessions, male/female groups, or other barriers such as fear and denial are a matter for more research. The project’s statistics show that 15 men were involved in individual counselling, but there is no explanation into how these men became involved or if it was on a one-time or ongoing basis. With respect to groups, one key requirement when dealing with sexual abuse is the need to keep perpetrators and victims separate. This may also be true for physical abuse to avoid blame, anger, and manipulation until a person is able to safely examine one’s own behaviours.

One resource developed to deal with Aboriginal men who abuse their spouses outlined several underlying philosophical perspectives, one of which was, “group work with abusive Native men is the most powerful forum for the confrontation and ultimate healing of men who have been violent. Individual counseling continues the isolation and secrecy around the issue and couples/family work is potentially dangerous prior to substantial work with the abusive male.” However, it is unclear whether this barrier was more centred in programming or recruitment approaches or whether emotional barriers were the main factor. One informant reflected, “the time will come for men to move forward, we’re just not there yet.” Several individuals continued to state the need to target men, and the general feeling was that until they get healing, the community would not be balanced. One person offered this solution: “[we] mostly use radio announcements, maybe personal invites might work to male sexual abuse victims.”

The project’s difficulty in involving men may be something other healing and training projects also experience, and an opportunity exists to explore the issue in greater detail. For example, it would be helpful
to know whether it is a recruiting problem: *If participant recruitment was done differently, would more men come?* Or a programming issue: *Do the kinds of healing and training programs offered appeal to men? Is there a difference between male participation in group events and in individual counselling?* The CHT may wish to pursue these questions with men in the community, perhaps through a survey, needs assessment, or just speaking with a wide variety of men.

When key informants were asked in an open-ended question to identify challenges or obstacles faced by the project, a variety of responses ensued. Figure 3 summarizes these challenges.

**Figure 3) Summary of Identified Challenges**

<table>
<thead>
<tr>
<th>Challenge</th>
<th># of Respondents (n=10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertainty over funding</td>
<td>2</td>
</tr>
<tr>
<td>Public scrutiny of facilitators</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty involving men</td>
<td>1</td>
</tr>
<tr>
<td>Resistance to healing (individual)</td>
<td>5</td>
</tr>
<tr>
<td>Programming issues (low attendance, finding trainers)</td>
<td>4</td>
</tr>
<tr>
<td>Resistance to healing (church, community)</td>
<td></td>
</tr>
</tbody>
</table>

Finally, the national survey response to what will improve the project was: family counselling sessions and family retreats out on the land; local healers to provide more healing activities in the community or out on the land; more activities for pre-teens and more recreation and land programs; and to find the approach to get more men in the community to start healing and have more balanced healing for families.

### 5.7 Lessons Learned

Whether it was a lesson learned before this project began or after, the fact that the CHT wanted to “remain focused on building community capacity,” as stated in quarterly reports, is a sound approach. It is unclear if this was prudence or lessons learned from previous attempts that prompted this measure. Several examples of lessons learned were found in quarterly reports, such as: bring in more male/female trainer teams; heal the healers first, recognizing they had to deal with personal issues first (personal growth); and hesitant to start a men’s group unless men can get healing and training to support the group.

The NPES stated that “one person cannot heal the community, [it] takes a team approach [and]... [t]eam effort is productive” is a lesson learned. Quarterly reports state that “the men wanted experienced group facilitators.” There were two male Elders on the CHT, and quarterly reports indicated that one or two male members attended the circles included at the planning sessions. Given the hesitancy stated earlier to start a men’s group unless more men received healing and training could be deemed as a cautious approach or lesson learned derived from program experience. Yet, it is unclear whether this lesson was learned through this project or from other efforts. In one response, an informant noted that teen girls and older women
were being reached, but there was a gap for ages 19 to 30. An attempt was made to seek more funding to cover this age gap in order to reach all women. “[W]e all need to recognize that it took two generations for our community to get to a state with the highest rate of suicide in the eastern arctic, high rates of incarceration, and all the other issues we face.”

6. Conclusion

A review of the project’s short-term outcomes suggests that progress is being made in a number of areas:

- increased skill and capacity of caregivers to support healing within their family and community;
- increased capacity to effectively manage individual and family crisis;
- strong, effective CHT;
- overcoming powerlessness and hopelessness; and
- increased sense of pride in culture and spirituality as it relates to healing.

Evidence of this progress is found in key informant responses to questions about observed changes in participants, benefits to the community, and skills learned in training sessions. It is corroborated by information submitted by the project in quarterly reports and the national survey. Although progress likely started with those first steps taken prior to AHF funding, what became obvious was that this funding afforded the project adequate resources to firmly establish healing and training to a core group of people. Several informant responses refer to the impact of this, such as: “people grew up, not in terms of age, but emotionally” and “very obvious, not just crying and crying anymore.”

Attitudes among participants have changed, which is an important aspect when you consider this description by a Court Elder: “I used to be scared to do these jobs until I took healing ... I used to dislike criminals before I started my healing. I thought they did everything by choice. Apparently it was me who had the pain.” Also, behaviours have been affected as other informants indicated through these examples: “I must be a good role model, I shouldn’t do things that would turn people away”; “it helped me to make healthier choices, to not commit suicide”; and “I’m worth something. I’m a better parent.”

Skills and knowledge have also increased as indicated by the following response during an interview: “learned to listen to a person in need of help, who is needing someone to talk to. Understanding and dealing with a suicidal person. Understanding grief helped me a lot and the affect [of grief] on a person.” This respondent gained skills in listening and providing knowledge and skills that could lead toward helping someone who is suicidal. Several others offered learning about what their children may be going through as sexual abuse victims.

The project was designed to “heal the healers first,” an approach that can only benefit those the core group comes into contact with: family members, community members, and clients in professional roles. Having a number of Elders on the CHT who also play active roles in planning is another example of designing and implementing both healing and training that invest in its own people. This fact is especially true for remote northern communities that do not always have the resources to fly in outside facilitators. One caution is in regards to men; although there is a need to take a closer look at why male involvement was low, there needs to be continuous well-planned efforts that do not place expectations on an individual to become a group facilitator or role model. In all cases, a person must choose and be supported to enter
healing for personal reasons. Spinoffs such as whether some men eventually assume roles that can lead to supporting others must be a secondary wish.

It is also clear that, for whatever reason, the word “healing” creates some division. Whether the term is misunderstood may be partly at issue, as three informants offered similar observations such as: “When radio announcements about healing happened, there was public resistance. Some didn't like the word ‘healing.’ I haven't heard that in awhile. Some entered healing when they didn't like that [healing] in the first place.” The announcements were amended and it now appears that as the project continues less people seem to be resisting the concept. This shift in the way some community members viewed healing may be found in examples such as community members helping transport people to on-the-land camps. One informant said:

People in the community are leaning towards believing that workshops/gatherings are beneficial to the community as a whole, having seen and heard from those who have taken workshops. More people are beginning to open up and stating that healing needs to be done by people who have not taken workshops or those who participated fully or partially.

The matter of a “healing strategy” is one that did not become obvious through the case study process. No document was made available and it appears that the healing strategy was more a work in progress that centred around healing and training, community awareness/gatherings, on-the-land camps, and planning and evaluation to discuss how better to reach men particularly. Perhaps needs assessment, especially dealing with men’s issues (as with other target groups), would better define a healing strategy. The CHT did, however, produce a mission statement, goals, objectives, and a statement of values and principles to guide its work.

A number of challenges still remain for this community and project. Evidence suggests that less progress was achieved with respect to increased capacity and effectiveness in serving hard-to-reach people, especially men; and community healing in areas of lateral abuse, violence, sexual abuse, and suicide. Indicator data show that suicide, physical abuse, sexual abuse, and incarceration rates remain high, and there is no consensus among key informants that these problems are decreasing. But a ripple effect is being witnessed as many informants spoke to how their families and partners have benefited.

The healing has begun for many in this small community. The spirit behind this project is strong and was often reflected through the very personal testimony that came through informant interviews. Although many expressed personal trauma, all gave examples of how their own journey has been made easier by the project and the CHT. Some spoke of healing from sexual abuse, others said they had stopped drinking alcohol, while others talked of gaining new jobs that they directly attributed to their healing journey. The Elder who inspired the title of this study is, again, quoted here:

Within healing, there’s something you can’t see but I’m aware of. In the past, I was not ready. I’m still learning to understand, share experiences, recommend choices. Determined voices. I’m willing to teach my people. That is my gift to my people. It’s not material, but it’s something.
7. Recommendations

This section will present recommendations in two key areas: 1) programming issues; and 2) evaluation issues.

Programming Recommendations:

- The issue of male involvement was by far the most frequently mentioned area of concern. From a programming perspective, some pieces are falling into place, such as the community awareness sessions and the request for support during the trial mentioned earlier. Ripple effects are being felt for some men, as their partners continue along in healing. Because men are also in counselling (court-ordered) offered by Probation, it is recommended that greater efforts to partner with Probation take place to: a) gain wider access to men in a captive audience; and b) utilize this opportunity to identify and support men in their healing on a personal level first. A secondary focus should be the eventual facilitator role that is being sought for the men’s group, so as to avoid undue pressure on men who may be solely interested (at this stage) in personal healing.

- Because men have expressed a desire and/or need to have experienced group leaders, it is recommended that more male facilitators be brought in until such time enough interest is generated to begin a group. In the absence of a group, this may create a key opportunity in providing some support that may trigger a willingness to become more involved.

- Men in the community should be asked directly about their healing needs and preferences. This could be done informally as well as through formal processes, such as a needs assessment or community survey.

- The project has already responded to some community and church resistance to “healing” by amending their radio announcements. As several people seemed to centre on the word “mamisag,” there may be opportunity to engage in broader discussions on finding different ways to promote the concept of “healing.”

- Improved reporting is recommended to capture and reflect age and gender breakdowns. All project activities should collect this data as a means of self-evaluation to identify where gaps may exist and improve upon.

- A healing strategy should be formalized into a document. It is recommended that findings from the planning events should be reviewed and summarized on paper and that broader community agencies be consulted on what form this healing strategy should take. It is further recommended that a needs assessment be designed and implemented to better determine the issues facing specific target groups and the community as a whole. Several informants echoed this as they felt not enough was being done to seek input and feedback from the community.

Evaluation Recommendations:

- Workshop evaluations need to be collected on an ongoing basis. This evaluation tool can help determine whether participants are gaining the skills and knowledge they need for their healing journey.

- The evaluation forms currently in use should be revised to capture more detail about the skills and knowledge gained in training workshops and other benefits to participation.

- Community surveys should occur to gauge how the community views the project and its activities. It is recommended that short surveys be distributed once or twice a year to chart how perceptions may or may not be changing.

- Community agencies should also be surveyed to better determine interest and willingness to participate in partnerships. If some agencies do not respond, simply asking their opinion may start a process that could lead to improved or stronger relations. It is recommended that occasional surveys be implemented.
• to all community agencies as a means of improving relationships and referral systems and of strengthening community ties.

• It is recommended that this study be provided to key related community agencies as a means of informing the community of what the project has been involved with, what it intended to address, and its findings. This could lead to greater capacity building and interest in developing a healing strategy.

Notes

1 Application for funding submitted to the AHF.
2 Please note that there was an excess of funds at the project end date and, therefore, the full amount was not released.
3 Application for Project Funding, Part A, Question 6: Expected results of the project.
4 The 1996 Census shows a population of 1,171, with 583 or 49.8 per cent in the 0 to 19 age group. The Cape Dorset Community Economic Development (CED) Plan, done in February 1999 by RT & Associates, cited the population as being 1,118 in 1996. Some community members and business owners estimated the population as being between 1,200 and 1,300, and the national survey response showed the population at 1,270.
6 This table is based on the project’s response to the national survey.
7 Government of Nunavut Bureau of Statistics (1999:27). 1999 Nunavut Community Labour Force Survey. “National Criteria,” which describe how unemployment is determined, include persons available for work during the week prior to the survey who: 1) were without work and had actively looked for work in the previous four weeks; 2) had been on temporary layoff; or 3) had definite arrangements to start a new job within the next four weeks.
8 Government of Nunavut Bureau of Statistics (1999:31). “Want a Job” criteria include persons who were not currently employed but say they want a job. For persons who were on temporary layoff or had a job to start within four weeks, “want a job” refers to a different job.
9 Government of Nunavut Bureau of Statistics (1999:29). “No Jobs Available” criteria include persons available for work during the week prior to the survey who: 1) were without work and had actively looked for work in the previous four weeks or had not looked for work because they perceived no jobs to be available; 2) had been on temporary layoff; or 3) had definite arrangements to start a new job within the next four weeks.
11 As reported earlier, community level data were obtained from individuals working in various community agencies, including the RCMP, Probation Services, and Social Services, and the majority of statistics were provided orally rather than in the form of published reports.
12 All RCMP figures cover the same time period—January 2000 to November 2001—and refer to incidents as opposed to cases where charges have been laid. An “incident” is described by the RCMP as a report that provides grounds for investigation.
13 Information from the Healing and Harmony in Our Families Project quarterly reports submitted to the AHF.
14 Isaacs, Sandy, Jamie Hockin, Susan Keogh, and Cathy Menard (1998). Suicide in the NWT: A Descriptive Report. Yellowknife, NT: NWT Health and Social Services. This report is based on data contained in the GNWT Suicide Database for the 11-year period from 1986 to 1996 and in coroner’s files for the period of 1994 to 1996 (78 cases over a three-year period).
15 Statistics Canada (2001:6–9). Crime Statistics. The Daily, Thursday, 19 July 2001. Statistics Canada shows the combined rate of violent crime and property offences in Nunavut to be 21,190 per 100,000 compared to a national rate of 7,655 per 100,000. Violent crimes show an even greater difference in rates: 6,074 per 100,000 in Nunavut compared to 982 per 100,000 for Canada as a whole.
16 This means that Cape Dorset manages its resources directly from funds transferred by the Government of Nunavut to Cape Dorset.
17 The Cape Dorset figures were provided by Social Services. Nunavut population figures were provided by the Government of Nunavut Bureau of Statistics, while Nunavut children in care figures were from Government of Nunavut Department of Social Services.
18 Application for funding submitted to the AHF.
This letter notes that both Social Services and the Tukkuvik women’s shelter had participated in training and healing offered by the CHT.

Information from the Healing and Harmony in Our Families Project quarterly reports submitted to the AHF.


Information from the Healing and Harmony in Our Families Project quarterly reports submitted to the AHF.
## Appendix 1

### Logic Model—Healing and Harmony in Our Families

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide healing and training to individuals who will support healing within their family/community.</td>
<td>Plan and deliver healing camps on the land.</td>
</tr>
</tbody>
</table>

### How we did it

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly healing circles; individual counselling; and workshops and training sessions.</td>
<td>Develop a healing strategy to target hard-to-reach groups, (men); identify workshop topics/facilitators; and develop mission and ethical code.</td>
</tr>
</tbody>
</table>

### What we did

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly women’s healing circle; weekly healing circles for teen girls; men’s healing circle not formed (2 facilitated workshops for men); individual counselling (approx. 37 people); and training (3 weeks, average 11–17 people).</td>
<td>Healing camps for youth, women, elders, and men.</td>
</tr>
</tbody>
</table>

### What we wanted

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased skill and capacity among caregivers; increased capacity to deal with crisis; community healing in areas of lateral abuse, violence, sexual abuse, and suicide; and overcoming feelings of powerlessness and uselessness.</td>
<td>Strong, effective CHT; and increased ability to reach hard-to-reach people, especially men.</td>
</tr>
</tbody>
</table>

### How we know things changed (short term)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td># of participants in healing circles, workshops, counselling (by target group); self-reported and key informant views on changes in attitude, skills, knowledge, and behaviour; and increased # of skilled caregivers.</td>
<td># of participants by target group; and self-reported and key informant views on changes in participants’ knowledge, skills, attitudes, and behaviour related to Inuit culture and healing.</td>
</tr>
</tbody>
</table>

### Why we are doing this

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restore balance and harmony in families and communities.</td>
<td>Reduced rates of physical and sexual abuse, suicide, incarceration, and children in care; and evidence of active, healthy community life.</td>
</tr>
</tbody>
</table>

### How we know things changed (long term)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of a healing strategy developed and implemented; increased participation of men; and key informant views of effectiveness of CHT.</td>
<td># of participants by target group; and self-reported and key informant views on changes in participants’ knowledge, skills, attitudes, and behaviour related to Inuit culture and healing.</td>
</tr>
</tbody>
</table>

## Why we are doing this

<table>
<thead>
<tr>
<th>Activity</th>
<th>Planning and evaluation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Restore balance and harmony in families and communities.</td>
<td>Reduced rates of physical and sexual abuse, suicide, incarceration, and children in care; and evidence of active, healthy community life.</td>
</tr>
</tbody>
</table>
### Performance Map—Healing and Harmony in Our Families

**MISSION:** Overcome feelings of powerlessness and uselessness by learning about Inuit spirituality, healing our spirits, and know again in our hearts that we are equal to other cultures of people in the human race.

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How?</strong></td>
<td><strong>Who?</strong></td>
<td><strong>What do we want?</strong></td>
</tr>
<tr>
<td>activities</td>
<td>Women, youth, elders, caregivers, and men.</td>
<td>Increased skill and capacity among caregivers; increased capacity to deal with crisis; increased capacity to serve hard-to-reach groups, especially men; community healing in areas of lateral abuse, violence, sexual abuse, and suicide; overcoming powerlessness and helplessness; and increased sense of pride in culture and spirituality as it relates to healing.</td>
</tr>
</tbody>
</table>

#### How will we know we made a difference? What changes will we see? How much change has occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$126,080 per year</td>
<td># of people in Cape Dorset participating and impacted by this program.</td>
<td># of participants in healing circles, workshops, counselling (by target group); self-reported and key informant views on changes in attitude, skills, knowledge, behaviour (e.g., self-esteem, coping, depression, suicide, abuse, participation in treatment); # of skilled caregivers; key informant and participant views of training and skills acquired; evidence of a healing strategy developed and implemented; increased participation of men; and key informant views of effectiveness of CHT.</td>
<td>Reduced rates of physical and sexual abuse, suicide, incarceration, and children in care; and evidence of change in community attitudes as seen by participation in community by healthier role models built upon Inuit culture and spiritual ways.</td>
</tr>
</tbody>
</table>
Appendix 2

Cape Dorset Questions: (CHT = Community Healing Team)

1. Can you please describe your role in or relationship to this project?

2. What changes, if any, have you observed in the project participants? (Changes in attitude? Changes in behaviour? etc.)

3. Please give an example of how the community has benefited by having this project?

4. What are some of the challenges or obstacles being faced by the project?

5. Please describe what the project is doing to deal with these challenges or obstacles?

6. For people who participated in healing activities, have you seen any improvements in the following areas?

<table>
<thead>
<tr>
<th>Developing healthier coping patterns</th>
<th>Yes</th>
<th>No</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>People developing better self-esteem</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Youth gaining better self-esteem</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Understanding effects of sexual abuse</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Dealing better with depression</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>People talking about thoughts of suicide</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Participants not attempting suicide</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Victims getting help for physical abuse/violence</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Abusers getting help to stop physical abuse/violence</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Men getting treatment</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Men dealing with violent behaviours</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>People getting support from Elders</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Community supporting Elders</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Women getting treatment</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Stronger Community Healing Team</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
<tr>
<td>Are there other areas not mentioned here where you have seen improvements?</td>
<td>Yes</td>
<td>No</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please explain:
7. For these 5 groups (youth, women, Elders, families, and men) the project wanted to work with, have you noticed if more people are seeking counselling?

<table>
<thead>
<tr>
<th>All groups</th>
<th>Yes</th>
<th>No</th>
<th>The same</th>
<th>Haven't noticed</th>
</tr>
</thead>
</table>

7a. Why do you feel that way?

8. From your perspective as (a member of the healing team, Justice Committee, a service provider, etc.) what did you like most about this project?

9. What, if anything, would you want to have seen changed?

10. Since the project began, please describe how you feel rates have changed for:

<table>
<thead>
<tr>
<th></th>
<th>gone up</th>
<th>the same</th>
<th>gone down</th>
<th>don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Incarceration</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children in care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10a. Why do you feel this way?

10b. Why do you feel this way?

10c. Why do you feel this way?

10d. Why do you feel this way?

10e. Why do you feel this way?

11. How has this project helped or not helped participants deal with suicide?

12. How has this project helped or not helped families deal with alcohol, drugs, and/or gambling?

13. How has this project helped or not helped participants deal with sexual abuse?

14. For training workshops you have taken, how have they helped you personally?

15. Is there a clear example of a skill you have learned that has really helped you support others?

16. Do you have any other comments to share?

Mandatory Questions:

A) What are the previously identified needs that the project is intended to address?

B) How would you rate the project's ability to address or meet those needs?

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
<td></td>
</tr>
</tbody>
</table>
C) How well has the project been accountable (i.e. engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:

D) How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:

E) Will the project be able to operate when funding from the Foundation ends?

F) How well is the project able to monitor and evaluate its activity? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tbody>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:
Centre for Indigenous Sovereignty

Project Number: RB-268-ON

Case Study Report

I da wa da di

Written by:
Wanda Gabriel

Under the direction from:
Linda Archibald and Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2001
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1. Introduction

Thirteen case studies are being conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case study process includes collecting data on selected social indicators to measure the impact of projects over time; in particular, for the year prior to AHF-funded activity and once again in the year 2003—an approach known in the evaluation field as a “within groups repeated measures” design. The case studies are intended to provide a detailed, holistic view of the projects and their outcomes. All data collection, analysis, and synthesis are being done by community support coordinators (CSCs) under the facilitative guidance of Kishk Anaquot Health Research.

The project that forms this case study is entitled I da wa da di (Mohawk translation for, “We should all speak”) (AHF-funded project # RB-278-ON). It is described as: “A range of traditional services will be provided to Aboriginal women who have suffered the legacy of sexual and physical abuse in residential schools or its intergenerational impacts. Culture-based training workshops for Aboriginal women who work with survivors will be provided.” This report provides a holistic overview of the traditional healing project I da wa da di, including a description of important project characteristics and provincial conditions that may influence the project. It is followed by a detailed discussion of project activities and anticipated short- and long-term outcomes and how change will be measured. It will discuss the range of potential indicators of change, including those chosen by the AHF Board to be applied to all projects (physical abuse, sexual abuse, incarceration rates, suicide, and children in care). The analysis of the project, and its impact to date, and conclusions are presented with aspects of the project that appear to be working well, lessons learned to date, and ongoing challenges.

Sources of information used in this case study include project files (funding proposal and quarterly reports); the project’s response to the AHF National Process Evaluation Survey that was sent to all funded projects in February 2001; key informant interviews with the project coordinator and selected service providers in Six Nations, Toronto, and Munsee-Delaware, Ontario; and documents and data collected by the CSC as part of the case study process. Important sources of information are the evaluation forms completed by project participants, which are summarized in quarterly reports submitted to the AHF, and a special report prepared by the project following its annual gathering (I da wa da di Project “Awakening the Spirit” Gathering, September 28, 29, 30th 2000, Report of Participant Evaluations).

2. Project Overview (Thinking Holistically)

I da wa da di was funded in a pilot year from 1 December 1999 to 30 November 2000 with a contribution in the amount of $191,532. Bridge funding was advanced in the amount of $47,883 to take the project to 31 March 2001, and a second phase was funded to the end of 31 December 2001. This study focuses on the period prior to 30 November 2000. The funding application submitted to the AHF states that the purpose of the project is as follows:

This project will work with Aboriginal women suffering the legacy of physical and sexual abuse in residential schools including inter-generational impacts. With the use of traditional healing approaches, the Program will seek to help women address and begin to resolve the childhood trauma of abuse and growing up in families and communities made dysfunctional by the residential school legacy.
The objectives outlined in the project’s work plan are to:

- begin a process of holistic healing from the legacy of physical and sexual abuse in residential schools and its intergenerational impacts by providing a safe, therapeutic, and traditional healing environment;
- help members recognize that past experiences of abuse fall outside the bounds of normative behaviour;
- teach traditional and non-traditional ways of maintaining physical, emotional, spiritual, and mental well-being;
- ensure support of members between sessions and after termination of the program;
- teach healing methods, tools, and approaches and provide cultural-based training for women who work with survivors of abuse;
- affirm the importance of self-care when doing healing work; and
- dispel isolation and further a sense of community among Aboriginal women involved in healing.

These objectives are being pursued through the delivery of three healing activities—healing circles, fasting retreats, and healing retreats—as well as training workshops and an annual gathering for 100 women survivors, counsellors, and healers.

The project is unique in its delivery of healing activities. The healing retreats, fasting retreats, and circle of healing are held on the Six Nations reserve next door to Brantford, Ontario, at the beautiful Earth Healing Herb Gardens & Retreat Centre. The centre, which is neither incorporated nor run as a business, is a result of 20 years of dedication to healing on the part of the project coordinator. The coordinator built the healing centre without financial assistance of any government program. The centre is open to all women who seek healing. The *I da wa da di* project is sponsored by the Centre for Indigenous Sovereignty (CFIS) because it, “seems to fall between the cracks of your [the Foundation’s] applicant eligibility criteria.”

The location and setting of the retreat centre warrant description. The property that houses the centre has been in the healer’s family for several generations. The main building, her home, is surrounded or attached by several smaller structures built over the years to provide a place to do healing work. Two bedrooms in the main building are reserved for anyone wishing to partake in a residential healing retreat, and there is a circular room where the circle of healing and other types of workshops are held. In a corner of the house is a small meditation room. The atmosphere in this room is so warm and kind that one just automatically sits and goes into a meditative state. In another corner of the house is a dark and cool room to hold herbs gathered from the centre’s herb garden. The whole interior of the house is modestly yet elegantly decorated. The artwork hanging on the walls illustrates the many gifts and teachings found within Mohawk culture. The rest of the house (dining area, kitchen, bathrooms, and living area) are all very cozy. The exterior of the property is very simple with a well-kept lawn and beautiful herbal garden. The garden is circular shaped and divided to represent the four directions and four aspects of the individual. Specific herbs are grown for each direction or aspect. Further off are four small lodges where fasting retreats take place. Each lodge holds sleeping space for two women. In summary, the place is well-organized and very conducive to a healing environment.

In the post-activity evaluation for the annual gathering and fasting retreats, women participants from other regions who had attended a healing activity have stated that the location and organization of the retreat centre are splendid, comfortable, and peaceful. They expressed appreciation for the somewhat reclusive environment as it helped set the mind, heart, and spirit for healing. Community members who had participated in the centre’s activities greatly appreciated that it was not attached to the band council or community services. They felt that their confidentiality and anonymity were better protected because of the
centre’s location. In contrast, a couple of local service providers stated that the retreat is too isolated from the rest of the community, but expressed respect and support for the work done by the coordinator.

The additional highlight to the *I da wa da di* project is that the coordinator–healer travels to different First Nations communities to bring traditional healing workshops to women who are working in the social, health, and healing fields. Characteristics of the women who participated in this project, including their home communities and nations, ages, and Survivor status are discussed below.

### 2.1 Participant Characteristics

The *I da wa da di* project targets adult Aboriginal women. According to the year-end report to the community and the AHF national survey, the project reached approximately 223 people. The following healing and training activities were held by the project over a full-year time frame:

Two 12-week sessions offered at the centre. Circles were three hours per week held on Monday evenings with a maximum participation of 20 women. The focus of the circle was to reintegrate the physical, emotional, mental, and spiritual aspects of the individual as they work through their issues and learn new ways to cope with shame, anger, confusion, and low self-esteem and build healthy relationships. All participants were adult women.

#### Table 1) Participation in Circle of Healing

<table>
<thead>
<tr>
<th>Session/Dates</th>
<th># of Participants</th>
<th>Participant Status</th>
<th>Survivor Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 24–April 10, 2000</td>
<td>17 completed session (19 began)</td>
<td>13 status on-reserve 4 status off-reserve</td>
<td>3 Survivors 14 later generations</td>
</tr>
<tr>
<td>April 17–July 11, 2000</td>
<td>19</td>
<td>4 status on-reserve 14 off-reserve 1 Inuk</td>
<td>2 Survivors 17 later generations</td>
</tr>
</tbody>
</table>

The retreats took place at the centre once a month from May to October, inclusive. Each retreat lasted three days for a maximum of eight women. The fasters were provided with one-to-one counselling, healing circles, drumming, and ceremonies.

#### Table 2) Participation in Fasting Retreats

<table>
<thead>
<tr>
<th>Session/Dates (2000)</th>
<th># of Participants</th>
<th>Participant Status</th>
<th>Survivor Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 7–9</td>
<td>4</td>
<td>4 status off-reserve</td>
<td>4 later generations</td>
</tr>
<tr>
<td>July 11–13</td>
<td>4</td>
<td>1 status on-reserve 3 status off-reserve</td>
<td>4 later generations</td>
</tr>
<tr>
<td>August 23–25</td>
<td>3</td>
<td>3 status on-reserve</td>
<td>3 later generations</td>
</tr>
<tr>
<td>September 13–15</td>
<td>5</td>
<td>3 status on - reserve 2 status off - reserve</td>
<td>1 Survivor 4 later generations</td>
</tr>
<tr>
<td>October 25–27</td>
<td>7</td>
<td>3 status on-reserve 2 status off reserve</td>
<td>1 Survivor 6 later generations</td>
</tr>
</tbody>
</table>
Residential service was provided to women who needed healing away from their families. Lodging was available for two women four days each in February, April, June, August, and November. This included nutritious meals, counselling, traditional teaching, ceremonies, and goal setting.

Table 3) Participation in Healing Retreats

<table>
<thead>
<tr>
<th>Session/Dates (2000)</th>
<th># of Participants</th>
<th>Participant Status</th>
<th>Survivor Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 11–14</td>
<td>3</td>
<td>3 status on-reserve</td>
<td>1 Survivor 2 later generations</td>
</tr>
<tr>
<td>June 28–July 1</td>
<td>2</td>
<td>2 status off-reserve</td>
<td>2 later generations</td>
</tr>
<tr>
<td>July 11–13</td>
<td>1</td>
<td>1 status off-reserve</td>
<td>1 later generations</td>
</tr>
<tr>
<td>August 28–31</td>
<td>3</td>
<td>3 status off-reserve</td>
<td>3 later generations</td>
</tr>
<tr>
<td>November 1–4</td>
<td>1</td>
<td>1 status on-reserve</td>
<td>1 later generations</td>
</tr>
</tbody>
</table>

Four three-day training workshops were provided to service providers working with Aboriginal women who are abuse survivors. The purpose was to teach healing methods and approaches, to provide tools for use in healing, and to affirm the importance of self-care by sharing ways for helpers and healers to maintain mind–body–spirit balance on an ongoing basis.

Table 4) Participation in Training Workshops

<table>
<thead>
<tr>
<th>Date and Location (2000)</th>
<th># of Participants</th>
<th>Participant Status</th>
<th>Survivor Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 22–24</td>
<td>19</td>
<td>12 status on-reserve 6 status off-reserve 1 other</td>
<td>18 later generations</td>
</tr>
<tr>
<td>KiiKeeWanNiiKaan Southwest Regional Healing Lodge, Munsee-Delaware First Nation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 25–27</td>
<td>15</td>
<td>15 status on-reserve</td>
<td>2 Survivors 13 later generations</td>
</tr>
<tr>
<td>West Bay First Nation, Manitoulin Island</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 19–21</td>
<td>45</td>
<td>21 status on-reserve 23 status off-reserve 1 non-status off-reserve</td>
<td>2 Survivors 43 later generations</td>
</tr>
<tr>
<td>Six Nations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct 18–20</td>
<td>17</td>
<td>6 status on-reserve 9 status off-reserve 2 non-status off-reserve</td>
<td>1 Survivor 16 later generations</td>
</tr>
<tr>
<td>De dwa da dehs nye&gt;s Aboriginal Health Centre, Hamilton</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An annual three-day gathering was held on 28–30 September 2000 at Six Nations. It provided an experiential, interactive, and networking forum for over 100 Aboriginal women impacted by residential schools; a venue for women to break the sense of isolation and to further a sense of community. In addition to the healer—coordinator, a number of other traditional people were on site to lead workshops and share their knowledge.
The participants for this activity totalled 120 people; 109 women, six men and five children. There were 20 participants who identified as residential school Survivors and 75 who were later generation affected by residential schools. Participants came from 44 different Ontario communities: Thunder Bay, Sturgeon Falls, Akwesasne, Curve Lake First Nation, Kenora, Sudbury, London, Parry Sound, Serpent River First Nation, Walpole Island First Nation, and Shawanaga First Nation as well as from communities closer to the Ohsweken/Brantford area. In addition, 14 different nations were represented, with the greatest representation from the Mohawk and Ojibway people. As well, participants reported being staff or board members of 47 different agencies, institutions, projects, or First Nations. These include a variety of health and social service agencies, treatment facilities, head start programs, and friendship centres.

Of the 233 people reached, the year-end report stated that participants came from 62 First Nations and other urban/rural Aboriginal communities in Ontario. Eight people were from another province or living outside of Canada. In fact, all of the activities drew women from outside of the Six Nations communities. Quarterly reports for 2000 describe participants of the fasting retreat as follows:

The women came from 10 different communities, both reserve and urban. They represented seven different Nations. The majority were between the ages of 26–49, while one woman was between 15–25. Two of the women were survivors of Residential School abuse while ten were descendants of survivors. Nine of the twelve women had participated in other programs offered by I da wa da di, i.e. Circle of Healing, Training Workshops and Awakening the Spirit Gathering.

It must be noted that the above data was available because the project was very diligent in gathering statistics and participant feedback on all their activities.

2.2 The Project Team—Personnel, Training, and Volunteers

The owner is a well-reputed traditional Mohawk woman, traditional herbalist and Elder who worked as a traditional healer at De dwa dehs nye>s, a health centre in Hamilton/Brantford and Anishnawbe Health in Toronto. She has taught at the University of Toronto, McMaster University, and Mohawk College (Brantford). The centre is a culmination of 20 years of experience in healing.

Approximately 15 people helped in the preparation and delivery of the gathering. In addition, the project received assistance from other traditional people from many different nations.

2.3 The Context

The Earth Healing Herb Gardens & Retreat Centre is located and serves the community of Six Nations, but also includes any Aboriginal woman living in the province of Ontario. The Department of Indian and Northern Affairs reports the following population statistics:

In Ontario as of December 1998, there were: 146,113 Registered Indians, 127 First Nations and 207 reserves. The Aboriginal population in Ontario is larger than any other province or territory. Nearly half the registered Indian population does not live on a reserve. The most populous First Nation is Six Nations of the Grand River, located near Brantford, Ontario, with nearly 20,000 members.³

As of 31 December 2000, Aboriginal women (ages 0–65) constituted 51 per cent of the total Aboriginal population. The largest populated age group is between the ages of five and 29. The Ontario Native
Women's Association (ONWA) reports that there are 40,959 working-aged Aboriginal women in Ontario. In its 1989 study, *Breaking Free*, ONWA found that eight of 10 Aboriginal women were experiencing violence, Aboriginal women and children are at the lowest rung on the socio-economic ladder, and elderly Aboriginal women are the poorest of all Canadians.¹

For the province of Ontario the AHF funded a total of 96 projects during the first year of operation (January 1999 to December 2000). The number of projects for each theme are: conferences (3); healing services (42); honouring history (8); knowledge building (8); needs assessment (5); prevention/awareness (19); project design and set-up (1); and training (10). In addition to the *I da wa da di* project, there are seven other projects in the province that target women as the population served and provide healing services, knowledge building, and training.

As noted earlier, Six Nations is one of the largest reserves in Ontario. As of 1 December 1999 the total membership was 20,435. According to the Six Nations Council, the on-reserve population was 9,527 in October 1996.² The growth rate was estimated in 1998 at 2.71 per cent. The territory is located 10 miles southeast of Brantford in southwestern Ontario; and, while the reserve is primarily rural, its administrative centre is in the village of Ohsweken. The community is abundant in resources with numerous programs and services as well as over 300 small businesses owned and operated by community members³ and five elementary schools.

Under the umbrella of the Six Nations Council, a wide range of services are provided. According to the *Six Nations of the Grand River Annual Report*, council expenditures for the year ended 31 March 2000 to operate these various services were $52,841,131 and the total revenue was $552,399,457. The list of organizations, agencies, and services that fall under the umbrella of the Six Nations Council include: Six Nations Welfare, Six Nations Health Services, Six Nations Social Services, Six Nations Economic Development, Six Nations Lands/Membership, Six Nations Forestry, Odrohetka—The Gathering Place, Chiefswood National Historical Site, Six Nations Housing, Six Nations Public Works (includes fire department), Six Nations Parks and Recreation, Personnel Department, Records Management, Secondary Services, Six Nations Community Resource Planning, computer systems specialist, policy analyst, Technical Services, Six Nations Land Claims Research Office, and Six Nations Commercial Leasing Office. Other services within Six Nations include the police department, in operation for 16 years, and fire and emergency medical services. The expenditures for these services were not listed in the annual report, and data on the legal, financial, and responsible authority were not available at the time of writing.

The community has their own radio station and newspaper. As well, several people own craft stores and sell local arts and crafts. Among these is the Iroqcrafts store, which sells books, crafts from other nations, and craft supplies. The community has several privately owned restaurants, one is operated by the son of a famous chef; a mini-mall that has a dollar store; a couple of small boutiques; several gas stations and convenience stores; and a small motel, the Bears Inn.

The community has a solid infrastructure with social, political, economic, and education systems operating for a number of years. Most of the organizations and agencies appear to be staffed by community members. During the data-gathering process, all of the services that were approached expressed a willingness to share information, and staff members were knowledgeable, open, and helpful. The atmosphere in many of the agencies (including social services and the police department) was comfortable, giving a sense that
people enjoyed being of service to their community. During an interview at the women’s shelter, a male community member came in to volunteer in any way possible. Apparently, this happens quite frequently, and the shelter boasts a solid volunteer network.

3. Using Common Sense: The Data Collection Process

This case study began with a thorough review of the project files. Based on the files, a logic model and a performance map were designed to provide an overview of the project. Next steps included contacting the project coordinator to gain general information about the community and to negotiate a time to conduct interviews. These steps guided the design and finalization of the interview questions.

During the week of 1 May 2001, interviews were conducted in Toronto, Six Nations, and Munsee-Delaware (near London, Ontario). In all, personal interviews were conducted with eight people associated with the project. Key informants included two project participants as well as representatives of Aboriginal women’s and social service organizations who were involved in or potentially impacted by the project. The organizations included: South West Healing Lodge (Munsee-Delaware), the Aboriginal Women’s Crisis Centre (Toronto), the Native Horizons Treatment Centre (New Credit), Six Nations Ganohkwásrá (a copy of their annual report was made available), and the Six Nations Social Services Program. Interviews were done in private and ranged from one hour to an hour and a half in length. A shorter version of the interview questionnaire was delivered to the project coordinator (Appendix 1).

A number of community level organizations were approached with requests for relevant background and statistical information related to physical and sexual abuse, children in care, incarceration, and suicide. Additional data (i.e., provincial statistics) were gathered from the Aboriginal Healing and Wellness Strategy of Ontario and various government websites. On a follow-up visit to the community, the Six Nations police provided data on physical and sexual assaults.

The following performance map (Figure 1) was used as a two-page reference guide to collecting information. It links the desired long-term outcomes (Aboriginal women living healthy lifestyles free of physical and sexual violence, women having a strong sense of community and identity, and more women fulfilling the traditional role in all areas of community living) with concrete measures of change, including reduced rates of physical and sexual abuse; reduced number of women incarcerated; reduced levels of children in care; reduced incidence of depression and suicide among women; increased number of women living healthy lifestyles and involved in community leadership and decision making; and evidence of revitalized Aboriginal culture.

Working towards such ambitious long-term outcomes is an enormous undertaking and one that the project cannot expect to accomplish on its own. However, progress can be mapped by identifying shorter term outcomes and indicators. In this case, the short-term outcomes focus on changes in project participants (e.g., increased coping skills and well-being) as well as changes in the environment (e.g., increased networking among healers). Measures of these changes include the number of women seeking healing services, evidence of increased self-esteem and improved self-image among participants, and evidence of increased knowledge of traditional teachings. In addition to the key informant interviews, the detailed participant evaluation information collected by the project provides an important means of assessing many of the desired short-term outcomes.
Threats to the reliability and validity of this case study relate primarily to gaps in the data. There were few relevant social indicator data available on Aboriginal women at the provincial level. Some community level data on physical and sexual abuse were made available, but concrete statistics related to children in care, incarceration, and suicide were not obtained. However, it could be argued that the appropriate focus for measuring impact in this case is the project participants and not the community of Six Nations or the province of Ontario. The strength of this study rests on key informant interviews and participant evaluations conducted by the project, and the participant voice is strongly represented in the evaluation material included in the project file, which are integrated into the analysis. The congruence between the interview data and the participant feedback reported by the project supports the internal validity or credibility of these two data sets.

**Figure 1) Performance Map— I da wa da di**

<table>
<thead>
<tr>
<th>MISSION: Aboriginal Women, the life givers and teachers of our society, will live in healthy relationships based on cultural pride and sobriety and an intolerance for abuse.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HOW?</strong></td>
</tr>
<tr>
<td>activities/outputs</td>
</tr>
<tr>
<td>Begin the process of healing from the legacy of residential schools and physical and sexual abuse and its intergenerational impacts through healing circles, fasting retreats, and healing retreats; provide a province-wide traditional gathering for women survivors, counsellors, healers, etc.; and provide culturally based training workshops for Aboriginal women working with survivors.</td>
</tr>
</tbody>
</table>

How will we know we made a difference? What changes will we see? How much change occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$191,532</td>
<td>223 Aboriginal women</td>
<td>Self-reported and observed changes in self-esteem, self-image, coping skills, and physical, mental, spiritual, and emotional well-being (participant feedback forms and views of key informants); # of Aboriginal women seeking traditional healing activities; # of referrals; # of traditional healers/helpers; # of traditional activities (healing circles, retreats, fasting, gatherings, etc.); # of women in shelters; and self-reported knowledge of traditional teachings, ceremonies, etc. among community members.</td>
<td>Reduced rates of physical and sexual abuse/violence, # of women incarcerated, levels of children in care, incidence of depression among women, as well as suicide rates; increased # of women living healthy lifestyles and more involved in community leadership and decision-making roles; and evidence of revitalized Aboriginal culture.</td>
</tr>
</tbody>
</table>
3.1 Thinking Logically: Activities and Outcomes

There is a logical link between the day-to-day activities a project undertakes, what they hope to achieve in the short term, and the desired long-term outcome. In this case, the project coordinator wanted to share her knowledge of traditional teachings with Aboriginal women interested in resolving the childhood trauma of abuse and growing up in families and communities made dysfunctional by the residential school legacy. It is through traditional teachings (prayer, ceremony, songs, healing circles, dance, drumming, fasting, and medicines) that the project intended to help women to address the legacy of physical and sexual abuse. Over the short term, the teachings were expected to: increase women's self-esteem, coping skills, and overall mental, physical, spiritual, and emotional well-being; decrease isolation; and increase the level of traditional knowledge and skills among counsellors and healers. In their funding proposal, the project identified the following examples of expected results:

- participants will learn they are not to blame for the abuse occurring to them;
- participants will learn the difference between healthy and unhealthy relationships;
- dispel feelings of isolation felt by Survivors;
- increase traditional knowledge and values; and
- increase sense of pride in being Aboriginal women.

Project activities were selected by the coordinator–healer based on extensive experience with healing processes and in consultation with a group of women who are residential school Survivors in Six Nations. Healing activities held at the centre include the circle of healing, fasting retreat, residential retreat, and the gathering. Training workshops were held in a variety of locations in partnership with other agencies in the province of Ontario.

The relationship between project activities and both short- and long-term benefits is set out in the following logic model (Figure 2). This model describes the project activities, how they were delivered, and what the project hoped to achieve. It then identifies how we will know things have changed in the short term, why this work is being done (i.e., long-term goals), and how we will know things have changed in the long term. There are five activity areas outlined in the logic model. Objectives outlined in both the contribution agreement between the project and AHF and quarterly reports fall generally into these five categories.
### Figure 2) Logic Model—*I da wa da di*

<table>
<thead>
<tr>
<th>Activity</th>
<th>Healing circle</th>
<th>Fasting retreats</th>
<th>Training workshops</th>
<th>Healing retreats</th>
<th>Annual gathering</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>How we did it</strong></td>
<td>Began a process of holistic healing in a therapeutic group environment; provided traditional healing to women; and ensured support between sessions and after the program.</td>
<td>Organized, taught, and conducted fasts for women in a safe, supportive environment.</td>
<td>Provided cultural-based training workshops for Aboriginal women who work with survivors of abuse.</td>
<td>Provided a safe and nurturing residential treatment for Aboriginal women suffering the legacy of residential school abuse or its intergenerational impacts.</td>
<td>Provided a traditional gathering for 100 women survivors, counsellors, healers, etc.</td>
</tr>
<tr>
<td><strong>What we did</strong></td>
<td>Two 12-week sessions of 3 hrs/wk; # of participants; content of teachings; # of referrals to community agencies and healing lodges; and # of counselling sessions, fasting retreats, etc.</td>
<td>Six 3-day fasting retreats for 8 women at a time with 24-hour support provided by traditional healers, Elders, and spiritual teachers; and # of participants and helpers.</td>
<td>Four 3-day workshops (2 Six Nations, 1 M’Chigeeng, 1 Munsee-Delaware), 20 women/workshop, and teachings reaffirm the importance of culture, women’s role, ceremonies, songs, etc.</td>
<td>Accommodations, meals, and 24-hour support provided at retreat for a total of 20 days (# of participants and # of days/participant).</td>
<td>A province-wide 3-day gathering in June 2000 by # of participants; and # and type of workshops and activities.</td>
</tr>
<tr>
<td><strong>What we wanted</strong></td>
<td>Increased coping skills, positive self-images, and physical, mental, spiritual, and emotional well-being.</td>
<td>A traditional healing environment for women; and to begin the process of healing from the legacy of residential school abuse.</td>
<td>Increased traditional and cultural healing skills among Aboriginal women who work with survivors of abuse.</td>
<td>Stabilize women in crisis.</td>
<td>Decreased isolation and increased networking among Aboriginal women involved in healing work.</td>
</tr>
<tr>
<td><strong>How we know things changed (short term)</strong></td>
<td>Participant satisfaction; key informant views on changes in participants; and # of women seeking traditional healing, counselling, and the safety of women’s shelters.</td>
<td>Increased # of women seeking traditional healing services, counselling and support; and self- and key informant reports of increased healing.</td>
<td>Increased # of qualified traditional care givers; and increased knowledge and skills among care givers.</td>
<td># of women using retreat; # of referrals from agencies and location of agencies; and key informant views on changes in participants.</td>
<td>Evidence of increased networking and # of women’s groups.</td>
</tr>
<tr>
<td><strong>Why we are doing this</strong></td>
<td>To break the cycle of abuse stemming from residential schools; to re-establish traditional methods of healing in the community; and to re-establish the traditional role of women in family and community life.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>How we know things changed (long term)</strong></td>
<td>Decreased rates of physical and sexual abuse, incarceration, and suicide among women; increased number of women living healthy lifestyles; decreased number of women living in poverty and of children in child welfare system (foster care, adoption); and evidence of an increased respect for the role of Aboriginal women in society.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.  Our Hopes for Change

The project was designed to provide healing activities to women and training workshops to front-line workers and others in the helping field. In the short period since the project began (December 1999), it is very difficult to assess whether or not significant and enduring changes have occurred. However, based on key informant interviews and participant evaluation forms, there is evidence of a number of changes taking place in participants’ lives. While this provides an indication of short-term impacts, there is a need to examine longer term impacts. In this regard, an attempt was made to collect social indicator data to provide a baseline from which to measure future progress. The data presented below include the social indicators identified by the AHF’s Board of Directors (physical abuse, sexual abuse, incarceration, children in care, and suicide) as well as information on the number of people participating in Six Nations therapeutic counselling services.

As noted earlier, attempts were made to collect social indicator data relevant to Aboriginal women in Ontario as well as Six Nations women. Therefore, geography and the target population have both been taken into consideration, including information on the number of people in Six Nations involved in counselling services outside the project.

Sources of community-level information include the Six Nations police department and annual reports from the Six Nations of the Grand River and the women’s shelter, Ganohkwasra. In light of the limited provincial-level data available, some national data have been included. In fact, provincial-level data on Aboriginal women for rates of suicide, incarceration in federal and provincial prisons, physical and sexual abuse, and children in care were not uncovered during the course of this study. It is unclear at this time whether such data are actually available, and more time would be required for a comprehensive and thorough search. It should be noted that even if the data were available, it would be difficult to attribute changes in rates of abuse, suicide, and incarceration among Ontario’s Aboriginal women with this project. Nevertheless, the indicator data contribute to the overall story this case study is attempting to relate. Moreover, on a larger scale the project is one of many healing initiatives, and the potential for change based on these collective efforts remains.

4.1  Suicide

Suicide is defined as an “intentional, self-inflicted death.” Experts in the field suggest that a suicidal person is feeling so much pain that they can see no other option. Those who are suicidal feel that they are a burden to others and, in desperation, see death as a way to escape their overwhelming pain and anguish. The suicidal state of mind has been described as being constricted, filled with a sense of self-hatred, rejection, and hopelessness.

Researchers investigating suicide among Canadian First Nations and Inuit report rates that range from zero to 15 times that of the general population. Furthermore, suicide rates vary considerably from community to community, with some communities being similar to those of the general population. With respect to Six Nations, a question posed in the national survey triggered the following response from the I da wa da di project:

In the community of Six Nations we are experiencing political upheaval, re-awakening of the culture, greater awareness of impact of residential schools (because of lawsuits and the Aboriginal
We have also experienced a recent rash of suicide attempts among the men.

There is a distinct gender difference with respect to suicide and suicide attempts. In general, women are more likely to attempt suicide than men while men are more likely to complete suicide. Health Canada reports that over a five-year span (1989–1993), Aboriginal women were more than three times more likely to commit suicide than non-Aboriginal women, and the National Forum on Health reports that the suicide rate for Aboriginal adolescent girls is eight times the national average. Despite literature and Internet search, no data were found on suicide rates for Aboriginal women in Ontario.

4.2 Physical Abuse

The chances for an Aboriginal child to grow into adulthood without single first hand experience of abuse, alcoholism are small ... the tragic reality is that many Aboriginal people have been victimized, and the non-Aboriginal community has largely ignored their suffering. A 1989 study by the Ontario Native Women's Association found that eight of 10 Aboriginal women in Ontario had personally experienced family violence; 87 per cent had been injured physically and 57 per cent had been sexually abused. In contrast, the report Family Violence in Canada: A statistical profile 2000 states that 7 per cent of women in Ontario experienced spousal violence. Provincial rates of spousal violence for women ranged from 4 per cent to 12 per cent; for men the range was from 5 per cent to 9 per cent. These data do not present a breakthrough of spousal violence in the Aboriginal community. The study identified that women are more likely than men to experience spousal violence in the past five years. This statistical profile did not identify the number of Aboriginal women. However, the final report of the Canadian Panel on Violence Against Women, Changing the Landscape, Ending Violence Achieving Equality, the chapter on Aboriginal women cites a relevant report done in 1991. According to this London, Ontario, area study, 71 per cent of the urban sample and 48 per cent of the reserve sample of Oneida women had experienced assault at the hands of current or past partners.

The Six Nations Ganohkwasra Family Assault Support Services' annual report for 1999–2000 indicates that there were 360 people who were provided safety, support, and counselling during the 1999–2000 fiscal year. There were 40 men, 193 women, and 127 children involved in programming. These individuals either participated in the shelter facility, Gayenawahsra (second-stage housing), or community (outreach) counselling. Ganohkwasra provides services to the whole family by utilizing a model that provides healing in all areas of a person's mental, spiritual, physical, and emotional realms. Since the inception of this program in 1988, the agency has provided support and assistance to 2,230 individuals from Six Nations and various other First Nations communities. The fact that large numbers of individuals participate in the shelter program could be viewed as a positive indication of healing or as an indicator of the level of violence in the community; more contextual information would be required before any interpretations are attempted.

Table 5 provides information on the number of assault charges laid by the Six Nations police in 1998, 1999, and 2000. Data based on police reports are limited because they can be influenced by numerous outside factors, including police charging policies and recording practices, changes to those policies and practices over time, as well as the willingness of victims to report to police. In reviewing the statistics from the Six Nations police department, assault level one had the highest incidence over the reporting period. These are summary convictions that range from spitting on someone to spousal assault. Assault level two are indictable offences that usually cause physical harm, and these can also include spousal assault.

<table>
<thead>
<tr>
<th>Offence</th>
<th>Number of Charges Laid</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1998</td>
</tr>
<tr>
<td>Assault (level 1)</td>
<td>54</td>
</tr>
<tr>
<td>Assault (level 2)</td>
<td>16</td>
</tr>
<tr>
<td>Aggravated assault</td>
<td>–</td>
</tr>
<tr>
<td>Assault police</td>
<td>6</td>
</tr>
</tbody>
</table>

Additional police data show that there were a total of 145 assault level one investigations and 30 assault level two investigations in the year 2000. The numbers included in the above table represent only those investigations that led to charges being laid. The data do not indicate whether offenders were male or female or show whether the offence involved family members.

4.3 Sexual Abuse

It is well recognized that official data under-reports the extent of sexual abuse. Victimization surveys indicate that up to 90 per cent of sexual assaults are not reported to police. In addition, prevalence of child sexual abuse is difficult to determine, as it is a hidden crime and many victims only report the abuse after they reach adulthood. Provincial-level data on rates of sexual abuse in the Aboriginal population were not available. In addition, Six Nations Social Service and Child and Family Services were unable to provide community-level statistics for this study. However, the Six Nations police provided data on the number of sexual assault charges laid in 1998, 1999, and 2000 (1, 2, and 5; respectively). As noted above, under-reporting is a major limitation of police data, but the numbers do provide a baseline for examining changes in the number of sexual assault charges over time. Additional information was provided for the year 2000 by Six Nations police who recorded 16 sexual assault investigations that led to 5 charges being laid.

Throughout Canada, women and girls are the primary victims of sexual abuse, although institutional abuse in residential schools and abuse in foster homes have impacted large numbers of Aboriginal male youth. The police data presented above do not include information about the age and gender of victims or offenders or the relationship between victims and offenders. Key informants who work in treatment or healing lodge settings stated that close to 90 per cent of their clientele had been sexually abused in their lifetime and that the sexual abuse occurred over a period of years. In most cases, the offender was a family member or friend of the family.

Participant evaluations for I da wa da di’s ‘Awakening the Spirit Gathering’ in September 2000 included the question, “What were you hoping to address, resolve or learn at the Gathering?” A small portion of respondents stated that they were hoping to resolve their issues and pain around sexual abuse. While others did not specifically mention sexual abuse, more than half of the 70 respondents wanted to understand trauma and its impact on their lives. These responses affirm that some project participants are dealing with issues associated with sexual abuse.
4.4 Incarceration

Women offenders in federal prisons number just over 850 as of September 1999. Aboriginal women offenders represent 21.1 per cent of that population, and they were incarcerated at the rate of 16.3 per 10,000.\(^{18}\) Interestingly, the recidivism rate for women released from the Okimaw Ochi Healing Lodge is only 1 per cent.\(^{19}\) Overall, 82 per cent of federally sentenced women and 72 per cent of provincially sentenced women have histories of physical and/or sexual abuse; the corresponding rate for federally sentenced Aboriginal women is 90 per cent.\(^{20}\) There are only two prisons that incarcerate women in Canada that provide programs for sexual abuse/incest survivors (the Okimaw Ochi Healing Lodge is one). The Elizabeth Fry Society reports that two-thirds of federally sentenced women have children: “Most were the primary, if not sole, caregivers for their children prior to their incarceration. Too many children end up in ... [provincial] care as a result of the imprisonment of their mothers and this is the most central problem for women ... after their release.”\(^{21}\)

There is a substantial body of literature dealing with male offenders, both Aboriginal and non-Aboriginal, but very little that specifically addresses Aboriginal women. An Internet search for rates or numbers of Aboriginal women in Ontario who are federally or provincially incarcerated was unsuccessful. No specific data on the number of Aboriginal women from Ontario incarcerated in federal and provincial prisons was found.\(^{22}\)

4.5 Children in Care

Obtaining both local and provincial data on this topic proved to be very difficult for a number of reasons. Locally, Six Nations Social Services did not have the time or resources necessary to compile the data; they estimated it would take over two months to provide a reasonable accounting of these numbers. It may be possible to obtain this information for the follow-up study if the agency receives the request early enough in the process. Provincially, it is difficult to identify the number of Aboriginal children in care because each regional and municipal agency holds its own statistics. However, more than half of all Aboriginal people in Canada are children and youth. Canada’s 424,000 Aboriginal young people make up 5 per cent of all children in the country under the age of 15 and 4 per cent of youth ages 15 to 24.

The history of Aboriginal children and child welfare agencies paints a bleak picture. It has been argued that the child welfare system is another tool in the process of assimilation. Many Aboriginal children have been removed from their homes in the early sixties up to the present date. Children have been adopted or gone into foster care into non-Aboriginal family settings.

In order to stop further destruction of children and families, the Ontario Chiefs Conference passed a resolution in December of 1981 that initiated the process for First Nations communities to plan and manage their own child welfare agencies. This resulted in First Nations agencies with distinct authorities over the lives of Aboriginal children. The current authorities, child welfare agencies (recognized as Children’s Aid Societies) include, Dilico Ojibway Child & Family Services, Payukotayno Family Services, Tikinagan Child & Family Services, Wabaseemoong Family Services, and Weechi-it-te-win Child and Family Services. Child welfare-related agencies (similar to a Children’s Aid Society without the authority to apprehend children) include, Six Nations of the Grand River, Kina Gbezhgomi Child & Family Services, Kuniwanimo Child & Family Services, Native Family and Family Services of Toronto, Nog-da-winda-min Family & Community Services, and Ojibway Tribal Family Services.\(^{23}\)
The report of the Royal Commission on Aboriginal Peoples stated that about 4 per cent of First Nations children living on reserve were in agency care outside their own homes. The percentage of First Nations children in care is six times that of children from the general population, and this disparity has actually increased since the 1970s.\(^{24}\)

### 5.6 Seeking Therapeutic Services

As noted, there were no data from Six Nations on child sexual abuse and children in care. However, information gathered on the type of therapeutic services being offered through the Six Nations social development program was available. While it is impossible to decipher the reasons why community members sought these services, the Six Nations annual report does provide a breakdown of the number of people who participated in the various services (Table 6).

<table>
<thead>
<tr>
<th>Type of services offered</th>
<th>Number of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual counselling</td>
<td>293</td>
</tr>
<tr>
<td>Group counselling</td>
<td>1,748</td>
</tr>
<tr>
<td>Referrals to on-reserve</td>
<td>21</td>
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<tr>
<td>Social skills</td>
<td>722</td>
</tr>
<tr>
<td>Crisis intervention (brief service 1–3 sessions)</td>
<td>71</td>
</tr>
<tr>
<td>Mental health services</td>
<td>91</td>
</tr>
<tr>
<td>Referred to psychiatrist</td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>36</td>
</tr>
<tr>
<td>Child</td>
<td>12</td>
</tr>
</tbody>
</table>

### 5. Reporting Results

Aboriginal women face many challenges, and this project is attempting to address those related to physical, mental, emotional, and spiritual well-being through healing activities as well as to increase the number of healers and their range of healing skills through training activities. This study noted changes in participants’ knowledge, attitudes, skills, and behaviour as perceived by key informants and what was reported in the participant evaluation forms. It also indicates that the project increased participants’ knowledge and understanding of residential school impacts and of traditional healing. Many women who completed the evaluation said that they were grateful for the opportunity to listen and share with other women. This showed that the project met one of the short-term objectives: decreasing isolation among Aboriginal women involved in healing work. There was no information to assess the impact on the other aspect of that objective—increased networking among healers—and this should be explored in the follow-up study in 2003. However, five of the eight key informants did note an increase in the number of traditional healers over the past year, and seven of the eight agreed that community members have become more knowledgeable of traditional healing practices.
Each of the three activity areas outlined in the performance map has been successfully completed; thus, the project has shown an ability to achieve its service delivery objectives. This section will review short-term outcomes, including changes in participants’ knowledge, attitudes, skills, and behaviour as reported in key informant interviews and the project’s participant evaluation forms. For example, all eight key informants responded “yes” to the question, “Do you think women who participated in this project are re-building pride in being Aboriginal?” They saw this evidenced by women who are using their voices more often and more strongly.

Progress towards long-term outcomes will be examined in the follow-up study to take place in 2003; however, it is understood that these will be difficult to measure given that the target group for this project encompasses Aboriginal women throughout Ontario. Even if the focus was on Six Nations women only, the indicator data presented earlier contain gaps that will make follow-up assessments difficult. Nevertheless, information will be extracted from the follow-up interviews with key informants (including their perception of changes in indicator data) as well as a review of the participant evaluation forms collected by the project. At this point in time, the focus is on examining what impact, if any, the project has had in four specific areas: influencing individuals, perceived changes in community, establishing partnerships, and reaching those in greatest need. There is enough information available to reach some preliminary conclusions.

5.1 Influencing Individuals

This project has been meticulous in gathering feedback from participants through post-activity evaluations, which they have included in project reports. Other sources of information used in this section include interviews with key informants and the national survey. Overall, this information points to the project having an impact on individuals in four areas: 1) participants’ knowledge and understanding of residential schools and their impacts; 2) participants’ knowledge of traditional healing; 3) participants’ healing skills; and 4) evidence of healing. In addition, the project’s response to the national survey states that the project has had “some influence” on empowering individual women participants as evidenced by the fact that some women have left abusive relationships, some facilitated workshops at the annual gathering, others began drumming and singing, and “most women have indicated they have a stronger sense of self upon completion of activity.”

During the interview process, one of the key informants commented that they felt the information was very useful in understanding the extent and impact of residential schools on Aboriginal people as a whole. One of the evaluation forms went much further, as a participant stated she had a better understanding on why there is so much “drinking and drugging” in the Aboriginal communities and why children are not safe in some environments.

The training workshops were particularly successful in increasing participants’ knowledge of the residential school legacy. For example, the project’s quarterly reports state that 31 out of 34 participants who completed evaluation forms after a training workshop felt that the information presented had increased their awareness and understanding of the impact of residential schools on Aboriginal people, families, and communities. Moreover, 30 of the 34 respondents identified ways the workshop would help them in working with residential school Survivors and later generations. A number of the comments suggest that the participants’ increased understanding will be passed on to clients and family members and will allow them to be more empathetic, supportive, compassionate, and non-judgmental in their work with clients.
Participants in the gathering were asked if it helped them address the trauma or issues that came from physical and sexual abuse at residential school or its intergenerational impact. Of the 70 people who filled out evaluation forms, 53 answered “yes.” This suggests that there was movement beyond gaining knowledge and understanding and that some participants were able to begin the process of healing from the legacy—one of the project’s desired short-term outcomes. In one case, a respondent wrote about how the gathering had motivated her to take further action, “after the conference, I and my 31-year old daughter went to a fast and further resolved some issues.” In addition, many respondents stated that this gathering gave them a feeling of empowerment that enabled them to seek help in dealing with these issues. For others, their responses focused on intended behavioural changes, such as becoming more attentive to their families and passing on cultural teachings, spending more time with Elders, and starting or continuing the healing journey. One person expressed a commitment, “to teach my children about Native culture and not feel stigmatized by the negativity surrounding by others.” The following comment exemplifies how a combined knowledge of the residential school legacy and traditional teachings impacted one participant:

> It helped me to gain greater awareness and understanding of [residential school] impacts. It affirmed many of my beliefs about what will help our people to stand up again to reclaim their true identities, to pick up their bundles again through our traditional ways as a people. It helped me to further look at and understand what happened to my grandmother and why I was raised the way I was. It helped me to become even stronger and more determined to give my children, my grandchildren the things, ways and teachings about who they are, a “good life.”

There is evidence that the project increased participants’ knowledge of traditional healing. The question was posed to key informants: “In your opinion, have community members become more knowledgeable of traditional healing practices than they were 12 months ago?” Seven out of eight responded, “yes.” When asked how they knew people were more knowledgeable, respondents stated that there was more discussion of traditional healing and people were attending more ceremonies and seeking out medicine and personal counselling. An interesting comment by one of the informants demonstrates a clear shift in attitudes; she stated that people now have a better idea of who is safe to see among traditional healers and that “they are not so wonderstruck by healers.” This can signify that people are beginning to see healers as part of the circle and not as people higher in status. This reflects a traditional non-hierarchical world view.

Participants spoke about concrete tools or skills that they gained as a result of their participation in the gathering. In fact, 90 per cent (63 of 70 respondents) stated that the gathering provided tools to continue their healing. Their responses included references to using the medicines and the medicine wheel, active listening skills, and the importance of sharing. Others reported that they had gained tools to assist them with their own self-evaluation. Another important aspect was that many commented on the benefits of the fasting retreat and how this tool could be used as part of their own self-care plan.

The final quarterly report for the first year provided commentary taken from evaluation summaries on the training workshops. For one of the workshops, 10 out of 11 respondents felt that it had met their learning goals and expectations. They identified group skills, strength to have a sharing circle so that survivors can express their pain and happiness, the stages of life, and “You have to walk the talk if you’re out there in the helping field” as healing skills or tools they learned.

Examples of changes in participants’ behaviour were noted, including more people attending ceremonies in the longhouse and an increase in the number of women seeking personal counselling to further their
healing. A poignant example was cited during the interviews: one woman shared that she had made a decision to leave an emotionally and psychologically abusive relationship/marriage of 20-some-odd years. She felt that as a result of her participation in the project she had gained enough self-confidence and self-love to conclude that she wanted a more healthy life and that meant ending an abusive marriage.

In addition to changes in their own lives, key informants were noticing changes in attitude and behaviour in project participants. Most notable changes were in levels of self-confidence and self-worth. Other noted changes include developing a stronger sense of identity and pride and a stronger commitment to personal wellness. The gathering participants also commented on how the gathering helped in strengthening their own identity and feeling less alone. Interestingly, several participants expressed that it helped them shift their attitude to one of forgiveness, either towards a parent or an abuser. Perhaps these changes in attitude will lead to changes in behaviour. It was also noted in the interviews that a couple of participants have returned to school to obtain a higher education, while others have made some sort of movement in their careers. Additionally, women are applying the skills they have learned to their lives. One of the women spoke about her experiences this way:

I have participated in the teachings on movement through dance and using the power of voice. Before I could not conceive of doing something like this, now I have no qualms about going through these exercises. Actually I do not feel as blocked emotionally as I once was. I am more at peace and serenity.

Other women have engaged in drumming and singing the traditional songs, as well as making their own traditional clothing, and still others have joined in the healing movement by facilitating workshops in the community and sharing their own healing journey.

5.2 Perceived Changes in Community

One of the most notable changes recorded in both the interviews and the participant evaluation reports is the fact that women are feeling less isolated and more involved in community life. It has been observed by key informants that women are taking small steps toward leadership roles and forming more solid networks in the community. One person commented that their social service agency noticed a decrease in their workload. This was interpreted as evidence that more people were seeking out the aid of traditional healers. On one hand, this was considered a good thing, but on the other hand, there was no formal structure in place for the community social service agency and healers, which was identified as a weakness. It was the desire of the agency to have a more collaborative approach.

Another manifestation of change noted by key informants in the community of Six Nations was an observation that there are more young people in mentorship with healers than in previous years. Also, comments were made that older people had been afraid of stepping out, but now more elders are taking an active role in the community. As well, members of the longhouse are noticing that people are more readily able to make a commitment to the longhouse and that people have developed the ability to question what they do not think is right or what they do not understand.

When asked about changes in women’s relationships or roles in the community, one key informant made the following observation:
We are hearing a different language, before people would not even say “my” community, they would say, “the” community. Now they are saying “my” community, this shows that people are taking ownership of who they are. Once we do this we can overcome ownership versus denial. This will help us to challenge more and more, and in this we can move ahead.

Another person mentioned that women are more active in the community and that a number of external services (i.e., catering and small businesses) are managed by women. As well, there is an increase in the number of women who volunteer, such as programming for children and after-school theatre. It should be noted, however, that in the project’s response to the national survey, they were unsure as to how effective the project was at empowering women as a group and changing the status and decision-making power of women in the community.

Sexism was noted by one respondent as a point of contention, since the teachings say that we need to make good use of people no matter what sex they are. There are not enough women chiefs, although many women work behind the scenes. The respondent also said, “Young people are amazing, they dare to do all the work being done. Still, it is difficult for women, elder women versus elder men. We need to foster leadership among women.” Other respondents noted the increase in healthy role models, better communication, more participation in community events, and women regaining their voice, learning who they are, and gaining a sense of purpose.

There were comments about women moving forward in healing while men were much less involved. This sends a note of concern as the roles of women appear to be expanding and now include roles in the home (including, arranging child care if working outside the home), at work, and in the community; whereas Aboriginal men’s roles are remaining static or losing ground, especially in areas of high unemployment and where traditional economic activities are no longer practised. Moreover, men tend to be less involved than women in healing projects.

5.3 Partnerships and Sustainability

As stated earlier, the centre operated without financial assistance prior to AHF funding. The centre is able to stand alone because of solid networks and the outstanding reputation established by the project coordinator. Each component that was offered by I da wa da di was done in partnership with an Aboriginal organization or through community volunteers.

I da wa da di training workshops were held in partnership with the following agencies: a workshop was held at KeeKeeWanNiiKaan Southwest Regional Healing Lodge in Munsee-Delaware, and they did the promotion and outreach as well; West Bay (M’Chigeeng) First Nations booked the facility, did outreach and promotion, handled registration, and arranged meals and refreshment breaks; and the De dwa dehs nye’s Aboriginal Health Centre in Hamilton assisted with outreach, promotion, and provision of meals and snacks. Included in these partnerships are the traditional healers and Elders from different regions who came to the training workshops and gathering to share their teachings and wisdom on healing.

In the national survey, the project coordinator estimated that approximately 144 hours of volunteer time were donated to I da wa da di. Volunteers were most likely to contribute their time in administration, food preparation, operations, transportation, and cultural/traditional activities.
Will this project’s life extend beyond the AHF lifeline? Is there any sustainability? Key informants were asked if the project will be able to operate when funding from the AHF ends. This quote reflects the general response of the informants: “I think so, certainly not as it is now, people will not stop pursuing their healing, they have just gotten a taste of the ‘Good Life!’” Another general opinion in response to this question was that the project will continue, but not to this extent as ongoing funding will always be a concern because of financial uncertainty.

5.4 Reaching Those in Greatest Need

In one year, the project was able to reach 223 women. Data from the national survey reveal that 32 participants were residential school Survivors and 166 have been impacted intergenerationally. It is evident from the discussion of the project’s impact on individuals that the project is addressing the legacy of physical and sexual abuse in residential schools, including intergenerational impacts. Survivors and their descendants are involved at all levels of this traditional healing program.

The healing programs are open to all Aboriginal women, and the target area is the entire province. Is this project reaching those in greatest need? It is unclear whether participation is hampered by the cost of travel or child care; however, Awakening the Spirit participants were from 44 communities across Ontario, which suggests that information about the project is reaching Aboriginal communities and that a good number of people had the means to travel to Six Nations. The gathering exceeded its aim to attract 100 participants, as the actual attendance was 120. This is a small project with one woman to lead the healing and training activities. There is enough evidence to conclude that the project is having a positive impact on participants, but further research would be required to determine if it is reaching those in greatest need.

5.5 Best Practices

It is clear that one of the project’s best practices is the safe environment it has been able to create. This was raised by respondents in their evaluation as well as in key informant interviews. For example, 67 out of 70 (95.7%) of the people who responded to the Awakening the Spirit evaluation said that they felt safe at the gathering. One person explained why she felt safe:

> The warm and kind atmosphere that enveloped us in the setting of a healing place in nature. The respect to each other and the healing words of the Elders and other speakers. Also, there were counsellors on the grounds to support the emotional and mental needs. The spiritual needs through prayer, song medicines, and drumming. As well as our physical needs through food.

The second best practice is in the area of group sharing. Having to share their stories enlightened participants that they were not alone and were connected by different things in many different ways. In response to the question about whether the group sharing was supportive, 61 out of 70 responded “yes.” To support these numbers, participants also included comments as to why they felt this way:

- “I felt I was not alone. I felt I belonged. The world today separates people. This group came together—we shared—we cried, laughed, sang, danced and ate together. This was all good for me and others who shared the experience with me.”
- “Everyone has their own story to tell and only they can tell it, to hear it first hand is to hear and see and feel it individually, and I will never feel alone again. I will feel a part of something bigger than me.”
- “For every story and step of healing a woman shared with, I could feel a small piece of myself healing as well.”
The project did well in addressing the residential school legacy and its impacts. Many participants of the gathering said that they were grateful to acquire an understanding of the historical content of their relationship with residential schools, family, church, and government.

The historical overview presented by one of the Elders was mentioned as being beneficial by many participants. Interestingly, the post-gathering evaluation asked people if they could identify the physical, emotional, spiritual, and mental trauma issues they experience that is related to physical and sexual abuse at residential schools or its intergenerational impacts. There were 59 out of 70 respondents able to provide answers. Responses are divided into the four categories: physical (P); emotional (E); spiritual (S); and mental (M). This suggests that a considerable amount of workshop time was spent on these issues. A few responses are listed below:

- P: “Headaches and neck pains (holding things in).”
- E: “Afraid to feel.”
- S: “Thought that this was ‘religion’ before. Didn’t know the difference.”
- M: “Tried to intellectually analyse things.”
- P: “I’ve been sexually abused all my life.”
- E: “Being and called hopeless and helpless, constantly being put down by my mother.”
- M: “There is a thing as mentally sexually abusing someone. My Stepdad has done this to me all the while I’ve known him.”
- P: “Beatings; Usually picked out to do heavy menial tasks; Pushed to be a leader when I am more comfortable to follow.”
- E: “Became self-contained. Still feel alone even in a crowd; I am unable to be emotional. When I am insulted or angry, I walk away.”
- S: “I am not a very spontaneous person since people in authority do no [sic] tell me what to do, and if I do something I wasn’t told to do, I still feel I’m committing a sin.”
- M: “I really don’t know who I am. I know what people think of me, and much of the time, I don’t believe them but I don’t contradict them either. I don’t want to tell them they lie. Don’t talk to men—I might get pregnant. (I have since learned it takes much more than just talk.)”

The project’s data collection and evaluation tools are outstanding, and very informative and extensive evaluation questionnaires for all activities are completed by participants at the end of each activity. The gathering generated 70 responses, which represents more than half of the participants for this activity, while response rates for smaller activities were much higher. In general, the evaluation aspect is well utilized by this project and assists them in developing their program design. It allowed the project to track participant characteristics, including age, Survivor status, nation, home community, and whether or not they have participated in previous project activities. It detailed questions about learning/healing goals, expectations, results, the environment, the facilitators, and the content of sessions and activities. The evaluations are included in regular reports to the AHF as well as in reports to the community and participants. One possible improvement to the project’s evaluation strategy would be to incorporate a follow-up questionnaire inquiring about long-term changes in participants’ lives.

The project itself identified the following best practices in the national survey: love, caring, respect, and nurturing of participants by the primary service provider; knowledge/use of traditional values, customs, and medicines; safe (emotional and spiritual) environment; and intimacy of one-on-one attention.
5.6 Challenges

One of the challenges this project faces is responding to the demand or need for its healing services. Challenges identified in the national survey include accessing additional help and support and the impact of “not anticipating the magnitude of the community’s positive response.” The retreat centre is equipped to deal with a limited number of individuals; therefore, the project has to set a strict limit to the number of participants allowed, especially with respect to the healing circles and the fasting and healing retreats. The project reported that there is a maximum waiting list of eight per healing/training activity. Training activities may be less limited as they also take place in other communities and are in partnership with other organizations. Similarly, the annual gathering, which last year accommodated 120 people, requires an entirely different set of organizing principles and environment. Another challenge noted by key informants was the need to work collaboratively by developing a more structured network around participants.

In fact, it is clear that efforts must be made in providing support to participants to continue their healing journey. Key informants were asked, “In addition to the support provided by this project, which of the following supports do people need on their healing journey?” Responses that generated the highest importance were extended family, immediate family, and friends. Participants’ comments following this question suggest that these supports must come from a place of health and healing, otherwise the environment would not be supportive for ongoing healing. Also noted in these comments was the need for abusers to validate the pain they have caused. This reflects the concept of the abuser being held accountable to those whom they have inflicted pain. Holistic healing can only happen when everyone in that circle is part of the healing. I da wa da di is only one piece of the holistic picture that is the reality of our communities.

One potential challenge relates to the ability of the project to sustain itself at current levels after AHF funding. When asked this question, key informant opinions ranged from “I think so” to “yes, some of it will continue.” One person raised the possibility of fees being charged, but then said, “only aspects of the process could continue.” Would it still be possible to reach the people who need it most? Another person simply stated that the question of money will always be there. While ensuring the project’s long-term sustainability may be challenging, the healing centre existed long before the AHF began funding its activities, and it is a good possibility that it will continue to operate after this funding ends.

One of the strengths of this project is the experience and skills of the coordinator—healer. However, one person can only lead so many workshops, training, and healing sessions. This could limit the number of participants and means that the project is dependent upon this one person. If the coordinator was no longer involved, could the objectives be transferred to another individual, group, or centre? It should be noted that one of the project’s goals is to increase traditional and cultural healing skills among Aboriginal women, and in training sessions, skills are being passed on to women participants. Another goal is to build a network to increase the number of healers. It will be important to re-examine this issue in follow-up work in 2003.

5.7 Lesson Learned

There were conflicting responses to the question of what could improve the gathering. Many appreciated having the gathering outdoors and the opportunity to be close to nature, while others found the outdoor
experience less desirable. This may be due to timing as the gathering was held late September. It is not clear from documentation how the project felt about the timing of the gathering.

The project coordinator, in response to the national survey, identified the following as important lessons learned while developing and implementing this project:

- finding qualified staff to match the project mission and principles;
- the critical need for training/healing Aboriginal caregivers; and
- the importance of having participants engage in comprehensive evaluation of the project and its activities.

### 6. Conclusion

It is evident that *I da wa da di* is having an impact on the Aboriginal women who participated in the healing and training activities. Contributing to this success are the safe healing environment created by the project and the support, sharing, and networking that took place among participants. In addition, the focus on historical and contemporary impacts of the residential school legacy appeared to establish a constructive framework for healing and training activities. The project’s tracking of participant feedback provides a solid basis for assessing such impacts. In terms of measuring long-term impacts, the development of a 12-month follow-up questionnaire is recommended to enhance the project’s current process for gathering and reporting feedback.

This project uses and promotes the tools found within our traditional systems. Traditionalism is part of the need for our people to form a strong identity as Aboriginal people. The systems, school, church and justice have, for hundreds of years, tried to eradicate the Aboriginal way of seeing the world. For a long time those with traditional teachings had to suppress their knowledge or share it only in an underground network. For a long time there was distrust and mystification around traditional Aboriginal teachings from those who held the knowledge and who sought out the teachings. This project breaks this barrier and brings together all these elements.

### Notes

1 Application for funding submitted to the AHF.
2 Letter from Gordon Peters, CFIS, to the Aboriginal Healing Foundation, 30 March 1999; a project proposal accompanied the letter.
3 This data was taken from the *Fast Facts* sheet web page hosted by Indian and Northern Affairs Canada for the province of Ontario, August 2000.
7 The Community Support Coordinator’s Guide to Completing Case Studies (Kishk Anaquot Health Research, February 2001) states “great caution and discretion is advised before CSCs consider any DIRECT assessment of participant perspectives on project performance.” In this case, a decision was made to include the two participants in the interviews as the project coordinator felt that their perspectives were important and that the interviews would not compromise their emotion or spiritual health in any way. Furthermore, participants on their healing journey are well-supported.
8 See Suicide Information & Education Centre website at: http://www.suicideinfo.ca/
9 See Suicide Information & Education Centre website.
10 NPES question: What other community/family events or healing efforts happened or are happening that may have impacted on your results?
14 Retrieved from: www.hc-sc.gc.ca/hppb/familyviolence
16 One study found that reasons for not reporting the assault include (in order of frequency) fear of the criminal justice system, fear of record disclosure, fear of impact on family, negative experiences with the justice system, the perpetrator could not be located or was dead, fear of the perpetrator, and fear of impact on the relationship. See Hattem, Tina (1998). Survey of Sexual Assault Survivors: Report to Participants. Ottawa, ON: Department of Justice Canada and Canadian Association of Sexual Assault Centres.
17 The organizations indicated that they had neither the time nor the resources required to compile these data at this time.
18 Retrieved from: http://www.elizabethfry.ca
20 Retrieved from: http://www.web.apc.org/~kpate
21 Retrieved from: http://www.elizabethfry.ca/facts1_e.htm
22 In theory, it should be possible to gather statistics on the number of incarcerated Aboriginal women who are from Ontario through contacting Correctional Service Canada and the Ontario Ministry of the Attorney General; however, for the purposes of this case study, there was not enough time to follow up on this.
25 This data would be even more helpful to the longitudinal component of the case study if the project was able to collect follow-up information on participants, perhaps one year after their involvement in a training or healing activity, about changes in their lives and work since their participation in the project.
26 Of the 120 participants, 20 were residential school Survivors, 75 identified as later generation affected by the residential school legacy, 19 said they were neither Survivors nor later generation, and 6 did not know if they were a later generation affected by the Legacy. See: I da wa da di Project, Awakening the Spirit Gathering, September 28, 29, 30th, 2000, Report of Participant Evaluations, page 4.
Appendix 1) Interview Questions— I da wa da di

1. How well has this project addressed the Legacy of Sexual and Physical Abuse in Residential schools including inter-generational impacts?

2. What are the previously identified needs that the project is intended to address?

3. How would you rate the projects ability to address or meet those needs?

4. In your opinion, how well has the project been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as for community input)

5. How well have the methods, activities, and processes outlined in the funding agreement led to desired results?

6. Will the project be able to operate when funding from the Foundations end?

7. How well is the project able to monitor and evaluate its activity?

8. In your opinion, have community members become more knowledgeable of traditional healing practices than they were 12months ago?

9. Over the last 12 months do you think there has been an increase in the number of traditional healers?

10. Do you think there has been an increase in the number of women seeking help from traditional healers over the past 12 months?

11. Which of the below do you think are problems women face?

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</tr>
<tr>
<td>Child Sexual Abuse</td>
<td>Parenting</td>
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</tbody>
</table>

11a. Would you care to elaborate or add to the above list of problems?

12. In general, do you feel there is support among the leadership of the community for the healing process as it relates to the legacy of residential schools?

13. How did you hear about “I da wa da di?”

14. What do you think “I da wa da di” is trying to accomplish?

15. What type of changes have you seen in the lives of Aboriginal woman as a result of this project?

16. Can you describe any negative effects, if any, that this program may have had? If so, what do you think can be done to avoid these negative effects?)

17. How would you describe the program credibility in the community?

18. What are some of the things that tell you this project has been successful so far?
19. Do you feel that adequate support was provided:
   To begin the process of healing?
   During?
   Afterwards?
   Comments:

20a. If you have been a participant in one of the activities, can you describe what you have learned from these activities that you have been able to incorporate into your personal and/or work life?

20b. If you are not a participant can you describe any changes that you have observed in the personal or work life of participants?

21. In addition to the support provided by the project, which of the following supports do people need on their healing journey?

22. What evidence, if any, is there that Aboriginal women are re-gaining their traditional role as women in our society?

23. Do you think that women who participated in this project are re-building pride in being Aboriginal?

24. Can you describe any changes in women relationships or roles in the community? For example, sense of belonging, more active in the community, taking on leadership roles, etc.

25. Do you feel that women are feeling less isolated as a result of this project?

26. Do you think that there are sufficient services to assist families to break the cycle of abuse?

27. Are there any questions or concerns about the project operations that you would like to see addressed by an evaluation?
Kikinahk Friendship Centre

Project Number: RB-67-SK

Case Study Report

Kikinahk Parenting Program

Written by:

Frank Hope

In consultation with:

Kim Scott, Kishk Anaquot Health Research

Prepared for:

Aboriginal Healing Foundation Board of Directors

2002
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1. Introduction

Thirteen case studies are being conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case studies are intended to provide a detailed, holistic view of the projects and their performance. All data collection, analysis, and synthesis are being done by community support coordinators under the facilitative guidance of Kishk Anaquot Health Research (KAHR). The case studies were selected to include representation from a variety of project types and targets. This case study examines a parenting skills course in a rural community that combines Western and traditional approaches and targets Survivors who are living in La Ronge, Saskatchewan, and surrounding area, whether they are First Nation, Métis, gay/lesbian, disabled, men, women, youth, or Elders.

The project addressed here is the Kikinahk Parenting Program delivered by the Kikinahk Friendship Centre Inc. of La Ronge, Saskatchewan (AHF-funded project # RB-67-SK). The primary purpose of the project is to ensure that families will develop traditional and modern parenting skills and ways of relating that will allow them to be functional and healthy. The centre hopes to accomplish this goal via a parenting program from where a blend of traditional parenting models together with opportunities to learn modern expectations of parents are offered. The report describes the program’s approach, what the project hopes to achieve in the short and long term, team and participant characteristics, La Ronge, Saskatchewan, the Aboriginal community, and the surrounding area. It also discusses the methods used, their limitations, and what could be discerned from available data about the changes in individual participants as well as in the community.

2. Project Description

2.1 Project Activities and Goals

The Kikinahk Parenting Program has been operational since 1 December 1999 with a contribution of $176,159 for one year until 31 December 2000; however, the project was renewed for another year and hopefully expects to be ongoing thereafter. It is open to parents, children, and grandparents of La Ronge and the surrounding area. The program expects to achieve its ultimate goal of healthy, functioning families by blending traditional and modern parenting exercises and experiences. These activities take place both at the friendship centre and through off-site camping trips where traditional parenting models are demonstrated and reinforced through positive interaction and “hands-on” opportunities. In addition to having very experienced and respected Elders deliver the parenting lessons, these efforts were supplemented with more general parenting skills training through conferences or forums where guest speakers presented.

The program was intended to meet the need for programming that specifically addressed the Legacy. Parents were offered an opportunity to come to the centre and take part in the program on a very informal, voluntary, “drop-in” basis. Some of the ways the program encouraged Survivors to participate in activities include: meeting with individuals or families in the centre’s facility; inviting individuals/families to visit the project; circulating pamphlets and brochures in the community; consulting with other social service and health care providers; doing home visits; holding an annual open house; and being involved in all aspects of human services in the community. It seemed that encouraging people via word of mouth was the most effective way of enlisting participation. The program allowed for dialogue, soul searching, and traditional advice through sharing. Invited youth were able to spend time with the Grandparents once a week or to just drop by.
Although most of the participants seemed to prefer to just drop in and not be registered, some were registered to enter the program. A few of the services provided included one-on-one counselling, weekly scheduled support groups, conferences, family evenings, and special events with Elders such as camping, harvesting traditional foods, and sharing traditional knowledge. It was hoped that these activities would lead to improved communication within the family, increased community involvement, increased parenting skill, improved community awareness and understanding of the Legacy leading to improved support for affected families, and, ultimately, reduced abuse within the family. The Kikinahk Parenting Program’s logic and outline of performance measurement are presented in Figure 1 and Table 1.

**Figure 1) Logic Model—Kikinahk Parenting Program**

<table>
<thead>
<tr>
<th>Our activities</th>
<th>Parenting education and support.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we did it</td>
<td>One-on-one counselling, weekly support groups, conferences, plays, family evenings, and special events with Elders (e.g., camping, harvesting traditional foods, feasts, and sharing traditional knowledge).</td>
</tr>
<tr>
<td>What we did</td>
<td># of counselling sessions; # of off-site activities (traditional); # of parenting sessions; and # of accessible community programs (e.g., guest speakers and conferences).</td>
</tr>
<tr>
<td>What we wanted</td>
<td>Increase involvement of parents and teens in community activities; improve communication between Survivors and their offspring; reduce incidence of abuse; increase awareness of family issues; and increase awareness of Legacy issues so community can better support and understand the impact of residential school.</td>
</tr>
<tr>
<td>How we know things changed (short term)</td>
<td># of participation involved in spinoff activity; # of observed changes in parenting skills; # of parent and teen participation in cultural activities; increase in # of participants involved in program; reduced rates of family violence with participants and rates of abuse; and # of participation in counselling sessions.</td>
</tr>
<tr>
<td>Why we are doing this</td>
<td>Families who have been impacted by residential school and living in La Ronge and the surrounding area can learn traditional and modern parenting skills and ways to relate to one another that will allow them to be functional and healthy.</td>
</tr>
<tr>
<td>How we know things changed (long term)</td>
<td>Healthy functional families taking responsibility and ownership of their own healing process and confronting the cycle of abuse through education and support from the community.</td>
</tr>
</tbody>
</table>
Table 1) Performance Map—Kikinahk Parenting Program

<table>
<thead>
<tr>
<th>HOW?</th>
<th>WHO</th>
<th>WHAT do we want?</th>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td>Address parenting issues (e.g., violence, sexual, and mental abuse), provide training for individual family members to change their individual and group behaviours; one-on-one counselling and support group meetings; evening activities (e.g., supper and dance); traditional activities (e.g., camping and harvesting traditional foods); conferences, culture week activities, group activities, and parenting weekend in the bush; neck bone and bannock supper with the Elders.</td>
<td>Residential school Survivors and those who have been affected intergenerationally living in La Ronge and the surrounding area, whether they are First Nation, Métis, gay/lesbian, disabled, men, women, youth, or Elders.</td>
<td>Increased involvement of parents and teens in community activities; improved communication and attachment between Survivors and their offspring; reduced abuse; and increased awareness of family issues and of issues for community to better support and understand the legacy of residential school resulting in reduced denial of the problem.</td>
<td>Confident and responsible parents raising children in non-violent homes and protecting their children from abuse; ongoing healing process; and increased awareness of issues related to the Legacy.</td>
</tr>
</tbody>
</table>

| How will we know we made a difference? What changes will we see? How much change occurred? |
|---|---|---|---|
| Budget | Reach | Short-term measures | Long-term measures |
| $186,190 | # of families who participated in community-based program. | Observed changes in awareness and understanding of the Legacy, communication skills, and attachment of parents and teens; participation in education and healing sessions; and individual service demand for healing and community demand for education on the Legacy. | Reduced rates of abuse, family violence, children in care, and child/teen suicide; and evidence of change in community support systems for Survivors and their families. |

2.2 Project Context

The program is being delivered by the Kikinahk Friendship Centre in La Ronge, Saskatchewan, a rural area with a population of about 7,000. It is closely linked to the other programs within the centre and the community, such as Lac La Ronge Indian Band, Piwapan Women’s Shelter, La Ronge Social Services, La Ronge Child Care Co-op, Aboriginal Head Start Program, Young Parent Program, Youth Mediation Diversion Program, youth outreach worker, Youth Service Canada, Youth Evening Recreation Program, and Prenatal Nutrition Program. Perhaps the closest working relationship is with the Piwapan Women’s Shelter that has a similar program for parents. The program budget for 1 December 1999 to 31 December 2000 was originally $186,190, but was amended to $176,159.
2.3 Project Team and Participants

The Kikinahk Parenting Program team includes a financial officer/administrator-in-kind from the Kikinahk Friendship Centre, a project coordinator (AHF-funded), an Elder-grandfather/parenting for fathers (AHF-funded), an Elder-grandmother/parenting for mothers (AHF-funded), and a part-time bus driver (AHF-funded). While it is not clear what qualifications or training any of the team members had, it was obvious that the grandparents selected as Elder models for traditional parenting were highly regarded, well skilled, and tirelessly motivated.

We did not expect to find grandparents that would become so involved in this program and who would outperform our expected activities. What we found in these Parents of Teens Workers are three individuals who for a long time wanted to make a difference in the way that Aboriginal parents were raising their children. They had all kinds of ideas, and just needed the opportunity to fulfill those plans ... Our program could not be luckier in that it has hired the Elders that were the Cree Curriculum teachers at the high school. They are furthering the program by not only dealing with the teens, but are including their parents in their meetings, and camp outs. They are also including other elders in upcoming culture week activities, and in their events.²

Most participants are young, single parents, mainly women from ages 20 to 40 years who accessed the program by dropping in or were referred by the mental health centre or by the Piwapan Women’s Shelter. Some women brought their spouses and children to participate. Forty individuals participated on a regular basis in all or most of the events sponsored by the program, but more than 100 individuals have participated in at least one group event associated with healing (e.g., family evenings, conferences, feasts, or sharing with Elders). Most participants were First Nation and intergenerationally impacted, and consistent with other participant profiles, women outnumbered men.

Figure 2) Healing Activity Participants

![Bar chart showing the number of participants by category.](chart-url)
A total of 150 people participated in broader community events intended to educate the community about the Legacy. Again, most were First Nations, intergenerationally impacted, and women outnumbered men four to one at this event.

![Figure 3: Participation in Awareness-raising Events](image)

### 2.4 Project and Community Context

The Kikinahk Friendship Centre has a big gymnasium that is used for many of the program’s functions. The grandmother and grandfather have their own office where they meet one-on-one with participants or where they teach groups traditional activities. There are also two boardrooms that are used for day or evening activities, and the family room is where parents can bring their children and still be involved with the program (babysitters are provided for the parents so that they can actively attend an activity). The decor is simple with your basic off-white walls and linoleum floors. There are two carved poles that greet you as you enter the centre. These were carved by the grandfather of the program, and one of the carved poles closely resembles the grandmother.

The centre prides itself for providing many different services to the people of La Ronge and the surrounding area. The centre consists of an administration area, offices in the back, a large gym with a stage for community events, an Elders’ office, a Head Start classroom, a sorting room, a dining area, and a kitchen. One notable charity that the centre participates in is receiving donated clothes and distributing these out to the communities in the area. The centre is currently looking at expanding their building to meet the high needs of their personnel and clients.

The town of La Ronge sits on the western shore of Lac La Ronge in northern Saskatchewan. It also consists of two other communities, Air Ronge and the Lac La Ronge Indian Band, which combines an urban population of 7,000. There are six reservations in the area, Far Reserve, Bell’s Point, Big Stone, Big Rocks, Jack Pine, and Morins Hill. La Ronge is 236 kilometres (145 miles) north of the city of Prince Albert and 375 kilometres north of Saskatoon, with services that include:
• a new health centre with emergency, acute care, and long-term care;
• two colleges and four grade schools;
• the Saskatchewan Environmental and Resources Management;
• the third busiest airport in Saskatchewan, hosting scheduled flights, charter services, and the water bomber base for fighting forest fires;
• mining and exploration offices;
• a forestry sawmill;
• wild rice harvesters and processors;
• six hotels and motels, plus cabins and campgrounds;
• nearly a dozen restaurants and eateries;
• two pharmacies;
• libraries;
• optometry and dental services;
• two financial institutions;
• boat and snowmobile dealers; and
• many other retailers for food, clothing, hardware, and other goods.

Not so long ago, many La Ronge residents were still living a traditional Cree lifestyle. The First Nations communities surrounding La Ronge are geographically complex. It is difficult to tell where the community starts and where the town of La Ronge ends. Acculturation has been swift and pervasive and accompanied by some stressful social dynamics, including racism, not just between Aboriginal and non-Aboriginal groups, but also between Aboriginal cultural groups (e.g., between First Nations and Métis). There is also a pronounced tension between Euro-Christian followers and those who practice traditional Aboriginal spirituality. Further, there is a clear class structure with non-Aboriginal Canadians at the top of the hierarchy, followed by Aboriginal people with jobs (known as the “assimilated Indians”), and then followed by Aboriginal people who are abused, addicted, unemployed, and uneducated.

According to responses to the National Process Evaluation Survey, KPP team members recognize the following community challenges to be severe (i.e., affecting 80% or more of the population): poor local economic conditions, substance abuse, fetal alcohol syndrome/fetal alcohol effects (FAS/FAE), as well as family violence.

Never before have we had so many children in broken or never made homes, children into alcohol, drugs and solvent sniffing, and children exposed to violence and sex. In this community we have had children killing themselves and others; many that have been put into care and are now raised by an institution rather than families, and children not doing well academically and children lost emotionally [emphasis added].

Moderate challenges (i.e., affecting 40%–80% of the population) included: adult illiteracy, sexual abuse, and lack of transportation and other community resources, facilities, or services. Apathy or lack of active Aboriginal community support and suicide or attempted suicide were considered a slight challenge (i.e., affecting less than 40%) when considering the community as a whole. La Ronge and surrounding Aboriginal communities are also plagued by housing shortages. In some cases, the housing shortage is so acute that as many as two or three families are living in one house. There is a high rate of homelessness among young people (i.e., <25 years) who may have been thrown out or who have left due to violence in the home. With a noted lack of incentive programs for the young and not enough work to go around, this created an environment of dismal prospects. Most young people do not have an education, including women with small children.
There is an unknown number of residential school Survivors, but there were two residential schools in the La Ronge area: Lake La Ronge Mission School was run by the Anglican Church from 1914 to 1947, when it burned down; and according to Elders, there was also a residential school located at Timber Bay, about 150 to 175 kilometres south of La Ronge after 1947.

Today, the children and youth who attended the Lake La Ronge Mission School are Elders, and their children may have attended the latter residential school in Timber Lake. According to one source, the Elders would rather not talk about their experience in residential school, while the men and women who are in their 40s and 50s are more willing to share and openly talk about it.

The community support coordinator did not have time to directly secure information on the social indicators desired by the board (i.e., rates of physical and sexual abuse, incarceration, suicide, and children in care); therefore, the project coordinator was requested to gather this information for inclusion in the case study. However, the project coordinator moved on to another job without completing this task or transferring the request to remaining program team members. In any case, the mental health centre that worked closely with the program provided the following statistics for the La Ronge area. It is clear that the solid majority (71%) of mental health clients are First Nation and many (41%) are youth (13–18 years old). The most common problems in order of frequency are related to: relationships, suicidal ideation, depression, anxiety, and behavioural problems. Assault charges have had a fairly unstable pattern over the past three years with almost one-quarter of these charges being dropped. Of all assault charges laid, many are of a sexual nature and an alarming proportion of sexual assault charges involve youth and children as victims! Figures 4 to 8 reveal mental health client characteristics, current mental health issues, and current trends in criminal assault.

Figure 4) Ethnicity of Mental Health Clients: LaRonge, Saskatchewan (1999)
Figure 5) Age Breakdown of Mental Health Clients: LaRonge, Saskatchewan (1999)

Figure 6) Mental Health Counseling Issues: La Ronge, Saskatchewan (1999)

*PTSD = post-traumatic stress disorder: physical and/or emotional manifestations caused by a traumatic event affecting an individual (e.g., depression, anger, skin rashes, hair loss, or symptoms with no known cause).
3. Methods

The case study will evaluate changes in the individual participant and in the community. More specifically, the evaluation questions were:

- Was the program effective at teaching traditional and current parenting skills?
- Did the community's awareness and understanding of the Legacy change?

The analysis is heavily reliant on information gathered from key informants (i.e., project team and selected community service providers), although other sources of information included project files (funding proposal, contribution agreement, quarterly reports, project response to AHF Supplementary Survey of July 2001, and the National Process Evaluation Survey of February 2001). The community support coordinator (CSC) also consulted the La Ronge library and The La Ronge Northerner (a weekly community newspaper). Program logic was the only tool available to determine a possible cause of any perceived change.

During the third week of October 2001, one-on-one interviews were conducted with 11 individuals associated with the project or with local community services, including two program team members, two Elders (i.e., the grandparents that were the heart of the program during the first year of the project), and community service personnel (i.e., the friendship centre’s personnel (past and present), social worker, mental health worker, alcohol and drug counsellor, and an educator at the elementary school). Other interviews were scheduled with Victim Services and a local First Nation community councillor, but their schedules did not allow for the interview to proceed as planned. In addition, an interview with the local
Frank Hope

social worker educator did not provide information as anticipated due to his/her limited interaction with the program. Historical information was sought from the town hall in La Ronge; however, the clerk stated that they did not have any prepared or readily available publications for distribution.

The development of interview questions was based on the project's desired short- and long-term goals (see Figure 1 and Table 1) gleaned from the funding proposal together with several generic and mandatory questions of special interest to the AHF Board. The logic model and performance map were sent to the project prior to the development of questions in order to confirm any changes to project goals from the proposal stage to implementation. The questions attempted to determine change, if any, in participants and community. Key areas of interest were:

- parenting confidence;
- parenting skills;
- use of traditional parenting practices;
- goal setting;
- parent–child interaction;
- youth confidence;
- aftercare;
- community understanding of the legacy of residential schools (Legacy);
- family willingness to participate in the program;
- family understanding of the Legacy; and
- ability of the program to meet the need, be accountable to the community, and monitor and evaluate its own activity.

A copy of the instruments used can be found in Appendix 1. Pilot testing the questionnaires was not a luxury in this case, and the majority of questions were based on the assumption that respondents would have some knowledge of program participants.

Due to time constraints and CSC workload, the Kikinahk Parenting Program project coordinator was given a general list of agencies that were considered desirable contacts. The coordinator facilitated information gathering by providing names, phone numbers, and setting up interviews on AHF’s behalf. Actual interviews were conducted by one AHF team member, the CSC for Yukon/NWT, and generally took about one to two hours. In the end, all interviews with one exception did take place. Most of the agencies in La Ronge that serviced Aboriginal people were interviewed or contacted. This allowed a non-biased, general perspective of the project and the community.

3.1 Limitations

There are several threats to reliability and validity that are worth noting here. No direct measurement of participants was conducted by the AHF, its employees, or agents due to ethical concerns about the possibility of triggering further trauma without adequate support for the respondent as well as to the limitations of AHF’s liability insurance. Because direct assessment was problematic, indirect assessment or the perceptions of key informants were weighted heavily. Furthermore, the program team did not actively solicit or record client satisfaction at the end of their participation or at the end of the project year as a follow-up measure. No standardized instrumentation was used to assess changes in parenting skills. Although it is highly probable that there is no psychometrically evaluated or standardized instrument to determine the unique healing stages of Aboriginal people recovering from the Legacy (institutional trauma),
it is still worth considering the use of other instruments that assess change in parenting ability. At the very least, the client group should have been asked about their perceptions of program effectiveness.

Two days of training were offered to CSCs in the case study process in March 2001 with a follow-up in July 2001. Work began in earnest on this case study in September 2001, and interviews were prepared based on the short-term outcomes identified in the performance map. Interviewers were independent in the field and, in this case, there was no debriefing at the end of each day of interviews. Field notes were reviewed, transcribed, and synthesized by Kishk Anaquot Health Research associates.

There are two lines of evidence in this case study: one directly obtained from the project team and the other from those on the periphery (e.g., school offices and mental health counsellors). Dissent was encouraged in at least two introductory remarks preceding interview questions:

- that there are no right or wrong answers, only answers that are true from your perspective; and
- the report will not be able to identify who said what, so please feel free to say things that may cause controversy.

No special efforts were made to secure unconfirmed evidence, rival explorations, or negative cases. While the program may not have been effective for all participants, the CSC was prohibited from gathering direct evidence from those participants. However, it would be useful for the program to profile those for whom the program was not satisfactory. Further, quantitative information was limited to statistics kept by local police and mental health officials. The luxury of multiple evaluators was not available within the resource limitations; however, all responses were recorded verbatim and discourse analysis done by an external evaluation facilitator. In most cases the CSC role would allow for extended and multiple contacts with most projects; however, in this case, the project was based in Saskatchewan and the CSC serviced the Northwest Territories and the Yukon. Therefore, a basis of familiarity between the CSC and the project team did not exist prior to the data collection phase.

The CSC was mostly reliant on information that was most readily available as only two days could be allocated to gathering data. Significant missing information includes board requested social indicators for the area, the characteristics of those participants who did not respond well to the program, and long-term follow-up of those for whom the program did work.

### 3.2 Impact on Individuals

From the program team's perspective, participant characteristics certainly changed over time. Initially, only women were coming to the program, but eventually they brought their husbands and teenagers. In fact, the level of participation surprised the program team: “Not in our wildest dreams did we think that this program would become this well accepted. There are fathers who for the first time in their lives are having an emotional family outing with their sons.”

Parents became increasingly comfortable to share insights and ask questions, and some appeared to become more relaxed, patient, and skilled communicators over time. They were less likely to “push their teenagers away” by more carefully selecting their tone and words, while others seemed better able to allow their teens to have fun or do things with their teens; they could not do so before. One respondent noted that mothers who have participated in the program are not accessing services as often as those who have
not participated. They believe that mothers who participated in the program are better able to keep their children healthier because of their newly acquired life skills (e.g., nutrition).

From the periphery, success was not always clear, although some respondents did note that at least a few have “straightened out” their lives by getting jobs, going back to school, and improving their relationships. However, not everyone heard evidence about parents sobering up, upgrading, or getting their children back. One community informant (i.e., not employed by the program) noted that some participants are more aware of the impact of addictions upon their family relationships and appear to be closer to their children, yet there are other participants who have relapsed once they returned to their normal routine. The program has inspired some to seek more information on addictions treatment and some to discover that they might suffer from FAS/FAE. In short, a respondent was quick to clarify that while dramatic change was observed in some participants, there were “absolutely no changes” in others, and it is not clear to what extent any change endured beyond the life of the project. Despite the promise shown by those most responsive to the program, some youth remain difficult to reach and, although mothers and teens attend for the most part, fathers remain elusive.

For teen participants, all but one showed a willingness to change. Interestingly, the youth who resisted was still motivated to be at almost all the program activities. In other words, just absorbing the transaction was sufficient enough to keep him coming back to the program. Respondents saw greater enthusiasm and motivation evidenced by increased teen participation in activities and knowledge of traditional practices. A few are thinking about going back to school and some have decided to stay in school. Changes at an emotional level were also obvious: “they enjoy hugging when being greeted and they are sharing at a deeper level about their families.”

Some participants accessed other programs (particularly to resolve addictions) and others have secured gainful employment. Still, prevalent substance abuse and family dysfunction hinder the enduring impact of the program on participant families.

There was a clear difference in opinion about whether the program was able to facilitate an increased understanding of the Legacy in participant families. Respondents were equally divided between believing that denial and resistance had not been dismantled and believing that there was an increased openness about the Legacy. Some noted an increased willingness to seek help from other parenting programs like the one at the Piwapan Women’s Shelter (such initiative is being taken on more by women than men across all age groups).

3.3 Impact on Community

Respondents are clearly divided on whether there has been an increased understanding of the Legacy in the community. While some argue that many are still in denial, others notice a willingness to at least discuss the Legacy, albeit superficially. In other words, discussion and information exchanges are more readily received when they do not address very sensitive issues. One respondent noted that over the past four years there have been at least three community-wide awareness workshops and a radio talk show in Cree on the Legacy. These media represent a distinct environmental difference from even just five years ago. It is as if hearing it in Cree on the radio made it okay to talk about the Legacy in other venues. Others noted that openness was related to age with those in the 40 to 50 year-old age category appearing much more willing to talk about the Legacy than those who were older.
There were some disagreement about the community's interest and willingness to participate in the program. At least one respondent indicated that, although the community is aware of the program, there was a serious lack of participation. However, other respondents indicated that the number of drop-in visitors and telephone inquiries about program activities increased over time. In fact, one team member related that community members would not wait to receive information about scheduled traditional activities sponsored by the program but actively sought the information. Engaging in harvesting and preparing traditional foods, especially caribou hunting and smoking fish, brought participants back to a fond time in their childhood, and this created an obvious and eager anticipation in the community. Even the young were enthusiastic about learning how to make whistles and other tools from the Elders.

No information was secured on the board-selected indicators of physical and sexual abuse, children in care, suicide, and incarceration; therefore, respondents were asked to offer their opinions about possible changes in these areas. There was no consistent opinion about whether changes in rates of physical abuse were apparent, although many were optimistic that a range of accessible services, such as parenting skills and anger management together with increased awareness of and willingness to deal with the problem, formed a basis for hope. One noted that abuse rates tended to follow a seasonal pattern: “It comes in stages ... people getting laid off, substance abuse, parents abusing their children. It fluctuates ... winter increases, summer goes down ... been like that for years.” Another key informant felt that rates of domestic violence were high, and victims, including children, were threatened once they had disclosed the abuse to authorities.

Trends in sexual abuse are also very unsettling. Key informants were clear that primary (directly abused) and secondary (witness to the abuse) victims were getting younger, rates continue to be high, and silence ensures perpetuation. One respondent noted that more emphasis on laying charges in sexual abuse cases and disclosures appear to come in waves with “two or three disclosures, then nothing.”

Again, there was a noted inconsistency in opinion regarding whether rates of children in care have changed. Some feel that the rates have increased and have observed that the community’s ability to accommodate these children has been saturated. Children in care are now being sent “east, west, and down south.” Others had no idea or only a vague impression about whether things were changing, and one felt that the program offered an alternative to placing children in foster care.

While respondents were clear that there is more awareness and education about suicide that allows for services and individuals to intervene earlier, most did not believe that suicide rates have changed from what is an unacceptably high rate: “In Stanley Mission, there were one hundred and twenty-five attempts in one year out of twelve hundred population.” Respondents did notice that suicides appear to happen in geographical and temporal clusters (i.e., they happen together in groups either in time or in space) and believe that they are most likely to happen following a relationship breakdown or the completed suicide of a friend.

Although no clear picture could be obtained about what story the selected social indicators might tell, about half of all respondents felt that the program was addressing the Legacy reasonably well, although many were not sure and a few felt that the project was struggling in this regard. Those who felt that the Legacy was addressed well did so because they saw an increase in a willingness to seek information and, ultimately, help. Others who did not feel the same felt that there was a misunderstanding about what the
Frank Hope

program had to offer. In other words, not everyone in the community was entirely clear that the program was a healing program and not a child and family service organization. In addition, there was some confusion about whether the program might be the organization of a class action suit. One suggested that more community-wide workshops on sexual abuse would have been beneficial.

Some respondents felt that sexual abuse issues were being adequately addressed, yet they were not convinced that such abuse was adequately linked to residential school, nor were they completely satisfied that the program was equipped to deal with sexual abuse issues (the program made referrals to social services when serious problems presented themselves). Figure 8 reveals the distribution of opinion regarding the program's ability to address the Legacy.

![Figure 8) Ability to Address the Legacy](image)

**3.3.1 Accountability to the Community**

Accountability is understood to be a board responsibility, which the Kikinahk Friendship Centre attempts to fulfill through a newsletter to the community as well as distributing brochures. One radio interview with the program team was also done in Cree, which provided a forum for community feedback. However, the program's steering committee did not meet. One respondent felt that this was due to the fact that most members were professional people who might be too busy.

Although the majority (80%) felt that the program was accountable to the community, they also felt that there was room for improvement. At least one respondent felt that there should be a variety of ways of communicating with the community that included efforts beyond radio, brochure, and newsletter distribution. Also, school officials felt that they should have had a formal opportunity to provide feedback. Figure 9 reveals the distribution of opinions about the program's ability to be accountable.
Outside of project files, records of participation, and AHF reports it is not clear how the program was evaluated, if at all. Files indicate that a formal evaluation was planned for 31 March 2000 that was to address program impact on participants (child, parents, and community); degree of satisfaction expressed by clients and personnel; whether the program was reaching its intended audience; consistency between goals, program design, and implementation; and the extent and efficiency of partnerships.

This evaluation would have followed the guidelines recommended in *Primary Prevention Programming for Children at Risk*; however, there is no evidence that the program was able to follow through with its evaluation plan. In fact, in many of the reports submitted to the AHF, it was clear the program’s administrators confused means with ends. In other words, most responses to questions about expected outcomes (i.e., changes in participants) focused almost exclusively on the attainment of implementation objectives (i.e., project participation).

4. Explaining the Results

Parenting education and traditional activities facilitated by skilled Elders, who have long thirsted after the opportunity to right the wrongs of residential school, set a solid footing for those who are eager to end the Legacy’s impact on their lives. While the program could not reach everyone in need or have an impact on all those who participated, the information suggests that at least an immediate, even if short-lived, difference was achieved for some families. In addition, albeit not comprehensive or perfect, it appears that the shackles of denial have been loosened in La Ronge. It is not clear whether or not the desired change has had a lasting impact on the program’s participants or if any ripple effect is happening in a more general way in the community. To address gaps in understanding, more information is needed by asking:

- What are the participant characteristics of those for whom the program works and of those for whom it does not?
- Does any difference endure six months, a year, or two years later?
- What are the current rates of physical and sexual abuse, children in care, suicide, and incarceration for the target group?
The Elders/grandparents who facilitated the program during its first year of operation won widespread allegiance, as shown by some participants dropping out of the program when the grandparents left. Their non-judgmental comforting and culturally relevant approach to strengthening parenting skills together with their tireless motivation was consistently cited as the reason the program had an impact. Group dynamics and Legacy education also won credit as being powerful change makers. By being part of a group, participants were not alone in their struggle and, over time, came to understand that their struggles were not unique. Participants no longer thought of themselves as “bad” parents, just parents lacking skill and support.

Change was also commonly attributed to participant motivation or a “readiness” for change. The Kikinahk Parenting Program teaches relationship skills that provide an alternative to emotionally charged and generally futile interactions. Participants clearly thirst for these alternatives and the opportunity to break the cycle of abuse, “to learn something different than how they were brought up.” Focusing on communication skills, quality time with loved ones, home visits, and the power of effective role modelling were important program elements contributing to change. Most importantly, perhaps, was that participants felt respect from the team, and this facilitated a climate of trust. For young people, feeling heard and understood as well as establishing friendships among their peers made attending the program a pleasant experience.

There are a myriad of explanations for those families and individuals who did not experience life-altering changes as a result of their participation in the program. Community socio-economic conditions and the endurance of denial are perhaps the most notable environmental barriers. However, lack of appropriate and sustained access to parenting education and support programs, personal challenges related to addictions, literacy and poverty, as well as racism and classism may also play a role.

4.1 Partnerships and Sustainability

The Kikinahk Parenting Program worked closely with other programs that ran out of the friendship centre as well as with local institutions and resource people, including the following:

- a teen parent worker position funded by social services,
- Kikinahk Mediation Program,
- Kikinahk outreach worker,
- Saskatchewan Social Services,
- addictions personnel at the health centre (e.g., mental health worker and alcohol and drug counsellor),
- local schools, and
- local Elders.

Still, respondents were almost unanimous in their opinions that the program could not sustain activity beyond the life of AHF. Although they saw a continued role for the program in the school, they were almost all doubtful that any other local agency or local fundraising efforts could support its continuation. Those who thought the program would continue beyond AHF cited the friendship centre’s efforts to secure federal funds for expansion and program continuation. At the time of this report, the program did not receive funding from any other source.

4.2 Addressing the Need

It is clear that the majority of participants at the program are young single mothers and that community-wide education on the Legacy was met with sparked enthusiasm. The program was also filling a service gap
as a non-mandated (not required or regulated by government), culturally relevant program with access to Cree Elders and traditional parenting skills education. Still, respondents felt that the need exceeded the program’s resources and that partnerships might have worked well to achieve greater results. Furthermore, there is evidence that denial persists in La Ronge. One respondent had this to say: “I don’t know if the residential school happened too long ago, but there is a lack of acknowledgement.” Eighty per cent of all respondents felt that there was room for improvement in the program’s ability to target those in greatest need. Figure 10 shows the distribution of opinions regarding the program’s reach.

![Figure 10) Ability to Address the Need](image)

### 6.3 Successes and Best Practices

The presence, experience, and character of the Cree grandparents were consistently credited with any positive change noted in program participants. Feasting, conferencing, lessons in parenting and communication, scheduled family outings, traditional activities, and Legacy education were also well received by participants and considered successful program elements by most respondents. In particular, a community conference, entitled *Journey to Awareness*, sponsored by the program was credited with opening the dialogue about sex, violence, and teen power struggles. It was a “bare all” conference where the community had opportunity to face the truth head on. Beyond widespread communication efforts, establishing working relationships with complimentary services and ensuring that the program’s team members maintained their own efforts to guard wellness were also considered best practices. Also, the team believe that the project’s location, leadership, and community support help to create conditions where change was possible.

### 4.4 Challenges

No clear message is apparent with respect to service demand and participation. While some believe that there are inadequate services to meet demand, others are equally adamant that lack of community involvement and soliciting program participation has been a challenge, particularly when it comes to enlisting youth. Other respondents felt that the drop-in nature of the program’s activities at the centre has led some community members to view it merely as a babysitting or daycare service, and there was a strong and nearly unanimous sentiment that limited resources spelled limited results. The need for strong
administration and dedicated teams with adequate training and education as well as vision for the long haul was clear. Short-term “patch it up” projects are no substitute for committed, continuing services. Annual fund-seeking efforts were felt to be diverting resources from those in need. "If they did not have to put in so much energy every year fighting for those dollars, that energy could be put into the program." There was also some noted tension between the centre's board and the program team. More specifically, the board was opposed to a variety of program ideas, including the use of traditional spiritual practices.

High personnel turnover was frustrating. Employees with education and skills are offered better paying jobs by other local organizations, which hinders program quality and communication efforts. The program did not have client satisfaction questionnaires for all its activities and sessions nor was a formal evaluation done as planned; therefore, the program's coordinator had a limited ability to make note of trends for unique groups. Transportation was a problem when it came to off-site delivery of the program, as there was inadequate vehicle space to transport all clients and materials. One of the challenges for the grandfather was encouraging teens who have been in trouble with the law to participate in the program. The grandfather recalled a disappointing time when a moose-hunting trip was planned and the fathers backed out at the last minute; the trip went ahead despite their lack of commitment.

According to results obtained from the national survey, poverty and lack of parenting skills are severe challenges (affecting 80% or more of program participants). Lack of Survivor involvement, denial, fear, grief, history of abuse as a victim, history of foster care, family drug or alcohol addictions, and lack of literacy and communication skills were considered moderate challenges (affecting 40%–80% of the group). But, according to local respondents interviewed for the case study, the issue of FAS/FAE is a big problem and almost all participants were affected and required greater than normal attention within the program as a result. History of suicide attempts and adoption affected less than 40 per cent of all participants, according to the national survey, but there were others who claimed that widespread substance abuse and suicides were having an impact on the program.

Denial was also a barrier to progress that respondents believed could be resolved by increased Survivor involvement in program planning. More involvement from parents of youth would also facilitate the program's ability to give support and guidance to other parents of teens. It was a constant challenge for the Elders to encourage participants to be with their families and attend activities with their children. Greater partnership with the schools could have supported youth involvement in the program, which was also considered very low.

4.5 Lessons Learned

In point form, some of the lessons learned by the program team include the following:

- a need to budget more time than originally anticipated to find the right people for the job;
- exhaustive criminal records checks are absolutely essential, even if time-consuming and frustrating (the program was faced with dismissing an employee who had a criminal record, which was only discovered after that person was hired);
- referrals were made to other more stable organizations so that dependency was not created within a short-lived program with an uncertain future, as the program saw the potential for some clients to become dependant on the services they provide;
- you cannot tell Elders what to do;
- the program underestimated the workload and team burnout was a constant risk;
• the neck bones and bannock supper organized by Elders for Elders and their families was generally very popular, and teen dances were a favourite with youth;
• more rigorous screening of professional credentials and abilities of team candidates is required if a professional element is needed or planned;
• bringing tough issues out in the open and speaking the truth about the socially stigmatized behaviours and conditions, which lurk behind silence, can lead to partnerships and initiatives to face problems head on (e.g., FAS/FAE);
• schools are very interested in finding Elders that are knowledgeable in traditional ways;
• a combination of Western and traditional healing methods would have worked well and was a part of the program's plan, but securing professionals with the necessary clinical skills was a challenge;
• it is wise to anticipate and immediately quash any efforts by lawyers to secure Survivors' names as a way of boosting participation in class action suits; and
• team members felt it might have been better to start in the smaller surrounding communities as La Ronge was too big to reach the target group.

5. Conclusion

Was the Kikinahk Parenting Program able to make parents feel more comfortable about their role and send them off with new skills? This was the case for some participants, yet a different approach may be required for others more resistant to change. The program appealed more to women than men. While it did spark an interest in Legacy education and increased community understanding of the impact, a wall of denial and silence still persists.

Several important ingredients have been credited with the progress that the program was able to achieve, which includes: the commitment, expertise, and interpersonal style of the Elder grandparents involved; participant motivation to ensure that their children's lives would be better than their own; the non-mandated, culturally relevant nature of the project; and a community and program climate that placed individual struggles within the context of a social injustice. But, like any healing process, the development of parenting skills takes time. It may require years of investment before the program could create lasting healing from the Legacy in the La Ronge area.

There is a clear difference between those who are ready to face and heal from the Legacy and those who are not. While initial and resource-restricted efforts should focus on those who are ready, some guidelines should be offered about how to creatively dismantle denial where it exists, not just in a community context because we know Legacy education works well in this regard, but also on an individual basis. It has been repeatedly demonstrated that inviting and attracting women to participate can act as a catalyst within the family, and unique strategies are needed for men who are consistently and significantly under-represented in healing programs.

6. Recommendations

Several recommendations emerge from examining the experience of the Kikinahk Parenting Program as well as from preparing this case study. These fall under three general headings: team building, project delivery, and evaluation.
Team Building:
- in selecting steering committee members, ensure that there is a willingness to commit themselves to the life of the project;
- hire dedicated project personnel that have the education and skills to carry out their roles and responsibilities and are in for the long haul; and
- consult Survivors in the hiring and program development processes.

Project Delivery:
- healing from the Legacy requires vision. There must be a stronger emphasis on continued services (i.e., 10–25 years);
- involve local schools in Legacy education through partnership with AHF-funded projects and local Elders;
- refer serious issues to the appropriate agencies upon disclosure of sexual, physical, mental, and child abuse and any other matter requiring professional care when it is not available in the context of the AHF-funded project;
- focus on target groups in the smaller surrounding communities; and
- build capacity and human resources, especially as it relates to breaking down the barriers of denial and enlisting the participation of men in healing programs.

Evaluation:
- the Kikinahk Parenting Program should create client satisfaction questionnaires from the Community Guide to Evaluating Aboriginal Healing Foundation Activity for funded projects, engage in the formal evaluations planned, and add a long-term follow-up of program impact;
- ensure the project team is clear about the distinction between activities and outcomes; and
- profile those for whom the program seemed to work and identify what is different about those for whom the program worked versus those for whom the program did not. Is denial the only barrier? What other distinguishing characteristics are clear? Age? Sex?

Notes

1 Métis, Inuit, First Nation, and non-status; youth, men, women, gay or lesbian, incarcerated, and Elders; urban, rural, or remote; north, east, and west; community services; conferences/gatherings; performing arts; health centre (centralized residential care); day program in the community; healing circles; materials development; research/knowledge-building/planning; traditional activities; parenting skills; and professional training courses.

2 Information from the Kikinahk Parenting Program quarterly reports submitted to the AHF.

3 Information from the Kikinahk Parenting Program application for funding submitted to the AHF.

4 Information from the Kikinahk Parenting Program quarterly reports submitted to the AHF.

Appendix 1 ) Questionnaires

KIKINAHK PARENTING PROGRAM Interview Questions

Before we begin I would like to ensure you:

- that there are no right or wrong answers, only answers that are true from your perspective, we are hoping to learn more about your attitudes toward the program and its performance and there may be questions that you cannot answer. It is completely acceptable to say that you don’t know.
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc and not on past/present performance, this is a case study, to help us learn more about the strengths and weaknesses of our effort.)
- we are only trying to learn from your experience so that we can help others get what they want from their AHF projects
- the report will not be able to identify who said what, so please feel free to say things that may cause controversy
- and, for the most part, it is important to focus your comments or opinions upon things that you have noticed in individual participants.

To start, I would like you to now think about the people involved in this project (please concentrate on those who have completed the program).

I would like you to first think about the parents and grandparents participating in the program:

1. Have you noted changes in Parent confidence?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Somewhat</th>
<th>No</th>
<th>Don’t know</th>
<th>Not sure</th>
</tr>
</thead>
</table>

Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
</table>

About how many participants are experiencing the same thing (i.e. Saying or doing the same thing)? Circle one.

<table>
<thead>
<tr>
<th>&lt;10%</th>
<th>&lt;20%</th>
<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
</tr>
</thead>
</table>

Why do you think this has happened? What could explain the changes that you have observed?

2. Have you noted changes in Parenting Skills?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
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magnitude of change?

<table>
<thead>
<tr>
<th>&lt;10%</th>
<th>&lt;20%</th>
<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
</tr>
</thead>
</table>
Why do you think this has happened?

3. Have you noted changes in the use of traditional parenting practices? Yes No
Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
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<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
</tbody>
</table>

Why do you think this has happened?

4. Have you noted changes in parents with respect to goal setting? Yes No
Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

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<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
</tbody>
</table>

Why do you think this has happened?

5. Have you noted changes in Parent and child interaction? Yes No
Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
</tbody>
</table>

Why do you think this has happened?

6. What other things about the parents would you like to share?
Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
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</thead>
</table>
Why do you think this has happened?

Now, I would like you to think about the children and the youth involved.

7. Have you noted any changes in Youth confidence?
   Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>almost all</td>
</tr>
</tbody>
</table>

   Why do you think this has happened?

8. To what extent do families maintain aftercare? (e.g. social/therapeutic)
   Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
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<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
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<td>more than 75%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>almost all</td>
</tr>
</tbody>
</table>

   Why do you think this has happened?

9. Which answer best describes your opinion about the participants who have completed the kikinahk Parenting program. Do you believe that as a group, their risk for:
   
   Physical Abuse: increased stayed the same decreased unsure
   Sexual Abuse: increased stayed the same decreased unsure
   Children in care: increased stayed the same decreased unsure
   Suicide: increased stayed the same decreased unsure

   Please explain:

I would like you to now think about the community more generally involved in this project.

10. Have you noted changes in your community’s understanding of the Residential School Legacy?  Yes  No

   What have you noted that makes you feel this way:
Frank Hope

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
</table>

How many people in the community have been affected?

- <10%
- <20%
- about 50%
- more than 75%
- almost all

Why do you think this has happened?

11. Have you noted changes in families understanding the impact of the Residential School Legacy?  Yes  No

Thinking very specifically about the community (i.e. What have you seen, or heard or felt), that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
</table>

How many community members have been influenced this way?

- <10%
- <20%
- about 50%
- more than 75%
- almost all

Why do you think this has happened?

12. Have you noticed if more families are indicating a need or willingness to participate in the Parenting Program?

  - Increased
  - Decreased
  - The same
  - Haven't noticed

Thinking very specifically about community members (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
</table>

magnitude of this change?

- <10%
- <20%
- about 50%
- more than 75%
- almost all

Why do you think this happened?

13. In the last 12 months, please state whether you feel community understanding of the Legacy has:

  - increased
  - stayed the same
  - decreased
  - unsure

How do you know this?

Why do you believe this has happened?

14. In the last 12 months, please state whether you feel participation in traditional activities has?

  - increased
  - stayed the same
  - decreased
  - unsure

How do you know this?
Why do you believe this has happened?

MANDATORY QUESTIONS:

1. How well do you believe “Kikinahk Parenting Program” has addressed the Legacy of Sexual and physical Abuse in Residential schools including inter-generational impacts? Please circle only one response.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Very well, hard to imagine any improvement</td>
</tr>
<tr>
<td>5</td>
<td>Very well, but needs minor improvement</td>
</tr>
<tr>
<td>4</td>
<td>Reasonably well but needs improvement</td>
</tr>
<tr>
<td>3</td>
<td>Struggling to address physical and sexual abuse</td>
</tr>
<tr>
<td>2</td>
<td>Poorly, needs major improvement</td>
</tr>
<tr>
<td>1</td>
<td>Is not addressing the legacy at all</td>
</tr>
<tr>
<td>0</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation for why you feel this way:

2. How would you rate the projects ability to address or meet those needs?

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Very well, hard to imagine any improvement</td>
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</tr>
<tr>
<td>1</td>
<td>Is not addressing the legacy at all</td>
</tr>
<tr>
<td>0</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation for why you feel this way:

3. How well has “Kikinahk Parenting Program” been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
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<td>Is not addressing the legacy at all</td>
</tr>
<tr>
<td>0</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation and some examples of the projects accountability to the community.

4. Do you see “Kikinahk Parenting Program” being able to operate when funding from the Foundation ends? Please specify.
5. How well is the project able to monitor and evaluate its activity? Please circle only one response:

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th></th>
<th>5</th>
<th></th>
<th>4</th>
<th></th>
<th>3</th>
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<th>1</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well but needs improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
<td></td>
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</table>

Please offer an explanation or examples on how you have seen this take place:

FINAL PERSONAL NOTES & OBSERVATIONS:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
GENERAL QUESTIONS (for respondents NOT employed by KPP) KIKINAHK

Name: ____________________ Profession: ____________________ Date: ____________________

Before we begin I would like to assure you:

- that there are no right or wrong answers, only answers that are true from your perspective, we are hoping to learn more about your attitudes towards the program and its performance and there may be questions that you cannot answer. It is completely acceptable to say that you don’t know.
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc. and not on past/present performance, this is a case study to help us learn more about the strengths and weaknesses of our effort.)
- the report will not be able to identify who said what, so please feel free to say things that may cause controversy
- and, for the most part, it is important to focus your comments or opinions upon things that you have noticed in your position as … (chief, nurse, etc.). To start, I would like you to share with me your involvement or knowledge of the KPP

I would like you to now think about the community generally:

1. Have you noted changes in your community’s understanding of the Residential School Legacy?
   
   Yes  No
   
   Thinking very specifically about the community (i.e. What you have seen, or heard or felt), that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

   How many people in the community have been affected?

<table>
<thead>
<tr>
<th>&lt;10%</th>
<th>&lt;20%</th>
<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

   Why do you think this has happened?

2. Have you noticed if more families are indicating a need or willingness to participate in the Kikinahk Parenting Program?

   Increased  Decreased  The same  Haven’t noticed
   
   Thinking very specifically about community members (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

   magnitude of this change?

<table>
<thead>
<tr>
<th>&lt;10%</th>
<th>&lt;20%</th>
<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

   Why do you think this happened?

   Thinking more specifically about the program:
3. How well do you believe Kikinahk Parenting Program has addressed the Legacy of Sexual and physical Abuse in Residential schools including inter-generational impacts? Please circle only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Reasonably well but needs improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation for why you feel this way:

4. How would you rate the projects ability to address or meet those needs?

<table>
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<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation for why you feel this way:

5. How well has Kikinahk Parenting Program been accountable to the community? (i.e., engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</tr>
</thead>
<tbody>
<tr>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation and some examples of the projects accountability to the community.

6. Do you see Kikinahk Parenting Program being able to operate when funding from the Foundation ends? If yes, how and what steps are you aware of?

7. How well is the project able to monitor and evaluate its activity? Please circle only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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<tbody>
<tr>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>
Please offer an explanation and examples on how you seen this take place

8. What do you think are KPP’s strengths? (What seems to be working well, what are the success stories)?

9. What type of change do you see happening in the lives of people who have participated in KPP? If any?

10. What are some of the challenges that KPP faces (What are its weaknesses?) Please specify.

11. Are there any other questions or comments about Kikinahk Parenting Program that you would like to see addressed that we may have missed?

12. Thinking very generally about the community, which answer best describes your opinion about the following rates of:

   Physical Abuse: increased stayed the same decreased unsure
   Sexual Abuse: increased stayed the same decreased unsure
   Children in care: increased stayed the same decreased unsure
   Suicide: increased stayed the same decreased unsure

   Please explain:
Council of the Atikamekw Nation

Project Number: 1311-QC

Case Study Report

Koskikiwetan

Written by:
Wanda Gabriel and Louise Tassé
Assisted by Melissa Gabriel-Ferland

Under the direction of:
Kim Scott, Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2002
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Acknowledgements

We wish to express from the bottom of our hearts all our gratitude to the Atikamekw Nation and especially to the staff of the Koskikiwetan Project for their support and their very warm welcome during this study. We would particularly like to thank the people in the communities who opened their doors and hearts to us to tell their story and to share their experience, without which this study would not have been possible.

We would also like to thank our assistant, Melissa Gabriel-Ferland, for her help and good ideas. She took notes conscientiously and made sure that Wanda’s use of the French language was appropriate.

A very big thank you to Kim Scott of Kishk Anaquot Health Research for her enormous patience, open spirit, valuable teachings, and wise advice.

During this whole collaborative effort, we both learned to complement each other with our respective knowledge and awareness. We are very satisfied and very happy to have been able to work together.

Thank you, Nia: wen

Wanda Gabriel and Louise Tassé
1. Introduction

Thirteen case studies have been conducted to evaluate the impact of the Aboriginal Healing Foundation (AHF) on the well-being of communities, which are intended to provide detailed, holistic views of projects and their outcomes. Community support coordinators, under the facilitative guidance of Kishk Anaquot Health Research, have done the data collection, analysis, and synthesis.

The project, which forms the basis for this case study, is titled “Return to the source” or, in the Atikamekw language, Koskikiwetan (AHF-funded project 1311-QC). This project is divided into three phases, offering activities both at the individual and group level in the three communities of the Atikamekw Nation—Opitciwan, Manawan, and Wemotaci: 1) training of workers and counsellors and establishment of a support network; 2) awareness and education of the legacy of residential schools; and 3) healing.

Sources of information used for this study include project files (funding proposal, contribution agreement, quarterly reports), interviews conducted in the field with members of the project team and selected community service providers, and other documents and data collected.

2. Project Description (Applying a Holistic Lens)

Koskikiwetan is a continuation of the first pilot project (Miromatisiwinik) submitted to the AHF on 15 May 1999. Koskikiwetan started in July 1999 and, at the time of writing, was in its third year of operation. The project serves the communities of Opitciwan, Manawan, and Wemotaci and has the same objectives as Miromatisiwinik: training of workers and counsellors and establishment of a support network; awareness and education regarding the Legacy; and healing. Koskikiwetan operated with a budget allocation of $517,317 from 1 July 1999 to 30 June 2000, and in the second year received $539,365 from 1 November 2000 to 31 October 2001, making a total budget of $1,056,682 for the two years of operation. This study focused on the period of operation between 1 July 1999 and 31 October 2001. This study specifically evaluated the outcome and impacts of activities related to training, therapy services, and development of a support network for which measurable data (qualitative as well as quantitative) are available.

Koskikiwetan seeks to restore individual and collective harmony in the communities in order to rediscover the pride and dignity lost during the time spent in residential schools. In the Atikamekw communities, the issue of the Legacy resurfaced in 1997 when an Atikamekw youth conference was organized as part of a series of local and national conferences and forums designed to examine different facets of social life in communities. Almost one-third of the members belonging to the Atikamekw Nation went to the Amos and Pointe-Bleue residential schools. Following a workshop on residential schools in 1998, the organizing committee responded to wishes expressed by participants by recommending the creation of community programs. The healing process began before the creation of the AHF, following the report of the Royal Commission on Aboriginal Peoples, as part of a process chosen by members of the communities rather than an endeavour influenced by external pressure. The Koskikiwetan team explained the contribution of the project to the healing process related to the Legacy:
The project will contribute to complete the basic training of the majority of community workers and counsellors, in order to consolidate the human resources involved in community healing. The project will also contribute by offering culturally appropriate therapy in harmony with Atikamekw values. The therapy will take into account the existing intergenerational factors as well as specific needs of members of the Atikamekw Nation.

The main objective of the project is to promote a change towards individual and collective well-being by raising the level of awareness of the Legacy and diverse therapeutic and training activities in order to enhance the skills and knowledge of workers and counsellors. In regard to these training and therapeutic activities, the team formulated three specific objectives that correspond to three phases of the project:

- **Training local workers and counsellor**
  In order to complete the training cycle that began during the first pilot project (Miomatisiwini), the team chose three training areas to provide workers and counsellors with specific skills and knowledge needed to respond to the Legacy. These training areas included: intervention techniques related to sexual abuse; crisis intervention; and group facilitation. Counsellors were initially invited to participate in sessions of Inner Child therapy and to commit themselves to this therapeutic process in order to provide training to others. The objective of this process was also to transform a five-day therapy into a 12-day therapeutic treatment that included information and on-the-land activities.

- **Offering a therapeutic process**
  Therapy was offered to residential school Survivors as well as their families. Six on-the-land therapeutic sessions were offered to each group and three were canoe expeditions for youth. The expedition was an intrinsic part of the therapy because one of the major consequences of residential schools was to tear away Aboriginal children from their culture and land. Each therapy session lasted 15 days (two sessions per month), one for adults and one for youth, held between March and August. Both groups met at the end of each month. “We have decided to do things this way out of a desire to build bridges between generations, since they have all suffered from the Legacy and its impacts, even if the context was different for each generation.”

- **Psychosocial intervention, pre- and post-therapy**
  Community workers and counsellors were available for the entire duration of the project for continuity of psychosocial intervention. They were also invited to give pre- and post-therapy sessions. “In addition, several other types of activities are organized in each of the three communities to continue the work started by the first project. Within these activities, emphasis was placed on sharing circles to include as many people as possible in the healing process.”

Koskikiwetan relied on existing local resources rather than outside experts in order to strengthen communication with existing networks at the local as well as regional level to ensure sustainability. The next section describes characteristics of the participants and project team including the Atikamekw Nation’s three communities: Opiciwan, Wemotaci, and Manawan.

### 2.1 Participant Characteristics

Koskikiwetan focused on the residential school impact on families. The awareness-raising and therapeutic activities targeted participants of all generations. The Atikamekw Nation has a young population: 60 per cent are less than 25 years old. All ages were invited to participate in all healing activities without restriction: workshops, communal suppers, activities, therapeutic retreats, plays, meeting with Elders, forums, sharing circles, and individual sessions with a psychotherapist or psychologist (forums and/or meetings for youth accompanied by parents). Adults over 25 were invited to participate in training sessions and meetings between counsellors and project workers.
The target population included all Aboriginals. The project also served participants with special needs who were either residential school Survivors, their descendants who were affected, homosexuals, disabled individuals, non-Aboriginals, or Elders. Recruitment was to be done before the start of the Koskikiwetan project through information and awareness-raising and through the creation of committees and services, such as: a regional committee entrusted with the collection of stories from each community; local support committees; integration of healing services within existing health and social services; information sessions for young people (in schools, youth clubs); intercommunity sharing circles with other nations; and organization of public information sessions in each community. At the community level, the existing communication system was used: community radio and television, production of bilingual (Atikamekw–French) flyers, brochures, and meetings with leaders of the community. The video and play were used for information and awareness-raising. The team continued its promotion and awareness-raising work on a regular basis via the community radio and television, and local coordinators were responsible for the promotion of the project. In addition, the team ensured that each participant met with an agent from the Sûreté du Québec in order to conduct a criminal background check. To date, all participants do not have a criminal record.

Table 1 shows the participation rate by activity, gender, and age. In the Opitciwan community, children aged 0–14 did not participate in healing activities unlike Wemotaci and Manawan. In all communities, females doubled the number of male participants.

**Table 1) Participation Rate by Activity, 1999–2000**

<table>
<thead>
<tr>
<th>Activities/Communities</th>
<th>Age</th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) OPITCIWAN</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited showing of video</td>
<td>0–14:</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>15–25:</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>26–49:</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>50+:</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Individual sessions</td>
<td>0–14:</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>15–25:</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>26–49:</td>
<td>5</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>50+:</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Public showing of video</td>
<td>0–14:</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>15–25:</td>
<td>4</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>26–49:</td>
<td>22</td>
<td>3</td>
<td>25</td>
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<tr>
<td></td>
<td>50+:</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Therapy with a psychologist</td>
<td>0–14:</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<tr>
<td></td>
<td>15–25:</td>
<td>23</td>
<td>13</td>
<td>36</td>
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<td></td>
<td>26–49:</td>
<td>84</td>
<td>44</td>
<td>128</td>
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<tr>
<td></td>
<td>50+:</td>
<td>38</td>
<td>21</td>
<td>59</td>
</tr>
<tr>
<td>2) WEMOTACI</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Workshop and supper</td>
<td>0–14:</td>
<td>1</td>
<td>1</td>
<td>2</td>
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<td></td>
<td>15–25:</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
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<td></td>
<td>26–49:</td>
<td>16</td>
<td>2</td>
<td>18</td>
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<tr>
<td></td>
<td>50+:</td>
<td>3</td>
<td>2</td>
<td>5</td>
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<tr>
<td>Activities before showing of video</td>
<td>0–14:</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td>15–25:</td>
<td>9</td>
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<td>18</td>
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<td>26–49:</td>
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<td>18</td>
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<td></td>
<td>50+:</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Activities/Communities</td>
<td>Age</td>
<td>Females</td>
<td>Males</td>
<td>Total</td>
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<tr>
<td>--------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Training given by a psychologist on helping/counselling others</td>
<td>0–14:</td>
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<tr>
<td></td>
<td>15–25:</td>
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<td></td>
<td>26–49:</td>
<td>4</td>
<td>2</td>
<td>6</td>
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<tr>
<td></td>
<td>50+:</td>
<td>3</td>
<td>3</td>
<td>6</td>
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<td>0–14:</td>
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<td>15–25:</td>
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<td></td>
<td>26–49:</td>
<td>17</td>
<td>7</td>
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<td>24</td>
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<td>0–14:</td>
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<td>0–14:</td>
<td>16</td>
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<td>41</td>
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<td>15–25:</td>
<td>89</td>
<td>55</td>
<td>144</td>
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<td>26–49:</td>
<td>282</td>
<td>152</td>
<td>434</td>
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<td></td>
<td>50+:</td>
<td>98</td>
<td>57</td>
<td>155</td>
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<tr>
<td></td>
<td>485</td>
<td>289</td>
<td>774</td>
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</tr>
</tbody>
</table>

Table 2 shows participant characteristics in the three communities by age, status, social group, and gender during the first and second years of operation, 1990 to 2000 and 2001 to 2002. During the first year,
the majority were registered female Aboriginal participants residing on reserve. Also, the number of non-Aboriginal participants was higher in Manawan where the total number of participants was highest. By the second year females were still participating in greater numbers, and there was also an increase in participants aged 50 and over. The number of non-Aboriginal participants showed a marked decrease in the second year, from 70 to two, and the overall participation rate decreased by 3 per cent. On the other hand, participation of residential school Survivors increased by 1 per cent and Elder participation remained the same.

Table 2) Overview of Participation Rate by Participant Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Females</th>
<th>Males</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0–14</td>
<td>16</td>
<td>7</td>
<td>41</td>
</tr>
<tr>
<td>15–25</td>
<td>89</td>
<td>66</td>
<td>144</td>
</tr>
<tr>
<td>26–49</td>
<td>282</td>
<td>164</td>
<td>434</td>
</tr>
<tr>
<td>50 and over</td>
<td>98</td>
<td>111</td>
<td>155</td>
</tr>
<tr>
<td>Status of participants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registered, living on reserve</td>
<td>435</td>
<td>308</td>
<td>687</td>
</tr>
<tr>
<td>Registered, living off reserve</td>
<td>11</td>
<td>27</td>
<td>19</td>
</tr>
<tr>
<td>Non-registered, living on reserve</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Non-registered, living off reserve</td>
<td>39</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Non-Aboriginals</td>
<td>39</td>
<td>1</td>
<td>40</td>
</tr>
<tr>
<td>Total</td>
<td>485</td>
<td>337</td>
<td>822</td>
</tr>
<tr>
<td>Participant social group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential school Survivors</td>
<td>162</td>
<td>228</td>
<td>390</td>
</tr>
<tr>
<td>Descendants affected</td>
<td>84</td>
<td>102</td>
<td>186</td>
</tr>
<tr>
<td>Homosexuals</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Aboriginals</td>
<td>8</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>Elders</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td>263</td>
<td>337</td>
<td>526</td>
</tr>
</tbody>
</table>

From quarterly reports, the project team reported several serious difficulties and challenges. Since the team did not participate in the AHF national survey, we cannot compare with other AHF-funded projects. From the beginning, encouraging participation was an arduous and lengthy process as people were still reticent and showed resistance toward the project. The team had to make personal contact by phone and letter in order to ensure good participation at the information sessions after having to postpone these several times.

Community radio was the most effective media with the exception of Wemotaci where it only worked sporadically. Research for the video production began in December 1999, and because editing was poorly done, the launch of the video was delayed several times. The communities are divided along two schools.
of thought when it comes to the Legacy: people deny the Legacy and do not accept there is a need for healing; and people feel the need to get support to begin their healing work.

2.1.1 Description of the Therapy Setting

Therapy sessions were conducted in the bush/wilderness; one in winter and the other in summer. The winter site is accessible from October to May. There were eight cabins, one for the kitchen, shower cabins, and outbuildings. The summer site could only be reached by canoe/portage and participants erected tents for their own accommodation. The kitchen operated in a round log cabin, and showers and toilets were in similar but separate cabins.

2.2 The Project Team—Personnel, Training, and Volunteers

The project team is composed of the following members:

- one project manager;
- one regional coordinator;
- three local coordinators;
- one clinical supervisor;
- local workers and therapists/counsellors; and
- support personnel (cook, maintenance person).

Since the project involved all three communities of the Atikamekw Nation, a need to collaborate between the local coordinators and counsellors, as well as supervision by the regional coordinator, was a necessity. The regional coordinator offered technical support to local coordinators and the evaluation process. The role of the three local coordinators (one per community) was to assess needs, supervise, and coordinate activities related to awareness-raising, consultation, and healing. The clinical supervisor provided professional advice, awareness-training, and healing activities, recommended working methods, and responded to specific clinical needs. The team had to work in collaboration with the Council of the Atikamekw Nation (Atikamekw Sipi), its education, social services, and other administrative and consulting services. Koskikiwetan originated from a joint endeavour with the Atikamekw Tribal Council, health and social services, as well as the education department of the police services in the three communities.

Before submitting a proposal to the AHF, the project coordinator approached several social workers for guidance. This led to the formation of an initial local and regional 14-member team that included a psychologist and a lawyer, and more than half the team were residential school Survivors. The present regional and local coordination of Koskikiwetan has been in place since July 1999. Project team members are Atikamekw with the exception of the manager and clinical supervisor/psychologist and all possess a solid working experience with Aboriginal communities in Quebec.

In addition to management tasks, the regional coordinator ensured there was an efficient information management system related to professional, clinical, and administrative activities; hired other personnel and oversaw their orientation, participation, motivation, and valorization; and represented the Koskikiwetan team among the local organizations and committees. Including the assessment of needs and supervision of training and healing activities, local coordinators had to: work in close cooperation with the regional coordinator and clinical supervisor; act as resource-persons and counsellors for support
groups; develop working tools and methods; make recommendations; coordinate community activities; and actively participate in the evaluation of the program. In addition to clinical and supervisory work, the clinical supervisor participated with local coordinators in the development, monitoring, and evaluation of programs and services; made recommendations for the promotion and evaluation of the quality of services; ensured implementation; and assisted the regional coordinator on community activities in collaboration with local coordinators. Elders from the three communities volunteered to offer their spiritual guidance and to sit on various committees.

The local and regional services who were involved made some form of contribution, which included:

- educational, linguistic, and cultural services from the Atikamekw school system;
- Regional Council for Education and Language;
- team members from the Atikamekw Teaching Services;
- Atikamekw Language Institute (Wasikahikan);
- Round Table for Education;
- Round Table for Culture;
- Atikamekw Nation Documentation Services;
- family–youth–children services, which include prevention and health services, services for youth aggressors, and resource services for the rehabilitation of youth in difficulties; and
- other services for adults and older people.

The management team of the Atikamekw Social Services includes the following human resources, as indicated in Table 3:

<table>
<thead>
<tr>
<th>Local Team</th>
<th>Coordinator</th>
<th>Professional therapists</th>
<th>Community workers</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manawan</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Opitciwan</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Wemotaci</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Regional Team</th>
<th>Director</th>
<th>Professional Services Director</th>
<th>Advisory Services</th>
<th>Community workers</th>
<th>Support</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>1</td>
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</tbody>
</table>

2.3 Community Context

The three communities of the Atikamekw Nation are located in the regions of Haute-Mauricie and Lanaudière: Opitciwan is beside the reservoir Gouin; Wemotaci beside the Saint Maurice River, north of La Tuque; and Manawan is north of Saint-Michel-des-Saints. Most members of the Atikamekw Nation live in one of the three communities.
Table 4) Population and Area of the Atikamekw Nation Communities in 2000

<table>
<thead>
<tr>
<th>Communities</th>
<th>Members</th>
<th>Area (hectares)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opitciwan</td>
<td>1,795</td>
<td>926.76</td>
</tr>
<tr>
<td>Wemotaci</td>
<td>1,106</td>
<td>2,978.00</td>
</tr>
<tr>
<td>Manawan</td>
<td>1,638</td>
<td>771.36</td>
</tr>
</tbody>
</table>

With over 4,500 members, the Atikamekw Nation ranks fifth in Quebec in population size with 60 per cent of the adults under 25 years of age. These three communities are situated in the heart of a vast territory, travelled and used by Atikamekw people for hundreds of years. Other communities in this territory occupied by the Atikamekw are accessible by dirt road and fairly distant from each other, causing some difficulty in implementing activities.

For centuries, well before the arrival of Europeans, Atikamekw people lived on this territory that ensured their livelihood; and it is the resting place of their ancestors. While taking part in modern life, Atikamekw people are still very attached to their traditional way of life, based on a close connection with nature. The Atikamekw Nation has been acculturated to the French language and the Catholic religion since the turn of the twentieth century. Roman Catholic churches were built in each of the three communities. Today, the Atikamekw Nation possesses its own school system that promotes Atikamekw education, language, and culture in a bilingual teaching system (Atikamekw and French) in each community. The school system includes a regional Council for Education, Language, and Culture (French acronym CRELC), a team responsible for curriculum and teaching material, the Atikamekw Language Institute (Wasikakikan) that was created in 1983 and is the authoritative body for all issues regarding language, a round table for culture, and a round table for language.

The Council of the Atikamekw Nation was created in 1982 and is composed of the chiefs from each community. The Council is the political, administrative, and negotiating voice of the Atikamekw Nation. In addition to providing services related to education, language, and culture as well as social and documentation services, the Council offers technical services for each community to implement community projects (construction, planning, maintenance, etc.).

During a youth conference in 1997, the Atikamekw Nation gathered to discuss and better understand the Legacy with the primary objective of finding solutions. At the conference, it became clear that a total of 119 children from the community of Opitciwan, 212 from Wemotaci, and 125 from Manawan attended residential schools. Workshop participants made the following recommendations:

- put in place support mechanisms;
- organize healing circles and encourage individuals to share their residential school experiences for themselves, their children, and their grandchildren;
- put in place, as soon as possible, an emergency service for people who have immediate and urgent needs;
- identify and teach Atikamekw values by using stories told by participants on their own healing journey and by using spirituality to help others deal with the Legacy and to find solutions;
- create a family healing circle for parents and their children;
- create a healing circle for individuals with similar experiences;
- create a community healing circle (Elders and youth);
- create an inter-community healing circle;
• create a circle or organize meetings between people from other nations who lived in similar circumstances;
• create, as soon as possible, a working group or review committee to develop a support program in order to improve the living conditions of Aboriginal people, especially in regard to education and professional training. This program (curriculum) should include the following four themes:
  • renewal of the relationship with First Nations;
  • strengthening Aboriginal governments;
  • new fiscal relationships; and
  • strengthening Aboriginal populations and communities and studying compensations;
• open a centre for counselling;
• reflect on the socio-cultural analogy between residential schools and reserves;
• begin a return to our source and to ancestral practices;
• begin the re-establishment of a social balance and a reconciliation process at an individual and a collective level; and
• put in place mechanisms for the preservation of patrimonial sites, such as birthplaces of ancestors and of living individuals.

3. Using Common Sense—Data Collection Process

In order to carry out data collection in the three communities, all project files were carefully reviewed (application for funding, quarterly reports, relevant data on suicide in the Atikamekw communities, and data on the testimonies and recommendations made by participants at the youth conference). After an initial review of all available documentation, a logic model and a performance map were designed to provide a measurement tool and an overview of the project. The interview questionnaire (Appendix 1) was based on project information and indicators of change highlighted in the performance map. During the week of 13–16 May 2002, the community support coordinator and her assistant visited the Atikamekw Nation communities to gather data from individuals involved with the project, information on participants, and the communities’ archives; all were very open and cooperative. A total of 15 interviews were conducted. The following performance map details the project’s mission, target, objectives, and goals. This map or one-page reference guide was used to determine what information should be gathered to measure change.
Figure 1) Performance Map—Koskikiwetan

Mission: Restore the individual and collective harmony of the members of the Atikamekw Nation to return pride and dignity lost in residential schools.

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<tr>
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</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td>activities/outputs</td>
<td>Workers in the three communities; Survivors and their families (intergenerational) and youth.</td>
<td>Workers who respond adequately to the psychological, psychosocial, and cultural needs of victims of physical and sexual abuse; increase in the number of members of the three communities in the process of individual and collective healing.</td>
<td>A support network in the three communities and expanding throughout the region; improved family, intergenerational, and community relationships; continuity of the healing process; and restored lost identity and harmony.</td>
</tr>
</tbody>
</table>

How will we know we made a difference? What changes will we see? How much change occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$672,290</td>
<td>All members of the Atikamekw Nation in Opitciwan, Manawan, and Wemotaci.</td>
<td>Psychological and psychosocial services availability; # of cultural activities; and self-reported or observed changes in family, intergenerational, and community relations.</td>
<td>Reduced incidences of suicide, alcohol and drug abuse, family violence, sexual and physical abuse, children in care, and unemployment.</td>
</tr>
</tbody>
</table>

3.1 Thinking Logically: Activities and Results

There should be a logical link between activities undertaken by a healing project and what they hope to achieve in the short and long term. The following is a presentation of activities and desired results found in quarterly reports of the Koskikiwetan project.

To deal with the significant rates of suicide among the youth, alcohol and drug use, and numerous cases of family and social violence, the short-term goal of the project was to train community workers in healing that included Atikamekw culture and values. In the long term, the project’s objective was to reduce rates of suicide; alcohol and drug use; family, physical, and sexual violence; foster home placement; and unemployment.

The expected short-term objectives and desired results were summarized as follows:

- increase resources by training local workers to specifically deal with the effects of residential school and modify therapies to include the Atikamekw socio-cultural context of past and present;
set up a healing process in a natural setting aimed at youth and adults with the goal of giving members of the communities access to their culture and territory;
- deliver psychosocial interventions and pre- and post-therapy activities;
- modify Western therapeutic processes with traditional Atikamekw culture and spirituality; and
- sustain a partnership with the Council of the Atikamekw Nation educational section in the three communities.

During the first phase of Koskikiwetan (training of workers and modifying Western and traditional therapies), the team felt that they achieved the desired short-term goals despite resistance among older members of the communities and technical difficulties related to the video production (Miromatisiwinik).

Prior to training and healing activities, there was a need for education and consciousness-raising on residential schools; thus, the video entitled Miromatisiwinik (North Wind) was produced. It proved to be an excellent working tool to begin individual and collective healing for Survivors and other members of the communities. Training activities included grief counselling, crisis situation management, holistic approaches, group processes, supportive counselling, and suicide intervention. Sixteen social and health service workers received training between September and December 1999. During the first year, the project team assessed intervention techniques of various training approaches. As a result and with the specific goal of linking conventional intervention approaches with Aboriginal culture and spirituality, the team modified a therapy entitled “Intergenerational Impacts” that included an approach referred to as the “Inner Child.” This approach consisted of having potential employees undergo therapy to initiate them into the healing process. The approach was tested in the last quarter of the project’s first year of operation and continued into the second year. In addition, two weeks of training on sexual abuse was offered. All participants had access to clinical supervision one week per month.

The project hired three psychotherapists to serve each community bi-weekly. A full-time social worker was also hired in each community to work closely with the psychotherapists. With Intergenerational Impacts therapy, six Atikamekw therapists were trained in the Inner Child approach. According to project staff, the Atikamekw therapists carried out training in addition to their regular work at the local level, causing some to be nearly burned out.

The trainers were familiar with the Aboriginal community as well as with specific problems experienced by these communities. Seventy-five per cent (75%) of the training was taught by two psychologists, one is Atikamekw, and the other training was taught by an Aboriginal and two non-Aboriginal people from La Tuque working in the social services area. The training activities consisted of 40 per cent theoretical and 60 per cent practical content (i.e., role-playing, situation scenarios, and case studies). An evaluation of this initial training was conducted, and the most significant results included the following:

- ninety-three per cent (93%) of the participants in grief counselling training were very satisfied
  - strong point: enriching albeit difficult training
  - weak point: lack of written documentation

- eighty per cent (80%) of the participants in the crisis situation management training were satisfied
  - strong point: the trainer’s self-management skills and know-how
  - weak point: digressions from the subject;

- seventy-four per cent (74%) of the participants in the holistic approach training were satisfied
  - strong point: training in the four elements
  - weak point: training too short, undertaking not sufficiently in-depth
• fifty per cent (50%) of the participants in group process training were satisfied
  • strong point: participation of the whole group
  • weak point: too much content for the short duration of the training

• ninety-one per cent (91%) of the participants in supportive counselling training were satisfied
  • strong point: sharing
  • weak point: group dynamics were affected by the departure of a participant

• sixty-seven per cent (67%) of the participants in suicide intervention training were satisfied
  • strong point: very good training tools
  • weak point: too many activities, not enough participants

A total of 46 people participated in training activities during the first year of operation (27 in suicide prevention and grief counselling, 30 in supportive counselling, 27 in group healing, and 34 in crisis situation management).

During the project’s healing phase, project staff felt that it obtained satisfactory short-term results despite some resistance in participation. Each therapy group was able to benefit from six sessions in a natural setting, including three sessions for youth in the form of a canoe expedition. Each session lasted fifteen days, two per month, one for adults and one for youth. Participation was relatively good during the information sessions, and participants clearly benefited from the skills of the clinical supervisor. All activities, including the sharing circles (Mokocan) in the bush, were spread out over the duration of the project. Depending on the extent of needs, the clinical supervisor had to be readily available. Among the traditional methods of intervention, the project team supported activities in a natural setting (oral testimonies, sharing circles, training workers); the use of a nurturing community; the use of traditional teachings of Elders; and traditional cooking activities combined with information sessions for the youth. Table 5 lists the training and therapy activities that took place during the first year of the project.
Case Study Report: Koskikiwetan

Table 5) Training and Therapy Activities, 1999–2000

<table>
<thead>
<tr>
<th>Activity</th>
<th>Quarter 1</th>
<th>Quarter 2</th>
<th>Quarter 3</th>
<th>Quarter 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional coordinator</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modifying adult therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Modifying youth therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy logistics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Registration period</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapy in a natural setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Youth therapy canoe expeditions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychosocial interventions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-therapy follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Post-therapy follow-up</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Evaluations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local committee meetings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regarding the third phase of the project (psychosocial and pre- and post-therapy interventions), project staff felt that they achieved the short-term objectives that were set out. The Koskikiwetan team was required to ensure local support was available to participants; community workers offered pre-therapy sessions to Survivors and their families in preparation of their healing journey. Once therapy was completed, post-therapy sessions were available.

The project also developed a partnership with the Opitciwan Issue Table, whose coordinator attended meetings of the local project committee. Another partnership being developed is with the Wemotaci Suicide Prevention Table where the clinical psychological supervisor brings his expertise in the area of preventing intergenerational suicide. The team contributed to the Effective Parenting training through efforts of a worker and the local Wemotaci coordinator. The project also linked with the Manawan social services, which gave technical support by facilitating the integration of the local project committee into the community. The logic model (Figure 2) below outlines the logical relationship between project activities and the short- and long-term benefits desired.
**Figure 2) Logic Model—Koskikiwetan**

<table>
<thead>
<tr>
<th><strong>Activity</strong></th>
<th><strong>How we did it</strong></th>
<th><strong>What we did</strong></th>
<th><strong>How we know things changed (short term)</strong></th>
<th><strong>Why we are doing this</strong></th>
<th><strong>How we know things changed (long term)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Train local workers and establish a support network.</td>
<td>Hired a regional coordinator, three local workers, and nine therapists; created regional and local committees; and trained and developed human resources.</td>
<td>Suicide prevention, grief work, supportive counselling, crisis situation management, and group facilitation; training in Inner Child therapy and on sexual abuse.</td>
<td>Community workers were available for the duration of the project to meet the needs of participants before, during, and after therapy sessions; and several other awareness activities were organized in the three communities in a spirit of continuity between Miromatisiwinik and Koskikiwetan projects.</td>
<td>Empower local resources; and individual and collective healing will contribute to cultural identity and re-establish harmony in the communities by giving people back their pride and dignity damaged by the suffering and injustice caused by residential schools.</td>
<td>Reduced rates of suicide, alcohol and drug abuse, family violence, physical and sexual abuse, children in care, and unemployment; and improvements in family and intergenerational relationships.</td>
</tr>
<tr>
<td>Offer individual and collective therapy adapted to traditional culture.</td>
<td>Six therapy sessions for adults who formerly attended residential schools; six therapy sessions for youth. All sessions took place in the bush and lasted 15 days each; three sessions for youth were carried out as a canoe expedition in the territory.</td>
<td>Two therapies a month, one for adults and one for youth. Each group (adults and youth) meets at the end of every month to promote exchanges of oral testimonies and to encourage discussions between adults and youth.</td>
<td>Increasing psychosocial and psychological interventions; reactions and testimonies of participants (caregivers and care receivers) in the healing process; and involvement of community members in community activities and organizations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop means of psychological and psychosocial support for participants within the community.</td>
<td>Pre-therapy sessions to prepare participants on their healing journey; post-therapy sessions to support participants; and sharing circles (Mokocan).</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>What we wanted</strong></td>
<td>Trained workers able to link traditional therapy with modern therapy; and a solid support network in the communities.</td>
<td>A bridge between the generations who endured the effects of the residential schools; bridges between adults and youth in the community; and change in social indicators reflecting individual growth.</td>
<td>Have the greatest number of people participating, not only in the process of individual and collective healing, but also in all activities related to this process.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workers respond adequately to the psychological, psychosocial, and cultural needs of victims of physical and sexual abuse; and support networks consolidated and other networks developed.</td>
<td></td>
<td>Increasing psychosocial and psychological interventions; reactions and testimonies of participants (caregivers and care receivers) in the healing process; and involvement of community members in community activities and organizations.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Our Hope for Change

This section reports on changes that Koskikiwetan hopes for over the long term. Information was collected from available data, studies, and reports related to the three communities of the Atikamekw Nation as well as testimonies and observations gathered during the interviews carried out in two of the Atikamekw communities (Wemotaci and Manawan) and from the project team with key informants from the communities. The social indicators identified by the AHF Board of Directors provided a base to evaluate changes related to suicide, physical abuse, sexual abuse, psychological distress, suicidal thoughts and actions, use of alcohol and drugs, children in care, and incarceration. Inconsistent data in terms of location and time for all the Atikamekw communities made it difficult to compare the three communities.

4.1 Suicides

Suicide is defined as “an intentionally self-inflicted injury with the intention of ending one’s life.”

According to studies, successful suicides represent a miniscule part of all suicide attempts. This is why it was essential to report on attempted suicides when data were available. The suicide rate in the Atikamekw communities is very high compared to the rest of Quebec and Canada. In fact, for the three Atikamekw communities, suicides are between 3.5 to 5 times higher than in Quebec or Canada, and mostly affect youth.

Suicide in the Atikamekw Nation represents one of the main reasons for the Koskikiwetan Project. Data was obtained from the results of a study called the “Mikon Project” for the prevention of suicide among youth of the Atikamekw communities. Koskikiwetan arose in the wake of the Mikon Project. The Mikon Project’s principal objective was to ensure that the Atikamekw population take a central role in understanding the fundamental problems that afflict the nation so that solutions can be created.

The methodology favoured by the Mikon Project was action-research within the framework of an intervention program. Community workers from the three Atikamekw communities as well as anthropologists from Inter-university Group for Research into Medical Anthropology and Ethnopsychiatry of the University of Montreal coordinated the project. The analysis used was based on data dealing with cases of the Atikamekw living in these three communities and not Atikamekw living outside of their community. The collection of quantitative data presented several difficulties because the information on causes of death in the three communities was inconsistent; the data began in 1977 for Wemotaci, 1972 for Manawan, and 1970 for Opitciwan. However, the Mikon Project was able to gather qualitative data to analyze risk factors and identify those persons at an increased risk of committing suicide. These types of data include:

- information related to the history of those persons who committed suicide;
- data on attempted suicides from records of workers in social, health, and police services from each community;
- testimonies of individuals who attempted suicide; and
- location-based family genealogy where cases of suicide and attempted suicides were identified.

Table 6 indicates the mortality rate for each Atikamekw community was substantially the same based on population rates. From 1970 to 1998, the total number of recorded deaths was 390 in the three communities; 169 in Opitciwan, 81 in Wemotaci, and 140 in Manawan.
Table 6) General Mortality Rate (per 1,000), 1996

<table>
<thead>
<tr>
<th></th>
<th>Opitciwan</th>
<th>Wemotaci</th>
<th>Manawan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality rate</td>
<td>2.77</td>
<td>3.04</td>
<td>3.81</td>
<td>3.22</td>
</tr>
<tr>
<td>Number of deaths from 1970 to 1998</td>
<td>169</td>
<td>81</td>
<td>140</td>
<td>390</td>
</tr>
<tr>
<td>Total population of the Atikamekw Nation</td>
<td>1,805</td>
<td>970</td>
<td>1,576</td>
<td>4,351</td>
</tr>
</tbody>
</table>

Table 7 presents the suicide rate for the total population in each community in 1996. The available demographic information did not allow for a yearly comparison nor did it allow the data to be grouped by a uniform age range. In 1996, death by suicide in Quebec was 19.4 (per 100,000), and in Canada, it was 13 (per 100,000). Compared to Quebec and Canada, death by suicide was 3.5 to 5 times higher in the Atikamekw communities and highest in Wemotaci with 103.09 (per 100,000).

Table 7) Suicide Rate by Age Group, 1996

<table>
<thead>
<tr>
<th>Suicide rate (per 100,000)</th>
<th>Opitciwan</th>
<th>Wemotaci</th>
<th>Manawan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>55.40</td>
<td>103.09</td>
<td>63.40</td>
<td>68.94</td>
</tr>
<tr>
<td>Age 16–20 years</td>
<td>507.61</td>
<td>–</td>
<td>862.07</td>
<td>682.59</td>
</tr>
<tr>
<td>Age 21–25 years</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Age 26–30 years</td>
<td>–</td>
<td>1,176.47</td>
<td>–</td>
<td>317.46</td>
</tr>
<tr>
<td>Age 16–25 years</td>
<td>271.00</td>
<td>–</td>
<td>378.78</td>
<td>432.90</td>
</tr>
<tr>
<td>Age 26–35 years</td>
<td>–</td>
<td>662.25</td>
<td>–</td>
<td>242.13</td>
</tr>
</tbody>
</table>

Results of the Mikon Project revealed that youth among the Atikamekw were at high risk of committing suicide. From 1977 to 1998, the age of suicides in Wemotaci ranged from 16 to 42 years of age; 75 per cent were male and 25 per cent female. In Manawan, the range was similar; however, a greater number of suicides were among females (33%). In Opitciwan, the age range was greater than in the other two communities (10 to 65) but similar in gender to that noted in Wemotaci (75% male; 25% female). Table 8 indicates the proportion of suicides by youth and young adults from 1977 to 1998 in the Atikamekw communities. Since the mid-1980s, the increase in number of deaths by suicide surpassed the total number of deaths due to violence such as drowning, fire, murder, accidents, freezing, and intoxication.

Table 8) Proportion of Suicides by Age Groups Among the Atikamekw (1977–1998)

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Opitciwan</th>
<th>Wemotaci</th>
<th>Manawan</th>
</tr>
</thead>
<tbody>
<tr>
<td>16–25</td>
<td>36.4%</td>
<td>58.3%</td>
<td>52.0%</td>
</tr>
<tr>
<td>26–35</td>
<td>45.4%</td>
<td>41.7%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Total</td>
<td>81.8%</td>
<td>100.0%</td>
<td>76.0%</td>
</tr>
</tbody>
</table>

According to Mikon Project results, factors that contributed to suicides or attempted suicides were family violence, separation of couples, sexual abuse, and violence due to social pressures (rumours, physical assaults, debts) with the added factors of alcohol and/or drug use. Violence and suicide represented a significant
portion of deaths in the Atikamekw communities: 32.6 per cent of deaths were due to violence and 7.8 per cent due to suicide. Violent deaths were particularly evident among male individuals: 69 per cent in Opitciwan, 83 per cent in Wemotaci, and 64 per cent in Manawan. The age range of victims were between two months and 57 years, with 32 per cent being children (2 months to 11 years). Acts of suicide occurred more often during spring and summer. Most cases of attempted suicide took place in the home during or after the separation of couples, and use of alcohol and drugs was noted in many of the cases.

Table 9 shows recent data (1998–2002) of the three Atikamekw communities on completed suicides by age and gender. It also shows the problem of suicide among the young is still a critical one. The majority of individuals who committed suicide were youth and young male adults. Between 1998 and 2002 there were 11 suicides among males between 15 and 44 years of age, and four suicides among females between 15 and 24 years. There were no suicides among individuals older than age 44. Suicide by hanging was the most frequent; firearms were used in two cases. There were no suicides in 1999, and this corresponded to the start of the Miromatisiwinik/Koskikiwetan project activities.

**Table 9) Death by Suicide Based on Age and Gender, 1998 to 2002**

<table>
<thead>
<tr>
<th>Age group</th>
<th>Opitciwan</th>
<th>Wemotaci</th>
<th>Manawan</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Women</td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>1998</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>15–19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25–44</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>45–64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>15–19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–24</td>
<td>2</td>
<td>2</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>25–44</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45–64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15–19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–24</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>25–44</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45–64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2002</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;15</td>
<td>1</td>
<td>2</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>15–19</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20–24</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>25–44</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>45–64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>1</td>
<td>5</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>


4.2 Physical Abuse

As stated earlier, detailed information on physical abuse could not be obtained. However, women were physically assaulted twice as often as men, and young adults between ages 25 and 34 endured more physical assaults. Individuals with college or university education and an annual income over $30,000 were assaulted most often. Table 10 provides information on the number of physical assaults.\textsuperscript{14}

Table 10: Respondents Who Were Physically Assaulted
Based on Gender, Age, Education, and Income in Wemotaci, 1997\textsuperscript{15}

<table>
<thead>
<tr>
<th>Respondents</th>
<th>Yes %</th>
<th>Never %*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>12.7</td>
<td>87.3</td>
</tr>
<tr>
<td>Women</td>
<td>32.6</td>
<td>67.4</td>
</tr>
<tr>
<td>15–24 years of age</td>
<td>13.3</td>
<td>86.7</td>
</tr>
<tr>
<td>25–34 years of age</td>
<td>32.9</td>
<td>67.1</td>
</tr>
<tr>
<td>25–39 years of age</td>
<td>26.1</td>
<td>73.9</td>
</tr>
<tr>
<td>50 years of age and over</td>
<td>14.3</td>
<td>85.7</td>
</tr>
<tr>
<td>Did not finish high school</td>
<td>18.6</td>
<td>81.4</td>
</tr>
<tr>
<td>Finished high school</td>
<td>20.0</td>
<td>80.0</td>
</tr>
<tr>
<td>CEGEP/University completed or not</td>
<td>35.5</td>
<td>64.5</td>
</tr>
<tr>
<td>Less than $12,000</td>
<td>12.9</td>
<td>87.1</td>
</tr>
<tr>
<td>$12,000 to $29,000</td>
<td>30.7</td>
<td>69.3</td>
</tr>
<tr>
<td>$30,000 and over</td>
<td>40.0</td>
<td>60.0</td>
</tr>
</tbody>
</table>

* The differences are significant in all cases

4.3 Sexual Abuse

Women endured almost twice as much sexual abuse as men in Wemotaci, while in Manawan it was about 33 per cent more. In other age groups, individuals aged between 35 and 39 endured most of the abuse in both communities. In Wemotaci, almost 25 per cent of individuals who suffered sexual abuse had an annual income of less than $12,000, and 40 per cent had greater than $30,000. Table 11 provides data on Wemotaci and Manawan on sexual abuse among respondents 15 years and older.
### Table 11) Respondents Who Have Been Victims of Sexual Abuse Based on Gender, Age, Education, and Income\(^6\)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes %</td>
<td>Never %</td>
</tr>
<tr>
<td>Men</td>
<td>19.4</td>
<td>80.6</td>
</tr>
<tr>
<td>Women</td>
<td>30.0</td>
<td>70.0</td>
</tr>
<tr>
<td>15–24 years old</td>
<td>15.6</td>
<td>84.4</td>
</tr>
<tr>
<td>25–34 years old</td>
<td>30.4</td>
<td>69.6</td>
</tr>
<tr>
<td>35–39 years old</td>
<td>18.5</td>
<td>81.5</td>
</tr>
<tr>
<td>50 years old and over</td>
<td>20.0</td>
<td>80.0</td>
</tr>
<tr>
<td>Finished high school</td>
<td>22.1</td>
<td>77.9</td>
</tr>
<tr>
<td>CEGEP/University completed or not</td>
<td>25.3</td>
<td>74.7</td>
</tr>
<tr>
<td>Less than $12,000</td>
<td>40.0</td>
<td>60.0</td>
</tr>
</tbody>
</table>

### 4.4 Psychological Distress and Suicidal Thoughts and Actions

Suicide and attempted suicide are always the result of great psychological distress. In comparing the problem of suicide attempts and suicidal thoughts in the Atikamekw communities among the Cree, Inuit, and non-Aboriginal people in Quebec, it was noted that suicides were generally twice as high for members of the Atikamekw communities and for Inuit than for Cree and non-Aboriginal people in Quebec, as indicated in Table 12. General data on suicide in the communities indicated that it was mostly youth and young adults who committed suicide.

### Table 12) Respondents Aged 15 Years and Over Who Have Thought of Suicide, Planned, and Attempted Suicide\(^7\)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicidal ideation</td>
<td>18.3</td>
<td>14.2</td>
<td>9.9</td>
<td>4.7</td>
<td>11.3</td>
<td>3.9</td>
</tr>
<tr>
<td>Planned a method of suicide</td>
<td>12.3</td>
<td>11.0</td>
<td>6.5</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Tried to commit suicide</td>
<td>6.5</td>
<td>5.7</td>
<td>3.7</td>
<td>1.9</td>
<td>5.4</td>
<td>0.6</td>
</tr>
</tbody>
</table>

When psychological distress is put in perspective with sexual and physical abuse, these indices were also very significant in that area. Table 13 shows causes of psychological distress in Wemotaci and Opitciwan.\(^8\) The data indicated abnormally high stress within the family: 78.6 per cent in Wemotaci and 75 per cent in Opitciwan. High stress in the home could be related to the fact that about half of these individuals want to leave their home; 57.8 per cent in Wemotaci and 44.2 per cent in Opitciwan.
Table 13) Psychological Distress of Respondents Aged 15 and Over
Based on Characteristics Related to the Household, 1997

<table>
<thead>
<tr>
<th>Characteristics Related to the Household</th>
<th>Wemotaci</th>
<th>Opitciwan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal %</td>
<td>High %</td>
</tr>
<tr>
<td>Unsatisfactory relations in the home</td>
<td>2.8</td>
<td>12.7</td>
</tr>
<tr>
<td>Lack of intimacy in the home</td>
<td>38.8</td>
<td>69.2</td>
</tr>
<tr>
<td>Tensions observed in the home</td>
<td>62.7</td>
<td>78.6</td>
</tr>
<tr>
<td>Rejection by members of the household</td>
<td>23.1</td>
<td>40.0</td>
</tr>
<tr>
<td>Would like to leave the household</td>
<td>26.9</td>
<td>52.7</td>
</tr>
</tbody>
</table>

When indicators of psychological distress in Wemotaci and Opitciwan were added to other indicators such as thoughts of suicide and sexual and physical abuse, results showed an alarming rate. Table 14 compares psychological distress with sexual and physical abuse in Wemotaci and Opitciwan, but nothing describes the normal and high comparisons. For Opitciwan, there were incomplete data on suicidal ideation and suicide attempts. Nevertheless, Wemotaci and Opitciwan showed a significant higher proportion than the norm.

A 1997 study found that over half (56.4%) of respondents in Wemotaci had suicidal ideation, and over three-quarters (77.4%) had suicidal ideation during the year. In addition, almost three-quarters (67.7%) of the total population of Wemotaci attempted suicide at least once during their lives. It should be noted that results of the Mikon Project showed Wemotaci had the highest rate of suicide in 1996. Rates of sexual and physical abuse were just as alarming: 46.3 per cent had experienced sexual abuse and 32.2 per cent had experienced physical abuse. In Opitciwan, the rate of sexual assaults and physical assaults were lower than in Wemotaci.

Table 14) Respondents Aged 15 Years and Over Who Thought of Suicide and Were Assaulted Sexually and/or Physically in 1997

<table>
<thead>
<tr>
<th>Suicidal Thoughts/Attempts</th>
<th>Wemotaci</th>
<th>Opitciwan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Normal %</td>
<td>High %</td>
</tr>
<tr>
<td>Suicide ideation during their life</td>
<td>26.6</td>
<td>56.4</td>
</tr>
<tr>
<td>Suicide ideation during the year</td>
<td>48.2</td>
<td>77.4</td>
</tr>
<tr>
<td>Suicide attempts during their life*</td>
<td>48.1</td>
<td>67.7</td>
</tr>
<tr>
<td>Suicide attempts during the year</td>
<td>20.8</td>
<td>67.7</td>
</tr>
</tbody>
</table>

* The differences are significant in all cases except for the variable relating to suicide attempt during their lives where the difference was significant only at a threshold of 92 per cent.

Table 15 details individuals who attempted suicide in Opitciwan. Individuals between 35 and 49 years of age were among the highest for suicide attempt (75%), followed by ages 25 to 34 (50%). Men and women attempted suicide with the same frequency (about 50%). Statistically speaking, only percentages related to family status (single, married) showed significant differences. Individuals living as a couple had an alarming rate of suicide attempts (75%) in a greater proportion than individuals living alone. Higher education and occupation were associated with suicide attempts: 80.0 per cent of individuals with higher education and 71.4 per cent with an occupation.
Table 15) Respondents Who Consulted a Health Professional After a Suicide Attempt Based on Age, Gender, Marital Status, Education, Occupation, and Income, 1997

<table>
<thead>
<tr>
<th>Opitiwan</th>
<th>Yes %</th>
<th>No %</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–24 years of age</td>
<td>38.5</td>
<td>61.5</td>
</tr>
<tr>
<td>25–34 years of age</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>35–49 years of age</td>
<td>75.0</td>
<td>25.0</td>
</tr>
<tr>
<td>50 years of age and over</td>
<td>100.0</td>
<td>–</td>
</tr>
<tr>
<td>Men</td>
<td>44.4</td>
<td>55.6</td>
</tr>
<tr>
<td>Women</td>
<td>52.9</td>
<td>47.1</td>
</tr>
<tr>
<td>Single</td>
<td>18.2 *</td>
<td>81.8 *</td>
</tr>
<tr>
<td>Part of a couple</td>
<td>73.3 *</td>
<td>26.7 *</td>
</tr>
<tr>
<td>Did not finish high school</td>
<td>44.4</td>
<td>55.6</td>
</tr>
<tr>
<td>Finished high school</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>CEGEP, university completed or not</td>
<td>80.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Working</td>
<td>71.4</td>
<td>28.6</td>
</tr>
<tr>
<td>Unpaid occupation</td>
<td>36.4</td>
<td>63.6</td>
</tr>
<tr>
<td>Inactive</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Less than $12,000</td>
<td>33.3</td>
<td>66.7</td>
</tr>
<tr>
<td>$12,000 to $29,999</td>
<td>63.6</td>
<td>36.4</td>
</tr>
<tr>
<td>$30,000 and over</td>
<td>100.0</td>
<td>–</td>
</tr>
</tbody>
</table>

* Indicates that differences are statistically significant.

Table 16 shows methods used in suicide attempts. Women attempted suicide more often than men in 1995 (13 men and 20 women). Among male individuals, most used firearms. Among female individuals, the most frequently used method was ingesting drugs or chemical substances. Solvents and gasoline were frequently used as a substitute for drugs among young people in Aboriginal communities, which can have fatal consequences on the health and lives of those who use them.
Table 16) Suicide Attempts Among Respondents Aged 15 and Over Based on Gender and Method Used

<table>
<thead>
<tr>
<th>Method</th>
<th># of Males</th>
<th>%</th>
<th># of Females</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs/chemical substances</td>
<td>2</td>
<td>15.4</td>
<td>15</td>
<td>75.0</td>
</tr>
<tr>
<td>Slicing wrists</td>
<td>1</td>
<td>7.7</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Hanging</td>
<td>5</td>
<td>38.5</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Asphyxiation</td>
<td>1</td>
<td>7.7</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Firearm</td>
<td>11</td>
<td>84.6</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Automobile accident</td>
<td>2</td>
<td>15.4</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Other</td>
<td>–</td>
<td>0.0</td>
<td>2</td>
<td>10.0</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>39.4</td>
<td>20</td>
<td>60.6</td>
</tr>
</tbody>
</table>

4.5 Alcohol and Drug Abuse

Suicide prevention among young people in the Atikamekw communities revealed that use of substances such as alcohol, cannabis, naphtha, or cocaine was always associated with violent behaviour, physical assault, and suicide attempt. Table 17 indicates the rate of alcohol use in the three Atikamekw communities was relatively the same as that of Quebec. The use of cannabis was almost twice as high in Opitciwan and Wemotaci than in Manawan (43.2% and 38.2% compared to 12.2%, respectively). The average rate of cannabis use in the Atikamekw communities was twice as high as compared to Quebec (29.8% compared to 16.8%, respectively). The rate of naphtha use indicated a more alarming situation in Opitciwan and Wemotaci (55.7% and 23.5%, respectively) than in Manawan (9.2%) where the rate was still four times higher than in Quebec (2.5%). Thus, the use of alcohol and drugs, including some of the most damaging such as naphtha, was a very serious problem for the Atikamekw communities. Manawan had the lowest rate of gasoline and cocaine use and no data was available for Quebec. Table 18 compares the rate of drug use in Manawan to that of Cree and Inuit.

Table 17) Alcohol and Drug Abuse Among Young Atikamekw (1992) and Quebec (1991) Based on Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Manawan %</th>
<th>Opitciwan %</th>
<th>Wemotaci %</th>
<th>Average %</th>
<th>Quebec %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco</td>
<td>74.5</td>
<td>79.6</td>
<td>61.8</td>
<td>75.0</td>
<td>36.8</td>
</tr>
<tr>
<td>Alcohol</td>
<td>60.2</td>
<td>75.0</td>
<td>52.9</td>
<td>66.8</td>
<td>65.7</td>
</tr>
<tr>
<td>Cannabis</td>
<td>12.2</td>
<td>43.2</td>
<td>38.2</td>
<td>29.8</td>
<td>16.8</td>
</tr>
<tr>
<td>Naphtha</td>
<td>9.2</td>
<td>55.7</td>
<td>23.5</td>
<td>29.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Gasoline</td>
<td>6.1</td>
<td>18.2</td>
<td>11.7</td>
<td>11.5</td>
<td>No data</td>
</tr>
<tr>
<td>Cocaine</td>
<td>4.1</td>
<td>17.1</td>
<td>11.8</td>
<td>11.1</td>
<td>No data</td>
</tr>
</tbody>
</table>
Table 18) Drug Use of Respondents Aged 15 and Over
Among the Atikamekw of Manawan, the Cree, and the Inuit

<table>
<thead>
<tr>
<th>Type</th>
<th>Manawan (1996) %</th>
<th>Cree (1991) %</th>
<th>Inuit (1992) %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana/hashish</td>
<td>11.0</td>
<td>15.2</td>
<td>37.3</td>
</tr>
<tr>
<td>Crack/crack</td>
<td>1.2</td>
<td>4.4</td>
<td>5.0</td>
</tr>
<tr>
<td>Solvents</td>
<td>1.2</td>
<td>0.8</td>
<td>2.9</td>
</tr>
<tr>
<td></td>
<td>0.9</td>
<td>2.6</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Individuals between ages 25 and 49 consumed the largest amount of alcohol (almost 65%); of those, men consumed the most (almost 70%). Among individuals who consumed the greatest amounts of alcohol, couples were in greater number than single people, and 75 per cent had only a high school education. The situation was alarming because more than half the population consumed large quantities of alcohol. However, data were not consistent across the board and must be interpreted with prudence. Table 19 shows alcohol consumption in Opitciwan.

Table 19) Alcohol Consumption of Respondents Based on Age, Gender, Marital Status, and Education

<table>
<thead>
<tr>
<th>Opitciwan (1997)</th>
<th>7 days/week %</th>
<th>1–6 per week %</th>
<th>1–3 per week %</th>
<th>Less than 1 per month %</th>
</tr>
</thead>
<tbody>
<tr>
<td>15–24 years of age</td>
<td>18.5</td>
<td>22.2</td>
<td>18.5</td>
<td>40.7</td>
</tr>
<tr>
<td>25–34 years of age</td>
<td>13.6</td>
<td>–</td>
<td>9.1</td>
<td>77.3</td>
</tr>
<tr>
<td>35–49 years of age</td>
<td>–</td>
<td>–</td>
<td>83.3</td>
<td>16.7</td>
</tr>
<tr>
<td>Single</td>
<td>21.4</td>
<td>21.4</td>
<td>14.3</td>
<td>42.9</td>
</tr>
<tr>
<td>Part of a couple</td>
<td>7.4</td>
<td>–</td>
<td>29.6</td>
<td>63.0</td>
</tr>
<tr>
<td>Working</td>
<td>5.6</td>
<td>11.1</td>
<td>27.8</td>
<td>55.6</td>
</tr>
<tr>
<td>Unpaid occupation</td>
<td>50.0</td>
<td>16.7</td>
<td>–</td>
<td>33.3</td>
</tr>
<tr>
<td>Inactive</td>
<td>4.2</td>
<td>8.3</td>
<td>29.2</td>
<td>58.3</td>
</tr>
<tr>
<td>Less than $12,000</td>
<td>24.0</td>
<td>20.0</td>
<td>8.0</td>
<td>48.0</td>
</tr>
<tr>
<td>$12,000 to $29,999</td>
<td>9.1</td>
<td>–</td>
<td>36.4</td>
<td>54.4</td>
</tr>
</tbody>
</table>

4.6 Perceptions of Change

Perceptions of change related to social indicators in the three Atikamekw communities are derived from 15 interviews carried out on-site during May 2002. The Koskikiwetan project team as well as key informants in the Atikamekw Nation’s social and health services were interviewed. These key informants were asked to give their opinions on physical abuse, sexual abuse, children in care, incarceration, and suicide. The questions were open-ended to provide qualitative information. Figure 3 indicates the perceived magnitude of change on social indicators noted by respondents.
Sixty per cent of respondents felt there was a reduction in physical abuse, particularly among those who took part in healing activities. Some respondents stated:

- “In general, it is less hidden; women are more inclined to report it.”
- “There is awareness; people are able to make the connection with the residential schools.”
- “It is difficult to determine, but there is much less tolerance for violent behaviour.”
- “There is less physical abuse, but on the other hand, there is more verbal and psychological abuse.”

Twenty-six per cent of respondents felt that sexual abuse increased, stayed the same, or were not sure and less than 20 per cent felt that sexual abuse had decreased. Although there were no dramatic differences, most respondents felt there was an increase in the reporting of sexual abuse. While respondents disagreed about change in sexual abuse rates, they were able to state that there was an increase in awareness on the subject and that the chains of silence were finally being broken. The respondents elaborated on their opinions about sexual abuse in the following manner:

- “The silence is shattered; people are talking about it more and more.”
- “Individuals who have been in therapy. Survivors have all experienced sexual abuse and have attempted suicide.”
- “There is more reporting of sexual abuse, but that does not mean that there is more sexual abuse.”

Thirteen per cent of respondents felt there was an increase in the number of children in care, while the majority (52%) felt rates had decreased or stayed the same and the remainder were uncertain. Most respondents stated they perceived an increase in awareness of parenting roles and responsibilities. Respondents also noted a trend in the community towards responsibility for children, and there were
conflicting opinions on the best method of intervening. The following comment clearly explains this situation:

- “There is a commitment towards community responsibility to keeping children and placing them in the community; conversely the influence of psychologists from outside is towards placing the children taken in charge outside the families and the community.”
- “Parents have become more protective.”

Sixty per cent of respondents were not certain if incarceration rates had changed. Some felt that it was too early to evaluate this problem, which explained the high percentage of individuals who were not certain. Only 20 per cent of respondents felt there was a decrease in the incarceration rate, and most of those who responded had considered the problem to be connected to individual awareness or to individuals dealing with their problems better. Moreover, 13 per cent felt there was an increase in the incarceration rate due to a different approach to maintaining order (i.e., new police officers are more ready to arrest and charge individuals). There has also been an increase in the number of youth charged in the last year. Finally, only six per cent of respondents felt the number of incarcerated individuals had decreased.

Forty-six per cent of respondents noted a significant increase in the number of suicides in the communities. Several pointed out that in January 2002 there were three suicides: the youngest victim was 11 years old. Only 20 per cent of respondents thought there had been a decline in the number of suicides, 20 per cent believed there was no change, and a small number were not sure if any change occurred.

5. Reporting Results

This section will examine the progress and successful accomplishments that occurred over the short term to highlight the logical link between activities and results achieved by Koskikiwetan; however, it should be noted that training and therapy activities were still ongoing and this case study covered only a short period of time (two years).

Intergenerational relations have been seriously weakened because of residential schools. The supervising clinical psychologist on the Koskikiwetan Project has noted that Atikamekw children assume an almost-parenting role by trying to reduce their parents’ anguish and suffering. “Potentially destructive, these roles can perpetuate themselves from one generation to the next and lead to intense conflicts of loyalties.”

Koskikiwetan was able to meet service implementation objectives by:

- sensitizing members of the communities to the effects of residential school;
- training local workers in suicide prevention, grief and supportive counselling, crisis situation management, addictions, and group facilitation, and on sexual abuse;
- offering Inner Child therapy to future workers;
- modifying conventional therapies to the process of traditional healing;
- offering individual and collective therapy and ensuring the preparation and psychological follow-up of these therapies; and
- carrying out psychosocial and cultural interventions.

The following discussion deals more specifically with short-term results during the two years of operation, with an emphasis on activities in the second year (2000–2001).
5.1 Influencing Individuals—Workers and Participants

To understand the impact of project activities on participants and counsellors, an analysis of the evaluations contained in quarterly reports and review of the evaluation of the Inner child workshop by participants was done together with a synthesis of responses from the questionnaire (Appendix 1). All information sources suggest that Koskikwetan was able to:

- create awareness of the Legacy;
- establish a support network;
- improve the quality of information on residential schools;
- reduce denial;
- increase participation of community members in various project activities;
- integrate the Inner Child approach with traditional healing culture;
- reduce suffering;
- address intergenerational relationship problems; and
- through pre- and post-therapy support and counselling activities, made it possible to set milestones for healing and logistical follow-up.

Results Achieved in Awareness Activities

During the second year of operation, the project team modified education and awareness activities in collaboration with the regional coordinator, local committees, and workers to take place in the bush or at traditional sites. There were also awareness workshops in the schools. The project’s most current education and awareness activities continued through community radio and displays. In addition, Survivor involvement during project development and coordination at both regional and local levels ensured that the team could refer to Survivor testimony.

Initially, it became clear that local workers were not sufficiently informing their community. Using community radio and television as well as publishing articles in local papers corrected the situation. Now, local workers and the regional coordinator regularly make presentations on the project. “The more the project workers are visible, the greater will be the participation of people,” said team managers. “Word of mouth contributes greatly to mobilizing people.” The workers talked about training activities and therapy during individual encounters on the subject of supportive counselling.

The video, Miromatisiwinik (Wind from the North), and sharing circles proved to be very effective means of education and awareness because they served as triggering tools, which lead several Survivors to begin a healing process.

Results Achieved in Training Activities

The project team instituted a review and healing process called “therapy follow-up” (to distinguish it from post-therapy follow-up). This consisted of bringing together the therapy team, local workers, regional coordinator, and other resource persons such as Elders to continually assess training and therapy activities. This made it possible to implement any short-term changes to the program that were needed and to discuss the development of the therapeutic approach. This lead to several changes to training activities, including the development of a training package that was better adapted to Atikamekw culture and spirituality. As a result, training was undertaken using the Inner Child therapeutic approach, taken from the Intergenerational Impacts therapy and adapted traditional Atikamekw healing.
The team also allowed for time off during training so that trainees could work on personal issues. Once the healing began, trainees were then able to share their experiences in order to avoid reproducing the attitudes and behaviours associated with the Legacy. As a result of these changes, the project team was able to observe active participation and a greater satisfaction among numerous trainees.

Thirty-two people who came from health, social service, and education sectors of the Council of the Atikamekw Nation received training on sexual and physical abuse during the first two years of the project. During the second year there were two successful training sessions on sexual abuse that were given by six workers from the three Atikamekw communities. A clinical supervisor service was available once a month to provide technical and psychological support to local workers and therapists.

Support services and steps to protect personnel working on the project included consultation sessions with a clinical counsellor and telephone consultations with a trainer who provided Inner Child therapy. There were also reporting sessions for accountability purposes with local committees, exchange sessions with Elders and speakers integrated into the healing process, as well as support sessions between workers and the regional coordinator.

Seven of 15 people interviewed had taken training and most considered it was relevant and satisfactory. One would have liked to have “more training on sexual abuse” and another “was very unsatisfied” with the number of training sessions. Five of seven respondents felt that the training “helps them to better manage their clients.” Only two felt it did not really help or helped a little. Two workers particularly appreciated the Inner Child therapy they were offered before training had begun. On crisis management, one worker explained that this method was relevant for all kinds of crises: “At work, during traditional ceremonies, or in daily life.” The seven respondents mentioned training on sexual abuse most often. Two workers felt they were more aware of the different types of assaults. Moreover, one worker replied that all the training had helped. Table 20 lists which training method helped the most.

Table 20) Frequency of Participant Response on the Most Helpful Training Method

<table>
<thead>
<tr>
<th>Type of training</th>
<th># of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supportive counselling</td>
<td>2</td>
</tr>
<tr>
<td>Suicide awareness</td>
<td>1</td>
</tr>
<tr>
<td>Crisis management</td>
<td>2</td>
</tr>
<tr>
<td>Inner Child therapy</td>
<td>2</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>3</td>
</tr>
<tr>
<td>All training methods</td>
<td>1</td>
</tr>
</tbody>
</table>

On acquiring new knowledge, respondents were generally proud and satisfied to have learned the early warning symptoms of suicide, the intergenerational effects of residential schools, the characteristics of assault, a complement of social-level development, how to listen and to help people, how to manage victims of sexual abuse, and knowledge about their ancestors. When asked what new knowledge they had learned in regards to intervention training, respondents felt they learned:

- “How to recognize the impact of the legacy on individuals and families.”
- “How to deal with powerlessness.”
• “How to respect another person’s rhythm.”
• “How to be open and share one’s experiences.”
• “How to give and receive compliments.”
• “How to hold children in one’s arms.”
• “How to perform interventions.”
• “How to facilitate a group.”
• “How to use tools adapted from western therapeutic practice with atikamekw groups.”
• “How to discipline the spirit.”
• “How to live rather than survive.”
• “How to work on therapy in classes and workshops.”
• “How to get a person to talk, how to reach and feel people.”

It became clear that community-based workers needed to undertake personal therapy (psychoanalytical or traditional) before starting their training. They “had learned to live rather than survive ... Learning to live despite everything that happened at the residential school.”

There were mixed feelings among respondents regarding the project as a whole. In the first year of operation, the goal was to create a team and to train members to work in the framework of a healing process, which proved to be a real challenge. Persons involved in the project felt a great deal of uncertainty in facing the healing process and demonstrated distrust toward each other. It took a lot of courage for individuals to take the necessary risks to build confidence within the project team. It was also difficult for people to remain available given that the project was only subsidized one year at a time. This meant there was always a significant turnover of personnel. However, those who remained faithful to the project were very motivated by the healing process. These individuals were successful in following a very enriching path for themselves and their families. In fact, in addition to taking the training, each member of the team had to attend therapy, which was a prerequisite, in order to work on the Koskikiwetan Project. For most of them, it was a very good experience. In addition, it allowed them to acquire a better understanding of the impact of residential schools and to make connections between behaviours in their adult lives and behaviours they developed in residential school.

Another interesting aspect is the fact of creating an intercommunity dynamic involving all three communities in the training and therapy activities. This approach created a healthy environment and gave team members time to get to know each other and to develop closer relations. In addition, this improved the ability of communities to work together more effectively. Most informants spoke of the benefits of revitalizing traditions and culture. It also gave the project team opportunity to explore traditional healing practices in-depth and to make use of the practices with participants as well as members of their family. The majority of the project team were Survivors simultaneously healing and leading therapy, which had both positive and negative outcomes.

As far as advantages and disadvantages of having Survivors on the team, some informants felt having Survivors direct the project and therapy created a healing effect on other workers and participants because they shared their experiences. Others stated that the Survivors understood and could really be empathetic towards participants who were also Survivors, in private or collectively. However, according to other informants, having Survivors act as therapists posed particular problems; for example, during a healing circle or therapy session, Survivor–therapists may waver and be unable to direct the session, thereby leaving the session open with no one to guide it. In a therapy process, there has to be someone
who sustains the group so that people feel safe to commit themselves to open up. Several informants felt that the therapists were not receiving adequate clinical support to deal effectively with their own issues so that they could lead therapeutic work without interruptions.

The difficulties that the project team and participants had to overcome and still must overcome are part of the healing process. The healing process involved awareness of repressing very personal as well as collective problems. In addition to emotional outbursts and reliving the past of residential schools, the healing process lead to an upheaval of family and community solidarity, denial, resistance, or change. All things considered, the training and therapy were enriching, albeit painful at times as much for participants as for members of the therapeutic team.

Results Achieved in the Healing Process
A regular evaluation with participants was carried out one month after therapy, and the team took into account recommendations of local committees who generally met each month. The project team made a very positive evaluation of results it obtained in terms of participation, ease of suffering, and the improvement of family relationships at the end of the second year. With a goal to have 99 participants, there was a total of 62 participants that completed Inner Child therapy during the two-year period under study. However, the team was aware that Koskikiwetan was only touching the tip of the iceberg: “Breaking the silence, healing, and proceeding with rebuilding requires a lot of time, energy, and resources of all kinds because the whole nation is affected down to its soul.”

Koskikiwetan offered a process of individual and collective healing based on the Inner Child approach. Therapy took place in the bush based on the traditional style of living. This approach focused on actual experiences of Survivors. In this way, the project created a link between the generations and met a pressing need for communication between parents and children. One session during the second year encountered some operational difficulties when three withdrawals as well as delays in modifying the therapeutic process for adults left only one participant. Also, the therapeutic team was made up of two therapists: one resource person for culture and spirituality and one senior therapist who was present for two days.

The initial expedition therapy session for youth that took place during the third quarter of the second year also encountered some difficulties, as there were several mistakes and shortfalls in not informing the youth about the type of therapy. They did not know what it was all about as several had thought it was a vacation camp. In addition, there was a shortage of counsellors. All these shortfalls were corrected during the second therapy expedition.

Sharing circles (makokan) held in the bush throughout the project encountered resistance “from some individuals to accept the role of Survivor” because they thought they had already suffered enough. However, the sharing circles were still beneficial for participants who had opportunity to relate their experiences of residential schools.

Elders participated actively in Koskikiwetan, some as members of local committees and others during therapy sessions as speakers. These Elders are now integrated into the healing process to share their knowledge about sweat lodges, medicinal plants, tales, and legends. Several participated in sharing circles at the Elders’ Conference held in Opitciwan during the summer of 2001.
In order to better ascertain needs and improve healing activities, the project team proceeded with an evaluation of the Inner Child therapy with participants using a confidential open-ended questionnaire (see Appendix 2). Overall, participants were very satisfied with the therapy, and only one had any previous experience of being in therapy. One person stated, “I liked the therapy because it allowed me to find myself and thereby find answers to my questions.” Another noted that he/she was agreeably surprised. The majority felt the number of participants in therapy was sufficient, “Just enough, not too many, not too few; enough to be able to work on yourself.” Only four of 11 responded that there were not enough participants. Their perception about satisfaction of other participants were very positive as one person revealed that a participant told him “that she would come back because twelve days is not enough,” and another noted, “one man in particular who felt really good.” Only one person did not want to comment on the satisfaction of others. Here are two very significant comments about this collective therapy process:

- “Overall, the participants seemed satisfied. Of course, at the beginning, some were asking themselves what they were doing in therapy. But as the days went by, we learned to know each other, all of us together.”
- “Everyone had fun working on himself or herself. Everyone had emotions too.”

All participants stated they would recommend the therapy to others. Participants revealed the psychological confusion and social isolation that existed among the members of the three Atikamekw communities. Participants emphasized that they were approached by other individuals who were suffering and hoped that everybody could receive the same type of help and comfort they received. Here are some participant comments:

- “It is really very good.”
- “There are people who ask me what therapy is and I tell them they also need to live.”
- “You live so much better afterwards.”
- “I recommended it to three people and they went. I told them to go live the therapy like me because they were asking me for help and to listen to their experiences. I spoke about it to some people who had lived in residential schools. Today, they are looking for themselves and they want to understand why the nuns treated them this way.”
- “I haven’t recommended anyone in particular but I pass on the message to those who have problems.”
- “Such therapy allows us to find ourselves. You feel good.”
- “Perhaps to those who have already undergone other therapies or maybe to those who are ready to go to the bottom, that is, to find their inner child.”
- “I think it is the first thing to do when we want to do a housecleaning inside yourself ... to go find the pure child who has been sleeping inside us for too long. As far as I am concerned, this has been beneficial in my life.”
- “The best place an Aboriginal can undergo therapy is in the forest.”
- “There are people who are doing drugs.”

The participants unanimously recognized the skills of the therapists:

- “They know the program very well. The mutual help they convey and especially the respect they give to the other person are very important for the participants to be able to succeed in their therapy. The physically abused can follow their own healthy course every day.”
- “The therapist greatly helped me even when I was blocked.”
- “They are competent. What they are doing is so hard and I am grateful for them and I admire them very much.”
- “As soon as I arrived at the site, I felt comfortable with them. They are competent, authentic people.”
Participants also praised the therapists and resource persons by stating they knew their work very well and guided them in search for their Inner Child. One participant felt part of a family. Five participants offered these reasons for participating in Koskikiwetan:

- “To find our cultural and spiritual identity and to understand our parents.”
- “The supportive relationship, the support, listening, the success of those involved in therapy, the way to recover our body and our inner child.”
- “To guide us well by giving us self-confidence. When frustration, anger arises during an activity and I no longer know what to do, the guides are there to bring me back.”
- “To help their people to find themselves and to deal with their problems in life. They were there to help people and to help themselves.”

Only four participants were positive to integrating other cultural activities into the therapy.

Yes, it would be good to integrate activities such as information on medicinal plants, on physical health, on tales and legends to understand the fundamental values of being a human being. We should give explanations of the usefulness of sweat lodges.

In my opinion, it is already a lot because we have to start at the beginning and learn to ask questions about our culture. That is the work of the individuals coming out of his/her therapy. Otherwise, he/she will only have acquired what he/she has been taught and not what they learn themselves by asking questions of those around them and of their community.

Two participants suggested other activities be added such as, “accentuate the Aboriginal aspect in the therapy” and “to do couples therapy.” Most agreed there were exactly enough activities integrated into therapy. Some participants felt that improvement could be made and offered these recommendations:

- “Have more time for the fourth phase.”
- “Have a larger space for the workshops and give more information on how an activity will take place.”

Although most participants were positive about their healing experience, there were some who held negative feelings about their experience, such as they did not like the “questionnaire on sexuality ... blocks with other people during the therapy ... people smoking in the tent ... the evacuation of the group because of the forest fire ... I felt like it was an abortion.” The family sculpture, which is a method of family systems therapy, was named most often among the activities participants liked best.

Pre-therapy was offered in a cultural context using the Inner Child approach and was done as a group or individually where the participant was seen two or three times on average. In addition, participants had to fill out an evaluation as part of post-therapy intervention one month after each therapeutic program. According to team members, the goal of post-therapy follow-up was achieved only after some modifications. Initially, participants were not attending individual follow-up; therefore, post-therapy in groups or workshops were offered as a way of enticing participants to engage in individual follow-up. The number of participants in a group varied from five to 12 people. Parent-child connections among participants created some difficulties at the beginning, but these became less of an obstacle when post-therapy was done as a group. Finally, participants were invited to do a post-therapy summary to evaluate their needs, although data were not available at the time.

Finally, some participants expressed the wish that the project continue so that there could be harmony between the generations and the communities, and until all members of the communities undergo therapy.
and not just the Survivors of residential schools. One participant stated, “I used to tell myself that I didn't need therapy, but today, I know that even I need it. It is really a nice present I gave myself.”

5.2 Influencing the Community

The opening created by this project regarding sexual and physical abuse contributed to the increase in knowledge of sexual abuse among children as well as adults and allowed more communication between generations. People are now more inclined to engage with their family or with others in their community about the Legacy. This led to an increase in the number of follow-ups. To meet this need, the project team trained 30 front-line workers on sexual abuse during the first two years of the project. Creating awareness of the Legacy caused people to be more in touch; however, some still refused to listen. “We believe that a project would be more likely to mobilize people if the Aboriginal culture, spirituality, and identity predominate in all the activities,” the project team noted. Figure 4 indicates the views of the 15 respondents regarding denial in the communities. The majority felt only a moderate reduction due to the fact that the hardest to overcome denial were Elders, most of whom were Survivors.

According to respondents, efforts undertaken to raise awareness were a real success. Figure 5 shows most respondents felt that those who participated in project activities demonstrated a moderate increase in understanding the history of residential schools. In addition, respondents noted that participants were able to make connections with current parental behaviour.
Figure 5) Perceived Change in Understanding the Legacy

![Pie chart showing perceived change in understanding the legacy.](Image)

- Slight increase: 2 respondents
- Dramatic increase: 2 respondents
- No change: 11 respondents

Figure 6 indicates the majority of respondents found there was only a slight or moderate increase in community understanding of traditional healing; however, these respondents added that many people still had serious concerns about traditional methods and approaches.

Figure 6) Perceived Change in Community Understanding of Traditional Healing

![Pie chart showing perceived change in community understanding of traditional healing.](Image)

- No change: 3 respondents
- Slight increase: 6 respondents
- Moderate increase: 5 respondents
- Dramatic increase: 1 respondent

Most respondents felt there was an increase in the understanding and demystification of traditional teachings, but that people were not really putting that knowledge into practice. Figure 7 indicates respondents noted a slight-to-moderate increase in the use of traditional teachings. Also noted was the fact that a lot of taboos still surround the use of traditional teachings in addition to many people still coping with the fear instilled by church representatives about traditional Atikamekw ceremony and ritual.
Figure 7) Perceived Change in the Use of Traditional Healing

- Dramatic increase: 2
- Slight increase: 6
- Moderate increase: 5
- No change: 1

Figure 8 indicates that most respondents felt there was a moderate increase in community spirit or community solidarity. Several respondents noted that there were a greater number of people participating in community activities and that families were providing support during closure ceremonies.

Figure 8) Perceived Change in Community Spirit

- No change: 2
- Slight increase: 4
- Dramatic increase: 3
- Moderate increase: 6

Figure 9 shows the increase in improved family relations was slight to moderate. Respondents noted that parents improved rapport with their children and began following scholastic activities more closely. Some respondents stated that parents were trying to ensure children stay within the community when social services would intervene and that parents wanted their children cared for by the extended family or the community.
Figure 9) Perceived Change in Improved Family Relations

Figure 10 illustrates the changes noted in interpersonal skills. A large proportion of respondents noted a significant increase in the way people were dealing with conflicts, resolving problems, and using communication skills.

Finally, participants have become more aware of existing connections between bad experiences in residential schools and the violence and abusive use of alcohol and drugs that exist in their community. A respondent noted, “The participants are asking themselves questions about the recurrence of the project ... The project had the effect of opening wounds and the healing process will take a long time.” Because of the depth of suffering and confusion they felt, participants are worried about the continuation of the project. They believe the healing process should be longer than the duration of Koskikiwetan activities and want the healing process continued for several more years.
5.3 Partnerships and Sustainability

In each community, there was a support group made up of education, social, health, and police services. Managers of these services also freed up members of their teams so they could participate in healing activities. The project team did not establish new partnerships but was pursuing linkages with members of these services to sensitize local authorities so that they could contribute actively in healing activities when AHF funding ran out. The project team felt that the knowledge acquired by workers, support networks, connections created, as well as community awareness will survive AHF’s funding.

5.4 Reaching Those With Greatest Need

It is not clear that pre-therapy activities were designed to select those in greatest need; rather, pre-therapy was intended to prepare those who were self-selected for the healing process. Continuous Legacy education and awareness programs respected individual and community readiness.

5.5 Accountability

The team implemented security measures for hiring, participation, and discharge. In addition, it ensured continued collaboration among various agencies by direct involvement or by informing them regularly on the progress of ongoing activities. However, they were unable to complete the quarterly report regarding CPIC (Canadian Police Information Centre) as stipulated in the contribution agreement because they did not know exactly what it was about.

In follow-up therapy (individual or collective post-therapy), each local team member worked in close collaboration with each service sector, including members of various local committees. At the end of each therapy session, local workers invited those agencies that were significantly involved with the participants to welcome and support them.

During the Elders’ conference held in 2001, team members promoted the project and provided information on its progress. The team also took advantage of meetings organized by social, health, education, and police services to provide a report on project activities. During the second year at a regional meeting of workers from various sectors of the three communities, the project team presented results of the evaluation of the project and a report on activities to a general meeting of the Atikamekw Nation.

5.6 Best Practices and Successes

The best quality of Koskikiwetan was the vigilance and creativity the team demonstrated in the continual examination of activities and its effects on the workers and participants. The project team had, in fact, implemented quality control of activities, corrective actions and innovations to deal with specific traumas of Survivors and their families, and the generational and cultural differences between workers and participants. The modification of the Inner Child therapy was an example. In addition, each local worker developed a work plan in collaboration with the regional coordinator and members of local committees who contributed to the process. The idea of having their healing experiences evaluated by each participant after therapy was another way of exercising vigilance and meeting needs.
Another quality of the project was the diverse and creative nature of Legacy education. Impact evaluation was done and any needed changes were made. For example, during the first year of operation, the team noted that the video *Miromatisiwinik* was an effective triggering tool that should have been produced before the start of the project. The team now uses *Miromatisiwinik* before each therapy session. The team also participated in radio shows. The clinical supervisor participated in teleconferences on suicide prevention and the intergenerational effects of residential schools. A play on Atikamekw ancestral knowledge was presented, written by an Atikamekw in collaboration with the Atikamekw Nation regional education service. Finally, information and awareness-raising meetings took place with high school students and primary school teachers. Even if the use of traditional methods was constant (therapy in the bush, sleeping in a tent, use of traditional rituals and ceremonies, sweat lodges, gathering medicinal plants, purification rites, relating tales and legends, and teaching ancestral history), the project team also used modern methods for publicity, pre-therapeutic evaluation, and training.

The project team endeavoured to follow the recommendations of each community’s regional coordinator and local workers’ committees to consolidate partnerships with other organizations. However, the project team was aware of improvements to be made to exercise best healing practices. According to them, it would be essential to continue the training, therapy, and pre- and post-therapy activities:

> Continuing training sessions seem to us to be a necessity ... We are also of the opinion that support must be given to the local workers and workers in the other sectors so that they can be in a better position to obtain support for their clients. The activities to raise awareness about the impacts of the residential school experiences must also continue.

5.7 Challenges

Healing for Survivors and their families was facilitated by Koskikiwetan activities. Parents and children were beginning to see an improvement in family interactions. The modification of the Inner Child therapy to the Aboriginal culture and spirituality produced a feeling of belonging and wellness, which was very invigorating and very encouraging for participants. Still, resistance remained for which the project team was working to improve educational and awareness activities.

Continuity, confidentiality, and safety were the primary conditions for effective interaction in the context of any healing process, as much for individuals as for the collective. Taking into account the time and complexity these conditions required, the principal difficulties in achieving sustainable results among participants was the high turnover of the project team. During the third quarter of year two, the team had to change resource persons and two local workers. During the fourth quarter of the same year, a new resource person joined the team and a local worker resigned. Thus, the resignation of some members of the project team as well as the process of modifying the healing activities in order to meet specific needs of individuals interfered with the schedule. Unplanned activities included the Inner Child therapy modified to traditional healing as well as a seminar on non-violence.

According to reports from a clinical supervisor involved with the project during its first year, one of the principal challenges faced is the revitalization of the bonds of solidarity at the community and tribal level. “The lack of solidarity is also one of the consequences of the process of Aboriginal acculturation, part of which was the locking away of Aboriginal children in residential schools.” At a basic level, this translates into conflicts among members of the communities and among communities themselves.
5.8 Lessons Learned

The lessons learned were obviously connected to the recommendations listed above. They related specifically to logistical organization and the therapeutic quality of the healing process to meet the needs of participants and the availability and networking of workers. The project team became aware that there was a lack of knowledge, more particularly on intervention with adolescents, for personnel to carry out post-therapy, to easily perform a follow-up in an office and with persons in need outside the community, to control the integration of workers into the training, and, as needed, to reduce the number of expeditions into the bush. In summary, the project must aim at putting together a reliable and competent team (clinical supervisor, therapists, workers, volunteers, and support personnel) who could ensure effectiveness, regularity, and continuity of activities.

The uncertainty regarding the duration of the project affected not only the time workers could dedicate to therapy activities but also the effectiveness of the healing process. During two years of operation, two project therapists had to provide two consecutive therapy sessions that required a lot of energy and proved to be an excessive workload. The project, therefore, decided not to demand this type of performance from their therapists. In light of their experience, the project team felt the ideal context in which residential school Survivors and their families could start a healing process was to have the process extended to at least three years. Their report stated, “it would be a good thing to be able to keep the same personnel and that they have a periodic evaluation. There is also a need, at the start of the process, to create an annual schedule of the activities with the team and to evaluate it periodically.”

Finally, the positive aspect of lessons learned is undoubtedly the integration of cultural elements within all awareness-raising, training, and therapy activities. This approach enhanced individual self-esteem, the feeling of belonging to the Atikamekw people, and, consequently, increased pride. Use of the Atikamekw language proved to be an important intervention tool.

6. Conclusion

Thanks to Koskikiwetan and the experiences that were lived, the Atikamekw Nation demonstrated its commitment to the healing process by breaking the cycle of abuse. The data presented in this report clearly showed the Atikamekw committed themselves to a healing process well before the AHF was created. It was evident that members of these communities would pursue this process well after AHF closed its doors. This intention was largely manifested by the dedication and commitment to healing and by the compassion the project team demonstrated for each other.

This being said, was Koskikiwetan able to achieve its objectives of training workers, mobilizing and sensitizing members of the Atikamekw communities, and thus getting people into therapy as outlined in the performance map? The data presented confirm that this project addressed the needs of individuals and successfully achieved its implementation objectives. The skills of the workers increased and they received specialized training modified to their particular vision of healing from the Legacy. On the one hand, the community now has a better understanding of the impact of residential schools, and on the other hand, there are more people in therapy and the demand for care and services is growing. Among awareness-raising activities, the project produced a video that is now used as a very effective tool to begin the healing process.
Workers were directly concerned with problems related to physical and sexual abuse. There were increasingly more people opening up on the subject of sexual abuse. The healing process was carried out through a unique and complementary method by modifying a Western therapeutic approach that included an Aboriginal cultural context. Members of the communities were then able to receive therapy in their own language and were also introduced to traditional methods, which once kept the First Nations’ culture alive. There are now more people trying to acquire knowledge on how to live in the traditional way, thanks to the revitalization of traditional and cultural methods. In the long term, the communities are going to achieve their goals and re-establish Atikamekw pride and dignity.

Like any healing process, the movement towards change and wellness takes time. It will be several years of constant effort and personal and collective investment before the Atikamekw will consider the period of acculturation as only a bad memory, a cursed heritage that residential schools represent today.

7. Recommendations

After two years of awareness-raising, training, and healing activities the project team was ready to make several recommendations for the continuation of the project with realistic objectives in mind. These recommendations covered five categories: the safety and wellness of participants and project team; organizational development; awareness-raising; team development; and the evaluation of the project. Several informants indicated that the main point of their recommendations concerned continuous examination of the healing process. If Koskikiwetan did not have enough qualified workers and team members did not receive the needed support and time to achieve their objectives, this would threaten the healing process and risk aggravating Survivors’ traumas and those of their family. Here are the principal recommendations made by team members:

Concerning the safety and well-being of participants there is a need to:
- ensure full-time clinical supervision just for the project;
- ensure the workers have vacations and cultural holidays;
- give more support to workers and coordinators; and
- ensure there are briefings and debriefings before and after each therapy session.

Concerning the organizational development there is a need to:
- ensure the regional office introduce the personnel to members of the communities;
- improve communication between the regional and local offices and during therapy sessions;
- strengthen and clarify the program structure by creating an organizational chart;
- have a cook and camp assistant in order to have less staff turnover; and
- select teams trained in intervention with adolescents, guides able to share their knowledge, and therapists able to carry out therapy with adolescents.

Concerning organization of healing activities there is a need to:
- accept or reject individuals for therapy on a case-by-case basis;
- ensure clients register at least one week in advance;
- organize pre-therapy information sessions and talk about culture and spirituality;
- ensure participation in pre-therapy activities is a prerequisite;
- ensure the speakers are present at pre-therapy rather than at therapy sessions;
- modify the application form to improve therapeutic follow-up;
- promote regular activities to improve healing; and
- include the cultural aspect in post-therapy and group activities.
Concerning the development of co-operation and networking within the work teams there is a need to:
• actively participate in the Issue Tables (education, health, police, etc.);
• ensure decisions are made at the local level in conjunction with the regional coordinator;
• develop team spirit;
• increase the number of meetings with all teams (local and regional); and
• establish a protocol to promote networking.

Concerning the continuing evaluation of project activities there is a need to:
• create a questionnaire to evaluate participant satisfaction using the Community Guide to Evaluating Aboriginal Healing Foundation Activity as a model;
• commit to formal planned evaluations and add a long-term follow-up on the impact of the program;
• ensure the project team has a clear vision of the distinction between activities and results;
• profile participants for whom the program seemed to work;
• clearly identify differences between those for whom the program worked or did not work, e.g., denial as the only obstacle or if there were other obstacles such as age and gender.

Notes
1 For the purpose of this case study, we have used the second title given to the project, Koskikiwetan, instead of its former title (Miromatisiwinik).
2 This data originates from quarterly reports submitted by the project during its first year of operation to the AHF.
3 According to data available from the third and fourth quarter reports submitted to the AHF.
4 Information from fourth quarter reports of the Koskikiwetan project submitted to the AHF.
5 Information from quarterly reports of the Koskikiwetan project submitted to the AHF.
6 Information from quarterly reports.
7 Information from quarterly reports.
10 Coloma (1999).
12 Coloma (1999).
13 Information received from the Council of the Atikamekw Nation in 2002.
15 CAN (1997a).
19 The differences are significant in all cases; CAN (1997a; 1997b).
20 CAN (1997a; 1997b).
21 CAN (1997b).
22 Rates exceed 100 per cent because respondents could mention more than one method; CAN (1996:124), see note 15.
25 CAN (1996:103). All these differences are significant; however, the data must be interpreted with caution as over 20 per cent contain values less than 5.
Information from Koskikiwetan second year quarterly reports submitted to the AHF.

Interview response, May 2002.
Appendix 1) Interview Questionnaire

Case Study—Council of the Atikamekw Nation

Miromatisiwinik and Koskikiwetan

Before we begin we would like to assure you:

- that there are no right or wrong answers, only answers that are true from your perspective
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc and not on past/present performance, this is a case study, not an evaluation)
- we are only trying to learn from your experience so that we can help others get what they want from their AHF projects
- the report will not be able to identify who said what, so please feel free to say things that may or may not cause controversy.

Name: ____________________________________________

Profession: ____________________________________________

Date: ____________________________________________

1. Please describe your role in this project.

2. What element of the project do you judge the most effective?

3. Can you give examples showing that the community has benefited from the project?

4. For each indicator, select which best describes the changes due to the project:

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Increased</th>
<th>Same</th>
<th>Decreased</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Sexual abuse</td>
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<td>Children in care</td>
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<td>Incarceration rate</td>
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<tr>
<td>Suicide</td>
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</table>

   Why do you think this way?

5. What have been the impacts of this project on your team?

6. What have been the impacts of survivors on the team dynamics? Explain:

7. What are the strengths and weaknesses of the project in terms of using local resources?

8. Explain in concrete terms what is traditional therapy and what is inner child therapy. In your opinion, what is the relationship between these two types of therapy (framework, cultural specificity, methods, expected results and outcomes)?

9. Please describe the natural setting where the healing and training activities took place?

10. To what extent the project treated effectively the Legacy of physical and sexual abuse in residential schools, including intergenerational impacts?

11. What were the needs identified that the project intended to respond to?

12. How would you evaluate the capacity of the project to deal with these needs and satisfy them?

13. In your opinion, were the people responsible for the project’s activities accountable to the community (did they report and communicate clearly with members of the communities, did they seek and obtain feedback?)

14. How do you deal with resistance, crises, and other reactions to the therapies?
15. To what extent the methods used, the activities and the process presented in the contribution agreement have helped in reaching the results that were planned?

16. Will the project continue to function when support from the AHF is no longer available?

17. To what extent has the project been able to monitor and evaluate its activities?

18. Here is a scale describing attitudes and behaviours. Reflect on these and choose the extent for each category:

<table>
<thead>
<tr>
<th>Category</th>
<th>Dramatic increase (&gt;80%)</th>
<th>Moderate increase (40–80%)</th>
<th>Slight increase (1–40%)</th>
<th>No change</th>
<th>Don't know</th>
<th>Slight decrease (1–40%)</th>
<th>Moderate decrease (40–80%)</th>
<th>Dramatic decrease (&gt;80%)</th>
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<tbody>
<tr>
<td>a) Denial</td>
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<td>b) Understanding residential schools</td>
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<tr>
<td>c) Capacity to resolve conflicts</td>
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<td>e) Autonomy</td>
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<td>f) Interpersonal communication skills</td>
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<td>g) Understanding of traditional healing</td>
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<td>j) # of individuals involved in healing</td>
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<td>k) Existence of support network</td>
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<td>l) Use of support network</td>
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<td>m) Community spirit</td>
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<td>n) Skills of the personnel</td>
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<td>o) Restoring family relationships</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

19. Other comments?
Questionnaire for Counsellors on the Subject of Training

Circle your answer

1. How do you evaluate the quality of training you received?
   1  2  3  4
   Excellent  Good  Average  Poor

2. Have you received the training you needed?
   1  2  3  4
   Very satisfied  Quite satisfied  Fairly satisfied  Not satisfied at all

3. To what extent has the training responded to your needs?
   1  2  3  4
   Completely  Quite well  Fairly well  Not at all

4. Are you satisfied with the number of training sessions you received?
   1  2  3  4
   Very satisfied  Quite satisfied  Fairly satisfied  Not satisfied at all

5. Has the training helped you deal better with your clients?
   1  2  3  4
   Very much  Quite a lot  A little  Not at all

6. Which method has helped you the most?

7. What new methods have you learned?

8. What can you do now that you could not do before?
Appendix 2) Evaluation Questionnaire

Conseil de la Nation Atikamekw
Rehabilitation Program
Residential School Syndrome
Koskikiwetan II

Evaluation Questionnaire

In order to better assess the needs for Koskikiwetan II project, your responses will enable us to enhance the quality of therapeutic services. The answers provided will only be used to obtain information and will remain confidential.

1) When did you attend therapy? (indicate the date)
2) What is your community of residence?
3) In your opinion, is the number of people attending therapy too high or too low?
4) In your opinion, was the therapy program satisfactory? If your answer is no, please explain why:
5) Would you recommend the healing program to others? Why?
6) In your opinion, were other participants satisfied?
7) In your opinion, are the therapists competent?
8) Did therapists and resource-persons show interest in the therapy? Why?
9) In your opinion, should there be more activities included in the program? (for example: cultural activities)
10) In your opinion, were there too many activities included in the program?
11) What could be improved?
12) What did you like best?
13) What did you like the least?

Comments:
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1. Introduction

A series of case studies is being conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF) and is intended to provide a detailed, holistic view of selected projects and their outcomes as well as to cover a range of unique circumstances. The case studies were selected to include representation from a variety of project types and targets (see Appendix 1 for selection criteria). This case study is being done by a community support coordinator (CSC) under the facilitative guidance of Kishk Anaquot Health Research and covers the following project types and targets:

- First Nations
- rural/remote
- west
- healing circles
- traditional activities
- professional training courses

The project that forms the basis for this case study is titled “Pisimweyapiy Counselling Centre” (AHF-funded project # CT-373-MB) and is described as a “community based, nine (9) week, two phase program aimed at enhancing and empowering the personal and social functioning of former students of residential schools and their families, as the means to an overall healthier community.”

The report describes Nisichawayasihk Cree Nation (aka Nelson House, Manitoba), service delivery, team characteristics, and what the project hopes to achieve in the short and long terms. The report will also focus on changes in individual participants and the community as well as how those changes were measured. Although efforts were made to include requested social indicators of change (physical abuse, sexual abuse, incarceration rates, suicide, and children in care), only rates of children in care have been reported.

2. Project Description

The idea of having a local outpatient healing and wellness program for the Nisichawayasihk Cree Nation grew out of a series of community discussions and actions taken to address the rise of social problems that many believe are related to the legacy of physical and sexual abuse in residential schools. Therefore, a proposal was sent to and approved by the AHF to create the Pisimweyapiy Counselling Centre, an addition to the existing services of the Nelson House Medicine Lodge and initially funded as a pilot (1 February 2000 to 31 January 2001). Funding continued to 31 January 2002 with a second contribution of $464,526, which is the year of focus for this case study. The target group includes all local Aboriginal (Métis, Inuit, First Nation, and on or off reserve) adults, youth, and families affected by residential schools. The funding application states the purpose of the project as follows:

Offering services in both the Cree and English languages, the program will run three (3) times over one calendar year and entails individual and family counselling/therapy plus structured group sessions designed to normalize, universalize and depathologize the participants negative life experiences symptomatic of the residential school syndrome. In responding to unresolved and often untreated grief characteristics of post-traumatic stress disorder, the first four weeks of the program addresses the healing and wellness of residential school survivors before incorporating their family and the community in the final four weeks of programming. Thus, phase one of the program limits intake to the fifteen (15) individuals with focus shifting to the participant’s family.
and the community during phase two. Upon completion of the program, the participants and their families become part of an expanded self-reclaimed and empowered support network of residential school survivors active in their own journey of healing and wellness. The final week of the program entails providing services to our community.

The objectives outlined in the project's brochure include:

- provide a safe, structured, nurturing environment for counselling;
- develop coordinated and integrated resource material that encompasses all facets of therapeutic process, effective and efficient service delivery, client management, and work schedules;
- provide a local and readily available network of support with service options with linkages to external service providers;
- provide direct, purposefully designed therapeutic support services;
- foster and strengthen communication and relationship skills;
- maximize pride, self-responsibility, and acceptance among participants; and
- provide an environment that will help reduce the number of deaths, family destruction, and cultural genocide resulting from the direct, negative impact of the residential school experience.

The project is purposefully designed and structured to operate as a community-based outpatient therapeutic program. Methods and activities include:

- case management: assessment and treatment planning, individual and family therapy, aftercare planning, and follow-up;
- small and large group sessions: men's and women's healing circles, self-help groups, workshops (e.g., sexual abuse, parenting, family, residential school syndrome, suicide intervention and postvention, communications skills, anger management, grieving, and loss);
- traditional teachings and ceremonies: sweetgrass, pipe, sweat lodge, cleansing, fasting, and cultural camps;
- field trips to Manitoba residential schools and to pick medicines (sweetgrass, sage, and cedar). An Elder/ traditional healer will conduct ceremonies on trips to residential schools;
- regular physical exercise and nutrition; and
- home visits to conduct family sessions.

The project is situated on the Nisichawayasihk Cree Nation and operates out of a house trailer on the grounds of the medicine lodge. While the trailer is conveniently located, lack of space and privacy are concerns (i.e., walls are not soundproof and participants are grouped too close together). The group sessions take place in the living area of the trailer and are often over-crowded. Both the medicine lodge and the counselling centre give an aura of peace when one enters. Respect is shown by keeping a cigarette smoke-free, tidy environment and by removing shoes at the door.

2.1 The Project Team—Personnel, Training, and Volunteers

The Nelson House Medicine Lodge Board of Directors consists of five Nisichawayasihk Cree Nation members that hold office for a period of three years or until a replacement is named. The board is ultimately responsible for the welfare and effectiveness of the entire organization and is answerable to leadership, funders, and the community for its actions.

Local leadership has demonstrated their commitment to healing with the building of the Family and Community Wellness Centre with resources from their Northern Flood Agreement. At 1,300 square
feet, the centre provides a formidable community focal point for wellness. The centre’s activities focus on prevention with the ultimate goal of returning to Cree values and standards by recognizing, honouring, and reconnecting traditional knowledge and strengths. Centre-based programs include child and family services, mental health, Brighter Futures, family violence, and daycare services. The building includes a whirlpool, sauna, Elders’ room, conference rooms, and offices.

The executive director of the medicine lodge serves as a working group member of the treatment centre. She holds a Masters in Social Work degree and has experience as an executive director and a senior counsellor at the medicine lodge as well as a post-secondary counsellor for Keewatin Tribal Council and regional child and family services worker for Awasis Agency. The program coordinator is responsible for project implementation encompassing all aspects of the therapeutic process, service delivery, client management, and team work schedules. The present coordinator holds a Bachelor of Social Work degree and has worked and volunteered extensively with Aboriginal organizations.

The team includes three therapists and an administrative assistant. The therapists are responsible for one-on-one, family, and small and large group therapy sessions and workshops using a combination of Western therapeutic and traditional Aboriginal healing practices. One is a trained social worker with 15 years experience in counselling and corrections dealing with First Nations people. This individual has sat on the National Parole Board for a five-year appointment and has worked as a parole officer for approximately 10 years. Another is a Survivor with an Applied Counsellor Certificate who has worked as a counsellor at the medicine lodge, as a head cook, and with the Nelson House Metis Federation in various positions. The third therapist is a Survivor, certified in community social development, who has held positions as community education facilitator, radio broadcaster, and life skills coach and has worked with adults in the education and social services fields. The administrative assistant is responsible for all general office procedures, and there has been at least one turnover in this position.

Elders are in constant use by the project. One member of the board of directors is a respected community Elder and Survivor. As the project continues to evolve, Elder utilization has increased sharply as the need for specific ceremonies pertaining to the healing and wellness journey for Survivors has become apparent.

Employee training began in April 2000 before the first intake in August of that year. Training was provided by Micro-age Computer, Rockhurst College Continuing Education Centre, Inc., Workforce Management for First Nation Communities, “Being You” Inc., and Four Directions International. The type of training included computer skills, supervision/management, time management, therapeutic change and development, as well as working with families and couples. Training is ongoing by way of conferences and workshops in and out of the community.

2.2 Activities and Outcomes

A logical link exists between the activities a project undertakes and what they hope to achieve in the short and long term. In short, the project has undertaken to develop a network of support by providing individual, group, and family therapeutic services (one-on-one sessions, gender- and age-specific healing circles, self-help groups, home visits, field trips, and after and continuing care). They have introduced and practised new and healthier ways of life through workshops and presentations, traditional teachings and ceremonies, exercise, and nutrition. The project has also attempted to expand support for Survivors by networking and sharing with other organizations. Desired short-term results include:
overcome or reduce denial sufficiently to have the program operate to capacity (exceed 85% of full capacity);
transform childhood trauma to healing and empowerment;
deconstruct unhealthy survival patterns; and
reduce the number of deaths and rate of family destruction and reverse cultural genocide.

A longer-term outcome is to have participants and their families become part of an expanded, self-reclaimed and empowered support network of Survivors active in their own journey of healing and wellness who have learned to live independently and found their spirit. The relationship between project activities and short- and long-term benefits is set out in the logic model on the following page (Figure 1). Following this is a “performance map” that details the project’s mission, resources, target, objectives, and goals and highlights what sources of information will be used to note change. The “map” was used to guide information gathering.

**Figure 1) Logic Model—Pisimweyapiy Counselling Centre**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Healing</th>
<th>Capacity building</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conducted community-based, integrated, and holistic outpatient therapeutic program based on Western and traditional therapies.</td>
<td>Employee training and professional care.</td>
</tr>
<tr>
<td>How we did it</td>
<td>Normalized, universalized, and depathologized negative life experiences related to the Legacy using case management, group sessions, traditional ceremonies, field trips, exercise, home visits, recruitment and intake, and after and continuing care; and introducing and practicing new and healthier ways of life.</td>
<td>Contacted professional trainers to deliver employee training and address training needs.</td>
</tr>
<tr>
<td>What we did</td>
<td># of sessions and participation in individual therapy and counselling; structured group therapy; traditional ceremonies; ceremonial circles; field trips; self-help groups; regular physical exercise; family therapy sessions and workshops; nutritional therapy; community beautification; follow-up with participants and families through home visits or “walk-ins.”</td>
<td>Provided two workshops on professional development and participated in a conference.</td>
</tr>
<tr>
<td>What we wanted</td>
<td>Initiate healing process and reduce unhealthy coping behaviours; expanded, self-reclaimed network of Survivors on a healing journey; reduce # of deaths and rate of family destruction; reduce or reverse cultural genocide; reduce denial sufficiently to have the program operate to capacity.</td>
<td>Well-trained employees to be leaders in community healing.</td>
</tr>
<tr>
<td>How we know things changed (short term)</td>
<td>Enrollment statistics; self-reported and observed (from perspective of therapists, leaders, Elders, and referral agencies) experience of reclamation; cultural pride and participation; and mutual support.</td>
<td>Feedback from participants and community and measures of skills.</td>
</tr>
<tr>
<td>Why we are doing this</td>
<td>To break the cycle of intergenerational abuse and to restore emotional, mental, physical, and social balance for residential school Survivors and their families in Manitoba.</td>
<td></td>
</tr>
<tr>
<td>How we know things changed (long term)</td>
<td>Suicide risk; dependency rate on welfare, and proportion able to live independently and find their spirit; and rate of homelessness and addiction.</td>
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</table>
Table 1) Performance Map—Pisimweyapiy Counselling Centre

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</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td><strong>activities/outputs</strong></td>
<td>Survivors, family and community members, and intergenerationally impacted in Manitoba.</td>
<td>Overcame/reduced denial sufficiently to have the program operate to capacity; increased transformation of childhood trauma to healing and empowerment; decreased participation in unhealthy survival patterns; improved family functioning; increased life-empowering behaviours; initiated healing; reduced unhealthy coping; and expanded self-reclaimed network of Survivors in healing.</td>
<td>Participants and their families become part of an expanded self-reclaimed and empowered support network of Survivors active in their own journey of healing and wellness who have learned to live independently and found their spirit.</td>
</tr>
<tr>
<td>Normalize, universalize, and depathologize the Legacy's impact using case management, small and large group sessions, traditional ceremonies, field trips, exercise, home visits, recruitment and intake, and after and continuing care; introduce and practise new and healthier ways of life; individual and group/family therapy; self-help; and community beautification.</td>
<td>Community employees and leaders.</td>
<td>Increased capacity to deal with the Legacy; increased knowledge and understanding of the Legacy; increased access to and participation in expanding network of support familiar with and capable of responding to those suffering from the Legacy.</td>
<td></td>
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</tbody>
</table>

How will we know we made a difference? What changes will we see? How much change has occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$464,526 one year only</td>
<td># of participants from within community (3 intakes per year)</td>
<td>Rates of participation; observed changes in family functioning; #s or % of population engaged in mutual support; feedback from participants, therapists, leaders, Elders, and referral agencies; and observed or indirectly (self-) reported changes in coping skills and transformation of childhood trauma.</td>
<td>Suicide and attempted suicide rates; dependency rate on welfare; rate of homelessness; and rate of substance abuse as measured by alcohol- or drug-related criminal offences and participation in treatment.</td>
</tr>
<tr>
<td># of trainees.</td>
<td>Observed and self-reported changes in understanding of and capacity to deal with the Legacy; and feedback from referral agencies regarding changes in access to skilled services to aid, and is appropriate for, Survivors.</td>
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</table>
2.3 Participant Characteristics

The most significant challenges facing the participant group included physical abuse affecting virtually all participants and alcohol abuse. Most are also dealing with a history of sexual abuse, family violence, and criminality and a lack of basic life skills. Figure 2 reveals the percentage of participants estimated to be affected by specific difficulties.²

![Figure 2) Challenges facing Participant Group](image)

There is roughly an even distribution between the sexes, although women still outnumber men and the bulk of participants are in the 25 to 45 age category. Almost all are First Nations on reserve and a large proportion is intergenerationally impacted. Tables 2, 3, and 4 show the participant group by age, sex, Aboriginal identity, and direct or indirect impact of residential schools.

<table>
<thead>
<tr>
<th>Project Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>12–18 (youth)</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>18–25 (adults)</td>
<td>6</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>25–35</td>
<td>12</td>
<td>16</td>
<td>28</td>
</tr>
<tr>
<td>35–45</td>
<td>5</td>
<td>13</td>
<td>18</td>
</tr>
<tr>
<td>45+</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>29</td>
<td>38</td>
<td>67</td>
</tr>
</tbody>
</table>
Table 3) Participants by Aboriginal Identity

<table>
<thead>
<tr>
<th>Aboriginal Identity</th>
<th>Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status on reserve</td>
<td>66</td>
</tr>
<tr>
<td>Status off reserve</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
</tr>
</tbody>
</table>

Table 4) Distribution of Survivors and Intergenerationally Impacted

<table>
<thead>
<tr>
<th>Project Population</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential school Survivors</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Later generation</td>
<td>24</td>
<td>33</td>
<td>57</td>
</tr>
<tr>
<td>Totals</td>
<td>29</td>
<td>38</td>
<td>67</td>
</tr>
</tbody>
</table>

Referral packages are completed by referring agencies and include information on personal data, family situation, involvement with the law, history of alcohol and drug abuse, employment and financial situation, influence of residential school, treatment history, and motivation to change (Appendix 2). Referrals are received from child and family services, a public health nurse, a community health worker, the mental health centre, the police, and probation workers.

2.4 Community and Regional Context

Nisichawayasihk Cree Nation is located on the northern shore of Footprint Lake west of Thompson and northeast of The Pas in northern Manitoba. Community access is provided by an all-weather road. The community has a total area of 5,852 hectares (14,460 acres) with a population of 4,581 (August 2001), including 1,169 living off reserve and 1,092 on Crown land. Nisichawayasihk Cree Nation is signatory to the 1908 adhesion to Treaty #5 and has an outstanding treaty land entitlement. Hunting, trapping, and fishing form the economic base of the community and traditional sharing of wealth is still practised by a group that donates wild meat and fish to community Elders. Local businesses include the trappers’ association, forest industries, air service, housing development, department and food stores, a convenience store/gas station, local taxi and school bus services, and a daycare. The community development corporation owns and operates a motor hotel and tavern, both located in Thompson.

Hydro development in northern Manitoba has caused significant disruption to traditional harvesting, homelands, and, consequently, social and familial well-being. Although the Nation is covered by the provisions of the Northern Flood Agreement (designed to compensate the Cree for the disruption), the impact of relocation is still being felt. In 2001, an agreement in principle was signed to guarantee the Nation’s agreement, participation, and compensation for any future development that would affect their lands and peoples. To manage the relationship, a Northern Flood Agreement Trust Office has been established.

Local facilities include a band office, a community hall, a recreation building, and a pool hall. A total of 249 houses have piped water and sewage, 134 have cisterns and trucked septic service, and three have water barrels and no sewage services. There is electricity by land line, single-party telephone service, and daily Grey Goose bus service. The community is served by five First Nations constables and a RCMP
detachment located in Thompson. The Otetiskiwin Kiskinwamahtowekamid School offers levels K–12 with an enrolment of 976; another 18 students attend school off reserve. The nursing station provides medical services by two community health representatives, and there is a dental station on reserve. The nearest hospital is located in Thompson with available ambulance service.

The Nelson House Medicine Lodge was established in 1989 as a community-based, 21-bed, residential alcohol and drug treatment facility servicing Manitoba Keewatinowi Okimakanak (MKO). Over time, other programs were housed in the Medicine Lodge including alcohol and drug prevention programs as well as outpatient counselling services. The evolution and integration of programming at the Medicine Lodge have led to the development of the Nisichawayasihk Healing and Wellness Program that provides more holistic care than residential addictions treatment services could alone.

Further efforts to gather contextual information were more challenging; namely, rates of suicide, children in care, incarceration, as well as physical and sexual abuse. Members were tired of constant study and requests for statistics. When questioned on an informal basis, they were willing to share anecdotal information or their personal views on these issues; however, no hard data was forthcoming despite follow-up attempts. What is clear is that incarceration rates in Manitoba have fluctuated wildly in the past decade due to the resurrection of restorative justice and the increased use of conditional sentencing. Respondents were also willing to share the fact that almost all physical assault and domestic abuse in the community, as well as most crimes committed by Nelson House members in Thompson are associated with substance abuse, and children as young as eight to 12 years old are collected from the community and brought to the “drunk tank.” Still, the community is described by outsiders as one with initiative that is organized, advanced with a variety of measures to minimize crime, and can deal with social problems. The leadership is considered “pro police” who regularly support First Nation constables as well as the RCMP and generously commit resources to healing.

Although suicide rates could not be secured, personal opinions were received from the RCMP, nurses, and the program coordinator for the project. The RCMP has noted a decline in suicides in the past decade, and the nurses concur. There have been no suicides for a long time, although there are accidents that are usually alcohol related. While they cannot be identified as suicides, there may be some that are questionable. The program coordinator said that there have been no suicides in the community since the start of the project. The director of child and family services reported that there are currently 62 family cases involving 229 children; and of the 2,058 residents living on the reserve, it is estimated that 242 are residential school Survivors (not counting those affected intergenerationally).

3. Methods

The focus of this case study was to determine what contribution the Pisimweyapiy Counselling Centre has made to the attainment of short-term outcomes, including:

- overcoming or reducing denial sufficiently to have the program operate to capacity;
- transforming childhood trauma to healing and empowerment;
- reducing unhealthy coping patterns;
- expanding the network of Survivors on a healing journey;
- reducing family destruction and cultural genocide;
increasing team capacity to deal with and understand the Legacy; and
increasing access to and participation in an expanding network of support that is familiar with and capable of responding to those suffering from the Legacy.

The indicators selected to reflect such changes include: rates of participation; observed changes in family functioning; numbers or percentage of population engaged in mutual support; feedback from participants, therapists, leaders, Elders, and referral agencies; observed or indirectly (self-) reported changes in coping skills and transformation of childhood trauma; observed and self-reported changes in understanding of and capacity to deal with the Legacy; and feedback from referral agencies regarding changes in service access for Survivors.

The development of interview questions (Appendix 3) was based on the project’s desired short- and long-term goals (see performance map) and AHF board-mandated questions. The key questions (Appendix 4) and answers used to develop the logic model and performance map were sent to the project prior to the development of the questionnaire in order to confirm any change to project goals from the proposal stage to implementation. The questionnaire attempted to determine if any desired change in participants and community were achieved. Pilot testing was not done in this case, and the majority of questions were based on the assumption that respondents would have some knowledge of the participants. Some questions were clearly misunderstood or repetitive. Interviews generally lasted about an hour and were conducted by the community support coordinator for the region who had not previously worked with the project.

Project files (funding proposal, contribution agreement, quarterly reports to date, and the project’s response to the National Process Evaluation Survey), key informant interviews with the project team, and selected community service providers were the primary data sources. The project did solicit participant feedback, but at the time of data collection, only 19 had completed the evaluation forms. In addition, the project did engage in collecting information upon intake. However, no summary was prepared or available for use. Internet searches were conducted to secure information on the community profile, and efforts extended beyond the community to secure social indicator data from the Assembly of Manitoba Chiefs.

One-on-one interviews were conducted with the project team using the questionnaire developed specifically for them (Appendix 5). In addition, a total of six outside agents were interviewed using the general questionnaire (i.e., for respondents not employed by Pisimweyapiy) and who were referred by the project team. Their profiles and reasons for selection are outlined below:

- a community consultant who is a Survivor and had individual counselling by one of the therapists employed by Pisimweyapiy, is a member of a committee that wanted this program in the community, and supports it fully because the counsellors are professionals;
- a band council member who holds the health services portfolio in the community and is a Survivor who helped in planning the program;
- a band council member who holds the justice portfolio and makes referrals to Pisimweyapiy has participated in the program as a Survivor (residential school trip to his old school), has solid experience in the sweat lodge and sharing circle, and is on his own healing journey;
- the director of Programs Health Services Division who has first-hand knowledge of the extent of family dysfunction in the community and sees a definite need to address the Legacy;
- a National Native Alcohol and Drug Abuse Program coordinator who refers clients to Pisimweyapiy and is a Survivor who sees the Legacy’s impact first-hand and believes that people have to deal with their addictions first before they can deal with other issues; and
the executive director of the Family and Community Wellness Centre who has only been on the job a short while and is not very familiar with the medicine lodge.

Others were interviewed on an informal basis, including two nurses who preferred to discuss community issues without the structure of an interview. Although they were not fully aware of the program, they did know of it and would refer people if needed. Other less-structured meetings took place with a community-based police officer and a residential school worker from another funded project that runs out of Thompson, Manitoba; both were unable to provide social indicator data. All interviews took place during the last week of October 2001; a total of five days were allocated to the data-collection effort. Although desirable, little opportunity existed for interviews (formal or informal) with community members that could have been selected more randomly or who might have provided disconfirming evidence.

3.1 Limitations of Our Methods

No direct measurement of participants was conducted by the AHE, its employees, or agents due to ethical concerns about the possibility of triggering further trauma without adequate support for the participant. Because direct assessment was problematic, indirect assessment or the perceptions of key informants were weighted heavily. Furthermore, although the team did secure client satisfaction at the end of treatment, no standardized instrumentation was used to assess changes in related cognitive or behavioural indices of healing. It is highly probable that there is no psychometrically evaluated or standardized instrument to determine the unique healing stages of Aboriginal people recovering from the Legacy (institutional trauma).

Two days of training were offered to the community support coordinators in survey development and interviewing techniques in March 2001, with a follow-up in July 2001. Work began in earnest on this case study in October 2001, and interviews were prepared based on the short-term outcomes identified in the performance map. The CSC was independent in the field and, in this case, no debriefing after each day of interviews took place. Field notes were reviewed and transcribed only after all interviews were conducted. There are really only three lines of evidence in this case study; directly obtained from personnel delivering the program (administration and counsellors), those referred by the team, and participant voice (obtained from client satisfaction surveys). Dissent was encouraged in at least two introductory remarks preceding interview questions:

- that there are no right or wrong answers, only answers that are true from your perspective; and
- the report will not be able to identify who said what, so please feel free to say things that may cause controversy.

However, no special effort was made to secure disconfirming evidence, rival explorations, or negative cases. While it is clear that there are some who are not satisfied with the project, the community support coordinator was prohibited by time, resources, and ethical considerations from gathering direct evidence from those participants. However, it would be useful for the project to profile those for whom the program is not satisfactory. This could be achieved through greater information management of client experience surveys. The only quantitative information obtained was limited to rates of children in care. Although some were initially interested and cooperative, follow-up efforts to secure social indicator data were met with non-responses. Others were clear from the outset that they felt over-studied and thus were unwilling to offer social indicator information, even though they were willing to talk informally about the issues.
The luxury of multiple evaluators was not available within the resource limitations; however, the context and data were reviewed and all responses were recorded verbatim, permitting verification and reanalysis by an external evaluation facilitator. As circumstance would have it, the community support coordinator did not have extended contact with this project, which may have inhibited familiarity and comfort in the data collection phase.

The information was collected and analyzed by Aboriginal people, some of whom may have also been affected by the Legacy, and their perspectives on healing may have influenced how the information was collected and reported. However, in an attempt to decolonize the evaluation effort and to ensure that cultural insiders offered insights that may not have been available to others, the decision to use Aboriginal researchers in this effort can be justified. Although it is not clear if their perspectives had more harshly or leniently judged the program, having the analysis verified and reanalyzed by an external evaluator may have reduced this bias. The CSC was most certainly reliant on information that was most readily available, as only five days were allocated to gathering data. The most important information missing are social indicator data, disconfirming points of view, summaries of intake information, characteristics of those participants who were not completely satisfied with the program, as well as more long-term follow-up of participant progress based on the desired outcomes identified in the proposal.

4. **Reporting Results**

4.1 **Impact on Individual Participants**

When respondents (team and community) were questioned about the development of healthy coping patterns, they had varying opinions; some felt that moderate change was obvious for most participants (>75% or more), while others felt that change was slight to moderate for a much smaller percentage (20%–50%) of participants. The observed changes tended to be behavioural, as some interviewees shared that participants appeared able to maintain sobriety, seek employment, disclose past trauma, be more outgoing, seek spiritual fulfillment, and recruit others to participate. Participants have also shared with the informants that they felt increasingly comfortable over the duration of the program. Respondents equally credited team qualities and program environment with any positive change. Counsellors who established a rapport with participants by being non-judgmental, sincere, trustworthy, gentle, respectful, committed, and culturally sensitive clearly facilitated healing. Others felt that the combination of group lectures, one-to-one counselling, and a safe environment created conditions for growth.

All respondents felt that there was a moderate change in understanding of the Legacy among project participants; however, they were in stark disagreement about how many participants have experienced this change. Two felt that the vast majority (75% to almost all) had experienced increased understanding, but other respondents felt that less than one-third of participants left the program with an increased understanding of the impact of the Legacy. One informant felt strongly that it may be too early to expect major changes in understanding, while others noticed an increased openness when discussing the Legacy. They felt that changes in understanding were facilitated by leadership support, Survivor participation (cited as 20% of the Survivor population in the area), and the project’s emphasis on education about the Legacy. Their special component on history and education clearly offered an explanation for self-destructive behaviours that people could understand and accept. Once this initial spark of understanding was ignited, participants began to “thirst for more ... then spreads to the older generation.” The environment created
Joan Molloy

at the Pisimweyapiy Counselling Centre led participants to feel safe, allowing them to speak freely about their experiences at residential school.

The team agreed that participants left the program with enhanced self-esteem, even if they do not agree about the magnitude of change or the proportion of participants who experienced this outcome. The behavioural evidence they saw included facial expressions changing from sadness to peace, securing gainful employment, and comfortable displays of physical affection. Others were more nebulous in offering evidence of enhanced self-esteem, but were still convinced of its existence: “You can see the change when you meet them [participants], it’s like they just woke up.” Although only some have enjoyed improved feelings of self-worth, the team is hopeful for a ripple effect. They credited Legacy education, focusing on responsibility and choice, as well as emphasizing self-trust for the observed changes in behaviour. Participants learned to trust their spirit despite the climate of shame, fear, and guilt in the community: this message is framed in the context of Cree culture that encourages participants to take it seriously. The team also believed that the training they received allowed them to skillfully address the Legacy and help Survivors.

While there was no agreement on how many experienced increased cultural pride or degree of change within individual participants, the team was sure that some change was obvious. The majority of participants were excited about cultural teachings and eager to learn more, with only some being resistant. The project team felt that their program, together with reinforcement from the medicine lodge, was responsible for such change and believed that group dynamics strengthened the impact: “We do our ceremonies and cultural practices in a group. It promotes awareness, helps the individual but it’s the group that makes the change.”

One team member believed that there was a decrease in all areas of physical abuse, sexual abuse, provincial wardship, and suicide when questioned about participant risk, while another felt that the risk stayed the same. Another team member felt that risk had been reduced in all areas but was unsure about sexual abuse. This uncertainty was rooted in the fact that there are many damaged people still out there who have not disclosed their histories of victimization and possible abuse. The last team member felt that participant risk was reduced for physical abuse and suicide, but was also unsure about sexual abuse and provincial wardship. Although there was no suicide in the community since the program began, they felt it was too soon to see a difference in sexual abuse and children in care.

The project did undertake efforts to solicit formal feedback from participants. At the time of data collection, 19 participants had responded. The majority (11) rated the service as excellent, while others (8) said it was good. Most (18) felt that they generally or definitely got the service they wanted, although one participant did not. Again, almost all (18) believed that the program met most of their needs; however, one participant felt the program addressed only a few needs. There were 15 who were very satisfied, and the rest were mostly satisfied with the service. Suggestions for improvement offered by participants include having a larger meeting room, improving attendance by participants, including more women’s groups and cultural teachings, offering home visits in addition to centre-based therapy and as a form of aftercare, offering smaller workshops on addictions, and increasing counselling sessions to a duration of four or five hours.

The majority had an overwhelming amount of positive praise for program content and the project team. Their voice is captured below:
• “Counsellors helped me lots with my healing. I highly recommend this program to anybody.”
• “I am very satisfied and happy with the services I received. I will continue to seek help with the counselling services.”
• “I have recommended friends/family for this program.”
• “... anyone thinking of getting help from this centre will be doing themselves a big favour and a big step towards healing because that’s what they will get! Excellent services!!!”
• “I guess the one thing that stands for me was the grieving and loss session. I was able to express my emotions in loss of my mom years ago. I don’t know why I held on to this grief for so long ... [The counsellor] was able to assist me in letting go of that pain. I would recommend this program for everyone ... Seeing the old residential school brought back some sad memories and kind of brought a closure to that bad experience ... [The counsellor] has given me confidence and raised my self esteem.”
• “I will refer anyone of my friends to this program. I got so much out of it. I realize my problem areas and need to work on them. I especially enjoyed the trip to my former residential school. It has brought some closure to some sad and bad memories over there. I offered tobacco and prayer in one of the rooms. I became emotional but it felt very good. I will continue to seek counselling after this program; however, I would feel much more comfortable if I could be counselled by ...[a certain counsellor]. Thank you.”
• “Only wish that my two sisters would come. Encourage mother to speak to them to come, it is terrific program!!”

4.2 Impact on Community

One of the more salient goals of the project was to sufficiently overcome denial so that the program could operate to capacity. During the period under examination, 67 of a possible 75 participants were engaged and 19 graduated from the program, representing an 89 per cent participation rate and a 28 per cent completion rate. Each successive intake showed increasing enrollment (usual intake is 15 participants), so that by the fourth intake they exceeded capacity by accommodating 20 participants and outgrowing their trailer. Eventually, participants engaged without having been referred by an outside agency. Overall, the project was able to achieve implementation objectives with little difficulty. Their only obstacle appeared to be getting family members involved in phase two of the therapeutic program; however, over the lifespan of the project, an increasing number of couples were participating. They credited positive change to the referral network, the confidential setting, peaked community curiosity, team skills, project visibility, and the example set by recent graduates. The community estimates that there are 242 Survivors in total (not counting those impacted intergenerationally) and recognizes that much work still needs to be done.

The project also wanted to facilitate the development of a support network in the community. The project team has formed self-help groups, enlisted Elders to make themselves available, and contracted therapists for those seeking further clinical support. The project also received many referrals from local agencies, some of which are mandated. Unfortunately, the team estimates that 80 per cent of those mandated to attend do not complete the program. In addition to creating a support network, the project was originally designed to enlist family members during phase two of the project; however, they acknowledge that this segment of therapy did not go according to plan. Support for the project team is provided by the residential school advisory group, Survivors’ committee, and the board of the Nelson House Medicine Lodge.

Team and community informants held different opinions about the extent of change in the community’s understanding of the Legacy. While some felt that only a few gained an increased understanding, others felt that more than half to almost all the membership more clearly understood the Legacy. When change was not abundantly apparent, respondents still believed that something was happening below the surface,
“They’re here (the changes) but not visual yet.” When it was clear, noted behavioural change included increased anticipation of monthly newsletters on residential school issues, increased open discussion, different attitudes about the Legacy, as well as clarity that the project is a healing (not compensatory) effort. In addition, the rate of disclosures has precipitated fundamental and structural acknowledgement of the Legacy.

Recently there were disclosures of a school principal who abused children for thirty years and had the school named after him. The board of education heard the disclosures and changed the name of the school. This is the first invitation for residential school Survivors to talk.

Increased understanding of the Legacy was attributed to community readiness, actions of the ad hoc committee on residential schools, increased resources to address healing, efforts of the project (e.g., conferences, field trips to residential schools, and public relation campaigns), project team members who are skilled Survivors able to inspire healing and make others feel safe; and Elder involvement.

One of the spinoffs was a five-day conference at Troy Lake successfully hosted by residential school Survivors from the community and other organizations around Thompson. Another conference was planned for March 2002 for caregivers that work with Survivors, and they are also planning for another summer conference in 2002.

While the skill of resource people in the community to deal with the Legacy is still unclear, increased openness, awareness, and eagerness to learn is observed. Leaders talk openly about the Legacy in meetings, the project is getting more referrals from other service agencies (e.g., mental health and family violence), and service deliverers ask questions and want to be involved—Pisimweyapiy Counselling Centre is breaking new ground. In other words, Legacy education is unprecedented in Nisichawayasihk Cree Nation, and local agencies and community members are just starting to learn about the Legacy and how to heal from it.

The project got high marks for its accountability to the community. The solid majority felt that the project needed little or no improvement in this regard. Accountability is fulfilled through local radio, community presentations, monthly newsletters, residential school advisory committee meetings, as well as posted program activity schedules. Figure 3 reflects the distribution of opinion on the project’s accountability to the community.

**Figure 3) Accountability to the Community**
About half of the respondents felt that the project was addressing the Legacy very well, requiring little or no improvement, some felt that the program could better address the Legacy, and a small proportion felt that the project was struggling in this regard. Figure 4 reveals the distribution of opinion about how well the project was able to address the Legacy.

![Figure 4) Ability to Address the Legacy](image)

4.3 Partnerships and Sustainability


Although there is a strong desire for the project to continue, respondents were unanimously fearful that it might not as it does not receive any additional funding other than what AHF provides. Still, they indicated that there is strong community interest and commitment to healing programs and speculated that alternative funding sources might include $4.5 million from hydro (Northern Flood Agreement compensation) to be used for programs, fundraising, doing outreach in other communities for a per diem, being integrated into one of the other programs, government assistance, or forming partnerships with other programs.

4.4 Addressing the Need

The local director for health services believes that Pisimweyapiy Counselling Centre is “a welcome relief” in the community, is eager to adopt their approach, and clearly recognizes the need for identical training for the health services team. The project makes therapeutic decisions based on client feedback, an approach having widespread appeal in the community and may be adopted by the Health Services Division. Still, informants felt that the project could better meet the need by providing whole family therapy versus individual-focused treatment. One felt very strongly that greater efforts need to be made to enlist and target dysfunctional families in the community that are fragmented by alcohol and drugs. He believed whole family treatment is the answer, and he dreams of a system of support and contribution that would
include fixing up their houses while they were away “fixing up their lives” so that they can return to a new life and have pride in their surroundings. The project should play a part in this plan because continuous crisis intervention is not serving the needs of families suffering from the Legacy nor is it serving the needs of the community. Still, all informants were positive about the project’s ability to address the need, as responses were evenly divided between believing that little or no improvement was needed or some improvement would be beneficial.

On a broader scale, the community felt that the proposal writing requirement may have missed some communities in greatest need who do not have the human or financial resources to participate in such a screening process. It was suggested that AHF’s efforts be more proactive and outreaching to those communities who suffer the most.

4.5 Successes and Best Practices

The members of the Pisimweyapiy Counselling Centre team are well-respected community members and Survivors who have healing skills. They are described as non-judgmental, sincere, trustworthy, gentle, respectful, committed, and culturally sensitive. The combination of motivated, skilled team members, supportive leadership, community partners, and participants who genuinely want personal transformation sets fertile ground for growth. Emphasizing personal responsibility, the power of choice or free will, the processes of colonization and decolonization, as well as self-trust worked well. Others felt that the combination of group lectures, one-to-one counselling, and a safe environment created conditions for change. Other specific activities that are planned to continue because of their resounding success are:

- healing/sharing circles (for unique groups, men/women, Elder/youth, self-help, and mixed groups);
- cultural ceremonies and traditional teachings;
- bringing in presenters from the outside;
- networking and sharing with other programs and organizations;
- working with the Elders;
- going on residential school trips with residential school Survivors;
- continued employee professional development;
Team members were also very clear about the powerful influence of framing the therapeutic process in the context of Cree culture. Field trips, workshops, and Legacy education have also been well received. One informant said that the anger management workshop was an “eye opener.” Activities that engage participants in light-hearted activities where they could relax, let their guard down, and simply have fun (e.g., the travelling theatre troupe that educates on the impacts of residential schools using comedy) were very popular. At last, the extent and variability of the program schedule allow for easy access both in the evening and during the day.

4.6 Challenges

Eventually the trailer became too small to accommodate all who wanted to participate, and the paper thin walls stressed confidentiality in one-on-one sessions. The image of Pisimweyapiy Counselling Centre also needs to change, as some still believe it is an alcohol and drug treatment program because of the project’s close affiliation with the medicine lodge. It was suggested that a different location with a clearly identifiable billboard be used to separate the project’s identity from the medicine lodge. This would eliminate the reluctance to participate due to the fear of stigmatization as a substance abuser.

Informants also believed that the project could engage more actively in outreach efforts by advertising on radio and television as well as using the school as a vehicle for Legacy education: a clearly competing priority to an ever-burgeoning participant group. They expressed fear that many are still hurting and that victimization has not yet come to an end. Efforts to expand the circle of healing to include family members did not materialize as the team had hoped, and treating the individual outside of the context of the family was a challenge. Similarly, those who were mandated to participate came once or twice and then most (80%) dropped out.

Daytime scheduling presented difficulty for employed participants who could only attend evening sessions. After and continuing care in the community were considered essential to preventing relapses but were not as fully developed as anticipated. Informants believed more Legacy education and a higher profile for the project would have helped in this regard.

4.7 Lessons Learned

Informants likened the AHF to “another government hierarchy” partially because funding took so long to secure and they felt that the resources should have gone directly to community agencies. In other words, instead of having a foundation, the money should have gone directly to the communities without having to engage in a proposal-writing process.

Others felt that there should be more community involvement in the development of the program through the use of “coffee nights” and other open gatherings. Also, reinforcing traditional skills, practices, and language should be a stronger focus of future project efforts. Some felt that the project accomplished a great deal in a short time period and that it could fill a continuing care role for those referred out of the community for other services. Greater networking, especially among the directors of health services in the community, would have helped ensure stronger partnerships and greater program complementarity.
5. Conclusions

“Things are happening, but it’s slow.”

Nineteen of 67 participants have completed the program at Pisimweyapiy Counselling Centre (28%) with clearly enthusiastic impressions about their healing experience. While the age and sex distribution of the graduate group is not known, it is obvious that they, along with other community members at large and the project team, believed several factors were responsible for their success, which included:

- a safe, culturally sensitive therapeutic process that combined group lectures with one-on-one counselling on a variably accessible schedule and emphasized Legacy education;
- a team composed of Survivors from the community who are skilled counsellors, successful on their own healing journey, gentle, committed, and professional without being imposing;
- supportive leadership, reinforcing, complementary partnerships, as well as community commitment to and readiness for healing; and
- Survivor involvement in program development.

The program was able to operate at almost full capacity (89%), which suggests that the project’s efforts to dismantle the wall of silence and denial were reasonably effective. While individual progress appears slow, the 28 per cent individual completion rate must be viewed in the context of family and community. Some participants were mandated to attend (most of whom dropped out) and all have suffered from physical abuse; 90 per cent come with a history of alcohol abuse; and the majority (>60%) have experienced family violence, conflict with the law, and lack of basic life skills. Even the tirelessly motivated would struggle with such a legacy. Unfortunately, no data have been collected to explain why those who had most to lose (i.e., their children or their freedom) would leave the program. It is entirely possible that special needs were not being addressed by the project or the “fit” between client and program was not appropriate. In other words, if some were still suffering from addiction or had fetal alcohol syndrome or fetal alcohol effects, the project may not have been able to meet their needs.

Furthermore, informants described a community climate of widespread poverty, addiction, and family dysfunction. In fact, although the project had intended to treat individuals in the context of family, phase two of the therapy (when the family gets involved) did not go as well as planned, which probably has more to do with the pervasive social problems in the community than it does with the skills or commitment of the team. Other events that may have influenced the program’s ability to achieve the magnitude of change it desired include clashes between Cree spirituality and Christianity, the socio-economic disruption caused by hydro flooding, low self-esteem, and widespread dependence upon social assistance.

Acculturative forces for the Nisichawayasihk Cree Nation have been recent and swift. The impact of flooding coupled with a rapidly expanding mining industry, the establishment of the city of Thompson in the fifties, and road access to an urban centre meant increased interaction and subjugation by thousands of Euro-Christian Canadians as well as access to alcohol.

With respect to an increased understanding of the Legacy, it is clear that some recognition at individual and institutional levels has occurred. More open discussion and different attitudes about family and history, together with public acknowledgement of high-profile perpetrators, suggest that the climate has changed. Community sentiment about the project is overwhelmingly positive even if the majority felt that some improvements were needed to better address the Legacy. They suggested a bigger facility with a distinct
identity (i.e., separate from the medicine lodge), more partners enlisted in Legacy education, and a process to ensure individual treatment in the context of family and continuing care should be realized. While the skills of the team were not directly assessed, they were clearly well received by program graduates. The community recognizes that outside forces may have had a facilitative influence in increased popularity and use of Cree systems of restorative justice, conditional sentencing, and a regional resurgence of culture. They also strongly believe that guaranteeing success for a few may pay long-term dividends for others who are inspired by their example. However, the resources to sustain the project are in question once AHF has closed its doors.

6. Recommendations

The following recommendations have been classified under three thematic areas: team, project delivery, and evaluation issues:

**Team Issues:**
- select team members with experience and ensure that they are well trained to address the unique needs created by the Legacy, can make participants feel safe, and are recognized Survivors who have modelled a successful healing journey; and
- counsellors should be non-judgmental, culturally sensitive, and respectful.

**Project Delivery Issues:** recommendations related to program delivery focus not only on therapeutic content but also upon how to overcome denial and encourage full participation. In no order of priority, they are as follows:
- ensure that facilities are adequate in size, structure (e.g., soundproof rooms for one-on-one sessions), and location with an identity distinct from other more stigmatizing institutions (e.g., alcohol and drug treatment facilities);
- recognize that aftercare is an integral part of the healing process, develop partnerships for or incorporate aftercare as an equally important part of program activity that should include home visits and centre-based outpatient therapy, and strengthen the urgency of securing sustainable partnerships so that healing can continue;
- consider increasing the time available for counselling sessions;
- special needs including FAS/FAE, addiction, and mandated care are often beyond basic programming, so effort must be expended to assess special needs, develop unique treatment plans, or make appropriate referrals;
- expend more effort to learn the characteristic differences of those mandated to participate to discover strategies that will support and engage them to complete the program and, similarly, seek out the opinions of self-motivated individuals for whom the program did not work to guide program evolution;
- facilitate individual and community readiness by recognizing that many are still in denial and by significantly boosting Legacy education and outreach efforts with more high-profile campaigns that enlist community-based partners such as schools, radio, and television;
- include more women's groups and cultural teachings;
- encourage family participation with "family" night or family fun activities;
- maintain Elder involvement; and
- conduct closer follow-up and one-on-one meetings either in the home or in the community with those Survivors who are working and not able to attend afternoon or morning sessions.

**Evaluation Issues:**
- make use of the Community Guide to Evaluating Aboriginal Healing Foundation Activity;
- be clear about the indicators that will be used to measure change;
• use client satisfaction questionnaires and other reliable and valid measurement tools to determine changes in project participants and community;
• increase efforts to explore rival explanations (e.g., What has been the contribution of leadership?); and
• profile those for whom the program seemed to work and identify what is different about those for whom the program worked versus those for whom the program did not work. Is denial the only barrier? What other distinguishing characteristics are clear? Age? Sex?

Notes

1 Information from the funding application submitted to the AHF, February 2000.
3 Indian and Northern Affairs Canada, First Nation Profiles (accessed August 2001).
4 This includes child and family, elder centre, resource centre, nursing station, fitness centre, youth leadership centre, and mental health centre.
Appendix 1) Case Studies Selection Criteria

1. Métis, Inuit, First Nation, Non-Status
2. Youth, men, women, gay or lesbian, incarcerated, Elders
3. Urban, rural or remote
4. North, east, west
5. Community services
6. Conferences/gatherings
7. Performing arts
8. Health centre (centralized residential care)
9. Camp/retreat (away from the community in a rural setting)
10. Day program in the community
11. Healing circles
12. Materials development
13. Research/knowledge-building/planning
14. Traditional activities
15. Parenting skills
16. Professional training courses
Appendix 2) Referral Package

Section A: Personal data/identification
- Information on next of kin.
- Who referred you to the program?
  - Self, court order, employer, agency, NNADAP, other
- Date of initial contact with referral agency.
- Interview conducted by (referral agent).

Section B: Family situation/history
- Marital status.
- List all family members living at home & away from home.
- List anyone who lives in the home.
- What role do they play in the home and why do they stay there?
- What child care arrangements have been made while you are in this program?
- Family support:
  - How do your family members and significant others feel about you coming into this program?
  - What type of support do you have while attending this program?
  - Please specify any type of family problems that are happening in the home/family:
    - Alcohol abuse, drug abuse, gambling, grieving/loss, anger/violence, apprehension of children, custody issues, separation/divorce, spousal abuse, legal issues, health problems, mental health problems, employment issues, lack of family supports, sexual abuse, suicide, depression, other, please specify
  - How often does abuse occur as identified in previous question?
    - Daily, occasionally, binge, rarely, never
- What is your opinion on abuse, explain.
- List areas you feel should be addressed while in program.
- What areas of the PCC interest you?
  - One on one counselling, small group session, family therapy, workshops, cultural/spiritual teachings, field trips to residential schools, other, please specify

Section C: Legal Status
- Current of pending charges, upcoming court hearings, recognizance, probation, parole, conditional or temporary release, children in care of a child care agency.
  - Please describe circumstances.

Section D: History of alcohol/drug use
- Abstainer, occasional user, moderate user, problem user, addicted.
- While attending PCC it is expected that all participants abstain from the use of alcohol and drugs. Would you be willing to abstain from the use of alcohol and drugs?
  - Yes, no, maybe, other, please explain

Section E: Finance/Employment situation
- Are you employed?
- What is your job title?
- Employers name?
- Address?
- Phone/fax?
- Will you job prohibit you from attending the PCC program?
- Does your employer require you to attend a treatment program?
- Are you willing to take a leave of absence from work if your employer approves your leave of absence?
  - Please explain.
If no, what is your source of income?
  UIC, unemployed, social assistance, pensioner, other

Section F: Residential School History
- Have you or family members ever attended an Indian residential school?
- How did the residential school experience affect your life?
  Check language, cultural beliefs/practices, parenting skills, identity, family relationships, friendship, physical abuse, emotional/mental abuse, alcohol/drug abuse/other addictions, other.
- Please explain what you lost/gained as a result of residential school or any residential school experience that affects your life today.

Section G: Treatment History
- Check off problems that the use of alcohol/drugs and other addictive substances may have caused for you.
  Relationship problems, getting fired, psychological problems, medical problems, legal problems.
- Do you believe you may have a problem with alcohol/drugs? If so please explain.
- What other treatment programs have you attended? specify dates.
- Have you ever over-dosed because of alcohol/drug use? If so please explain
- How ready are you to deal with change while in PCC program?
  Pre-contemplation - unsure at present time; contemplation - thinking about it; determined - willing to participate whole heartedly; action - the process is already being taken place; maintenance; following program gridlines as required

Signatures
- Medical Assessment report
  Physician's data
  Patient data
Appendix 3) General Questionnaire

General Questions (for respondents NOT employed by Nelson House Medicine Lodge)

Name: ___________________________________ Profession: __________________________ Date: __________________

Before we begin I would like to assure you:

• that there are no right or wrong answers, only answers that are true from your perspective, we are hoping to
  learn more about your attitudes toward the program and it’s performance and there may be questions that you
  cannot answer. It is completely acceptable to say that you don’t know.
• your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
• the project has been selected based upon the criteria that were important to the board (i.e., geographic, group
  representation, project type, etc and not on past/present performance, this is a case study to help us learn more
  about the strengths and weaknesses of our effort)
• the report will not be able to identify who said what, so please feel free to say things that may cause
  controversy
• and, for the most part, it is important to focus your comments or opinions upon things that you have noticed
  in your position as . . . . . (chief, nurse, etc.)

To start, I would like you to share with me your involvement or knowledge of the NHML, Nisichawayasihk
Healing and Wellness Program

I would like you to now think about the community generally.

1. Have you noted changes in your community’s understanding of the Residential School Legacy?
   Yes   No
   Thinking very specifically about the community (i.e. ,What have you seen, or heard or felt), that makes you
   feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
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<tbody>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
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</table>

   Why do you think this has happened?

2. Have you noticed if more families are indicating a need or willingness to participate in the Nisichawayasihk
   Healing and Wellness Program?
   Increased   Decreased   The same   Haven’t noticed
   Thinking very specifically about community members (i.e. what they have said or done), what have you observed
   that makes you feel this way:

<table>
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   Why do you think this happened?
Thinking more specifically about the program

3. How well do you believe Nisichawayasihk Healing and Wellness Program has addressed the Legacy of Sexual and physical Abuse in Residential schools including inter-generational impacts? Please circle only one response.

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<td>Reasonably well but needs improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
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</table>

Please offer an explanation for why you feel this way:

4. How would you rate the projects ability to address or meet those needs?

<table>
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<tr>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation for why you feel this way:

5. How well has Nisichawayasihk Healing and Wellness Program been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

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<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation and some examples of the projects accountability to the community.

6. Do you see Nisichawayasihk Healing and Wellness Program being able to operate when funding from the Foundation ends? If yes, how and what steps are you aware of
7. How well is the project able to monitor and evaluate its activity? Please circle only one response.

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<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
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</table>

Please offer an explanation and examples on how you seen this take place.

8. What do you think are Nisichawayasihk Healing and Wellness Program strengths? (What seems to be working well, what are the success stories)?

9. What type of change do you see happening in the lives of people who have participated in Nisichawayasihk Healing and Wellness Program? If any?

10. What are some of the challenges that Nisichawayasihk Healing and Wellness Program faces (What are its weaknesses?) Please specify.

11. Are there any other questions or comments about Nisichawayasihk Healing and Wellness Program that you would like to see addressed that we may have missed?

12. Thinking very generally about the community, which answer best describes your opinion about the following rates of:

   - Physical Abuse: increased stayed the same decreased unsure
   - Sexual Abuse: increased stayed the same decreased unsure
   - Children in care: increased stayed the same decreased unsure
   - Suicide: increased stayed the same decreased unsure

Please explain:
Appendix 4) Key Questions

✓ ① *Why are we doing this?*
   (What long term goals are we striving for?)

✓ ② *What do we want?*
   (What do we hope will happen in next 6 months to a year?)

✓ ③ *Who do we expect to influence?*
   (Who is most likely to benefit from this activity?)

✓ ④ *How are we going to do it?*
   (What activities, services, products do we believe will help us get what we want?)

✓ ⑤ *How will we know that things have changed?*
   (What things will indicate to us that change is happening? What measures and indicators of change will we use?)

✓ ⑥ *What will we see, hear and feel?*
   (How will we measure change?)

✓ ⑦ *How much have things changed?*
   (Is there a clear difference from before we started our program? What indicators or measures tell us that?)

✓ ⑧ *Who else sees the change?*
   (What is the opinion of other people whose perspective is important, e.g. family members, local health professionals, police, social services, youth services?)
Appendix 5) Employee Questionnaire

Nelson House Medicine Lodge
Nisichawayasihk Healing and Wellness Program

Before we begin I would like to assure you:

- that there are no right or wrong answers, only answers that are true from your perspective
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc and not on past/present performance, this is a case study, not an evaluation)
- we are only trying to learn from your experience so that we can help others get what they want from their AHF projects
- the report will not be able to identify who said what, so please feel free to say things that may or may not cause controversy
- and, for the most part, it is important to focus comments on individual participants.

To start, I would like you to now think about the people participating in this project (please concentrate on those who have completed the program). Please select the answer that best describes how you feel about the development of the following desired changes; remember, there are no right or wrong answers

1. Development of healthy coping skills (life skills)?

<table>
<thead>
<tr>
<th>Not sure/don't know</th>
<th>No evidence of change yet</th>
<th>Slight change</th>
<th>Moderate Change</th>
<th>Dramatic change</th>
</tr>
</thead>
</table>

Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

<table>
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<th>Individual ideas</th>
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</table>

If some change is noticeable, about how many participants are experiencing change? (circle one)

<table>
<thead>
<tr>
<th>&lt;10%</th>
<th>&lt;20%</th>
<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
</tr>
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</table>

Why do you think the change has not happened/ the change has happened?

2. Understanding the impact of the Legacy?

<table>
<thead>
<tr>
<th>Not sure/don't know</th>
<th>No evidence of change yet</th>
<th>Slight change</th>
<th>Moderate Change</th>
<th>Dramatic change</th>
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Thinking very specifically about the participants in the program (i.e. what they have said or done), what have you observed that makes you feel this way:

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<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
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Why do you think this has happened?

3. Self esteem or self-worth?

<table>
<thead>
<tr>
<th>Not sure/don't know</th>
<th>No evidence of change yet</th>
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Thinking very specifically about the participants in the program (i.e. what they have said or done), what have you observed that makes you feel this way:

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Why do you think this has happened?

4. Cultural Pride?

What have you noted that makes you feel this way:

<table>
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Why do you think this has happened?

5. Family functioning (family health, quality of family relationships)?

Not sure/don’t know  No evidence of change yet  Slight change  Moderate Change  Dramatic change

Thinking very specifically about the participants in the program (i.e. what they have said or done), what have you observed that makes you feel this way:

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Why do you think this has happened?

6. Which answer best describes your opinion about the participants who have completed the NHWP: Do you believe that as a group, their risk for:

- Physical Abuse: increased stayed the same decreased unsure
- Sexual Abuse: increased stayed the same decreased unsure
- Children in care: increased stayed the same decreased unsure
- Suicide: increased stayed the same decreased unsure

Please explain:
Now, I would like you to think about your own experiences with the training component of the NHWP. Would you say that the training program
1) reinforced what I already knew about the treatment of residential school Survivors
2) helped me to develop new skills to help Survivors
3) helped me to understanding the impact of the Legacy
I would like you to now think about the community involved in this project.

7. Have you noted changes in your community’s understanding of the Legacy?
   What have you noted that makes you feel this way:

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<td>&lt;20%</td>
<td>about 50%</td>
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8. Have you noted that resource people have become more skilled at addressing the impact of the Legacy?
   Yes   No
   What have you noted that makes you feel this way:

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</table>

MANDATORY QUESTIONS:
We know that you have already supplied information to the Aboriginal Healing Foundation through your quarterly reports, but we would like to offer you another opportunity to provide further insight in the following areas:

1. How well do you believe Nisichawayasihk Healing and Wellness Program has addressed the Legacy of Sexual and physical Abuse in Residential schools including intergenerational impacts? Please circle only one response.

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Please offer an explanation for why you feel this way:
2. How would you rate the projects ability to address or meet those needs?

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Please circle one response only:

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Please offer an explanation and some examples of the projects accountability to the community.

4. Do you see Nisichawayasihk Healing and Wellness Program being able to operate when funding from the Foundation ends? Please specify.

5. How well is the project able to monitor and evaluate its activity? Please circle only one response

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Please offer an explanation or examples on how you have seen this take place.
Tsow-Tun Le Lum Society
Project Number: HC-36-BC
Case Study Report
Qul-Aun Program

Prepared by:
Pauline McCrimmon

Under the direction from:
Kim Scott, Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2001
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Acknowledgements

I would like to extend my appreciation to the following people involved in the completion of this report; sharing this report would not be possible without their input and story.

For Kim Scott and her tireless support to me while preparing the maps and questionnaires, collecting all the data necessary, and writing the final report.

To my colleagues who so generously shared their obstacles, successes, and tips as they journeyed through their reports.

To the Tsow-Tun Le Lum Treatment Centre administration and staff for their willingness to take the time throughout the interviews and collection of additional data.

For the referral workers in the community who so willingly agreed to be part of the interviews and took time out of their busy schedules for me.

Gi’lakas’la, Thank You!
1. Introduction

This case study reports on the progress of the Qul-Aun Program (means moving beyond the traumas of our past; HC-36-BC) sponsored by the Tsow-Tun Le Lum Society. It was selected as an in-patient treatment centre model based on a blend of traditional healing activities and centralized residential care. Qul-Aun’s mission is to “strengthen the ability of Aboriginal People to live healthy, happy lives and the affirmation of pride in Aboriginal identity.”

This report describes the services of the Qul-Aun Program and its participants’ needs, physical context, and team characteristics and what it hopes to achieve in the short and long term. The report will also describe how change was measured and what trends were apparent.

2. Methods

Two days of training were offered to community support coordinators in survey development and interviewing techniques in March 2001 with a follow-up in July 2001. Work began in earnest on this case study in September 2001, and interviews were prepared based on the short-term outcomes identified in the performance map. Interviewers were independent in the field and, in this case, there was debriefing after each day of interviews. Field notes were reviewed and transcribed immediately after the interviews.

There are two lines of evidence in this case study: one directly obtained from client experience surveys; and the other from the personnel delivering the program (administration and counsellors) as well as the referral agents. Dissent was encouraged in at least two introductory remarks preceding interview questions:

- that there are no right or wrong answers, only answers that are true from your perspective; and
- the report will not be able to identify who said what, so please feel free to say things that may cause controversy.

Seven community referral workers were contacted whose names were provided by Qul-Aun’s intake worker. They were located throughout the province, from Victoria to Campbell River, and all those contacted were more than willing to participate. The project had participants from all over British Columbia and even Manitoba, Saskatchewan, Alberta, and Seattle; however, work was restricted to Vancouver Island to ensure the interviews were manageable and cost effective. The seven referral workers came from backgrounds such as addictions counselling, corrections, and residential school workers.

Over the period of six days, 13 interviews were conducted (see Appendix 1). They were divided into three categories: administration, staff, and community referral workers. During the course of the interviews some minor on-the-spot changes were incorporated to avoid duplicating questions. The most important factor during the interviews was having a compassionate, sensitive approach and validating the interviewee as well as ensuring confidentiality. Discussion on how information for all referrals to the program could be tracked led to the agreement that the files be kept open for four years and contact with their referred clients be continued. If any referral worker should leave the position, there should be assurance that the new person is aware of this case study.
2.1 Limitations

There are several threats to reliability and validity of this case study that are worth noting here. No direct measurement of participants was conducted by the AHF; its employees, or agents due to ethical concerns about the possibility of triggering further trauma without adequate support for the participant as well as to the limitations of AHF’s liability insurance. Because direct assessment was problematic, indirect assessment or the perceptions of key informants were weighted heavily. Furthermore, although the Qul-Aun team did secure client satisfaction at the end of treatment and again at a three-month follow-up, no standardized instrumentation was used to assess changes in related cognitive or behavioural indices of healing. It is highly probable that there is no psychometrically evaluated or standardized instrument to determine the unique healing stages of Aboriginal people recovering from the Legacy (institutional trauma).

The most important information missing are the characteristics of those clients who were not completely satisfied with the program as well as the more long-term follow-up of their progress based on the indicators identified in the Qul-Aun evaluation plan submitted with their funding proposal.

3. Project Overview

3.1 Regional Profile

Qul-Aun is administered by the Tsow-Tun Le Lum Society located on Nanoose First Nation near Lantzville, British Columbia, which is in the central Vancouver Island region, 20 minutes north of Nanaimo. Nanoose First Nation community has a population of approximately 151 living on reserve.

The clients who attend the treatment centre arrive from all over British Columbia: some are from isolated communities; remote fly-in only; on reserve; rural areas; out of province; and as far as Seattle, Washington. Therefore, there is no single community description or context from which clients originate. While it is clear that some will return to communities where isolation, poverty, and unemployment are problematic, not all will face these challenges upon returning home.

The Tsow-Tun Le Lum Society has operated programs to treat those suffering from addictions and those who are sex offenders or survivors of sexual abuse. The main funding source for the Society is the First Nations Inuit Health Branch of Health Canada. The Society receives other income from per diem charges and from program delivery funding for treatment beds assigned to inmates that participate in Qul-Aun. The centre has accumulated over 50 partners who continue to contribute to referrals and aftercare.

The centre prides itself in the traditional decor of its facility internally and externally. The facility consists of an administration area, a common lounge, an Elder suite, a dining area, a kitchen, a small gym, three group rooms, an outpatient/psychologist office, five counselling rooms, 10 bedrooms, and a craft and workout area. All the bedrooms have full ensuites. The building is complemented by a sweat lodge area and a traditional healing pond located in the natural forest that surrounds the centre. The lounge and greeting area are decorated by First Nations arts and crafts from local island community members. This display often inspires clients to pursue creative activities and demonstrates pride in Aboriginal artistic talents.
Case Study Report: Qul-Aun Program

From 1996 to 1998, with the support of Non-Insured Health Benefits of Medical Services Branch, Tsow-Tun Le Lum Society developed and launched a pilot trauma treatment program for residential school Survivors. Survivors of residential schools and those affected by multi-generational effects were assisted by trained and experienced staff who could relate to the clients in a positive, helpful, respectful, and caring manner. The pilot team included a psychologist, an Aboriginal therapist, and a contracted psychodramatist. The pilot included outreach education/awareness and therapeutic in-patient services. An evaluation of the pilot (Appendix 2) included many recommendations that were implemented. However, some limitations remain; for example, it was recommended that all clients prior to admission be informed about psychodrama and how it works and that an outreach component be added. This was done in a limited fashion due to staff changes and to the outreach workers’ inability to reach all geographic areas. One-on-one counselling was added with the awareness and sensitivity toward clients who had past negative experiences with non-Native counsellors. Introducing the concept of one-on-one counselling during the first week and explaining its value appeared to put clients at ease. “The Tsow-Tun Le Lum Society believes that healing begins with individual, extends to the family and moves out into the entire community.”

3.2 Qul-Aun Program Description

The unique program now known as the “Qul-Aun Program” is the natural extension of the established two-year pilot in-patient treatment program for residential school Survivors originally funded by Health Canada. The experienced and trained staff guide participants who are dealing with unresolved trauma through a therapeutic in-patient program that includes individual daily work, reading assignments, journal work, men’s and women’s groups (focus is on abuse and abandonment issues), anger management work (for those who cannot control or suppress their anger), inner child work, psychodrama, healing circles, individual morning and evening workouts, team sports, and group activities. The traditional methodologies include traditional ceremonies, rituals (sweat lodge, pond, cedar cleansing, etc.), and reclaiming traditional spirituality. A balance of cultural ceremonies and rituals, with the support of resident Elders, provides a culturally sensitive environment for participants to learn about the process and to reclaim spiritual wellness.

The project was initially funded as a pilot healing centre project for one year in the amount of $459,560. It was designed to provide in-house healing activities to Aboriginal men and women who survived the residential school system and to their extended families and, secondly, to provide training for staff and community front-line workers. The project received an extension, which brought the contribution agreement up to $689,340 for a 17-month program, plus in-kind contributions from the substance abuse program in the amount of $235,000, which made the actual total to run the program at $924,340. “The primary ... [long-term goal] of the [Qul-Aun] program is to strengthen the ability of Aboriginal people to live healthy, happy lives and the affirmation of pride in their Aboriginal identity.” The objective of the program is “To develop an In-Patient Program which will provide a healing opportunity for those people who have issues caused by abuse trauma which have been contributing factors in their substance abuse relapse; inability to deal with life stresses in the areas of self-care, parenting and relationships.”

The project’s main goals and objectives, as stated in the proposal, include:

- developing lasting healing from the legacy of physical and sexual abuse from the residential school system, including intergenerational impacts;
• developing the pride of identity and a healthy state of well-being through the use of traditional methodologies;
• initiating a healing process that will lead to the emotional, mental, physical, and spiritual health and well-being of Aboriginal people;
• developing the capacity of individuals, families, service providers, and communities to address the Legacy;
• releasing blocked emotions and unresolved trauma;
• supporting the validation and resolution of trauma;
• identifying relationships between unresolved trauma and defensive mechanisms, coping devices, survival techniques, and destructive behaviours;
• providing new approaches and healthy practices to address the challenges of life and to acquire health and well-being; and
• increasing capacity through the transfer of knowledge and skills to individuals, families, service providers, and communities to assist them in addressing the legacy of abuse and restoring the health of Aboriginal people.

The Qul-Aun Program’s three main components for the first 17 months of implementation and operation are program planning and development, training, and in-patient treatment. The activities associated with each component are outlined below:

• Program planning and development involves hiring a team of professionals, reviewing, and revising material from the trauma treatment pilot project, establishing community contact and holding an open house, advertising the program through the newspaper, newsletters, and faxes to local Aboriginal organizations, holding staff meetings to review programming, and assigning an outreach worker to Correctional Service of Canada.

• Training involves facilitating a 12-week core training program for all staff designed to examine ways to generate breakthrough experiences that release their clients from past patterns of suffering and insignificance, refine and enhance understanding and skills to guide others toward self-mastery and self-sufficiency in their everyday lifestyles, and become more powerful to promote harmonious living through awakening and engaging unused or underused competencies; providing internship for a trauma counsellor; and having staff enroll and attend training workshops (see Appendix 3).

• In-patient treatment program involves promoting awareness of the program, providing counselling services (e.g., psychodrama, post-traumatic stress therapy, healing/talking circles, and traditional ceremonies), having Elder peer support throughout the session, soliciting continuous feedback from user group (pre/post) and referral workers, monitoring the outreach service, reviewing the aftercare plan with clients before departure, implementing a special session for front-line workers, and conducting an evaluation.

Because the effectiveness of planning, development, and training can be implied by the program’s performance, the evaluation effort was focused on the impact of treatment on individual participants. What follows is a week-to-week description of Qul-Aun:

• **Week 1—Connecting**: content consists of a Welcoming Home ceremony, an orientation, techniques for grounding, building trust and safety; an Elder visit, attending drug and alcohol activities, and identifying resiliency, strengths, triggers, validation, and support.

• **Week 2—Discovering**: includes circles and sweat lodges, examining the definition of post-traumatic stress disorder, family of origin, early childhood development, relationship, shame and guilt, history of residential schools, Elder visits, and effects of unresolved trauma, cultural oppression, shame, sexual abuse, and residential schools.
• **Week 3—Reclaiming**: psychodrama is introduced and essentially allows participants to role play scenarios of unresolved trauma in order to heal past hurts.

• **Week 4—Moving Beyond**: continuation of circles, sweat lodges, and Elder visits, debriefing from psychodrama, understanding and honouring defenses and empowerment, and identifying, defining, and understanding what constitutes healthy grieving, lateral violence, community, and crisis-oriented.

• **Week 5—We Made It Through**: continuation of circles, sweat lodges, teachings on resiliency and empowerment, and Elder visits and a self-care plan, an aftercare plan, and re-entry into community.

The underlying assumptions are that these series of activities will have created experiences that will lead to: development of lasting healing from the legacy of abuse from residential schools, including intergenerational impacts; development of pride in identity and a healthy state of well-being through the use of traditional methods; increased emotional, mental, physical, and spiritual health and well-being for Aboriginal people; and development of capacity for individuals, families, service providers, and communities to address the legacy of abuse from residential schools.

3.3 **Thinking Logically**

There is a logical link between Qul-Aun’s activities, what they hope to achieve in the short term, and desired long-term outcomes. In this case, Qul-Aun aimed to address the impact on residential school Survivors and their families by providing a five-week trauma treatment program to assist them in the restoration of well-being. As outlined previously, the 12-week core training prepared both Qul-Aun and addictions staff for the implementation of the five-week treatment program. The purpose of training all staff was to ensure a fully qualified team to work with Survivors.

The selected project activities were based on the centre’s extensive experience with healing processes, the consultation with some staff who are residential school Survivors, the trauma training program, and feedback from the two-year pilot.

The relationship between project activities and short- and long-term benefits is set out in the following logic model (Figure 1). It shows the logical link between project activities and what the program wants to achieve in the short and long term. It then goes on to identify how we will know things have changed. Although the focus of this evaluation effort is on the healing component, all three activity areas (program planning and development, training, and treatment services) are outlined. Indicators of change and how they are being measured are outlined in the performance map (Figure 2), which was used as a one-page reference guide to collect information. To prepare the map, the following questions were asked:

- Why are we doing this?
- What do we want?
- Who do we expect to influence?
- How are we going to do it?
- How will we know that things have changed?
- What will we see, hear, and feel?
- How much have things changed?
- What information was really important and why?
### Figure 1) Logic Model—Qul-Aun Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>How we did it</th>
<th>What we did</th>
<th>Why we are doing this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engage in program planning and development.</td>
<td>Hire team; review other treatment material for relevance; establish community contacts; hold open house; mass mail-outs; news ads; ongoing staff meetings to review programming; and assign outreach worker to Correctional Service of Canada.</td>
<td>Revised/organized program manual and assessment tools; education/training; in-house aftercare and outreach; communication strategy; and evaluation process based on pilot project.</td>
<td>To assist in the restoration of the emotional, mental, physical, and spiritual health and well-being of participants, families, and communities by honouring their stories and encouraging them to begin or continue their healing journey.</td>
</tr>
<tr>
<td>Provide training.</td>
<td>Facilitate core training of all staff; provide internships for trauma counsellors; and enroll and attend workshops.</td>
<td>Staff attended training in re-enactment therapy; earthquake preparedness; accreditation coordination; trauma treatment; reintegration; traditional teachings; racism; team building; and “Pursuit of Excellence” workshop and networking meetings.</td>
<td>Need for and rate of participation in treatment programs; observed and self-reported changes in parenting skills; and reduced rates of children in care, family violence, and suicide (including attempts).</td>
</tr>
<tr>
<td>Offer safe and effective treatment that addresses the Legacy.</td>
<td>Promote awareness of program; provide counselling services (e.g., psychodrama, post-traumatic stress therapy, healing/talking circles, and traditional ceremonies); solicit continuous feedback; monitor outreach; review aftercare; implement special session for front-line workers; and evaluate.</td>
<td>Increase in pride in Aboriginal identity, confidence, feeling of empowerment, community knowledge of Legacy, and personal capacity to address Legacy; and reduction in abuse and feelings of victimization.</td>
<td></td>
</tr>
</tbody>
</table>
Figure 2) Performance Map—Qul-Aun Program

| MISSION: Strengthen the ability of Aboriginal people to live healthy, happy lives and the affirmation of pride in Aboriginal identity. |
|---|---|---|---|
| HOW? | WHO? | WHAT do we want? | WHY? |
| Resources | Reach | short-term outcomes | long-term outcomes |
| activities/outputs | | | |
| Provide counselling services (e.g., psychodrama, post-traumatic stress therapy, healing/talking circles, and traditional ceremonies); solicit feedback; monitor outreach; review aftercare; hire team; review other treatment material for relevance; establish community contacts; hold open house; mass mail-outs; news ads; ongoing staff meetings to review programming; core training for all staff; internships for trauma counsellors; workshops; promoted awareness of program; implement special session for front-line workers; and evaluation. | Aboriginal adults (>19 years-old, status blind, on or off reserve) residing near vicinity of Tsow-Tun Le Lum, Vancouver, and Yukon and inmates from Correctional Service of Canada; and team delivering trauma treatment. | Increase in pride in Aboriginal identity, confidence, feelings of empowerment, community knowledge of Legacy, and personal capacity to address Legacy; reductions in abuse and feelings of victimization; smooth implementation of trauma treatment combining the best of traditional and Western approaches that works well for and feels right to Survivors and families; and increased knowledge and skill to address Legacy. | Restoration of the emotional, mental, physical, and spiritual health and well-being for participants, families, and communities; broken cycle of abuse; and lasting healing. |

How will we know we made a difference? What changes will we see? How much change occurred?

<table>
<thead>
<tr>
<th>Budget</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$459,560 (12 months), $680,157 (17 months), plus $235,000 (in-kind); budget for development, $18,000; and budget for training, $16,000</td>
<td>123 participants and 12 staff trained.</td>
<td>Observed and self-reported changes in substance abuse, violence, and use of healthy parenting skills; cultural pride; feelings of empowerment and victimization; understanding of self; knowledge and understanding of Legacy and its impacts; awareness of needs and issues of Survivors by leadership and referral network; # of community organizations seeking education on the Qul-Aun Program; service demand for residential trauma treatment; measures of skill or capacity to address the Legacy; # of partnerships established (either by formal protocol or informal networking opportunities); documents on issues and needs of residential school Survivors; Survivor feedback on quality of trauma treatment program and trainee’s ability to facilitate healing; and self-reported and observed changes in skills, knowledge, treatment application, awareness of needs, and issues of Survivors in trainees.</td>
<td>Need for and rate of participation in treatment programs; observed and self-reported changes in parenting skill; and reduced rates of children in care, family violence, and suicide (including attempts).</td>
</tr>
</tbody>
</table>
3.4 Participant Characteristics

The Qul-Aun Program focuses on providing treatment services for all Aboriginal (Métis, Inuit, and First Nations on or off reserve) adults 19 years and older, inclusive of incarcerated males ready for parole. Participants are mainly from British Columbia and the Yukon, but clients from as far as Alberta, Saskatchewan, Manitoba, and Seattle, Washington, have been accepted. It is noted that groups to date are predominately women, sometimes the female-to-male ratio is 7:3 or 6:4. The centre is currently seeking ways to encourage men to attend. There is a maximum of 13 participants per session. These sessions are held in conjunction with the addictions program; thus parts of the sessions will overlap with the program. Disabled clients are also accepted and accommodated into the program, and one to three incarcerated males attend each session.

The participants are first assessed by community referral workers to determine the extent and willingness to improve their personal life situation. The intake counsellor for Tsow-Tun Le Lum Society reviews all applications (Appendix 4) and makes the final decision based on the participant meeting the following program criteria:

- substance free for six months inclusive of any active/mood-altering drugs;
- demonstrates pre-/post-treatment support;
- mentally stable and able to participate in intense individual and group counselling situations;
- prepared to address past trauma in both group and individual experiences;
- committed to review his/her present lifestyle, behaviours, and feelings;
- free of any acute care hospital requirements;
- in control of all disease and free from any communicable disease; and
- free of any appointments or court dates to attend that would occur during the program, such as physician or court appearances.

Parole-ready inmates must attend the addictions program prior to entry. The selected participants must have a strong desire to improve their lifestyle and commitment to arrive at and maintain healthy habits. This is determined or assessed by their community referral worker and intake counsellor.

At least 90 per cent of all participants attending Qul-Aun (n = 123) before or up to July 2001 have a history of physical, sexual, and substance abuse as well as family violence. Almost three-quarters have abused drugs (74%) or have a history of foster care (77%), and over half (65%) lack basic life skills. Forty-six per cent have attempted suicide and 20 per cent have suffered from incest or have a criminal record. Figure 3 illustrates the characteristics of Qul-Aun participants.
The vast majority of participants are First Nations (94%), some participants are Métis (3%), and there are no Inuit participants at Qul-Aun. An overwhelming majority are residential school Survivors and, congruent with most other AHF-funded programs nationally, women outnumber men by almost two to one. A small number of Elders and incarcerated individuals have also participated in treatment. Worthy of note is that some of the participant group are also service providers.
3.5 Project Team

The project is administered by the Tsow-Tun Le Lum Society and overseen by an active board of directors. There are two full-time Aboriginal counsellors (one is also the project coordinator) who handle the day-to-day activities of the treatment program with the periodic assistance of Elders, a therapist, a psychologist for one-on-one counselling, a psychodramatist who comes in during the third week only, an outreach worker, a cook, an intake counsellor, and a night counsellor that complement and complete the service delivery. The two Aboriginal counsellors have the most constant contact with the participants throughout their five-week stay and who create a family-type setting and role model healthy boundaries.

The project coordinator reports to the executive director and is responsible for all project activities, coordinates staff evaluation meetings, and works with administration, outreach workers, the intake counsellor, therapists, and Elders. She has worked with the centre for 12 years and is very well respected by her colleagues and clientele. She has taken many training courses and has trained under her mother in the area of traditional healing and therapeutic approaches.

The other Aboriginal counsellor works with the project coordinator in facilitating the five-week session. He is a residential school Survivor and was involved, from its inception, with the Provincial Residential School project in 1994. He brings a fatherly figure and male-balanced role to the program and is highly respected by his colleagues and clientele, and the clientele call him “Pa.” He holds an addictions counsellor certificate.

The outreach worker’s main function is to provide outreach and aftercare services to the clients of the project. The work is pursued in close cooperation with the program coordinator and other staff. The outreach and aftercare workers are considered to be members of the therapeutic team and participate in day-to-day operations while facilitating the involvement of participants in program activities.

The executive director, who has been with the centre since its inception, is responsible for the overall management of the project/centre and the quest for further funding resources to ensure sustainability of the program. He attends all staff team meetings and strategic planning sessions to review programming on what is working or needs improvement. He is visible in the centre and highly regarded. He has a master’s degree and 26 years of experience in the addictions field.

The assistant director also acts as the human resource manager, has the responsibility for programming within the centre, and relieves the director when he is on leave. She attends all staff team meetings and strategic planning sessions to review programming on what is working or needs improvement. She is visible in the centre, adds a soft, caring gentle touch, and has also been part of the team since inception. She has university training in management and administration.

The bookkeeper’s main responsibility is handling the cash flow for the project, and the cook does the shopping for food and household supplies for the centre. The cook also participated in the core team training and is able to recognize when clients are in need of support or when they simply need to be left alone. The benefit of having the cook take the training is also to help identify if clients are heading for a crisis and can then contact the counsellor on site. This position is funded by the substance abuse program.
The intake worker’s main responsibility is to handle all client applications received from the referral workers and ensure that all documents are filled appropriately and that there is a minimum six weeks of sobriety. She also works with Correctional Service of Canada to ensure that the incarcerated clientele have entered the substance abuse program prior to attending the Qul-Aun Program. Her position is an in-kind donation provided by the substance abuse program.

The board of directors of the Tsow-Tun Le Lum Society consists of 11 members, including five Elders, who give generously of their time and advice. They are nominated and elected from the community and have professional, diverse backgrounds. This contribution is essential to the functioning of the Qul-Aun Program as well as other programs at the centre. Elders and board members are offered honoraria for their service and time.

4. Our Hopes for Change

The service delivery area is very broad geographically, and it is unfair and difficult to focus on one community for statistical information. However, an attempt is made to provide as many provincial statistics on AHF board-requested areas of concern (i.e., sexual abuse, physical abuse, incarceration, and children in care) reasonably within the resources for this case study. What follows is a very brief statement about provincial information on each social indicator, as well as the sentiments of Qul-Aun’s participants on how the issue was addressing treatment (e.g., foster care, sexual abuse, etc.). The reader will note the term “n=#” is included in many statements. The “n” refers to the number of participants who voiced an opinion on the topic.

4.1 Children in Care

Aboriginal children and families are disproportionately represented in the number of caseloads of the provincial Ministry for Children and Families.

Aboriginal Children In Care comprise 30 percent of all children in care averaged across the regions, with several regions reporting near or over 50 percent, whereas Aboriginal children make up only 8 percent of the total B.C. child population. [In addition,] ... Aboriginal communities ... have an infant mortality rate 63 percent higher than the provincial average.4

The participant characteristics in Figure 3 show that almost 80 per cent of Qul-Aun’s participants have a history of foster care. If we assume that only those impacted by abandonment and a history of foster care would address these issues in individualized counselling sessions, then it is clear that 69 per cent of the respondents struggle with abandonment issues and 14 per cent are affected by foster care placement. Although participants felt equally satisfied with Qul-Aun’s team (n=55) and the individualized (n=41) approaches to abandonment issues, there was a clear preference for individualized treatment (n=14, group; n=8, individualized) when foster care placement was discussed.

4.2 Sexual Abuse

Rates of sexual abuse are higher among Aboriginal students; 28 per cent of females and 6 per cent of males report some experience of sexual abuse compared with non-Aboriginal females (14%) and males (3%). Sexual abuse among all girls has decreased, but not significantly, since the first Adolescent Health Survey (38% in 1992 compared with 28% in 1998). Data for this report were obtained from the re-
responses of 1,707 Aboriginal students who took part in a province-wide health survey in 1998. Forty-five per cent of these students were male and 55 per cent were female. Students in the survey were evenly distributed across grades and ages. The survey was conducted by the McCreary Centre Society, a non-profit provincial organization with extensive experience on youth issues. There is no definition available in the document on sexual abuse.\(^5\)

The vast majority of Qul-Aun's group (\(>90\%\)) have suffered as victims of sexual abuse. Sexual abuse was specifically addressed in both individualized and group treatment settings. For those participants for whom sexual abuse was a relevant topic in group sessions (n=45), the majority felt either completely or extremely satisfied. For those in individualized sessions who addressed sexual abuse (n=38), a greater proportion of them felt completely or extremely satisfied. It is possible that such stigmatized behaviours lend themselves better to individualized treatments for some who feel uncomfortable addressing or expressing the full impact of sexual abuse on their lives in a group setting.

There is a clear preference for those who have a history of sexual offences (n=12) to prefer individualized counselling rather than group treatment. This is understandable given the stigmatization of the offence, and this may be part of the explanation of why men are not attracted to the group healing context of residential treatment facilities.

4.3 Physical Abuse

Nearly a third (31\%) of Aboriginal girls report having been physically abused compared with 16 per cent of Aboriginal males. These rates are higher than for non-Aboriginal females (20\%) and males (13\%).\(^6\) Almost all (\(>95\%\)) Qul-Aun participants have a history of physical abuse or family violence; physical abuse, anger, violence, and spousal abuse were addressed in treatment. There appears to be an even distribution of satisfaction in the treatment of these issues for each group (n= 46, anger and violence; n=28, spousal abuse) and individualized settings (n=35, anger and violence; n=21, spousal abuse).

4.4 Incarceration

Aboriginal people constitute 3 per cent of Canada's population, but constitute 15 per cent of incarcerated federal offenders and 9 per cent of federal parolees. Aboriginal people who are granted conditional release get out later in their sentence than non-Aboriginal offenders. Only 34 per cent of incarcerated Aboriginal people will receive full parole versus 41 per cent of non-Aboriginal people. Aboriginal people are twice as likely as non-Aboriginal people to fully serve their sentence. Eighty-seven per cent of incarcerated Aboriginal people are sentenced for murder or category one offences (violence or drugs) compared to 80 per cent of non-Aboriginal people, and they are twice as likely to come back to prison for a third time or more. In 1996, 73 per cent of incarcerated Aboriginal people in provincial/territorial correctional facilities in Canada were under 35 years of age compared to 61 per cent of non-Aboriginal people (federal estimates were 63 per cent compared to 49 per cent).\(^7\)

The following statistics identify the clients (First Nations, Inuit, Métis, and non-Aboriginal people) of the Native Courtworker and Counselling Association of British Columbia served in 2000 and show what types of charges were laid:
Table 1) Clients Served by Offence Type

<table>
<thead>
<tr>
<th></th>
<th>Lower Mainland (Vancouver)</th>
<th>South Coast (Vancouver Island)</th>
<th>Southern Interior Region (Kootenays to Williams Lake)</th>
<th>Northern Region</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total clients served</td>
<td>4,244</td>
<td>1,738</td>
<td>3,040</td>
<td>3,797</td>
</tr>
<tr>
<td>Adults</td>
<td>3,515</td>
<td>1,567</td>
<td>2,603</td>
<td>3,360</td>
</tr>
<tr>
<td>Youth</td>
<td>703</td>
<td>170</td>
<td>425</td>
<td>445</td>
</tr>
<tr>
<td>Youth raised to adult court</td>
<td>–</td>
<td>6</td>
<td>14</td>
<td>–</td>
</tr>
<tr>
<td>Damage to property</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>189</td>
</tr>
<tr>
<td>Robbery</td>
<td>295</td>
<td>42</td>
<td>139</td>
<td>–</td>
</tr>
<tr>
<td>Assault</td>
<td>591</td>
<td>349</td>
<td>480</td>
<td>748</td>
</tr>
<tr>
<td>Theft</td>
<td>1,071</td>
<td>287</td>
<td>638</td>
<td>527</td>
</tr>
<tr>
<td>Drinking and driving</td>
<td>146</td>
<td>261</td>
<td>448</td>
<td>408</td>
</tr>
<tr>
<td>Fish and wildlife offenses</td>
<td>–</td>
<td>119</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Failure to appear for court</td>
<td>421</td>
<td>–</td>
<td>72</td>
<td>288</td>
</tr>
<tr>
<td>Breach of probation</td>
<td>677</td>
<td>232</td>
<td>272</td>
<td>564</td>
</tr>
</tbody>
</table>

When examining participant satisfaction in the Qul-Aun Program, there is a clear preference for those who have a history of conflict with the law (n=11, group; n=8, individual) to prefer individualized counselling to group treatment. The stigmatization of illegal activity may be part of the explanation for this preference. Figure 5 shows the proportion of participants who were either completely or extremely satisfied with Qul-Aun’s treatment approaches to various issues.

Figure 5) Comparison of Participant Satisfaction with Group and Individual Treatment Experiences
4.5 Suicide

Almost half (46%) of Qul-Aun participants have a history of attempted suicide. While suicide was not specifically addressed in Qul-Aun, self-abuse and depression, both closely related to suicide, were topics of discussion. These topics appeared to create the greatest satisfaction when addressed in the individualized treatment context (n = 28, self-abuse; n = 29, depression) and were also satisfactorily addressed in the group context by the majority (n = 49, self-abuse; n = 46, depression). Figure 5 above shows the proportion of participants who were either completely or extremely satisfied with Qul-Aun’s various approaches to dealing with these issues.

Suicide continues to be a leading cause of death among young people, especially young men, in many Aboriginal communities. Survey results confirm that suicide has touched the lives of most Aboriginal youth. In all, 64 per cent of Aboriginal youth, including 71 per cent of females and 56 per cent of males, know someone personally who has attempted or committed suicide (Figure 6). Nearly one in five Aboriginal youth have considered suicide, and 10 per cent have actually attempted to kill themselves. These rates are higher than for non-Aboriginal students.9

5. Reporting Results

The following results are summarized responses from one-to-one interviews with Qul-Aun team members (4), community referral workers (7), and administration (2); a total of 13 people. The discussion highlights the opinions of these key informants regarding change in Qul-Aun participants and in the community, which is enhanced with information from client feedback.
5.1 Impact on Individual Participants

While the Qul-Aun team was unanimous that changes in cultural pride had occurred (n=4), referral workers (n=6) did not all uniformly share that optimism. However, 80 per cent did agree that change was noticeable. Respondents most often indicated that they observed changes in individual spiritual beliefs and cultural practices, like taking up crafts/carving; however, they did not believe that all participants had been affected. When asked to estimate how many participants changed, most felt that half or more of the participants had enhanced feelings of cultural pride. One felt that such change was restricted to less than 10 per cent of the participants. Respondents most often attributed changes to program content. They recognized that the integration of traditional practices honoured at the treatment centre probably accounted for increases in cultural pride. Those who saw little change believed that participants may have already had a strong cultural base before arriving at treatment. Table 2 displays their perceptions about the magnitude of change in cultural pride as well as in other select variables that will be discussed.

<table>
<thead>
<tr>
<th>Change in Clients in...</th>
<th>Respondent Type</th>
<th># of Respondents Noting Proportion of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Qul-Aun</td>
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<td>Cultural pride</td>
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<td>Healthy coping patterns</td>
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<td>Self-worth</td>
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<td>Planning for the future</td>
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<td>Maintaining aftercare</td>
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<td>Qul-Aun</td>
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<td>Referral</td>
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<td></td>
<td>Qul-Aun</td>
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<td></td>
<td>Referral</td>
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Respondents unanimously agreed that changes were visible (n=13) when asked about participants’ coping patterns, self-worth, and life skills. On what evidence of change was observed, respondents equally noted behavioural and cognitive change (e.g., going back to school and higher self-esteem). When asked to estimate the magnitude of change, there was very little discrepancy. It was unanimously felt that 80 per cent of participants had more confidence, feelings of empowerment, and personal capacity to address the Legacy and had reduced feelings of victimization. At least two people felt that these changes were restricted to a small group (<10% and <20%). Respondents most often attributed changes to the combined influences of program content, team quality, the cultural component, group dynamics, and forms of therapy such as psychodrama. Those who saw little change believed that participants may already have a strong support system or developed life skills and healthy coping patterns from participation in substance abuse treatment programs prior to arriving at Qul-Aun.
When respondents were asked about the extent to which clients maintain aftercare, it was noted by referral workers that a high percentage of clients continue with external counselling and self-support groups. However, this analysis is not unanimous as some believe that participants who go back to the correctional facility or go to remote regions do not get the support they require. There was some disagreement when asked to estimate the magnitude of change; although most felt that 50 per cent or more of participants had maintained aftercare, one felt that such change was restricted to less than 10 per cent. Respondents most often attributed client maintenance of aftercare to aftercare planning, although community isolation or incarceration presents some challenges. Those who saw little change believed that participants may already have a strong support system prior to arriving for treatment.

Respondents unanimously felt that change was obvious \((n=11)\) when asked about participants’ understanding of the Legacy, although most felt that the increased understanding was restricted to about 75 per cent of participants. They unanimously credited program content, including psychodrama and history, with participants being able to come to a place of acceptance and understanding of the impact of the Legacy.

These results of immediate evaluation from participant’s, team’s, and referral workers’ perspectives are overwhelmingly positive, although it is not clear how long the good feeling lasts or how effective the program is at changing behaviour over the longer term \((e.g., \text{one to two years})\). It was acknowledged that some clients slip through the cracks or do not remain substance free, and respondents felt that more consultation with community workers was needed. A small percentage of negative feedback was also left on voicemail or pagers. Results from a follow-up survey of clients \(\text{three months after Qul-Aun}\) show some promising endurance to the overwhelmingly positive client evaluations done at the end of treatment. While characteristics of these clients were not obtained, it is known that these results are based on 23 responses to this survey. When asked if the program assisted them to act upon their strengths in ways that produced results for them, the majority reported that it did completely or extremely well \((70\%)\) or reported that the impact in this regard was very good \((22\%)\). When asked if the program had made a difference in their lives, over three-quarters of the group \((78\%)\) reported that it did so completely or extremely well. The program’s ability to prepare clients for handling future trauma was felt by the majority \((78\%)\) that it did so completely or extremely well.

In the evaluation plan submitted with the Qul-Aun Program funding proposal, a more detailed follow-up of clients was considered. However, at the time of data collection, this information had not been collected by Tsow-Tun Le Lum, which probably owed to the limited resources to collect the data.

5.1.1 Program Development Process

Respondents in Tsow-Tun Le Lum’s administration attributed their smooth implementation to their 14-year track record of treatment and program/organizational stability. They implemented the first treatment cycle within the first month of operation. However, it is noted that they are without personnel to fill gaps when staff are ill or on leave as was experienced midway through the program. Some processes like the referral source questionnaire, program staff self-evaluation, quality assurance policies, and evaluation processes were not implemented but are added to this year’s work plan.

At the end of each five-week session, the Tsow-Tun Le Lum team solicits feedback from clients in the form of a self-administered survey \((\text{Appendix 5})\) and again three months after the last session \((\text{Appendix} \text{...})\).
As part of the exercise, clients are asked to rate the program's ability to facilitate the achievement of their personal goals. The following results presented here are based on client responses (59) from five different Qul-Aun sessions. First, respondents were asked to identify four personal goals for participating in the Qul-Aun Program. When asked to what degree their personal goals were met, the majority indicated extremely well or completely. Figure 7 illustrates the distribution of opinions with respect to the achievement of personal goals.

With respect to the program-driven goal of assisting them to move beyond the trauma of their past, 76 per cent of participants (n=49) noted that they experienced this program aim either completely or extremely well. Participants rated their experience of the admission process very highly as well, with more than three-quarters indicating that they felt welcomed and supported, were advised of the program and its guidelines in a clear way, and were engaged in a way that was respectful of their beliefs, values, language, and culture.

Qul-Aun is essentially a blend of group and individualized experiences. Participants were questioned about the efficacy of each treatment approach on a range of issues addressed. Figure 8 shows the percentage of participants who indicated that the program addressed the following issues either extremely well or completely. Participants were most likely to be satisfied with their group experience when addressing the following issues: concerns specific to the impact of residential schools and past trauma, anger, violence, being the child of alcoholic parents, shame, abandonment, guilt, grief, and identifying triggers. In all cases, more than 60 per cent of participants reported that these issues were either completely or extremely well addressed. Responses were not as consistently enthusiastic for a group setting when sessions dealt with spousal abuse, cultural oppression, conflicts with the law, sexual abuse, drug addiction, depression, sexual offending, self-abuse, relationship conflicts, and foster placement (see also Figure 5).
Although slight, there is an apparent trend for the participants to favour group experiences over individualized counselling when addressing matters directly related to residential schools, the impact of past trauma, and drug addictions. Individualized treatment, however, was clearly favoured when it addressed foster placement, identifying triggers, and cultural oppression. Other elements of the group experience were also assessed, including the value of the group experience, use of psychodrama, and the climate of respect in the group context. Figure 9 depicts the participants' ratings of various elements of the group experience.
5.2 Impact on Trainees

Staff rated the quality of training they received to facilitate healing from the Legacy as excellent (Appendix 7). Most believed they were getting the kind of training they needed and were very satisfied with the amount of training. Overall, the team was very satisfied; they believed that it helped a great deal to effectively deal with clients. When asked to note which experiences were most helpful, on-the-job training, their own residential school experience, Middleton-Moz, and core team training were noted. Only one person indicated the need for more psychodrama training.

When staff, administration, and referral workers were asked about their opinions regarding the Qul-Aun Program’s ability to address and deal with the Legacy, all but one indicated a noted increase in ability. Most felt that the Qul-Aun team was able to address and deal with the Legacy reasonably to very well with minor improvements; however, one respondent was not sure. Respondents unanimously attributed the team’s ability to the combined influences of a well-developed program team, consistency in ensuring fully trained staff, and having highly qualified trainers.

5.3 Impact on Community

Respondents were asked about their attitude regarding the community’s understanding of the Legacy, and they unanimously noted that change was obvious (13). However, they did not believe that the entire community had been affected. There was some disagreement when asked to estimate the magnitude of change. Many had felt that at least half the community or more now had a better understanding of the impact of the Legacy, although there were at least two people who felt that the change in knowledge and understanding of the Legacy was restricted to a small group (<20% and <10%). Figure 10 displays their perceptions about the magnitude of change in the community’s understanding of the Legacy.

Based on interview responses, it would appear that the community has become more aware of the Legacy; however, the impact of Qul-Aun on all communities of origin (i.e., where clients reside) was not measurable with the resources allocated to this effort. The outreach component played the major role in getting the
information to regional communities. Word of mouth also functioned as a communication vehicle. In fact, many participants “have been empowered to advocate for community healing and have lobbied their local councils to support and encourage healing activities. We have indications that a number of clients have taken on a support role in going to different communities to speak on the issues of the effects of residential schools.” Respondents have noted that people are asking more questions and that there is an increase in the amount of referrals to Qul-Aun as well as in participation in other AHF-funded or other health-related programs.

5.4 Accountability to the Community

Qul-Aun has gathered much feedback from project participants, staff, and community referral workers. They have done this through client experience surveys after each session, follow-up client experience surveys three to six months after treatment, informal referral source questionnaires completed by phone, and informal program self-evaluations through group discussions using a SWOT analysis (i.e., looking at strengths, weaknesses, opportunities, and threats). These activities demonstrate commitment to program evolution and accountability. Figure 11 outlines respondents’ attitudes regarding Qul-Aun’s ability to be accountable.

**Figure 11) Accountability to the Community**

![Diagram showing accountability levels](image)

5.5 Addressing the Need

Respondents were asked specifically about Qul-Aun’s ability to address physical and sexual abuse and more generally about their ability to meet community needs. Almost all informants felt that Qul-Aun addressed issues of physical and sexual abuse reasonably or very well or felt that some improvement might be needed. Some comments made during the interview included sentiments that the program was very impressive, they offered a safe environment to talk about sexual abuse, there was a balance of male and female counsellors felt to be very important, and there was sharing of the history of the Legacy. However, there are still some clients slipping through the system who are not prepared to address their issues. Respondents believed that more information is required in the community on Qul-Aun’s entrance criteria. Figure 12 describes Qul-Aun’s ability to address the legacy of physical and sexual abuse.
Participants have reported that Qul-Aun’s setting or environment was comfortable and peaceful and that they felt safe while there. They expressed appreciation for a place that is somewhat isolated as it helps to set the mind, heart, and spirit into a frame for healing. When asked more generally about Qul-Aun’s ability to address needs, most respondents believed that the program did very well but needs minor improvements. Figure 13 describes Qul-Aun’s ability to address needs.

5.6 Partnerships and Sustainability

Qul-Aun has established credibility with Correctional Service of Canada in serving inmates ready for parole and is funded by per diem for each bed inmates occupy. However, this would not be substantial to run a full program. The centre is reviewing other methods of funding to ensure the continuation of meeting the needs of the community.

Qul-Aun is overseen by the substance abuse treatment program administration and is supported by in-kind contributions from Tsow-Tun Le Lum. Most staff and community referral workers are not familiar
with the financial structure of the organization and could not answer whether this program could run after AHF funding ceased. Most hoped it would continue while others indicated fear of it not continuing. The only volunteer element of Qul-Aun is its board of directors who give generously of their time and knowledge.

5.7  Best Practices

It is recognized that a substance-free lifestyle allows participants to stay focused and to complete their treatment sessions. Clients who have prior counselling and understand healing techniques achieve the most (based on referral workers’ statements) and often require minimal aftercare. The clients who come in with a minimal understanding of healing techniques often require longer aftercare/counselling and need a refresher course or second session most of the time. Therefore, it is safe to assume that the five-week session works best if participants have a solid commitment to heal as well as a support system.

Having the centre run as a substance abuse program played a huge role in the program being able to get off the ground quickly. Arriving with a commitment to heal, a healthy support system (counselling), and, sometimes, attendance in the substance abuse treatment program prior to Qul-Aun all contribute to success. Another area worth mentioning is the genogram done by each individual. This process allows them to walk through their own history whether they are Survivors or descendants to clarify what patterns they learned, why their parents acted or treated them in a certain way, why they do what they do today, and know they have a choice to not repeat this pattern.

Having other AHF-funded projects within the region is considered very beneficial because these programs provide support before and after the Qul-Aun Program. Since June 2000, Qul-Aun has shared its experiences during local networking meetings and has hosted the first meeting of AHF-funded projects on Vancouver Island. This activity continues and the projects rotate in hosting the quarterly meeting.

An opportunity arose for one counsellor (who is also a Survivor) to do internal work with an adult child who participated in the program. The referral worker’s feedback through clientele was that the experience was most inspirational and rewarding to see their leader as a participant as well as having the program teach and support the clients. One referral worker said, “Best program seen in twenty years, and staff role model spirituality for clients.”

Qul-Aun has been fortunate to have weekly clinical supervision from professional consultants, such as a psychologist, a medical doctor, a dietitian, a nurse, Alcoholics Anonymous sponsors, and a parole officer. Qul-Aun has also been able to second staff from other programs to fill vacancies in the short run. One referral worker noted that “[I am] now able to utilize what I learned from first-hand experience” and believes all referral workers should go through the Qul-Aun Program to have a more solid understanding of psychodrama. Qul-Aun has even been able to attract Elders for a special “Elders only” session. They return as support once they have worked through their own issues, and some become board members for the Tsow-Tun Le Lum Society.

Among Qul-Aun’s best practices include: engagement of Elders as cultural teachers and peer support counsellors; Qul-Aun team members who have attended residential school and can model healing; use of a blend of traditional approaches (Welcoming Home ceremony, sweats, spiritual pond) and Western
approaches (most particularly psychodrama); assurance that the Qul-Aun team is well trained, thoroughly healed, professional, compassionate, and able to create a safe environment; treatment of participants is equal and consistent; education about the history of residential schools and client rights; and assurance that participants are well screened and have adequate aftercare.

5.8 Challenges

Contrary to a couple of comments stating that Tsow-Tun Le Lum is located on reserve land (leased from Nanoose First Nation), there are some fears about the lease coming up for renewal in five years time.

Additional staff is required to support regular staff on sick days or unexpected leave as well as to increase the quality of service. Outreach also requires greater resources to appropriately train referral workers, provide more pre-/post-service to clientele, and keep the community informed. The majority of referral workers indicate that the region is too large for just two outreach workers whose work is considered valuable. Many communities remain uninformed as a result. Efforts to increase awareness are needed not only to cover a large region but also to help overcome denial. Staff turnover in outreach also played a role in hindering communication efforts.

The project experienced many delays when funding was in question and underwent two extensions before negotiating their final agreement. This caused uncertainty and stress on administration and staff who feared the loss of excellent team members. Extension and bridge funding did not alleviate staff uncertainty.

One challenge identified by a respondent was finding the balance among sexual abuse, residential school, and intergenerational impacts when clients have all issues to contend with in only five weeks, not to mention their substance abuse and foster care issues. Inappropriate referrals (e.g., still abusing substances) do slip through the intake process. It is also identified that more than one staff person is required for the night shift when many participants could be triggered, as most abuse in residential schools happened during the night when students were alone. At least one team member felt the need to include the psychodrama therapist in staff meetings to discuss what worked and did not work. Psychodrama is arguably the most preferred treatment method at Qul-Aun, as there is a great deal of comfort and support during this process.

5.9 Lessons Learned

Bunk beds and the use of flashlights on night patrol are clear triggers for some clients. One employee felt that these features of a residential in-patient facility can sometimes keep clients away. Other triggers of in-patient treatment are illustrated by the following excerpt of a story of one Elder's food experience:

She found little meat in her soup during her stay at the treatment centre and would not say anything about it. During the night she woke up hungry and realized since residential school, this was the first time she was hungry. She was able to talk about it the next day, but when asked why she did not say anything during her meal, she said one did not comment on anything in residential school for fear of being punished. The difference for her today is that she could eventually talk about it once she was able to name it, feel it, and know where it came from and that it is not the reality of today.

These types of stories validate the work being done in the Qul-Aun Program during treatment and how important it is to work through those triggers in order to heal and separate what is real. This story also
illustrates the degree of trauma residential schooling has had on Aboriginal people. Qul-Aun learned that family-of-origin discussions are essential to breaking through self-blame, participants require solid preparation for residential trauma treatment, referral workers require more information about Qul-Aun, and there is a clear need for behavioural boundaries in treatment.

6. Conclusion

It would be difficult to say that the program has developed lasting healing from the Legacy, as this cannot be measured for a few years. However, from the interview and program satisfaction survey, it would be safe to say that there is tremendous instant gratification still felt six months after completing the program. The Qul-Aun Program is only having an impact on a limited number of residential school Survivors and their descendants, as the program appears effective for about three-quarters of those who participate. However, all respondents interviewed noted it has quality and merit.

The Qul-Aun Program has a very strong cultural and traditional component; this is echoed by client responses and the value that it adds to their lives. For some, it is a re-introduction to their own traditional practices. The overall message from the community is that the program is very well respected and accepted for its admirable standard of service delivery and success rates. What is necessary from here is for the project to teach more people what and how they do the work.

7. Recommendations

Although part of the Qul-Aun public relations/communications plan, the creation of a video on trauma treatment has been delayed. The video would be a cost-effective way to reduce the outreach workload. It is recommended that the program be funded and supported to create this video to increase awareness.

It is premature to determine whether or not the changes noted by staff and referral workers will have long-term effects. Some referral workers believe that there is not enough time in five weeks to adequately address complex issues like sexual abuse. Not having client satisfaction questionnaires summarized for each session as well as the lack of group identifiers (e.g., age, sex, front-line workers) limited the ability to make note of trends for unique groups. In the pilot evaluation, it was recommended that the client satisfaction questionnaire be revised, but no changes were implemented. This caused difficulty for clients to record information accurately. The outreach worker’s second summary report had noted that the client satisfaction questionnaire needed revision. For example, participants should have been offered a “not applicable” response category for items that did not apply. Therefore, it is highly recommended that Qul-Aun revise and simplify the questionnaire so that the client can fill out the form on his/her own to avoid social desirability biases. Questions that are unclear need to be written in user-friendly language. It is strongly recommended that AHF consider supporting Tsow-Tun Le Lum in gathering information directly from individual participants, as it will be the most powerful evidence of Qul-Aun’s long-term success.

Program activities include program planning and development, training, and healing services; however, the focus of this evaluation effort was on the impact of healing services. Presumably, if program development and training were effective, then the ultimate results would be clear of the impact Qul-Aun had on their clients. Although social indicators were examined for the province of British Columbia, they were done
so only as supplementary information. It is clear that Qul-Aun cannot, on its own, significantly influence change in the entire province. To that end, it is clear that a 12- to 24-month follow-up of Qul-Aun participants should include some answers to the following questions adapted from the evaluation plan submitted with Qul-Aun’s funding proposal. The following list identifies key evaluation questions to be answered as well as the possible indicators that could be used to identify the long-term impact of Qul-Aun:

- **Do clients achieve an enduring sense of peace and resolution of specific traumas and issues?**
  - **Possible indicators:** client mental and physical health status.

- **Do clients acquire specific life skills, routines, and techniques to help them maintain harmony and stability in their daily lives (e.g., structure and rules, constructive management of family, work and leisure time, stress management)?**
  - **Possible indicators:** stability and place of client living situation (e.g., marital home, with friends, boarding, transient on the street); and use of routine in day-to-day life (e.g., gets up in the morning at regular time, has meals at regular time, goes to work at certain time).

- **Are community aftercare support systems developed to help maintain client abstinence from alcohol/drugs for an extended period (e.g., one year)?**

- **Do clients develop and implement life plan goals and objectives (e.g., get a job, continue school, improve family relations, develop and use other methods in dealing with people and their environment that reflect quality existence rather than immediate gratification)?**
  - **Possible indicators:** client employment or attendance at school; degree of client commitment and achievement of life plan and goals; and degree to which client copes with stressful situations without utilizing alcohol/drugs.

- **Do clients develop a social and therapeutic network of friends and counselling support such that they are not alone and can get help when needed?**
  - **Possible indicators:** existence of family/social support network; involvement in other counselling; and attendance at Narcotics Anonymous or other self-help groups.

- **Do clients develop an improved sense of self-worth and a more realistic perception of who they are and what they can contribute to their community?**
  - **Possible indicators:** degree to which client is able to see self clearly and realistically; degree to which client wants higher quality of life; and extent to which client participates in community.

- **What other benefits do clients achieve in terms of improved functioning in areas of work, family life, educational upgrading, and health?**

At the time of data collection, this information was not available for graduates of the Qul-Aun Program, but this would be the most valuable information to secure to determine the long-term impacts of Qul-Aun.

**Notes**

1. Information from the Qul-Aun Program funding proposal (1999) submitted to AHF.
6 McCreary Centre Society (2000).
9 McCreary Centre Society (2000).
10 The Capital/Victoria region had insufficient data to make an estimate.
11 Information from quarterly reports submitted by the Qul’Aun Program to the AHF.
Appendix 1) Staff, Referral, and Administration Interview Questions

HC-36-BC Tsow-Tun Le Lum Society
“Residential School & Intergenerational Effects Healing Initiative”
Staff interview questions

Before we begin I would like to ensure you:

- that there are no right or wrong answers, only answers that are true from your perspective
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc and not on past/present performance, this is a case study, not an evaluation)
- we are only trying to learn from your experience so that we can help others get what they want from their AHF projects
- the report will not be able to identify who said what, so please feel free to say things that may or may not cause controversy
- and, for the most part, it is important to focus comments on individual participants.

To start, I would like you to now think about the people involved in this project (please concentrate on those who have completed the program).

1. Have you noted changes in the development of healthy coping patterns?  Yes  No

   What have you noted that makes you feel this way:

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<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
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<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
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<td>almost all</td>
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   What do you feel is the magnitude of this change? Circle one.

   Why do you think this has happened?

2. Have you noted changes in understanding the impact of the Residential School Legacy?  Yes  No

   What have you noted that makes you feel this way:

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<th>Participation</th>
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<th>Individual behaviours</th>
<th>Community conditions</th>
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<td>almost all</td>
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   What do you feel is the magnitude of change?

   Why do you think this has happened?

3. Have you noted changes in sense of self-worth?  Yes  No
What have you noted that makes you feel this way:

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<th>Participation</th>
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<th>Individual behaviours</th>
<th>Community conditions</th>
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What do you feel is the magnitude of this change? Circle one.

| <10% | <20% | about 50% | more than 75% | almost all |

Why do you think this has happened?

4. Have you noted changes in life skills? (e.g. managing families, work, leisure, stress)

   Yes  No

What have you noted that makes you feel this way:

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<th>Individual behaviours</th>
<th>Community conditions</th>
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What do you feel is the magnitude of this change? Circle one.

| <10% | <20% | about 50% | more than 75% | almost all |

Why do you think this has happened?

5. Have you noted changes in cultural pride?

   Yes  No

What have you noted that makes you feel this way:

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<th>Individual behaviours</th>
<th>Community conditions</th>
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What do you feel is the magnitude of this change? Circle one.

| <10% | <20% | about 50% | more than 75% | almost all |

Why do you think this has happened?

6. Have you noted changes in the client having new plans, goals and objectives?

   Yes  No

What have you noted that makes you feel this way:

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<th>Individual behaviours</th>
<th>Community conditions</th>
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What do you feel is the magnitude of this change? Circle one.

| <10% | <20% | about 50% | more than 75% | almost all |

Why do you think this has happened?
7. To what extent do clients maintain aftercare? (eg: social/therapeutic network to maintain coping skills for a year) How do you know?

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<th>Participation</th>
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<th>Individual behaviours</th>
<th>Community conditions</th>
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<th>about 50%</th>
<th>more than 75%</th>
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Why do you think this has happened?

I would like you to now think about the community involved in this project.

8. Have you noted changes in your community’s understanding of the Legacy? Yes No

What have you noted that makes you feel this way:

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<th>about 50%</th>
<th>more than 75%</th>
<th>almost all</th>
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9. Have you noted that resource people have become more knowledgeable of Trauma Treatment? Yes No

What have you noted that makes you feel this way:

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MANDATORY QUESTIONS:

We know that you have already supplied information to the Aboriginal Healing Foundation through your quarterly reports, but we would like to offer you another opportunity to provide further insight in the following areas:

10. How well do you believe Qul-Aun Program has addressed the Legacy of sexual and physical abuse in residential schools including inter-generational impacts? please circle only one response.

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Please offer an explanation for why you feel this way:

11. How would you rate the projects ability to address or meet those needs?

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Please offer an explanation for why you feel this way:

12. How well has Qul-Aun Program been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

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Please offer an explanation and some examples of the projects accountability to the community.

13. Do you see Qul-Aun Program being able to operate when funding from the Foundation ends? Please specify.

14. How well is the project able to monitor and evaluate its activity? Please circle only one response

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Please offer an explanation or examples on how you have seen this take place.
Case Study Report: Qul-Aun Program

HC-36-BC Tsow-Tun Le Lum Society
“Residential School & Inter-generational Effects Healing Initiative”
Referral Interview Questions

Before we begin I would like to ensure you:

- that there are no right or wrong answers, only answers that are true from your perspective
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc and not on past/present performance, this is a case study, not an evaluation)
- we are only trying to learn from your experience so that we can help others get what they want from their AHF projects
- the report will not be able to identify who said what, so please feel free to say things that may or may not cause controversy
- and, for the most part, it is important to focus comments on individual participants.

To start, I would like you to now think about the people involved in this project (please concentrate on those who have completed the program).

1. Have you noted changes in the development of healthy coping patterns?  Yes No
What have you noted that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
</table>

What do you feel is the magnitude of this change? Circle one.

| <10%          | <20%          | about 50%        | more than 75%         | almost all |

Why do you think this has happened?

2. Have you noted changes in understanding the impact of the Residential School Legacy?
Yes No
What have you noted that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
<th>Individual behaviours</th>
<th>Community conditions</th>
</tr>
</thead>
</table>

What do you feel is the magnitude of change?

| <10%          | <20%          | about 50%        | more than 75%         | almost all |

Why do you think this has happened?

3. Have you noted changes in sense of self-worth?  Yes No
What have you noted that makes you feel this way:

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
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<th>Community conditions</th>
</tr>
</thead>
</table>

What do you feel is the magnitude of change?

| <10%          | <20%          | about 50%        | more than 75%         | almost all |
**Participation** | **Individual ideas** | **Individual behaviours** | **Community conditions**
---|---|---|---
magnitude of this change |
<10% | <20% | about 50% | more than 75% | almost all

Why do you think this has happened?

---

4. Have you noted changes in life skills? (e.g. managing families, work, leisure, stress)  
   Yes  No
   What have you noted that makes you feel this way:

```markdown
<table>
<thead>
<tr>
<th>Participation</th>
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<th>Community conditions</th>
</tr>
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<td>&lt;20%</td>
<td>about 50%</td>
</tr>
</tbody>
</table>
```

Why do you think this has happened?

---

5. Have you noted changes in Cultural pride?  
   Yes  No
   What have you noted that makes you feel this way:

```markdown
<table>
<thead>
<tr>
<th>Participation</th>
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<td>&lt;20%</td>
<td>about 50%</td>
</tr>
</tbody>
</table>
```

Why do you think this has happened?

---

6. Have you noted changes in the client having new plans, goals and objectives?  
   Yes  No
   What have you noted that makes you feel this way:

```markdown
<table>
<thead>
<tr>
<th>Participation</th>
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<td>about 50%</td>
</tr>
</tbody>
</table>
```

Why do you think this has happened?
7. To what extent do clients maintain aftercare? (e.g. social/therapeutic network to maintain coping skills for a year)
How do you know?

<table>
<thead>
<tr>
<th>Participation</th>
<th>Individual ideas</th>
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<tr>
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</tbody>
</table>

Why do you think this has happened?

I would like you to now think about the community involved in this project.

8. Have you noted changes in your community's understanding of the Residential School Legacy?
Yes  No

What have you noted that makes you feel this way:

<table>
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Why do you think this has happened?

9. Have you noted that resource people have become more knowledgeable of Trauma Treatment?
Yes  No

What have you noted that makes you feel this way:

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Why do you think this has happened?

10. Have you noticed if more individuals are indicating a need or willingness to seek trauma treatment for residential school issues?
Increased  Decreased  The same  Haven't noticed
What have you noted that makes you feel this way:

<table>
<thead>
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<td>magnitude of this change?</td>
<td>&lt;10%</td>
<td>&lt;20%</td>
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</table>

Why do you think this happened?

11. In the last 12 months, please state whether you feel community involvement has:

<table>
<thead>
<tr>
<th>increased</th>
<th>stayed the same</th>
<th>decreased</th>
<th>unsure</th>
</tr>
</thead>
</table>

How do you know this?

<table>
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Why do you think this has happened?

MANDATORY QUESTIONS:

12. How well do you believe “Qul-Aun Program” has addressed the Legacy of Sexual and physical Abuse in Residential schools including inter-generational impacts? Please circle only one response.

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Please offer an explanation for why you feel this way:

13. How would you rate the projects ability to address or meet those needs?

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Please offer an explanation and some examples of the projects accountability to the community.

15. Do you see “Qul-Aun Program” being able to operate when funding from the Foundation ends? Please specify.

16. How well is the project able to monitor and evaluate its activity? Please circle only one response

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Please offer an explanation or examples on how you have seen this take place.
HC-36-BC Tsow-Tun Le Lum Society
“Residential School & Intergenerational Effects Healing Initiative”
Administration interview questions

Before we begin I would like to ensure you:

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I would like you to now think about the community involved in this project.

1. Have you noted changes in your community’s understanding of the Legacy? Yes No
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MANDATORY QUESTIONS:

We know that you have already supplied information to the Aboriginal Healing Foundation through your quarterly reports, but we would like to offer you another opportunity to provide further insight in the following areas:

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Please offer an explanation for why you feel this way:

5. How well has “Qul-Aun Program” been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

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Please offer an explanation and some examples of the projects accountability to the community.

6. Do you see "Qul-Aun Program" being able to operate when funding from the Foundation ends? Please specify.

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Please offer an explanation or examples on how you have seen this take place

8. Can you please identify the Strengths, Weaknesses, Opportunities, Threats of your program. (SWOT)
Appendix 2) Tsow-Tun Le Lum Pilot Trauma Treatment Project Summary

Medical Services Branch funded a two-year Trauma Treatment pilot project for Tsow-tun-le-lum Society. In consultation with both MSB and the executive director this evaluation process was designed to be constructive in nature and participatory from a hermeneutic perspective. As such, the findings have been reviewed by stakeholder program personnel to ensure the findings are value based and reflective of the unique underpinning of the project. The outcome and recommendations were based on a complete review of the program process, delivery, structure, intake/assessment process, file reviews, evaluations, referral resources and interviews with program staff.

Over the life of the project, the project team became increasingly conceptually aware of the immensity of the task undertaken. Overall, the treatment practices were sound, safe and sensitive to addressing what it was competent to address without overextending its capabilities.

Several findings:

- Psychodrama is an excellent treatment modality to release First Nation’s peoples from the chains of past Trauma as reported by client evaluations.
- One dilemma is that the training requirements to deliver this form of treatment are extensive, requiring as many as six years to become capable of delivering the competency level required. This would be an inhibiting factor given the virtue of having Aboriginal people delivering the service.
- It appears that six months sobriety is a meaningful period of time for a client to be ready for Trauma Treatment.

Recommendation hi-lights:

- Clients be informed in advance what psychodrama is, how it works in treatment, what benefit they will receive and how their participation is required.
- It is strongly recommended that adding outreach service to any further delivery of Trauma Treatment.
- Admission protocols be further clarified.
- The program should include an “arms length” evaluation plan that allows for follow-up review 4-12 and 24 months post trauma treatment. It is recommended that the current “Client Satisfaction Questionnaire” be revised.
- Clinical file management is in need of re-working.
- Explore ways to encourage more male interest in the program.
- It is suggested that an independent party administer a confidential questionnaire, as opposed to being done in a group setting.
Appendix 3) Training Outline

HC-36-BC
Tsow-Tun Le Lum Society—Residential School & Intergenerational Effects Healing Initiative

<table>
<thead>
<tr>
<th>Type of training</th>
<th>Number of trainees</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 day Core training</td>
<td>all staff</td>
</tr>
<tr>
<td>5 day leadership training/seminar</td>
<td>1 employee</td>
</tr>
<tr>
<td>3 day food and nutrition seminar</td>
<td>1 employee</td>
</tr>
<tr>
<td>Occupational first aid</td>
<td>&quot;all staff requiring&quot;</td>
</tr>
<tr>
<td>4 day team-building workshop</td>
<td>all staff</td>
</tr>
<tr>
<td>JI-Trauma Counseling Certificate program</td>
<td>1 TTLL employee</td>
</tr>
<tr>
<td>Restoring Justice for Women &amp; Youth (several)</td>
<td>1 employee</td>
</tr>
<tr>
<td>4 days “Pursuit of Excellence” program</td>
<td>9 employees</td>
</tr>
<tr>
<td>Earthquake Preparedness workshop</td>
<td>6 employees</td>
</tr>
<tr>
<td>Re-enactment Therapy</td>
<td>2 employees</td>
</tr>
<tr>
<td>Residential School Conference - Edmonton</td>
<td>6 employees</td>
</tr>
<tr>
<td>Traditional teachings workshop</td>
<td>entire staff</td>
</tr>
<tr>
<td>Accreditation coordinator forum</td>
<td>1 employee</td>
</tr>
<tr>
<td>Special front-line workers retreat/training</td>
<td>10 community workers</td>
</tr>
<tr>
<td>Kakaws Trauma training</td>
<td>1 outreach worker</td>
</tr>
<tr>
<td>Racism workshop</td>
<td>entire staff</td>
</tr>
</tbody>
</table>
Appendix 4) Referral Package

QUL-AUN PROGRAM

"Moving Beyond the Traumas of Our Past"

Referral Package

Effective January 2000
TSOW-TUN LE LUM SOCIETY
Vancouver Island Residential
Aboriginal Programs

QUIL-AUN PROGRAM
TS LH UWQ NAMUT

"Moving Beyond the Traumas of Our Past"

Please Note: Six months clean and Sober is essential before applying for this program.

Referral Package

INTRODUCTION

Tsow-Tun Le Lum means Helping House. The Tsow-Tun Le Lum mission is to strengthen the ability of Native peoples to live healthy, happy lives and have pride in their native identity. For Native people, we "help" through providing co-educational residential treatment programs for substance abuse, survivors of trauma (sexual abuse, unresolved grief), and survivors of residential school.

The Vancouver Island Native residential centre participates in the healing cycle through providing balanced, state-of-the-art therapy programs that acknowledge and support physical, emotional, mental and spiritual health.

For information about specific healing programs, please refer to our program folder.

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</table>
REFERRAL PROCESS

To the referral person – Thank you for your referral.

We appreciate your cooperation in completing the referral and admissions process. If we can be of assistance, please call us at Tsow-Tun Le Lum Admissions at (250) 390-3123.

As the referral person, you are requested to follow these procedures when sending clients to our program. Please check ☑ when complete.

☐ Read the sections called Admission Criteria and Paying for Treatment to determine eligibility of the prospective client (pages 4 and 6).

☐ Fill out and return the forms in this package to Tsow-Tun Le Lum, PO Box 370, 699 Capilano Road, Lantzville, BC V0R 2H0. The application for admission is to be completed in the presence of the prospective client.

☐ Ensure that the following Admission forms are submitted as part of the application. Use this list as a checklist –

☐ Residential Treatment Evaluation ☐ Contact Assessment
☐ House Guidelines Agreement ☐ Consent for Treatment
☐ Personal Information ☐ Pre-admission Medical Evaluation
☐ Client History

☐ Upon receipt of all the forms, the referring person and/or client will be notified of an admission date. No admission date will be considered until the WHOLE admission form has been completed.

☐ If your client is on probation, it is imperative that the probation information be included in the appropriate spaces in the assessment package. Your client must also submit a copy of the parole, probation or temporary absence order. Our admission policy allows for one probation client per intake. Should this information be omitted from the referral package, it could result in your client being discharged from treatment.

☐ Confirm the payment of fees, comfort monies and travel arrangements (including return fare).

☐ Discuss the Admission Criteria and House Guidelines for Residents with your client.
Discuss follow-up and after-care plans with your clients. During the latter part of the program, the client prepares a personal recovery plan and the counsellor writes a Completion Summary. The community After Care and Completion Summary are available with a signed release (see page 29 of this package).

Ensure your client has a valid medical care card and that coverage is adequate.

Ensure your client is aware of clothing and personal needs including items on the list below –
- white soled/non-marking soled runners,
- slippers,
- men – large towel, sweat shorts and T-shirt,
- women – large towel, long flannelette/cotton gown (covering to the neck, ankles and wrists),
- swimsuit,
- towels (we do not supply),
- toiletries (shampoo, toothpaste, razors, feminine needs, etc.),
- writing paper, envelopes, stamps,
- $10 to $15 for book and material purchases; comfort/spending money for 35 days,
- arts and crafts projects, if on hand, and
- musical instruments are allowed.

At least ten days prior to admission, confirm that all the forms are completed and mailed and that all financial arrangements are complete. This includes arrangements for all travel, comfort money, and any additional expenses.

Note that intake arrival time is **between 1:00 PM and 4:00 PM** and that residents are responsible for their transportation to and from the Centre during the program.

In our work at Tsow-Tun Le Lum we feel it is extremely important to welcome program participants upon arrival. In our opening circle participants are able to introduce themselves and connect with group members. This helps them to start working openly and honestly.

During the welcoming, we take participants on a tour of the building, explain the program and outline what to expect. We then follow with a video. By bedtime, participants are somewhat settled in.

**This referral package is effective from January, 2000. Please photocopy these materials as necessary. You are kindly requested to complete all the sections attached before forwarding for admission review.**
ADMISSION REQUIREMENTS

Applicants for the QUAL-AUN Program, “Moving Beyond the Traumas of Our Past” are to be –

☐ over 19 years of age;
☐ mentally stable and physically able to participate in intense individual and group counselling situations;
☐ clean and sober for a period of six months prior to application;
☐ free of any psycho active/mood altering drugs, painkillers, sleeping pills, or tranquilizers that are being used additively for a period of three months prior to admission unless approved by our consulting physician;
☐ free of any appointments or court dates to attend that would occur during the program such as doctor, physiotherapist, dentist, chiropractor, childcare, and court appearances;
☐ prepared to address past traumas in both group and individual experiences;
☐ committed to review his or her present life-style, behaviours and feelings;
☐ free of any acute care hospital requirements;
☐ in control of all disease and free from any communicable disease; and
☐ medically covered with a valid health care card.
# PRELIMINARY RESIDENTIAL TREATMENT EVALUATION

(For Referring Persons)

If the client answers "No" to any of the questions – 1 through 5, he/she is not yet ready for intense treatment and the following recommendations should be taken into consideration –

- May need to be referred to our outreach team for assistance or to another treatment program more suitable to his/her needs.
- Refer client to a community based therapist for residential treatment readiness preparation.
- Conduct a re-assessment of client’s readiness for treatment again in three to six months.

1. Client expresses a need to change his life situation, become clear from past traumatic life experiences?  
   - Yes  
   - No

2. Client shows willingness to participate in –
   - Pre-treatment evaluation?  
     - Yes  
     - No
   - Residential treatment?  
     - Yes  
     - No
   - After-care?  
     - Yes  
     - No
   - Follow-up?  
     - Yes  
     - No

3. Is client routinely able to physically and mentally do daily living chores, treatment and recreation activities?  
   - Yes  
   - No

4. Is client able and willing to be involved in intensive group and individual counselling activities?  
   - Yes  
   - No

5. Does client have post-treatment plans –  
   - For basic needs? (e.g. housing, finance, etc.)  
     - Yes  
     - No
   - For outpatient/self-help?  
     - Yes  
     - No
   - To continue cultural/spiritual activities?  
     - Yes  
     - No
   - Other (specify)  
   - Yes  
   - No

6. Client has family/friends to support him/her being in treatment?  
   - Yes  
   - No

7. Is client’s expression of anger, harmful to self, others or property?  
   - Yes  
   - No

8. Is the client aware that Tsow-Tun Le Lum is not willing to accommodate any personal obligations or appointments during the treatment cycle?  
   - Yes  
   - No

---

Tsow-Tun Le Lum Society  
Referral – 5 – 01/2000

---
1. All Status and non-status Indians are eligible for subsidized treatment.

2. Prospective non-native clients referred by Alcohol and Drug Program Counsellors, may apply and be eligible for a user-fee subsidy.

3. Prospective clients who are unable to obtain funding support are required to arrange for per diem payment prior to admission.
HOUSE GUIDELINES FOR RESIDENTS

To all participants –

The following guidelines will assist you in contributing to a healthy and positive environment for your program and healing. Please read the guidelines carefully.

ALCOHOL AND DRUGS

a. There will be no alcohol or other drugs not authorized by the DIRECTOR within the bounds of TSOW-TUN LE LUM. Residents are not to consume alcoholic beverages or any unauthorized drug while attending the TSOW-TUN LE LUM Program either inside or outside of the residence (non-compliance with this guideline will result in discharge from your program).

b. All medications are to be turned in to our staff upon entry.

c. It is expected that you will refrain from frequenting places that promote the use of drinking, drugs, or gambling.

d. If it is believed to be necessary, your luggage or rooms may be checked by staff.

e. If you arrive with prescriptions not noted on your Intake Paperwork, you will need to meet with our consulting physician.

PASSES, VISITORS, AND TELEPHONE CALLS

a. Passes are a PRIVILEGE and they are issued as they fit with your treatment plans.

b. All residents are to remain on the grounds unless on pass or on an negotiated walk.

c. Passes are reviewed by your Program Counsellor. Requests for passes should be made by 12 noon on Thursdays.

d. It is understood that you will refrain from frequenting places that promote the use of drinking, drugs, or gambling.

e. For the first week visiting hours will be from 1:00 PM to 5:00 PM on Sundays. On the second and subsequent weekends visiting is from 1:00 PM to 5:00 PM on Saturdays and Sundays.
f. Visitors are prohibited from entering the sleeping quarter area.
g. Visitors are allowed only in the designated visiting area.
h. Visitors under the influence of alcohol or drugs are prohibited.
i. Sexual relations between residents and visitors are prohibited.
j. You are responsible for your visitors and letting your visitors know of the Guidelines for the House.
k. A pay telephone is available for residents to make personal calls.
l. Collect calls will not be accepted.
m. You will not be called out of session to answer the telephone. Staff will take messages and distribute them after program each day.
n. Cellular phones and pagers are not to be used by clients while they are residents at Tsow-Tun Le Lum Society. Cellular phones and pagers are to be turned in at the front desk on Intake Day. Phones and pagers may be checked out for the day or weekend passes.

REGULATIONS REGARDING PASSES, VISITING HOURS, AND TELEPHONE PRIVILEGES

<table>
<thead>
<tr>
<th>DAY PASSES</th>
<th>VISITING HOURS</th>
<th>TELEPHONE PRIVILEGES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Friday</strong>: None</td>
<td><strong>Saturday</strong>: 1:00 PM – 5:00 PM</td>
<td><strong>Friday</strong>: after program</td>
</tr>
<tr>
<td><strong>Saturday</strong>: 9:30 AM – 10:30 PM</td>
<td><strong>Sunday</strong>: 1:00 PM – 5:00 PM</td>
<td><strong>Saturday</strong>: after all house chores are completed</td>
</tr>
<tr>
<td><strong>Sunday</strong>: 10:30 AM – 6:00 PM</td>
<td><strong>Sunday</strong>: 1:00 PM – 5:00 PM</td>
<td><strong>Sunday</strong>: after all house chores are completed</td>
</tr>
</tbody>
</table>

WEEKEND PASSES

From after program (usually 4:00 PM) Friday, until return to Centre at 6:00 PM Sunday.

a. All residents are reminded that weekend staff have the authority to take away privileges if residents do not comply with house guidelines.
b. Please be advised that you are responsible for your own transportation to and from the Centre. Tsow-Tun Le Lum Society will NOT cover transportation costs. Staff will not be available to answer phone calls in the evening and on weekends. Our answering service picks up all our phone calls from Friday 4:00 PM to Monday 9:00 AM.
c. You are welcome to return to the Centre at anytime during a weekend pass.
d. Special requirements need to be addressed by your counsellor and your group.

HEALTH AND SAFETY

a. Smoking is not permitted in the building. Smoking is allowed outside the building. Ashtrays are supplied, please use them. Smokers are responsible to keep ashtrays clean.
b. All medication will be turned over to the administration office upon entrance. TSOW-TUN LE LUM's staff will monitor the taking of the medication.
c. You are expected to keep yourself clean. Regular bathing is required and laundry facilities are available for washing clothes.
d. Use only the bed you are assigned. You are responsible for making your bed and cleaning your sleeping area and bathroom each morning.
e. You are assigned regular daily chores.
f. Horseplay, running, or swearing in the building is not accepted.
g. Money and valuables can be safeguarded by handing them in to the administration office.

SCHEDULE

a. You are to be up in the morning by 6:45 AM during the week and by 8:30 AM on the weekends.
b. From Sundays to Thursdays, you are requested to be inside the building by 9:00 PM and lights out by 10:30 PM. The TV will be turned off by 10:00 PM.
c. On Fridays and Saturdays, unless you are on a pass, you are to be inside the building by 9:00 PM. TV should be off by 1:00 AM and lights out by 1:30 AM.
d. You are accountable and responsible for attending all program sessions.
e. Residents out on a pass are to return by 6:00 PM Sunday evening, in time to take part in the scheduled program.
f. Radios, TV, ghetto blasters, walkmans, CD players, etc. are not to be turned on until after 6:00 PM, or until all chores are completed.
g. You will be required to attend closing ceremonies and assist in hosting visitors.
GENERAL HOUSE GUIDELINES

a. Residents fighting or destroying property will be discharged from the program.

b. Sexual relations between residents and staff will not be tolerated. Sexual relations between residents are prohibited.

c. Walks must be either solitary (one person) or in a group of no less than five (5) residents unless approved by staff. Residents must inform staff when they are leaving or returning to the building. Residents are also required to sign in/out in the log book for fire/emergency purposes. Please make yourself aware of designated walking areas.

d. You are to remain within the boundaries of Tsow-Tun Le Lum at all times, except when accompanied by staff or on pass.

e. There will be absolutely no visiting in anyone else’s bedroom.

f. The group room on the men’s side of the building is to be used by men only during leisure time. The group room on the ladies’ side of the building is for ladies only during leisure time.

g. The exercise room and craft area downstairs is also out of bounds for co-ed activity during leisure hours. A schedule for men only, women only hours is posted and must be adhered to.

h. Rooms behind the green doors in the basement are by schedule use only, and therefore out of bounds unless being cleaned or you are with staff.

i. All valuables and monies in excess of $20.00 should be turned in to the administration for safekeeping. They will be returned to you upon request. Tsow-Tun Le Lum “bank” is open at 12:45 PM, Monday through Friday.

j. Do not hang or stick anything on the walls. Bulletin boards are provided for this purpose.

k. You are responsible for all your personal belongings and effects. Any items left behind when you leave will be disposed of (normally after 30 days). Tsow-Tun Le Lum accepts no liability or responsibility for the personal belongings and effects of residents or visitors.

l. Gambling is not allowed.

m. You may bring musical instruments with you. We encourage their use.

n. Running or soft-soled shoes are to be worn in the gymnasium and the kitchen.
o. Appropriate clothing is mandatory and reflects respect – no halter tops, bare midriffs, muscle shirts, short shorts, see through or ripped clothing, logos promoting alcohol or drugs, etc. Spandex shorts or pants must be worn with a long shirt.

p. Residents are responsible for their own transportation to and from the Centre.

q. Absolutely **NO** videos are to be brought in from the outside.

---

**House Guidelines for Residents Agreement**

I understand the House Guidelines and agree to follow them.

Resident’s Name *(please print)*

Signature

Date
**LOCATION**

The Tsow-Tun Le Lum Centre is located on Capilano Road on the NanOOSE Band Reserve Land. Travelling north on the Island Highway from Nanaimo, take the first left after the Superior Road traffic lights. Capilano Road is just before the pedestrian overpass.

![Map of Tsow-Tun Le Lum Centre](image)

**TRANSPORTATION**

Tsow-Tun Le Lum is located approximately 10 kilometres north of Nanaimo. A taxi is recommended and costs are approximately –

- from Nanaimo airport to Tsow-Tun Le Lum: $50.00
- from Nanaimo bus depot to Tsow-Tun Le Lum: $30.00
- AC Taxi: Telephone: (250) 753-1231
- Swiftsure: Telephone: (250) 753-8911 or (250) 758-8911

The above taxi companies will accept taxi vouchers.

Please be advised that you are responsible for your own transportation to and from Tsow-Tun Le Lum. We will not cover transportation costs.

Clients are advised that if they choose not to complete our program, or are discharged by staff of Tsow-Tun Le Lum, that Medical Services will not cover any return travel costs (including to the Yukon).
TSOW-TUN LE LUM SOCIETY
Vancouver Island Residential
Aboriginal Programs

PO Box 370, Lantzville, BC, Canada V0R 2H0
Telephone: (250) 390-3123  Fax: (250) 390-3119

QUL-AUN PROGRAM
TS LH UWQ NAMUT

“Moving Beyond the Traumas of Our Past”

Assessment Package

NAME OF CLIENT

Assessment/Referral Agency

Address

Telephone

Fax

Referral Worker

Date of Referral  Received

Tsaytun Le Lum Society  13 – 01/2000
ASSESSMENT OVERVIEW

CONTENTS

I. **Personal Information** – basic client information for intake at *Tsow-Tun Le Lum*.

II. **Client History** – an overview of the client’s past and present situation.

III. **Contact Assessment** – an assessment of the client’s presenting problem(s).

IV. **Consent for Treatment** – client consent to be treated.

V. **Consent for Release of Information** – client consent to allow the package of information to be sent to *Tsow-Tun Le Lum*.

VI. **Pre-Admission Medical Evaluation** – an evaluation of the client’s health. The first page is to be filled out by the client and worker; subsequent pages are filled out by the client’s doctor.

GLOSSARY OF TERMS IN THE SALISH LANGUAGE

<table>
<thead>
<tr>
<th>Qu̱-Aun</th>
<th>Something bad in the past</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ts̓ Lh Uwq Namut</td>
<td>Gone through the bad time to the good</td>
</tr>
<tr>
<td>Tsow-Tun Le Lum</td>
<td>Helping House</td>
</tr>
</tbody>
</table>
# I. PERSONAL INFORMATION

<table>
<thead>
<tr>
<th>Surname (legal name)</th>
<th>Given Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Insurance Number</td>
<td>Birth Date (Day/Month/Year)</td>
</tr>
<tr>
<td>Sex</td>
<td>Male</td>
</tr>
<tr>
<td>Status Indian</td>
<td>Yes</td>
</tr>
<tr>
<td>Street (Permanent Address)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street (Residential Address)</td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>Province</th>
<th>Postal Code</th>
</tr>
</thead>
</table>

| Known As (most often called) | Telephone | Social Insurance Number |

<table>
<thead>
<tr>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Divorced</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Status (present employment situation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Employed</td>
</tr>
<tr>
<td>Permanent</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Income Source (present source)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Job</td>
</tr>
<tr>
<td>Family</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Band Name</th>
<th>Full Status Number</th>
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</thead>
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<table>
<thead>
<tr>
<th>Family Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Alone</td>
</tr>
<tr>
<td>Living with Parents</td>
</tr>
<tr>
<td>Living with Friends</td>
</tr>
<tr>
<td>with Extended Family</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Next of Kin</th>
<th>Relationship</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Telephone</th>
</tr>
</thead>
</table>

Tsow-Tan Le Lum Society  
Assessment - 15 - 01/2000
Highest level of Education
- No Education
- Primary School
- Junior High
- Secondary
- Some Primary
- Some Secondary
- Trade School
- University
- Adult Education
- Community College

Location of Education
- Boarding School
- Public Off Reserve
- Public On Reserve
- Residential

Legal Status (present involvement)
- Not Applicable
- PArole
- PRobation
- Temporary Absence
- OTher

Usual Occupation
Language

Were you ever in a treatment centre?
Year_________Number of Times_________Location_________Yes_________No
Year_________Number of Times_________Location_________
Year_________Number of Times_________Location_________
Year_________Number of Times_________Location_________
Year_________Number of Times_________Location_________
Year_________Number of Times_________Location_________

Substances Abused
Primary Drug of Choice
- Alcohol
- Hallucinogens
- Narcotics
- Prescription Drugs
- Solvents/Inhalants
- Other
Recent Ingestion (Day/Month/Year)
Secondary Drugs of Choice

Referral Source (please check)
- NNADAP Projects Outpatient Clinic
- Correctional Service of Canada
- Residential Treatment Centre
- Halfway House
- Hospital
- G Detox Unit
- K Employer
- B Other Outpatient Clinic
- F CHR/NNADAP Worker
- I Band Social Worker
- H Native Court Worker
- N Family

Will client continue working with referral source after treatment? Yes No
If not, to whom is the client being referred? 
Address
Telephone

Assessment – 16 – 01/2000
Tsaw-Tun Le Lum Society
II. CLIENT HISTORY

A. Nutritional Needs

1. Are you comfortable with your weight?
2. Have you ever taken drugs to control your weight?
3. Do you have a history of anorexia or bulimia?
4. List significant nutritional issues (i.e. obesity, diabetes).
5. Do you have specific goals?
6. Is a special diet required? If yes, give details.

B. Background Medical/Psychological Factors/Mental Health Issues

1. Significant past and present medical issues (i.e. cancer, diabetes, impairment – hearing loss, loss of limb).
2. Significant past and present psychological issues (Have you ever thought of suicide? Do you have a history of depression?).
3. Do you have a problem sleeping? If yes, do you take any medications for this problem?
4. Details of client’s history of involvement with the following –

<table>
<thead>
<tr>
<th>Service</th>
<th>When?</th>
<th>How long?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic Anonymous</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Narcotics Anonymous</td>
<td></td>
<td></td>
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<tr>
<td>Psychologist</td>
<td></td>
<td></td>
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<tr>
<td>Psychiatrist</td>
<td></td>
<td></td>
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<tr>
<td>Counsellor/Friendship Centre</td>
<td></td>
<td></td>
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<tr>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment Centre</td>
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<tr>
<td>Social Services</td>
<td></td>
<td></td>
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<tr>
<td>Detox</td>
<td></td>
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<tr>
<td>NNADAP</td>
<td></td>
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<tr>
<td>ADP Centres</td>
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<td></td>
</tr>
<tr>
<td>Other Support Groups</td>
<td></td>
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</tbody>
</table>

Please give details of the outcome of the above involvement.

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Assessment – 18 – 01/2000
Tsow-Tun Le Lum Society
## SOCIAL BACKGROUND

### Personal/Family of Origin

1. Was client raised by natural parents? __Yes ___No  
   If no, by whom was the client raised? ____________________________________________

2. Was there alcohol or drug problems in the family of origin while client was growing up (i.e. parent, guardian, sibling)? If yes, give details. ____________________________________________

3. How did the client's family alcohol and drug use affect the client? Give details. ____________________________________________

4. Has there been a death in the family due to substance abuse? __Yes ___No

5. Have there been any suicides in the family? __Yes ___No

6. Did the client's parents attend residential school? __Yes ___No

7. Did any other family members attend residential school? __Yes ___No

### Marital/Common-law

1. How long has client been involved in present marital/common-law situation? ____________

2. How many previous marital/common-law relationships has the client been involved in the past? ____________

3. How many different sexual partners has the client had in the past year? ____________

---

*Tsow-Tun Le Lam Society*  
*Assessment – 19 – 01/2000*
4. How many mothers and fathers did the client have in his/her life?

5. Does the client have any children?  Yes  No
   If yes, how many?  Status (indicate whether they are)
   ___ at Home  ___ in Care  ___ Apprehended

6. Have the client's children ever been in foster care or apprehended?  Yes  No

7. Has there ever been violence in any of the client's relationships?  Yes  No
   If yes, give details.

8. What is working well in the client's relationships?

9. What could make it better?

10. Was the use of alcohol or drugs affecting the marital/common-law situation?
Social/Support

1. Indicate client’s potential support network, i.e. family, friends, religious organizations, healers, cultural organizations, self-help groups.

2. Where does the client actually go for support?

3. Is that working well?

Legal

1. Does client have any prison convictions or a criminal record? If yes, indicate reasons and outcomes.

2. Are there any
   ___ Outstanding warrants? ___ Charges? ___ Court cases?

3. Is client presently on
   ___ Parole? ___ Probation? ___ Incarcerated?

4. Name and phone number of Probation Officer.

5. Are there any outstanding custody issues?

6. Was any of the client’s legal history related to sexual offending? If yes, give details.
Employment

1. Describe client’s past and present employment situation(s). Note number of previous jobs and reasons for leaving.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

2. Has addiction affected your past and/or present employment situation? If yes, give details.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Spiritual/Cultural

1. Ancestry Nation

2. Is client involved with spiritual practices, cultural events, native healers, self-healing practices. Give details.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

3. Past and present spiritual/philosophical values.

____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
III. CONTACT ASSESSMENT

PRESENTING PROBLEM

1. What event(s) took place that caused the client to seek help at this time? Include details surrounding the event(s).

2. Was client coerced (includes attendance required by law) into coming or did he/she come voluntarily? Give details.

CLIENT’S PERSPECTIVE/PERCEPTION OF PROBLEM

1. Does client feel he/she has Post Traumatic Stress Disorder?

2. What past traumas are of primary concern to the client?
   _ Residential School
   _ Sexual Abuse
   _ Physical Abuse
   _ War
   _ Emotional Abuse
   _ Spousal Abuse
   _ Abandonment
   _ Effects of Alcohol/Drug Abuse
   _ Cultural Oppression
   _ Health/Suicide of Family Member
   _ Foster Home/Adoption
   _ Orphanage

3. Client’s concerns about the most important past trauma(s).

4. Does client express a need to change his/her life situation?  _ Yes  _ No

5. Are native culture and values significant for client’s change?  _ Yes  _ No
REFERRAL WORKER’S PERSPECTIVE

1. Client’s emotional/mental health state (include any diagnosed disorder).

2. Client’s insight into presenting problem.


SPECIAL NEEDS AND ISSUES

1. Disabilities, illiteracy, etc.

2. Has the client disclosed sexually abusive behaviour? ___ Yes ___ No

3. Has the client been sexually abused? ___ Yes ___ No

4. Is the client receiving Workers Compensation Benefit? ___ Yes ___ No

5. Is the client receiving Criminal Injuries Benefits? ___ Yes ___ No

REFERRAL

1. Is client in an on-going relationship with the referral person? ___ Yes ___ No

2. If yes, how much contact in the last six months?

3. Will relationship continue after referral? ___ Yes ___ No

4. Will referral person be doing follow-up after program completion? ___ Yes ___ No

Assessment – 24 – 01/2000

Tsow-Tun Le Lum Society
CLIENT RELEASE

I, ____________________________, hereby request and permit Tsow-Tun Le Lum Society to forward my treatment completion summary to ____________________________.

Client’s Signature ____________________________ Date ____________________________
IV. CONSENT FOR TREATMENT

I, ____________________ (name of client), understand that my participation in the Qul-Aun Program at Tsow-Tun Le Lum Society requires that I am –

☐ aware that Tsow-Tun Le Lum Qul-Aun Program is a continuous five (5) week program which begins upon my arrival and ends following the completion ceremony,

☐ aware that there is a schedule of events and activities which will require my full participation, and

☐ aware that if I am UNWILLING to participate fully, I may be asked to leave.

I understand for the client and staff to work effectively, the treatment program will include –

☐ Counselling assessments and treatment plans,

☐ Arts and crafts, recreational activities, and ceremonies,

☐ Group therapy sessions/lifeskills training/sessions with Elder/assignments,

☐ Alcoholic Anonymous/Narcotics Anonymous meetings,

☐ Contact with my referral sources, and

☐ Maintenance of confidential client records as stated in the Privacy Act.

I understand that there are on-going programs at Tsow-Tun Le Lum, where applicants have been referred from NNADAP, Friendship Centres, Social Workers, Doctors, Detox, Employers, Alcohol and Drug Counsellors, and Parole.

I understand that treatment is a continuum. Therefore, I agree to be involved with after-care.

I am aware that according to the Family and Child Services Act, staff at Tsow-Tun Le Lum are required to report to the appropriate authorities any information received regarding the abuse or risk of abuse of any individual presently under the age of nineteen (19).

I understand the explanation of the above points and the above-named agency’s program and guidelines and I, therefore, consent to undergo treatment at Tsow-Tun Le Lum.

I am aware that whenever people gather, such as at home communities, social and spiritual functions, family and treatment programs, etc., there may be identified and unidentified sex offenders present. This is also true of Tsow-Tun Le Lum Society.

I also understand that I can withdraw or amend my consent to the release/request of information at any time.

Client’s Signature __________________________ Date __________________________

Referral Worker’s Signature __________________________
V. CONSENT FOR RELEASE OF INFORMATION

This section is to be filled out if referral is made and client information is required.

Client Name

Date of Birth

I, ______________________ (client's name), hereby give my permission for Tsow-Tun Le Lum Society Substance Abuse Treatment Centre, PO Box 370, 699 Capilano Road, Lantzville, BC V0R 2H0
to contact (name and address of agency providing information)

for information to be released, limited to (describe type[s] of information to be released)

I understand that no other information will be released to any other persons without my written consent unless these persons have a court order or are concerned with my medical treatment in an emergency situation. I also understand that I can withdraw or amend my consent to the release/request of information at any time.

ALL INFORMATION IS CONFIDENTIAL in accordance with relevant statues.

State date of consent

End date of consent

In order for this release to be valid, it must be completed in its entirety.

Client’s Signature

Witness
(may be referring person or assessor)

Date

Tsow-Tun Le Lum Society Assessment - 27 - 01/2000
VI. PRE-ADMISSION MEDICAL EVALUATION

Client’s Name ____________________________ Medical Number ____________________________
Date ____________________________
Referral Agency ____________________________
Address ____________________________

CLIENT RELEASE

I., hereby request and permit my physician to release medical facts and assessments about me to __________ and Tsow-Tun Le Lum Society. The photocopy of my signature on this form is as valid as the original.

Client’s Signature ____________________________

TO THE PHYSICIAN

The above named client is to be medically assessed as a potential participant in our five week Qul-Aun program. Our program is designed to address the special needs of people who have suffered, or who are experiencing trauma in their lives, including emotional, mental, physical and spiritual health issues that stem from the effects of the residential school experience, substance abuse, violence – domestic or physical, unresolved grief, and issues that are often passed from generation to generation unless the cycle is broken. Tsow-Tun Le Lum requires a client to have had a complete physical examination prior to admission. In order for a client to be successful in our program, the client has to be free of any psycho active/mood altering drugs, painkillers, sleeping pills, or tranquilizers that are being used addictively.

MEDICAL EXAMINATION

Name ____________________________

1. Date of last alcohol/drug use ____________________________
2. Date of last psycho active drug use ____________________________
3. Current Diagnosis ____________________________

4. Medical problems to be followed while in treatment (MD is available for follow-up)

Assessment – 28-01-2000

Tsow-Tun Le Lum Society
5. Any allergies? _______________ If so, what? ____________________________

6. Is patient pregnant? ____________________________________________

7. Date of latest chest x-ray, if known, and result. (Please note, if last chest x-ray more than one year ago, it is mandatory for client to have had a chest x-ray before coming to treatment.)

8. Functional inquiry – is there any disorder of the following?
   Hair, skin, nails (especially current or recent infestations or infections)     Yes    No
   Ear, nose, throat                                                               Yes    No
   Musculo-skeletal system                                                         Yes    No
   Blood, lymphatic system                                                         Yes    No
   Cardio-vascular system                                                         Yes    No
   Respiratory system                                                             Yes    No
   GI system                                                                      Yes    No
   GU system                                                                      Yes    No
   CNS – especially hx of seizures                                                Yes    No
   Past history of TB                                                             Yes    No

9. Family History
   Alcohol/drug problem                                                           Yes    No
   Psychiatric history                                                            Yes    No
   Adopted                                                                        Yes    No

10. Physical Examination
    Height ___________________ Weight ___________________ BP/PR __________________

<table>
<thead>
<tr>
<th>Appearance</th>
<th>Normal</th>
<th>Abnormal</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hair, skin, nails</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reticuloendothelial system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculo-skeletal system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardio-vascular system</td>
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<tr>
<td>Respiratory system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central nervous system</td>
<td></td>
<td></td>
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<tr>
<td>Evidence of sexually transmitted disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Tsaw-Tun Le Lum Society

Assessment – 29 – 01/2000
11. Please comment on any abnormalities noted above.

12. **Present Medications**

13. Have you any comments, suggestions or insights that might be helpful in terms of client’s being physically and mentally able to participate in group, one-to-one counselling and living in residence for five and a half weeks?

Client attending treatment should be as free as possible from all drug abuse and should not be on any sedative-hypnotics. The client is not in need of acute hospital care; diseases are to be under control as much as possible – ESPECIALLY contagious diseases.

I have examined this client and find him/her to be fit to attend treatment.

Physician Signature

Date

Address

Telephone

*Assessment – 30 – 01/2000*  
Tsow-Tun Le Lum Society
STATEMENT OF DECLARATION
for
QUIL-AUN PROGRAM
"Moving Beyond the Traumas of Our Past"

1. I understand that my participation in the QUIL-AUN Program, “Moving Beyond the Traumas of Our Past” at Tsow-Tun Le Lum requires that I am:

   a) aware that TTLL Society is not a crisis intervention centre.
   b) clean and sober for six months, or longer.
   c) free of any mood altering substances (including Tylenol #3, benzodiazepine and sleeping pills) for a period of six months, or longer. I understand that it is imperative for my safety in the trauma program to be substance free. **Disregard of this requirement will result in discharge.** Client may reapply when free of all substances.

   Applicants are allowed prescriptions authorized by our consulting physician.

   d) seeing my Counsellor/Therapist on a **regular** basis and they assess me as being a suitable candidate for intense trauma **group work**. I have signed a Consent for Release of Information with my Counsellor/Therapist and Tsow-Tun Le Lum.

   Aware that as part of my recovery care plan, I am committed to follow-up with my Counsellor/Therapist in my community upon completion of Tsow-Tun Le Lum programs.

   My Counsellor/Therapist may be reached at:

   Name: __________________________ Phone: ( ) ____________
   Address: __________________________ Fax: ( ) ____________

2. I understand that there are on-going addictions programs at Tsow-Tun Le Lum, where applicants have been referred from NNADAP, Friendship Centres, Social Workers, Doctors, Employers, Alcohol and Drug Counsellors, and Parole.

   Please note, whenever people gather, such as at home communities, social and spiritual functions, family and treatment programs, etc. there may be identified and unidentified sex offenders present. This is also true of Tsow-Tun Le Lum.

   Signed by, __________________________ Date: __________________________

   The Client __________________________ Referral Worker/Counsellor/Therapist

---

Tsow-Tun Le Lum Society

Assessment – 31 – 01/2000
SOW'S EAR MEDICAL CLINIC
7186 Lantzville Road, PO Box 190
Lantzville, BC V0R 2H0
Phone: (250) 390-4542 Fax: (250) 390-4561

Chart No. ________________

PATIENT INFORMATION

Name ____________________________________________

Address ____________________________________________

Telephone (home) __________________________ (work) ____________________________

Birth Date (Day/Month/Year) ____________________________

Personal Health Number ____________________________

Social Insurance Number ____________________________

Previous Surname or Maiden Name ____________________________

Next of Kin and Relationship ____________________________

Employer ____________________________

Drug Allergies ____________________________

FOR DR. STRONGE'S USE ONLY

<table>
<thead>
<tr>
<th>Current Problems</th>
<th>Previous History</th>
<th>Medications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family History

32 – 01/2000

Tsow-Tan Le Lum Society
Appendix 5) Client Experience Survey

TSOW-TUN LE LUM
QUL-AUN Program

CLIENT EXPERIENCE SURVEY

Today's Date ____________________________  Age _______  Male □  Female □
Name _________________________________  Male □  Female □

Note: Ratings in the box below are as follows –
1 – not at all  2 – minimally  3 – somewhat  4 – Good
5 – very good  6 – extremely well  7 – completely

RATING 1 2 3 4 5 6 7

1. Did the program assist you uncover your strengths?

COMMENTS
__________________________
__________________________

RATING 1 2 3 4 5 6 7

2. Did the program assist you act upon your strengths in ways that produced results for you?

COMMENTS
__________________________
__________________________

RATING 1 2 3 4 5 6 7

3. Did the program assist you address or resolve issues of shame?

COMMENTS
__________________________
__________________________
4. Did the program assist you address or resolve any issues of abandonment?

COMMENTS

5. Did the program assist you address or resolve any issues of guilt?

COMMENTS

6. To what degree was the program able to respect and value your thoughts and feelings?

COMMENTS

7. To what degree did the program contribute to your cultural identity?

COMMENTS
8. Did the program assist you with issues that generated anger and show you effective ways to use anger in a good way?

COMMENTS

9. To what degree did you feel safe in the experience of the program?

COMMENTS

10. Has the group experience made a different in your life?

COMMENTS

11. How effective was psychodrama in addressing your goals for future well being?

COMMENTS
12. To what extent were you able to get beyond surviving the trauma of your past?

COMMENTS

13. To what degree did the program assist you resolve possible past experiences of humiliation?

COMMENTS

14. Did the program provide you with practical experience that enhanced your sense of self worth?

COMMENTS

15. To what extent did the program prepare you for handling future trauma?

COMMENTS
16. To what degree are you now able to assist others your experience in Trauma within your community?

COMMENTS

17. To what degree did the program assist you with your Healing Journey following the Trauma Treatment experience?

COMMENTS

18. How valuable would attending a refresher week of treatment in the near future be for you?

COMMENTS

19. To what extent do you feel the program met your individual needs and expectations?

COMMENTS
20. Have you handled any Trauma since your treatment, and if so, did your treatment experience make a difference for you?

COMMENTS

21. What would you benefit from next?

COMMENTS
Appendix 6) Program Completion Client Experience Evaluation

TSOW-TUN LE LUM  
QUL-AUN Program

PROGRAM COMPLETION CLIENT EXPERIENCE EVALUATION

Assurance of Confidentiality: The information on this form is being requested on a voluntary basis. The information you provide will assist us continue to improve the services we offer to you and others. If you choose not to provide some of the information, it will not effect the services we provide to you. All information will be kept in strict confidence.

Today’s Date ____________________________

Name ___________________________________ Age _______ Male ☐ Female ☐

Your Intake Date _________________________ Program Finishing Date _________________________

Program completed Yes ☐ No ☐

If program was not completed, what were the reasons?

____________________________________________________________________________________

____________________________________________________________________________________

A. GOALS

1. Briefly outline the goals or expectations you had prior to admission.

   Goal #1 ______________________________________________

   Goal #2 ______________________________________________

   Goal #3 ______________________________________________

   Goal #4 ______________________________________________

2. Did these goals or expectations change during treatment? Yes ☐ No ☐

   If yes, please feel free to comment.

   COMMENTS

   ______________________________________________

   ______________________________________________

   ______________________________________________

   ______________________________________________
B. ADMISSION EXPERIENCE

1. Was the written information on the program provided to you upon admission?

2. Did the program assist you feel welcomed and supported during the first few days of attending the program?

3. Were you advised of the program guidelines in a clear way?

4. Were you engaged in a way that was respectful of your beliefs, values, language and culture?
C. TREATMENT EXPERIENCE – GROUP

1. Which of the following issues did you work on and if so, to what degree did you experience satisfaction?

- Drug addictions
- Spousal abuse
- Self abuse
- Relationship conflicts
- Conflicts with the law
- Cultural oppression
- Abandonment as a child
- Impact of past trauma
- Guilt
- Shame
- Anger and violence problems
- Depression
- Child of alcoholic parents
- Sexual abuse
- Foster placement experience
- Residential school concerns
- Sexual offending
- Identifying triggers
- Grief work
2. Group Treatment

Were you prepared well enough to make use of psychodrama?

Was psychodrama impactful for you in a good way?

Was the group psychodrama experience educational?

Were the group experiences practical?

Did you discover ways to get support from others?

Did the group experience make an overall difference in your resolving major issues in your life?

Was the group work supportive?

Did you feel safe in expressing yourself with the group?

Overall, to what extent was the group work beneficial?

Were your rights protected and promoted in all group treatment experiences?
D. INDIVIDUAL TREATMENT EXPERIENCE

1. Did you request individual treatment with a psychologist? Yes □ No □

2. Approximately how many one-to-one sessions did you receive with your program counsellor? _______

3. Approximately how many sessions did you have with a psychologist? __________________________

4. Which of the following issues did you work on in the individual sessions, and if so, to what extent did you experience satisfaction?

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Please check box below if applies</th>
<th>Addressed by Psychologist</th>
<th>Addressed by Program Counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Drug addictions</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Spousal abuse</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Self abuse</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Relationship conflicts</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Conflicts with the law</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Cultural oppression</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Abandonment as a child</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Impact of past trauma</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Guilt</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Grief work</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Shame</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Identifying triggers</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Anger and violence</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Child of alcoholic parents</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Sexual abuse</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

Did your counsellor assist you discover your strengths?

Did the psychologist assist you discover your strengths?

Did your counsellor assist you in engaging your strengths?

Did the psychologist assist you in engaging your strengths?

Did your counsellor assist you towards moving beyond the trauma of your past?

Did the psychologist assist you towards moving beyond the trauma of your past?

Was the program counsellor available when you needed it? Was a psychologist available when you needed it?

Did your experience with the psychologist promote your sense of self worth?

Were you able to develop a trusting relationship and receive meaningful support from your program counsellor?

If you received services from a psychologist, were you able to develop a trusting relationship and receive meaningful support?
6. What aspects of the treatment with the psychologist did you like the most?

7. Would you go see a psychologist in the future if you felt the need for treatment? Yes □ No □

E. HEALTH EXPERIENCE

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>1. To what extent did your physical health change?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>2. Were your medical concerns addressed?</td>
</tr>
</tbody>
</table>

F. SPIRITUAL EXPERIENCE

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>1. Did the program respect your spiritual beliefs and values?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>2. Were the spiritual experiences sufficient?</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>3. Did the spiritual experiences make a difference for you?</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>4. Were the spiritual experiences available at your own choice?</td>
</tr>
<tr>
<td>1 2 3 4 5 6 7</td>
<td>5. Were the native cultural approaches used effectively and did they fit with the other treatment approaches?</td>
</tr>
</tbody>
</table>
G. AFTERCARE SERVICE

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>1 2 3 4 5 6 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you experience a summary review of the results of your treatment?</td>
<td></td>
</tr>
<tr>
<td>2. Were you engaged in developing a plan for continuing healing beyond the program experience?</td>
<td></td>
</tr>
<tr>
<td>3. To what extent did the program prepare you for handling future trauma?</td>
<td></td>
</tr>
<tr>
<td>4. Were you sufficiently supported in connecting to other organizations as needed?</td>
<td></td>
</tr>
</tbody>
</table>

H. OTHER PROGRAM COMPONENTS

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>1 2 3 4 5 6 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How meaningful were the recreational activities?</td>
<td></td>
</tr>
<tr>
<td>2. How meaningful were the social activities?</td>
<td></td>
</tr>
</tbody>
</table>
Case Study Report: Qul-Aun Program

Evaluation

1. How meaningful were the information sessions?
2. How valuable was developing a self care plan?
3. How workable were the routines of meals and activities?
4. How meaningful was inner child work?
5. How meaningful were the role playing experiences?
6. To what extent did you experience the staff work together as a team?

COMMENTS

I. SUMMARY COMMENTS

1. What would you benefit from next?

2. What recommendations would you like to make to improve the program?

3. What new skills did you develop or enhance during the treatment program?
4. What goals do you want to accomplish or change when you return home?

5. How valuable would attending a refresher week of treatment in the near future be, if available?

6. To what extent did the program as a whole meet your individual needs and expectations?

7. Was the program too long ☐ too short ☐ just right ☐?
Appendix 7) Staff Training Interview Questions

I would like you to now think about the training involved in this project and respond to the following questions. Thank you for your support during this interview.

CIRCLE YOUR ANSWER

1. How would you rate the quality of training that you received?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excellent</strong></td>
<td><strong>Good</strong></td>
<td><strong>Fair</strong></td>
<td><strong>Poor</strong></td>
</tr>
</tbody>
</table>

2. Did you believe that you are getting the kind of training that you need?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excellent</strong></td>
<td><strong>Good</strong></td>
<td><strong>Fair</strong></td>
<td><strong>Poor</strong></td>
</tr>
</tbody>
</table>

3. To what extent has the training met your needs?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Almost all of my needs have been met</strong></td>
<td><strong>Most of my needs have been met</strong></td>
<td><strong>Only a few of my needs have been met</strong></td>
<td><strong>None of my needs have been met</strong></td>
</tr>
</tbody>
</table>

4. How satisfied are you with the amount of training that you have received?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quite dissatisfied</strong></td>
<td><strong>Indifferent or mildly dissatisfied</strong></td>
<td><strong>Mostly satisfied</strong></td>
<td><strong>Very satisfied</strong></td>
</tr>
</tbody>
</table>

5. Has the training provided by the project helped you deal more effectively with your clients?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes, they helped a great deal</strong></td>
<td><strong>Yes, the helped somewhat</strong></td>
<td><strong>No, they really didn't help</strong></td>
<td><strong>No, they seemed to make things worse</strong></td>
</tr>
</tbody>
</table>

6. In an overall, general sense, how satisfied are you with the training that you received?

<table>
<thead>
<tr>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very satisfied</strong></td>
<td><strong>Mostly satisfied</strong></td>
<td><strong>Indifferent or mildly dissatisfied</strong></td>
<td><strong>Quite dissatisfied</strong></td>
</tr>
</tbody>
</table>

7. Which method of training was most helpful to you?

8. Have you noted changes from the core team training? Yes No

What have you noted that makes you feel this way?

<table>
<thead>
<tr>
<th>Degree of this change? Circle one.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;10%</td>
</tr>
<tr>
<td>&lt;20%</td>
</tr>
<tr>
<td>about 50%</td>
</tr>
<tr>
<td>more than 75%</td>
</tr>
<tr>
<td>almost all</td>
</tr>
</tbody>
</table>

9. Other comments
Shining Mountains Living Community Services

Project Number: 1397-AB

Case Study Report

Tawow Healing Home

Prepared by:
Flora Kallies
Dolores Gadbois

Under the direction of:
Kim Scott, Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2002
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1. Introduction

The following report is one of 13 case studies being conducted for the impact evaluation of the Aboriginal Healing Foundation (AHF). The case studies were selected to include representation from a variety of project types and targets (see Appendix 1 for selection criteria). This case study covers the following project types and targets: all Aboriginal groups; youth (children/adolescents), men, and women; urban; camp/retreat (away from the community in a rural setting); traditional activities; and parenting skills.

The project addressed here is the Tawow Healing Home delivered by the Shining Mountains Living Community Services of Red Deer, Alberta (AHF-funded project # 1397-AB). The primary purpose of the project is to “provide a culturally based therapeutic home environment for Aboriginal children/adolescents and their families – at risk for involvement with protective services.” The report describes Red Deer, Alberta, the Aboriginal community within, service delivery, team characteristics, and what the project hopes to achieve in the short and long term. The report will also focus on changes in individual participants, most prominent changes in the community, and how those changes were measured. These changes include AHF board-requested indicators of change (physical abuse, sexual abuse, incarceration rates, suicide, and children in care) as well as others based on the recognized needs of the Aboriginal community of Red Deer.

2. Methods

This case study evaluates changes in the individual participant and in the community by gathering and analyzing qualitative information on areas of desired change selected cooperatively with the project. Through the use of program logic, the report also examines whether change can be attributed to the efforts of Shining Mountains Living Community Services or to other contributing environmental factors. In addition, information was collected on other social indicators; namely, family violence, housing, employment, and homelessness to provide contextual information and for use in any other longer term evaluative efforts to determine if the Tawow approach leads to its ultimate goal.

Project files (funding proposal, contribution agreement, quarterly reports to date, and a community needs assessment), the project’s response to the AHF Supplementary Survey of July 2001, Internet, library, and key informant interviews with the project team and selected community service providers were the primary data sources. Although a six-month self-evaluation was planned, insufficient funding prohibited its completion, which is particularly unfortunate because intake forms and case management plans could have provided very useful information for this case study.

During the first week of October 2001, one-on-one interviews were conducted with 14 individuals associated with the project or with local community services. The people interviewed included three Shining Mountain team members, three board members, two Elders, and those from community service agencies (Royal Canadian Mounted Police (RCMP), legal counselling (2), child welfare, social services, and community programming). Statistics were collected from Red Deer RCMP detachment, Red Deer Native Friendship Society, Office of the Chief Medical Examiner (Calgary), Red Deer Housing Committee, Internet sites for Statistics Canada and Indian and Northern Affairs Canada (INAC), project statistics, and client satisfaction forms that three of nine participants completed.
Observation of behavioural change is a common measurement strategy in parenting and family programs, and although Tawow had the tools to complete a comprehensive assessment using reasonably well-developed intake forms, qualified personnel to record ongoing observations and to complete an outcome assessment was lacking. Still, key informants based their opinions on observed participant competencies.

The development of interview questions (Appendix 2) was based on the project’s desired short- and long-term goals (see performance map) and AHF board-mandated questions. The logic model and performance map were sent to the project prior to the development of questions in order to confirm any change to project goals from the proposal stage to implementation. The questions attempted to determine if any desired change in participants and community were achieved. Pilot testing was not done in this case and the majority of questions were based on the assumption that respondents would have some knowledge of the participants. Some questions were found to be redundant and not clearly understood.

The project team was asked to secure other contacts from a list of agencies, and interviews were set up with informants that the project felt could offer pertinent information. Actual interviews were conducted by two AHF employees, one being a community support coordinator. Interviews in the community had to be rescheduled to accommodate agency workload, board members’ availability, and length of interviews (half were three to four hours or longer). In the end, all interviews with the exception of one did take place, albeit some could not offer their opinion on many issues.

Allowing the project to control what agency was to be interviewed may have given the impression that responses would be favourable towards the project. In this case, it is not true, although the majority of responses were favourable. Every agency in Red Deer that involved Aboriginal people, with the exception of Métis Links (Aboriginal newspaper), was interviewed or contacted. This allowed a general view of the project and the community in a relatively non-biased light.

3. Project Description

In November 1999 a community needs assessment was conducted in the city of Red Deer to determine gaps in service to Aboriginal children and families. It showed that available services were not culturally sensitive and thus developed a lack of trust, understanding, and willingness to access such services. It was recommended that services should be culturally sensitive and that more programs should be delivered by Aboriginal service providers. As a result, a proposal was sent to and approved by the AHF to create a program that offered a non-mandated (not required or regulated by government) alternative family care service to meet the needs of the healing Aboriginal family that is adaptable and culturally appropriate. The project commencement date was 1 March 2001 and was funded as a one-year project with a contribution in the amount of $150,000.

The main focus of this project is to provide Red Deer and the surrounding communities of Hobbema and Rocky Mountain House with a non-mandated culturally based, therapeutic home environment for Aboriginal children/adolescents and their families at risk of involvement with protective services. Key components of the project are to ensure:

- service delivery by Aboriginal providers;
- independence in parenting through modelling, positive encouragement, and partnership between the parent(s) and healing helper(s) (co-parenting);
Case Study Report: Tawow Healing Home

- the use of traditional teaching, recreation, values, and parenting methods in the healing of families;
- a comprehensive, cooperative approach for families to access community resources based on the principles of healing and family empowerment to promote the growth of the family;
- a healing environment service specific to the unique needs and beliefs of the Aboriginal person;
- aftercare, i.e., open house at Tawow, invite participant families to continue with community involvement and healing, and participant families pairing with other graduate families in accessing community resources if needed; and
- safety and security of the family.

Three major health/social issues affecting the Aboriginal community that relate to physical and sexual abuse as a result of residential schools were identified as substance abuse/addictions, suicide and depression, and family and community violence. Evolving from these issues, the project’s main goals are:

- to build independence in parenting and self-sufficiency based on significance, power, competence and virtue (the four bases of self-esteem and traditional educational practices); prior to invasive involvement of government systems in the family (child welfare, justice);
- to provide a healing environment which is specific to the unique needs and beliefs of the Aboriginal person by ensuring that direct services are delivered by Aboriginal service providers who assist in rebuilding Aboriginal values, principles and beliefs; and
- to provide a non-threatening, voluntary process for family healing and empowerment which promotes the growth of the family as a unit (residential schools destroyed Aboriginal families and thereby communities, we seek to rebuild family and thus community).

A small group of Aboriginal community leaders formed the Tawow Development Group to develop the model for this program. One project team member and two board members were the key people involved in writing the proposal. Input from Elders and residential school Survivors were also important to its development.

Co-funding for this project was provided by Métis Local #84 and Shining Mountains, and through private donation. One of two partnerships listed in the application, Double Diamond Recreations, had not yet been utilized. It was felt by the project that participants were not ready for a major outing at the time. But there are plans for a recreational trip that, at the time of writing, had not been implemented. The program makes use of services available from other agencies, such as the Family Life Improvement Program (FLIP) newly offered by the Native Counselling Services of Alberta. The FLIP program is delivered by an Elder and encourages participation in traditional activities that other Aboriginal agencies coordinate.

The house where the Tawow Healing Home is situated is located 20 minutes north from downtown Red Deer and has an ideal country-home setting that gives a feeling of comfort and warmth. It is an isolated five-bedroom house with a large lot for play. The house mother lives in the home to provide full-time care. The home can provide care to approximately three to four families at one time, depending on the family size.

3.1 Participant Characteristics

The Tawow Healing Home focuses on providing services to children/adolescents and their families at risk for involvement of protective services. The parents of the families who have completed or are participating in the program are 22 to 40 years old, with the majority being in the children/adolescent category (25
years of age and under). The children range from infant to teen with the majority being under the age of 10 (Figures 1 and 2). The majority of participant families are single-parent families led by women under the age of 25. The Aboriginal identity of participants are mostly status First Nations, with some who are either non-status or Métis. Almost all the family participants have been referred by the Kasohkowew Child Wellness Society located on Samson First Nation in Hobbema.

**Figure 1) Participants by Age and Gender**

![Bar chart showing participants by age and gender](image1)

**Figure 2) Participants by Aboriginal Identity**

![Bar chart showing participants by Aboriginal identity](image2)

The participants are first assessed to determine the extent and willingness to improve their family life situation and to keep the family whole. Intake evaluation forms for both children/adolescents and parents (Appendix 2) were developed by the program coordinator. Information from the intake form for parents provides an in-depth understanding of personal, educational, vocational, criminal, and treatment history and how he/she functions as a romantic partner, homemaker, and employee with his/her own children, friends, and parents. Information from the intake form for children/adolescents provides personal information on education, legal, medical, or other concerns and short- and long-term goals. It is unclear
as to the exact criteria or extent of the problems for accepting families as participants other than children at risk of protective services and the parents’ willingness to improve their family life.

Once participants have been accepted into the program, a healing plan is developed for both parents and children (Appendix 3). Six of eight (75%) participant parents have been through substance abuse treatment or had accessed Alcoholics Anonymous or National Native Alcohol and Drug Abuse Program (NNADAP) prior to or after entering the program, and all had their children removed from the home at one time or another. By accessing these services, the participants showed a clear desire to make change in their lives. Five of eight (62.5%) participant parents were referred by Kasohkowew Child Wellness Society. They were given the option to either participate in the Tawow Healing Home program or have their children put in foster care.

There are no programs in the area where parents can stay together with their children when they are unable to be self-sufficient or care for either themselves or their children. The remaining participants (37.5%) were self-referred or were urged to participate by their families. Their length of stay in the program is dependent on whether they feel they are ready to leave. All Aboriginal groups are eligible to participate, although the executive director stated that “the project will not discriminate against any who are not of Aboriginal descent.”

Since the majority of participants are referred by the child welfare agency located on Samson First Nation in Hobbema and by the city of Red Deer, we will focus only on their population statistics to determine the total target group for this project. As of September 2001 the total registered population for Samson First Nation in Hobbema is 5,815. Using the 1996 Census data there were 2,075 (3.5%) Aboriginal people out of a total of 58,980 people in Red Deer. The executive director stated that the Elders of the community believe there are approximately 10,000 Aboriginal people living in Red Deer, including the homeless. To date, it is determined that a total of 2,403 are now living in Red Deer. Therefore, the total population for the project’s target group is estimated to be 8,218.

There has been no contact with Rocky Mountain House, although it was listed as one of the target communities. The major reason is due to the high need of Samson First Nation to access this program. Except for one advertisement in the Aboriginal newsletter (Métis Links) in Red Deer, there has been no other push to advertise for the program. Occupancy for the Tawow Healing Home has been full since it opened its doors. There is a sadness amongst the project deliverers that they have had to turn away a large number of possible participants to the program.

Seven of the eight participating families are headed by lone parents, and lack of parenting skills and alcohol abuse are their most extreme challenges (see Table 1).
Table 1) Participants Dealing With Issues by Age*

<table>
<thead>
<tr>
<th>Issues*</th>
<th>Age 0–9</th>
<th>Age 10–17</th>
<th>Age 18–37</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical abuse**</td>
<td>–</td>
<td>–</td>
<td>3</td>
</tr>
<tr>
<td>Verbal abuse**</td>
<td>–</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Emotional abuse**</td>
<td>–</td>
<td>–</td>
<td>5</td>
</tr>
<tr>
<td>Boundary issues***</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>–</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>–</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Gambling addiction</td>
<td>–</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Lack of parenting skills</td>
<td>–</td>
<td>–</td>
<td>8</td>
</tr>
<tr>
<td>Fetal alcohol effects (FAE)</td>
<td>2</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Lack of self-esteem</td>
<td>1</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Lack of cultural knowledge</td>
<td>3</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

* Numbers for physical, verbal, and emotional abuses are for both victims, who are adults or children, and adult perpetrators.
** Confirmed by the social service agency with the project that two of the participants disclosed of being victims of sexual abuse.
*** Means "being able to say no and meaning it," as defined by the executive director.

3.2 The Project Team—Personnel, Training, and Volunteers

Shining Mountains Living Community Services is an agency that has been in existence since 1995 but started servicing only Aboriginal people as of 1997. Based on information from the funding application, the following is a list of services the agency has provided in the past:

- PEY WAPUN—an Aboriginal conflict resolution program designed by Aboriginal people;
- Cross Cultural Awareness Training—a three-day workshop for non-Aboriginal service providers/agencies (this program is still being provided);
- Family Violence Prevention—a 20-week program that addresses the issues of violence in a cultural context; and
- Women's Anger Management—a program originally designed for women's groups but has been modified for delivery to federally incarcerated women.

The other programs the agency will provide services to were still under development. One includes the Recovery Home, which is a post-alcohol and drug treatment safe haven for individuals who are at risk of homelessness that will also teach positive life skills in a holistic manner. Another is the Mobile Outreach Unit, which provides heating supplies, coffee, bannock, soup, dry footwear, and headgear for homeless individuals.

Shining Mountains is now housed with four other Aboriginal agencies: Alberta Native Counselling Services, Aboriginal Community Council, Métis Local #84, and Métis Links. Other Aboriginal agencies are located within several blocks, which allows close contact with key Aboriginal service providers as well as increased knowledge of issues and opportunities.
Currently, three project team members handle the day-to-day activities. A large portion of program responsibilities are being shared by the executive director and the bookkeeper: the executive director oversees all details of program delivery and shares the duties of the community liaison worker with the bookkeeper. The executive director has extensive experience in addiction, rehabilitation, crisis, family, and life counselling. Her calm, endearing qualities and fierceness to improve the quality of living for Aboriginal people in her community has been the guiding force behind the project. The bookkeeper handles cash flow, food and household supplies, and transportation. There was a project coordinator with a background in social work and experience in program development and research who was also one of the key people in the development of the model for the program and the application for funding, but she was forced to find other employment due to insufficiency in the amount of funding received. She did voluntarily participate as a board member but no longer does at the time of writing this report.

The third team member, a live-in house mother, has the most contact with participants. She provides motherly care in a holistic, traditional Cree way. Through role modelling and discussions, she offers the participants different options in dealing with family situations. She is considered among some as an Elder due to her wisdom and knowledge of Cree culture and language and her expertise on parenting and life. The house mother rules the roost in that she monitors all tasks and chores within the household, keeping a safe, clean, comfortable dwelling for all the participants.

The four Elders who visit the project provide consultation and traditional wisdom for an honorarium. Other volunteers include: three Survivors who give support and circle guidance to the project team members and participants; two older children who provide support to the younger ones in recreational pursuits and yard care; and one parent/grandparent who offers transportation, social interaction, and yard care.

The number of board members seem to fluctuate from four to six and includes both Aboriginal and non-Aboriginal community members. Constant politicking seems to influence who stays and who leaves, as mentioned by one previous board member.

3.3 Community Context

Red Deer, Alberta, is an urban community located halfway between Calgary and Edmonton with a population of 68,308. The city of Red Deer is well known for its agriculture, oil, and gas industries. The largest industries, oil and gas, are on the rise, allowing for increases in employment and population growth. Available housing cannot meet the need, which makes this the most dire problem for the city at zero per cent vacancy.

It was expressed by all key informants that outside the Aboriginal community, Red Deer has a reputation as being a hostile environment for Aboriginal people. Landlords are reluctant to rent to Aboriginal people or agencies and employers are reluctant to hire Aboriginal people. Red Deer also has a high transient population with a huge problem of homeless children/adolescents falling victim to prostitution and substance abuse.

On a more positive note, the number of Aboriginal organizations and services in Red Deer has grown. Fifteen years ago there were only the Red Deer Native Friendship Centre and Métis Local #84 offering services to the Aboriginal community. Today, there are the Métis Links, Native Counselling Services of
Flora Kallies and Delores Gadbois

Alberta, Red Deer Aboriginal Employment Centre (recently replacing Atoskewan Aboriginal Career Centre), and the Aboriginal Community Council (newly in place as of July 2001 that include members of all Aboriginal service agencies). Together they meet monthly to discuss issues and to decide which agency would best be suited to deliver new programs. This ensures non-duplication of services.

Shining Mountains is the only available service to Aboriginal families in Red Deer that offers a non-mandated option. The other agencies in Red Deer that provide services for children who are at risk of protective care are the Red Deer Native Friendship Centre and the Diamond Willow Child and Family Services Authority; the Kasokowak Child Wellness Society is the agency that services the Samson First Nation. All agencies under the Alberta Association of Services for Children and Families must take cultural awareness training to ensure that service providers have an understanding of cultural differences, residential school issues, and policies and legislation affecting Aboriginal people. Provincial social services within government are “finally realizing their interference [in] services is part of the problem, so now they’re trying to fix it.”

While there is an unknown number of residential school Survivors in the area, three residential schools did exist around the Red Deer area:

- Ermineskin Indian Residential School in Hobbema, run by the Roman Catholic Church from 1916 to 1973;
- Blue Quills Indian Residential School aka St. Paul’s Residential School in St. Paul, run by the Roman Catholic Church from 1931 to 1970; and
- Red Deer Industrial School aka Red Deer Boarding School in Red Deer, run by the Methodist Church from 1889 to 1944.

One key informant believed that the Red Deer Industrial School was a residential school for Aboriginal people before it closed in the early 1900s and reopened as a boarding school, which by then was available to anyone. Many Aboriginal residents of Red Deer believe that there was no residential school, but a small cemetery was discovered by a farmer who was clearing his land, located just outside of Red Deer, and found the remains of Aboriginal children who had died while at Red Deer Industrial School. Another respondent, an Elder from Hobbema, could not offer any opinions regarding the project but was able to offer her opinion on community change there.

3.4 Activities and Outcomes

A logical link exists between the activities a project undertakes and what they hope to achieve in the short and long term. In this case, the project wanted to reduce the high occurrence of family violence and the contributory factors that lead to family breakdown, which include:

- lack of parenting and life skills;
- lack of employment, education, and training skills;
- lack of involvement in community activities;
- lack of awareness in services available to assist family function;
- lack of cultural pride and knowledge of heritage and language;
- lack of self-esteem;
- drug/alcohol and gambling abuse;
- suicide and depression; and
- family and community violence.
The main program feature expected to reduce these factors is a home environment for the family as a unit that was non-threatening and voluntary. During the participants’ stay, they were encouraged to: learn parenting and life skills through role modelling and participation in parenting classes; increase their knowledge of culture and language through participation of traditional activities; seek employment/training or education; and dialogue with their family, project team members, and other participants through the use of healing/talking circles and day-to-day activities. Through these activities, it is the project’s long-term hope that families will be healed and reunited, the cycle of abuse will be broken, and a self-supporting community on its healing journey will exist. The relationship between project activities and short- and long-term benefits is set out in the logic model (Figure 3).

The “performance map” that follows details the project’s mission, target, objectives, and goals. It also shows what measures will be used to note what changes have occurred and the extent of those changes. This “map” or reference guide was used to determine what information should be gathered to measure those changes.

**Figure 3) Logic Model—Tawow Healing Home**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Provide a non-mandated culturally based therapeutic home environment for Aboriginal children/adolescents and their families at risk of involvement with protective services.</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we did it</td>
<td>Create a non-mandated program to provide alternative family care services to meet the needs of the healing Aboriginal family that is adaptable and culturally appropriate; provide services delivered by Aboriginal providers; build independence in parenting through modelling, positive encouragement, and partnership between the parent(s) and healing helper(s) (co-parenting); utilize traditional teaching, recreation, values, and parenting methods; provide aftercare, i.e., open house at Tawow, invite participant families to continue with community involvement and healing, and participant families paired with other graduate families in accessing community resources if needed; and maintain safety and security of the family.</td>
</tr>
<tr>
<td>What we did</td>
<td># of sessions; # of community programs accessed; and # of traditional activities.</td>
</tr>
<tr>
<td>What we wanted</td>
<td>Reduce occurrences of family violence within participant families; increase involvement of participant families in community activities and education or employment; reduce the contributory factors that lead to family breakdown; increase awareness of services available to assist family function in the community; rebuild cultural pride by supporting involvement of participants and their families to connect with their heritage and community; enable parents to resume their role in the care of their child(ren); maintain the safety and security of all family members; and increase independency and self-sufficiency.</td>
</tr>
<tr>
<td>How we know things changed (short term)</td>
<td>Observed improvement in parenting; # of participants in traditional healing activities; # of families involved in the community; # of participants seeking or engaging in education/training and employment; reduced rates of family violence with participants; # of participants seeking counselling; and observed and self-reported changes in independency in parenting and self-sufficiency.</td>
</tr>
<tr>
<td>Why we are doing this</td>
<td>Healing and reunion of the family will be complete; cycle of abuse will be broken; and self-supporting community on its healing journey.</td>
</tr>
<tr>
<td>How we know things changed (long term)</td>
<td>Restoration of the family and thus community to reduce the high rates of residential school-related issues, e.g., drug and alcohol abuse, gambling, suicide, depression, family and community violence, and lack of cultural pride currently afflicting the Aboriginal community in Red Deer and nearby Hobbema and Rocky Mountain House.</td>
</tr>
</tbody>
</table>
**MISSION**: Restore, rebuild, and reunify our children, families, and communities in physical, emotional, intellectual, and spiritual health.

<table>
<thead>
<tr>
<th>HOW?</th>
<th>WHO?</th>
<th>WHAT do we want?</th>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td>activities/outputs</td>
<td>Aboriginal children/adolescents and their families at risk for involvement with protective services.</td>
<td>Reduce occurrences of family violence within participant families; increase involvement of participant families in community and traditional activities, counselling sessions, and education or employment; reduce the contributory factors that lead to family breakdown with our target population; increase awareness of services available to assist family function in the community; and increase independency in parenting and self-sufficiency.</td>
<td>Create a self-supporting healing community.</td>
</tr>
</tbody>
</table>

How will we know we made a difference? What changes will we see? How much change occurred?

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term measures</th>
<th>Long-term measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$150,000</td>
<td>14 Aboriginal children and their families (9 adults) at risk with protective services in Red Deer, Hobbema, and Rocky Mountain House.</td>
<td>Participation in co-parenting, traditional and community activities, counselling sessions, employment, and education; reduced occurrences of family violence; and observed changes in awareness of available services, parenting behaviour, and self-sufficiency.</td>
<td>Reduced rates in family violence, children in care, and incarceration; and change in number of families involved in community.</td>
</tr>
</tbody>
</table>
4. Results

Two desired outcomes were examined in-depth for this case study, parental skill and self-sufficiency. The key indicators of change selected specifically for Tawow Healing Home include: parental involvement; parent–child interaction; employment, training, or educational opportunities; goal setting, self-esteem, and peer support; cultural awareness; and seeking treatment and using services. An attempt was made to gather data on the AHF Board-selected indicators: physical abuse, sexual abuse, children in care, incarceration, and suicide. What follows is a report on the information obtained, and these are almost exclusively based on the opinions of key informants and any participant assessments that were done by the project. Ultimately, what the project hopes to accomplish is to improve the parenting skills of participants.

4.1 Impact on Individual Participants

Overall, the majority of respondents stated that there were changes in participants in one form or another, and they claimed that these changes were due to project team qualities, the atmosphere of the home, and the concept of the program.

Most respondents noted some change in parental involvement, and they were equally divided in their beliefs that change was obvious in ideas and behaviour. Those who noted changes in ideas had observed that parents are more aware of the issues that affect their parenting styles, are increasingly motivated to change daily routines (e.g., homework and household duties), and have learned to manage and control anger. For others, the change was obvious in behaviour; parents rebonding with their children, attending classes (such as the Family Life Improvement Program [FLIP]), and sharing their thoughts with the house mother facilitated their development as healthy, involved parents. Figure 5 shows the perceptions of respondents regarding the magnitude of change noted in participants.

Figure 5) Perceptions of Magnitude of Change Noted in Participants

<table>
<thead>
<tr>
<th>Indicator</th>
<th>% of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental involvement</td>
<td>almost all</td>
</tr>
<tr>
<td>Parent–child interaction</td>
<td>&gt;75%</td>
</tr>
<tr>
<td>Parental skills</td>
<td>about 50%</td>
</tr>
<tr>
<td>Independence/self-sufficiency</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>Parent self-esteem</td>
<td>almost all</td>
</tr>
<tr>
<td>Youth self-esteem</td>
<td>&gt;75%</td>
</tr>
<tr>
<td>Peer support</td>
<td>about 50%</td>
</tr>
<tr>
<td>Cultural awareness</td>
<td>&lt;20%</td>
</tr>
<tr>
<td>Goal setting</td>
<td>&lt;20%</td>
</tr>
</tbody>
</table>

# of responses
Respondents believed these changes were facilitated by the healthy example provided by the house mother whose parenting style created less stress and conflict, participant motivation, an emphasis on planning, parental freedom to exercise decision-making skills with non-judgmental guidance, a program environment of acceptance where healthy living patterns were the norm, and the fact that Aboriginal women were helping other Aboriginal women.

Behavioural change was the most noted observation in parent and child interactions. The parents had changed to a more positive way in how they view their children’s behaviour. Through the development of coping skills, parents were better able to deal with issues or problems and increased their patience and confidence in the nurturing of and interaction with their children. These positive changes were shown by how parents were tending to their children by observing the cooking, laundry, play, and quality time spent with their children. Before attending the program, one parent was ready to give up on her oldest child but now wants to keep the family together. What facilitated this change in behaviour was attributed to program qualities, most particularly the role modelling between participants and the positive support and feedback from the house mother. Participants became motivated to stay together as a family. Social services do not allow this type of interaction to develop because of the standard practice of removing the child(ren). This may be the reason why there was unease when a social worker visited the Tawow Healing Home.

Respondents were asked if they observed any changes in parenting skills in participants. Some noted a change in ideas as they observed that the parents were learning patience and becoming more confident in making responsible decisions to ensure what is best for their children. Being comfortable with the program may have allowed parents to open up to traditional ways and to focus on healing and being healthy. The majority of respondents felt that change took place in the participants’ behaviour. Most participants were making decisions on their own rather than relying on social services to tell them how to do things. They were entering the program with a lot of aggression and were now able to discuss issues with respect and not just “fly off the handle.” The introduction of traditional ways of raising families was also a key element in helping with discipline and coping skills. Support and guidance from the project team, use of traditional approaches to parenting, and attending parenting classes were credited with facilitating these changes.

The majority of respondents noticed that there was some change in behaviour in how participants felt about themselves in terms of independence and self-sufficiency. They saw that participants were starting to do things more on their own without asking for help, and two of the participant families had become stable and were living on their own. (It should be noted that one of these families came from a homeless situation.) Participants were increasingly able to resist the confining regulations imposed by social services and to become more assertive by asking for what they thought they needed. One respondent felt that there was a change in independence but not in self-sufficiency because of the reliance on the welfare system. (All participants, even those who have already gone through the program, rely partially or wholly on social assistance.) Respondents credited change to the unique program environment and content that supports and encourages participants to make decisions on their own via the guidance and compassion from the house mother, including aftercare. One problem noted was that participants relied heavily on Shining Mountains Living Community Services team members to get them to their appointments and classes due to the home being situated outside the city. All respondents felt that at least half of the participating families increased their level of independence and self-sufficiency.
Other areas of interest included participation in traditional activities, development of self-esteem, support towards each other, and setting goals. These changes showed that participants are starting to feel more comfortable with themselves to make decisions on their own and to respect one another. Respondents believed that over 50 per cent to almost all participants had shown a change in their understanding of traditional culture, self-esteem, peer support, and goals setting.

Some participants decided to seek or secure employment, training, or educational opportunities who were not doing so before. Respondents felt this change in ideas was based on the participants’ commitment to the program as well as expectations of improved stability in themselves. This was not only partly due to the quality of the program but more to do with the qualities of the participants who now think they are worth hiring, have become more sure of themselves, have increased self-worth and pride, and have become aware of having control over their lives. However, time was a factor in determining the extent of their commitment to seek employment, training, or education as the program only allows stays of up to three or four months. Figure 6 shows the magnitude of change in participants noted by respondents with respect to participants seeking or securing employment, training, or educational opportunities.

Confidence in seeking treatment and services would also indicate a measure of self-sufficiency. This would indicate growing self-worth and a willingness to make changes. All participants are still in contact with the project, which shows an appreciation of the time participants spent in the program. Figure 7 shows that the majority of respondents felt that participants were seeking treatment and accessing more services because of their participation in the program.
4.2 Impact on Community

The original intent of this case study was to measure change in the community that included Red Deer, Samson First Nation (Hobbema), and Rocky Mountain House. Since the participants only came from Hobbema and Red Deer and the majority of statistical information found was for Red Deer, this study focused mainly on change in Red Deer.

Major developments to improve services to the Aboriginal community in Red Deer has increased tremendously over the past couple of years. Some of these include: funding for homelessness; community-supported housing money; opening of the Red Deer Aboriginal Employment Centre; opening of the new Aboriginal council that oversees all programs affecting the Aboriginal community; and the implementation of cultural awareness education mandated to all personnel working at agencies dealing with Aboriginal people. These improvements cannot be ignored when considering the longer term impact of the Tawow Healing Home. Despite having the following information collected to help determine longer term change in the community (i.e., as baseline information), the AHF will not be following up on the social indicators at a later time. Still, the data are extremely important for the project’s independent evaluation efforts. In determining whether the project’s impact on the community had reduced rates in family violence, children in care, and incarceration and increased participation of families involved in the community, this will also answer the project’s own questions on whether it helped to create a self-supporting healing community.

4.2.1 Physical Abuse

Physical abuse includes many degrees of physical violence such as pushing, shoving, slapping, kicking, punching, hitting, spitting, pinching, pulling hair, choking, throwing things, hitting victims with an object, and using or threatening to use a weapon.

The project estimates that there are 1,240 Aboriginal community members living in Red Deer and suffering from physical abuse. Out of 13 respondents, seven (53.8%) felt there was a decrease in the rate for physical abuse and six (46.2%) were unsure. Most respondents felt that the overall crime rate had decreased, despite the rash of suicides in Hobbema and an increase in alcohol and drug consumption that led to date rape over the past summer. The majority felt that this decrease was due to more people accessing programs as well as to new programs becoming available (e.g., program for the homeless).
Table 2 highlights reported assaults obtained from the RCMP detachment in Red Deer that services the town and outlying areas (including Hobbema and Rocky Mountain House) as well as other towns. The numbers do not identify the type of occurrence (e.g., a bar brawl or a domestic dispute), but it does include domestic or family violence. There was an overall decrease in assault cases in 2001 that may have been affected by the increase in employment opportunities, new programs, and the fact that Red Deer has a highly migratory population.

<table>
<thead>
<tr>
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<tr>
<td>Assault (level 1)</td>
<td>590</td>
<td>481</td>
</tr>
<tr>
<td>Assault weapon/bodily harm</td>
<td>60</td>
<td>32</td>
</tr>
<tr>
<td>Aggravated assault</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Assault causing bodily harm</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>657</td>
<td>519</td>
</tr>
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</table>

4.2.2 Sexual Abuse

Sexual abuse is making victims do any sexual acts they do not want to do. The project estimates that there are 360 (3.3%) Aboriginal community members suffering from sexual abuse. Only four of 13 (30.8%) respondents felt that the rate for sexual abuse had decreased, and the rest (69.2%) were unsure if there was a change. Table 3 shows the number of reported sexual assaults, which may or may not include Aboriginal people. Although the numbers indicate very few attacks, there is a possibility that a much greater undisclosed number exists. These data are clearly in contrast to the opinions of respondents to the AHF Supplementary Survey who felt that as many as 360 people may be impacted by sexual abuse.

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<thead>
<tr>
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<tbody>
<tr>
<td>Aggravated sexual assault</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Sexual assault with weapon</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>–</td>
<td>2</td>
</tr>
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4.2.3 Children in Care

The following figure shows the rates for Aboriginal children placed in care for the areas that Diamond Willow Child and Family Services Authority serviced for the 2000–2001 period.
A total of 18,220 (18.2%) under the age of 20 were living in Red Deer in 1996, and the current total population for Red Deer is 68,308. If we assume that 3.45 per cent of the population is Aboriginal, then it is estimated there were 825 Aboriginal children under the age of 15 living in Red Deer in 2001. The project estimated there were 454 children in care in the Red Deer area, which probably included rates from Hobbema and Rocky Mountain House.

Between 1 January 2001 to 4 October 2001, a total of 286 Aboriginal children from Red Deer were placed in care through the intervention of the Red Deer Native Friendship Society, which includes both temporary and long-term care. If 286 children were in care from an approximate population of 825 Aboriginal children, it is estimated that 34.6 per cent of all Aboriginal young people in Red Deer are or have been provincial wards at least once in their lives. Caution is required in interpreting this estimate because no information could be obtained on the number of children who had gone through a revolving door child care system. In other words, one child could be counted more than once in the total number of children in care.

When questioned about whether rates of children in care had changed, opinions from respondents differed slightly, but 46.2 per cent felt that there was a decrease in the rates for children in care, 15.4 per cent felt there was an increase, 7.7 per cent felt there was no change, and 30.8 per cent felt unsure of any change. In any case, it appears that a large number of Aboriginal families are having difficulty raising their children.
4.2.4 Incarceration

There were unsuccessful attempts to gather statistics from the Native Counselling Services of Alberta’s Red Deer office on the number of Aboriginal people who are at risk of incarceration due to family violence, physical abuse, and sexual abuse. The project has estimated that 125 (1.1%) Aboriginal community members have been incarcerated. Out of 13 respondents, only one felt that there was an increase and another felt that there was a decrease in the rates for incarceration. The rest of the respondents were unsure.

4.2.5 Suicide

The number of Aboriginal people who completed suicide in the province of Alberta total 43 for 2000 (35 status/non-status, 8 Métis) and 35 for 2001 (33 status/non-status, 2 Métis). The project estimated there were 42 (.4%) Aboriginal people who committed suicide (this most likely includes attempted as well as completed) within the past year. The number of deaths in Red Deer and surrounding area that occurred during the period from 1 January 2000 to 31 August 2001 for both Aboriginal and non-Aboriginal people totals 72 (29 for 2000 and 43 for 2001).

Although it was already mentioned that there was an increase in suicides in Hobbema during the past summer (one respondent said that there were four suicides), 46.2 per cent still felt that there was an overall decrease in the rates for suicide. These respondents, who are leaders of the Aboriginal community in Red Deer, perceive that suicide is on a decline and that the rash of suicides in Hobbema was not indicative of a trend. The majority (53.8%), however, could not decide whether rates had changed.

Table 4 shows that 11.6 per cent of Aboriginal suicides in Alberta for 2000 took place in Hobbema and Rocky Mountain House, while there were no suicides in the city of Red Deer for the same year. It also shows that 31.4 per cent of Aboriginal suicides for 2001 took place in Red Deer and Hobbema. This percentage indicates a severe increase in the number of suicides for this region within the past year and negates the opinions of some respondents.

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<tbody>
<tr>
<td>Under 15</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>15–19</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>20–24</td>
<td>–</td>
<td>–</td>
<td>1</td>
<td>2</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>25–44</td>
<td>1</td>
<td>–</td>
<td>1</td>
<td>–</td>
<td>3</td>
<td>–</td>
</tr>
<tr>
<td>Unknown</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>3</td>
<td>–</td>
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</table>
4.2.6 Family Violence

Family violence under the Protection Against Family Violence Act includes any act, threatened act or failure to act that causes injury or property damage (or causes a reasonable fear of injury or property damage). To qualify as family violence, these acts must be carried out with the intention to intimidate or harm a family member. Forced confinement and sexual abuse are also part of this definition. What is not included are those situations where a parent uses force to correct a child. However, the force used must be reasonable in the circumstances.¹⁰

The only estimates that were available on family violence were provided by the AHF Supplementary Survey of July 2001 that the project had completed. It listed 1,650 (15%) Aboriginal community members who suffer from family violence (based on the project’s belief that there are approximately 11,000 Aboriginal people living in Red Deer as of July 2001). This number may also include violent acts against children, as it is not certain how the project defines the term “family violence.”

The National Clearinghouse on Family Violence suggests that one in ten women are physically abused by their husband or partner and that Aboriginal women are at a higher risk than non-Aboriginal women. It also stated that half of all Aboriginal children who die as a result of maltreatment suffered physical abuse. Several risk factors for fatal child abuse include adults using/abusing alcohol and drugs, family living in poverty with parents unemployed, children of parents with poor parenting skills, and high family stress level reflected in frequent arguments.¹¹ These factors are also the main contributors to family breakdown. The following figure indicates that the majority of respondents believed the social indicators listed had decreased in their community or that they were unsure if any change had occurred.

Figure 9) Magnitude of Change Noted in Community on Social Indicators
4.3 Impact on the Project Team

The team felt that they had learned about traditional protocols, Cree language, and how to start on their own spiritual journey when asked what they had learned from their involvement with the project. Becoming aware of lost traditions gave them a sense of pride, and being involved in Tawow showed them that there are people who care and that there is hope.

4.4 Partnerships and Sustainability

As it stands now, the only hope the project has for continued service once AHF funding runs out will be a partnership with Kasohkowew Child Wellness Society in Hobbema. Hobbema hopes that Shining Mountains Living Community Services will be able to acquire five homes and said that it “will have no problems to fill them.” However, one respondent felt that if the project does partner with Kasohkowew, it will lose its uniqueness and will not be able to provide a voluntary service. “It will end up being just another group home where the families will be separated. Also, the structure of the program guidelines will be rigid in that they will not be allowed to choose which programs to access but will be told what to do.”

The one successful partnership has been with the Family Life Improvement Program (FLIP) that all participants are encouraged to attend; in fact, they do attend. The program is taught by an “apprenticing” Elder who is also involved with Tawow as a visiting Elder.

4.5 Addressing the Need

Almost half the respondents felt that the project was addressing the Legacy and identified needs as set out in the project proposal; but physical and sexual abuse may require professional counselling that the project cannot administer directly. Aside from a referral strategy, respondents felt that increases in team membership might better address the need. With respect to achieving desired results, most respondents were unsure and felt that it was too soon to tell. However, some felt that the project did accomplish implementation objectives as program flexibility was being consistently cited as a best practice. Figure 10 indicates the magnitude of change noted by respondents.

Figure 10) Magnitude of Change Noted in Participants on Key Variables

<table>
<thead>
<tr>
<th></th>
<th>Not sure</th>
<th>Reasonably well</th>
<th>Very well, minor improvement needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addressing Legacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addressing needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Led to desired results</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.6 Successes and Best Practices

The majority of respondents felt that Tawow Healing Home offered a unique solution to an identified need in the Aboriginal community. The environment itself—voluntary, Aboriginal-run home environment versus mandated, non-Aboriginal-run institutional environment—allows for a greater opportunity for Aboriginal people to empower one another. Some respondents believe that once participants leave the program, they leave with positive tools to help them live healthy lives with their families. The fact that the program format is quite relaxed means that it can respond to situations with unique solutions based on individual needs. The program also brings awareness to the public on understanding the Legacy through another program that Shining Mountains Living Community Services runs.

Most respondents felt that any change in the participants’ thinking was mainly due to the influence of the house mother. Her patience and knowledge of parenting as well as her ability to facilitate independent decision making encouraged participants to gain confidence in their ability to parent in a positive way. Respondents clearly respected and admired the project team’s commitment to the program and to participating families.

4.7 Challenges

Non-mandated, voluntary family therapy is an alternative service for which its need and demand exceed Tawow Healing Home’s capacity. Many families who have been referred by child welfare agencies have been turned away (four to five families that fit the criteria for the program). The executive director stated, “funding is very tricky to acquire when social services does not intervene and remove the children.” Some respondents felt that the project was constantly challenged by repeated attempts of outside systems (social services) to superimpose their expectations and requirements of First Nations’ processes in dealing with family issues and by those systems who do not listen or respect First Nations’ ways. Respondents also felt that social services saw these families as being in a “child protection” service and that the project needed to follow certain regulations. A respondent from a child welfare agency did feel that the project did not have restrictions or rules according to agency regulations and that safety issues were a concern. When this respondent was later asked to elaborate, it was regarding an incident where one of the parents (whose child was initially apprehended with the agency) was found to be “high on something” upon returning to the home after a weekend spent on her reserve, and it was not reported to the agency until a week later. The agent did not, however, elaborate how Tawow handled this situation, only that it did not report the incident to the agency. The agent only appeared to wish for better communication that would appease any concerns regarding safety for the children. This issue, if not resolved, may impede on any partnerships with child welfare agencies. (It should be noted that, overall, this respondent thought the project was an excellent program.)

One respondent, who is a board member, felt that Tawow Healing Home is not like a real home and is located too far from Red Deer. This only allowed participants to learn country life and would not acquire any “street smarts.” Also, smoking is allowed in the home, thus raising health concerns for the children. On another note, most respondents felt frustrated by the lack of alternative service options and the fact that the home is needed at all.
When the project discovered that one of their participants was severely affected by fetal alcohol effects (FAE), the Shining Mountains team members realized that the program was not well-equipped to deal with the extra care and attention needed for this young woman and her infant. It was also discovered that she suffers from an obsessive–compulsive disorder. The child welfare agency that previously handled her case informed Shining Mountains of the extensive family violence, both physically and sexually, that she had disclosed to them. By having extensive links with other programs, Shining Mountains was able to get a proper assessment in order to access other appropriate programs. The young woman’s future would have otherwise been bleak if Tawow did not take her and her infant into the program, and the infant would most certainly have been taken away from her. At present, the project is looking into other arrangements for them.

The other participant suffering from FAE was unaware of her problem and thought of herself as “stupid.” When she first came to the program, project team members soon realized that something was wrong and had her assessed by the mental health agency to confirm their suspicions. She is now aware of her problem and is starting to look at herself and her family in a different light.

The reduced amount of funding that was originally requested caused several problems, including the loss of a team member who was capable of evaluating the program, not being able to have more Elders or Aboriginal people to offer their wisdom and expertise, and the inability to have participants access more programs and attend other activities that were originally planned.

Dealing with the strict regulations of child welfare agencies that are contrary to the whole concept of the program has reduced the chances of future funding from these agencies. If Shining Mountains Living Community Services accepts funding from the Kasohkwew Child Wellness Society in Samson, the program will have to change to adhere to their guidelines and will thus lose its unique approach.

It has been a real challenge to sustain Survivor involvement. The project did engage Survivors in developing the program, but they are not involved in day-to-day activities. Having Elders who may or may not be Survivors visit the home to offer their wisdom has been difficult for young participating parents. Some respondents felt that it was too uncomfortable for the participants to open up to an Elder, possibly due to the lack of traditional ways in accepting the wisdom of Elders or the fact that they have built up a mistrust towards anyone with authority. It was indicated that the Aboriginal community was still struggling with the issue of residential schools, and most could or would not admit to being a Survivor.

4.8 Lessons Learned

The importance of whole family therapy and traditional ways have been key in keeping families together. First Nations approaches to dealing with neglect, racism, and abandonment (where non-Aboriginal agencies have no guidelines or the expertise to deal with) has increased the number of participating families and their pride in being Aboriginal. To increase the desire of participants to learn traditional ways, it was recommended that hands-on bush experience was needed. Also, the project team felt that the need to modify intake forms and referral processes to better detect FAS/FAE as well as to clarify whether to accept FAE participants.
It is clear that one alternative care home is not enough. Increasing service and team capacity are felt to be urgent matters to adequately meet needs. Facility restrictions (e.g., having one bathroom) also caused some challenges.

5. Conclusion

Tawow Healing Home appears to be having an impact on the majority of participants although not all respond to the same degree. It is clear that the program is not able to address serious special needs alone. Environmental and physical stresses affect the degree to which participants can engage in and benefit from the program. For example, some participants had other commitments that took them away from the program (i.e., employment outside the city). Evidence provided through the completed participant feedback forms and interviews shows that the participants who have gone through the program so far have come away with a more positive approach to caring for their families and life in general. However, it is not clear how enduring these changes are nor to what extent they are life-altering. In addition, it is also unclear to what extent the role of referring agencies and established partnerships contribute to these changes. The house mother, who is credited with much of Tawow’s success, may be one of the more powerful influencing elements of Tawow. Unfortunately, the project is reaching only a small number of its target group; therefore, community impact is limited. If resources are not forthcoming, both personnel and financial, the Tawow Healing Home will no longer exist or expand its reach. The difficulties in establishing partnerships caused by differing philosophies and practices with child welfare agencies decreases Tawow’s chances of sustainability.

6. Recommendations

As a whole family, non-mandated, culturally sensitive therapy facilitated by cultural insiders in a home setting, Tawow Healing Home appears to be having a positive influence on most who participate and is well received by the community. However, the following recommendations are suggestions to enhance administration and evaluation of the program.

Program recommendations:

- make time to summarize oral reports into a written format for evaluative purposes to give proof of positive impact on participants;
- give more detail in AHF activity reports to show that the project is addressing the Legacy and needs that were set out in the funding proposal;
- increase efforts to pursue other resources outside the child welfare system in order to sustain and expand the project to reach more of its target group and to maintain project integrity; and
- amend intake forms regarding mental health as the project has no in-house counsellor to deal with critical mental health issues, i.e., FAE.

With respect to the continued evaluation of Tawow Healing Home, it is recommended that the intake form be used as a baseline measure and that the project team summarize all participants’ information regarding personal, educational, vocational, criminal, and treatment histories and functioning with a romantic partner, as a homemaker, in an occupation, and with their own children, friends, and parents. The intake form could be used as a follow-up at the end of the program, six months, and one year later during aftercare. This is valuable information that can be used to evaluate the project’s effectiveness and
is a powerful tool that can be used when securing resources for the program. In addition, it would also be useful to examine social indicators discussed here (i.e., children in care, sexual and physical abuse, suicide, and incarceration) in 2007 to determine trends over time.

Notes

1 Project proposal for funding submitted by Shining Mountains Living Community Services to the AHF, February 2000.
3 The Red Deer Aboriginal Community Assessment was completed by the Research, Evaluation, and Communication Department of Native Counselling Services of Alberta in collaboration with Diamond Willow Child and Family Services Authority and Central Alberta Aboriginal Council on 8 November 1999.
4 Application for funding submitted by Shining Mountains Living Community Services to the AHF.
5 Information from Figure 1 and 2 are taken from quarterly reports submitted by Shining Mountains Living Community Services to the AHF.
7 Between 1996 and 2001, there has been a growth rate of 15.8 per cent for the population of Red Deer.
8 Sexual abuse has not been disclosed; however, it has been reported historically from referring parties and has now become apparent in the self-esteem and boundary issues of participants.
10 Stated by the executive director during an interview, 1 October 2001.
11 At the time of writing, a list of residential schools was being compiled by the AHF.
12 The project believed that there are 172 (.01%) Aboriginal people who are homeless, as indicated in their response to the AHF Supplementary Survey, July 2001. Also, a housing survey indicated that approximately 68 per cent of Aboriginal people who are homeless have children.
13 This is through a joint committee of all Aboriginal and non-Aboriginal agencies where voice is given to their concerns and suggestions for improvement.
14 They had 220 clients between the period December 2000 to September 2001.
17 Compiled by Red Deer City RCMP detachment and includes both Aboriginal and non-Aboriginal.
20 Compiled by Red Deer City RCMP detachment and includes both Aboriginal and non-Aboriginal.
21 Census 1996 lists Sunchild Reserve total population at 435 with 255 (58.6%) under the age of 20; the town of Rocky Mountain House total population was 5,805 with 1,945 under the age of 20 and an Aboriginal population of 255 (4.4%); and the town of Olds (located between Red Deer and Calgary) total population was 5,700 with 1,675 under the age of 20 and an Aboriginal population of 95 (1.7%).
22 Based on 1996 Census data. It was estimated that Aboriginal children accounted for 35 per cent of all Aboriginal people. Statistics Canada 1996 Community Profiles. Retrieved 18 October 2001 from: http://www12.statcan.ca/english/profil/details/details1pop.cfm?SEARCH=BEGINSSPSGC=48&SGC=4808011&A=&LANG=E&Province=48&PlaceName=red%20deer&CSDNAME=Red%20Deer&CMA=830&SEARCH=BEGINSSDataType=1&TypeNameE=City&ID=11728
Flora Kallies and Delores Gadbois

24 This was gathered through the Community Care Coordinator at the RDNFS in charge of the program who intervenes when an Aboriginal child living in Red Deer is involved. They do not deal with Aboriginal children living outside of Red Deer.
25 AHF Supplementary Survey, July 2001. Rates were for one year, but it is unclear if it was for 2000 or from June 2000 to July 2001.
26 Compiled by the Alberta Office of the Chief Medical Examiner.
28 These numbers were compiled by the Red Deer City RCMP Detachment and are derived from reports on the Coroner’s Act that reflect assistance files to other detachments (outside Red Deer) but do not break down types or causes.
29 Compiled by the Office of the Chief Medical Examiner. There were no Aboriginal deaths by suicide in Rocky Mountain House recorded for 2001. Also, the numbers recorded are for January 2001 to October 2001.
30 Alberta Justice (2000:3).
Appendix 1) Case Studies Selection Criteria

1. Métis, Inuit, First Nation, Non-Status
2. Youth, men, women, gay or lesbian, incarcerated, Elders
3. Urban, rural, or remote
4. North, east, west
5. Community services
6. Conferences/gatherings
7. Performing arts
8. Health centre (centralized residential care)
9. Camp/retreat (away from the community in a rural setting)
10. Day program in the community
11. Healing circles
12. Materials development
13. Research/knowledge-building/planning
14. Traditional activities
15. Parenting skills
16. Professional training courses
Appendix 2) Intake Evaluation Forms for Youth and Parents

SHINING MOUNTAINS LIVING COMMUNITY SERVICES
TAWOW HEALING HOMES PROGRAM

CONFIDENTIAL
(when completed)

Intake Evaluation Form

Liaison Worker: ______________________  Date: ______________

1. IDENTIFICATION
Participant Name: ______________________  Date of Birth: ______________
SIN: ____________________________  Age: ___  Marital Status: S. CL. M. SEP. D.
Home Address: ____________________________  Home Phone #: ______
Phone Contact #: (if applicable) ____________________________
Number in Family: ___  Number in TAWOW Program: ___
Family Doctor: ____________________________  Phone #: ______
Residential School Background (i.e. who in family was in Residential School, what school, how long and what impact do you feel it has had on you and your family)

__________________________________________________________________________________________________

What concerns do you need to address as a parent before entering the program? (i.e., Treatment, incarceration, attending out of town program)

__________________________________________________________________________________________________

2. PRESENTING CONCERN(S)
Referred By: __________________
Reason for Referral

__________________________________________________________________________________________________

Those Referred:
Parent(s) and Children  Yes  No
Children Only  Yes  No
3a. **PERSONAL HISTORY – BIRTH FAMILY**

1. What was your family position or birth order?
   1. Only child
   2. Eldest child
   3. Middle child
   4. Youngest child

2. Are you an adopted child? YES ___ NO ___

3. Number of children in your family? ___

4. In childhood, how well off was your family?
   1. High income
   2. Average income
   3. Below average -(social assistance, handicapped)

5. a. Was your father of Aboriginal background YES ___ NO ___ Unsure ___
   b. Was your mother of Aboriginal background YES ___ NO ___ Unsure ___

6. How happy was your childhood?
   1. Happy ___ 2. Average ___ 3. Unhappy ___

7. How stressful was your childhood?

8. What kind of mothering did you receive in childhood?
   1. Mostly warm & supportive
   2. Average
   3. Mostly dominating
   4. Mostly over reactive
   5. Mostly loveless
   6. Mostly inconsistent
   7. Mostly critical/rejecting
   8. Absent

9. What kind of fathering did you receive in childhood?
   1. Mostly warm & supportive
   2. Average
   3. Mostly dominating
   4. Mostly over reactive
   5. Mostly loveless
   6. Mostly inconsistent
   7. Mostly critical/rejecting
   8. Absent

10. How “good or easy” to parent were you as a child?
    1. Usually a “good or easy” to parent child
    2. Sometimes a “difficult” or “hard to parent” child
    3. Usually a “difficult” or “hard to parent” child

11. Who were you closest to in your family?
   1. Father
   2. Older Brother
   3. Younger Brother
   4. Grandfather
   5. A pet
   6. Mother
   7. Older Sister
   8. Younger Sister
   9. Grandmother
   10. No one
   11. Other (please specify)
12. Before age 18, what childhood problems did you have?

1. Childhood social isolation  
2. Childhood anger  
3. Childhood anxiety  
4. Childhood poverty  
5. Childhood physical abuse  
6. Childhood sexual abuse  
7. Childhood pressure to grow up “too fast”  
8. Childhood conflict with brother or sister  
9. Childhood illness  
10. Childhood law-breaking  
11. Childhood alcohol/drug problems  
12. Childhood removal from the home  
13. None  
14. Other (please specify) __________

13. What problems did your parents have in your childhood?

1. Parental social isolation  
2. Parental hostility  
3. Parental anxiety  
4. Parental financial irresponsibility  
5. Parental neglect  
6. Parental violence  
7. Parental sexual  
8. Parental illness/disability  
9. Parental marital conflict  
10. Parental inconsistency  
11. Parental indifference  
12. Parental alcohol/drug abuse  
13. None  
14. Other (please specify) __________

14. While growing up did you live

a) On reserve  
   Was it violent, poor, well off, high social problems i.e. suicide, alcohol etc.

b) On Métis Settlement  
   Was it violent, poor, well off, high social problems

c) Urban community  
   Was it violent, poor, well off, high social problems

d) Rural community  
   Was it violent, poor, well off, high social problems

15. While growing up, how did you like yourself?

1. Mostly positive feelings toward self  
2. Mostly negative feelings toward self  
3. Equal mixture of positive and negative feelings toward self

3b. PERSONAL HISTORY – CREATED FAMILY

16. Length of Marriage: _____

17. Spouse's Name: ____________________ Age: ___ Tel #: ___________________

18. Previous Marriage(s) ____________________ Dates: ____________________

19. Children living with you ______________ Living Apart ____________________

20. Children's Names & Ages: 1. ____________________ 2. ____________________
   3. ____________________ 4. ____________________ 5. ____________________

4. EDUCATIONAL HISTORY

21. How far did you go in school?

1. No or minimal education  
2. Completed less than grade 3  
3. Completed less than grade 6  
4. Completed grade 7  
5. Completed grade 8  
6. Completed grade 9  
7. Completed grade 10  
8. Completed grade 11  
9. Completed grade 12  
10. Completed College Certificate or more
22. What were your last marks like in school?
   1. Honors         3. Average
   2. Above Average  4. Below Average

23. How popular were you in school?
   1. Had many friends  3. Had few friends
   2. Had several friends 4. Had no friends

24. What was your school behavior like?
   1. Good (well behaved, rarely skipped classes)
   2. Average (between good and poor)
   3. Poor (poorly behaved, often skipped classes)
   4. Bad (repeatedly suspended from school, fighting, rule breaking etc.)

5. **VOCATIONAL HISTORY**

25. How has your employment been over the past 3 years?
   1. Steadily employed, full or part time
   2. Employed on casual basis
   3. Unemployed

26. If you were not employed, why? __________________________

27. What limited your employment over the past 3 years?
   1. Emotional or psychiatric problems
   2. Household responsibilities
   3. Physical illness
   4. Going to school/training
   5. Job market
   6. Type of work
   7. Alcohol/drug abuse
   8. Other __________________________

6. **CRIMINAL HISTORY**

28. Do you have a criminal record? YES _____ NO_____

29. Legal Status (at present time)
   1. No Involvement
   2. Bail/Own recognizance
   3. Probation
   4. TA/Intermittent
   5. Impaired Driving
   6. Outstanding warrant(s)
   7. Remanded in jail
   8. Sentenced incarceration
   9. Parole
   10. Other (please specify) ________

30. In what way do you believe that past experiences of Residential Schools has had an impact on these problems?
   1. Made them worse
   2. Had no effect
   3. Made them better

7. **TREATMENT HISTORY**

31. Are you currently receiving counselling or therapy? YES _____ NO_____  

32. Which counseling/therapy or training programs?
   1. Behaviour medication therapy
   2. Family therapy
   3. Group therapy
   4. Parenting Skills
   5. Family life skills
   6. Other
33. Are you attending any self-help group(s) such as; AA, NA, CA, GA etc.  YES ___ NO___

34. Are you taking any prescription medications?  YES ___ NO___
   If YES which ones?
   1. Anti psychotic medication   5. Anti anxiety medication
   2. Anti Parkinsonian medication  6. Anti alcoholic medication
   3. Antidepressant medication   7. Anti convulsant medication
   4. Lithium Carbonate           8. Stimulant medication

8. CURRENT FUNCTIONING IN MAJOR LIFE AREAS

FUNCTIONING WITH ROMANTIC PARTNER

35. Who are you describing?
   1. Spouse/common law   5. Ex-spouse/common law
   2. Boyfriend           6. Ex-boyfriend
   3. Girlfriend          7. Ex-girlfriend
   4. No romantic partner

36. How are you getting along with your romantic partner?
   1. No or minimal problems 3. Moderate problems
   2. Mild problems          4. Severe problems

37. What problems are there in this relationship?
   1. Relationship dissatisfaction 11. Sexual problems
   2. Nagging or complaining  12. Boredom
   3. Quarreling               13. Alcohol/drug problems
   5. Lack of conversation together 15. Living arrangement problem
   7. Lack of activities together 17. Child rearing problem
   8. Lack of affection and caring 18. Problem with relatives
   9. Lack of commitment       19. None
   10. Lack of intimate talk    20. Other 

38. In what way do you believe that past experiences of Residential School has had an impact on these problems?
   1. Made them much worse 3. Had no effect
   2. Made them worse       4. Made them better

FUNCTIONING AS A HOMEMAKER

39. How did you function as a homemaker this week?
   1. No or minimal problems 3. Moderate problems
   2. Mild problems          4. Severe problems

40. How enjoyable was your homemaking this week?
   1. Enjoyable            3. Unpleasant
   2. Neutral              4. Very unpleasant
41. How much homemaking did you do this week?
   1. All………………………………of the expected homemaking duties
   2. More than half……………………of the expected homemaking duties
   3. About half……………………of the expected homemaking duties
   4. Less than half……………………of the expected homemaking duties
   5. None………………………………..of the expected homemaking duties

42. In what way do you believe that past experiences of Residential School has had an impact on these problems?
   1. Made them much worse
   2. Made them worse
   3. Had no effect
   4. Made them better

**OCCUPATIONAL FUNCTIONING**

43. How did you function at work this week?
   1. No or minimal problems
   2. Mild problems
   3. Moderate problems
   4. Severe problems

44. How much of last week did you work?
   1. All of the past week
   2. More than half of the week
   3. About half of the week
   4. Less than half the week
   5. None of the week

45. What kept you from working full time for the week?
   1. Emotional/psychological problems
   2. Physical problems
   3. Retirement
   4. Household responsibilities
   5. Attending school/training course
   6. Job market
   7. Type of work i.e. seasonal
   8. Other

46. Which of these problems did you have?
   1. Work dissatisfaction
   2. Work impairment
   3. Absenteeism
   4. Unemployment
   5. Work demotion
   6. Partial disability, limits work to part time
   7. Partial disability, requires sheltered employment
   8. Total disability, prevents any employment
   9. Exaggerated disability
   10. None

47. In what way do you believe that past experiences of Residential School have had an impact on these problems?

**FUNCTIONING WITH OWN CHILDREN**

48. How many children do you parent?
   1. One child
   2. More than one child
   3. A mix of children and adolescents
   4. One adolescent
   5. More than one adolescent
   6. All are children or adolescents

49. How are you getting along with your children?
   1. No or minimal problems
   2. Mild problems
   3. Moderate problems
   4. Severe problems
50. What problems are there in this/these relationship(s)?
   1. Relationship dissatisfaction   11. Use of leisure time problems
   2. Nagging or complaining   12. Sexual activities/problems
   3. Quarreling (yelling, swearing)   13. Boredom
   5. Lack of conversations together   15. Problems with friends
   6. Lack of joint problem solving   16. Living arrangement problems
   7. Lack of parent/child activities   17. Financial difficulties
   8. Lack of affection/caring   18. Parenting problems
   9. Lack of responsibilities   19. Interference from relatives
  10. Medical difficulties   20. None
  21. Other problem

51. In what way do you believe that past Residential School experiences have had an impact on these problems?
   1. Made them much worse   3. Made them better
   2. Had no effect

FUNCTIONING WITH FRIENDS

52. How are you getting along with your friends?
   1. No or minimal problems   3. Moderate problems
   2. Mild problems   4. Severe problems

53. What problems are there in this relationship?
   1. Relationship dissatisfaction   10. Sexual activities
   2. Nagging or complaining   11. Boredom
   3. Quarreling   12. Alcohol/drug problems
   5. Lack of communication   14. Living arrangements
   7. Lack of activities together   16. Family conflict difficulties
   8. Lack of responsibility   17. None
   9. Problem with other friends   18. Other

54. In what way do you believe that past Residential School experiences have had an impact on these problems?
   1. Made them much worse   3. Made them better
   2. Had no effect

FUNCTIONING WITH PARENTS

55. Who are you describing?
   1. Both parents (or parent & step-parent)   7. Grandfather (as a single parent)
   2. Father (as a single parent)   8. Grandmother (as a single parent)
   3. Mother (as a single parent)   9. Uncle & Aunt
   4. Step-father (as a single parent)   10. Uncle (as a single parent)
   5. Step-mother (as a single parent)   11. Aunt (as a single parent)
   6. Grandparents   12. Other parent substitute
   13. None of the above

56. How are you getting along with your parent(s)?
   1. No or minimal problems   3. Moderate problems
   2. Mild problems   4. Severe problems
57. What problems are there in this relationship?

1. Relationship dissatisfaction
2. Nagging or complaining
3. Quarreling
4. Physical violence
5. Lack of communication
6. Lack of problem solving
7. Lack of activities together
8. Lack of affection & caring
9. Lack of commitment/ responsibility
10. Gambling/bingo problems
11. Sexual activities
12. Boredom
13. Alcohol/drug problems
14. Problem with friends
15. Living arrangement problems
16. Financial problems
17. Child rearing problems
18. Problem with other relatives
19. Use of leisure time problems
20. None
21. Other__________

58. In what way do you believe that past Residential School experiences have had an impact on these problems?

1. Made them much worse
2. Had no effect
3. Made them better
TA WOW HEALING HOME

Youth intake Form

(Confidential when completed)

Youth Name: ___________________________ Age: _______ Date of Birth:______________________

Treaty Number: __________________________ Alberta Health Care Number:____________________

Status: _______ Non Status: _______ Métis:______ Gender: Male: _______ Female: _______

Date of program entry: _______________________

Names of Parents/Guardian:______________________________________________________________

Parent/Guardian Address:_____________________________________________________________

Contact Phone Number:______________________________________________________________

Education:

Last School Attended:_______________________________________________________________

Grade:_______ Completed:_______ Not Completed:_______

What are your educational plans and goals?

_________________________________________________________________________________

Which would you prefer: Attend school:___________ Take home schooling:______________

If school which would you prefer: Regular school:___________ Outreach Program:____________

Legal Concerns:

Court Appearances:___________________ Court Orders:______________________________

Charges Pending: If so, what are they:______________________________________________

Medical Concerns:

Allergies: _______ Other:___________________________________________________________

Medications: _______ Attending Counselling:_________________________________________

Other Concerns:

Alcohol Use: Yes:_______ No:_______ If yes: How Often: Daily / Weekly / Other

What type of alcohol drinks do you prefer:____________________________________________

What other drugs do you use: potent/cocaine/other How Often:__________________________

What is your drug of choice:___________________________________________________________

Do you use it: When alone:_______ With others only:_______ Usually with others:_______

Is your parent/guardian aware of your drug use:________________________________________

Where you see yourself:

Short Term Goals (in six months)

Personal:_______________________________________________________________

Education/Skill Training:_______________________________________________________

Family:_______________________________________________________________
Case Study Report: Tawow Healing Home

Social/Recreation

Other:

Long Term Goals (in five years)

Personal

Education/Skill Training

Family

Social/Recreation

Other:

Youth Signature Date:
Appendix 3) Healing Plan for Youth and Parents

PARTICIPANT CASE HEALING PLAN

PARTICIPANT NAME: ________________________________
SPOUSE/PARTNER'S NAME: _________________________
DATE: _____________________________
Children: __________________________________________

SELF CARE PLAN

<table>
<thead>
<tr>
<th>Skills/Training to Acquire</th>
<th>Location</th>
<th>Start Date</th>
<th>End Date</th>
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<tbody>
<tr>
<td>Anger Management Program</td>
<td>_______</td>
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<tr>
<td>Stress Management Program</td>
<td>_______</td>
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<tr>
<td>Communication/Assertiveness</td>
<td>_______</td>
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<tr>
<td>Other</td>
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<tr>
<td>Personal Journals</td>
<td>Home</td>
<td>________</td>
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- include something positive about partner’s actions/words and what this meant to you and your response to it.
- something positive about your actions/words and what this meant/felt to you and others response to it.
- at least 1 compliment for your spouse/partner each day
- at least 1 compliment for yourself each day
- 1 thing (behaviour/habit/thought/voice tone or words) to work on and improve this week for myself is_____
- I will do this by______________________________
- 1 showed affection to my partner/spouse today by__________________________________________
- My spouse/partner showed affection to me today by__________________________________________
- I showed affection to my child(ren) today by__________________________________________
  (Monetary items do not count)

Knowledge of Aboriginal Culture/Tradition
## PARTICIPANT HEALING/GROWTH CASE PLAN

**CHILD NAME and AGE**

**Parent Name**

**Skill Building Activities:**

<table>
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<tr>
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<th>End</th>
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<th>End</th>
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**Education/Cultural Activities:**

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**Self Care Activities:**

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<th>Start</th>
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**Parent Signature & Date**

**Family Support Signature & Date**

## ALTERNATIVES TO APPREHENSION PLAN

1. Treatment/Incarceration Time **PHASE ONE**
2. Refer to Treatment
3. A.A./C.A./G.A./ or other Support Group Meetings **PHASE TWO**
4. Budgeting, Homemaking Skills, Other Training
5. Native Parenting Program
6. Native Counselling F.L.I.P. Program
7. Refer to Employment Access, Housing, etc. **PHASE THREE**
8. Other Needs, (specify)

## MISCELLANEOUS

**Phase 1 Dates:** Start________ Finish__________

**Phase 2 Dates:** Start________ Finish__________

**Phase 3 Dates:** Start________ Finish__________

Alternatives to Apprehension Plan Agreement

**Signed By:** __________________________ Date: __________

Participant Signature

**Signed By:** __________________________ Date: __________

Liaison Worker Signature
# YOUTH GROWTH MANAGEMENT PLAN

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<tr>
<th>Area of Growth</th>
<th>Initial</th>
<th>Start Date/Ongoing</th>
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<td><strong>Education:</strong></td>
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<tr>
<td>Enrollment in Classes</td>
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<tr>
<td>Enrollment in Outreach Program</td>
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<tr>
<td>Enrollment in Home Schooling</td>
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<td><strong>Personal Growth:</strong></td>
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<td>Happiness Skills</td>
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<tr>
<td>Native Awareness</td>
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<td>Self Esteem</td>
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<td>Other</td>
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<tr>
<td><strong>Social/Recreational:</strong></td>
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<td>Beading, Other crafts</td>
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<tr>
<td>Nature Activities</td>
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<td><strong>Spiritual:</strong></td>
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<td>Smudging/Sweetgrass</td>
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<td>Contemporary Church</td>
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Youth Signature & Date

House Support Worker & Date
Appendix 4) Shining Mountains Living Community Services Interview Questions

To start, I would like you to now think about the people involved in this project (please concentrate on those who have completed the program). Have you noted changes in any of the following?

1. Parent self-esteem  
   Yes  No
   What have you noted that makes you feel this way?

1  2  3  4
 Participation Individual ideas Individual behaviours Community conditions

1  2  3  4  5
<10% <20% about 50% more than 75% almost all

Why do you think this has happened?

2. Youth self-esteem  
   Yes  No
   What have you noted that makes you feel this way?

1  2  3  4
 Participation Individual ideas Individual behaviours Community conditions

1  2  3  4  5
<10% <20% about 50% more than 75% almost all

Why do you think this has happened?

3. Parental involvement  
   Yes  No
   What have you noted that makes you feel this way?

1  2  3  4
 Participation Individual ideas Individual behaviours Community conditions

1  2  3  4  5
<10% <20% about 50% more than 75% almost all

Why do you think this has happened?
Why do you think this has happened?

4. Parent/Child Interactions  

What have you noted that makes you feel this way?

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<td>Individual behaviours</td>
<td>Community conditions</td>
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<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
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Almost all

Why do you think this has happened?

5. Peer Support  

What have you noted that makes you feel this way?

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<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
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Almost all

Why do you think this has happened?

6. Cultural Awareness/Pride/Practice  

What have you noted that makes you feel this way?

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<td>Individual behaviours</td>
<td>Community conditions</td>
</tr>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
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</table>

Almost all
Why do you think this has happened?

7. Goal Setting  
   What have you noted that makes you feel this way?

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<th>4</th>
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<td>Individual behaviours</td>
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</tr>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
</tbody>
</table>

8. Have you noticed if more individuals are indicating a need or willingness to seek alcohol and drug treatment?  
   Yes  No  The same  Haven't noticed

9. How many participants are currently seeking or have secured employment, training or educational opportunities that were NOT doing so before they participated in Shining Mountains Community Service program?  
   - Seeking
   - Have Secured
   - employment
   - education or training

   Why do you think this has happened?

10. Independence/Self Sufficiency  
    What have you noted that makes you feel this way?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Individual ideas</td>
<td>Individual behaviours</td>
<td>Community conditions</td>
</tr>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
</tr>
</tbody>
</table>

   Why do you think this has happened?

11. Parenting Skills  
    What have you noted that makes you feel this way?
<table>
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<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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</thead>
<tbody>
<tr>
<td>Participation</td>
<td>Individual ideas</td>
<td>Individual behaviours</td>
<td>Community conditions</td>
<td></td>
</tr>
<tr>
<td>&lt;10%</td>
<td>&lt;20%</td>
<td>about 50%</td>
<td>more than 75%</td>
<td>almost all</td>
</tr>
</tbody>
</table>

Why do you think this has happened?

12. What do you like most about this project?

13. What do you like least?

14. What have you learned from your involvement with this project so far?

15. Is there anything you could suggest that might improve this project?

16. What are the most powerful threats to this project being able to achieve its goals?

17. In your opinion, for each of the following, which answer best describes whether rates have changed as a result of this project for:

   - Physical Abuse: increased stayed the same decreased unsure
   - Sexual Abuse: increased stayed the same decreased unsure
   - Children in care: increased stayed the same decreased unsure
   - Incarceration: increased stayed the same decreased unsure
   - Suicide: increased stayed the same decreased unsure

18. How did you decide what strategies to use to improve parenting skills?

19. In your opinion, how well has this project functioned in your community as a non-mandated service rather than an enforced program?
20. We know that you have already supplied information (that information has already been reported by the project team) to the Aboriginal Healing Foundation through the quarterly reports, but we would like to offer you another opportunity to provide any further insight in the following areas:
   a) the extent of survivor involvement
   b) the extent of Elder involvement
   c) what challenges/obstacles threaten the project
   d) the effectiveness and extent of partnerships and linkages
   e) the project's ability to monitor and evaluate its activity
   f) support of local leadership

21. Do you have any final comments to share?

22. Thinking more generally of the Aboriginal community as a whole have you noticed if the use of services to assist Aboriginal families has:
   increased          stayed the same          decreased          unsure
   How do you know?

   Why do you think this is so?

23. In the last 12 months, please state whether you feel community involvement has:
   increased          stayed the same          decreased          unsure
   How do you know?

   Why do you believe this has happened?

24. In the last 12 months, please state whether you feel participation in traditional activities has?
   increased          stayed the same          decreased          unsure
   How do you know?

   Why do you believe this has happened?
MANDATORY QUESTIONS:

25. How well is the project addressing the legacy of physical and sexual abuse in Residential Schools, including inter-generational impacts? Please choose only one response.

Please offer an explanation why you feel this way:

26. What are the previously identified needs that the project is intended to address?

27. How would you rate the project's ability to address or meet those needs?

Please offer an explanation why you feel this way:

28. How well has the project been accountable (i.e., engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

Please offer an explanation why you feel this way:

29. How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

Please offer an explanation why you feel this way:

30. Will the project be able to operate when funding from the Foundation ends?
31. How well is the project able to monitor and evaluate its activity? Please choose only one response.

<table>
<thead>
<tr>
<th></th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
</tbody>
</table>

Please offer an explanation why you feel this way:
Urban Native Youth Association

Project Number: CT-302-BC

Case Study Report

Two-Spirited Youth Program

Written by:

Kevin Barlow

Under the direction of:

Linda Archibald, Kishk Anaquot Health Research

Prepared for:

Aboriginal Healing Foundation Board of Directors

2001
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Preface

In the body of this case study the term “two-spirit” has been replaced with the term “gay/lesbian” because it was felt that some people may not be familiar enough with the term. The author applies gay/lesbian to be inclusive of all those the project sought to work with, including those who self-identify as being transgendered, bisexual, or two-spirited or who question their sexuality. The author hopes the Urban Native Youth Organization who hosted the project accepts this re-designation for the purposes of this document.

On a sad note, during the final editing of this case study the author was informed by the counsellor/facilitator that a gay man from Vancouver was found semi-naked and beaten to death in Stanley Park by baseball bats or pool cues. Police suspect that at least three individuals committed what is being called a hate crime directed at a person for no apparent reason other than being gay. This case study is in his memory and in the hope that gay/lesbian youth will never have to endure the same fate.
Acknowledgements

I would like to gratefully acknowledge the efforts of the counsellor for this program who made special efforts to describe the issues facing this project and the group of youth who face many challenges, including discrimination and alienation. His dedication and commitment showed the benefits of having someone with his background serving the community.
1. Introduction

A series of case studies was conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). A case study provides a holistic, in-depth view of a project and its outcomes. The project that forms this study is sponsored by the Urban Native Youth Association (UNYA) in Vancouver, British Columbia, and is entitled, “Two-Spirited Youth Program” (AHF file #CT-302-BC). It targets youth who self-identify as being two-spirited or gay, bisexual, lesbian, or transgendered. In the application for funding, the program is described as “bringing together Two-Spirited Aboriginal youth in a regular, weekly group setting. The youth, with the help and support of two group facilitators, will be in the company of their peers, share their common experiences, and gain empowerment through group discussions, counselling and role modelling.” The project also includes a public education component with specific attention being paid to the intergenerational impacts of residential schools.

The case study process included collecting data on selected social indicators that will be used to measure the impact of projects over time. In particular, data are being collected for the year prior to AHF-funded activity and once again in 2003, based on an approach known in the evaluation field as “within groups repeated measures.” Sources of information include project files (application for project funding and quarterly reports), key informant interviews with the project team and agencies that partnered with the program, and documents and data collected by the community support coordinator. The AHF National Process Evaluation Survey (February 2001) was also available.

2. Using Common Sense (The data collection process)

All project files were thoroughly reviewed prior to conducting the interviews, starting with the application and quarterly reports. Preliminary contact was made with key informants to make introductions and begin planning when interviews would take place. After initial review of all documentation, a logic model and performance map were created to provide an overview of the project. These steps then guided the design and finalization of the interview questions.

A preliminary list of people to be interviewed was provided by the program counsellor–facilitator who offered names of those he had worked with the most, thus making them very familiar with the program. This list includes three agencies that operate drop-in groups. They were strategically located within the city in terms of areas frequented by street-involved youth. Partnering with these agencies also demonstrated strategic thinking, since the gay/lesbian youth program was experiencing low participant rates and partnering allowed the program to be brought to the street-involved youth. The AWAY (Aboriginal Ways to Accelerate Youth) drop-in service delivered by UNYA is where the counsellor–facilitator devoted part of his time as well.

Over the course of one week seven key informants were contacted, and one was not interviewed as she had only recently become involved with the project. In-person and telephone interviews were conducted with the counsellor–facilitator, other group facilitators with AWAY, the project coordinator, and people from the three partnering agencies. A questionnaire was delivered to these individuals soliciting their observations, feelings, and opinions as well as their knowledge of the issues facing the target group as it relates to the project’s purpose (Appendix 1). It was clear from interview responses that all had a clear understanding of what the project intended to do. Five key informant interviews were done in person.
and one by telephone. Interviews averaged approximately 35 to 45 minutes in length. In addition, three people associated with the project were asked the mandatory questions set out by the research team under the direction of the AHF’s board of directors. Interviews took place at the offices of each individual. The counsellor–facilitator made special efforts to provide directions and, in some cases, transportation to the interviews.

As part of the research process, those contacted or visited to secure background information and social indicator data include the offices of United Native Nations, Healing Our Spirit BC First Nations AIDS Society, BC Aboriginal AIDS Awareness Program of the BC Centre for Disease Control Society, Vancouver Native Health Society, Save the Children Canada, and websites for Statistics Canada, Indian and Northern Affairs Canada, Correctional Service of Canada, Health Canada, and the Canadian Centre for Justice Statistics.

Most of these sources did not have information directly related to Aboriginal gay/lesbian youth. In many instances, information targeted British Columbia’s Aboriginal population or, in some cases, the Canadian population. Some data were available on Aboriginal people living in Vancouver but not in relation to rates of physical and sexual abuse, children in care, incarceration, or suicide for gay/lesbian Aboriginal youth living in Vancouver. However, the information that does exist provides a helpful context for understanding this population.

2.1 Limitations

Research was limited in three specific areas: 1) lack of social indicator data related to the target group; 2) a small number of interviews conducted; and 3) very little participant evaluation/feedback information was available. Thus, the analysis relies heavily on the documents contained in the project file and the six interviews, three of which were with individuals directly involved with UNYA. Although the three agencies who partnered with UNYA have a mandate to serve Aboriginal youth, not all worked one-on-one with youth and so were unable to speak on changes in Aboriginal gay/lesbian youth.

As with the other case studies, no direct measurement of participants was conducted by the AHF or its employees and agents due to ethical concerns about the possibility of triggering further trauma without adequate support for the participant as well as to the limitations of the AHF’s liability insurance. Moreover, the project provided only limited participant evaluation data, and it is unclear whether the evaluation process outlined in the application for funding was carried out. The application stated, “Every four months, evaluation of the program and group facilitators will take place in the form of a written survey given to participants ... Staff other than the group facilitators will come into the group meeting place and collect the completed surveys to give to the Executive Director.” In addition, the project indicated in its application for funding that it would be accountable to the community in the following manner:

The success of the project will be measured by the numbers of participants who attend the weekly sessions. Serious attempts will be made on the part of group facilitators to draw in as many youth as possible to participate in this project. The group will run on a continuous intake, with an accounting of how many participants attend regularly, how many drop out, etc. If numbers drop too low, a concerted effort will be made to do more outreach in order to obtain more participants.

Access to these data (if they had been available) would have facilitated an initial assessment of client satisfaction, participation rates, dropout rates, reasons for dropping out, and, depending on the nature
of the survey questions, self-reports of progress, successes, and barriers to healing. In the absence of such information, any analysis of the impact of the project on participants must be viewed with caution.

3. Project Overview (Thinking Holistically)

“Two-spirited” is a term used by many Aboriginal people who self-identify as being gay, lesbian, bisexual, or transgendered. The term is felt by some to more accurately reflect cultural attitudes and traditional roles that were once commonly held in a wide number of Aboriginal cultures.

Two-Spirited people have a long history with most of Turtle Island’s Nations. Before first contact with Europeans, First Nations people across Turtle Island recognized the special people given the responsibility of carrying two spirits. Very often, we were the visionaries, healers, the medicine people. 2-Spirits were respected as vital parts of the societies of our ancestors.

When considering the concept of “two-spiritedness,” one must examine several factors as to how this concept may have existed prior to European contact. Some Aboriginal cultures, such as the Sioux, used a term called “winkte,” which meant “contrary.” This term was applied to two-spirited people because they lived contrary to the norms within that society but were still accepted. Some Mi’kmaq apply the term “puoin,” which is literally translated as meaning “person of power.” Again, some felt puoins were two-spirited people, and the reference to power applies to them as being gifted in terms of doing ceremonies. It may be useful to remember that Aboriginal cultures have been influenced by Christianity that taught its members to be against homosexuality. Assimilation over generations may have caused some loss of traditional knowledge about these roles. Also, sexual abuse can distort views on sexuality, especially when same-sex abuse occurs, thus creating mixed emotions toward gay/lesbian people.

The Two-Spirited Youth Program was funded from 1 July 1999 to 30 June 2000 with a contribution in the amount of $81,420. The focus of this study is for the same time period. The project served Aboriginal gay/lesbian youth through individual and group counselling, and it provided public education on residential school and gay/lesbian issues to various other target groups (social service providers, university students, and high schools). Its purpose was to better serve or meet the needs of Aboriginal gay/lesbian youth, to increase peer support, and, in the case of educational presentations, to address homophobia and related abuses (verbal, emotional, physical). Shortly after this case study began the project was informed that its funding would not be renewed.

The funding application asserted that many of the youths’ parents are residential school Survivors. It also went on to state that some of the youth are street-involved and that the intergenerational impacts of “societal attitudes of institutionalized racism and homophobia severely crush youth’s self-esteem to the point of disempowerment, leaving them so marginalised by society that they are vulnerable to harassment, abuse and violent attack.” The application described many gay/lesbian youth as feeling ostracized and rejected, being at risk for turning to alcohol and drug abuse, and becoming victims of sexual exploitation and suicide. Breaking the cycle of intergenerational abuse and providing alternatives, such as role modelling, and other preventative measures would expose these youth to positive and supportive environments free of homophobia and judgmental attitudes. The funding application stated that the project would hire two facilitators, plan a program (develop curriculum activities, design and produce a brochure, and contact and confirm all guest speakers), conduct outreach by liaising with agencies and communities, hold weekly groups, and hold two program evaluations where participants evaluate the program and facilitators.
Although the application sought two facilitators, only one staff member was hired to serve as both counsellor and facilitator. The counsellor–facilitator delivered approximately 40 presentations to frontline agencies, service providers, schools, universities, and Aboriginal organizations. The AHF national survey states that over 200 people participated in training, but it appears that references to the training component most likely refer to the education and awareness activity. The two key areas mentioned in the stated goals and activities for the project are awareness and counselling, but the extent of evaluation activities that were cited in the project proposal remains unclear.

The host agency for this project was UNYA located at 1640 East Hastings in Vancouver, British Columbia. It has been incorporated since August 1989 and has administered a wide range of programs and services with funding from various sources, such as the BC Ministry for Children and Families. These programs and services include:

- Aboriginal Safe House, self-referred short-term housing for street-involved youth aged 16 to 18;
- Aboriginal Ways to Accelerate Youth (AWAY), a pre-employment 5-month leadership and life skills training for youth aged 16 to 24;
- Native Youth Drop-in Centre for ages 15 to 24;
- Aries Project, an alternative schooling for Native youth ages 13 to 18;
- school support workers, a resource to Vancouver School Board staff to help youth stay in school and to prevent alcohol and drug abuse;
- a prevention/outreach team who work with youth and their families, community members, schools, community centres, and others;
- a Youth Agreement Support Worker for ages 16 to 18 under youth agreements with the BC Ministry for Children and Families and by referral only;
- Young Bears Alcohol & Drug Treatment Program, a five-bed 16-week alcohol and drug treatment program for those aged 13 to 18;
- Youth Drop-in Clinic, a confidential and free resource for youth aged 13 to 24 provided by ‘street nurses’; and
- FUNYA, team building and wellness for UNYA staff.

Three external agencies and one program by UNYA were more directly involved with the gay/lesbian youth program, such as providing space for drop-ins or group activities. These include the Broadway Youth Resource Centre, Boys R Us, Family Services of Greater Vancouver, and UNYA’s AWAY program. The AWAY program of UNYA was the drop-in group that the gay/lesbian youth program offered its services through. The national survey stated that approximately 70 individuals participated in a healing activity. In a follow-up call to the host agency, they explained that this figure comprised those attending both the AWAY groups and the individual counselling sessions. There were also two other drop-in clinics at the Broadway Youth Resource Centre and at Boys R Us where counselling and support were offered by the gay/lesbian youth program.

3.1 Participant Characteristics

The two major aspects of the program were the counselling and support services provided to youth and the education and awareness activities for social service providers, students, and educators. Participant recruitment was aimed at Aboriginal gay/lesbian youth who were either living at home and participating in the educational system or were street-involved. One source that was quoted in the review of the Vancouver Native Health Society’s Safe House Program noted an unexpected connection between street involvement and a sense of community:
Community, the need to belong to community, this often is a factor for street entrenchment, or street involvement. This is the community that the individual identifies with, and states they feel a part of, or belong to. Street-involved youth are those individuals who, for whatever reason, find themselves living on streets. Their personal needs, such as financial, housing, food, companionship, community and social needs are largely met through participation at a street level.

The national survey asked about specific participant characteristics that present challenges or difficulties for projects. The UNYA identified four areas that posed a severe challenge (affecting more than 80% of participants): 1) denial, fear, and grief; 2) family drug or alcohol addictions; 3) cultural self-hatred; and 4) internalized homophobia. Moderate challenges or difficulties (affecting between 40% to 80% of participants) included lack of Survivor involvement in the project and literacy and communication skills, poverty, and history of suicide attempts, abuse as a victim, and foster care.

The national survey also asked about the number of clients participating in healing activities who require greater attention because of special needs. The project reported that “five clients have been referred elsewhere, due to dual diagnosis, treatment programs, etcetera. But, in reality, I would say all clients suffer from some form of inability to open up in group and deal with severe trauma, i.e., sexual abuse, racism, sexism, et cetera.”

Participant recruitment included the drop-in service that the program initiated as well as being visible at two other drop-in groups offered by partnering agencies. The idea was to be visible enough that youth attending other groups could put a face to the program. This might later encourage them to access services at UNYA. The partnering agencies were a strategic decision in that the agencies had already been well established for a long period of time and their geographic locations were in close proximity to areas where street-involved youth frequented; namely, Boystown (Hornby/Drake), Broadway Youth Resource Centre (East Broadway/Fraser), and the area of East Hastings.

The counselling, group, and drop-in clinics had an open-door policy. In some cases, non-Aboriginal youth may have been provided counselling at some of the drop-in clinics. One of the agencies felt that it was dangerous to be offering counselling to people on the streets because there is no safety net to catch them if wounds become opened. This agency also wondered what kind of clinical supervision was being provided to the counsellor–facilitator. In another interview, this concern may have been answered when that agency stated that it provided clinical supervision to the counsellor–facilitator. Table 1 shows the participation rates recorded by the project and submitted in their quarterly reports.

<table>
<thead>
<tr>
<th>Activity</th>
<th>1st Quarter</th>
<th>2nd Quarter</th>
<th>3rd Quarter</th>
<th>4th Quarter</th>
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</thead>
<tbody>
<tr>
<td>Drop-in groups</td>
<td>5 youth @ Boys R Us</td>
<td>29 youth</td>
<td>31 youth</td>
<td>25 youth</td>
</tr>
<tr>
<td>Individual counselling</td>
<td>no data</td>
<td>6 youth</td>
<td>11 youth</td>
<td>16 youth</td>
</tr>
<tr>
<td>Community awareness</td>
<td>40 organizations and 100 faxes</td>
<td>177 people</td>
<td>144 people</td>
<td>137 people</td>
</tr>
<tr>
<td>Education</td>
<td>4 workshops</td>
<td>37 people</td>
<td>52 people</td>
<td>15 people</td>
</tr>
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</table>

Workshops and presentations were provided to a variety of organizations and agencies, including the Musqueam Band, Britannia, Toominos, and Templeton schools, Gab Youth Services, Parole Officers Trainees, Gay and Lesbian Youth Coalition, Vancouver Métis Association, Gay Men Service Providers.
Commission, and Broadway Youth Resource Centre. It was also reported that direct linkages were established with groups such as the Healing Our Spirit BC First Nations AIDS Society, Street Youth Services, Youth Access Centre, Native Health, The Centre, Family Services of Greater Vancouver, Nisha Children and Family Services Society, Unloading Zone, AIDS Vancouver, Downtown Eastside Youth Activities Society, Covenant House, Vancouver Aboriginal Friendship Centre, Susila Lelum Healing Centre, WATARI, Positive Women's Network, and Hey Way Noqu Healing Circle. In fact, project files list linkages with 31 agencies in addition to the partnering programs and four media outlets (radio, television, newspapers). It is clear that numerous workshops and presentations reached a large number of participants, but it is difficult to determine the effectiveness as there are few participant evaluations to rely on.

3.2 The Project Team

As stated, the project hired only one staff member who was both counsellor and group facilitator. The program was coordinated by UNYA's community developer who oversaw all aspects of program delivery. The project coordinator stated that there was no advisory committee in place due to difficulties in recruiting interested members. In place of this, the staff member relied on the executive director, the project coordinator, and other gay/lesbian staff at UNYA as well as discussing issues at staff meetings.

Training received by the project person included “Reclaiming Aboriginal Youth” workshop by Dr. Martin Brokenleg, a proposal writing workshop, “Life Space Crisis Intervention” (received certification), Enhancing Services for Transgendered People' workshop (St. Paul’s Hospital), and the “Female Condom” workshop (FUNYA). In addition, the project’s response to the national survey indicated other types of training received, which included basic training in learning about the history and impact of residential schools and advanced training in suicide intervention, crisis intervention, counselling skills, dealing with family violence, professional development training, chemical dependency, early psychosis of mental disorders, teen dating violence, and enhancing services to transgendered clients. The survey also indicated the types of training still needed were basic training in Aboriginal language/culture, advanced training in learning about history and impact of residential schools, and both basic and advanced training in CPR/first aid and programs related to family functioning (e.g., child development and parenting skills).

3.3 Regional Profile

According to Statistics Canada, the Aboriginal population in British Columbia was listed at 139,655 in the 1996 Census, and there were 93,835 registered under the Indian Act living both on and off reserve. In keeping with similar Aboriginal demographics across the country, almost half of British Columbia’s Aboriginal population (57,645) are under the age of 19. Adding the 20 to 24 age group, this figure rises to 69,595. The 1996 Census also cited 26,000 Métis persons in British Columbia. Some gay rights groups estimate that one in ten people could be gay/bisexual, which may suggest that a significant number of Aboriginal youth in British Columbia would qualify for support from the gay/lesbian youth program.

When using language as a basis of classification, British Columbia has ten major linguistic groups of First Nations. There are 193 bands, 33 tribal councils, and well over 200 umbrella political and social organizations. British Columbia has nearly 20 per cent of the total Aboriginal population in Canada, 32 per cent of the total number of bands, and 1,634 of 2,323 reserves. A fair number are remote, isolated communities found in the northern portion of British Columbia.
3.4 Local Profile

The target group for this project resided within the greater Vancouver or lower mainland area, which includes the metropolitan city of Vancouver and the Vancouver/Richmond area. Metropolitan Vancouver has an estimated population of 1,831,665 (1996 Census) of which there are 31,140 Aboriginal people. There are also a number of First Nations situated within a very short distance of Vancouver; for example, the Musqueam Band falls within the Vancouver/Richmond Health jurisdiction. Thus, the proximity of these communities may contribute to the number of Aboriginal people or youth who come into the city for various reasons or lengths of time. Milder weather during winter months attracts many people who are street involved. They would migrate to this area to escape harsher climates found in the prairies and elsewhere. Therefore, the Aboriginal population may fluctuate depending on the season. In terms of reach, greater Vancouver has a significant Aboriginal population.

A 1998 study estimates that the Vancouver/Richmond Aboriginal population is about 30,000 (plus or minus 6,699). This figure was produced through an approach known as mark-recapture methodology using multi-list studies. This means that several sources were used to estimate a more accurate figure, but there is room for error in either direction. The study goes on to say that many Aboriginal service providers believe this figure to be a conservative one. The report cites Aboriginal leaders and service providers estimating the Aboriginal population to be “up to 60,000 Aboriginal people live in the lower mainland or Greater Vancouver area.” An area where UNYA is located is also home to a significant percentage of the Aboriginal population.” More than half the Aboriginal population resides in Vancouver East including CHA2 [Community Health Area] and CHA3 as well as a corner of CHA5.”

What we have provided so far is only a sense of the Aboriginal population, a glimpse of some participant characteristics, and what the project intended to accomplish. It is difficult to estimate the size of the Aboriginal gay/lesbian population. Likewise, the number of street-involved persons both fluctuates and is difficult to measure because street-involved people are often moving targets or migratory. The program cited two startling figures in its year-end report: “40% of the street youth population in Vancouver has self-identified themselves as gay, lesbian, bisexual, transgendered or questioning youth ... 40% of the total street population were Aboriginal.” This may offer some insight into the potential client base of the target group for the gay/lesbian youth program.

The Ontario First Nations AIDS and Healthy Lifestyles Survey may show why so many gay/lesbian youth end up on the streets or leave their home community or family. “The majority of respondents felt that homosexuality was wrong, and perceived their family and community to support this view.” This study was based on 800 completed surveys of the on-reserve population in Ontario, and it ensured adequate representation from the north, central, and south regions based on percentages of the population size for each area. Four questions were asked seeking individual views on homosexuality and also what they felt were the views of their family and community. Each of the four response areas showed that approximately 80 per cent of the responses held negative views toward homosexuality.

Many people who identify as two-spirited, gay, lesbian, or bisexual migrate to larger cities where there is greater anonymity as well as a gay community. This does not imply that homophobia or other negative feelings and attitudes toward gay/lesbian people do not exist in a city. In fact, gay bashing does occur and street-involved people, gay/lesbian or not, also find themselves as victims of assault. These key aspects will
be explored throughout this study as it relates to the needs and services provided through the gay/lesbian youth program.

3.5 Thinking Logically: Activities and Outcomes

In order to guide the community in measuring change, this section links the short- and long-term goals of the project with how change will be measured. There is a logical link between the day-to-day activities a project undertakes, what they hope to achieve in the short term, and the desired long-term outcome. In this case, the program wanted to provide support through individual and group counselling to gay/lesbian youth, which included creating awareness of and healing from the intergenerational effects of residential schools. Education on both residential school and gay/lesbian issues was delivered to social service providers, schools, universities, and other community agencies.

The relationship between project activities and short- and long-term outcomes is set out in the logic model (Figure 1). The following performance map (Figure 2) provides a summary of project activities, outputs, outcomes, and information required to measure progress over the short and long term. Despite the limitations noted earlier, the remainder of this study uses the information available to discuss the project’s impacts, successes, and challenges to the extent possible.
## Figure 1) Logic Model—Two-Spirited Youth Program

<table>
<thead>
<tr>
<th>Activity</th>
<th>How we did it</th>
<th>What we did</th>
<th>What we wanted</th>
<th>Why we are doing this</th>
<th>How we know things changed (long term)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular group meetings for gay/lesbian Aboriginal youth.</td>
<td>Monday evening drop-in; Tuesday evening group for sexually exploited gay/lesbian youth; and Friday morning AWAY group</td>
<td># of groups and sessions; and # of participants.</td>
<td>Peer support to enhance healing around issues of sexual abuse, low self-esteem, depression, and homophobia.</td>
<td>Gay/lesbian youth are off the streets and engaged in healthier lifestyles, free of abuse, depression, and suicide.</td>
<td>Reduced rates of suicide, attempted suicide, and gay/lesbian youth living on the streets and engaged in abusive behaviours (alcohol and drug abuse, sexual exploitation).</td>
</tr>
<tr>
<td>Individual counselling.</td>
<td>Individual counselling aimed at healing present-day crises and intergenerational impacts of residential school abuse.</td>
<td># of individuals involved in counselling and # of sessions.</td>
<td>Healing around issues of sexual abuse, low self-esteem, depression, coping with sexuality, and homophobia in schools.</td>
<td>How we know things changed (short term)</td>
<td></td>
</tr>
<tr>
<td>Community awareness of programs.</td>
<td>Establish contact with youth agencies (mainstream, Aboriginal, and gay-specific); distribute information about program; and direct street outreach.</td>
<td># of new and ongoing contacts; nature of contacts; # of brochures distributed; and # of media reports.</td>
<td>Increased awareness of programs for and among Aboriginal gay/lesbian youth and among front-line workers, agencies, and community at large.</td>
<td>How we know things changed (short term)</td>
<td></td>
</tr>
<tr>
<td>Education on gay/lesbian people and residential school impacts.</td>
<td>Workshops and public education aimed at increasing understanding about gay/lesbian youth and residential school legacy.</td>
<td># of workshops, participants, and, media reports.</td>
<td>Increased awareness among front-line workers, agencies, community, and gay/lesbian youth on residential schools and gay/lesbian issues.</td>
<td>Why we are doing this</td>
<td></td>
</tr>
</tbody>
</table>
**Figure 2) Performance Map—Two-Spirited Youth Program**

**MISSION:** Gay, lesbian, bisexual, and transgendered Aboriginal youth are free of the abuses that have been damaging their lives—they are travelling down the long road to recovery and gaining realistic hope for a healthier lifestyle for the future.

<table>
<thead>
<tr>
<th>HOW?</th>
<th>WHO?</th>
<th>WHAT do we want?</th>
<th>WHY?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td>Provide peer support/healing through regular group meetings and individual counselling; establish contact with youth agencies and other social service providers, the media, youth on the streets, and the community at large regarding issues of residential school abuse, intergenerational impacts, and gay/lesbian youth (including the availability of programs to serve them).</td>
<td>Gay/lesbian youth and agencies, community, etc.</td>
<td>Increased healing to reduce incidences of suicide, depression, substance abuse, sexual exploitation, and youth living on the street; enhanced self-esteem and ability to cope with sexuality and homophobia; increased peer support to enhance healing; and increased awareness of the intergenerational impacts of residential school abuse and gay/lesbian youth issues to reduce homophobia and to increase community understanding and support.</td>
<td>Gay/lesbian youth are off the streets and engaged in healthier lifestyles free of abuse, depression, suicide, and sexual exploitation.</td>
</tr>
</tbody>
</table>

**How will we know we made a difference? What changes will we see? How much change occurred?**

<table>
<thead>
<tr>
<th>Resources</th>
<th>Reach</th>
<th>Short-term Measures</th>
<th>Long-term Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$81,420</td>
<td># of participants from gay/lesbian youth community; and community at large.</td>
<td>Level of participation in individual and group counselling/healing; evidence of peer support and healing (individual and group feedback, perceptions of key informants); social indicator analysis (rates of suicide, attempted suicide, sexual abuse, substance abuse); #s of gay/lesbian youth living on the street; evidence that media and other agencies understand the intergenerational impacts of the residential school system; extent to which the Legacy is acknowledged and openly discussed in counselling and group work; and level of homophobia in schools and agencies.</td>
<td>Reduced rates of suicide and attempted suicide; and reduced numbers of gay/lesbian youth living on the streets and engaged in abusive behaviours (alcohol and drug abuse, sexual exploitation).</td>
</tr>
</tbody>
</table>

4. **Our Hopes For Change**

Over the long term, measures of change in the target group would include data showing reductions in rates of suicide and attempted suicide and in the number of gay/lesbian youth living on the streets and engaged in abusive behaviours (alcohol and drug abuse, sexual exploitation). In this regard, an attempt was made to collect social indicator data to provide a baseline to measure change, including the indicators identified by the AHF’s board of directors (physical abuse, sexual abuse, incarceration, children in care, and suicide). However, as earlier noted, such information is extremely difficult to obtain, especially for a mobile, urban population such as gay/lesbian Aboriginal youth. The following discussion provides an overview of this population's social situation based on available data, studies, and reports.
Aboriginal gay/lesbian youth living in greater Vancouver face a number of challenges and risks. Vancouver has had its share of notoriety, more specifically on the downtown east side (DTES), which include injection drug use, poverty, the sex trade, and the spread of life-threatening infectious diseases such as human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) and hepatitis C. As mentioned earlier, more than half the Aboriginal population of Vancouver live in DTES as well as access services in this area. The Vancouver Native Health Society's annual report for 2000 stated, “The clinic saw 4204 patients in 2000. Caucasians accounted for 50% of the clinic’s caseload while Aboriginals were 40%.”

Injection drug use is a particular problem in DTES. While this does not suggest gay/lesbian youth are overrepresented in this group, it does mean that those who use injection drugs become involved in a vicious cycle of trying to feed the habit and doing whatever it takes to survive, literally. Many needle exchanges across the country are showing an overrepresentation of Aboriginal clients. Reports from the Laboratory Centre for Disease Control state that HIV/AIDS is particularly affecting two key groups: Aboriginal people and men who have sex with men. Although other groups are also showing increases in HIV infection rates, Aboriginal people who are testing positive for HIV show that injection drug use (specifically sharing unclean needles), being a partner to an injection drug user, or having unprotected sex are key modes of transmission. Thus, the chances of HIV/AIDS and/or hepatitis becoming health threats to Aboriginal gay/lesbian youth could be significant. There is a lot of documentation on the presence of injection drug use within DTES and elsewhere. The Vancouver Native Health Society cited 41 per cent among the new referrals to drug- and alcohol-related services are Aboriginal clients. The Vancouver/Richmond Health Board states, “there is greatest concern about substance abuse by youth (first) and women (second).”

People who become street involved do so for many reasons. A relevant factor for Aboriginal gay/lesbian youth could very well be a family disowning their child because of their sexual orientation. The 1993 study by Ted Myers and colleagues showed that approximately 80 per cent of respondents (First Nations on reserve in Ontario) had a negative attitude towards homosexuality. This is an issue especially for those considered to be transgendered. Many people, parents included, do not understand the biological and emotional challenges that face this population. Some may consider them gay or cross-dressers or think it is simply a matter of choice because they wear what may be seen to be “opposite sex” clothing. However, transgendered individuals consider it a gender issue, with one sex being trapped in the wrong body. Although no data were available to describe the challenges faced by a transgendered person, try imagining what it would be like. How would you react or respond if your child said he/she was a gender other than the one assigned to him/her at birth? Add the emotional turmoil and confusion that may occur when the transgendered person begins the sex change process. Case in point, when someone is deemed eligible to undergo a sex change operation, it is usually at the end of a long process involving counselling, medications, wearing clothes associated with the gender being biologically pursued, and use of public washrooms for that gender. Without some form of professional support, the average person or parent would have difficulty comprehending what this would be like.

Suicide also becomes a reality for too many Aboriginal gay/lesbian youth, and it is a serious threat for both these at-risk groups: Aboriginal and gay/lesbian people. Becoming street involved also factors in those, especially youth, who were ill-prepared for the move from a small or rural community to one of the larger cities. As stated earlier, the population of greater Vancouver fluctuates depending on the season, and it has a highly mobile street population. Without money, a place to go, or someone to turn to, living
and/or working the streets can easily mean the difference between surviving or being swallowed up by an unfriendly environment.

Affordable housing and employability can also influence whether a person can settle in to what some call the “norm”; that is, to find decent work to support yourself so you can have a roof over your head, food on the table, and the ability to pay your bills. The Vancouver/Richmond Health Board cites, “In 1996, there were almost twice as many Aboriginal youth aged 15 – 24 years unemployed compared to the general population (28% versus 15%).” Some poverty advocates, however, support the assertion that there are some people on the streets who do so by choice. That is to say, some people abandon the pressures to conform to society and choose to live on the streets, migrating from city to city, province to province, and never really establishing roots in any one place. Whatever the reasons, many find themselves facing very real threats to life and personal safety.

Through this project, UNYA sought to expand its role to include a unique target group. The specific focus to include Aboriginal gay/lesbian youth may suggest there was an awareness of issues being faced by this population that were not being met. One project person describes the challenges: “The frustration of dealing with chemically dependant people, seeing hopelessness in young people’s eyes, and hearing fourteen to sixteen year olds saying they won’t be alive by twenty-five.”

Efforts were made to secure social indicator data reflecting the situation of Vancouver’s gay/lesbian Aboriginal youth. Useful information was gleaned from reports and studies prepared by Aboriginal and mainstream social service agencies that only deal with the city’s Aboriginal people or Aboriginal youth and not gay/lesbian Aboriginal youth. It is reasonable to suggest that the Aboriginal people living in Vancouver, especially those who are street involved, have experienced higher than average rates of physical and sexual abuse and incarceration and are among those at risk of suicide. We can also conclude that gay/lesbian youth are vulnerable, especially if they are also street involved. However, the available data cannot be used to suggest a relationship between past experiences of abuse, current and future risks, and the impact of the Two-Spirited Youth Program.

4.1 Suicide

The Vancouver/Richmond Health Board states, “over half the external causes of death among Status Indians were the result of accidental poisoning within the 25–44 age group. The second leading cause of external deaths was suicide within the same age group: three out of five were male.” The Vancouver Native Health Society estimates that of the youth who participated in their Youth Safe House Program, 20 per cent had mental health issues.

Statistics consistently show that suicide is extremely high among Aboriginal people and that Aboriginal youth make up a vast majority of these statistics. This issue is compounded when the Aboriginal youth in question are gay/lesbian. Some studies show that gay men, lesbians, and people who have experienced child sexual abuse may be at higher risk of suicide. Those that identify as gay/lesbian who may be questioning their sexuality or are struggling with transgender issues face high risks of suicide or attempts. In essence, these issues become a double-loaded barrel. The Vancouver/Richmond Health Board engaged many community members, leaders, managers, and service providers in a 12-month review on the issue of severe mental illness, which cites:
If psychotic conditions occur at rates similar to the general population, then the 1-1.5% of Aboriginal admissions to Riverview [hospital] suggests about one-third of Aboriginal people requiring care actually receive care. Though studies show mood disorders are less common as an admitting diagnosis, depression is very common among Aboriginal people. The fact that suicide rates are considerably higher suggests that mis-diagnosis and under-treatment may be a problem. 

This review also indicated the seriousness of suicide facing Aboriginal people living in Vancouver: “suicide rates among Status Indians are twice that of the remainder of the population (3.7 vs 1.4 per 10,000 Standard Population).” Three of six key informants felt that the areas the project was addressing could have a lot of affect or impact on the issue of suicide, two felt it could have some, and one said a little.

4.2 Incarceration

UNYA’s annual report for fiscal year 1999–2000 stated, “The incarceration rate of Aboriginal youth is 11 times the provincial, and 5 times the national rate than for non-Aboriginal youth.” There were no data available on incarceration rates for Vancouver’s Aboriginal youth nor any related to gay/lesbian Aboriginal youth.

A study by Carol La Prairie on Aboriginal people living on the streets of Edmonton, Regina, Toronto, and Montreal involved with street-level agencies provides some insights that may be applicable to Vancouver. La Prairie reports on the high levels of incarceration among the study sample:

In terms of detention, fully 63% of the total sample reported spending time in some form of custody, including juvenile, pre-trial, provincial or federal detention (comprising 78% of the males and 43% of the females in the sample). Of the total detentions served, 21% were for juvenile detention, 38% for pre-trial, 35% for provincial, and 7% for federal detentions ... It was surprising that 39% of those who had been in detention had their first custody experience at 15 years or less.

La Prairie also noted that recent research points to urban areas where the majority of Aboriginal inmates committed crimes. While this research does not apply to either gay/lesbian youth or Aboriginal people in Vancouver, it does suggest that incarceration rates for inner-city Aboriginal youth are probably high. In addition, it identified four variables related to the number of juvenile charges in the sample: being male, child abuse, violence on reserve/home community, and child sexual abuse. For Aboriginal youth who become involved in the sex trade, they face societal intolerance, threats of safety, and increased chances of becoming involved with the police and justice system.

4.3 Sexual Abuse

The issue of sexual abuse remains a disturbing and serious one for both mainstream and Aboriginal children. According to the Canadian Incidence Study of Reported Child Abuse and Neglect, “In 1998, there were an estimated 21.52 investigations of child maltreatment per 1,000 children in Canada. Forty-five percent were substantiated, 22% remained suspected, and 33% were found to be unsubstantiated ... [10 per cent of these investigations related specifically to sexual abuse.] Thirty-eight per cent of these cases were substantiated.” The Province of British Columbia co-funded this study in order to have a larger sampling of their population. Prior reports cited that “there are few national statistics on child sexual abuse in Canada.” One report stated, “In British Columbia, more than 500 complaints of sexual abuse
were received in March 1992 ... 53 percent of women and 31 percent of men were sexually abused when they were children.\textsuperscript{26} When discussing the issue of child sexual abuse, it is important to understand the different reasons a case may be deemed unsubstantiated; for example, there may be a lack of evidence, a child may be deemed emotionally or psychologically unable to withstand the court system, or a child recants his/her claim, usually because of fear.

The issue, as it relates to Aboriginal people, is just as serious. One project managed by the Vancouver Native Health Society showed that “66 % of these [clients] reported being physically, mentally, emotionally, or sexually abused.”\textsuperscript{27} The percentage of those who have a history of sexual abuse is unclear, but this demonstrates that over half the group came from backgrounds with significant mental health issues.

One form of sexual abuse as it relates to youth is that of sexual exploitation. The Vancouver Native Health Society, operating a Youth Safe House Program, with intakes ranging from ages 12 to 16, stated that “Twenty-six (26) of the 53 youths that accessed the safe house were known to have been sexually exploited.”\textsuperscript{28} Another study by Save the Children Canada defines commercial sexual exploitation as, “the exchange of sex for food, shelter, drugs/alcohol, money and/or approval.”\textsuperscript{29} It also states that “up to 80 percent of youth who are commercially sexually-exploited in Canada report having been sexually abused.”\textsuperscript{30}

Data collected from across the country acknowledges the relationship between a history of sexual abuse and sexual exploitation. The following profile of commercially sexually exploited Aboriginal youth was presented:

- Low self-esteem.
- Average age of entry is 14 years.
- A history of poor school attendance, often has not completed grade 9.
- Has had experience of early sexual activity, often as sexual abuse.
- Has been physically, sexually and/or emotionally abused.
- Has run away from unstable/fragmented homes and/or care institutions.
- Has few, if any, traditional job opportunities.
- Little or no access to networks of family or services.
- Homeless and/or nomadic.
- Commonly passes through the stages of involvement in the sex trade, from 1) drift: the process of drift from abuse and/or casual sex to the first act of prostitution, 2) transition: alternating between soliciting and a more conventional life to 3) professional: associating entirely with others in the sex trade, where they are accepted for who and what they are.\textsuperscript{31}

A study in 1990 by the Helping Spirit Lodge Society stated that “physical (84% of [215] respondents) and sexual abuse (75%) as the main features of family violence.”\textsuperscript{32} It is unclear whether respondents were speaking of first-hand experience or sharing observations of people they knew. For those interviewed in this case study, three of six informants felt that the areas addressed through the program could have either a lot or some effect or impact on the issue of sexual abuse. However, it is difficult to gauge how well the project would impact on this area.

4.4 Physical Abuse

The family violence literature supports a relationship between alcohol abuse and elevated rates of violence,\textsuperscript{33} although it is well recognized that this relationship is not directly causal but complex, multi-faceted, and not well understood. The 1990 study by the Helping Spirit Lodge Society showed that the majority
of respondents reported physical abuse as one of two main features in family violence. The Aboriginal Health and Service Review reported opinions of 40 individuals on their health concerns over a 17-month period: “Everyone voiced some concern about this issue as it contributes to domestic violence and child apprehension.”34 “The histories of street-involved youth are chronicles of separation and loss. Any one street-involved youth may have experienced separation from family, frequent moves, abuse, many schools, school failure, learning difficulties and social rejection.”35 Street life in the inner city can be characterized as a violent way of life being a normal behaviour for many. The issue of physical abuse can apply to gay/lesbian youth who may experience physical abuse from family or peers because they are different. The issue of disownment is a very real and present reality for too many gay/lesbian youth.

For this case study, three of six key respondents felt that the project could have a lot of affect or impact on the issue of physical abuse, two felt it could have some, and one said it would have a little. One of these respondents qualified their response by saying, “in theory.”

4.5 Children in Care

There are significant factors, including poverty and addictions, which can directly relate to why children may be placed in care. This program was not intended to directly intervene in regards to this issue; however, the counsellor–facilitator provided examples of where youth had reunited with their family. The program also had opportunity to deal with street-involved youth, some of whom may have been homeless or perhaps staying at a safe house or other temporary shelter.

According to the Vancouver/Richmond Health Board, “In March 1999, about half (48%;638 out of 1,329) of Vancouver children in-care were Aboriginal and in Richmond 13%. This monthly rate varies in Vancouver, where a monthly high may be 60%.”36 These numbers underscore the seriousness behind the difficulties being faced by Aboriginal families in the greater Vancouver region. The Vancouver Native Health Society also referred to the high levels of Aboriginal children in care: “at least 90% of the foster children registered with ICFPP [Inner City Foster Parents Project] are aboriginal ... Within the inner city and downtown eastside corridors of Vancouver, it has been identified by MCF [Ministry of Children and Families] that there are approximately 500 children in care.”37

Three of six respondents felt that the gay/lesbian youth program would have some affect or impact on the issue of children in care, two felt it would have a lot, and one was unsure. When further asked if they were aware of examples of how residential school Survivors, their families, and communities benefited from the gay/lesbian youth program, one respondent cited four cases in the last year where clients (youth) were reunited with their families, and another stated, “[a] few youth have returned to their families and communities in what should be a healthy way, not just to fight.”

5. Reporting Results

5.1 Influencing Individuals

As a target group, the gay/lesbian youth population is varied in that some may still be in school while others are street involved; some are open about their sexual orientation while others may be hiding or questioning this aspect of their life. The issues facing a youth who is either a transgendered individual or
a candidate for the medical procedure would likely be unique, and perhaps other gay/lesbian youth may not fully comprehend them.

Peer support and healing was the purpose behind both the weekly group and individual counselling sessions being offered. A small number (4) of counsellor evaluation forms were completed as well as two participant evaluation forms. In summary, the counsellor was felt to be “non-judgmental,” “genuine,” “very well informed,” “very caring,” and “easy to get along with.” Most offered the highest score, with one participant giving a 7 and another an 8 (1 low, 10 high). Unfortunately, nothing in the feedback forms offered insight as to how participants were changing their perspectives, knowledge levels, or behaviours. It is also not possible to assess progress in the area of peer support. One key informant provided a small glimpse of how participants may be responding: “when we talk about these issues and something clicks for them [the youth] ... their whole demeanor changes. They come out saying things like, ‘There’s nothing wrong with me!’” Table 2 indicates key informants’ observations when asked about the changes they saw in gay/lesbian youth participants.

Table 2) Observed Changes in Participants*

<table>
<thead>
<tr>
<th>Noted Changes</th>
<th>A lot</th>
<th>Some</th>
<th>A little</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>More self-esteem</td>
<td>–</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Making personal changes</td>
<td>–</td>
<td>5</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Offering/accepting peer support</td>
<td>1</td>
<td>3</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Facing homophobia</td>
<td>4</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Dealing with their sexuality</td>
<td>3</td>
<td>2</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>Understanding residential school legacy</td>
<td>1</td>
<td>2</td>
<td>–</td>
<td>3</td>
</tr>
<tr>
<td>Dealing with depression</td>
<td>4</td>
<td>–</td>
<td>–</td>
<td>2</td>
</tr>
<tr>
<td>Facing alcohol and/or drug usage</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

* n=6

A majority of informants felt that there was a lot or some change among gay/lesbian youth. Facing homophobia, dealing with sexuality, and making personal changes were areas where five of six respondents noted either a lot or some change. In the national survey, the project identified internalized homophobia among project participants as a severe challenge (along with denial, fear, grief, family drug or alcohol addictions, and cultural self-hatred). This would suggest that in helping youth face homophobia and deal with their sexuality they are meeting an important need.

Only one respondent felt that the youth had gained a lot of understanding around the Legacy and two felt that there was some understanding. Four respondents felt that opportunities for residential school Survivors and families to address residential school issues were improved. Likewise, five respondents felt that gay/lesbian youth had better opportunities to discuss residential school issues. However, the program may not have had the desired benefit of creating understanding among youth, or youth may have only talked about these issues with the counsellor and not with their family.

The responses indicate no clear movement in terms of gay/lesbian youth facing alcohol and/or drug use. Two informants felt that there was a lot of change, one felt there was some change, two felt there was a
little, and one was unsure. Some people working in the addictions field suggest that addiction rates are higher among the gay population than with the general population. In knowing about addiction rates among some segments of the Aboriginal population, it may be fair to say that Aboriginal gay/lesbian youth have been dealt a double blow in regards to the potential for addictive behaviours around alcohol and drugs. In fact, reducing the number of incidences for substance abuse was identified as one of the project’s desired short-term outcomes, and a key informant spoke about the frustration of dealing with “chemically dependent people.” The following lists responses from informants regarding what they had learned from their involvement with the project:

- “We really are one people, no different. Very spiritual, once past the facade, the anger, betrayal, being dismissed, we allow them to be first-class citizens and see they are really amazing young men.”
- “Need for support and acknowledgment from social services and government.”
- “Need to create awareness. That the need and thirst is there, but perhaps not with the leadership.”

This suggests not only was there an education and awareness process taking place among the key informants themselves, but also further support and awareness were required. All of those interviewed had a clear understanding of the project:

- “Connecting with two-spirited youth, offering support and connection to other services.”
- “build self-esteem and community.”
- “Awareness and education.”
- “Educate Native and non-Native people about two-spirit traditional roles.”
- “Bridge the gap between two-spirited youth and our Native communities.”
- “Two-fold: being there for two-spirited youth via counselling and educate others (Native, gay, social service providers).”

Unfortunately, data do not allow for conclusions to be reached regarding the extent these objectives were reached.

In the national survey response, the program indicated that the healing component is measured by informal observations (not written or recorded), formal observations (written and recorded), evaluations, solicited feedback (asked for the opinions of others and recorded), and unsolicited feedback. In addition, the project’s funding application stated that it would evaluate the program every four months. The project was asked to provide participant evaluation material for this case study, but only six completed feedback forms were provided. There is difficulty in relying on the data collected due to the limited number of interviews and feedback. The case study process did not allow for participants to be directly interviewed, thereby creating a gap in available information to draw reasonable conclusions. The present information may indicate low attendance in group sessions or the project failed its own stated requirement of holding program evaluations every four months.

5.2 Influencing the Community

One of the project’s identified short-term outcomes was to increase awareness of gay/lesbian youth and the Legacy. In addition, there were efforts to increase awareness among gay/lesbian youth of other programs and services available to them while promoting an understanding of the Legacy. As reported earlier, numerous awareness-building workshops were delivered to schools, universities, and social service agencies. However, there appeared to be no specific activity targeting older members of the gay/lesbian community to secure role models or support that would help meet the needs of the youth.
An interesting discrepancy surfaced in the data: the three social service agencies interviewed felt that there was positive receptivity by the Aboriginal community to the gay/lesbian youth program, but the program itself disagreed with this. One service deliverer stated, “The potential is huge for this program but they haven’t reached that yet, I think. [It] benefits Bands on dealing with homophobia, it has been well-received by the Native community.” It appears that those more closely affiliated with the program found homophobia among the Aboriginal community to be a closed door. When asked what level of support community agencies had provided, two Aboriginal respondents gave a 2 to 2.5 rating (1 low, 5 high), and all the non-Aboriginal respondents gave a score between 4 and 5.

An example is given by the counsellor–facilitator that shows the intensity of at least one person’s opposition: “We had one pamphlet promoting the program on the bulletin board of the Native Centre; someone actually tore it down, marked it up with ‘you are turning all our youth gay,’ then mailed it to me. They actually took the time to mail it to me!” In response to how these challenges or obstacles were being dealt with, some people provided positive measures, such as “connecting with relevant agencies, doing their own outreach,” or “the best way is to be consistent, nonjudgmental, offering consistent care, and positive leadership.” One person spoke of the counsellor–facilitator as a positive asset and being gay/lesbian also. One responded with “putting it right in their face and not allowing them to sweep the issue under the rug.”

Without interviewing a wider audience, it is difficult to measure what impact or response was being felt among the target groups for education and awareness activities. Data are sparse from participant feedback, and only three social service agencies participated in this case study. Observations from the Aboriginal informants paint a different picture than what non-Aboriginal service providers felt. The three Aboriginal informants felt resistance from the Aboriginal community even around hearing about gay/lesbian issues as the biggest challenge. However, the counsellor–facilitator had developed direct linkages with at least nine Aboriginal organizations, and it appears the program had repeatedly tried to outreach to the Aboriginal community through faxes and other promotion. This suggests that efforts were being made and that the reported resistance was based on experience. In the mandatory questions asked to the three respondents affiliated with the program, there was an indication that the program wanted to hear people’s concerns so that, if necessary, the program could be modified. When asked about how well the project had been accountable, similar responses were given, including, “we’ve put out a lot but not a lot of feedback coming in. People don’t express why they aren’t utilizing the program. If they did, maybe we could respond.”

Based on the project’s quarterly reports, extensive awareness sessions were offered and a large number of individuals were reached: 40 organizations in the first quarter and 177, 144, and 137 people in the second, third, and fourth quarters, respectively. The counsellor–facilitator indicated that he was being asked back by two secondary schools and twice by the Musqueam Band. In terms of influencing the community, it is difficult to suggest any significant movement, except perhaps with non-Aboriginal service providers. Even with this target group, there may have only been minimal impact, as the three service providers interviewed stated that they had not changed anything in how they do their work as a result of the program.

The national survey showed that mostly gay males participated and that gay females who did participate felt satisfied: “Most First Nation people do not want to acknowledge two-spirited women, let alone changing the status and decision making power of the community.” By serving only a few lesbians, it can be said that the project had minimal influence for this group. The survey also identified a number of issues or challenges affecting the community. Under severe challenges it listed:
lack of acceptance of Aboriginal language and culture by local institutions (e.g., schools, hospitals);  
apathy or lack of active Aboriginal community support;  
local community opposition (fear, denial);  
poor local economic conditions (e.g., high unemployment, poor housing conditions);  
substance abuse;  
family violence;  
sexual abuse; and  
lack of transportation (local bus, vehicles, etc.).

Moderate challenges were identified as adult literacy, lack of community resources, suicide or attempted suicides, and fetal alcohol syndrome/fetal alcohol effects (FAS/FAE). This reaffirms the contention that the program had targeted a high-needs community but, again, there is not enough information to assess its success on impacting the primary target group (gay/lesbian Aboriginal youth) or the secondary target group (Aboriginal and non-Aboriginal agencies and institutions).

5.3 Partnerships and Sustainability

As noted earlier, the program reported linkages and partnerships with many organizations, including Aboriginal and mainstream health and social service providers, schools, gay and lesbian groups, and First Nations organizations. They delivered public education and awareness workshops and presentations and reached a significant number of Aboriginal and non-Aboriginal individuals. Although there are no data to assess the impact of these activities, almost all of those interviewed reiterated the need for this type of program. One respondent stated that since most services were quite generalized, the potential seemed realistic for this program to have a lasting impact. However, it is unrealistic to expect it to have that sort of impact or benefit in just one year.

Using a scale of 1 to 5 (1 low, 5 high), a clear majority of key informants felt that the program was both filling a gap and enhancing services. Average scores were 4.5 and 4.8, respectfully. Four respondents said that agencies who had partnered with the program are more aware of the Legacy. When asked how well partnering agencies can now deal with residential school issues differently, three respondents said that things had improved. One response referred to the complexity of the issues and to whether the agencies had a full comprehension of the Legacy. Another respondent said that it still needed a lot of work, and another was hopeful that partnerships would “allow the left hand to know what the right hand was doing.” Still, another response was, “[agencies] now have another resource available, and the two-spirited youth program can be called in to team meetings.” Such comments reaffirm that the project was meeting a service need. However, when informants were asked what changes they had made in how they do their work as a result of the program, two of three agencies said that they made no changes. The remaining comments were related to achieving increased awareness:

- “Their eyes had been opened.”
- “More open about two-spirit issues in the public school system.”
- “I talk more openly about two-spirit issues.”

Although some people may have made changes in how they view or speak on issues facing the two-spirit community, it may be fair to say that the agencies made no changes but had benefited somewhat by having a person who was knowledgeable about both residential school issues as well as those issues affecting gay/lesbian youth. However, individuals who spoke of becoming more vocal were the Aboriginal informants.
There were also numerous references to homophobia in the project files and in the interviews. In fact, this was the reason why the program pulled out of networking with other AHF-funded projects in the city. The counsellor–facilitator’s response when asked about how he saw other AHF-funded projects related to the gay/lesbian youth program was:

I don’t. This is a totally unique program. I have no support from the other ones. At the AHF Networking meeting last November, I pulled out. Even healers don’t want to talk about it [two-Spirit issues]. I found this meeting to be very patronizing. I confronted the whole room and said, “Until I get support, I won’t come back.” I feel all alone out there.

While homophobia is clearly a very real barrier, the claim that there was no support from other AHF-funded projects remains unanswered at this stage, as these projects were not approached by the interviewer. The number of AHF-funded projects that exist in the same area do not appear to be duplicating the services of the program. Thus, it appears the project was filling a service gap by specifically targeting gay/lesbian Aboriginal youth and publicly advocating their issues. However, given the extent of homophobia, much more time would probably be required to achieve a sustainable impact. Based on the large number of partnerships and linkages established by the project and its education and awareness activities, there may have been an impact over the short term, but this is merely speculation in the absence of evaluative material.

The program operated with a single staff person without an advisory committee in place. This may have impacted the project’s sustainability as well as contributed to the isolation experienced by the counsellor–facilitator. The national survey did state there was a board of directors, but this refers to the one for UNYA. A small committee to oversee and guide the program may have eased the frustrations experienced by those interviewed and evident in their responses. In a follow-up communication with the community developer at UNYA, it was stated that efforts to form a committee were made but did not materialize due to low interest. It was also indicated that support was provided to the counsellor–facilitator by other gay/lesbian staff at UNYA, the executive director, and the community developer as well as at team meetings.

5.4 Reaching Those in Greatest Need

The national survey indicated that approximately 70 people had participated in a healing activity hosted by the project. The quarterly reports, on the other hand, show that attendance figures for the drop-in groups were around five youth. Individual counselling figures also show that the caseload rose to approximately 11 youth by the end of the fourth quarter. One key informant spoke about the lack of clients and said, “we need to ask what is it they [the youth] aren’t able to connect with the program on.” Perhaps low participation rates can be expected when trying to work with those termed “hard to reach.” One other possible factor was that the drop-in group at the Broadway Youth Resource Centre was situated in an area where there is a high number of Aboriginal housing units but was later moved to the UNYA location. The two organizations are in different areas of the city and would require access to transportation. To what extent this move affected attendance rates cannot be determined at this time without further investigation and interviewing of participants.

As mentioned, this is a high-needs target group and the issues being addressed could range from substance abuse to healing from sexual abuse to coping with one’s own sexuality in a homophobic society. One respondent said that the biggest challenge was, “reaching kids that don’t want to be reached.” The national
survey confirms that their client group had a significant number of needs. The survey also said that five high-needs clients had been referred elsewhere; thus, there is a contradiction as to whether the project is reaching those in greatest need.

5.5  Best Practices

Three things may be deemed to have worked well for this program: 1) the counsellor–facilitator was an Aboriginal gay/lesbian person, increasing the likelihood that clients could identify with; 2) the program linked with key service providers also serving the Aboriginal community and maintained a key presence through drop-ins, which may have allowed gay/lesbian youth to become familiar and comfortable with the counsellor–facilitator at their own pace, increasing chances that they may later approach UNYA for services; and 3) the program included services to transgendered youth who oftentimes find themselves with many barriers and stigmas that inhibit or prevent participation in more generalized programs.

In several of the responses during the interviews there was mention of the quality and dedication of the counsellor–facilitator. Some said that the program was the counsellor–facilitator and that he made the program what it was. Certainly, what became clear in the interviews was the dedication, though the counsellor–facilitator admitted he had not really worked with youth before.

5.6  Challenges

There was a sense that the frustrations of dealing with homophobia were becoming a challenge for the counsellor–facilitator. This frustration is understandable, especially when care goes into the work and the people served. It is here that an advisory committee would have benefited and eased the isolation and frustration that staff may have been feeling.

Staffing levels was found to be one of the weaknesses of this program. Given the high needs and nature of work surrounding the target group, the program may have done well to use foresight in estimating the difficulties one person would face. Almost all those interviewed repeatedly indicated the need to expand the program to have more than one staff. One respondent said, “with a second person, this program would really take off.” Another said, “I need to stress the amount of work to be done in the Aboriginal community in order for real healing to occur.” It seems that staffing levels was a key issue, and the counsellor–facilitator admitted, “I really feel I’m giving half efforts to very important things: education and counselling.” The funding application did seek to hire two facilitators. In a follow-up conversation with the community developer at UNYA, it was stated that the budget did not allow for a second facilitator despite securing $49,395 in salaries and benefits, representing almost two-thirds of the project budget.

5.7  Lessons Learned

What remains clear from the challenges the project faced was the issue of staffing. Perhaps this is why most informants interviewed had suggested that a second staff person might improve the project. It was also suggested that a female staff member would provide for gender balance. The counsellor–facilitator felt that he was doing a half-service to each area (counselling and awareness/education) and that awareness efforts could have been more strategically delivered by reducing the number of education and awareness activities. The counsellor–facilitator indicated a personal lesson learned by speaking of how he operated
at the beginning of the project and towards the end: "I’ve become more flexible. I never really worked with youth before, strictly speaking, and I was so available at the start. Now I have limits. I turn my cell off from 11 p.m. to 7 a.m. and the youth know that. I really live my job."

Two respondents mentioned how they speak more openly and frequently about gay/lesbian issues. Perhaps this is an indication of how they have gained more knowledge of how homophobia needs to be talked about if it is ever to be removed. Non-Aboriginal service providers who linked with this program expressed their support. One respondent said, “it’s taking giant steps in small ways.” Some agencies indicated that there were no substantial changes in how they did their work; however, they did indicate a benefit to their agency, and one informant said he learned more about gay/lesbian issues. The other side to this may be that there was no need to change how they did their work, if indeed they were both gay-positive and appropriately linked to the Aboriginal community.

6. Conclusion

UNYA has been serving the many and diverse needs of Aboriginal youth living in the greater Vancouver area since 1989. It would seem a natural progression that program experience would lead the organization to begin reaching a specific group such as those who are gay/lesbian. Aboriginal youth, gay/lesbian youth in particular, are undoubtedly a high-needs population. Specific issues facing street-involved people, such as HIV infection rates, hepatitis C, other health issues, and migratory patterns are especially high in a large urban centre such as Vancouver.

While it seems fairly clear that the project was addressing a service gap, there was no mention in the project files that a needs assessment was done. If one had been completed, some of the questions on how to improve participation rates in drop-in groups and individual counselling may have been answered. Nevertheless, the project took a positive step in attempting to reach this high-needs group. Perhaps the challenges were too great for just one staff person. In all fairness, it appears the counsellor–facilitator was spread too thin, and it is unclear how much of a difference a second facilitator would have made.

There is some indication that the program had an impact on increasing knowledge and awareness on both residential school and gay/lesbian issues through numerous workshops and presentations. Without participant evaluations, however, it is difficult to know what was learned from them. The venues for presentations (universities, schools, social service providers) suggest some strategic reasoning for giving them. Future professionals who might serve Aboriginal and/or Aboriginal gay/lesbian people and peers or students who attend school with gay/lesbian youth could have their eyes opened to the issues being experienced by the target group.

Further benefits can be seen in examples provided where four gay/lesbian youth reunited with their families and communities, as one person put it, “in a good way and not just to fight.” No dollar figure can be placed on the value for even one youth reconciled with his/her family. Moreover, the program was just beginning. Since “street-involved youth have experienced a series of losses: family, housing, innocence,” it seems another loss was dealt them when the gay/lesbian youth program ended at a time when the youth were beginning a process of building a relationship and reliance on this service. The group is called “hard to reach” for a reason and, as one informant pointed out, “the best way is consistency.”
Programming issues included no advisory committee, unclear data of what support the gay/lesbian youth program had from other programs at UNYA, and only one staff to serve a significant high-needs population. The absence of a systematic participant evaluation process combined with no needs assessment provides little concrete information to help support or guide the direction of the program. Also, not working with the Aboriginal gay/lesbian community seemed a weakness. There was an assertion that there were not enough positive role models for this group and that it was difficult to find gay/lesbian Elders. The need for gay/lesbian Elders is not a necessity provided the Elder could demonstrate compassion and empathy. Likewise, there are positive role models among the gay/lesbian population, some who are on the “red road” (in recovery or following traditional teachings), and they may have been a valuable resource and support to both clients and staff. Many are involved with the International Two-Spirit Gatherings that have been occurring for the last 13 years at various locations across North America. The location for the 2001 gathering was in British Columbia, a short distance outside of Vancouver, and was voluntarily coordinated by another person at UNYA. Clearly, there was opportunity to link with the Aboriginal two-spirit community.

7. Recommendations

- Given the nature of this work and the size of the population, efforts to secure two staff for this project would have minimized the isolation and frustration felt by the counsellor–facilitator. It is felt that the budget was sufficient to hire at least two positions: one full-time and one part-time. At the very least, other sources of funding could have been pursued to ensure meeting this requirement. A second aspect to this would have been the benefit of having gender balance to increase the opportunity for clients to bond with at least one staff member, especially if they had gender issues.

- An advisory committee could have been organized to help formally guide the counsellor–facilitator and the program.

- Greater efforts to find healthy, positive role models from the older Aboriginal gay/lesbian community would have been a logical place to start, especially since the program felt that the Aboriginal community was the most resistant. Drawing on the knowledge of Aboriginal gay/lesbian people who may have experienced many of the same issues as Aboriginal gay/lesbian youth would have allowed for greater opportunities to create a support base for the youth.

- The program had difficulties finding gay/lesbian Elders, yet involving healthy Elders who are compassionate to the needs of youth and who are not homophobic is felt to be all that was necessary.

- Partnering with appropriate Aboriginal agencies could have provided links into the Aboriginal community. The local Aboriginal AIDS organization based in North Vancouver has done a lot of work to gain support from leaders and health care workers in dealing with both HIV/AIDS and gay/lesbian people who are living with this disease. The case study author disagrees with statements from the project that this Aboriginal AIDS organization was not supportive because it was trying to distance itself from being classified as “gay.” Although interviews with this or other organizations would help determine what relationship did occur, there are several local people affiliated with the Aboriginal AIDS movement who would have done well as both a support and a linkage.

- Implementing the evaluation plan outlined in the proposal may have allowed for revising the work plan to place emphasis where it was needed most and/or where it would have been most effective.
Notes

1 While it was important to interview individuals with knowledge of the program, it is also recognized that relying on the project's counsellor–facilitator to provide the names of interviewees presents problems. In particular, it is unlikely that the names of individuals or organizations who might be critical of the program were offered. Such limitations may have been overcome if the researcher had lived in Vancouver or was able to spend more time in the city. The small number of personal interviews conducted for this study is a severe limitation and a threat to its reliability and validity.

2 Four counsellor evaluations and two participant evaluation forms were completed and provided for this study.


4 This number is based on the quarterly reports submitted by the project to the AHF.


6 This was in response to a question about their strongest contribution to the project.

7 It appears that the project did not have or use the AHF reporting template for the first quarter to collect statistics per activity/objective; therefore, the information under the first quarter did not include all participant figures. Interestingly, the project modified the AHF's statistics sheet used in the final three quarters to include the category “transgendered” for reporting the sex of participants (i.e., the categories used were male, female, transgendered, total).


9 Vancouver/Richmond Health Board (1999:9).


12 Vancouver Native Health Society (no date:2). *Vancouver Native Health Society 2000 Annual Report.* Vancouver, BC: VNHS.

13 Vancouver Native Health Society (n.d.:2).

14 Vancouver Richmond Health Board (1999:35).

15 Vancouver/Richmond Health Board (1999:37).

16 Vancouver/Richmond Health Board (1999:27).


19 Vancouver/Richmond Health Board (1999:33).


21 Urban Native Youth Association (n.d.: 5th page).

22 La Prairie, Carol (1995:35). *Seen But Not Heard: Native People in the Inner City,* Ottawa, ON: Ministry of Public Works and Government Services Canada. Study sample size: 621 Aboriginal people in four inner-city areas living on the streets identified by street-level organizations. The majority of people interviewed were between the ages of 24 to 44, and 60 per cent were male.


26 Health Canada (1997:2).

27 Vancouver Native Health Society (n.d.:26).

28 Vancouver Native Health Society (n.d.:33).


31 Krawczyk (2000:33).

32 Cited in Vancouver/Richmond Health Board (1999:24). Although the Helping Spirit Lodge Society study was cited, there was no further information on the methodology used. It was referenced in this context because it provided figures related to the social indicators of interest to this case study.

Vancouver Native Health Society (2001:18). It also reported that the substances being used most are cocaine, alcohol, and heroin, in that order.


Vancouver Native Health Society, (n.d.:34).

It may be useful to point out that the concept of two-spiritedness, including their traditional roles, will vary among Aboriginal cultures. This case study does not assume or dictate that there is any homogenous view among Aboriginal people on the role or concept of two-spirited people. Some First Nations, for example, believe that two-spirited people had held more respectful roles and were accepted within their societies, while others believe that they had been banished.

Appendix 1) Interview Questions

UNYA QUESTIONS:

1. On a scale of 1 to 5, (1 being low, 5 high) what level of support do you feel community agencies are giving to this project?
   
   1  2  3  4  5

2. On a scale of 1 to 5, (1 being low, 5 high) how well do you feel the Two-Spirited Youth Project is filling a gap?

   1  2  3  4  5

3. On a scale of 1 to 5, (1 being low, 5 high) how well do you feel the Two-Spirited Youth Project is enhancing services?

   1  2  3  4  5

4. In your view, what is the most important goal of the Two-Spirited youth project?

5. Please describe what role Residential School Survivors may have had with respect to the Two-Spirited youth project?

6. What do you perceive the benefits are, by having the Two-Spirited Youth project in this community?

7. What did you see as the biggest challenge or obstacle the project is facing?

8. Please describe, how this challenge or obstacle is being addressed?

9. In your view, how do you see other Aboriginal Healing Foundation projects relating to this project?

10. In your view, would you say the opportunities for Residential School Survivors and families to address Residential School issues are:

   better      the same      less      not sure

11. In your view, would you say the opportunities for Two-Spirited Youth to discuss Residential School issues are:

   better      the same      less      not sure

12. What is the strongest contribution you can make in helping the project reach it’s goals?

13. What do you like most about the project?

14. What do you like least?

15. What have you learned from your involvement with the Two-Spirited Youth project so far?

16. Is there anything you would suggest that might improve the project? Why?

17. How well do you feel the areas addressed through this project will have an affect or impact on the issue of:

   Physical Abuse :  a lot  some  a little  none  not sure
   Incarceration :   a lot  some  a little  none  not sure
   Suicide :         a lot  some  a little  none  not sure
   Sexual Abuse :    a lot  some  a little  none  not sure
   Children in care : a lot  some  a little  none  not sure
18. Are you aware of examples of how Residential School Survivors, their families and communities have benefitted from this project? If yes, please elaborate.

19. Do you feel agencies who have partnered with the Two-Spirited Youth project are more aware and informed on the legacy of Residential Schools?  
   yes  no  the same as before  not sure

20. In your opinion, how well do you feel partnered agencies can now deal with Residential School issues differently?

21. In the last 12 months, what changes have you seen with Two-Spirited Youth regarding:  
   More self-esteem  a lot  some  a little  none  not sure
   Making personal changes  a lot  some  a little  none  not sure
   Offering/accepting peer support  a lot  some  a little  none  not sure
   Facing homophobia  a lot  some  a little  none  not sure
   Dealing with their sexuality  a lot  some  a little  none  not sure
   Understanding residential school legacy  a lot  some  a little  none  not sure
   Dealing with depression  a lot  some  a little  none  not sure
   Facing alcohol and/or drug usage  a lot  some  a little  none  not sure

22. What changes, if any, have you made in how you do your work, as a result of your involvement with the Two-Spirited Youth project?

23. Would you have any final comments to share?

MANDATORY QUESTIONS:

A) How well is the project addressing the legacy of physical and sexual abuse in Residential Schools, including inter-generational impacts? Please choose only one response.

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<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the Legacy at all</td>
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Please offer an explanation why you feel this way:

B) What are the previously identified needs that the project is intended to address?

C) How would you rate the project’s ability to address or meet those needs?

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D) How well has the project been accountable (i.e. engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

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Please offer an explanation why you feel this way:

E) How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

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<td>Is not addressing the Legacy at all</td>
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Please offer an explanation why you feel this way:

F) Will the project be able to operate when funding from the Foundation ends?

G) How well is the project able to monitor and evaluate its activity? Please choose only one response.

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Please offer an explanation why you feel this way:
Odawa Native Friendship Centre
Project Number: 1291-ON
Case Study Report
When Justice Heals

Written by:
Karen Jacobs-Williams

Under the direction of:
Linda Archibald and Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2002
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Acknowledgements

I would like to honour all of the people who spoke passionately about their involvement in the When Justice Heals project and willingly gave of their time during the interview process. One participant thanked me for doing the interview and another said, “I felt good about the questions that were asked. There is a need to focus our thoughts on the future.” I also wanted to express my gratitude to my case study supervisor and to my colleagues for offering their unconditional encouragement and wisdom.
1. Introduction

The following report is one of a series of 13 case studies being conducted by the Aboriginal Healing Foundation (AHF) as part of the impact evaluation process. The case studies were selected to include representation from a variety of project types and other criteria. The criteria specific to this case study include all Aboriginal groups (Métis, Inuit, First Nation, and non-status), urban, east, incarcerated, healing circles, and professional training. The case studies are intended to provide a detailed, holistic view of the projects and their outcomes. For the most part, data collection, analysis, and synthesis were done by community support coordinators under the guidance of case study supervisors affiliated with Kishk Anaquot Health Research.

The project that forms the basis for this case study is entitled “When Justice Heals” (AHF-funded project 1291-ON) sponsored by the Odawa Native Friendship Centre. The primary purpose of the project is “to provide appropriate alternatives to the mainstream justice system for Aboriginal people in the Ottawa-Carleton Region referred to the Aboriginal Peoples Justice Circle (APJC) by the courts and to engage in a healing program and a Circle Sentencing process.”

Sources of information used in this case study include the application for funding, the contribution agreement, and quarterly reports found in the project files; the February 2001 AHF National Process Evaluation Survey completed by the project; key informant interviews with members of the Aboriginal Peoples Justice Circle and selected community service providers; and other pertinent documents and data collected by the community support manager as part of the case study process.

2. Methodology

All of the project files were thoroughly reviewed prior to conducting any interviews. Project files included the application for funding, the contribution agreement, quarterly reports, all correspondence, and the AHF national survey. A logic model and performance map were then created to use as guides for information gathering. Both guides were sent to the project prior to the development of the questionnaire to ensure that any change to the project goals and objectives would be included in the analysis of the documents.

A customized interview tool was designed based on the model and map, which also included seven mandatory questions. Key informants were then identified and initial contact was made by telephone to determine if the informants would be willing to participate in the case study process. Interviews were scheduled upon availability. It is important to note that the summer months are vacation months, and many messages and callbacks were attempted. Some informants were unavailable while others were never reached. All of the interviewees were employed in their regular day jobs and this necessitated booking some of the interviews in the evening. Sporadically, interviews were completed between 18 June 2002 and 1 August 2002.

A total of eight interviews were completed; four by telephone and four face-to-face interviews. All of the respondents live in Ottawa with the exception of one who now resides in British Columbia. After pilot testing the questionnaire, question #12 was shortened to a single question instead of asking for examples and percentages under each category (see Appendix 1). In the end, four interviews used the longer version of question #12 and the remaining four used the shorter, revised version. The interviews were between one and three hours in length.
There was an equal gender split among the key informants and all were chosen because of their involvement with the project and their availability, which included a project coordinator, two volunteer project coordinators (one of which was also a co-chair), a project sponsor, a circle keeper, and two agency representatives who were also co-chairs. It was unfortunate that the Crown attorney and the representative from the Ottawa police could not be reached for an interview due to the exigencies of time and/or unavailability.

Material collected from the project included the Sentencing and Healing Circles Guidelines, the Application Form for Sentencing and Healing Circles, a copy of an information letter to the community, a five-month report compiled by the project coordinator, and a document entitled *Needs Identified by the Aboriginal Peoples Justice Circle*. The evaluation tools for participants that were to be developed by the project did not materialize. Extensive Internet searches were conducted to secure information on the community and the indicator data needed for this case study. Other pertinent information such as articles, reports, and various publications were also gathered and included in the overall analysis.

### 2.1 Limitations

As with other case studies, no direct measurement of participants was conducted by AHF, its employees, or agents due to ethical concerns about the possibility of triggering further trauma without adequate support for the respondent as well as the limitations of AHF’s liability insurance. Moreover, it appears that the project did not collect any formal written feedback from participants. As a result, the analysis relied heavily on key informant observations of changes in participants as a result of their involvement with the project. These observations were supplemented by material from documents submitted to the AHF by the project.

Previous case studies have recommended that the ideal number of interviews is in the range of 12 to 14. As reported above, only eight interviews were conducted, in part, because respondents were difficult to track down over the busy summer period. However, the range of views expressed in the interviews suggests that respondents did not share a single perspective and that they felt comfortable expressing themselves. It is clear that dissenting opinions were captured in the eight completed interviews, although a larger number would have invariably added to the breadth and depth of the analysis.

Social indicator data were difficult to find for Aboriginal people in the Ottawa region. Initial research uncovered Aboriginal-specific sexual assault and assault statistics from the Ottawa Police Service, but a follow-up check could not duplicate or verify the data; therefore, these statistics were not used. It is possible that the researcher initially uncovered statistics reported by the Ottawa Police Service in Statistics Canada’s Uniform Crime Reporting Survey, but, again, this was not confirmed. Had more time been available, it would have been possible to meet with the police and Aboriginal service providers to at least obtain an estimate of rates of physical and sexual abuse among Ottawa’s Aboriginal residents.

### 3. Project Description

The When Justice Heals project was funded from 1 October 2000 to 30 September 2001 with a grant contribution in the amount of $71,165. This case study focused on the same time period, although some of the interviewees may have responded to the interview questions within the time they were associated
with the project. In other words, some respondents described their experiences prior to AHF funding as well as after AHF funding was discontinued. The contribution agreement and application for funding described the intent of the project, which was:

- to provide appropriate alternatives to the mainstream justice system for Aboriginal people in the Ottawa-Carleton Region [and] to work in partnership with the Crown’s office at the Ottawa Court House and with the Aboriginal services in the Ottawa-Carleton Region. Moreover, the project would: provide the opportunity for Aboriginal people to be referred to us by the courts and to engage in a healing program and a Circle Sentencing process [by] provid[ing] support for the offender and for the victim and offer Circles for both, separately, in an effort to resolve conflicts, help the offender face his [or her] behaviour and begin a journey of healing and reconciliation. The purpose in our work is to restore relationships where possible and to support strategies for healing for the offender. Families are hurting as well and we offer support, through the Circle process, to family members.

The contribution agreement further stated that the project:

- will help the APJC establish and operate a community-based Aboriginal justice program that will help individuals to recover from the legacy and the pain they carry and regain a positive sense of themselves and their culture. It will also help inform the mainstream justice system about Aboriginal ways of working with our people and the benefits that come from following those ways.

The project identified the following three goals it had intended to address:

- to firmly establish the APJC as a mechanism for providing an alternative to the mainstream justice system for Aboriginal people;
- to help Aboriginal individuals caught in the justice system reintegrate into the community by involving them in Aboriginal ways of dealing with conflict and ways of healing; and
- to present training opportunities to members of the APJC to enable them to work with the people more effectively.

The activities listed in the application included monthly organizational meetings and meetings with mainstream justice officials; consolidating operational procedures; establishing Aboriginal practices; visiting individuals in jail; reviewing applications to the APJC; establishing separate support groups and healing circles for offenders and victims; referring clients to needed services and treatment facilities; and providing training workshops to members of the APJC and other interested volunteers. Overall, the project was intended to break the cycle of incarceration and involvement with the justice system and establish positive life patterns and relationships with families. Additional outcomes were to expand the membership; increase the capacity to respond to the needs of those caught in the justice system; assist clients in establishing themselves in the community; increase the level of interaction and trust with the justice system; and reinforce the need to be culturally responsive.

The project team, as identified in the application for funding, consisted of 10 volunteers with an equal gender split between male and female. Six of the volunteers were Aboriginal and four were non-Aboriginal. The non-Aboriginal volunteers were all agency representatives while the Aboriginal volunteers sat on the APJC as agency representatives or as community volunteers. However, the individual volunteers fluctuated over time as some stepped down and others came on board for a variety of reasons, chief of which was the time needed to commit to the project—over 100 volunteer hours per month for the committee as a whole as reported in the AHF national survey.
Although the project relied almost exclusively on volunteers, one coordinator was employed with the funding received from the AHF, albeit for a short time; there was a time lapse of approximately seven months before the coordinator’s position was filled. A volunteer coordinator completed the first and second quarterly reports, the paid coordinator submitted the third quarterly report, and a different volunteer coordinator completed the fourth quarterly report. Some of the paid coordinator’s duties were to recruit and oversee new volunteers, oversee the sentencing circles, ensure communication between all partners, ensure the sentencing circles follow the proper APJC protocol, and provide administrative duties between the Crown, the police, and the APJC.

For the most part, the APJC team consisted of two co-chairs (one male and one female), a circle keeper, and the circle volunteers/agency representatives. Training workshops for the APJC members were to be offered during the course of the project (all quarterly reports indicated a recognition of the need for training), especially circle keeper and conflict mediation training. Although some training was offered through a Toronto agency, circle keeper and mediation training were not provided.

Training was also addressed in the national survey. It was reported that basic and advanced training were needed for the APJC members in the areas of crisis intervention, trauma awareness, counseling skills, Aboriginal language/culture, history and impact of residential schools, Charter of Rights and Freedoms, dealing with family violence, advanced circle keeper, and sentencing circle. The quarterly reports stated that “although the volunteers have a vast amount of experience in their respective fields, we recognize that we are not experts in our work with the APJC and that there is always knowledge that we do not have.”

During the course of the project the APJC met on a monthly basis, but the members did break for the summer months when it became too difficult to schedule meetings and maintain a quorum. There was mention of “regular” healing circles, talking circles, and sentencing circles taking place for offenders in the quarterly reports, but those reports did not record any data on the number of circles or on the number of APJC members participating in any particular circle. The quarterly reports described the healing and talking circles as using cultural and traditional methods such as smudging and prayers; the eagle feather is also used to empower the holder to speak and share their personal thoughts in the circle. Sweats and feasts were incorporated and viewed as indispensable components of every circle. A January 2001 document entitled Sentencing and Healing Circles: Aboriginal Peoples’ Justice Circle reported that healing circles are held for victims and offenders and are an important part of preparing for a circle hearing. Healing circles are confidential and restricted to participants, while sentencing circles are open to the public—the same for any court hearing. All decisions in the healing processes are made by consensus.

Each circle was facilitated and led by the volunteer circle keeper. It is believed that using traditional methods of the circle assists in building trust of the participant and instills respect and honesty. An added bonus for those individuals who had little or no cultural identity was an introduction to cultural practices, and this in turn contributed to their self-esteem and self-worth.

The majority of activities carried out by the project took place at the Odawa Native Friendship Centre in the urban setting of Ottawa. On occasion, some of the sentencing circles were held at the Ottawa courthouse in the presence of judges and lawyers.
3.1 Participant Characteristics

The target population served by the When Justice Heals project is Aboriginal people in conflict with the law. Potential participants were recruited largely through the mainstream justice system. In other words, representatives from the project visited the prisons and advertised the existence of the circle. They also made presentations to Crown attorneys and defense lawyers to raise awareness of the alternative to the mainstream justice system for incarcerated Aboriginal people.

As a result of the awareness campaign, individuals interested in the project could make an application to the APJC for sentencing and healing circles (Appendix 2). In order to qualify, the offenders had to be found guilty, plead guilty, or otherwise admit responsibility for their actions. The applications considered were from both adult and young offenders who were motivated and committed to follow through with a wellness or healing plan and had at least two community members who agreed to support them. All parties had to be in agreement, including the judge in sentencing cases, the Crown attorney in post-charge diversion cases, or the police in pre-charge diversion cases. All applicants were advised that if they did not comply with the requirements of the APJC or they breached the conditions of their release, the APJC would have the case returned to the mainstream justice system.

Approximately nine months (up to a year in some cases) were given to participants to carry them through all four quarters of the project, more or less, because of the length of time involved in the healing process. Table 1 illustrates participants in healing activities by age and sex. The data were gleaned from the project’s four quarterly reports.

### Table 1) Participants by Age and Sex

<table>
<thead>
<tr>
<th>Report Period</th>
<th>Age Group</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st quarterly</td>
<td>26–49</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>2nd quarterly</td>
<td>26–49</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3rd quarterly</td>
<td>26–49</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>0–14</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td>4th quarterly</td>
<td>26–49</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>15–25</td>
<td>1</td>
<td>–</td>
<td>1</td>
</tr>
</tbody>
</table>

For a more realistic number of participants, the data recorded in the national survey can be extracted. Here, the project reported that only one woman and two men participated in AHF-funded healing activities. Of that total, one participant was a residential school Survivor while the remaining two were intergenerationally impacted. One of the three did not complete the healing process because the “individual was not ready to heal; not complying with bail conditions; not participating in the treatment and counselling services – although attended.” After being charged with breaching conditions, this person expressed a desire to have the matter returned to the mainstream justice system.
3.2 Community/Regional Context

The population of Ottawa in 2001, according to Statistics Canada, was 774,072. The population of the Ottawa-Hull region was approximately 875,100. Population statistics for Aboriginal people in the national capital region vary from one Aboriginal organization to another. Indeed, it has been argued that the government-collected regional data are grossly underestimated.

According to the 1996 Census, there were approximately 142,920 Aboriginal people living in the province of Ontario; more specifically, those numbers included 118,830 North American Indian, 22,790 Métis, and 1,300 Inuit. A cursory review of the applications submitted to the AHF from Aboriginal organizations in the national capital region found that the Aboriginal population estimates were within a range of 11,090 to 40,800, with 35,000 being a commonly reported figure. These numbers included all Aboriginal groups, both male and female, adult and youth. Tungasuvvingat Inuit’s website estimates that there are approximately 900 Inuit living in Ottawa.

Ottawa is best known as being the seat of the federal government and, consequently, the offices of a number of national Aboriginal organizations are located within the city. It is an architecturally stunning city whose very origins lie in meeting and trading. It was the traditional meeting place for numerous Aboriginal people in the territory originally inhabited by the Algonquin. It is not a new phenomenon that First Nation, Métis, and Inuit from the east and west coasts and from the territories to the northern regions migrate to major cities throughout Canada, not the least of which is Ottawa.

Some Aboriginal people come to urban centres to seek a better life for themselves and their children, while others come for post-secondary education or for employment. Indeed, the reasons are as diverse as the Aboriginal people themselves. However, some Aboriginal people end up in cities after their release from prison, foster care, or hospitals and many unable or unwilling to make their way back to their home communities. Once here, Aboriginal people, whether they chose to migrate or stay, may face a myriad of challenges, including homelessness, poverty, unemployment, discrimination, substance abuse, prostitution, inappropriate and inadequate services, substandard housing, and conflict with the law. Housing shortages and high rents are creating serious problems for low income individuals and families in the city, and Aboriginal people are overrepresented among the poor. In 1995, the poverty rate for Aboriginal people living in Ottawa was 51.2 per cent.

Despite the paucity of mainstream culturally appropriate services, there are a few organizations that exist for Aboriginal people in the Ottawa-Carleton urban community. They include, but are not limited to: Gignul Non-Profit Housing Corporation, Odawa Native Friendship Centre, Aboriginal Women’s Support Centre/Minwaashin Lodge, Oshki Kizis Lodge, Pinganodin Silent Wind Lodge, Tungasuvvingat Inuit Community Centre, and Wabano Centre for Aboriginal Health.

The sponsor for When Justice Heals is the Odawa Native Friendship Centre, which was founded on 19 April 1975 in order to assist the increasing number of Aboriginal people moving into the national capital region. The friendship centre movement started approximately 35 years ago and was initially created to:

provide services to urban newcomers, their information and referral services are designed to help urban Aboriginal people and migrating Aboriginal people gain access to the range of services and resources available in urban areas. Throughout their history, friendship centres have played
two fundamental roles in meeting the needs of urban Aboriginal people: a referral service and a gathering place ... and have generally been more successful than other Aboriginal institutions in meeting the needs of Aboriginal people in urban areas.\(^{14}\)

Over the last 27 years, the Odawa Native Friendship Centre has provided a wide range of community-based services, with activities planned each year to respond to needs. These activities include the involvement of the community in the operation of programs. Activities are developed for all age groups and include cultural, recreational, developmental, supportive, and healing programs. Recently, healing activities have been organized through Aboriginal Healing and Wellness Programs, Aboriginal Family Support Program, Sweetgrass Home Day Care, Aboriginal Head Start Day Care, Dream Catchers Aboriginal Youth Program and Centre, and Aboriginal Peoples Justice Circle.\(^{15}\)

The Aboriginal community continues to face issues that present challenges to the project. Those were described in the national survey and are outlined in the following table.

**Table 2) Issues and Extent of Challenges Facing the Community**

<table>
<thead>
<tr>
<th>Issue</th>
<th>Severe Challenge</th>
<th>Moderate Challenge</th>
<th>Slight Challenge</th>
<th>No Challenge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Survivor involvement in project</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>History of incarceration</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denial, fear, grief</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of parenting skills</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of suicide attempts</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of abuse as a victim</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of abuse as an abuser</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of adoption</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of foster care</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug or alcohol addictions</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poverty</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of literacy skills</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of communication skills</td>
<td></td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

Clearly, suicides, abuse, and addictions were by far the most severe challenges faced by the project, and these same challenges were also identified in the project’s original funding application.

### 3.3 Outcomes and Measures

A logical link exists between the activities a project undertook and what they hoped to achieve in the short and long term. In essence, a project met its service delivery objectives when it carried out planned activities. However, further information is required to assess the actual impact of activities. This means linking desired outcomes (what the project hoped to achieve in the short and long term) to indicators of change, such as changes in participant knowledge, skills, attitude, behaviour, and, ultimately, changes in
environmental or social conditions. The following summarizes the project’s goals and objectives (referred to as long- and short-term outcomes) as well as the indicators that show how change is being measured. Desired short-term outcomes include the following:

- provide an alternative to the mainstream justice system for Aboriginal people in conflict with the law;
- work more effectively with Aboriginal people in conflict with the law;
- make the justice system more culturally relevant and more culturally responsive;
- assist in facilitating reconciliation with victims;
- help offenders face their behaviours;
- restore relationships wherever possible;
- encourage reconciliation;
- assist offenders to regain a positive sense of themselves and their culture and to reintegrate into the community; and
- increase skills, capabilities, and effectiveness of the APJC and other interested volunteers.

The longer term outcome was to break the cycle of incarceration and involvement with the justice system and to establish positive patterns and relationships with their families. The relationship between project activities and short- and long-term benefits is set out in the logic model (Table 3). The performance map that follows (Table 4) details the project’s mission, resources, target, objectives, and goals and also emphasizes what sources of information can be used to denote change. The map was used to guide the information gathering.
### Table 3) Logic Model—When Justice Heals

<table>
<thead>
<tr>
<th>Activities</th>
<th>How we did it</th>
<th>Provide training.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish an alternative to the mainstream justice system.</td>
<td>Held regular support circles for offender while in custody; facilitated separate healing circles for offenders and victims; connected offender with an Elder; held ceremonies, sweats, and feasts; conducted sentencing circles in co-operation with the presiding judge; and informed providers in mainstream justice system about Aboriginal ways of working with our people and the benefits that come from following those ways.</td>
<td>Visited incarcerated Aboriginal individuals awaiting court disposition (i.e., pre-sentencing).</td>
</tr>
<tr>
<td>Assist individuals to reintegrate into the community.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify training needs and organized periodic training.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide training.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How we did it</th>
<th>What we did</th>
<th>What we wanted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Held regular support circles for offender while in custody; facilitated separate healing circles for offenders and victims; connected offender with an Elder; held ceremonies, sweats, and feasts; conducted sentencing circles in co-operation with the presiding judge; and informed providers in mainstream justice system about Aboriginal ways of working with our people and the benefits that come from following those ways.</td>
<td>Monthly organizational meetings; # of and participation in support, sentencing, and healing circles; # and content of meetings and consultations with representatives from the mainstream justice system (including information session at the courthouse); consolidated APJC operational policies and protocols for circle work; established Aboriginal practices; and developed evaluation format for participants.</td>
<td>Provide an alternative to the mainstream justice system for Aboriginal people in conflict with the law; work more effectively with Aboriginal people in conflict with the law; make the justice system more culturally relevant and more culturally responsive; assist in facilitating reconciliation with victims; help offenders face their behaviours; restore relationships wherever possible; and encourage reconciliation.</td>
</tr>
<tr>
<td>Visited incarcerated Aboriginal individuals awaiting court disposition (i.e., pre-sentencing).</td>
<td># of applications to the APJC reviewed; # of incarcerated individuals visited; # of and participation in support groups for offenders and victims; and # of referrals to needed services and treatment facilities.</td>
<td>Help offenders regain a positive sense of themselves and their culture and reintegrate into the community.</td>
</tr>
<tr>
<td>Identified training needs and organized periodic training.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How we know things changed (short term)</th>
<th>How we know things changed (long term)</th>
<th>Why we are doing this</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence that the program has gained trust and credibility with the justice system and Aboriginal service providers (views of key informants, APJC members, justice personnel; # of applicants and court referrals; and # of committed Elders and volunteers involved with APJC); reduced reliance on defense lawyers to advocate on behalf of the APJC; and reduced level of interaction in the courts.</td>
<td>Evidence that the program has gained trust and credibility with the justice system and Aboriginal service providers (views of key informants, APJC members, justice personnel; # of applicants and court referrals; and # of committed Elders and volunteers involved with APJC); reduced reliance on defense lawyers to advocate on behalf of the APJC; and reduced level of interaction in the courts.</td>
<td>Break the cycle of incarceration and involvement with the justice system; and establish positive life patterns and relationships with families.</td>
</tr>
<tr>
<td>Reduced rates of incarceration and recidivism among participants; self-reported or key informant observations of changes in participants involvement with substance abuse, family violence, sexual abuse, emotional abuse, and homelessness; and reduced rates of suicide among participants.</td>
<td>Reduced rates of incarceration and recidivism among participants; self-reported or key informant observations of changes in participants involvement with substance abuse, family violence, sexual abuse, emotional abuse, and homelessness; and reduced rates of suicide among participants.</td>
<td>Reduction in incarceration rates and # of Aboriginal people in conflict with the law; and reduced rates of addictions, physical and sexual abuse, family violence, self-abuse, homelessness, and suicide.</td>
</tr>
</tbody>
</table>
### Table 4) Performance Map—When Justice Heals

**MISSION:** Provide an Aboriginal-specific alternative to incarceration in the mainstream justice system in the Ottawa-Carleton region.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Resources</td>
<td>Reach</td>
<td>short-term outcomes</td>
<td>long-term outcomes</td>
</tr>
<tr>
<td>activities/outputs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hold regular support circles for offenders while in custody; healing circles for offenders, families, and victims; sentencing circles (in cooperation with presiding judge); facilitate ceremonies, sweats, and feasts; inform providers in the mainstream justice system of Aboriginal ways; connect offenders with Elders; conduct monthly APJC meetings; develop evaluation tools; assist offenders to reintegrate into the community to begin their healing journey; provide training to APJC staff and volunteers; provide referrals to treatment facilities and services; and assist in the victim/offender reconciliation process.</td>
<td>Members of the APJC; mainstream justice system employees; Aboriginal persons in custody; Aboriginal people in conflict with the law; victims and families; and Aboriginal service providers.</td>
<td>Provide an alternative to the mainstream justice system for Aboriginal people in conflict with the law; work more effectively with Aboriginal people in conflict with the law; make the justice system more culturally relevant and more culturally responsive; assist in facilitating reconciliation with victims; help offenders face their behaviours; restore relationships wherever possible; encourage reconciliation; assist offenders regain a positive sense of themselves and their culture and reintegrate into the community; and increase skills, capabilities, and effectiveness of the APJC and other interested volunteers.</td>
<td>Break the cycle of incarceration and involvement with the justice system and establish positive life patterns and relationships with families.</td>
</tr>
</tbody>
</table>

| How will we know we made a difference? What changes will we see? How much change occurred? |
|---|---|---|---|
| Resources | Reach | Short-term measures | Long-term measures |
| $77,165 | # of Aboriginal offenders, victims, and families participating in the program; # of APJC members; and # of Aboriginal service providers and mainstream justice personnel involved with the project. | Evidence trust and credibility of the program with the justice system and Aboriginal service providers (views of key informants, APJC members, Justice personnel, # of applicants and court referrals, and # of committed Elders and volunteers involved with APJC); reduced rates of incarceration and recidivism among participants; self-reported or key informant observations of change in participants involvement with substance abuse, family violence, sexual abuse, emotional abuse, and homelessness; and reduced rates of suicide among participants; self-reported and observed reports of knowledge, capabilities, and skills of APJC members and of the committee’s contributions to the community. | Reduction in incarceration rates and # of Aboriginal people in conflict with the law; and reduced rates of addictions, physical and sexual abuse, family violence, self-abuse, homelessness, and suicide. |
4. Social Indicators

In evaluating AHF-funded activities, five social indicators are closely associated with the impact of the legacy of physical and sexual abuse in residential schools, including intergenerational impacts. These social indicators, selected by the AHF Board of Directors, are physical abuse, sexual abuse, incarceration, suicide, and children in care. Over the long term, decreased rates of these indicators can be viewed as evidence of sustainable healing. The case studies attempted to gather indicator data relevant to the communities and regions where projects were located. However, it was recognized in the case study design that Aboriginal-specific social indicator data might be difficult to collect, especially in urban areas. This, in fact, proved to be true for the Ottawa region. Thus, the information presented below is limited in its applicability to Aboriginal people living in the Ottawa region.

4.1 Physical Abuse

Ottawa police statistics show that crime rates have fallen in Ottawa over the past five years for both violent offences and property crimes, although rates were slighter higher in the past two years than in 1999. In 2001, the rate for assault (including sexual assault) was 691.1 per 100,000 and the five-year average was 730.0 per 100,000. The 2001 homicide rate was 0.4 per 100,000, and attempted murder was 1.6 per 100,000. "A higher proportion of women than men are victims of crimes against persons, especially sexual assault, robbery, attempted robbery and assault."17

No data were available on rates of physical abuse or assault involving Aboriginal people living in Ottawa; however, the Ontario Native Women’s Association’s 1989 study, Breaking Free, stated that eight of 10 Aboriginal women had experienced family violence and that 87 per cent of these women had been physically injured.18 The Family Violence in Canada: A statistical profile 2000 reported that 7 per cent of women and 5 per cent of men in Ontario had experienced spousal violence during the five years previous to this report. Overall, women in violent relationships reported more severe forms of violence; for example, twice as many women as men reported being beaten, and they were five times more likely to report being choked.19

In 1993 and 1994, the Ottawa Police Service recorded a total of 387 hate crimes, the most frequent targets being racial minorities followed by religious groups. Of a total of 215 racially motivated crimes in the two-year period, six (3%) were anti-Aboriginal.20

4.2 Sexual Abuse

Sexual abuse refers to unwanted or forcible sexual touching or activity. Child sexual abuse is more precisely defined any incident when a child is used for sexual purposes by an adult or adolescent including exposing a child to sexual activity, engaging them in fondling, intercourse, juvenile prostitution or exploitation through pornography.21

Actual rates of sexual abuse among Aboriginal people in urban areas are estimated to be less than rates for reserves or in rural areas. This may be due, in part, to urban law enforcement agencies being more visible and accessible.22 It is well recognized that official data under-report the extent of sexual abuse. Victimization surveys indicate that up to 90 per cent of sexual assaults are not reported to police.23 Prevalence of child sexual abuse is especially difficult to determine as it is a hidden crime, and many victims only report the abuse after they reach adulthood. In a study of the training needs of police serving Aboriginal communities,
the Institute for the Prevention of Child Abuse concludes that 80 per cent to 90 per cent of victims do not want to testify regarding their victimization. The reluctance to testify can influence decisions about reporting an assault.

The Ontario Native Women’s Association’s 1989 study reported that 57 per cent of Aboriginal women had been sexually abused. Statistics Canada’s 1993 Violence Against Women Survey found that half of Canadian women (51%) had been victims of at least one act of physical or sexual violence since the age of 16. In the AHF national survey, the project reported that a history of abuse, both as a victim and as an abuser, were severe challenges among participants, and family violence and sexual abuse were severe challenges affecting the community. The Ottawa Police Service’s published annual statistics include “sexual assault” under the more general “assault” category. As reported above, assault rates for 2001 were 691.1 per 100,000, based on a total of 5,598 incidents. There were 76 “other sexual offences” reported, with a rate of 9.4 per 100,000.

4.3 Incarceration

No incarceration data were found for Ottawa; however, statistics were available on the numbers of Aboriginal offenders for the Ontario region’s federally and provincially incarcerated populations. The following table indicates the federal Aboriginal offender population for the year 2001.

Table 5) Federal Offender Populations, 2001

<table>
<thead>
<tr>
<th>Aboriginal Identity</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>North American Indian</td>
<td>339</td>
<td>15</td>
<td>354</td>
</tr>
<tr>
<td>Métis</td>
<td>35</td>
<td>2</td>
<td>37</td>
</tr>
<tr>
<td>Inuit</td>
<td>53</td>
<td>–</td>
<td>53</td>
</tr>
<tr>
<td>Total</td>
<td>427</td>
<td>17</td>
<td>444</td>
</tr>
</tbody>
</table>

Aboriginal people constituted 15 per cent of all federal offenders in 2000, but rates varied according to the crime they committed. In all, 17.2 per cent of those incarcerated for homicide identified as Aboriginal, along with 21.1 per cent of sex offenders, but only 9 per cent of those incarcerated for drugs and 14.3 per cent for robbery. The provincial incarcerated population for Aboriginal inmates is not broken down in the same manner as the federal inmate population; the overall number of Aboriginal inmates in Ontario institutions in 2001 was 32,815, of which 328 or 10 per cent were of Aboriginal descent.

Studies of male Aboriginal offenders in federal prisons have found that they became involved with the criminal justice system at a younger age more so than non-Aboriginal offenders and were more likely to have served a prior term of incarceration in a federal or provincial institution. Youth incarceration (or involvement with the criminal justice system) may be a significant indicator of future adult incarceration rates.

It is well recognized that Aboriginal people are overrepresented in federal and provincial correctional institutions, and youth incarceration rates are even higher. While male Aboriginal offenders are often incarcerated for offences related to physical and sexual assault, research on women offenders highlights the relationship between being a victim of abuse and incarceration. Seventy-two per cent of provincially
sentenced women, 82 per cent of federally sentenced women, and 90 per cent of federally sentenced Aboriginal women have histories of physical and/or sexual abuse.32

4.4 Suicide

“Suicide is an injury deliberately inflicted on oneself with the intention of ending one’s life.”33 Initial research found that there were 97 reported cases of attempted suicide involving Aboriginal people in the Ottawa region over the past five years, but this number could not be confirmed in published reports. In general, Aboriginal suicides are twice as likely to happen between the ages of 14 and 22 than for non-Aboriginal people of the same age. Ottawa police noted that at least 20 per cent of suicide cases were reported one to two weeks after the incident had occurred.34 Poverty and unemployment rates played a major factor in most deaths. As well, children who show suicidal tendencies did not undergo counselling or psychotherapy.35 The project’s response to the AHF national survey indicated that a history of suicide attempts constituted a severe challenge for participants and the community.

There are distinct gender differences with respect to suicide and suicide attempts. In Canada as a whole, suicide is the leading cause of death in men between the ages of 25 and 4436 and, overall, males are four times more likely than females to commit suicide. The highest rate of suicide for men was in the 20 to 24 age range; while for women, the higher rate was among those aged 45 to 54. Suicide among Aboriginal peoples has been reported to be two to seven times more frequent than in the population at large, with the highest reported rates being among Inuit.37

Risk factors associated with suicide include a recent family or relationship breakup, facing criminal proceedings, previous attempted suicide, affective disorders, alcohol and drug dependency, and access to firearms.38 A portrait of youth at risk in Ottawa found that during the 12 months prior to its study, a third of youth between the ages of 14 and 17 had acknowledged having serious thoughts about suicide.39 Overall, 27 per cent of female participants and 29 per cent of male participants had identified as Native or visible minority. The study found an association between suicidality and the protective influence of prosocial behaviour among male participants, but not female. No significant association was found between minority status and suicidality or emotional disorders, but a significant association was noted among participants with non-heterosexual orientation.

4.5 Children in Care

Children in care is defined broadly to include all children (under the age of 18 years) placed in out-of-home care by child welfare agencies, whether voluntary or involuntary, temporary, emergency or long term, court-mandated or not, including all forms of placement – foster homes, group homes, institutions, and placement in the care of relatives or customary care.30

Records show that in the year 2001, there were 92 Aboriginal children in foster care and approximately 33 Aboriginal children in institutional care for a total of 125 in Ottawa. Forty per cent of all children come from single-parent homes and have been put in care for less than one year. In many cases, poverty or homelessness were the deciding factors in placing a child in foster care.41 Aboriginal children in intermediate care, living in homeless shelters, or living with a non-legal guardian are estimated to be six times higher in urban areas.42
5. Reporting Results

The information in this section relies heavily on the responses of eight key informants to questions asked in a structured interview. This is supplemented by material from documents collected during the case study research and from project files, especially quarterly reports and the national survey.

5.1 Impact on Individuals

Given the small number of participants (three to five in total, with two completing the circle process), impact on individuals must be viewed with caution. Yet as one person noted, “it may not be high numbers but the healing process takes time and needs lots of patience. But we see the result even if it is only one per year. It is like seeding another way of life and we hope that they [clients] carry on with cultivating that seed.”

The majority of respondents felt that participants were less likely to be in conflict with the law as a result of the project. As one person pointed out, “for those that completed the process then the answer is less likely. However, if the client did not follow through then the answer is more likely.” Another person distinguished between those with a long history of conflict with the law and those without:

- This all depends on the individual’s history. For those individuals who come to the circle and have not had a previous record, then I would say conflict with the law is less likely. The ones who have been through the system over and over would be more likely to get into conflict with the law again.
- I am a big believer in harm reduction and if you look at this question in terms of harm reduction the behaviour may not stop but it may get less and less serious ... weaning yourself off of some harmful behaviour with something less harmful means that the message is slowly clicking in.

A number of respondents credited the circle process as the reason for a reduced level of conflict with the law, including the “inordinate amount of time” spent with the accused. One referred specifically to the two participants who completed the circle process:

- In the two cases that went all the way, one client called me up and disclosed that he had relapsed and had a drink, but I told him that the relapse was a much lesser charge than he was charged with before. He was charged with domestic violence and drug use. So, this is still an example of a change in behaviour. The other example is the client called to invite me to a powwow and to meet his extended family.

One person who was unsure about the impact of the project on participants and whether there was the likelihood to reoffend said that this was “because our aftercare program for our clients was not implemented. There was nothing set up to get feedback.” Another felt that the likelihood was the same, whether they participated in the project:

- It is my experience that the people are going to reoffend. It is the nature of the person and sometimes it is the nature of the offence [i.e., prostitution/alcoholism]. The system is not set up for healing because there are so many rules. Is a women going to sell her body to feed her family? Probably. Each step is a success for where they are in their life. Maybe we will not prevent future conflict with the law but a seed is planted.

Three respondents noted a greater awareness and knowledge of culture and traditions when asked to describe any changes they had observed in participants’ attitudes, knowledge, skills, or behaviour. Also,
there were references to participants regaining self-esteem, dignity, and confidence and recognizing the destructive nature of their addictions. One client built his own house on his reserve and another client is going back to school and taking a Native studies course. Other changes noted by key informants included the fact that clients express themselves better at the end of a circle and that they go through a range of emotions, including gratitude, relief, compassion, understanding, respect, and a sense of self-worth. Also, the fact that they are required to ask family members to be part of the circle means that they must reach out to others.

In explaining why such changes have taken place, one person said, “they are given a chance. The court is not a chance. In the circle, all have an equal voice, they may not like what is said in the circle but there is no judgment later and there is no fear of retribution in the circle.” Another said that in dealing with the committee, clients learned how to negotiate for themselves and that the circle is not an easy way out. One spoke about the value of the teachings:

They understand their pain. They received the teachings and as a result began to realize that what they did was stupid. The circle sees small steps forward and it is exciting. We see the struggle. They learn how and when to smudge. They learned that they deserve to sit in a circle and that they are worth it ... Even in an unsuccessful circle, you hear the client admit their faults and you see the door open.

Another spoke of the role of the Elders, “due, for the most part to the participation of the Elders. Most have never heard from an Elder or listened to their versions [teachings] before.”

Respondents were asked if they noticed whether victims and their families were more or less likely to participate in alternative justice initiatives over the course of the project. Interestingly, there was no consensus among respondents. Only two of eight people felt it was more likely. It appears that victims were not necessarily Aboriginal, and non-Aboriginal victims were not particularly interested in alternative justice processes, as one of the two stated, “victims are oftentimes new Canadian business people and their view of justice is not in keeping with the alternative view. They tended to reject the circle process.” The other said, “If the victim and family are Aboriginal they may be resistant to participate at first, but they eventually do. But if the victim, usually an immigrant, is running a bank or a store, they are less likely to invest their time with someone else’s healing.” One person who felt that the likelihood of participation remained the same over the course of the project pointed to the need for more education for victims. Another felt that the likelihood was even less now than before the project: “It was hard for some victims and we could not force them to participate, especially in cases of domestic violence. If the victims were non-Aboriginal they did not care.”

In spite of these diverging opinions, respondents unanimously agreed that opportunities for victims and their families to participate in reconciliation were better. Moreover, most respondents felt that the project ensured the safety of women victims (i.e., protection against re-victimization and further harm by the offender) to some degree, although a few were not sure (Figure 1). One person said that the project was not addressing the issue at all: “From what I could tell, safety mechanisms were never implemented in our program for women.”

Those who felt the issue was addressed cited the high proportion of female circle members and the fact that these women were knowledgeable about resources and support services for women. It was not clear
whether the circle dealt specifically with domestic violence cases, as some of the references suggest this was the case and others state clearly that it was not. It is possible that family violence issues were raised in the course of the circle, whether or not this was the formal charge. It was also reported that victims can be represented and/or supported in the circle by the Spousal Assault Team and Victim Crisis Unit or they could send a letter or have someone else speak for them.

Respondents were also asked how well social services and justice-related services ensured the overall safety and well-being of the offender (i.e., safe from community retribution or ostracization). Figure 2 shows that respondents were divided almost evenly between those who felt some level of safety was in place and those who felt agencies were struggling or not addressing the issue (one person was not sure).

5.2 Influencing the Community

It is unlikely that a small project, such as When Justice Heals, operating in a large urban centre will significantly influence social or environmental conditions (as measured by rates of physical abuse, sexual abuse, children in care, suicide, and incarceration), especially over a short period of time, as in this case,
where only two participants had completed the healing process. The case study did, however, uncover some evidence of progress. For example, respondents had a number of thoughts about how the When Justice Heals alternative justice project benefited the Aboriginal community.

All of the interviewees recognized the advantages that the project brought to Ottawa, especially in light of the growing Aboriginal population within the region. One person stressed how the city needed more projects and services, and another was reminded of the importance of doing preventative work despite the fact that their hands were already full. “Community members in conflict with the law now have somewhere to turn, and even if they do not want to participate in the circle process, we have other referrals for them.” Four respondents also recognized that an alternative justice project in an urban area could benefit the Aboriginal clients in terms of anonymity, lower cost, fewer restrictions, and ready access to healing and treatment services in the city. Other benefits of the project included the observation that the “community can consider the impact of the criminal justice system on our members ... it represented a proactive measure consistent with self-determination.” Another perceived benefit was that the project had the potential to bring the community together.

When asked how the project made the mainstream justice system more culturally relevant and more culturally responsive, it was reported that the coordinator delivered awareness sessions to defence lawyers about the APJC, what it does, and why. Those awareness sessions at the courthouse were viewed as a sensitizing process for mainstream justice personnel. One respondent spoke passionately about the impact of networking on justice officials: “The most important part is that they [justice officials] have begun to listen and learn and to accept our teachings ... and that we are here to help each other ... this type of networking allows us to gain credibility and more respect and there is more willingness to learn our ways.”

Another interview question asked how the perceptions of mainstream justice officials have changed over time. Some respondents felt that change was due to increased awareness of the alternative justice system. Indeed, one Crown attorney approached an APJC member and confided that his experience of “the sentencing circle process was more satisfying than anything he had ever done.” Two others felt that a greater respect for the work of the APJC was evidence of change as expressed in the following quote: “there is greater respect for the medicines now in the mainstream justice system and a healthier respect for those peoples who want to have the right to use their own teachings. It blew me away to go into a courtroom and smudge and the court respected it.” The number of referrals from the mainstream justice system was another indicator for change; but even with the increased numbers, the APJC “had to turn away some of [them] because we had no coordinator, not even a phone number.” It was difficult, if not impossible, to determine exactly how many referrals could have come before the circle if they had the capacity for client intake.

Despite the unanimous responses from the interviewees on the benefits of the project, there were a few dissenting opinions about the influence the project had on both the Aboriginal and non-Aboriginal communities. For the Aboriginal community this was principally because the community as a whole “did not support the project.” They believed that the APJC was “comprised mostly of non-Aboriginal members ... and they stepped back.” One respondent said, “tried to figure out why [the APJC] got funded by the AHF ... even our support letters were from people who were not active in the community.” Inexorably, the cohesiveness of the circle “broke down after a while. It was overwhelming.”
There were similar opinions, although not as discordant, about the non-Aboriginal community partners. One interviewee thought that the justice officials did have a willingness to learn about the circle process but that there was never enough time. Some of the justice personnel appeared impatient with the circle process presumably because of the slower pace of healing throughout the course of the proceedings. Another not so complimentary response maintained that “the mainstream justice representatives liked to have the circle experience just as a notch in their belt. The circle was more or less a token for them.”

5.3 Impact on the Aboriginal Peoples Justice Circle

One of the questions asked of the respondents in the interview process was to describe what measures were taken by the APJC to ensure that the circle members did not experience burnout. In other words, what mechanisms did the circle use to care for their team given that the project used volunteers almost exclusively. Being vigilant for signs of fatigue appeared to fall under the responsibility of the circle keeper, especially in the case of Elders. One respondent stated, “This depend[ed] on the circle keeper. At the end of a healing circle either the client or the victim or the circle keeper d[id] a closing prayer and they asked how everyone was doing and if we needed to get together again.” The same respondent argued that circle keeper training was important and much needed. However, other respondents were not so positive about the mechanisms for coping with burnout or felt that it was not an issue:

The only measures we had were within the healing circle and getting support from the medicines. It is an individual thing. But we had no money to do a staff retreat ... if we recognize that someone is over-extending we bring it up to them in the meeting. The majority of the committee members are professional people and they know how to recognize burnout in themselves. We do lots of check-ins and lots of debriefing ... we could have done more.

There was no mechanism for circle members to alleviate potential or real burnout and very little debriefing was going on for our volunteers. Circle after circle after circle failed, and the stress level was quite high and was also due to a lack of Elders to help the group debrief. I was very surprised at the lack of formal procedures even after the circle, the protocol was to relax and have some food, but that never really happened. It was mostly on the way out, or down in the elevator, or walking to the car. There was no Elder to help cleanse [us].

I do not think that burnout was a concern due to the low numbers of clients that the circle processed.

Respondents were also queried on how the project dealt with community criticism or opposition to the APJC project. One person said that they were not aware of any community opposition while another thought that the community was “hesitant or sceptical about those who commit crime.” The only opposition came from “people who don't know who we are.” Half of the interviewees were less than complimentary in their responses:
Honestly everything that I heard was hearsay in terms of criticism ... [I] heard comments from a lawyer that stated that the APJC is a white-run justice system, I guess because the circle is comprised of the Crown attorney, police, Aboriginal justice, et cetera. There were comments from a number of Aboriginal persons sitting on the circle that other community members were not thrilled with the APJC or that the Elders were not happy.

The project pretended the criticism was not there. They turned a blind eye and did not respond.

When we discovered that the community felt that our committee was overtaken and run by whites, we took it very hard. We tried to recruit more Aboriginal members but two of the grandmothers refused to be on the committee because they thought it was white-run, and this surprised me coming from a grandmother.

The interviewees were also asked for their comments on how the project dealt with internal disagreements among the circle members. Again, one respondent was not aware of any internal conflict. Overall, respondents explained that differences of opinion were talked out in the circle, “as respectfully as possible,” and the group tried not to leave the meeting until the dispute was resolved. Despite the good intentions, some attempts to settle disagreements were unresolvable due, for the most part, to personality differences:

- “We fell down on some of those issues ... we did not deal with conflict as good as we could have, but then we were all volunteers”;
- “[One of the] biggest conflicts was about being too white or not Indian enough”; and
- “If the project had a problem it was not dealt with in a professional way. If one member stayed on, the other dropped off, and their disagreements were never resolved. It was highly dysfunctional.”

Another respondent was optimistic about internal APJC disputes and conflicts: “The committee may get off-balanced or disjointed but we are all volunteers and a lot depends on the group. One group did not deal with conflict respectfully but one individual can’t compromise the whole committee.”

5.3.1 Training

The final question in this section dealt with training and if the respondents believed they had received adequate and appropriate training for their project roles and responsibilities.

<table>
<thead>
<tr>
<th>Table 6) Views on Adequate and Appropriate Training*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
</tr>
<tr>
<td>Excellent, hard to imagine any improvement</td>
</tr>
<tr>
<td>—</td>
</tr>
</tbody>
</table>

* (n=8)

Only two of the respondents rated the training received as either very good or reasonably good, yet even these two followed up with comments that call their ratings into question:
• “Education cannot be stressed enough, both traditional or for mainstream education. Our education dollars were insufficient to meet our needs; our training budget was underestimated.”
• “Training was not always available and what was available was not specific enough. We got overall training but it should have been more specific to the needs of the circle. We did get RCMP training on collaborative justice, but this was before AHF funding. We did not have the proper training for circle sentencing. We did not have the skills required.”

Two respondents stated that no training was provided and three were unsure. Two people mentioned that a two-day session was provided by a Toronto group but felt that this was more an attempt to advocate for the community council model than a training course. One respondent emphasized that the circle definitely “needed more training.” As previously stated, training was identified in all quarterly reports submitted to the AHF by the project; in particular, circle keeper training and conflict mediation training. Training needs were also identified in the national survey.

5.4 Partnerships and Sustainability

Partnership information contained in the national survey cited two key community agencies linked with the project: Bimadiszi Inuujujut Lodge offered fast-track counselling services to APJC clients and victims and the Aboriginal Women’s Support Centre (AWSC) offered victim support. Agency partnerships were also identified in the quarterly reports: Wabano Centre for Aboriginal Health, Centre for Treatment for Sexual Abuse and Childhood Trauma, Pinganodin Lodge, House of Hope, office of the Crown attorney, and the police liaison offices. The application for funding submitted to the AHF listed three sources of community support; namely, Tungasuvvingat Inuit, Wabano, and Ottawa-Carleton Regional Police Service Post-Charge Diversion.

As can be seen in Figure 3 below, respondents did not agree on the level of support community partners gave the project, but most felt it was at least fair. Support from Aboriginal and non-Aboriginal partners was perceived as following a similar pattern. Respondents’ comments, however, were less positive, and differences can be seen in how these two groups of partners were viewed.

![Figure 3) Support from Community Partners](image-url)
With respect to Aboriginal partners, one person was concerned that not enough Aboriginal people were involved and another felt that there was no sense of ownership by the Aboriginal partners. Some Aboriginal organizations allowed their staff to attend meetings, but other than the employees’ time, there was no additional financial support. However, it was recognized that volunteers were expected to commit a substantial amount of time, and this may have hindered participation. A “hostile” committee environment was also recognized as contributing to the lack of agency support.

The non-Aboriginal partners included representatives of the justice system, the Crown attorney, Ottawa Police Services, judges, as well as the executive director of the House of Hope. One respondent lamented that so few Aboriginal people hold positions in the mainstream system, and thus these positions are filled by non-Aboriginal individuals. Another noted polarization around the issue of ownership and non-Aboriginal partners. The influence of non-Aboriginal partners on the APJC was recognized and, at times, Aboriginal members were outnumbered. However, one person said, “recently the participation of our non-Aboriginal partners is next to nil. They are not attending meetings.” Another was concerned that “the Crown only wanted to support sentencing circles and not more services for Aboriginal people.” The lack of financial support from the Ministry of the Attorney General was also commented upon.

On a more positive note, one respondent said, “We received privileged information because of our non-Aboriginal partners. We could call the court directly and get information. It was very valuable to have judges as partners and we need to work with them.” One of the respondents felt that the individuals involved were compassionate and open to Aboriginal cultures and teachings, but “some community members do not want to participate on the committee because they feel that there are too many white people on board. For a period of time there were more non-Aboriginal people on the committee.”

Respondents were asked how the project would be able to operate when funding from the AHF ends. The issue of sustainability was addressed separately in the national survey where it was reported that the value of donated labour from community agencies, including the Crown attorney, was approximately $9,500. In addition, the court provided a meeting room for the sentencing circles.

In terms of sustainability, there was undeniable evidence from the interview data that the project will continue. In fact, the project has continued after the project’s second year application for funding was declined by the AHF. Despite the fact that many of the respondents observed major problems with the project, including its accountability to the community and the lack of training for the APJC, most believed that it is viable and merits ongoing support, albeit largely through volunteers.

All respondents stated that the project will rely on volunteers to continue its operation mostly because they “want to be there for the circle” and because there is “no decrease in the number of applications to the APJC.” One of the respondents hoped that the AHF would release the 10 per cent holdback so that they could “hire someone to do the fundraising to sustain the project.” As the work of the APJC continues, the volunteers recognize that there will be little or no time for fundraising. Unfortunately, without sustainable funding, opportunities for training will significantly decrease.
5.5 Ensuring Accountability

There are significant concerns about the lack of community participation and support. Only one of eight respondents felt that the project was reasonably accountable (i.e., engaged in clear and realistic communication with the community as well as allowed community input); the rest said it was struggling, not addressing it at all, or they were unsure (Table 7).

Table 7) Views on Project Accountability*

<table>
<thead>
<tr>
<th>Very well, hard to imagine any improvement</th>
<th>Very well, but needs minor improvement</th>
<th>Reasonably well, but needs minor improvement</th>
<th>Struggling to address accountability</th>
<th>Poorly, needs major improvement</th>
<th>Is not addressing accountability</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>–</td>
<td>–</td>
<td>12.5%</td>
<td>12.5%</td>
<td>–</td>
<td>12.5%</td>
<td>62.5%</td>
</tr>
</tbody>
</table>

* (n=8)

When asked to explain their responses, interviewees gave a variety of reasons. One pointed out that they put a letter in the Odawa newsletter and got four new circle members as a result. Another spoke of annual information sessions and the coordinator promoting awareness of the APJC through media promotions and brochures. This person added that improvements were always needed and it was a struggle to get funding. One person, who was not sure, said that it was because some volunteers were not Aboriginal. However, the non-Aboriginal community was very supportive. This same individual also said, “If the community was opposed to us, I wish they would come out and say it.” Another respondent stated, “We did not have a clear strategy other than contact with the committee members. We have to do better, be more public. The reason we were not more public was because of a lack of members and lack of staff.”

Two different views were expressed regarding the involvement of Survivors. Most respondents reported on Survivor involvement, especially in the planning phase, and one said the involvement was “significant”:

“[A]lmost all of us came from multi-generational impacts of the residential school system and we saw how it affected us as individual workers and as parents. We know where addictions, violence, poverty, and no culture came from. We are aware it is still there and can take four to five generations to lessen the effects of residential school abuse and the effects of colonialism.

However, this view was disputed by another respondent: “I never came across any intergenerational or direct Survivors involved with the project, and this made me very upset.”

When asked how well the project had addressed the legacy of physical and sexual abuse, including intergenerational impacts, half of the respondents were not sure. One person stated that the project was not addressing the Legacy at all and another felt that it was doing poorly. The remaining two reported the project was doing reasonably well, with one of these respondents noting that while the issue was not dealt with directly, “it gets addressed when we talk about the person’s experience about their culture.”

Responses were also split regarding how well the methods, activities, and processes outlined in the funding agreement led to desired results. Five people were unfamiliar with the funding agreement and therefore unable to respond. Of the three who answered, one said very well, one rated the performance as poor,
and one claimed it was not addressing the stated methods and activities at all. Such divergence among interviewees probably reflected the conflicts and differences among APJC members noted elsewhere in this study. One person spoke bluntly about the need for improvement. Interestingly, this person said the project was doing very well and that only minor improvements were needed: “I agree with the sponsor and the AHF for not agreeing with us; we never really got off the ground, i.e., didn’t get incorporated; there was money left over because the coordinator left early. We could have improved, especially in the area of training.”

The respondent who rated the project’s performance as poor began in a positive tone and then explained the reasoning behind his response: “There is no doubt that the committee enabled there to be some alternative to the mainstream. The training was a complete letdown. There was also little direction for the coordinator.”

Table 8 shows responses to a question about how well the project was able to monitor and evaluate its activity. One person noted confusion about the nature of the circle and suggested that a closer relationship with Odawa would have been preferable. Another observed a need to get more information down on paper, especially codifying traditional knowledge. The national survey reported that the project measured change in participants through written and recorded observations and solicited feedback, but the files did not contain these documents. Administration reportedly suffered because everyone was so busy. One respondent stated that the project was not accountable to the AHF and, “in our activities, we could have reported anything.” Finally, one person spoke about making the evaluation process more formal:

At the end of each healing circle, we gave all participants the opportunity of speaking their mind. In hindsight we should have given them the opportunity to speak their mind anonymously, perhaps through the use of an evaluation form. We needed more monitoring and evaluation for clients as well as for ourselves.

Table 8) Views on How Well the Project Monitored and Evaluated Its Activity*

<table>
<thead>
<tr>
<th></th>
<th>Very well, hard to imagine any improvement</th>
<th>Very well, but needs minor improvement</th>
<th>Reasonably well, but needs minor improvement</th>
<th>Struggling to address monitoring &amp; evaluation</th>
<th>Poorly, needs major improvement</th>
<th>Is not addressing monitoring &amp; evaluation</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>–</td>
<td>–</td>
<td>25%</td>
<td>12.5%</td>
<td>12.5%</td>
<td>12.5%</td>
<td>37.5%</td>
</tr>
</tbody>
</table>

*(n=8)*

No consensus was observed among respondents on issues related to accountability, evaluation, and monitoring. It is clear that accountability was a problem for at least some of the APJC members. Similar concerns were reflected in the recommendations made by AHF staff.

5.6   Addressing the Need

In the national survey, the project reported that it reached those who needed the service the most, although it could have been better. It is the offender who must make an application to the APJC in order to qualify. At the time they completed the survey, the project had two clients and stated they could handle two additional offenders without having to recruit new volunteers.
Interviewees were asked about the previously identified needs the project was intending to address, and responses focused on achieving a fairer, more culturally relevant justice system, providing alternatives for Aboriginal people in conflict with the law, and stopping the revolving door of incarceration. However, these responses were provided by only three of eight respondents as the remainder did not respond, perhaps because they were not involved in the various stages of the project. Had a community needs assessment been conducted, it may have been easier for circle members to answer this question. Similarly, half of the respondents were unsure about the project’s ability to address and meet identified needs. The remaining responses varied significantly: one person said poorly; one said reasonably well; another said very well; and one claimed that it was doing reasonably well for those clients who made an application while it was struggling to address the needs of those who did not know about the project.

5.7 Successes and Best Practices

When asked to describe the project’s successes, respondents spoke of improvements in the lives of clients: a big change in how the client dealt with his children and spouse; smudging for the first time; and enrolling in a Native Studies course. One person felt that there was an increase in the community’s knowledge of justice processes, and a number of examples were given of successful interactions with the mainstream justice system, including strong partnerships with police and courts.

- “The partnerships with the police services and the courts were very strong, and relationships with the Crown were very supportive and respectful of what the circle is and what we want to do.”
- “Having a white male judge come in and talk to us about restorative justice and accepting Aboriginal ways, then having the same judge sit down to dinner at my house and recognizing that some Aboriginal people have been systematically abused in their life—this is hope. It is improving the quality of life for our clients. Cultivating the seedlings takes a lot of work.”

Quarterly reports submitted to the AHF stated that the assistant Crown attorney, as a member of the APJC, had been “instrumental in having Aboriginal persons diverted away from the mainstream justice system.” This suggests a growing recognition by the justice system of alternative processes. Two respondents made it clear that progress did not have to be dramatic for an intervention to be considered successful:

- “When a person walks through our doors that is success. Many applications were made to the APJC and all must be complimented, even if they do not complete the healing circle.”
- “Just because the client did not continue in the circle, I would still consider it a success because the secret was brought out in the community. Even if the client went back into the mainstream justice system, he still learned something.”

In speaking about their most memorable experiences with the project, two people focused on the sentencing circle experience:

- “Every sentencing circle was beautiful, it is what you go home with. Emotions are poured out in the circle, especially when you hear of a mom and dad saying how the circle made such a difference.”
- “The first sentencing circle in a court room, it is seeing the probation officer backing up his client and seeing the lawyers who were educated about our ways, it is seeing the family and knowing that they appreciated what the healing did for their son, it is seeing that the system had a lot of respect for the medicines. It blew me away, the realization that this is why we are here.”

One of the spinoffs of having an alternative justice project in the community is that it can fill a service gap. For example, a couple of people mentioned the need for a courtworker. One of the respondents, who
filled the coordinator position on a volunteer basis, noted that people came by to get advice: “Most of the drop-ins already had their remands and were nervous about their upcoming court trial and needed to talk to someone who understood.” Also, the paid coordinator met with a number of young offenders, both as an advocate and someone to do cultural assessments for the court. He also took time to meet with representatives of Aboriginal and non-Aboriginal service agencies and members of the mainstream justice system.

The national survey identified this best practice: “Traditional and holistic methods are used for the healing circles and it is often the re-engagement for those individuals to their culture.”

5.8 Challenges

Interviewees were especially open about the problems and conflicts they confronted in their various roles within the project. This kind of honest criticism is an important and necessary step in building a strategic plan. As sentencing circles and other alternative justice initiatives are increasing in popularity, the challenges facing this project can provide insights and lessons for others embarking on similar initiatives. The national survey identified the following as the greatest challenge: “when an offender decides not to participate any longer and when the victim(s) refuse to take part in the circles.” This comment was indicative of the APJC’s commitment to the individuals they worked with; in essence, the circle was composed of people who cared about and wanted to make a difference in the lives of Aboriginal people in Ottawa. The challenges they faced were first of all philosophical (differing perspectives among APJC members) and structural (related to the mainstream system), which were compounded by administrative and resource limitations and the fact that the project appears not to have been firmly rooted in the community. Yet as one person said, “even though it may look very dysfunctional at times, we have always been there.”

Within the APJC, there were differing views about alternative justice. Some supported the community council model used by Aboriginal Legal Services of Toronto (ALST) and felt that the Ottawa approach was too closely tied to the mainstream justice system. Others strongly disagreed with the ALST model and were annoyed with a two-day training session provided by this organization because they viewed it as advocacy rather than training. ALST was described by one respondent as “the first and only alternative justice system.” This person felt the project did not want the community council model, in part, because they would have lost some control. In contrast, another respondent saw ALST as “basically a card to get out of jail free.” As discussed below, the APJC sentencing circle process and the ALST community council model are actually two distinctly different approaches to alternative justice. A 1999 review of literature on justice projects in Aboriginal communities included this description of the ALST model:

> Aboriginal Legal Services consists of a courtworker program, a native legal aid clinic, a training program for court workers, an inmate liaison program, and ... a diversion program. This intervention diverts adult aboriginal offenders in Toronto before their case gets processed in court ... It differs [from other programs] in having a broader eligibility for offences, in its handling of cases where the disposition is not completed, in the pattern of offences dealt with (primarily theft, prostitution, and court offences), and in its aggressive advocacy and pursuits of cases for diversion.

From this description it was clear that ALST had a broader range of services and a more comprehensive program than what was available in Ottawa. Also, the fact that it is a diversion program (dealing with offenders before their cases go to court) is qualitatively different from a sentencing circle. Although
a couple of people were concerned that the APJC was too closely linked with the mainstream justice system, as sentencing circles necessarily involve the judge and prosecuting and defence attorneys (as well as the community) in setting the sentence. They were also predicated on the offender being found guilty or admitting guilt. Therefore, when one of the people interviewed about the APJC project said, “I totally disagree that they have to plead guilty,” it indicated an underlying discomfort with the particular alternative justice model being used (i.e., sentencing circles). “Review of court experience to date indicates that the purpose of sentencing circles is to shift to sentencing principles other than retribution, and to involve the victim and the community.”47

An information letter on the APJC stated that a justice committee would review applications for sentencing and/or healing circles and that “there is an agreement by the Judge in sentencing cases, the Crown Attorney in cases diverting post-charge, or the police in cases diverting pre-charge.”48 However, it appeared that the project focused its activities on sentencing and healing circles: “Healing circles for victims and offenders were an important part of preparing for a circle hearing.”49

One interviewee said the project was based on the sentencing circles made popular by Judge Barry Stuart of the Yukon. These circles, along with a similar model used in Saskatchewan, have been much discussed in the alternative justice literature, including a range of potential problems and limitations, such as power imbalances in domestic violence cases, long delays required to shore up victim participation, the need for protection, especially for victims, and the fact that sometimes there was less support for the victim than the offender. Concern was raised about the absence of detail in the plans for Aboriginal justice and that there was often little discussion of community needs and realities. The literature presented a series of questions regarding restorative justice initiatives, including the following:

- is the practice carried out as theoretically conceived? are all legal guarantees there for both offender and victim? is the overall position of the victim better off under this approach? is it better for the rehabilitation and education of the offender? for what types of offences and kinds of offenders is it suitable? is it an alternative or just another strategy? how does restorative justice impact on the community with its diversity, conflicts, and power imbalances?250

The literature also asked how the community was defined and who represented it, what are the levels of community participation and involvement, and if it has the skills and willingness to deal successfully with offenders.

Community justice committees could take on an organizational role; they sometimes reviewed cases and recommended which ones were to be referred to circle sentencing. Many of the articles included in the literature review stressed the importance of having the necessary community resources to support the process, the willingness of the community to participate and its ability to provide follow-up. A discussion paper by the Saskatchewan Department of Justice addressed similar questions:

[W]ho is responsible for investigating the potential for the Circle, for handling its arrangements ... how does one identify ‘the community’, who should attend and what should their role be, what is the process to be followed in the actual sentencing circle (e.g., sitting arrangements, judge presiding, introductions, prosecution and defence sentencing submissions), whether the judge’s final decision is seen as informed by the discussions or as directed by the group consensus, what if any rules apply with respect to perjury, slander, etc.51
It is clear that a great deal of research, planning, and discussion and debate precede the implementation of any community justice initiative and that this process should fully engage the community. The extent to which the APJC went through such a process remains unclear, especially since at least some of the conflicts among circle members appeared to be rooted in philosophical differences regarding the model they implemented. For example, some members were unhappy with the number of non-Aboriginal people involved in the circle, but this seemed inevitable given the need to involve the judges and lawyers in sentencing circles and the fact that most people in those professions are non-Aboriginal. However, the group also had difficulty recruiting Aboriginal members, in part, because of the extensive time commitment required by volunteers. It was also probably true that the overall lack of community involvement and unresolved conflicts among APJC members around the sentencing circle model made recruitment more difficult.

Three-quarters (6 of 8) of those interviewed made reference in some way to a lack of community support and involvement. One stressed that there was no sense of ownership and control and another spoke of the project not being community-based design. One respondent mentioned that a community forum was held, but the project files do not indicate how many people attended. Two people spoke about the need to get more information out into the community: “The only opposition came from people who don’t know who we are. There is a barrier getting the message out” and “The first step should be that more information needed to go to the community about APJC. There was no time for that.”

One person referred to two possible approaches: starting off the project in a manner that ensured community participation gain support as they grow or getting community support first. The project chose the first route: “We saw that a job needed to get done and we went ahead and did it without full community support.” Another stated, “I do not believe that the community was ready for this project. The people who started the project hoped that the community would rally behind them.”

The active engagement and support of the Aboriginal community in Ottawa would seem a prerequisite for a successful alternative justice project. Some respondents also mentioned a need for more volunteers and for greater participation by Elders. At one point in the project’s life Aboriginal membership on the APJC was down to only one or two people. Low levels of Aboriginal participation may have been less of an obstacle if the project had greater community support. A paper on planning and evaluating corrections and healing projects in Aboriginal communities used a case study example to explain why projects fail. In this example, the evaluator listed five key weaknesses related to planning and implementation:

1. Community consultation was insufficient as community residents and front-line personnel were excluded from the initial planning process.
2. Many of the key program organizers did not have credibility in the communities.
3. The programs did not address the specific needs of the communities or of victims and offenders.
4. There was political unrest in the communities and during the program there was intervention by tribal council members and [E]lders in the cases of family members.
5. The program did not take into account the fact that not all community residents shared the same cultural values.52

The project team was composed entirely of volunteers except for a paid coordinator during five of the 12 months it received AHF funding. As a result, the volunteer workload was high. One person said the APJC was raising false expectations by “doing more than they can practically do.” Another concern was
the lack of “qualified Aboriginal people to fill the capacity and the low salary scale for the staff position.” At the time of the interviews there was no funding, no office, and the coordinator’s position was filled by a volunteer. A lack of resources within the community created additional challenges; for example, the need for a courtworker was mentioned a couple of times during the interviews.

A number of administrative problems were cited, some associated with the lack of resources while others seemed to be rooted in the ambiguous relationship between the project and its sponsor. The APJC had intended to file for incorporation, but the process was never completed. Odawa provided office space, but other links with the sponsor were tenuous. Also, there was a complaint that the committee operated like an independent board even though it was not incorporated. One person reported problems getting information about the project’s finances: “The accounting was done by Odawa and we never had a financial statement at our meetings.” Moreover, “the sponsor is listed as the official contact person so when the coordinator would try to contact the AHF no one would even talk to him. There was no administrative staff position, and when the AHF funding ended, we stopped using the money even though we still had money in the bank.”

The quarterly reports stated that there was no formal management structure. The APJC operated as a volunteer committee with a chairperson, a co-chair, and one paid coordinator (for five months). Except for the paid coordinator, the structure had been the same since the outset of the committee in 1997. The circle process was guided by a circle keeper, and monthly meetings were held to report on clients’ progress. The need for greater clarity with respect to the roles and structure of the APJC to revise the terms of reference, to review the circle process, and to clarify Odawa’s role with respect to the APJC were reported in a document entitled, “Needs Identified by APJC Members to Serve Clients Better and to Operate Effectively.”

The need for a procedure to deal with applications and how to proceed with circles including procedures for young offenders was identified, and in June 2001, a checklist for the application and circle processes were developed. On 27 September 2001, just days before the end of the AHF project, an emergency meeting was held where a decision was made to continue while reviewing the structure and operation of the APJC before accepting new clients. However, the coordinator’s report for this period states that there was no quorum and the chair and co-chair were not present. In summary, it appeared that the APJC was well aware of the need for formalizing and updating its procedures, but it was still struggling to take action at the time the funded project ended.

As noted earlier, it appears that the only training provided was based on ALST’s community council model, which was controversial to some members. The need for training for circle members and circle keepers was reiterated in the four quarterly reports prepared by the project. The interviews confirmed that training was an unmet need.

A number of systemic challenges related to the mainstream justice system and non-Aboriginal agencies were noted in the interviews. One person spoke about how defence lawyers do not get paid by legal aid for up to six months if their client went through circle sentencing. In such cases, the attorneys may be reluctant to support the process. There were also problems with non-Aboriginal service agencies:

When the client went into an Aboriginal service the safety was damn good. The accountability is not as strong with the non-Aboriginal referral agencies. My beef? Treatment centres are reluctant
to take court-ordered clients. They are at the bottom of the list. Treatment centres would rather give the seat to someone on their own volition. Clients are refused because of Hep C, AIDS, poor health, or major medical problems because they are viewed as a health risk. There is a waiting list of four or five months, and if a young offender has to wait six months then sometimes the court dates conflict. There is less and less for young offenders.

Sometimes the lengthy process was a challenge and a client might have to go back to court before they had come before the circle. Interestingly, in light of criticisms that the mainstream justice system was too slow, one person noted “lawyers would approve a ‘conditional release’ in a heartbeat because then someone else would have the responsibility.” This approach may have added to the burden of Aboriginal services in the Ottawa region. While the APJC did have the support of many of these organizations, it was important to recognize that the existence of adequate and appropriate community resources and services were essential components of holistic, community-based justice projects. A formal survey of community agencies would have been helpful in identifying service and resource gaps and potential stresses and supports for the project and its clients.

Interviewees mentioned the long hours required by volunteers, high levels of stress, and the high potential for burnout. Moreover, circle members had access to confidential information that could not be shared with the community, which created difficulties: “We got privileged information from our non-Aboriginal partners, information that could not be shared with the community and because of the confidentiality aspect of our work, we were criticized. The committee took unfair abuse.” There was another side to this pressure, one related to the information Aboriginal circle members had about their community: “Another barrier is that as Aboriginal people, we know things that the Crown does not. We know where the clients are and know when they abscond from the process. This was a big dilemma because you can’t go to the Crown and advise them of all you know about the client.” This person went on to raise concerns about the safety of APJC members: “And this work was ... dangerous! I often wondered if someone in our community would come after me. It is also very hard to be neutral in the circle when you know the family of the accused. How can you be completely impartial? The committee was constantly under a microscope.”

Overall, the pressure on circle members may have been alleviated if some of the other challenges outlined in this section were addressed, then the circle members may have functioned more effectively; for example, if the initiative was fully understood and supported by the community and community members were involved in its design, if it had sufficient resources with access to a full range of complementary and supportive community services, if circle members had access to ongoing training as required, and if the committee had a well-developed (and community-approved) structure and set of policies, procedures, and processes to guide their work. Challenges related to the mainstream justice system were more difficult to overcome, but as noted elsewhere, the APJC broke down through their work with judges, lawyers, and other representatives of the justice system.

5.9 Lessons Learned

Interviewees were asked to describe what they would have done differently to better serve the needs of the clients, the volunteers, and staff of the APJC. The issue of community support elicited the most reaction from the interviewees. By far, the majority recognized the need for full participation of the community, both Aboriginal and non-Aboriginal, through regular communication and information sharing. It was argued that without community endorsement and encouragement the project would continue to operate
in isolation and never receive the validation required to realize desired success. Moreover, with community support the project would be in a better position to solicit additional volunteers for committee work. Training was also identified by one respondent who said, “we needed more specific training so that we could fine tune our processes.” The following are other suggestions and methods for obtaining project achievements and are in no particular order of priority:

- develop an information package for new volunteers;
- re-evaluate and restructure the APJC terms of reference;
- pursue incorporation;
- advisory role only for non-Aboriginal APJC members;
- clearer role for police to ensure safety of participants and victims;
- follow-up with victims and families;
- client follow-up;
- recognize client suitability and return those deemed unsuitable to the courts;
- have an Elder deal with internal conflict between individual APJC members;
- establish a mechanism for possible volunteer burnout;
- bi-monthly reports to the committee; and
- have a paid committee.

The quarterly reports were also a source for identifying lessons learned throughout the life of the project. As a result of challenges outlined in quarterly reports, the project decided to divide the committee into two parts: an executive committee to do administration and a circle advisory committee to deal with screening of clients and circle participation. “This system [will] enable us to utilize our volunteer abilities more effectively, while at the same time empowering and acknowledging their [the committee] contributions to the APJC.”

Other suggestions for improvement listed in the quarterly reports were regular circle meetings, which are vital; development of an evaluation form for participants; explore alternate sources for funding; explore circle keeper training; outreach to area reserves; and visit federal inmates in Kingston.

In spite of the challenges, one respondent summed up the lessons learned with, “What have I learned? That we are not always going to win, but at least when you participate you give it a shot ... and it is knowing that project outcomes do not necessarily always show project success.”

6. Conclusion

If we measure change by the impact the project had on its clients, then change occurred. Indeed, because of the seemingly inordinate amount of time, care, and concern the circle gave to their clients, they “won them over ... the clients were overwhelmed,” and some profound transformations were made. And, if we measure progress by the awareness raised in the mainstream justice system, then progress was also evident. The APJC did break down barriers through their work with judges, lawyers, and other justice system personnel. When Justice Heals was aptly named because, as one respondent said, “no one expects justice to heal.” Yet for a very few individuals, a modicum of healing was exactly what was received.

The Aboriginal Peoples Justice Circle wanted change as outlined in the logic model and performance map. They wanted to provide an alternative to the justice system for Aboriginal people in conflict with the law. They wanted to make the justice system more culturally relevant and more culturally responsive. They wanted reconciliation and restoration of families wherever appropriate. The extent that they did this was corroborated throughout the key informant interviews. In the short term, the APJC gained a measure of
credibility with the justice system, although reduced rates of recidivism will be harder to verify. The longer term measures of reduced incarceration rates will also be difficult to ascertain.

Nevertheless, the case study identified a number of substantive challenges: internal conflicts over the sentencing circle model; lack of community support and participation; lack of training and resources; administrative concerns; and systemic barriers within the mainstream system. There are some grounds for concern that the APJC has moved ahead of the Aboriginal community in embracing and implementing a particular alternative justice model without having fully involved the community. It is hoped that the recommendations set out below will assist the project in overcoming their difficulties, chief of which is the lack of sustained funding for a cadre of committed volunteers who are skilled in their individual fields and who have gained experience with circle sentencing through their participation in the APJC.

7. Recommendations

Program Delivery Issues:
- the APJC should begin by engaging the community in discussions about its work to date as well as present examples of alternative justice models currently in use. Community support and participation are recognized as key components of successful alternative justice projects and, to this end, methods could include organizing a series of community forums and taking advantage of all opportunities to make presentations to Aboriginal community agencies and organizations;
- the community be involved in a strategic planning process that includes discussions regarding whether the APJC should incorporate or if it should fall under an existing organization;
- the administrative and management structure and policies and procedures should be formalized paying close attention to safety, debriefing, and burnout prevention for the APJC members, and job descriptions for volunteer, paid staff, a board/advisory or steering committee, and an Elder;
- APJC members should receive training in a number of areas, including advanced sentencing circle and circle keeper training, mediation, alternative dispute resolution, and any other training needs identified by the committee, and these should be ongoing to ensure access by new members and volunteers;
- APJC should conduct a survey of Aboriginal and non-Aboriginal service providers to assess the range of support services available and to identify obstacles and gaps; and
- recognizing the difficulties involved in implementing the above recommendations when the APJC is operating on a volunteer basis and without operational funds, APJC should seek funding to continue its work.

Evaluation Issues:
- evaluation procedures and tools should be developed to collect and record confidential feedback from clients and victims as well as community and APJC members; and
- a process should be put into place for client and victim follow-up and to track aftercare progress.

Notes

1. Application for funding submitted by the project to the AHF.
2. The logic model, performance map, and questionnaire went through several revisions with the case study supervisor before they were shared with the project or tested.
3. On 12 August 2002 one potential interviewee returned my call to ask for more information about my July 31st telephone message. I advised him that the interview process was complete and that I was writing the final report for the case study. He was interested in receiving a copy of the final document.
4. Application for funding submitted by the project to the AHF.
5. As stated in the contribution agreement between Odawa Native Friendship Centre and AHF.


Approximately 20 applications for funding from various Aboriginal groups and organizations in the Ottawa area were reviewed. Source: confidential internal AHF proposals.

Source: http://www.ontarioinuit.ca/ottawa.htm

For example, the Assembly of First Nations, Inuit Tapiriit Kanatami, Congress of Aboriginal Peoples, Métis National Council, National Aboriginal Health Organization, and Aboriginal Healing Foundation.

Source: http://www.ottawa-conventions.com/frm_about.html


Application for funding submitted by the project to the AHF.

This information is reported in the Ottawa Police Service’s 2001 Activity Report, which notes that a new records management system in 1999 is largely responsible for the larger number of reported incidents in subsequent years.


Source: http://www.inac.gc.ca/pr/pub/urban

Hattem, Tina (1998). Survey of Sexual Assault Survivors: Report to Participants. Ottawa, ON: Department of Justice Canada and the Canadian Association of Sexual Assault Centres. In this study, reasons for not reporting the assault include (in order of frequency) fear of the criminal justice system; fear of record disclosure; fear of impact on family; negative experiences with the justice system; the perpetrator could not be located or was dead; fear of the perpetrator; and fear of impact on the relationship.


Aboriginal people comprise approximately 2 per cent of the Canadian population, but they make up 8 per cent to 10 per cent of the federal corrections institutional population and considerably more in provincial and territorial institutions. Source: LaPrairie, Carol (1992). The Role of Sentencing in the Over-representation of Aboriginal People in Correctional Institutions. In Robert Silverman and Marianne Nielsen (eds.). Aboriginal People and Canadian Criminal Justice. Markham,
ON: Butterworths Canada Ltd. Other authors have used a higher rate: Welsh and Ogloff (2000) state that Aboriginal people comprise 17 per cent of all federal offenders.

31 Welsh and Ogloff (2000).
33 Kishk Anaquot Healing Research (2001:17) [footnotes removed].
38 Canadian Institute for Health Information (1995:146).
40 Kishk Anaquot Health Research (2001:15) [italics removed].
41 Source: http://www.firstnationsfind.com/on/pub/index/childcare/community
42 Source: http://www.childwelfareresearch.net
43 Readers should note that the regional police service has amalgamated under the name “Ottawa Police Service.”
48 Aboriginal Peoples’ Justice Circle (APJC) Ottawa-Carleton Region (no date). Information sheet. It describes the application, healing circle, and sentencing circle processes.
49 APJC (no date).
50 Clairmont (1999:72).
51 Clairmont (1999:97).
53 Similarly, the foremost challenge for the Aboriginal Legal Services project in Toronto was sustained funding as their current funding was somewhat tenuous. See RCAP (1996:158). Bridging the Cultural Divide.
54 This February 2002 report was prepared by a member of the APJC for the period 7 May 2001 to 4 February 2002. The AHF-funded project ended 30 September 2001, so this document applied to a period of time after the funded project was over. Nevertheless, the document provided useful insights, and some of the required actions were identified during the period the project was operating with AHF funds.
55 Quarterly report submitted by the project to the AHF.
Appendix 1) Interview Questionnaire

Odawa Native Friendship Centre Questionnaire

When Justice Heals ID 1291-ON

Before we begin I would like to assure you:
• that there are no right or wrong answers, only answers that are true from your perspective;
• your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit;
• the project has been selected based upon the criteria that were important to the board such as geographic location, group representation, project type, etc and not on past or present project performance;
• it is important to remember that this is a case study, not an evaluation;
• we are only trying to learn from your experience so that we can help others get what they want from their AHF projects; and
• the report will not be able to identify who said what, so please feel free to say things that may or may not cause controversy.

1. I would like to begin by asking you to describe your role in the project.

2. What level of support do you feel the Aboriginal and non-Aboriginal community partners have given to this project?

Aboriginal Partners:

<table>
<thead>
<tr>
<th>Level of Support</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
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<tbody>
<tr>
<td>Wholehearted support, hard to imagine any improvement</td>
<td>Good support, but needs minor improvement</td>
<td>Fair support, but needs improvement</td>
<td>Inadequate support, needs major improvement</td>
<td>Clear resistance to the project</td>
<td>Not sure</td>
<td></td>
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</table>

Non-Aboriginal Partners:

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<tr>
<th>Level of Support</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
<tbody>
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<td>Wholehearted support, hard to imagine any improvement</td>
<td>Good support, but needs minor improvement</td>
<td>Fair support, but needs improvement</td>
<td>Inadequate support, needs major improvement</td>
<td>Clear resistance to the project</td>
<td>Not sure</td>
<td></td>
</tr>
</tbody>
</table>

3. What are the benefits of having this alternative justice project in the Ottawa-Carleton urban Aboriginal community?

What have you observed that makes you feel this way?

4. Can you describe some of the project’s successes or things that have worked especially well?

5. What are the some of the obstacles or barriers facing the project?

6. Can you describe how residential school survivors where involved in or contributed to the development of this project?

7. How has the project made the justice system more culturally relevant and more culturally responsive?

8. I understand that low participation rates have been a challenge in this alternative justice project. Can you describe what was done to try to increase participation among offenders?
9. Thinking about those who have participated in the project, do you feel that they are more likely or less likely to be in conflict with the law as a result of this project?

- More likely: __
- The same: __
- Less likely: __
- Not sure: __

What have you observed that makes you feel this way?

10. Over the course of the project, have you noticed if victims and their families are more likely or less likely to participate in alternative justice initiatives?

- More likely: __
- The same: __
- Less likely: __
- Not sure: __

What have you observed that makes you feel this way?

11. In your view, would you say the opportunities for victims and their families to participate in reconciliation process are:

- Better _____
- The Same _____
- Less _____
- Not sure _____

12. Thinking about project participants, can you describe any changes you have observed in their attitudes, knowledge, skills and behaviour?

i) Examples of Changes in Attitude, Knowledge, Skills and/or Behaviour:

- Why do you think these changes occurred?
- Can you estimate what proportion of participants may have experienced these changes?

<table>
<thead>
<tr>
<th>Only a few (less than 10%)</th>
<th>Some, but less than half (10%–49%)</th>
<th>Between half and three-quarters (50%–75%)</th>
<th>Almost all (76%–100%)</th>
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<td>Extremely well, hard to imagine any improvement</td>
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<td>Struggling to address the issue</td>
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13a. How well has the project ensured the safety of women, in cases involving women as victims (i.e. reluctance of female victims to support the justice circle process due to fear of re-victimization and further harm by the offender)? Please circle only one response.

- Comments:

13b. How well have referral social services and justice-related services ensured the overall safety and well-being for the offender (i.e. safe from community retribution or ostracization)? Please circle only one response.

- Comments:

13c. What measures are taken to ensure that the Circle Members do not experience burn-out?
14. Thinking about how mainstream justice officials have viewed the project, how have their perceptions changed over the course of the project? How do you know this?

15. How did the project deal with community criticism or opposition to the project?

16. How did the project deal with internal disagreements among the circle members?

17. Was the training that the Circle Members received adequate and appropriate for their project roles and responsibilities? Please circle only one response.

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Excellent hard to imagine any improvement

Very good needs only minor improvement

Reasonably good, but needs minor improvement

Fair, improvement required

Poor, needs major improvement

No training provided

Not sure

Why do you feel this way?

18. What was your most memorable experience about this project?

19. What did you like the least?

20. Thinking back over the project, are there things you would do differently or lessons you learned along the way? (If so, please describe them.)

MANDATORY QUESTIONS:

1. How well has the project addressed the legacy of physical and sexual abuse in Residential Schools, including inter-generational impacts? Please choose only one response.

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Very well, hard to imagine any improvement

Very well, but needs minor improvement

Reasonably well, but needs minor improvement

Struggling to address physical and sexual abuse

Poorly, needs major improvement

Is not addressing the legacy at all

Not sure

Please offer an explanation why you feel this way:

2. What were the previously identified needs that the project was intended to address?

3. How would you rate the project’s ability to address or meet those needs?

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Very well, hard to imagine any improvement

Very well, but needs minor improvement

Reasonably well, but needs minor improvement

Struggling to address physical and sexual abuse

Poorly, needs major improvement

Is not addressing the legacy at all

Not sure

Please offer an explanation why you feel this way:

4. How well has the project been accountable (i.e. engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

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Very well, hard to imagine any improvement

Very well, but needs minor improvement

Reasonably well, but needs minor improvement

Struggling to address physical and sexual abuse

Poorly, needs major improvement

Is not addressing the legacy at all

Not sure

Please offer an explanation why you feel this way:
5. How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

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<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
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</table>

Please offer an explanation why you feel this way:

6. Will the project be able to operate when funding from the Foundation ends? How?

7. How well was the project able to monitor and evaluate its activity? Please choose only one response.

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<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
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<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
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Please offer an explanation why you feel this way:

8. Final comments?
Appendix 2)

APPLICATION FOR SENTENCING AND HEALING CIRCLES

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone</th>
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<tbody>
<tr>
<td>Young Offender</td>
<td>Adult</td>
</tr>
<tr>
<td>Address</td>
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1. What Aboriginal Community do you identify with?

2. If you are aware, indicate the sentence the Crown is seeking.

3. List all charges before the Court.

4. List any people or agencies that you have contacted for assistance and the steps you have taken to begin your healing journey and to accept responsibility for your actions.

5. List any steps you plan to take to begin your healing journey and to accept responsibility for your actions.
6. You are encouraged to find at least two (2) community members who will support you.

As a support person I have discussed how I can offer support to this applicant and assist in his/her healing journey. I am also willing to attend the Sentencing and/or Healing circles and, if required, to attend the Aboriginal Peoples’ Justice Circle meetings to answer any questions.

<table>
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<tr>
<th>Name</th>
<th>Signature</th>
<th>Phone Number</th>
<th>Date</th>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Phone Number</th>
<th>Date</th>
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</table>

7. You are encouraged to make an offering to an Elder of your choice in accordance with Aboriginal tradition. If you require assistance with the step, the Aboriginal Peoples’ Justice Circle is available to assist you.

I have accepted the offering made by the applicant and have given him/her my support to apply to the Aboriginal Peoples’ Justice Circle for Sentencing and/or Healing Circles.

<table>
<thead>
<tr>
<th>Name of Elder</th>
<th>Signature</th>
<th>Phone Number</th>
<th>Date</th>
</tr>
</thead>
</table>
Willow Bunch Métis Local #17
Project Number: 1176-SK
Case Study Report
Willow Bunch Healing Project

Prepared by:
Flora Kallies

Under the direction of:
Kim Scott, Kishk Anaquot Health Research

Prepared for:
Aboriginal Healing Foundation Board of Directors

2002
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1. Introduction

The following report is one of 13 case studies being conducted for the impact evaluation of the Aboriginal Healing Foundation (AHF). The case studies were selected to include representation from a variety of project types and targets (Appendix 1). This case study covers the project types and targets for Métis, rural, west, and materials development.

The project addressed here is the Willow Bunch Healing Project delivered by the Willow Bunch Métis Local #17 of Willow Bunch, Saskatchewan (AHF-funded project #1176-SK). The primary purpose of the project is to, “Give a positive awareness of history of the Willow Bunch Métis to the community ... [and] increase pride in being Métis.” The report will describe Willow Bunch, the Métis and non-Aboriginal communities within, the project’s service delivery, team characteristics, and what it hopes to achieve in the short and long term. The report will also focus on changes in individual participants, the most prominent changes in the community, and how these changes were measured. AHF board-requested indicators of change (physical abuse, sexual abuse, incarceration rates, suicide, and children in care) were not collected in this case because they were insufficiently sensitive to the recognized needs and desired outcomes of the Métis community of Willow Bunch.

2. Methods

This case study evaluates changes of Métis participation in cultural activities, interviews, and meetings and of community awareness of true Métis history by gathering and analyzing qualitative information on areas of desired change that were selected cooperatively with the project. Through the use of program logic, the report also examines whether change can be attributed to project effort or to other contributing environmental factors.

Project files (funding proposal, contribution agreement, quarterly reports, and a tourism and economic development plan), the project’s response to the AHF Supplementary Survey of July 2001 and the National Process and Evaluation Survey, Internet, and key informant interviews with the project team and selected community service providers were the primary data sources. Although participant feedback forms were mentioned in the proposal as being one of the evaluative and accountability measures the project had planned, this was not the case. This is unfortunate as feedback could have provided very useful information for the case study. It seemed the project relied only on verbal feedback at the time of each activity.

During the first week of March 2002, one-on-one interviews were conducted with 11 individuals associated with the project or with local community services. The people interviewed included three team members, an advisory council member who is also president and board member of Métis Local #17, an Elder, a youth who was also the coordinator for the committee developing the historic village in the community, and the remainder were from community service agencies—two Royal Canadian Mounted Police (RCMP), the school principal, a retired local parish priest, and the postmaster.

Statistics were collected from websites for Statistics Canada, Indian and Northern Affairs Canada, and Government of Saskatchewan as well as from project files. Attempts to collect data from the Coronach RCMP detachment and the Willow Bunch town office were unsuccessful as there were no reported incidences of crimes and the town office did not keep statistics up to date.
The development of interview questions (Appendix 2) was based on the selected project’s desired short- and long-term goals (see performance map) and AHF board-mandated questions. The logic model was sent to the project prior to the development of questions in order to confirm any changes to project goals from the proposal stage to implementation. The questions attempted to determine if any desired social change in participants and in the community was achieved. Pilot testing was done in this case to ensure whether the questions were easily understood. Separate questionnaires were developed, one for team members that were based on the assumption respondents would have some knowledge of the participants. The other questionnaire was for outside agencies (i.e., school, museum, and town office) in the hopes to determine whether project output (i.e., information on Métis culture and history) was achieved and knowledge of the Métis was expanding.

The project was able to secure interviews with some of the leading community members who were not necessarily involved with the project. Contact with some of the potential interviewees was difficult as some worked outside the community and one had become very ill. Actual interviews were conducted by an AHF employee, and two of the three project team members were interviewed at the Local where privacy was limited to the project coordinator’s office.

2.1 Limitations

Because direct assessment was problematic, indirect assessment or the perceptions of key informants were weighted heavily. Furthermore, the only participant feedback was unsolicited and informal, which did not allow for the discovery of trends or anomalies.

Two days of training were offered to community support coordinators and others of the AHF in survey development and interviewing techniques in March 2001, with a follow-up in July 2001. Work began in earnest on this case study in January 2002, and interviews were prepared based on the short-term outcomes identified in the performance map. The interviewer was independent in the field and, in this case, no debriefing after each day of interviews took place. Field notes were reviewed and transcribed only after all interviews were conducted. There is really only one line of evidence in this case study, which was directly obtained from, or referred by, the project team. However, dissent was encouraged in at least two introductory remarks preceding interview questions:

- that there are no right or wrong answers, only answers that are true from your perspective; and
- the report will not be able to identify who said what, so please feel free to say things that may cause controversy.

Attempts to secure disconfirming evidence, rival explorations, or negative cases were limited to only one respondent. Other possibilities to secure this type of information was negligible due to lack of time and scheduling of interviews. The only quantitative information obtained was limited to rates of participation in some project activities. The luxury of multiple evaluators was not available within the resource limitations; however, the context and data were reviewed and most responses were recorded verbatim. This allowed verification and reanalysis by an external evaluation facilitator, which may have reduced bias associated with only one investigator.

The interviewer was mostly reliant on information that was readily available as only three days were allocated to gathering data. The most important information missing are social indicator data, disconfirming
points of view, as well as more long-term follow-up of community progress based on the desired outcomes identified.

3. Project Description

Historical information on the Métis of Willow Bunch is almost non-existent, and what does exist gives the Métis a negative image as well as being written by non-Métis people. This project hopes to change the historical image of the Métis who contributed to the settlement of Willow Bunch. In this light, the project also hopes to change the views of non-Métis to allow pride of being Métis to flourish.

A proposal was sent to and approved by the AHF to identify, collect, and disseminate true historical contributions of the Métis of Willow Bunch in order to heal the negativity toward the Métis, thus meeting the needs of the Métis community. It is not the project’s wish to rewrite history but to show the community of Willow Bunch, the Métis community of Saskatchewan, and the rest of Saskatchewan that the Métis established Willow Bunch and later contributed to the present-day community. The project commencement date was 1 October 2000 and was funded as a one-year project that ended 30 September 2001, with a contribution in the amount of $109,200. The project is currently in its second year of operation.

3.1 The Project Team

The project is delivered out of a recently purchased house. Métis Local #17 was established in the 1940s but has never received core funding nor has it delivered any services from an established location. It existed solely through membership fees, and the elected board participated on a voluntary basis. At present, its only other funding source comes from the AHF.

Although the AHF National Process Evaluation Survey stated that the project had four full-time employees, two part-time employees, and a number of volunteers who contributed approximately 40 hours per month, it became clear that the project coordinator was the only full-time team member. The consultant and researcher visit the project three to four days per month. There was another researcher–interviewer for the first six months but is no longer with the project.

The project coordinator is Métis, born in Willow Bunch but left when he was 10 years old. He returned years later to settle in the community. He was president of the Willow Bunch Métis Local #17 from 1996 to 2000 but stepped down as president in order to become the project coordinator. Since 1996, he has been involved in various Métis and community issues (i.e., member of the Willow Bunch museum board, past Métis Nation of Saskatchewan board member of the Métis Employment and Training Services Inc., the southern Saskatchewan representative on the Métis Nation of Saskatchewan Hunting and Land Rights Task Force, and member of the Southern Saskatchewan Tourism Association). Prior to 1996, his experiences included rodeo announcing, auctioneering, stand-up comic, rodeo competitor, park guide, and horse packer. As project coordinator, he sets up all activities and conducts interviews for the project, which include cultural events and workshops.

The project consultant (co-coordinator for the current year) is also Métis with familial ties to Willow Bunch. He offers consulting services on many projects for a number of Aboriginal organizations and governments. His services include evaluations, research, needs assessments, and proposal submissions.
on issues relating to economic development and tourism, homelessness, family violence, hunting, and education. For the project he developed the proposal, completed the quarterly reports, and supported the research. As well, he prepared a tourism and economic development study for the Local in 1998.

The project researcher and writer holds a doctorate in educational policy and administrative studies, a master in Indian and northern education, a bachelor of arts in history, and a professional teaching certificate. She has completed an extensive list of reports for a number of Aboriginal organizations, both national and provincial, such as the Métis National Council, Royal Commission on Aboriginal Peoples, Métis Nation of Saskatchewan, Gabriel Dumont Institute, and other Métis organizations and Aboriginal communities. Her more recent research has concentrated in the area of economic development for Métis people.

According to the project coordinator, 30 to 35 volunteers contributed to the office setup for the Local. Elder involvement appears to be one Elder, but there was some confusion as to whether he was on the advisory committee or not. In either case, he openly contributes advice whenever called upon.

Involvement of youth seems limited as there is only one at present who is involved. He recently identified as a Métis and is now a member of the Local as well as the coordinator of the historical village. Members of the advisory committee for the AHF-funded project also make up the board of the Local.

3.2 Activities and Outcomes

Three major social issues affecting the Métis community identified in the project’s funding proposal were high incidences of depression, drug and alcohol abuse, and racism. The main program activities expected to produce change in these conditions were:

- collect and analyze stories, interviews, research material;
- examine the loss of Métis identity;
- identify what it means to be Métis;
- identify Métis families and their contributions;
- involve Métis Elders and youth;
- develop a communication plan;
- revive and appreciate traditional Métis activities, e.g., Aboriginal Day, Riel Day, fly the Métis Nation flag;
- maintain regular public meetings and newsletters and use all media to inform and promote a positive image;
- re-educate the Métis and the non-Métis community of true history;
- work with the museum, schools, provincial Métis agencies, and organizations to promote positive Métis history;
- co-sponsor workshops and cross-cultural awareness in Willow Bunch and elsewhere with other Métis organizations, agencies, and services; and
- work with community leaders on promoting Willow Bunch for a new positive image.

These activities would lead to the production of booklets, brochures, and posters on Métis contributions to the area, a book or publication on the healing process, and a book or publication on the Willow Bunch Métis. In the short term, there would be an increased number participating in cultural activities, interviews, and meetings; an increased number of Métis sharing their stories; and an increased number aware of the true Métis history. These would ultimately create conditions where there would be an increase in pride
in being Métis, a positive awareness of the history of the Willow Bunch Métis, a better relationship with the non-Métis community, and an improved Métis image.

The relationship between project activities and selected short- and long-term benefits is set out in the logic model (Table 1). The performance map that follows details the project’s mission, target, objectives, and goals. This map or reference guide was used to determine what information should be gathered to measure any change that has occurred.

**Table 1) Logic Model—Willow Bunch Healing Project**

<table>
<thead>
<tr>
<th>Activities</th>
<th>Address the legacy of a nation of Aboriginal people, the Métis of Willow Bunch, which has lost its Métis identity.</th>
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<tbody>
<tr>
<td>What we did</td>
<td># of cultural activities; and developed communication plan.</td>
</tr>
<tr>
<td>What we wanted</td>
<td>Increase # of Métis participation in cultural activities, interviews, meetings; and increase awareness of true Métis history.</td>
</tr>
<tr>
<td>How we know things changed (short term)</td>
<td># participating in cultural activities; who shared stories; and # aware of true Métis history.</td>
</tr>
<tr>
<td>Why we are doing this</td>
<td>Ensure a positive portrayal of the history of the Willow Bunch Métis; and increase pride in being Métis.</td>
</tr>
<tr>
<td>How we know things changed (long term)</td>
<td># who are proud to be Métis; and # of people who are aware of the true history of Métis in the community.</td>
</tr>
</tbody>
</table>
Table 2) Performance Map—Willow Bunch Healing Project

<table>
<thead>
<tr>
<th>MISSION: Give a positive awareness of history of the Willow Bunch Métis to the community; increase pride in being Métis; and community will begin the healing process.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOW?</td>
</tr>
<tr>
<td>Resources</td>
</tr>
<tr>
<td>activities/outputs</td>
</tr>
</tbody>
</table>

How will we know we made a difference? What changes will we see? How much change occurred?

<table>
<thead>
<tr>
<th>Budget</th>
<th>Reach</th>
<th>Short-term Measures</th>
<th>Long-term Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>$109,200</td>
<td># of Métis who participated in cultural activities and # of participants who attended meetings.</td>
<td># participating in cultural activities; # who shared stories; and # who are aware of true Métis history.</td>
<td># who are proud to be Métis; and # of people in the community who are aware of the true history of Métis.</td>
</tr>
</tbody>
</table>

3.3 Participant Characteristics

Attendance at public events where activities were organized by the project included: the old-time fiddle dine and dance (150 to 300 Métis and non-Métis people attended); a workshop on Métis identity (50 Métis people attended from the towns of Assiniboia, Wood Mountain, Rock Glen, and Willow Bunch); and the cultural day event that took place at the school (approximately 120 participants attended of whom 110 were students). All other activities that occurred did not indicate participant estimates. The following figure indicates the total number of participants for the full year submitted by the project in the fourth quarterly report.5
3.4 Community Context

The town of Willow Bunch, Saskatchewan, is located at the southern end of the province approximately 50 kilometres from the United States border. It is a picturesque, small community typical of southern Saskatchewan. On a hill at the back of town are remnants of small shacks where the Métis who worked as seasonal labourers lived. This part of town was considered the lower class section and approximately 40 Métis families lived in these dwellings. "In fact, early in the twentieth century, the Métis were actually removed from the village by the French-Canadian elite and were forced to live in a nearby road allowance community known as the 'Métis hamlet.' " Today, only a few remaining structures still stand, a legacy of how the Métis lived and were treated. Commercial buildings along the main street include a garage, motel/restaurant, tavern, and gas station. Recently acquired, Métis Local #17 now has its own building. Within the town, there are the town/fire hall, rural municipality building, co-op store, post office, library, school, retirement home, and convent that has been converted into a museum and community/day care centre. A few heritage buildings lie vacant and many homes have long-standing “for sale” signs giving the town an abandoned look.

The population of the town is 400 with 50 per cent being Métis. It is now felt by the project that there are approximately 90 per cent who are Métis, but most do not identify or know they are Métis.

I feel ninety per cent are Métis really, but that there’s still a vast majority that wouldn’t even admit. A lot of them, not so much that they wouldn’t admit it, they don’t know it. It has been hid from them and because of the past experiences over the years, you could fit into the community and your family got along a lot better in the community if you could deny being Métis or if you could hide it in a way then you would [and] you could fit in with the church a lot better. You could fit in with the structures that the non-Métis community had brought into the area such as credit unions, school boards, different kinsmen clubs, and different organizations. You would be accepted by them a lot more if they thought you were other than Métis.
As of July 2001 there were 395 people living in Willow Bunch\(^7\) compared to 430 in 1996.\(^8\) This decrease is indicative of the economic turmoil this small rural town faces. Many high school graduates leave for education or opportunity and few return.

Major industries in the area include agriculture and the mining of natural non-mineral resources used in agricultural, industrial, and craftsmen products. The farming and ranching community is struggling with a three-year drought that is still ongoing. Tourism is an industry the town of Willow Bunch wishes and needs to improve and expand upon. In terms of dollars for economic growth, very little trickles into the community. Mostly, small grants from the Quebec government are awarded to improve francophone initiatives in Willow Bunch. Since the Saskatchewan government has made it policy to include and improve the well-being of Métis people as a separate and distinct society in the province, more dollars have become available for education and other programs that include a Métis component.

Regarding issues facing the community, moderate challenges were stated as lack of acceptance of Aboriginal language and culture by local institutions, local community opposition (fear, denial), substance abuse, and lack of transportation (i.e., local bus, vehicles). Slight challenges include adult illiteracy, apathy or lack of active Aboriginal community support, poor local economic conditions, family violence, sexual abuse, and lack of community resources, facilities, and services. It should be noted that there were no problems with suicide or fetal alcohol syndrome/fetal alcohol effects (FAS/FAE) and no severe challenges facing the community.\(^9\) Analysis of social indicators revealed that there were no cases of physical or sexual abuse, children in care, or attempted or completed suicides in Willow Bunch for the year 2001. Although the data suggest that Willow Bunch is a healthy community, some respondents feel this may not be the case. They feel that small community dynamics, such as lack of trust in police services, may influence reporting.

There were no residential schools in this area; however, Sisters of the Cross Convent did operate as a school between 1914 and 1971 and has since been converted to a museum. The Willow Bunch public school, opened since 1888, accepts both Métis and non-Métis students from the area. When the convent opened as a school it accepted and boarded both girls and boys from the outlying areas until 1923. No evidence could be found to determine the number of Métis children who attended either school. All students, both Métis and non-Métis, were taught that Métis were people of mixed background, they have some qualities and some faults of both races. Many of them are irascible, inconsistent, wasteful and love alcoholic beverages. They cannot work consistently nor can they adapt as farming or business. They become easy prey to the European settlers that unscrupulously buy their land for a piece of bread or a bottle of whiskey and are thus reduced to a miserable existence ... Today with few exceptions, the Métis are rather miserable.\(^10\)

This excerpt is from a history book that is still held in the Willow Bunch library and, thus, reinforces the non-Métis community’s negative views toward the Métis. As stated in the project files, this constant degradation has led Métis to abuse, violence, and addictions and feelings of low self-esteem, depression, fear, and shame. It has created fear, distrust, anger, suspicion, gossip, and open hostility towards Métis by non-Métis people: “There were stories of beatings, name calling, racism”\(^11\) that some Métis came forward and told.
Historical documentation reveals how the Métis were mistreated and shunned from institutions such as the credit union, community councils, and organizations: “They could be part of the parish. They were part of the fold. However, there was not any of them that sat on parish council or school boards.” Even the young did not escape the racism:

I definitely seen a lot of segregation and that type of thing. The first day of school, I remember playing with a French boy and we were getting along fine and the nun come over and I couldn't understand French. I couldn't speak French that good but I could understand some of it to get by and I remember her saying, “you don't play with Mitchif, you play with your own kind.” She took him away from me, you know, the dirty half-breed.

The Métis were considered intellectually inferior and mainly restricted to agricultural labour. If a Métis wanted to increase employment opportunities he had to forego his identity: “I think that a lot of the people in this community were anti-Métis for a long time. A lot of people.”

In 1998, Métis Local #17 received a grant from the Clarence Campeau Development Fund, a Métis-controlled funding agency established to provide a means for Métis communities to plan economic development opportunities. This grant allowed the Local to hire consultants to prepare a tourism and economic development plan for the Métis. It was then discovered that the community did contain a rich Métis history that has been neither identified nor clearly documented. It was this discovery that led the Local to work on rectifying this omission.

4. Results

The desired outcomes that were examined focus upon social and environmental changes but also include a look at individual change. More specifically, the following discussion highlights: impact on the individual, including project awareness, Métis involvement, and identification; and impact on the community, including response to the project, access to information on the Métis, community relations, and community knowledge of Métis. It should be noted that some of the activities set out in the contribution agreement between the project and AHF did not take place. There was no book produced or distributed as the project had difficulties in obtaining the number of stories and interviews that were hoped for, no formal communication plan was developed, and there was no evidence of any brochures, pamphlets, or posters produced by the project.

4.1 Impact on the Individual

The majority of respondents were aware of the project, although most saw it as the Local’s activities rather than the Willow Bunch Healing Project. The following lists what respondents believe is the central message of the project:

- “an understanding of the healing project”;
- “learning one’s own culture”;
- “Métis oppression is revealed”;
- “the way Métis were treated historically”;
- “heal loss of Métis identity”;
- “bring community of Willow Bunch together”;
- “jobs for Métis”;
- “start another museum”;


• “portray accurate historical account of the Métis”; and
• “clear the Métis name by showing Métis people as being positive.”

While only a small portion of the non-Métis community may have been exposed to project material, those who were appeared positive toward Métis culture and history.

Métis membership and identification are clearly on the rise. The Local reports a membership of 250 from the towns of Willow Bunch, Coronach, Rockglen, and Bengough; the membership was at 100 four years ago. This increase may have been influenced by AHF-funded activity, as some only discovered that they were Métis once the project started: “A lot of it is people didn’t even know that there were Métis. They didn’t even know that there was an organization or a nation that there could be a membership.” The increased identification could also be attributed to recent legislative changes to policies that benefit Métis people.

Many Métis appear more interested in their family and group history, which is manifested through their attendance at Local meetings and the increase in discussion about Métis identity. When asked about changes in project participants, respondents agreed that there was a dramatic increase (over 80%) in participant knowledge of accurate Métis history as well as involvement and pride in Métis culture. One respondent said, “I see kids in my classes that talk about being Métis now and I don’t know if that would have happened ten years ago or five years ago, for that matter.” Another stated, “I feel more proud to be Métis now.” The Métis flag is now flown on all occasions, and more community members wear the Métis sash with pride. Respondents also felt there was a moderate to dramatic increase (over 40%) in participant knowledge of Métis culture and identification. Although there was some disagreement about the extent of change, respondents did believe that there was an overall increase in non-Métis’ knowledge of accurate Métis history. Respondents credited a variety of actions and conditions for the noted change, including: an individual desire to learn; the influence of the school librarian and principal; the commitment of the project team and project activities; no accurate information on Métis history existed before; open and inviting cultural events during holidays and school time that are focused on reconciliation and not blame (i.e., a Métis dine and dance where about 150 to 300 people attended); and the existence of the Métis Local facility as well as their increased participation with Métis Nation of Saskatchewan affiliates.

4.2 Impact on the Community

There were mixed feelings regarding what percentage of the community was positive about the project—anywhere from less than 10 per cent to 50 per cent. Those that were positive were the Métis involved with the Local, students, people who have an appreciation for history, many of the Elders, those with a broad world view, and those who have left Willow Bunch and gained an opportunity to experience other environments and different cultures.

The ones that did live in a Métis way or recognized as Métis people here, they really are reluctant ... because they were always put down all their life about being proud of who they were ... the people that are enthusiastic are the ones that were never treated any differently ... they never really went out to say they were [Métis]. They were a little more light-skinned ... and given opportunities to better themselves economically or agricultural businesses or what have you. The people that went to the convent that were identified as Métis people—most of their memories are quite hurtful. So they don't [want to engage]. It's hard getting through to them.15
Others who showed enthusiasm included the mayor, the librarian, the nuns at the rectory, the kinsmen club, and the local principal who was particularly supportive. One respondent stated, “He’s been involved in many of our feasts and he participates in the cultural events at the school and he encourages the Métis to come in the community and present the Métis point of view at the school. That is something that didn’t exist before and is now become stronger and stronger.” The Local is also gaining ground with the museum board that has resisted changes to its displays. Now, however, they are starting to listen.

Still, some were resistant and respondents estimated that anywhere from 10 per cent to 50 per cent felt apprehensive, as one respondent stated, “Older Métis but they’re enthusiastic about the project. They are glad something is being done, but as participants they are reluctant.” The less enthusiastic were older and more closed-minded who felt threatened by an accurate history and changing of school language laws—English rather than French would be the primary language—and resented economic development funding for the Métis. One respondent stated, “The people who never left Willow Bunch who have taken one interpretation of history for granted for so long and because a project like this is going to challenge some of those assumptions, they’re perhaps a little defensive about it.”

All respondents were generally pleased with what the project had been doing. One non-Métis respondent felt it was great that the Métis were writing their own history. A member of the school authority also expressed his appreciation of the Local’s eagerness to help in school cultural activities related to Métis issues. The profile of the Métis still has opportunity for growth, as two respondents were admittedly unaware of the project and the Métis Local but understood that education could only improve community relations.

Some respondents observed that there had been an increase in the amount of information on the Métis. Information dissemination is taking place for the first time, which is also influenced by new benefits for the Métis (e.g., education funding). The following lists what the project has done in the past year to get the information out to the public that has never been done before:

- 10 to 12 workshops held that were open to the general public;
- 8 to 10 cultural activities were held and hosted by the project;
- the Local is working within the school;
- other Métis organizations are visiting the community;
- several newspaper articles and reports on Métis have been written; and
- interviews regarding the project have taken place.

Community respondents noted that there was increased discussion about Métis issues and Local activity. Information sharing included monthly handouts, historical documentation available to Local members, and what is being taught in the school (although curriculum changes occurred prior to the project). The project intended to produce brochures, pamphlets, and posters but has instead made use of already developed pamphlets and posters of other Métis organizations. Still, communication has occurred mainly through open discussion with animated displays of Métis culture rather than through written handouts. This seems to work well, albeit limited to a smaller audience. Métis history and culture, rich with life and colour, is better related through demonstration.

Since the project started, some felt that views toward Métis had improved, shown by the increased community involvement in Métis activities, especially by the youth, and an informal agreement made
between the historic village committee and the project. Also, some community members are encouraged by opportunities for prosperity. The impact from project activity is being felt outside the community, with some wondering how Willow Bunch got so far ahead while other communities have not. One respondent said, “I’ve gotten phone calls from some people that used to live here that I don’t even know and thanking me for what we have been doing and wish me all the success.” Progress will happen when presence, resources, committed people, and experts combine. The steadfast enthusiasm, congenial approach, and firm vision of the project team have influenced many to become more open-minded about Métis issues.

The majority of respondents also felt there was an improvement, albeit minor, in the broader community’s view of the Métis as evidenced by more people hiring Métis and those starting to ask questions, especially the students at school. Although minor, respondents credited the improved image to Métis displays, the physical presence of the Local, other Métis organizations in the province, Métis in the media, provincial education policy, and more open discussion about Métis issues. To determine how much knowledge the community has on the Métis, respondents were asked what it means to be one. Responses included:

- “Aboriginal blood mixed with non-Aboriginal blood.”
- “Trace roots back to a particular people and culture.”
- “Descendants from seven Métis families from the Red River settlement near Winnipeg who were the first settlers of the prairies and have a separate culture.”
- “Musical history and sash.”
- “I don’t really know. As far as I’m concerned I’m a Canadian, Canadian-Métis. But first of all I’m Canadian. I would say. But I’m Métis I don’t deny that. I grew up to be. In the early years you see you didn’t go around bragging that you were a Métis. But now it seems everybody wants to be a Métis. So I don’t know ... the project ... As far as I can see it hasn’t changed me at all but I’m glad to see the way things are going.”

All informants concur that the broader community has greater knowledge of Métis history and traditions as evidenced by the increase in youth identification as well as invitations to participate in non-Métis events and committees. They believe that a number of factors have created conditions where change was possible, such as:

- workshops and activities associated with Métis history and culture, especially those enabled by AHF support where experts came (e.g., Gabriel Dumont Institute and the Métis Employment and Training Services Inc.);
- the importance of having someone validate your identity;
- recognition of Métis contributions to the community in a positive, non-threatening way;
- having a physical presence in the community (i.e., the building);
- available information about the Métis for distribution; and
- the Saskatchewan government’s education policy that encourages Aboriginal history to be incorporated into school curriculum.

Overall, respondents believe that increased awareness of and respect for Métis culture and history has evolved as a result of project activities:

The more I can see, it’s even broadening my own perspective to know that some of the most highly decorated veterans from this community were Métis. That the giant was Métis. You know, it makes you look at some of that history a little bit differently because the giant with a name Beaupre has been very much promoted as a francophone and his Métis heritage has never really been promoted. And I think most of the history of this area has come from a euro-centric perspective up until the healing project.
Pride in Métis culture has resulted in increased identification:

The Métis people were shunned traditionally and it’s kind of grown through time to where we are now. Now I think the Métis association has such a positive impact on the community and I think it’s opening up eyes and people are seeing that, you know, it’s not that beneath you. It’s good to be Métis and to be proud of who you are.  

4.3 Partnerships and Sustainability

No formal partnerships have been established and sustainability is really a non-issue. Once the book is published the objective will have been achieved. Still, informal partners are plenty. As one respondent said, “You’ve got the kinsmen involved, you’ve got the community involved, you’ve got the school involved, you’ve got the museum involved, you got the historical society involved, and the Métis themselves. So this something that’s never happened before.”

Although there seems to be support from local organizations, the extent of that support is not evident, and trust issues are still an undercurrent in the relationship between the Métis and others in the community. Some suspect that overly enthusiastic “partners” may be clamouring for Métis-specific funding without any intent of sharing the “power” with the Métis. Overall, it was felt that support of the local leadership, school principal, kinsmen club, parks and recreation, postmaster, town council, and rural municipality were helpful and earnest. Even Métis organizations outside the community have shown their support through visiting the community and by participating in cultural activities on the project’s behalf.

As for financial sustainability of the Local, it will be difficult to continue because AHF is its only funding source. They will be looking at Heritage Canada, Gabriel Dumont Institute, and the Clarence Campeau Development Fund for future funding.

There are no co-sponsors involved with the project, but support linkages have been established with Métis Addictions Council of Saskatchewan Inc., Gabriel Dumont Institute of Native Studies and Applied Research, and Métis Nation of Saskatchewan. The project is currently working with the Willow Bunch Historical Village Committee to ensure that the Métis component of the village is accurately portrayed.

4.4 Accountability

One team member believed that the Métis leadership is constantly monitoring and evaluating activities at monthly Local meetings that are also open to the community. Even though the project stated they were using feedback forms to evaluate and monitor, none were submitted with project monitoring reports. The project may have felt that completing the project monitoring reports was the only evaluation exercise required. Communication with the community included sharing the project’s work plan for the second year and having constant informal communication with the school, museum, historical committee, and other Métis institutions. Press releases, public announcements, and live interviews were included as well.

4.5 Addressing the Need

The project is not addressing the legacy of physical and sexual abuse in residential schools, but it does state that the intent was only to focus on Métis identity and history. Residential schools were only one
of many tools used to assimilate Aboriginal people, and there were many other colonial institutions that also attempted to quash Métis identity and culture.

The project has set a foundation for an improved relationship, not only with others, but within the Métis community as well, by examining the loss, reclaiming Métis identity, documenting an accurate history, and using this information to re-educate the community. Overall, the team feels that the activities undertaken have contributed to changes in attitude and acceptance of the Métis from most people who have been exposed. The project credits the Métis members of the community for their progress to date.

4.6 Successes and Best Practices

One best practice was to have one-on-one and group discussion and communication with the community and to work with the local school system. Métis cultural events that provide opportunity to see, hear, and taste the culture through food, song, and dance have been very well received. Involvement of local agencies in project activities has improved trust and relationships, and the linking with other Métis organizations has increased information flow to the community. A constant presence (flying the Métis flag and showcasing the Red River cart) and voice in the community have encouraged communication on history and culture. The most notable success seems to be the cultural activities at the school, as youth tend to be more open to different ideas and are eager to increase their knowledge.

4.7 Challenges

Some community relations are strained, especially with the older set. The project identified the difficulty in dealing with some Métis elders who were reluctant to relate their experiences; however, the elders are becoming more involved in Local activities.

During Canada Day celebrations, the project put on a display with the Métis flag and Red River cart, demonstrated how to make bannock, and played traditional Métis music that most attendees seemed to enjoy by spending more time at this display than at others (including the Francophone community display). Leaders and demonstrators of the Francophone display went to the Métis display, interrupted the festivities, and announced that they were going to sing some French songs, including what they believed that “les sauvages et les Métis, voyageurs” had played. This show of dominance and hostility dampened festivities and was done with a sense of complete normality. In order to change this attitude, the project feels that it will take more than two years.

The project also had difficulty convincing people that it is trying to improve community relations. Support from some church members does exist (e.g., nuns allowing access to birth and death records), but most suspicion and doubt appears to emanate from other church members.

4.8 Lessons Learned

Only a small number of interviews have taken place thus far, and the team felt they needed more time to interview older Métis. They did not take into consideration the guilt and denial older Métis feel about their heritage and the time needed to develop trust. They also realized that recent funding is being allocated to Métis initiatives, causing some resentment from those feeling left out of the resource loop. One way
to improve relations would be to work jointly on St. Joseph’s Day celebrations. The project stated that teaching the youth about Métis history and about being Métis would be more beneficial because they felt the youth are more open-minded, and those of the older generation tend to be more set in their ways. Thus, the project is planning to coordinate a cultural youth camp at one of the provincial parks in the area.

The tenacity of those who are threatened by a new social order where Métis value is recognized was unanticipated and underestimated. They are the ones who control how local heroes are portrayed and resist any message that threatens their place in the historical social hierarchy. While the team is not entirely clear on how to influence them, it is clear that the endeavour will be long-standing. The team felt that lateral violence is seen on a daily basis and will not go away once history has been accurately documented. They presented a wish list of what they would like to see done, which was to restore the Métis cemetery and to prepare a documentary on the life of Métis-born Edward Beaupré (the Willow Bunch Giant who was the tallest man in Canada and the fourth tallest in the world).

5. Conclusion

Historical segregation of the Métis in schools, employment opportunities, and housing has led to racism, distrust, and lost identity that still exist today in Willow Bunch. Educating the community about true Métis history, encouraging pride in Métis identity, and attempting to improve the relationship between Métis and non-Métis appear to have contributed to positive changes in the community. As a program focused on re-educating the community with a positive message about the value of Métis identity and contribution to the region, the Willow Bunch Healing Project appears to be having a positive influence on those who participate and is generally well received by most. Those exposed to project material and activities, who appeared to have gained knowledge and were positive toward Métis culture and history, are Métis involved with the Local, students (many now identify as Métis), historians, many Métis Elders, people re-entering the community who hold a broader world view, the mayor, the librarian, nuns at the rectory, members of the kinsmen club, the local principal, and members of the museum board who previously resisted changes to the Métis displays but are now starting to listen.

In addition, more Métis attend meetings at the Local and appear to be interested in their family and group history. For some, they have discovered that they are Métis. Influence in the broader community has been credited to a community desire to learn, the influence of school authority, a committed project team, open and friendly cultural events, the existence of the Métis Local, and participation of other Métis organizations. Basically, project activities are allowing for accurate information and cultural celebrations to be shared for the very first time. These activities have been conducive to positive learning experiences, improved community relations, and views toward the Métis. Evidence includes increased employment for Métis and more interest in Métis culture and history. Informal communication has worked well in some cases; however, written material from the project could supplement informal efforts.

Increased Métis membership and identification indicates pride. This change in attitude may be influenced by the project team, including the coordinator’s dedication and humorous, down-to-earth approach. Other influences include the physical presence of the Métis (i.e., Métis flag is flown, Red River cart is displayed, cultural events with animated displays are taking place, and Métis Local facility is evident for the first time), economic opportunities, and provincial legislative changes that benefit the Métis in Saskatchewan.
Those who seemed not to respond well to project materials and activities were older community members, some church members, those who have never left the community, and those who resent historical changes to school language laws. The feeling is that it will take much longer than the life of this project to change attitudes and ease suspicion. Also, some older Métis are still reluctant to share their stories, and feelings of guilt and denial will need more time to change.

Although the project’s first year plan was to complete an accurate historical account of the Métis of Willow Bunch, they found that it was going to take a lot longer as only one quarter of the book was done. Historical information on the Métis in general was difficult to obtain; however, work with the museum committee to improve the Métis displays is well underway. Finally, while the extent and magnitude is not entirely clear, something beyond physical changes is definitely different in Willow Bunch. A community-wide survey would be needed to quantify the impact.

6. Recommendations

The following recommendations are suggestions to enhance administration and evaluation of the program.

Program recommendations:

- increase exposure of information on Métis (open discussion and written materials) and include demonstrations of Métis song, dance, and food;
- include project-produced documentation to hand out during cultural demonstrations and information sessions; and
- project-produced documentation and advertising of events to be included in local paper and distributed to the whole community to ensure information dissemination to everyone in Willow Bunch.

Evaluation recommendations:

- develop a participant feedback form to guide improvements; and
- develop and conduct a community survey to determine the extent of Métis knowledge and rate of racial discrimination.

Notes

1 Information from Willow Bunch Healing Project proposal for funding, February 2000 submitted to AHF.
2 It should be noted that the town office was occupied solely by the secretary and that the mayor and other councillors were employed full-time elsewhere.
3 The project submitted statistics in all four quarterly reports, but the final report (fourth) contained numbers for the full year. Quarterly reports request statistics for each activity that occurred during the quarter, but this was not done.
4 Excerpt from draft of historical book being developed.
5 AHF Supplementary Survey (July 2001).
6 Interview response, 6 March 2002, Willow Bunch, SK.
8 Statistics Canada 1996 Census: Population Statistics for Willow Bunch (Town), Saskatchewan (retrieved data on 14 January 2002). The Aboriginal population was not listed due to the community receiving only the short form of the Census questionnaire that did not include questions regarding Aboriginal ancestry. The town office still uses the 1996 Census.
“One of the biggest impacts of unresolved trauma and abuse is lateral violence. This kind of violence is how oppressed people show their rage and frustration from being constantly put down. It usually happens without people knowing that it is part of the cycle of oppression. The violent acts are directed at our own people (laterally) rather than at those who have oppressed us. The ways that lateral violence shows itself include: blaming others, putting others down, gossip, family feuds, jealousy and in-fighting within a group or community, to name a few. Lateral violence has become a way of life in many Aboriginal communities. It is tearing many communities apart.” Aboriginal Healing Foundation (1999:A5). *Aboriginal Healing Foundation Handbook, 2nd edition.* Ottawa, ON: Aboriginal Healing Foundation.
Appendix 1) Case Studies Selection Criteria

1. Métis, Inuit, First Nation, Non-Status
2. Youth, Men, Women, Gay or Lesbian, Incarcerated, Elders
3. Urban, Rural or Remote
4. North, East, West
5. Community services
6. Conferences/gatherings
7. Performing arts
8. Health centre (centralized residential care)
9. Camp/retreat (away from the community in a rural setting)
10. Day program in the community
11. Healing circles
12. Materials development
13. Research/knowledge-building/planning
14. Traditional activities
15. Parenting skills
16. Professional training courses
Appendix 2) Interview Questionnaires

Willow Bunch Healing Project
Interview Questions—Project Team

It is important that they know that:

- that there are no right or wrong answers, only answers that are true from their perspective
- their participation is strictly voluntary and they can choose to answer or not answer questions as they see fit
- they have been selected based upon the criteria that were important to the board (i.e. geographic, group representation, etc and not on their past performance or any fears about their performance so far)
- that we are only trying to learn from their experience so that we can help them get what they want and help others get what they want from their AHF projects
- that the report will not be able to identify who said what,
- that they should feel free to say things that may cause controversy and
- that for the most part, it is important to focus their comments on participants.
- It is also important to stress that there are a wide range of acceptable and truthful answers including “I don’t know” and “I’m not sure”.

1. To start, I would like you to now think about the project participants. Have you noted changes in any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Dramatic Increase (&gt;80%)</th>
<th>Moderate Increase (40-80%)</th>
<th>Slight Increase (1-40%)</th>
<th>No change</th>
<th>Don’t Know</th>
<th>Slight Decrease (1-40%)</th>
<th>Moderate Decrease (40-80%)</th>
<th>Dramatic Decrease (&gt;80%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) knowledge of Métis culture</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>(b) knowledge of accurate Métis history</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(c) involvement in Métis cultural activities</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
</tr>
<tr>
<td>(d) identify as Métis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(e) pride in being Métis</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(f) non Métis knowledge of accurate Métis history</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(g) non Métis institutions (e.g. schools, museums) intentions to use renewed Métis history publication</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>

Why do you think things turned out the way they did? In other words, if there was no change or things got worse, how would you explain why this has happened?

OR, if there was change? Why did things change?
What do you believe caused things to change/remain the same/ or get worse?

2. In the last 12 months, have you noted if information regarding the Métis available to the general public has:
   increased   decreased   stayed the same   not sure
   What have you observed that makes you feel this way?

3. What have you learned from your involvement with this project so far?

4. Is there anything you could suggest that might improve this project?

5. We are aware that you have supplied information through the submission of your quarterly reports, but we would like to offer you another opportunity to provide any further insight in the following areas:
   i. the extent of survivor involvement
   ii. the effectiveness and extent of partnerships and linkages
   iii. the project's ability to monitor and evaluate its activity
   iv. support of local leadership

6. In the last 12 months, please state whether you feel the non-Métis community knowledge of Métis history and traditions has:
   increased   decreased   stayed the same   not sure
   How do you know?

   Why do you believe this has happened to the participants?

   Why do you believe this has happened to the community?

7. In the last 12 months, please state whether you feel the broader community's views towards Métis has:
   increased   decreased   stayed the same   not sure
   How do you know?
Why do you believe this has happened?

8. Does a formal communication plan exist with any local institutions (e.g. schools, museums, other Métis organizations)? Can we have a copy?

9. Do you have any final comments to share?

MANDATORY QUESTIONS:

10. How well is the project addressing the legacy of physical and sexual abuse in Residential Schools, including inter-generational impacts? Please choose only one response.

<table>
<thead>
<tr>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>0</th>
</tr>
</thead>
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<tr>
<td>Very well, hard to imagine any improvement</td>
<td>Very well, but needs minor improvement</td>
<td>Reasonably well, but needs minor improvement</td>
<td>Struggling to address physical and sexual abuse</td>
<td>Poorly, needs major improvement</td>
<td>Is not addressing the legacy at all</td>
<td>Not sure</td>
</tr>
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</table>

Please offer an explanation why you feel this way:

11. What are the previously identified needs that the project is intended to address?

12. How would you rate the project’s ability to address or meet those needs?

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13. How well has the project been accountable (i.e. engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose only one response.

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Please offer an explanation why you feel this way:
14. How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose only one response.

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Please offer an explanation why you feel this way:

15. Will the project be able to operate when funding from the Foundation ends?

16. How well is the project able to monitor and evaluate its activity? Please choose only one response.

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Please offer an explanation why you feel this way:
Willow Bunch Healing Project
Interview Questions—Outside Agencies

It is important that they know that:

- that there are no right or wrong answers, only answers that are true from their perspective
- their participation is strictly voluntary and they can choose to answer or not answer questions as they see fit
- they have been selected based upon the criteria that were important to the board (i.e. geographic, group representation, etc and not on their past performance or any fears about their performance so far)
- that we are only trying to learn from their experience so that we can help them get what they want and help others get what they want from their AHF projects
- that the report will not be able to identify who said what,
- that they should feel free to say things that may cause controversy and
- that for the most part, it is important to focus their comments on participants.
- It is also important to stress that there are a wide range of acceptable and truthful answers including “I don't know” and “I’m not sure”.

1. Are you aware of the Willow Bunch Healing Project?

2. If so, can you tell me what is the central message they are trying to promote?

3. Can you describe for me in your own words, what it means to be Métis?

4. Do you believe that your (school, museum, etc, etc) will incorporate the renewed Métis history currently being prepared into the curriculum (reference material), etc.

5. Do you currently teach Métis history (display Métis contributions to the region)?

6. If not, is there a plan to incorporate Métis history into the curriculum (museum displays), etc.

7. What do you believe will change as a result of the project activities?

8. In the last 12 months, have you noted if information regarding the Métis available to the general public has: increased decreased stayed the same not sure

What have you observed that makes you feel this way?
9. In the last 12 months, please state whether you feel the non-Métis community knowledge of Métis history and traditions has:
   increased     decreased     stayed the same     not sure
   How do you know?

   Why do you believe this has happened in the community?

10. In the last 12 months, please state whether you feel the broader community’s views towards Métis has:
    increased     decreased     stayed the same     not sure
    How do you know?

    Why do you believe this has happened?

11. Do you have any final comments to share?