JOURNEY AND BALANCE

Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity

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Prepared by Kishk Anaquot Health Research

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Preface

Quotes from case studies are not referenced according to standard recognized citation style to protect the anonymity of informants.

Definitions

This glossary of terms has been provided as a way of ensuring clarity throughout the document. Please read through these definitions and refer to them as needed.

best practices - activities that appear to work best and feel right for Survivors and their families.

capacity-building · increased ability, skill or knowledge on the part of healers, project administrators, volunteers and community members.

greatest need · where AHF-selected indicators of mental health and family functioning (e.g., physical and sexual abuse, incarceration, children in care and suicide) show that the group is at greatest risk, as well as behavioural indicators (e.g., addictions and violence) reveal to community members which individuals and families are at greatest risk.

healing efforts · refer to all activities whether they are program, home, institution or centre based.

holistic healing · healing of the mind, body, spirit and emotions.

individual healing · is focused upon personal growth and not community development.

intergenerational impacts · refers to the effect that residential school has had upon the children and grandchildren of those who have attended residential schools.

long-term · refers to the results that are realistic in 10-15 years.

median · the median is a measure of central tendency (or the "middle") used in statistics and represents the "half-way" mark. In other words, half of all values fall below and above the median.

(n = x) · this refers to the number of responses received on a survey item.

outcome · intended or unintended result.

output · product or service delivered.

program · or project are used interchangeably and refer to the action taken at the community level that is grant specific. In other words, many communities have several grants from the AHF; however, each grant is considered a distinct project.

short-term · refers to the kinds of results that are immediately apparent and most often refer to cognitive change (e.g., changes in attitudes, motivation, ideas, knowledge) and realistic within the lifespan of the project.

Survivors · primarily, this term refers to those who attended residential school; however, for stylistic simplicity, this term is often used to denote those that attended residential school as well as those impacted intergenerationally.

sustainability · an indication of longevity beyond the limits of the Aboriginal Healing Foundation either through the financial contributions of others or through voluntary effort.

the Foundation · refers to the program activity of the Aboriginal Healing Foundation.

the Legacy · refers to the enduring effect of the physical and sexual abuse suffered in residential schools including intergenerational impacts.

Executive Summary

Methods

This report discusses the contribution made by AHF-funded project activity in realizing the desired and unintended short-term outcomes as a way of being accountable to various primary stakeholders and to provide valuable, relevant information for users and decision makers. Case studies (13 in total) were used to examine selected priorities in depth and included representation from all Aboriginal groups, special need categories and communities, as well as a full range of project types. Community Support Coordinator's (CSCs) were enlisted to complete case studies under the guidance of an external evaluator. Over time, it became clear that tracking project influence on community rates of incarceration, children in care, physical and sexual abuse or suicide were not sufficiently sensitive to detect the early contributions of AHF-funded project activity. Rather, it makes more sense to track individuals over time; however, no direct measurement of change in participants was conducted due to ethical concerns. In particular, each case study addressed the project's impact on individuals and communities as well as issues related to sustainability, partnerships, addressing need, best practices, challenges and lessons learned. To secure several lines of evidence, the results of a document review of 36 files and the national process evaluation survey were also used to supplement case study information.

Context and Participant Characteristics

Thirteen sites were selected, at least one per region (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Atlantic and the North). There are striking differences in the social, economic and cultural environments in which projects operate. Yet, patterns can appear even across such diversity, including poor economic conditions, unemployment and housing shortages.
The following table provides a summary of the case study projects, including community size and target groups.

Project Descriptions

Project	Description	Community	Target Group
Healing & Harmony in our Families	Healing and training a core group of community caregivers	**Cape Dorset**, Nunavut: 1,200 (remote)	Inuit
Two-Spirited Youth Project	Peer support and healing activities for gay, lesbian, bisexual and trans-gendered youth	**Vancouver**, BC (urban)	gay/lesbian youth
Honouring Survivors Theatrical Production (Every Warrior's Song)	Researching, writing, and delivering a play that honours Survivors and addresses the Legacy of physical and sexual abuse in residential schools	**Chase** BC: performances throughout region (rural)	Aboriginal, primarily First Nations
Qul Aun Program	In-patient healing centre based on a blend of traditional healing and centralized residential care	**BC** (province-wide); healing centre on Nanoose First Nation: 151 (Vancouver Isl.)	Aboriginal, primarily First Nations
Tawow Healing Home	Culturally-based, non-mandated therapeutic home for children/adolescents and their families at risk of involvement with protective services	**Red Deer**, Alberta: 68,308 (urban)	First Nations, Métis
Healing the Multi-generational Effects of Residential School Placement - Urban Access Program (Building A Nation)	Training for beneficiaries to better manage crisis, cross-cultural training, Legacy education, healing services and adjunctive services (e.g., client advocacy and support related to child custody, justice and social service, housing, life skills).	**Saskatoon**, Saskatchewan: 200,000; Aboriginal population: 30,000 (urban)	Urban Aboriginal people
Willow Bunch Healing Project	Activities to increase awareness of Métis history and pride in being Métis	**Willow Bunch**, Saskatchewan: 400 (rural)	Métis
Kikinahk Parenting Program	Parenting skills program combining traditional and western models and approaches	**La Ronge**, Saskatchewan: 7,000 (rural)	First Nations, Métis
Pisimweyapiy Counselling Centre	Nine-week, community-based out-patient program for Survivors and their families	**Nisichawayasihk Cree Nation**, Northern Manitoba (rural)	Aboriginal, primarily First Nations
I da wa da di	Healing circles, fasting and healing retreats for Aboriginal women; training workshops for service providers who work with Survivors	**Ontario**-wide: host organization in Toronto, healing centre in Six Nations	Aboriginal women
When Justice Heals	An urban alternative justice project that incorporates healing and sentencing circles.	**Ottawa**, Ontario: 875,100; Aboriginal population: 35,000 (urban)	Aboriginal
Koskikiwetan	Training of community workers and counsellors, establishment of a support network, Legacy education and land-based healing activities	**Opitciwan, Wemotaci, Manawan**, Quebec: Atikamekw Nation (rural)	Primarily First Nations, on and off reserve but includes non-status Indians, Métis, Inuit and non-Aboriginal family members
Our Youth, the Voice of the Future (Big Cove Youth Initiative)	Activities to support the personal, social, mental and physical well-being of youth	**Big Cove**, NB: 2,458 (rural)	First Nations youth

Participants in the case study projects varied according to program goals and target group. This diversity is evident in the following examples:

- Over one-third of healing participants and two-thirds of training participants in Cape Dorset were Elders.
- The majority of participants in the Tawow Healing Home project were young single women who previously attended some form of substance abuse treatment and had their children apprehended.
- Similarly, most participants in the Kikinahk Parenting Program were young single parents, mainly women, who accessed the program by dropping in or were referred by the mental health centre or women's shelter. Some women brought their spouses and children to participate.
- Groups to date in the Qul Aun Program are predominately women; however, the centre is currently seeking ways to encourage men to attend. Disabled clients are accommodated into the program and one to three incarcerated males attend each session. An overwhelming majority are residential school Survivors.
- At the Pisimweyapiy Counselling Centre, there was roughly an even distribution between the sexes, although women still outnumber men. The majority were in the 25-45 age category. Almost all are First Nations on-reserve and a large percentage are inter-generationally impacted.
- I da wa da di reached Aboriginal women from sixty-two First Nations and urban/rural communities in Ontario, including a few from other provinces and some living outside of Canada. One quarter were Elders and 6.7% were youth. Almost three-quarters identified as inter-generationally impacted.
- The theatrical production honouring residential school Survivors, *Every Warrior's Song*, reached an estimated 4,000 people.
- The Big Cove Youth Initiative reported reaching approximately one hundred and fifty of the community's nine hundred youth and children on a weekly basis.
- As stated in a 2001 survey, the population of Willow Bunch is four hundred with 50% Métis. The project team, however, believes that approximately 90% are Métis but do not identify or do not know.
- Building A Nation serviced the Aboriginal population of Saskatoon which included over 500 individuals, who were primarily First Nations with some Métis participants. Special targets reached included incarcerated and homeless individuals.
- Koskikiwetan provided training and therapy to over 400 individuals, primarily First Nations women aged 26-49 residing on reserve.
- The Aboriginal Peoples' Justice Circle (When Justice Heals) recruited participants through the mainstream justice system. Two people completed the healing process.

While the case studies provide project-specific information about participants, the national survey allows a look at the broader picture. The survey found that addictions, victimization and abuse are clearly the most severe[1] participant challenges affecting the majority of projects (69%, 58% and 58% respectively). Other common challenges reported as severe by a sizable group include denial or grief, poverty, and a lack of parenting skills. Males outnumber females in only two target groups: gay/lesbian and the incarcerated. All others included more women participants (Survivors, later generation, disabled, and Elders).

Influencing Individuals

The planned impact of AHF-funded project activity upon project participants includes:

- increased awareness and understanding of the Legacy;
- increased participation in healing; and
- strengthened capacity of Aboriginal people to heal others.

Many felt that raising awareness and understanding of the Legacy was a pivotal first step to successful healing and the need for continued sharing of Legacy information and experience was regularly reinforced. Where denial is strong and trust still needs to be established, information sessions were more highly attended than therapeutic ones. Legacy education motivated others to break the cycle of physical and sexual abuse.

At least 48,286 individuals have participated in healing programs, almost all of whom had never participated in a similar healing program before. Projects often saw healing as a broad range of ideas and behaviours. While dramatic change was observed in some participants, others showed little or no change. There was often disagreement about the depth and extent of change.

Connecting Survivors to one another, ensuring clarity about their rights at the outset and ensuring they had access to skilled counsellors with whom they could identify worked well to establish safety. Large public forums, widespread publicity and group counselling offered Survivors union. Counsellors who were non-judgmental, sincere, gentle, respectful, committed, patient and culturally sensitive were clearly credited with creating a safe therapeutic climate.

Changes in cultural awareness were more easily influenced than changes in parental involvement. Some participants developed leadership skills, greater goal orientation, enhanced self-esteem, improved family relations and peer support. They felt better able to face homophobia, deal with their sexuality, address their addictions or reunite with their families and communities. They described cultivating a stronger sense of self, becoming more attentive to their families, committed to passing on cultural teachings, spending time with Elders and personal wellness. They felt less alone, more forgiving and returned to school or made career moves.

Some were better able to cope and became more confident and stable although lower levels of improvement were noted for those simultaneously participating in addictions treatment and known

[1] Severe means that the characteristic affects 80% or more of participants.

violent perpetrators. Others appeared better able to maintain sobriety, seek and secure employment, disclose past trauma, display physical affection, seek spiritual fulfilment and, recruit others to participate, demonstrate pride in their heritage andor identify as Métis. Parent child interactions were characterized as more patient, relaxed, confident and nurturing.

Although reports were based upon immediate assessment of outcomes, there is some evidence to suggest that intensive therapies create enduring results. However, those who return to correctional facilities or remote regions may not get the support they require. Complete recovery can remain elusive in scenarios where aftercare is in question.

Many trainees felt more empathetic, supportive, compassionate, and non-judgmental in their work with Survivors and better equipped to use traditional approaches. At least 10,938 received training; yet, there was a common belief that teams would have benefitted from greater capacity. Although most projects could make referrals when the special needs of their groups exceeded capacity, others had no choice but to try to address special needs with whatever resources they had. They also made the case for counsellors specifically trained in residential school abuse but warned against simultaneous program delivery and training. On occasion, teams and beneficiaries were equally impacted by the Legacy. Strong, positive participant satisfaction leads to the conclusion that the training and experience of some teams were well suited to facilitate healing.

Influencing Communities

While it is too early to examine long-term outcomes, progress can be measured through the analysis of anticipated shorter term outcomes. At the community level, these include:

- increased understanding and awareness of the Legacy;
- increased ties between Survivors and healers;
- increased capacity to facilitate healing;
- evidence of strategic planning with a focus on healing;
- increased partnerships; and
- increased documentation of the history of residential schools.

Not all the case study projects addressed all of these outcomes, but there is evidence to suggest that progress is being realized, especially in two areas: addressing the Legacy and increasing the capacity of communities to facilitate healing. The community healing process, like individual healing, goes through four distinct stages or cycles.[2,3]

The first stage often begins with a commitment by a core group of individuals to address their own healing needs. A growing recognition of social problems such as addictions or suicide can motivate

[2] Herman, J. (1997). Trauma and recovery: The aftermath of violence – from domestic abuse to political terror. New York: Basic Books.

[3] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada.

key agencies to also become involved. For example, the amount of work required to complete an AHF application and the clarity with which communities must identify problems and interventions place them firmly within the first stage of healing. Other aspects of the application process propel them further along the path by supporting a growing clarity about root causes of social problems.

The second stage of community healing is characterized by an increase in healing activity and recognition of the root causes of addictions and abuse. Understanding of the Legacy can be a pivotal first step in individual healing. When history is shared, a social context is created for addressing the problem. For example, over the past four years in La Ronge (Kikinahk), 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 as hearing the radio talk show in Cree made it okay for individuals to talk in other venues. For the Nisichawayasinhk Cree Nation (Pisimweyapiy Counselling Centre), more open discussion about and different attitudes toward the Legacy, together with public acknowledgment of high profile perpetrators, suggest that the climate has changed.

I da wa da di training sessions for front-line workers were also especially successful in increasing participants' knowledge of the Legacy; this new understanding was used in their healing work with clients. The theatrical production honouring residential school Survivors, *Every Warrior's Song*, was built around the experiences of Survivors; the production involved them in the research phase and as advisors throughout the project. This project documented residential school history and impacts. Guided discussions with the audience after each performance led one person to observe that conversation is opening up as family members attend together, *"all crying, all supporting, all spoke. The healing was transpiring right before our eyes."*

By the third stage of community healing, a great deal of progress has been made but momentum is beginning to stall. AHF-funded projects provided community-level employment and training opportunities not previously available. Large numbers of Aboriginal people have been hired and trained and are now participating actively in community healing initiatives. This represents a significant contribution to building a healing capacity within participating communities. In addition, AHF has placed considerable emphasis on projects developing partnerships and cooperative relationships and there are good reasons for this. The Foundation does not wish to foster dependency on a fund with a ten-year life span, and partnerships are one way of promoting longer term sustainability. There is also a well-established body of literature that supports a coordinated, holistic approach to health and healing through community development.

During the fourth stage, healing is more integrated with other community development initiatives and the focus shifts from fixing problems to transforming systems. Significant reductions in rates of physical and sexual abuse, children in care, incarceration and suicide are most likely to occur at this stage. It is still too early to assess the contribution of AHF-funded projects by measuring improvements in the environment based on these social indicators.

Managing Program Enhancement

Case study project files were rich in detail regarding the achievement of service delivery objectives

and some did formally collect feedback from participants that was invaluable to adding participant voice to this report. Although all projects submitted evaluation plans, many selected for case study evaluation did not have the expertise, time, resources or appropriate tools to carry out their evaluations. It is also possible that project teams may have confused their investment in completing project monitoring and administrative evaluation forms requested by the Foundation as sufficient to meet evaluation requirements. Clear and specific evaluation methods were articulated by only a few of the projects selected for document review (36 in total); only a handful had completed evaluation reports. Some who did engage in evaluations as planned provided stellar examples of community-based, participatory self evaluation with solid defensible evidence. Nevertheless, more clarity on the difference between the ability to measure implementation objectives (e.g., what we did or output) and real change (e.g., what we wanted or outcome) is needed. It would be preferable if projects were comfortable enough to strive for more realistically attainable goals that can be articulated in finer detail so that the theory underlining each effort is clearer.

In the future, indicators that are adequately discriminating must be selected and a strategy enabling direct measurement of individuals must be considered because communities are not always appropriate targets for study and most certainly not provinces. Individuals should be followed over the long-term and some effort should be made to determine how successful participants differ from those who are not successful. Information should include personal, educational, vocational, criminal and treatment histories as well as level of functioning in the home, relationship with their partner, in the workplace, with their children, friends and parents. Youth development projects could also adapt tools which measure resiliency. Of particular interest to addressing the Legacy could be the work of Mary Jane Alexander, Ph.D.[4] who is developing a reliable and valid instrument to assess healing from sexual abuse trauma. In addition, more community-wide endeavors would be well suited to use the community Welles report card suggested by Four Worlds.[5]

Moreover, because a "within groups repeated measures" design (measuring before and after program intervention) is no longer practical, case studies were redesigned as post program only. In other words, performance was measured after participation in the project. Ideally, the Foundation could compare project participants with an equivalent comparison group or, at least, a non-equivalent comparison group. But, funding policy would have to be changed to ensure that any group enlisted as an equivalent or non-equivalent comparison would eventually be funded to address the Legacy at some later point in time. To compare interventions to one another, the Foundation may also want to consider a "post program only" design using a variety of different approaches to healing or training.

Accountability to Community and Survivors

Three of the four urban case study projects struggled with issues of community participation and

[4] Research scientist with the Nathan Kline Institute: 140 Old Orangeburg Road, Orangeburg, NY 10962, Phone: 845-398-6584, Fax: 845-398-6592.

[5] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada.

Survivor involvement. It may be that extraordinary efforts are required to engage Survivors and community members in urban areas where the community is geographically dispersed among a larger non-Aboriginal population. Four of the remaining projects appear to have achieved high levels of Survivor and community engagement, while the others had mixed results. Koskikiwetan is a stellar example of a Survivor-driven project – over half of the fourteen-member multi-disciplinary team that developed the project proposal were Survivors. Later, Survivors directed the project and delivered the therapy. This had a cathartic effect on local workers as well as participants. Survivors can share experience, model healthy behaviour, truly understand and empathize and they appear to be more effective at shattering silence that surrounds abuse. In contrast, the national process evaluation survey (NPES) found that, overall, Survivors were least likely to be involved in the development of program content or materials but were more commonly enlisted as advisory committee members.[6]

Addressing the Need

Turbulence is to be expected, when projects are faced with the dilemma of having to simultaneously develop local capacity and deliver much needed therapies. After all, becoming aware of repressed personal issues and collective problems is part of the healing process. While the reasons for selecting community members to lead the healing process are clear, being thrust into the role of Survivor/healer can lead to unintended and potentially harmful consequences which raises important questions. What risks are tolerable when moving forward with simultaneous training and healing? Does the need for community based healers (who are also Survivors) mean that some parameters need to be defined for scenarios where training and healing are simultaneous? How will the Survivors' safety be guaranteed in such scenarios?

The majority of projects (55%, n=234) were able to accommodate all who needed therapeutic healing or desired training. But, teams also admitted to facing a service demand that exceeded resources and needs that went beyond team abilities. At least 7,589 individuals with special needs (e.g., suffered severe trauma, inability to engage in a group, history of suicide attempt or life threatening addiction) were identified. On average, more than a third of participants in every project required greater than normal attention to deal with their special needs. In addition, some target groups remain difficult to engage and information about barriers to participation remains unclear. Projects also filled identified service gaps such as:

- providing services to gay and lesbian youth;
- offering a non-mandated, culturally sensitive blend of traditional and contemporary parenting skills program;
- whole family therapy; or
- celebrating and reinforcing Métis culture.

Lessons Learned

Adequately trained and sufficiently healed individuals, preferably community-based Survivors are

[6] Kishk Anaquot Health Research (2001). An interim report of Aboriginal Healing Foundation program activity. Ottawa: Aboriginal Healing Foundation, page 65.

essential to facilitate healing. However, at least two projects warned against simultaneous training and service delivery.

More women than men participate in healing and there is some evidence to suggest that men may be more resistant to the therapeutic process itself. The literature on treating male Survivors of sexual abuse points decidedly to the need for more research, more gender-specific treatment programs, more male therapists and more understanding of the effects of therapy on men and boys.

In light of the Legacy, one of the more disturbing consequences is the potential for male Survivors of unresolved sexual trauma to commit sexual offences. While the links between victimization and offending are not fully understood, there is a need for greater understanding of the therapeutic healing needs of male Survivors and intergenerationally impacted men and boys. This is a precondition to creating effective programs that engage male participants.

The interim evaluation reported that many projects affirmed the value of traditional healing and the need to increase the use of traditional healers, Elders and cultural teachings, either alone or in collaboration with other methods. However, more specific and detailed information is required about the blending of traditional and western approaches and how this actually works in the therapeutic environment. For example, which specific traditions and western approaches work well together, in what ways have they been blended, in what proportions and with what results? Given the significant variation in Aboriginal cultures and communities and the corresponding variation in western therapies, a great deal more needs to be known about integrating these two approaches.

For many of the case study projects, culture and traditions played a supportive rather than therapeutic role. Schools were reported to be very interested in finding Elders who are knowledgeable in traditional ways; some projects incorporate on-the-land excursions and camps. Social activities such as feasts and dances often brought people together.

The report cites a number of examples of learning that took place at the project level, including the following:

- improved networking, especially among the directors of health services, would guarantee program complementarity;
- the importance of whole family therapy and traditional ways has been key to keeping families together;
- bunk beds and the use of flashlights on night patrol are clear triggers for some clients;
- other triggers of in-patient treatment are related to food quality, which is not always optimal in institutional environments;
- family-of-origin discussions are essential to breaking through self blame;
- there appeared one major lesson learned, and that was the underestimation around what effort was actually needed to organize the youth;
- bring in more male-female training teams;
- the project was hesitant to start a men's group unless men can get healing and training to support the group; the men wanted experienced group facilitators;
- there is a critical need for training/healing Aboriginal caregivers.

. I learned a lot about accountability and going slower - being better prepared;
. guard against team burnout; and
. targeting efforts at youth who are more open may be the best use of resources.

Best Practices

Legacy Education

Legacy education was commonly recognized as a catalyst for healing. Awareness campaigns felt safe to the majority prompting further action to address the Legacy often before a crisis could occur. Many felt that schools were particularly important partners in this regard and that greater efforts with students should be undertaken.

The Healer

Selecting highly skilled Survivors, fluent in their language who could model successful healing worked very well. Success was further reinforced if healers were like their target group on a variety of other dimensions (e.g., gay or lesbian, teens, female, male, parents or grandparents and respected members of the community). Survivors wanted respectful, non-judgmental, culturally sensitive, patient, committed, role models able to facilitate independent decision-making in a way that supported self esteem and feelings of safety. Caring for the care giver meant preparatory work to ensure they did not assume the role of rescuer, a continuous process of the intense emotional nature of their work and regular professional development opportunities.

The Environment

When serving a regional population, using an already established centre of healing worked to lend credibility to AHF-funded projects. When servicing a local population, it may be more important for projects to have an identity and location of their own. Sufficient space and private facilities with soundproof rooms for one-on-one counselling sessions were considered basic essentials. An environment that reinforced cultural identity was silent but powerful. Residential programs need to be particularly mindful of potential triggers (e.g., bunk beds, night watchmen with flash lights, low budget menus).

Therapeutic Approach

Therapy was best initiated with some clarity and education regarding client rights. Developing whole programs or specific activities to meet the unique needs of special groups (e.g., transgender youth, teens, men, parents, women, Elders, students) appeared to maximize program influence. Sometimes, unique solutions were created based on individual needs; one-on-one counselling functioned well in this regard. Emphasizing personal responsibility together with self trust also worked well. Blending traditional and western therapies was popular although traditional healing alone was also recommended for those open and willing to engage in cultural reclamation. Having fun was an important element in the healing equation, especially with teens. Light-hearted family outings offered important bonding experiences and was a welcome break from the heavier emotional work done in counselling. Connecting and sharing was often cited as a best practice and included examples such as conferences, active outreach, home visits, role modelling, healing circles, whole family treatment and voluntary services where Aboriginal people could empower one another.

Program Administration

Letting the target group make program decisions ensured that activities remained relevant and evolved to best suit Survivors' needs. Ensuring participants are well-

screened and selected from those who genuinely want personal transformation as well as from the group with needs that best "match" the services offered set fertile ground for growth. Service access was ensured by scheduling evening and day sessions, promoting services in and out of the community and providing childcare or travel when it was needed.

Partnerships

Schools were often mentioned as powerful allies not only in Legacy education, but also as institutions which could guard Aboriginal cultural integrity. Establishing working relationships with complementary services meant more holistic care could be offered as an avenue for Survivors to continue engaging in healing, even if their needs exceeded the expertise of the project team. These same alliances were important when it came to planning and ensuring adequate aftercare. Lastly, but perhaps most important, supportive leadership played a pivotal role in contributing to desired outcomes.

Challenges

Continuum of Care and Whole Family Treatment

As much can be learned from the difficulties facing projects as from their successes. It is also critical to remember that a range of social and economic conditions and individual and community strengths stand behind every project. For example, the Pisimweyapiy Counselling Centre, a community-based therapeutic program located on Nisichawayasihk Cree Nation, is impeded by a variety of factors ranging from inadequate facilities to a therapeutic approach – involving the whole family – that appears not to have been totally embraced by participants' families. Other challenges relate to the need for a continuum of care in the community, including outreach and aftercare, and for the counselling centre to establish an identity separate from the addictions service that sponsors the project. Surveyed on their own, these challenges appear daunting. Yet, viewed in context, one becomes aware of the strengths the project has to work with: a community with strong ties to its culture, language and values and which is viewed from outside as independent and organized, fully capable of dealing with its social problems.

Mandated Participation

Another challenge identified in the Pisimweyapiy Counselling Centre study – the failure to engage mandated clients – highlights a problem that other projects may also be experiencing. Simply stated, people cannot be forced to heal. For Survivors, there may actually be good reasons for resisting mandated participation since the same feelings of powerlessness and helplessness that occurred in the traumatic experience can be recreated in therapy.

Resistence and Denial

Resistence and denial were reported in many of the projects. In one case, it was observed that Elders would rather not talk about their experience in residential school, while the men and women in their forties and fifties were more willing to share openly about it. Another project found the community was still struggling with the issue of residential schools and most could not or would not admit to being a Survivor.

Resources

There were concerns regarding the high level of uncertainty over funding, as well as problems related to a lack of resources. Often, it

was human resources that were required. Other resource restraints influencing projects included: loss of team members, inadequate access to Elders and other programs and activities, reduced ability to initiate new activities to meet growing demands, insufficient outreach, inability to train referral workers and provide more pre/post service to clients, and reduced public education.

Level of Need

Case studies point to the high level of need among project participants. This not only places a burden on the ability of projects to meet the demand for services, it also challenges their professional capacities. For instance, meeting the unique needs of those still struggling with addiction or suffering from FAS/FAE challenged a number of projects. Specialized skills and training may be required for projects to deal internally with some of the special needs of clients; alternatively, access to appropriate outside professionals is necessary. Many projects found that tremendous effort is required to address such high level needs and the challenges associated with maintaining momentum are severe. Certainly, employee burnout is one of the consequences that projects experience. Many AHF-funded projects also fill gaps in community services.

Availability of Skilled Healers/Trainers

The success of many of the projects has been attributed to highly skilled individuals and teams, but there is a need for an even greater number of Aboriginal healers with recognized skills and reputed practices. Yet, it is not universally clear how to determine when a healer has gained sufficient skills and experience or is sufficiently healed to lead others into healing. The need for more healers must not take precedence over the safety needs of Survivors.

Engaging Men

The Cape Dorset healing project identified, *"getting men involved because of their need to appear strong"* as a challenge. Men who attended a community workshop, *"expressed a desire to start up a men's group, but wanted someone experienced leading them."* This suggests that lower male participation in healing may, in part, be addressed through developing male healers, facilitators and role models.

Time

While lack of time was not explicitly highlighted as a challenge among the case study projects, the need for more time was often cited as a lesson learned. AHF-funded projects are not a quick fix, and more than a five-year band-aid is required. The literature is clear that the failure to provide clients with adequate time and support to heal is irresponsible.

Cultural Clashes

Sometimes, integrating with non-Aboriginal services agencies in an urban context revealed fundamental tensions between client and mandate centred approaches. When it became clear that Aboriginal people preferred culturally appropriate services that apparently worked better, some provincial service providers felt threatened or became territorial.

Conclusions

Legacy education created a climate that facilitated movement toward healing without first facing crisis.

Legacy education also created a constructive framework for training. But, informants were clear that their work was not complete in this regard. Many more felt intimately familiar with and capable of responding to Survivors' needs and effectively managing crisis. Still, on occasion, the connection between Survivors and potential healers was not the best 'fit' because Survivors' needs exceeded team capacity. Embracing hard to reach groups will be an ongoing challenge.

Some case studies indicate that years of development and careful attention to Survivors' needs were undertaken to develop a strategic therapeutic plan. AHF-funded project activity has been credited with contributing to a shift from crisis management to a more effective long-term wellness planning and community development that often functioned to reduce gaps in service. Nevertheless, most projects are at risk because they have been unable to secure long-term financial commitments.

Indicator data show that suicide, physical abuse, sexual abuse, children in care and incarceration rates remain high. There is no consensus among key informants that these problems are decreasing. But a ripple effect is being witnessed, as many informants spoke about how participants' families and partners have benefitted. Within projects, there appears to be large differences between individuals. While some move quickly toward desired outcomes, others apparently do not; it is still unclear what the differences are between these groups. Although it is premature to conclude that activities have developed lasting healing from the Legacy, it would be safe to say in some programs there has been tremendous instant gratification for Survivors. In some communities, progress is slow because the project is reaching only a small number of its target group. Creative solutions are needed to dismantle denial not just in a community context, but also for individuals.

A variety of reasons have been offered or discovered to account for the changes observed. Some credited participant motivation or the therapeutic approach. Others believed that team characteristics and community dynamics played a role. No effort can, however, discount the contributions of the broader context and historical events. And finally, healing from institutional trauma is not well understood. In fact, research scientists haven't yet come up with reliable and valid ways to measure healing from physical and sexual abuse or institutional trauma in Aboriginal populations. Many more immediate outcomes need to be identified. Precise information on what happened, who it happened to, and for how long the intervention occurred was not always available.

Recommendations

The following recommendations are not presented in order of importance or frequency. Rather, they should be viewed as equally important in addressing the Legacy of Physical and Sexual Abuse in Residential Schools.

Recommendation 1 - Shape the vision

The vision must reflect what is known about individual and community stages of healing. It must also emphasize support and guidance beyond the first stages to ensure that Survivors and communities work through the longest and most arduous tasks of reclamation and transformation.

Recommendation 2 - Develop creative, effective and unique strategies for men

There is a need to address the unique needs of men and to secure gender balance in project teams. Men in the community should be asked directly about their healing needs and preferences.

Recommendation 3 - Continue and reinforce efforts to dismantle denial and reduce fear

Depending upon the contagious influence of successful healing is a passive approach. This approach will likely NOT break the cycle in families or communities that endure very isolated social conditions whether they are self or geographically imposed. To effectively and completely break the cycle of physical and sexual abuse, creative forms of active outreach and continuous, reinforced efforts in Legacy education are required. Some consideration should be given to substituting the word 'healing' with a word or phrase that accurately reflects the courage to engage in a process of reclamation or transformation; one that suggests the process is about boldly exercising an inherent right to a life of peace and balance.

Recommendation 4 - Profile the healer

Highly regarded counsellors and trainers must be studied in greater detail so that other projects may be able to screen or detect potential team members with the same experience and skill. More practical detail is required about their qualities, roles and responsibilities so that others can be trained to address Survivors' unique needs. What factors enable them to make long-term commitments to their work and what professional development opportunities and support are required to manage and process the intense emotional nature of their work.

Recommendation 5 - Stregthen and maintain partnerships

To strengthen and maintain partnerships, a variety of approaches, long-term commitments and the ability to support a morally independent and culturally appropriate approach are best.

Recommendation 6 - Support the achievement of results

To support the achievement of results, it is important to identify what is different about those for whom the program worked versus those for whom the program did not work. It is also necessary to be clear about the distinction between activities and outcomes and offer projects defensible tools and methods to assess change that is relevant to their unique goals (e.g., resiliency, healing from sexual abuse, self esteem). The AHF must offer a quick and universal measurement tool for all projects that address the short-term outcomes of the Foundation as a whole. Finally, there is a need to explore the nature of the "blend" between western and traditional therapies and determine under which circumstances the impact is maximized.

Recommendation 7 - Focus

Avoid the temptation to know all and heal all. Impact was maximized when unique needs were addressed with special strategies. Projects should be encouraged to aim for realistically attainable outcomes with reasonably restricted targets groups.

Recommendation 8 - Share the good news

Much has been learned and many rewards attained. These stories need to be told. An essential part of this campaign could include honouring the leaders who have passionately supported the effort.

1. Introduction

> *Survivors of atrocity of every age and every culture come to a point in their testimony where all questions are reduced to one, spoken more in bewilderment than in outrage: Why? The answer is beyond human understanding.*[7]

This report is the second in a series of evaluation reports for the Aboriginal Healing Foundation (AHF). It is assumed that the reader is familiar with the rationale for the AHF as well as the history of events which led to its creation. The first report in this series focussed upon the evaluation of process and only touched lightly on impact. This report, on the other hand, focuses upon results. Although repetitive, a refresher of the Foundation's central activities and desired outcomes are reiterated here, followed by a more detailed discussion of the conceptual and technical issues associated with the evaluation of AHF's impact. The results of a series of case studies are then presented and recommendations offered. When relevant, the analysis is also supported by the results of document review and the process evaluation survey.

1.1 The Aboriginal Healing Foundation

The Aboriginal Healing Foundation (the Foundation) is a federally funded Aboriginally-run, non-profit corporation that was created on March 31, 1998 to support community-based healing initiatives for Métis, Inuit and First Nations people living on and off reserve who were affected by physical and sexual abuse in residential schools. The Foundation's ultimate, long-term goal or vision statement is:

> *. . . one where those affected by the Legacy of Physical Abuse and Sexual Abuse experienced in the Residential School system have addressed the effects of unresolved trauma in meaningful terms, have broken the cycle of abuse, and have enhanced their capacity as individuals, families, communities and nations to sustain their well being and that of future generations.*[8]

AHF's approach views Aboriginal people as key agents of change and builds on their strengths and capabilities to heal. The belief is that planned, day to day activities will lead to immediate outcomes that will, in turn, lead to the longer term outcomes and the ultimate goal.

1.1.1 Activities

The mission is to encourage and support Aboriginal people in building and reinforcing sustainable healing processes that address the Legacy of Physical Abuse and Sexual Abuse in the Residential School System, Including Intergenerational Impacts (the Legacy). Initially, a wider range of eligibility

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[7] Herman, J. (1992). Trauma and recovery: The aftermath of violence - from domestic abuse to political terror. New York: Basic Books, page 178.

[8] Aboriginal Healing Foundation (2001). Program Handbook, 2nd Edition. Ottawa: Aboriginal Healing Foundation, page 6.

for AHF funding existed. However, as the Foundation evolved, support was sharply targeted to fund those projects which could optimize impact on the community, ensure sustainability, as well as address the healing needs of those who suffer most from physical and sexual abuse with safe healing practices. Project types eligible for funding included:

Healing Services	Provide direct healing services through either traditional or western approaches focussed either on the community, family or individual and that meet the ethical standards of therapeutic care and community-based healing.
Prevention/Awareness	Activities aimed at raising awareness of the Legacy, early detection and prevention of the effects of abuse.
Training	Providing instruction or specialized education for potential healers and curriculum development to build sustainable capacity for the healing process.
Knowledge-Building	Research in program design and capacity building.
Needs Assessment	Assessing the healing needs of the community.
Honouring History	Memorials, genealogy and other projects related to remembrance.
Conference	Gatherings that include speakers, sessions and participants from a wide geographic area.
Project design and setup	Projects which only address the startup and do not yet provide other services.

These project types are not to be construed as mutually exclusive; rather, they are offered to bring more specificity, clarity and organization to the kinds of projects that the AHF has funded.

1.1.2 Anticipated Outcomes

The underlying assumptions are that these series of activities will create experiences which will lead to:

- **increased understanding and awareness** of the Legacy, as well as Survivors' healing issues and needs;
- **increased capacity of Aboriginal people** to engage in the healing arts/professions;
- **strengthened positive ties between those suffering the Legacy and those in a position to heal**;

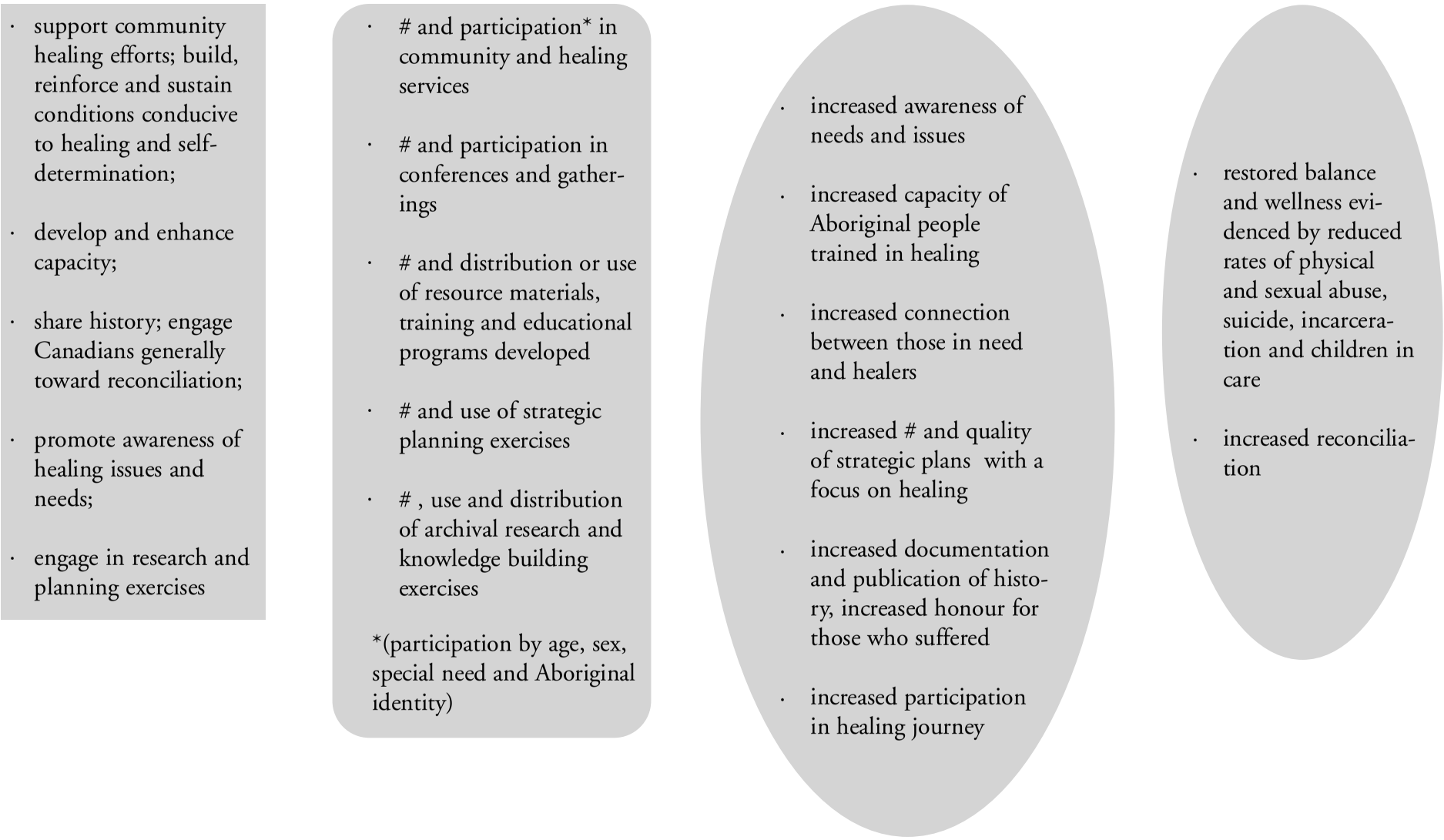
- **more strategic planning with a focus on healing**;

- **increased documentation and publication of the history, increased honour for those who have suffered**; and

- **enhanced healing**.

The underlying theory is that these short-term outcomes will lead to sustainable healing activities that restore balance and wellness to Aboriginal families and communities, as well as lead to reconciliation. The logical steps are illustrated in further detail in Figure 1 on the following page which clearly identifies how AHF expects to achieve long-term goals. In short, Figure 1 offers the reader a bird's eye view of AHF activities that will lead to a series of outputs (or products and services) that will have an immediate impact believed to set the stage for longer term results.

Figure 1) Aboriginal Healing Foundation: The Logic Model



2. Methods

2.1 Evaluation Objectives

This report is a program[9] evaluation of the Aboriginal Healing Foundation (AHF). Although an organizational evaluation is part of the review exercise for the AHF, it is not the focus of this report. Rather, this report discusses the contribution made by AHF- funded project activity in the realization of desired and unintended short-term outcomes as a way of being accountable to several primary stakeholders; namely, those impacted by the Legacy, internal moral authorities[10] and external supporters of the Foundation. Another primary goal of this report is to provide valuable, relevant information to users and decision makers at both the national and community level.

2.2 What is the Big Picture? (conceptual issues)

Before undertaking a discussion of methods in more technical detail, it is important to clarify the conceptual issues related to this evaluation effort which included the following:[11]

- Who are the **primary stakeholders** for the evaluation?
- What is the **purpose** of the evaluation?
- What **approach**, model or framework will be used to provide direction for the evaluation?
- What **political considerations** should be taken into account?
- By what **standards and criteria** will the evaluation be judged?
- What **resources** are available for the evaluation?
- What are the primary **evaluation questions** or issues?

The primary **stakeholders** for this evaluation are internal moral authorities, those at the community level whose singular interest is healing for Survivors. In addition, external authorities (including public and private funders) also have a stake in the realization of the desired goals of the Foundation. This document is one of the vehicles used to ensure that the Foundation remains accountable to internal and external stakeholders. The **purpose** of this evaluation is to determine

[9] It is important to distinguish *program* evaluation from *organizational* evaluation with respect to the AHF. Program evaluation deals specifically with what happened "on the ground" and refers exclusively to the Foundation's *facilitative role in promoting healing* within Aboriginal communities. An *organizational* evaluation of the AHF reviews the "entity" and its capacity to function as an institution outside government and national Aboriginal organizations. In an organizational evaluation, the foundation is under scrutiny as a funding and support mechanism to determine if it is a workable, if not superior (or inferior), model to other organizations working with Aboriginal communities.

[10] For the sake of clarity, internal moral authority refers to any individual or group which is the accepted and acknowledged "law" making body who holds collective interests at heart and includes traditional examples such as clan mothers and Elders' councils who have significant decision-making power and can apply sanctions to those operating outside of commonly accepted ethical codes. Contemporary examples could be residential school Survivor groups, youth groups who have been impacted intergenerationally, Aboriginal women's groups, human service organizations, parent committees and youth committees who have a vested interest in improving the lives of young Aboriginal people.

[11] Patton, Michael Quinn (1987). How to use qualitative methods in evaluation. Sage Publications.

the AHF's contribution to the attainment of desired goals, to offer insights to key decision makers and other information users and to ensure community experience is featured prominently. The **approach**, therefore, is really a blend of goal and user oriented, as well as decision focussed techniques within the framework of what is generally thought of as action anthropology or the use of research to empower communities. Dialogue is used to produce knowledge, guide action and assess the effort's worth while improving motivation and capacity to manage for results. In essence, the approach attempts to bridge the need for community relevance with scientific rigour and encourages the use of appropriate evaluation practice while building Aboriginal capacity.

Some of the **political considerations** revolved around the fact that the Aboriginal Healing Foundation is an Aboriginal entity, operated and administered by Aboriginal peoples. Most of the AHF personnel and external parties associated with the evaluation are also Aboriginal. This is the first effort of its kind in North America. AHF's existence is public recognition of the institutional trauma that resulted from residential schools. Other political considerations associated with this evaluation are, in large part, dictated by resource limitations. While an evaluation committee of various stakeholders would have been ideal, there were no resources available to ensure that such a committee was developed or accessible. To address this concern, at least in part, an Aboriginal firm, Kishk Anaquot Health Research was contracted to do an evaluation because it specializes in ' decolonizing' how evaluation is done, as well as how results are communicated. In other words, while rigorous adherence to the parameters associated with causality is considered to the extent that resources allow, utmost care was taken to ensure an ethical approach that is, first and foremost, accountable to internal moral authorities where qualitative information features prominently (e.g., respect for the stories told about journeys of community and institutional growth, struggles and lessons learned). Unfortunately, no resources exist for the evaluation to be conducted in the Aboriginal language of choice; however, a popular version of the report should be prepared as a mechanism for reporting to internal moral authorities. **Resources** for the evaluation included joint efforts of external facilitators and internal team members (e.g., the Community Support Coordinators and Research Department of the AHF). It is anticipated that this **report will be judged** by the extent to which it offers communities a voice and shares considerations for future direction in addressing the Legacy. The primary evaluation questions are presented in Table 1.

Table 1) Primary Evaluation Questions

	What has been the impact on individuals? · understanding and awareness of the Legacy · healing · capacity as healers
Goal Orientation What evidence is there that AHF has contributed to desired outcomes and experiences?	**What has been the impact on community?** · understanding and awareness of the Legacy · ties between those suffering and those in a position to heal · strategic planning with a focus on healing · healing · reconciliation · established partnerships · documentation and publication of the history, honour for those who have suffered
For Users and Decision Makers What will improve success?	What were the best practices and greatest challenges? What lessons have been learned? What can be done to better manage program enhancement? Did we address the need? Is the healing process sustainable?

To bring further clarity to the underlying theory of funded activity and offer a simplified view of program activities, desired outcomes and performance measures, a performance "map"[12] is presented in Table 2 on the following page.

[12] Adapted from Montague, S. (1997). Evaluators and performance measurement: Bringing the logic model to the manager. Canadian Evaluation Society Newsletter, vol. 17, No. 2, June.

Table 2) AHF Performance Map

Mission Statement: To support, build, reinforce and sustain the healing process in Aboriginal individuals, families and communities			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**longer-term outcomes**
supporting community/centre based healing services and cultural/traditional activities; providing community services; promoting awareness; sponsoring conferences/ gatherings; developing capacity; developing resource materials, training and educational programs; sharing history; ensuring honour; engaging in strategic planning, research and knowledge building; engaging key stakeholders in reconciliation; returning voice to women	those suffering from the Legacy of Physical and Sexual Abuse in the Residential School system, those seeking to be healers, broader Canadian public (institutions and individuals)	increased awareness and understanding of the Legacy; increased strategic planning, increased partnership; increased connection between those in need and healers; increased capacity to facilitate healing; increased documentation; enhanced healing	those affected by the Legacy of Physical and Sexual Abuse in the Residential School system have addressed unresolved trauma, broken the cycle of abuse and enhanced their capacity to sustain their well being and that of future generations; increased reconciliation

How will we know we made a difference? What changes will we see? How much change occurred?			
Resources	**Reach**	**Immediate Measures**	**Long-term Measures**
$350 million	# of people and communities who benefited	# of sustainable partnerships established; #, quality and potential impact of strategic plans; participation in healing activities; measures of awareness and understanding; participation in and opinions regarding conferences/gatherings; opinions of Elders, participants, program deliverers	reduced rates of physical and sexual abuse, children in care, suicide and incarceration among Aboriginal peoples

2.3 What are the Details? (technical issues)

The more technical issues involve addressing the following questions:[13]

- What will be the **method(s) of inquiry**?
- What **types of data** will be collected? From whom? When? Using what instruments?
- What will be the **sampling** strategy?
- What will be the primary **unit of analysis**?
- What **comparisons**, if any, will be made?
- How will the **quality and accuracy of the data** be ensured? What level and type of accuracy are needed?
- How will concerns about **validity and reliability** be addressed?
- What kind(s) of **analyses** will be conducted?
- What kind(s) of **statements and findings** will result from the analysis?

The **method of inquiry** used was by case study (13 in total) where a few select priorities are examined in depth. Case studies relied upon document review, interviews with key informants from purposefully selected projects and examination of community- based social indicators. Documents were reviewed for:

- evidence of the project's impact;
- Survivor involvement and sensitivity;
- shared sponsorship; and
- participant voice.

More specific details about the **types of data** collected in case studies, their source and methods of collection are highlighted in Table 3.

[13] Patton, Michael Quinn (1987). How to use qualitative methods in evaluation. Sage Publications.

Table 3) Information Sources, Types and Collection Methods

Source	Type of Information Collected	Collection Method
project monitoring reports, evaluation reports; funding applications; memoranda; correspondence; needs assessments; eligibility criteria and guidelines	participation rates, participant profiles (e.g., age, sex, Aboriginal identification and special need), description of activity (# and type); # and strength of partnerships; observations on achievement of focussed objectives; social indicators analysis accountability practices descriptions of program environment (e.g., infrastructure, team capacity, community context needs and service access); impressions (e.g., potential impact and methodological merit) related to mandatory criteria (e.g., internal accountability, addressing the Legacy, etc.)	document review
program participants (when collected by the project team)	satisfaction with the program, opinions about what is worth keeping or changing,	guided or self administered questionnaire
select communities and organizations; project team members and their referral agents (on occasion, more random selection of community members)	detailed contextual information; highlights of unique strategies, communities or circumstances; best practices and greatest challenges program evolution, impressions regarding impact on individuals and community, ability to address need, address the Legacy, be accountable	one-on-one interviews
published and unpublished literature (e.g., Statistics Canada, Royal Commission on Aboriginal Peoples, First Nations and Inuit Regional Health Surveys, Internet, AHF- sponsored research, Aboriginal political organizations as well as federal, provincial, municipal publications)	social indicators including rates of suicide, children in care, physical and sexual abuse, incarceration, community context	research, interviews with key informants

A maximum variation sampling strategy was used to ensure that cases selected would include representation from all Aboriginal groups, special need categories and communities which varied in geographic remoteness and infrastructure, as well as a full range of project types. Thirteen cases were selected in total that cover the following project types and targets:

Groups	Métis, Inuit, First Nation, Non-Status, francophones, youth, men, women, gay or lesbian, incarcerated, Elders
Locations	urban, rural or remote, north, east, west
Project Types	community services; conferences/gatherings; performing arts; health centre (centralized residential care); camp/retreat (away from the community in a rural setting); day program in the community; healing circles; materials development; research/knowledge-building/planning; traditional activities; parenting skills and professional training courses

photo: Aboriginal Healing Foundation

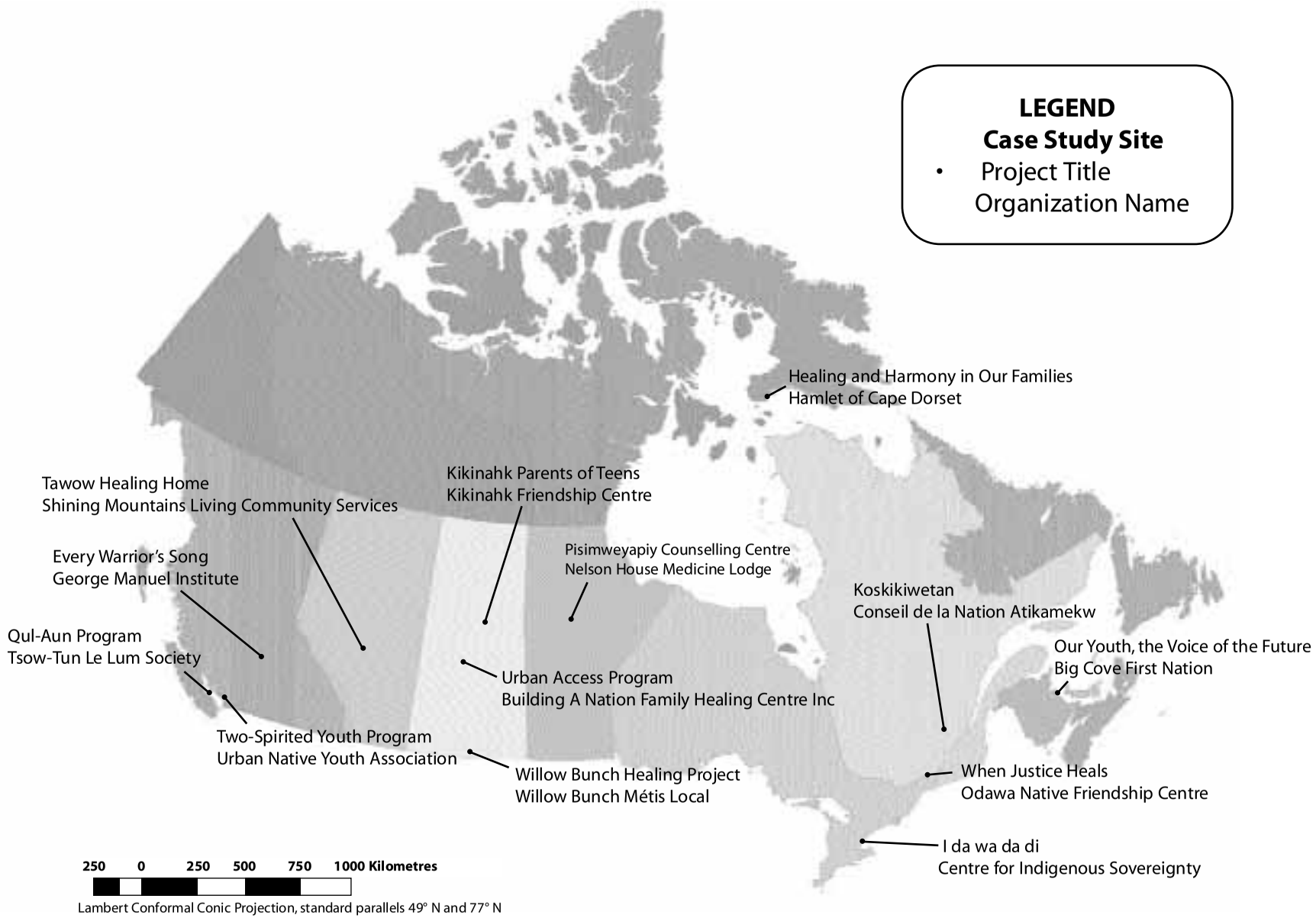
The projects selected are presented in Table 4 and the criteria used in their selection are presented in Appendix A.

Table 4) Case Studies Selected for the Impact Evaluation of AHF-Funded Activity

Project Name/Sponsor	Location
Healing and Harmony in Our Families / Hamlet of Cape Dorset	Cape Dorset, Nunavut
Two-Spirited Youth Program / Urban Native Youth Association	Vancouver, British Columbia
Honouring Survivors Theatrical Production (Every Warrior's Song) / George Manuel Institute	Chase, British Columbia
Qul-Aun Program / Tsow-Tun Le Lum Society	Lantzville, British Columbia
Tawow Healing Home / Shining Mountains Living Community Services	Red Deer, Alberta
Healing the Multigenerational Effects of Residential School Placement - Urban Access Program / Building A Nation Family Healing Centre Inc.	Saskatoon, Saskatchewan
Willow Bunch Healing Project / Willow Bunch Métis Local	Willow Bunch, Saskatchewan
Kikinahk Parents of Teens / Kikinahk Friendship Centre	La Ronge, Saskatchewan
Pisimweyapiy Counselling Centre / Nelson House Medicine Lodge	Nelson House, Manitoba
I da wa da di / Centre for Indigenous Sovereignty	Toronto, Ontario
When Justice Heals / Odawa Native Friendship Centre	Ottawa, Ontario
Koskikiwetan / Conseil de la Nation Atikamekw	La Tuque, Quebec
Our Youth, the Voice of the Future / Big Cove First Nation	Big Cove, New Brunswick

The geographical distribution of the case studies selected are depicted on the following map.

Case Study Sites

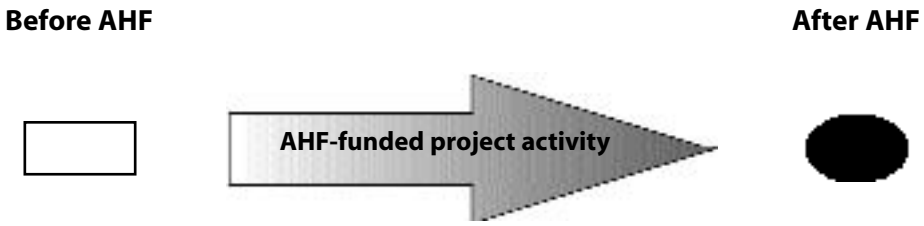


Source: AHF Research
Produced: Aug 14, 2002, AHF

While **comparisons** would be valuable, the Foundation is on an unprecedented course of supporting Aboriginal communities to heal from institutional trauma. While arguably comparable, family violence and addictions programming have been designed to treat the symptoms of colonization, while activities funded by the Foundation have addressed colonization itself. Evaluation resources have been concentrated to ensure an empowering and capacity building exercise rather than providing exhaustive research from the international arena. Hence, no comparisons with the efficacy of other community based healing initiatives within Canada or internationally have been undertaken. However, comparisons within groups were attempted.

Initially, a within groups repeated measures **design** was selected over the more scientifically rigorous between group comparison.[14] In other words, the evaluation began with the intent to compare what the community was like before the program and what they were like sometime during or after the program. Represented schematically, the planned design looked like Figure 2 below. The arrow represents project activities. The impact of the environment is represented as an ever increasing concentration of colour within the arrow. The darker the arrow gets, the more environmental and historical influences impact on the participant making him/her increasingly complex (as represented by the increasing complexity of the fill inside the geometric figures). The change in shape from a rectangle to an oval shows the change in the participant over time that might be attributed to AHF-funded activity.

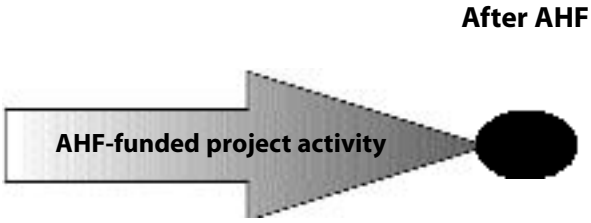
Figure 2) Within Group Comparison or Repeated Measures Design



Most case studies were conducted with the intent of engaging in a follow up data collection phase at some time in the future (e.g., 2003/2004). With a rapidly approaching Foundation sunset, a repeated measures design was no longer feasible and case studies were redesigned as post-test only. The new design is graphically represented in Figure 3.

[14] Of course, there are disadvantages associated with within group comparisons or repeated measures design. First of all, it is very difficult to weed out all of the things that go on in a participant's life over the course of the program. They will spend significantly more time with their families and in the community than they will in the program and over time, program or no program, people change. Still, a within group design was considered better than a more scientifically rigourous between group design for a number of reasons. First and foremost, is it reasonable to assume that a community who is roughly similar but not identical would be willing to participate in the evaluation when it will not likely benefit from the program but really need the intervention? Would approaching an already over-studied group to participate in the evaluation without some guarantee of future intervention be palatable or reasonable?

Figure 3) Post Test Only Design



Communities were to be compared to themselves over time because the Foundation was keen to see reductions in rates of physical and sexual abuse, incarceration, suicide and children in care. Examination of social indicators implies that the **unit of analysis** is the community; however, the target population is not always so contained. In fact, it is more appropriate in urban centres and for programs whose target population may be region wide to examine individual participants, not community level indicators or provincial level data. It is unfair and insufficiently discriminating to expect AHF activities to influence rates of incarceration, children in care, physical and sexual abuse or suicide in entire provinces or urban centres in two to five years. Rather, it makes the most sense to track individuals over time. However, ethical and legal concerns prohibited direct assessment and projects did not always engage in direct assessment. Therefore, each case study addresses suggestions or recommendations on how follow up would best be completed.

Data quality and accuracy were ensured by first attempting to secure information that was relevant. In addition, data sources and methods were triangulated.[15]

In other words, information was secured from a variety of sources (including those with differing points of view) and methods. Interviews with various stakeholders, social indicators analysis and document review were the primary sources and methods used. In addition, the results of document review (36 project files) and the national process evaluation survey completed in 2001 were used to strengthen quality and accuracy (a more detailed description of the methods used for document review and the national process evaluation survey are included in Appendix B). Due to time constraints, many interview schedules were not piloted to ensure clarity and relevance, and some questions were clearly misunderstood. The interview schedule relied upon face validity and no tests were done to measure reliability.

With respect to reliability and validity it is important to note that no direct measurement of change in participants was conducted due to ethical concerns about triggering further trauma without adequate support. Because direct assessment was problematic, indirect assessment or the perceptions of key informants were weighted heavily. In most cases, data was triangulated (e.g., three lines of evidence were secured); however, two lines of evidence (e.g., client satisfaction and social indicator information) were not always readily available. While most participant satisfaction was collected at the end of treatment, only in one case study was satisfaction assessed at three months followup. No

[15] Patton, Michael Quinn (1987). How to use qualitative methods in evaluation. Sage Publications.

standardized instrumentation was used to assess changes in related cognitive or behavioural indices of healing. In fact, although there are other trauma recovery initiatives, it is highly probable that there are no psychometrically evaluated or standardized instruments to determine the unique healing stages of Aboriginal people recovering from the Legacy (institutional trauma).

One of the richest sources of evidence was from document files, but it is important to note that they tended to focus more on positive aspects than on the negative. There was also wide variability in the detail and sophistication in these reports. Some refer to use of standardized instruments, external evaluations or raw data but few include their reports or aggregate information. Many projects either were not able to do the evaluation as planned or believed that their project monitoring reports were adequate to meet evaluation requirements and like so many programs, there was a common confusion between outcomes and outputs. In other words, while all are reporting progress related to activities and products, very few move beyond this to report change resulting from activities.

A case study guide was prepared specifically for the Community Support Coordinators (CSCs) and was intended to be a quick reference and readily available tutor during the case study process. In addition, two days of training were offered to CSCs in survey development and interviewing techniques. The training and the case study guide were intended as a way of reducing bias and ensuring some conformity in methods across diverse projects, thereby enhancing reliability. This was especially important since no standardized instrument was developed; rather, interview questions addressed issues specific to the desired outcomes of each project.[16] When work began in earnest, interviews were prepared based upon the short-term outcomes identified in the performance map. Interviewers worked independently in the field and may or may not have had debriefing after each day of interviews. In most cases, a significant amount of time elapsed from conducting interviews to reviewing and transcribing field notes. If other competing duties allowed, interviews were transcribed immediately. Dissent was encouraged in at least two introductory remarks preceding interview questions which follow:

- 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 disconfirming evidence, rival explorations or negative cases. While it is clear that there are some who are not satisfied with AHF- funded activity, the CSC was prohibited from gathering direct evidence from those participants. However, it would be useful to profile those for whom the program is not satisfactory. Quantitative information was limited and the luxury of multiple evaluators was not available; however, the context and data were regularly reviewed and in most cases, responses were recorded verbatim permitting verification and re-analysis by an external evaluation facilitator. Half the time, the CSC role as the public relations and support arm of the AHF allowed for extended and multiple contacts with informants before the evaluation, thereby increasing familiarity and comfort in the data collection phase.

[16] While the Case Study Guide included seven mandatory questions for key informants, the majority of interview questions were based on logic models and performance maps prepared by the CSCs after reviewing the project's file.

Some of the CSCs are Survivors. Their perspectives on healing may have influenced how the information was collected, although it is not clear if their perspectives would have more harshly or leniently judged the programs. Having the analysis verified and re-analyzed by an external evaluator may have reduced this bias. CSCs were reliant on information that was most readily available as sometimes only two days (but other times as many as five days) were allocated to gathering data. Still, the amount of information gathered in this exercise may have been more than could be processed within the time available. The most important information missing are the characteristics of those participants who were not completely satisfied with the program, as well as the more long-term follow up of their progress based upon the indicators identified.

Qualitative interviewing generates large data sets. For each case study, a content analysis of the interviews and the documents contained in project files was conducted. Content analysis is the process of organizing and categorizing data so that common themes and patterns can emerge, along with conflicting and divergent perspectives. In addition to the case study guide, two documents were prepared to facilitate data organization and analysis: "A Step by Step Approach to Completing Case Studies" and "Draft Table of Contents for Case Studies." While the process of data analysis was largely inductive (e.g., themes, patterns and categories emerging from the data), some themes (or organizing principles) were also imposed by the evaluation questions. In particular, each case study addressed the project's impact on individuals and communities, as well as issues related to sustainability, partnerships, meeting the need, best practices, challenges and lessons learned. Within each of these primary theme areas, content analysis was approached inductively. For example, when examining challenges or barriers to success, interview material and project files (including the national process evaluation survey) were reviewed, relevant sections and passages marked, then coded (e.g., thoughts or ideas were given labels or code words). Similar concepts were then grouped together providing a framework for analysis. A similar process guided the preparation of this report, except that case study summaries were used as the primary material for content analysis.

The **statements and findings** reported here will speak to the contribution[17] that the Aboriginal Healing Foundation has made in the journey toward balance. It will provide users and decision makers with guidance for developing programs that work better and feel right. The process is less about meeting the rigours of scientific scrutiny than it is about sharing understanding and experience. Science, after all, with its narrow and deductive focus, does not take complex socio-political contexts into account, and even in strictly controlled scenarios, cannot offer proof of cause in an absolute way. On the other hand, without attention to rules of logic, the evaluation can also fail to reasonably assess contributions made by program efforts. But, inordinate and sometimes questionable methods or measurements are not required or best suited to determine a "plausible association"[18] between activities and outcomes, especially when evaluating community development.

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[17] Mayne, John (1999). Addressing attribution through contribution analysis: Using performance measures sensibly - discussion paper. Ottawa: Office of the Auditor General of Canada.

[18] Hendricks, Micheal (1996). Performance monitoring: How to measure effectively the results of our efforts. Presented at the American Evaluation Association Annual Conference, Atlanta, Georgia, 6 November 1996.

Evaluation practice hasn't fully caught up with a recent shift towards community control of programs. Although there are models for studying community health efforts, community initiatives are often evaluated using research methods borrowed from clinical trials and other researcher-controlled techniques. While these methods work very well in the fields for which they were developed, they're not necessarily a "good fit" for evaluating community work. It's like trying to put a square peg into a round hole – with a lot of work, you might be able to do it, but it will never be as smooth as you want.[19]

2.4 Community Support Coordinators' Commentary

Although a case study guide was prepared and a preliminary meeting outlining the process were used to communicate the work involved, for many Community Support Coordinators (CSCs) things only became clear when case studies were underway. In fact, constructing case studies within a capacity building framework was an underestimated task by everyone involved. As each case and each CSC was unique, it was difficult to determine the level and nature of support required in advance. In effect, CSCs were engaged in an on-the-job training process where they learned how to look at project activities and outcomes logically, establish reasonable ways to measure performance, develop interview schedules, conduct interviews, gather indicator data, organize information, conduct an analysis and write a report. Although some felt the guide was helpful, it was also intimidating.

My only concern was my initial reaction which made it sink in HOW MUCH work was about to unfold. The more I read through the manual, the clearer picture I got of what I had to do.

CSCs recommended that the initial meeting and subsequent training should have followed the manual more closely taking one full week to ease apprehensions about the work ahead. One CSC felt that particular attention should have been paid to threats to reliability and validity which were not part of training opportunities. When it became clear that expectations associated with addressing methodological issues were unrealistic given the time for training and support, the responsibility for addressing them was transferred to the Kishk Anaquot Health Research (KAHR) evaluation facilitation team.

To address the concerns of those who felt that the guide caused an information overload, a revised, simplified step-by-step "to do" list was prepared which most found more helpful. Still, the guide was very limited as a support tool, especially when out in the field on your own.

It's easy to say refer to the guide, but it was not so easy. Some days it felt like Greek to me ... For me it's because I am a very visual and oral learner. I am not one to read and get it. I have to see it, feel it.

Two days of training were offered to CSCs in preparation for case studies. One full day was devoted

[19] Fawcett, S.B., A. Adrienne Paine-Andrews, V.T. Francisco, J. Schultz, K.P. Richter, J. Berkley Patton, J.L. Fisher, R.K. Lewis, C.M. Lopez, S. Russos, E.L. Williams, K.J. Harris and P. Evensen. Evaluating community initiatives for health and development. Rootman, I. and D. McQueen, et al. (Eds.) (in press). Evaluating health promotion approaches. Copenhagen, Denmark: World Health Organization - Europe.

to preparing logic models and performance maps or guides and the other day addressed questionnaire development and interviewing techniques. Although, most CSCs felt this training equipped them for preliminary work, the majority also felt it did not prepare them for making sense of the information and reporting results. To address this, notes about how to report results were offered, but came only after the writing began and did not replace the need for more intensive training. Some CSCs struggled independently with other resources (e.g., text books and writing manuals). The newest team members were the most stressed because their learning also included how to find important answers in the document files. The sheer volume of the effort, in addition to their roles as CSCs, caused an inordinate strain.

> *There was many new things to learn at the same time that report writing was being done and it was very challenging to the best of minds.*

Most felt that the guidance they received from the KAHR team was helpful and encouraging but would have felt better with more opportunity for discussion. To that end, they recommended that a team be developed to do case studies rather than each CSC "going it alone." Conference calls were scheduled throughout the process to discuss challenges and solutions but some CSCs felt the need for more frequent sharing and support. They also felt that their involvement compromised their roles as CSCs primarily because it took time away from the community, but also because it caused some role confusion. On the one hand, they were to be viewed as the public support arm of the Foundation, and on the other, they were research agents supporting the evaluation. At least one CSC felt that it may have strengthened trust for the project involved. Juggling responsibilities between the case study and CSC duties meant that much time was wasted shifting focus. To avoid wasting time, they recommended that a core group be temporarily relieved of other duties to do just case studies. At last, the estimated time for report writing was considered way off target.

Despite the hardships and initial confusion, most felt rewarded by their participation and believe that the experience has left them with program development and evaluation skills that will help them in their roles as CSCs. CSCs who had the opportunity to participate more than once did so with greater confidence and less time.

> *The case study was one of the most valuable pieces of work that I have ever been involved in and left me with many new tools.*

3. Context and Participant Characteristics

Variations in project settings and target groups are a reflection of both the reality of community diversity and the procedure used for choosing the case study sites. A maximum variation sampling strategy was used to ensure that the full range of AHF-funded activities is represented (see Appendix A, Criteria Used to Select Case Studies). Thirteen sites were selected, at least one per region (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, Quebec, Atlantic and the North). One project is located in a remote Inuit community, one in a small Métis community, and six are located in First Nations communities (although two of these have province-wide catchment areas). A theatrical production travelled to give performances in Vancouver and ten rural communities. Four of the projects are located in urban centres – Vancouver, Red Deer, Saskatoon and Ottawa. Community size varies from one hundred and fifty to almost two million (metropolitan Vancouver). Other selection criteria ensured that the full range of eligible programs, services and target groups were represented.

Each project is unique and must be understood in its own socio-economic context. There are striking differences in the social, economic and cultural environments in which projects operate and these must be considered in the analysis and interpretation of data. For example, in Cape Dorset, the Inuit culture and Inuktitut language are an integral part of the community context, whereas a hostile, racist environment in Willow Bunch, Saskatchewan has contributed to a history of suppressing Métis identity. Such factors become part of the context in which a project is understood, and it is the nature of a case study to present this type of in-depth descriptive data. Yet, patterns can appear even across such diversity, and these are valuable in identifying cross-cutting themes and even impacts. *"Any common patterns that emerge from great variation are of particular interest and value in capturing the core experiences and central shared aspects or impacts of a program."*[20]

The Foundation's mandate and funding criteria result in almost all projects dealing to some degree with the Legacy of Physical and Sexual Abuse in Residential Schools. It is not surprising, then, to find commonalities among the social problems facing communities where projects are located. Moreover, poor economic conditions, unemployment and housing shortages in Aboriginal communities have been well-documented, so again their appearance in a significant number of project sites are to be expected. However, Aboriginal people living in urban areas deal with a very different environment, as characterized by the following description of services in Saskatoon:

> *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*

[20] Patton, Michael Quinn (1999). Qualitative evaluation and research methods, second edition. Newbury Park, CA: Sage Publications, page 172.

environments into which they are hired; mainstream denial and de-culturation mechanisms dominate what address is given to Aboriginal issues.[21]

Local contextual information was collected because, as the case study guide points out, *"The context in which AHF projects are operating is **enormously important**. A case study is complete **only** when we know what life is like in the community. Extreme poverty, isolation, poor housing, air and water quality all impact upon mental and physical health."*[22] Table 5 summarizes project descriptions, community size and target groups while Table 6 presents the range of social issues that were highlighted in the thirteen completed case studies.

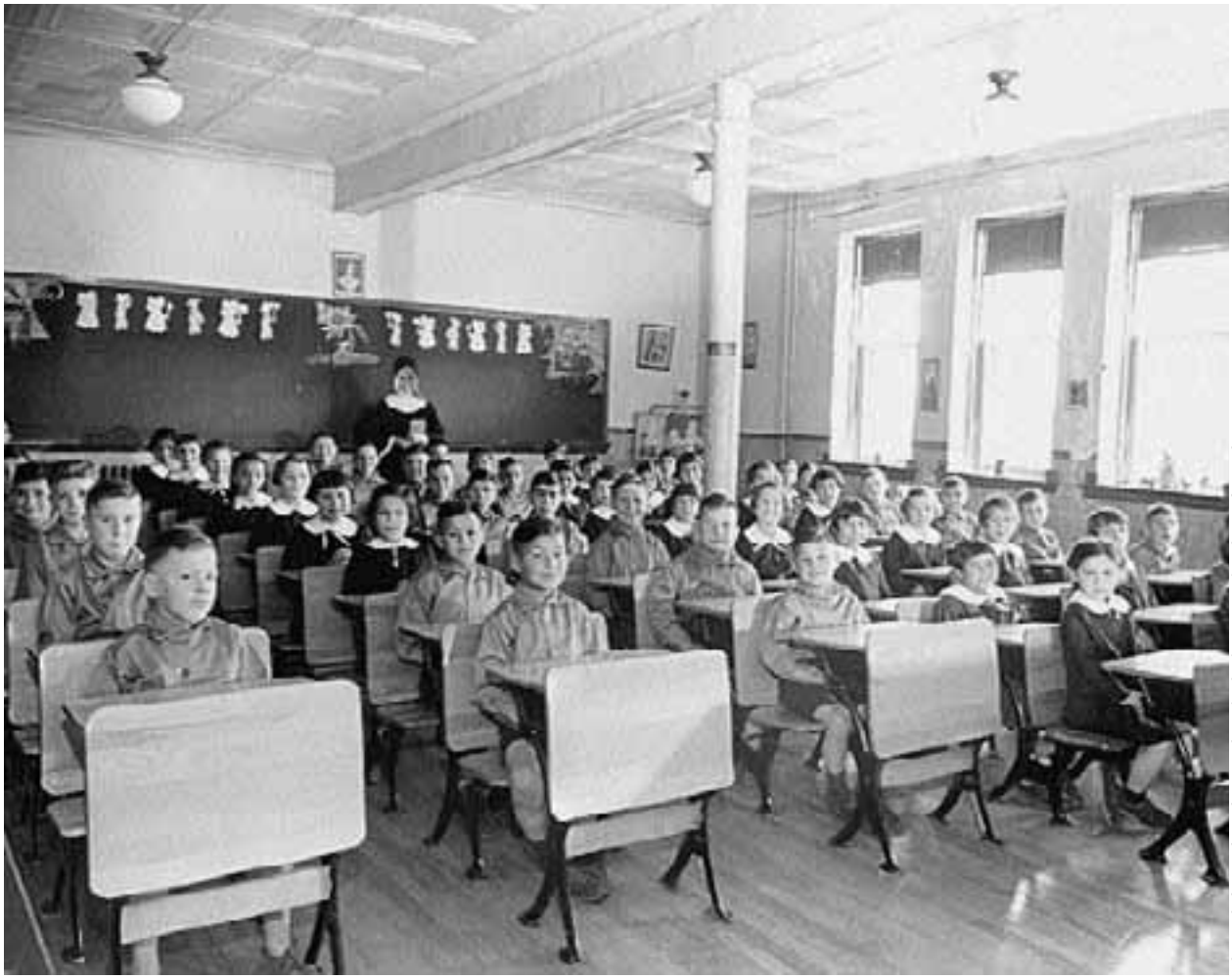


photo: Shubenacadie Indian Residential School – National Archives of Canada

[21] A Case Study on the Building a Nation Family Healing Centre Inc. project: "Healing the Multi-generational Effects of Residential School Placement - Urban Access Program." This quote is from the project's Year Two Application for Project Funding, Part C, Community Profile, Question 13.

[22] Kishk Anaquot Health Research (2001). The community support coordinator's guide to completing case studies. Ottawa: Aboriginal Healing Foundation, page 2.

Table 5) Project Descriptions

Project	Description	Community	Target Group
Healing & Harmony in our Families	Healing and training a core group of community caregivers	**Cape Dorset**, Nunavut: 1,200 (remote)	Inuit
Two-Spirited Youth Project	Peer support and healing activities for gay, lesbian, bisexual and trans-gendered youth	**Vancouver**, BC (urban)	gay/lesbian youth
Honouring Survivors Theatrical Production (Every Warrior's Song)	Researching, writing, and delivering a play that honours Survivors and addresses the Legacy of physical and sexual abuse in residential schools	**Chase** BC: performances throughout region (rural)	Aboriginal, primarily First Nations
Qul Aun Program	In-patient healing centre based on a blend of traditional healing and centralized residential care	**BC** (province-wide); healing centre on Nanoose First Nation: 151 (Vancouver Isl.)	Aboriginal, primarily First Nations
Tawow Healing Home	Culturally-based, non-mandated therapeutic home for children/adolescents and their families at risk of involvement with protective services	**Red Deer**, Alberta: 68,308 (urban)	First Nations, Métis
Healing the Multi-generational Effects of Residential School Placement - Urban Access Program (Building A Nation)	Training for beneficiaries to better manage crisis, cross-cultural training, Legacy education, healing services and adjunctive services (e.g., client advocacy and support related to child custody, justice and social service, housing, life skills).	**Saskatoon**, Saskatchewan: 200,000; Aboriginal population: 30,000 (urban)	Urban Aboriginal people
Willow Bunch Healing Project	Activities to increase awareness of Métis history and pride in being Métis	**Willow Bunch**, Saskatchewan: 400 (rural)	Métis
Kikinahk Parenting Program	Parenting skills program combining traditional and western models and approaches	**La Ronge**, Saskatchewan: 7,000 (rural)	First Nations, Métis
Pisimweyapiy Counselling Centre	Nine-week, community-based out-patient program for Survivors and their families	**Nisichawayasihk Cree Nation**, Northern Manitoba (rural)	Aboriginal, primarily First Nations
I da wa da di	Healing circles, fasting and healing retreats for Aboriginal women; training workshops for service providers who work with Survivors	**Ontario**-wide: host organization in Toronto, healing centre in Six Nations	Aboriginal women
When Justice Heals	An urban alternative justice project that incorporates healing and sentencing circles.	**Ottawa**, Ontario: 875,100; Aboriginal population: 35,000 (urban)	Aboriginal
Koskikiwetan	Training of community workers and counsellors, establishment of a support network, Legacy education and land-based healing activities	**Opitciwan, Wemotaci, Manawan**, Quebec: Atikamekw Nation (rural)	Primarily First Nations, on and off reserve but includes non-status Indians, Métis, Inuit and non-Aboriginal family members
Our Youth, the Voice of the Future (Big Cove Youth Initiative)	Activities to support the personal, social, mental and physical well-being of youth	**Big Cove**, NB: 2,458 (rural)	First Nations youth

Table 6) Social Indicators

	Healing and Harmony in our Families	Two-Spirited Youth Program	Every Warrior's Song	Qul Aun Program	Tawow Healing Home	Building A Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Physical Abuse/Family violence	●	●		●		●		●	●	●	●	●	●
Sexual Abuse (including Legacy)	●	●	●	●		●		●	●	●	●	●	●
Housing Shortages								●			●		●
Suicide/suicide attempts	●	●		●		●		●			●		●
Unemployment/poor economy	●	●				●	●	●		●		●	●
Addictions/substance abuse		●		●	●	●		●	●		●	●	●
Homelessness		●			●	●		●			●		
Racism/Cultural Conflicts					●	●	●	●			●		
Incarceration/crime/vandalism	●	●		●		●			●	●	●		●
Children in care/parenting issues	●			●	●	●		●	●	●	●	●	●
Homophobia		●											

3.1 Participant Characteristics

Participants in the case study projects are not a representative sample of the full population served by AHF-funded projects; therefore, no generalizations can be made. Insights, however, can be gained by examining the more qualitative aspects of participant characteristics. In most instances, the characteristics of project participants reflect program goals and objectives and the selected target group. For example, I da wa da di targets Aboriginal women, so it is not surprising to find that almost all their participants were women. On the other hand, Cape Dorset had difficulties attracting men even though they made a concerted effort to do so. Overall, projects engaged more women than men in healing. One project (Big Cove) targeted youth and found participation rates based on gender were almost equal for all activities except for sports, which attracted more boys. Another – the Two-Spirited Youth Project – served gay and lesbian youth, although almost all of this project's participation came from young men. Two of the projects addressed parenting issues; both experienced significantly more participation from mothers. Similarly, the Qul-Aun residential healing program found that women outnumbered men by almost two to one. Yet, this program also served parole-ready inmates, all of whom were men. Consistent with these observations on gender, the national survey found that in only two target groups did males outnumber females: gay/lesbian and incarcerated. All others included more women (Survivors, later generation, disabled, and Elders).

The diversity of participant characteristics in the case study projects is evident in the following descriptions:

- The Cape Dorset healing initiative, a community-based project which adopted a heal the healers approach, involved an unusually large number of Elders. Over one third of healing participants and two thirds of training participants were Elders.
- The majority of participants in the Tawow Healing Home project were single women (7 out of 8), under 25 years of age (range 22 to 40) who previously attended some form of substance abuse treatment (6 out of 8) and had their children apprehended at one time or another. Lack of parenting skill and substance abuse are considered their most significant challenges. The majority of children are under the age of ten (range infant to teen).
- Similarly, most participants in the Kikinahk Parenting Program were young, single parents, mainly women (ages 20-40 years), who accessed the program by dropping in or were referred by the mental health centre or a women's shelter. Some women brought their spouses and children to participate.
- The Qul-Aun program noted that groups to date are predominately women, and sometimes the female to male ratio is 7/3 or 6/4. Disabled clients are also accepted and accommodated into the program and one to three incarcerated males attend each session. The vast majority of participants are First Nations (94%), some participants are Métis (3%), but there are no Inuit participants. An overwhelming majority are residential school Survivors.
- At the Pisimweyapiy Counselling Centre, there was roughly an even distribution between the sexes, although women still outnumber men. The majority of participants were in the 25-45 age category. Almost all are First Nations living on-reserve and a large percentage are intergenerationally impacted.
- I da wa da di reached two hundred and twenty-three people from sixty-two First Nations and

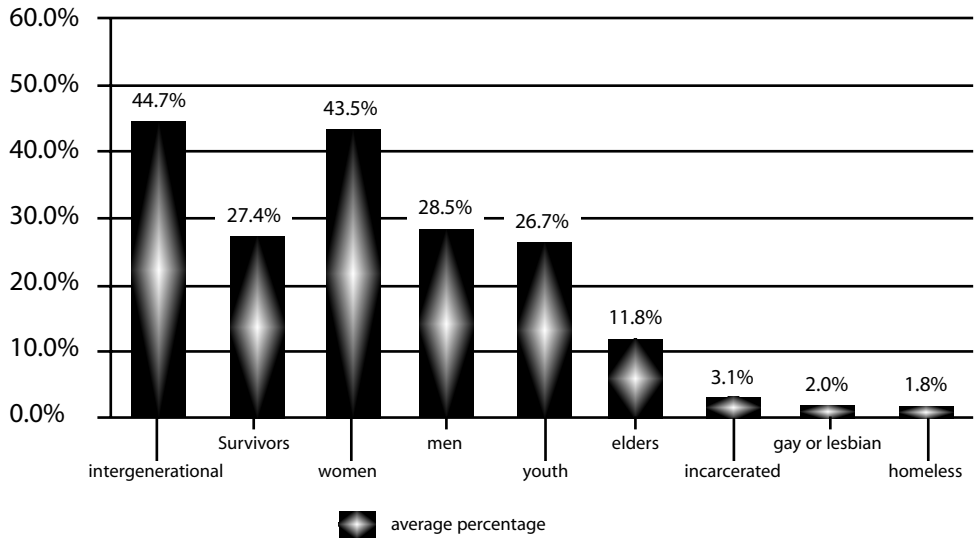
urban/rural communities in Ontario. Eight people were from another province or living outside of Canada. Participants were primarily women (97%): one quarter were Elders and 6.7% were youth. Almost three-quarters (74.4%) identified as intergenerationally impacted while 14.3% were Survivors and 11.2% were either not impacted or they did not know. In terms of Aboriginal status, 46.2% were First Nations on-reserve, 47.1% First Nations off-reserve, 3.6% Métis, 0.4% Inuit, 2.2% identified as non-status off-reserve and 0.4% other.

- The theatrical production honouring residential school Survivors (Every Warrior's Song) reached an estimated 4,000 people and many interviewees reported standing room only at the facilities where the performances were held.
- The Big Cove Youth Initiative reported reaching approximately one hundred and fifty of the community's nine hundred youth and children on a weekly basis; one-time events, such as conferences or gatherings, were attended by up to three hundred people.
- As stated in a 2001 survey, the population of Willow Bunch is four hundred with 50% Métis. The project team, however, believes that approximately 90% are Métis but do not identify or do not know.
- Koskikiwetan reached between 400 to 500 participants from Opitciwan, Wemotaci, Manawan (Quebec), most of whom were First Nations women living on reserve, ages 26-49 and direct Survivors of residential schools.
- Building A Nation offered training and services to primarily an urban-based population, all of whom were dependent upon social assistance (some represented a third or fourth generation on social assistance). Most (70%) had a history of physical abuse and, surprisingly, men outnumbered women in healing. Incarcerated and homeless individuals also received services.
- The Aboriginal Peoples' Justice Circle (When Justice Heals) recruited participants through the mainstream justice system. In light of the lengthy healing process (nine months to a year), participation rates were low, and only two people completed the healing process.

While the case studies provide project-specific information about participants, the national survey allows for a look at the broader picture. Participation in healing was examined based on target group, where the average number of participants was reported based on the following (non-exclusive) categories: gender, Survivor status, youth, Elders, incarcerated, gay/lesbian and homeless (see Figure 4). The national survey also found that addictions, victimization and abuse are clearly the most severe[23] participant challenges affecting the majority of projects (69%, 58%, and 58%, respectively). Other common challenges which are reported as severe by a sizable group (>40%) include denial or grief, poverty and lack of parenting skills. At the project level, community conditions such as high rates of physical and sexual abuse, unemployment, suicide and addictions are quite naturally reflected in the issues that confront participants. For example, almost eighty percent of Qul Aun's participants have a history of foster care and more than ninety percent have suffered as victims of sexual abuse. All participants in the Pisimweyapiy Counselling Program reported suffering from physical abuse, ninety percent from addiction and more than sixty percent have experienced family violence, conflict with the law and lack basic life skills. These examples reflect the high level of need among participants and this holds true across most of the case study projects.

[23] Severe means that the characteristic affects 80% or more of participants.

Figure 4) Healing Participation by Target Group[24]



[24] Kishk Anaquot Health Research (2001). An interim report of Aboriginal Healing Foundation program activity, Ottawa: Aboriginal Healing Foundation, page 22, Figure 7.

4. Performance Report

Now that a framework for understanding the context in which projects operate, as well as the needs of their participants has been presented, let's examine the nature of influence funded activity has had. For readers with a goal orientation, information has been gathered to determine what contribution, if any, AHF funded activity has made toward:

- influencing individuals, most particularly their:
  - awareness and understanding of the Legacy;
  - personal healing; and
  - capacity as healers.

- influencing communities:
  - awareness and understanding of the Legacy;
  - connection between Survivors and healers;
  - strategic planning with a focus on healing;
  - establishing partnerships and ensuring sustainability; and
  - documentation and publication of the history.

For users and decision makers, information has been offered on best practices, greatest challenges, lessons learned, together with strategies to better manage program enhancement.

4.1 Impact on Individuals

> *... in the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection.*[25]

Survivors appear to live through a natural sequence of events on their healing journey that can begin with awareness of the impact of the Legacy on the individual psyche and family relations. Following awareness comes understanding which precipitates self reflection, discovery and acknowledgement that can, by themselves, lead to healing engagement but may also be accompanied by crisis. Of course, crisis alone can catapult individuals into seeking help. Once in a therapeutic environment or relationship, Survivors need to feel safe and this is where the hard work begins. The second phase is characterized by remembrance and mourning; a time when past trauma is faced and resolved, when the individual develops relationships with others on the journey. Finally, there is reclamation of the rightful place of Aboriginal people to live healthy productive lives and expect the same outcomes as other Canadians. This phase takes considerably more time and requires immense discipline as well as continued support and guidance to establish stability. Reconciliation fits at end stages because healing is not complete without forgiveness. In the end, some rest comfortably in their own healing while others are called to heal family, friends or community. In any case, this phase is where a personal vision comes to fruition. Represented schematically and blended from the

[25] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 155.

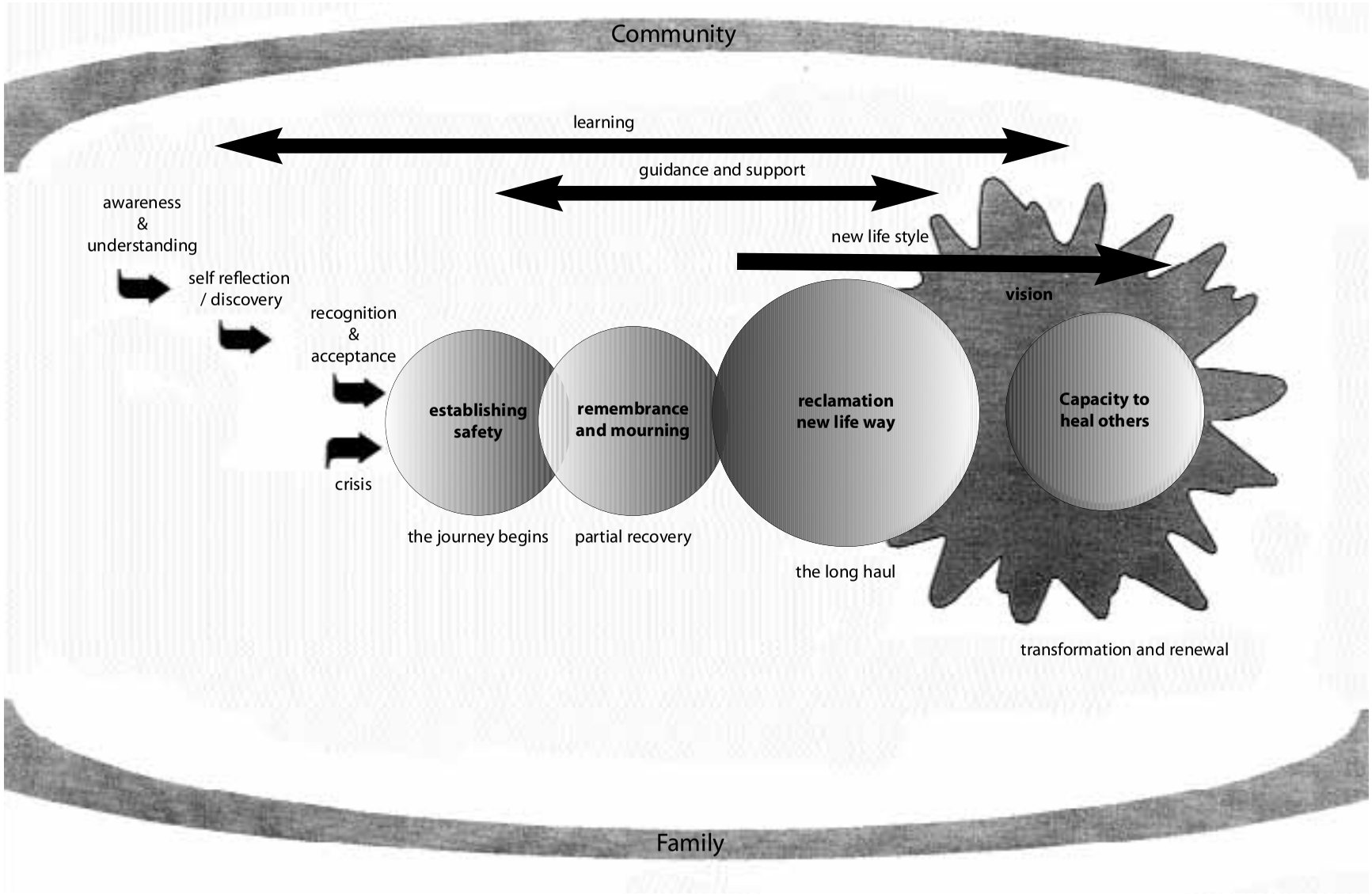
the stories told to us by those addressing the Legacy, therapeutic practice,[26] and broader Aboriginal healing experiences,[27] the Survivor's healing path might crudely be represented by Figure 5.

photo: Fred Cattroll

[26] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 155.

[27] Lane, P., M. Bopp, J. Bopp and J. Norris, (2002). Mapping the healing journey: the final report of a national research project on healing in Canadian Aboriginal communities. Four Directions International, unpublished research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General.

Figure 5) A Survivor's Journey



The following discussion is framed in this sequence with some phases obviously having more rich detail than others. After all, the work of addressing the Legacy has just begun. While it can be argued that other programs have treated the symptoms of colonialism, the Foundation is charting new territory by attempting to provide for the needs of individuals recovering from institutional trauma.

4.1.1 Awareness and Understanding of the Legacy

Many felt that raising awareness was a pivotal first step to the eventual success of healing endeavours. When history is shared, a social context is created for what is often viewed as an individual's problems. In fact, one project reported that Elders embarked on new levels of healing once they began to talk about their experiences. The need for continued sharing was regularly reinforced.

> *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.*

Surprise was expressed at how little information and understanding there is about the Legacy, especially among youth[28] and non-Aboriginal human service providers. Where trust still needs to be established, information sessions are more highly attended than therapeutic ones. Active efforts with local media, especially radio, were considered very effective but in some situations, awareness was raised passively (e.g., simply by the existence of the project). Many first-time disclosures took place during debriefing sessions after *Every Warrior's Song* (a theatrical production honouring Survivors). Surrounded by family, community, roving counsellors and a skilled facilitator, Survivors felt supported and safe to process these revelations. Still, projects were open about their struggles with denial. In fact, resistance to disclosure should be anticipated and understood as a natural reaction to trauma.

> *They* [Survivors] *may feel stigmatized by any psychiatric diagnosis or wish to deny their condition out of a sense of pride. Some people feel that acknowledging psychological harm grants a moral victory to the perpetrator, in a way that acknowledging physical harm does not. Admitting the need for help may also compound the Survivor's sense of defeat.*[29]

In Qul Aun, respondents unanimously felt that an increased understanding was obvious, although restricted to about seventy five percent of the participant group. In the I da wa da di project the vast majority of participants (91.2%, n=34[30]) felt the information presented had increased their awareness and understanding of the Legacy's impact. One I da wa da di participant illustrates how knowledge gave her the resolve to break the cycle.

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[28] The history of residential schools is not taught in school and parents and grandparents are often reluctant to talk about it.

[29] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 159.

[30] Where n = the number of responses.

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."

Understanding the impact of the Legacy is perhaps best indicated by program demand. Some who are still struggling with denial did not operate to full capacity although many projects did. Others could not meet service demand. The following quotes illustrate how understanding has gathered healing momentum:

- healing Circle attendance is growing;
- the number of referrals has close to tripled;
- more northern communities are providing transportation and lodging for clientele to attend;
- receiving calls from all over the province and other provinces who have heard about the program;
- trust is building up and gradual increase of clients;
- friends bring friends to the program;
- workshops picked up momentum as various members from different communities joined in; and
- new clients approaching the healer on a regular basis.

And finally, on a more national scale, there is evidence of an increased understanding evidenced by Survivors reaching out to other Survivors to encourage them to heal; youth/Elder dynamics seeming particularly successful in this regard.

4.1.2 Healing

Once an understanding has developed, then the hard work begins. Establishing safety, uncovering past trauma and reclaiming a healthy life take time and project goals fell everywhere along this journey. In fact, project teams have imagined healing as a broad range of ideas and behaviours variably represented by positive movement in any or all of the following:

- self esteem;
- cultural reclamation or reinforcement;
- independence (emotional and financial);
- goal orientation;
- employability;
- leadership skills;
- movement beyond past trauma;
- seek or continue treatment and secure support;
- communication, relationship and parenting skill;
- healthy coping strategies;
- empowerment or assertiveness; and
- freedom from self abuse (including addiction) and suicidal ideation.

The national process evaluation survey revealed that 48,286 individuals (from 221 projects) had participated in healing programs with a clinical focus (e.g., where the goals are on *personal* progress

and *not* community development). It is interesting to note (and clearly reflective of the need for AHF supported activity) that *less than one percent* of participants (3,585) had previously participated in a similar healing program before they began attending an AHF project (n=114). They spent an average of one hundred and eighty three (183) hours in programmed healing activity (median[31] = 60 hours, n=162) and would get as little as two or as many as 2,821 hours of support and guidance.

Although dramatic change was observed in some participants on desired outcomes, others showed little or no change. Furthermore, there was often disagreement about the magnitude (or depth of change within individuals) and the extent (proportion of individuals in a group) of change. Still, it was possible to gather a picture of the nature of change and, in only a few cases, it was clear that observed change endured beyond the life of the project.

4.1.2.1 Establishing Safety

Establishing safety was the platform upon which subsequent stages were based. Connecting Survivors to one another and to skilled healers worked well in this regard. Large public forums and widespread publicity offered Survivors union. The team of *Every Warrior's Song* (a drama honouring Survivors) remarked that disclosure was an anticipated and supported event after every performance. Over 95% of those who responded to the I da wa da di evaluation said they felt safe at the gathering. In La Ronge, Saskatchewan, Cree radio productions on the Legacy facilitated discussion in other venues. In more individually focussed therapeutic environments, establishing safety was again reinforced by offering opportunities for connection through group counselling sessions or by having a therapeutic team with whom Survivors could identify. Counsellors who are non-judgmental, sincere, trustworthy, gentle, respectful, committed and culturally sensitive were clearly credited with noted progress toward comfort. Time was also a factor in establishing comfort. Survivors needed to know that their inner most selves would be safeguarded before accepting support.

> *Because the tasks of the first stage of recovery are arduous and demanding ... It is often tempting to overlook the requirements of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.*[32]

One young mother spent the first two weeks in her room at the Tawow Healing Home (a whole family parenting skills program for families at risk) with her infant child. When it became clear to her that coercion would not be a defining feature of intervention, she was able to receive warm, culturally appropriate guidance. In the Kikinahk Parenting Program (for parents of teens), only women came initially. Eventually, they brought their husbands and teenagers. In fact, the level of participation surprised the team. *"There are fathers who, for the first time in their lives, are having an emotional*

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[31] The median is a measure of central tendency (or the "middle") used in statistics and represents the "half way" mark. In other words, half of all values fall below and above the median.

[32] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 172.

emotional family outing with their sons.'[33] Parents became increasingly comfortable to share insights and ask questions. Beyond connection and time, the physical environment was also critical. Building a Nation seems particularly successful at creating an environment where even "hard to reach" groups (e.g., homeless individuals) feel welcome and safe. Complete acceptance, "drop-in" availability, together with culturally appropriate and client-centred services delivered by Aboriginal people (some of whom speak Cree) have been credited with creating an environment where participants feel they belong. In fact, all beneficiaries return. But, residential treatment facilities with bunk beds, night security who carry flashlights and low budget cafeteria style food may work against establishing a climate of safety. Sometimes, facilities that were too closely associated with addictions treatment also inhibited those seeking help for fear of stigmatization as an addict.

Honouring Survivors was also particularly effective in creating a climate of safety. The cast and crew of *Every Warrior's Song* described the play's impact on their audience.

- *My Mom is a Survivor, she attended one performance and I acknowledged her there as a Survivor for the first time … she started talking more which she never did before … like she used to have problems hugging and now she does [hug].*
- *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 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.*
- *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.*

After five performances, forty-one individuals and fourteen families sought counselling and four individuals were referred elsewhere. By providing honour for those who suffered and a non-threatening venue for the story to be told, *Every Warrior's Song* facilitated an individual decision to seek help.

4.1.2.2 Remembrance and Mourning

Remembrance and mourning were not featured in every case study selected but where it was a part of the therapeutic process, it was clearly handled in a variety of ways. One of the most popular was the use of psychodrama at the Qul Aun program. Many participants were completely or extremely satisfied with Qul Aun's group and individualized approach to a variety of therapeutic issues. There was an even distribution of satisfaction in the treatment of spousal abuse, abandonment, depression, and anger and violence in group and individualized settings; however, there was *a clear preference for individualized sessions when addressing sexual offending, conflict with the law and foster care issues.*[34]

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[33] Kikinahk Friendship Centre, Kikinahk Parenting Program, Project # RB-67-SK/64-SK, Project Monitoring Second Quarterly Report, 2000, Objective # 2.

[34] Figure C.1 in Appendix C reveals the distribution of participants who were completely or extremely satisfied with Qul Aun's approach to a variety of therapeutic issues.

In the I da wa da di project, seventy five percent (n=70) of those participating in the gathering agreed it helped them address past trauma.

A core feature of the Pisimweyapiy Counselling Centre's approach was to return Survivors to the residential schools they attended for cleansing and healing ceremonies. The majority were very satisfied with Pisimweyapiy services and generally felt that it met their needs. Praise for this approach is captured below:

> *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. … Seeing the old residential school brought back some sad memories and kind of brought a closure to that bad experience.*
>
> *I especially enjoyed the trip to my former residential school. It has brought some closure to some sad and bad memories over there. … I will continue to seek counselling after this program.*

4.1.2.3 Reclamation

In the last phases of the healing journey, the Survivor endeavours to reclaim their *rightful* place in a life of peace and balance. It is the most energy and time consuming of all healing phases and can involve learning a variety of skills to maintain healthy patterns of behaviour. Some projects focussed their efforts on this phase of healing *without* directly addressing past trauma. Instead, they exercised and developed skills to deal with stress, manage family life, enhance personal industry and esteem, reinforce cultural identity or cultivate leadership through a variety of interventions.

In Big Cove, change was most dramatic in cultural awareness but weak in parental involvement. Youth didn't seem as angry as before, they felt heard, supported and their group has shown healthy, steady attendance. They started showing up on time, trusting and confiding in, as well as bonding with others. One teacher noted increased youth voluntarism and willingness to help with younger children. Of particular note is the extent of initiative, leadership and assertiveness demonstrated by the youth team involved. For example, in Mi'kmaq communities, wakes are almost always held in family homes. Youth team members challenged this tradition, held the wake of a young suicide victim at the drop-in centre and monitored the facility on a twenty-four hour basis assuming responsibility for the direction taken. Moderate change was noted in the development of social and leadership skills, goal orientation, self-esteem, mother/daughter communication, family relations and peer support.[35]

Gay and lesbian youth in the Urban Native Youth Association project felt their ability to face homophobia, deal with their sexuality and depression improved. They better understood the impact of the Legacy and felt motivated to face their alcohol or drug use head on. In fact, four gay/lesbian youth reunited with their families and communities. After the I da wa da di project, some women went on to facilitate workshops, others began drumming and singing, and most left with a stronger

[35] Figure C.1 in Appendix C reveals the distribution of participants who were completely or extremely satisfied with Qul Aun's approach to a variety of therapeutic issues.

sense of self. Some became more attentive to their families, committed to passing on cultural teachings, spending time with Elders and personal wellness. One woman gained enough self-confidence and love to leave an emotionally abusive relationship of twenty years. Others felt less alone, more forgiving, returned to school or made career moves.

In Cape Dorset, people spoke about "growing up" emotionally, finding other ways to deal with personal strife other than just crying. Some were happier, better able to cope as well as more confident and stable. Lower levels of improvement were noted for those simultaneously participating in addictions treatment and among known violent perpetrators. For participants at the Pisimweyapiy Counselling Centre, evidence of change included some appearing better able to maintain sobriety, seek and secure employment, disclose past trauma, display physical affection, be outgoing, seek spiritual fulfilment and recruit others to participate. While the majority were clearly excited about culture teachings and eager to learn more, some with strong Euro-Christian ideals were resistant.

Reinforcement of culture and identity is also characteristic of the healing journey. For the Métis of Willow Bunch, Saskatchewan, Local membership stands at 250 (from Willow Bunch, Coronach, Rockglen and Bengough) up 150 from four years ago. *"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."* Increased attendance at Local meetings, discussion about Métis identity and knowledge of accurate Métis history as well as involvement and pride in Métis culture were all noted.

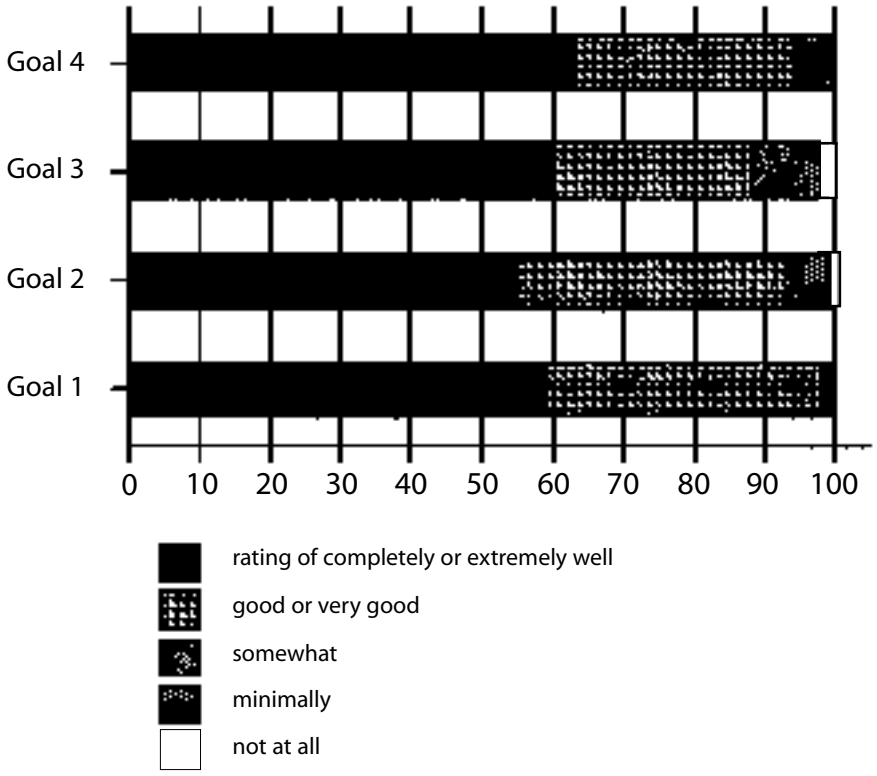
For projects which addressed individuals in the context of their families, there was also noted change. Parent child interactions were characterized as more patient, confident and nurturing evidenced by investments in cooking, laundry, play and quality time spent with children. Before attending Tawow, one parent was ready to give up on her oldest child but now wants to keep the family together. Two families became sufficiently stable to live on their own, one of which was previously homeless. While there were clearly changes in emotional independence, economic self-sufficiency may be a longer term goal as all still rely partially or wholly on social assistance. In the Kikinahk Parenting Program for parents of teens, some became more relaxed, patient and skilled communicators over time. They were less likely to "push their teenagers away" by more carefully selecting their words and tone while others seemed better able to allow their teens to have fun or to do things with their teens. Mothers who participated were not accessing services as often as those who did not attend Kikinahk.

Other examples, taken from the project files show the variety of changes noted in project participants:

- *Some parents have proven dedicated and eager to examine past and current patterns which impact on their parenting role.*
- *The changes they make in their own healing and personal growth impacts directly on other family members. Increased parental involvement in school.*
- *Only one student out of the eleven students who have gone through the program has had further diffi-*
- *culties …. parents are requesting their children go through the program as a means of support and help. The silence around sexual abuse and family violence has been broken. Women healing from their own*
- *sexual abuse can better provide their children with safety. … As women heal and recover … the men are beginning to see a need to change also.*

Of course, these reports are based upon the *immediate* assessment of desired outcomes. In only one case was the *endurance* of project goals secured. At three months follow up, the majority (70%, n=23) reported that Qul Aun helped them to act upon their strengths, made a difference in their lives, (78%, n=23), helped them move beyond the trauma of their past (76%, n=49) and prepared them to handle future trauma (78%, n=23) completely or extremely well. The majority also indicated that Qul Aun helped them to achieve their personal goals extremely well or completely (n=59, from five different Qul Aun sessions). Figure 6 illustrates the distribution of opinions with respect to the achievement of *personal* goals.

Figure 6) Enduring Achievement of Personal Goals (Qul Aun)



While most Qul Aun graduates continue with external counselling and self-support groups, those who return to a correctional facility or remote regions did not get the support they require. Because residential treatment focusses upon the *individual*, the essential task of re-connection or reclamation of a balanced life is left to aftercare. Therefore, it is likely that complete recovery can remain elusive in scenarios where aftercare is in question.

> *The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the Survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation.*[36]

[36] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 133.

In one case (Building A Nation), a variety of therapeutic and post-therapeutic supports were available. The project rightfully assumed that beyond psychological help, other adjunctive services would be required including life skills development, advocacy services, even help finding lost parents. Such a continuum of service, support and guidance creates opportunity for individuals to achieve real transformation in their lives.

4.1.3 Capacity to Heal

For Survivors, the capacity to heal comes at the end of a long, arduous journey and while supporting and guiding others on their healing path is not a Survivor's responsibility alone, we heard regularly that healers with whom Survivors could identify appeared to work best. Projects employed primarily Aboriginal people, including residential school Survivors and their descendants who, along with volunteers, had access to a wide range of training[37]opportunities. In fact, training was provided to at least 10,938 (n=124) participants and trainees spent an average of 193 hours in training. Over half of the project files (36) reviewed found that they would have benefited from greater capacity. Although most projects could make referrals when the special needs of their groups exceeded capacity (e.g., FAS/FAE or life threatening addiction), others had no choice but to try to address special needs with whatever resources they had. They also made the case for counsellors *specifically trained in residential school abuse* but warned *against* simultaneous program delivery and training. On occasion, teams and beneficiaries were *equally impacted* by the Legacy. One project noted:

> *Training for frontline workers was a huge factor in them realizing that they themselves had inherited the dysfunctional behaviours of the Residential School Legacy. It gave the participating frontline workers an opportunity to dig deeper within themselves recognizing that each of them need to work …. so that they can enhance their helping skills and abilities.*
>
> *We continue to recognize our own need for personal growth as part of our need as caregivers working towards supporting our families and communities in their healing.*
>
> *Some trainees took leave from their training to work on their own issues.*

Because teams had the unenviable and *unprecedented* task of *simultaneously* building capacity, struggling with denial while designing and implementing programs to address the Legacy, a longer time frame is needed to strengthen healing capacity. Nevertheless, many Survivors do leave projects with a vision to heal others. Some enter the field of social work and give back to the community as volunteers or serve on governing boards. There is also evidence that they leave with skills. In the Pisimweyapiy Counselling Centre, Qul Aun and I da wa da di case studies, strong, positive participant satisfaction leads to the conclusion that the training and experience of the team was well suited to facilitate healing and the training programs used for these teams may be appropriate for others. In I da wa da di, participants felt that they would be more empathetic, supportive, compassionate, and non-judgmental in their work with Survivors and both Tawow's team and I da wa da di's participants

[37] Training activity refers to any regular or routinely scheduled instruction such as courses, workshops, conferences, and formal classroom or academic training where the emphasis is on individual skills acquisition.

felt better equipped to use traditional approaches to support Survivors. On the other hand, the volunteer members of the Aboriginal Peoples' Justice Circle in Ottawa came to the committee with *"a vast amount of experience in their respective fields,"* but they also recognized the need for training specific to sentencing circles. Skills learned at the training workshops in Cape Dorset included active listening and recognizing pain. Trainees also felt more committed to their role as models, better able to empathize with the sexual abuse victim, intervene in a crisis and share their learning.

> *Caregivers have a big job, they are available at deaths, crisis [sic]. They now have the tools to deal effectively in these situations.*

Overall, seventy-four percent believed that training provided was adequate (n=226 projects). Trauma awareness and Legacy education were reported as adequate most often (81% for both). The four most commonly cited areas of continued training needs included crisis intervention, trauma awareness, counselling skills and dealing with family violence. A strong majority of the document files reviewed revealed that projects provided training of some kind to a variety of targets including leadership, project personnel and community members, generally as a way of developing healthy and culturally respectful programs. Some offered instruction as a way of developing community based trainers; however, there was some noted resistance to becoming "an expert" because of the daunting task ahead. The files suggested training may need to change to better recognize a more step-by-step approach to healing. For example, it may be more effective to teach basic adult child interaction skills before setting out to teach parenting. It was also suggested training be focussed upon leadership and project personnel.

> *We have had to look at the health and healing of our staff in order to provide safe practices for our clients. We have had to take a better look at our leadership and the direction that they are taking before we are able to move forward.*

Finally, capacity to heal others was also believed to be something more than just counselling skills or crisis intervention; it was envisioned as consciousness, hope and the ability to challenge the status quo to ensure that tomorrow would be better than today.

> *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.*

4.2 Influencing Communities

Over the next ten to twenty years, it is anticipated that AHF-funded project activities will positively influence those affected by the Legacy, and that they will have addressed unresolved trauma, broken the cycle of abuse and enhanced their capacity to sustain well being. Selected measures of these impacts at the community level included reduced rates of physical and sexual abuse, children in

care, suicide and incarceration. Some key informants expressed the view that rates of physical and sexual abuse, suicide and children in care had already declined, but there was by no means a consensus. Many people said they just did not know, while others had observed no change in rates. There were fewer references to incarceration and these data were actually more difficult to collect. For the most part, social indicator data suggest that the incidence of suicide, suicide attempts, physical and sexual abuse, and children in care remain high. It is unrealistic to expect anything else over the course of a year or two, or even five. Reconciliation, another desired long-term outcome, is expected to become more evident once a critical mass of individuals, families and communities have progressed further along the healing path.

Thus, the contribution of AHF-funded projects in influencing community level social indicators is not yet clear. Social indicator data have been reported in individual case studies to the extent that they are available.[38] Such data are probably only relevant for community level projects; at the regional or provincial level, it would be almost impossible to attribute a decrease in suicide rates, for example, to a particular project. As reported earlier, the *within groups repeated measures* evaluation design anticipated collecting follow-up data in 2003 to 2004. While this is no longer the case, there are opportunities for community-level projects to follow through by collecting comparable data at three or five year intervals. Case study sites for which some community-level baseline data have been collected include Big Cove, Cape Dorset, Nisichaqayasihk Cree Nation, La Ronge, Red Deer, Saskatoon and the Atikamekw communities.

While it is too early to examine long-term outcomes, progress can be measured through the analysis of anticipated shorter term outcomes. At the community level, these include:

- increased understanding and awareness of the Legacy;
- increased ties between Survivors and healers;
- increased capacity to facilitate healing;
- evidence of strategic planning with a focus on healing;
- increased partnerships; and
- increased documentation of the history of residential schools.

Not all of the case study projects addressed all of these outcomes, but there is evidence to suggest that progress is being realized, especially in two areas: addressing the Legacy and increasing the capacity of communities to facilitate healing. Collectively, AHF-funded projects have increased awareness of the Legacy, broken through some of the barriers of silence; and built support systems, networks and partnerships. Projects employed Aboriginal people, including residential school Survivors and their descendants who, along with volunteers, had access to a wide range of training opportunities.

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[38] The availability of social indicator data varied from project to project. In general, it was easier to report on incidents (primarily limited to reported cases) of physical and sexual abuse, suicide and children in care for projects that are community-based as opposed to those which are urban, regional or provincial in focus. Incarceration rates were available at the provincial and territorial levels.

Mapping the Healing Journey,[39] a paper prepared for the AHF and Solicitor General of Canada, suggests that the community healing process, like individual healing, goes through distinct stages or cycles. Each stage has specific "drivers" or conditions that propel the community to begin healing and move from one stage to the next, as well as indicators of success and restraining forces or challenges. The four stages of community healing, summarized in Table 7,[40] include a depiction of how the Foundation's desired short and long-term outcomes fit into the overall community healing journey. This is followed by Figure 7, a visual representation of the community healing journey.

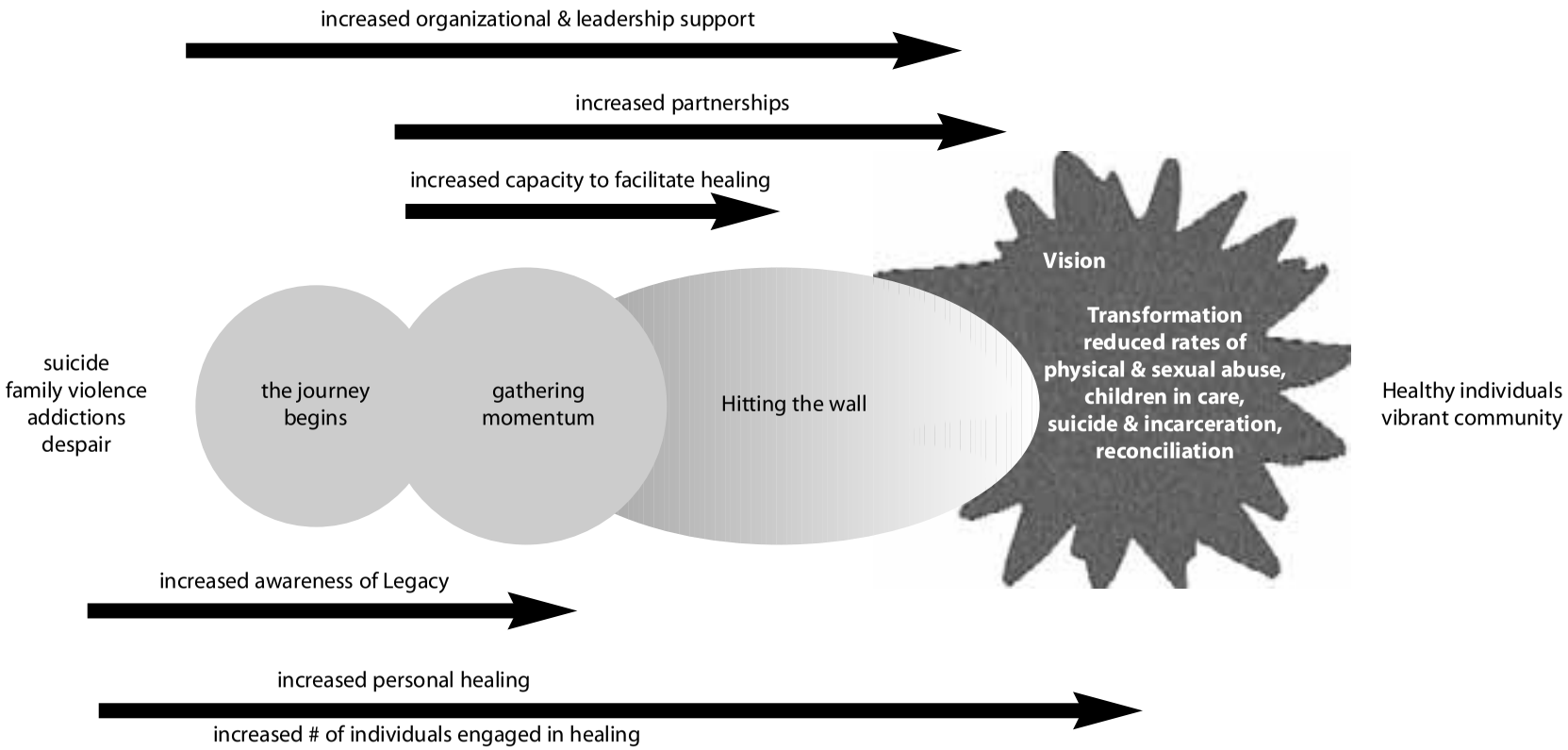
[39] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada.

[40] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada, pages 63-72. The table is based on the four stages of community healing presented in this paper.

Table 7) Stages and Indicators of Community Healing

	1) The Journey Begins	2) Gathering Momentum	3) Hitting the Wall	4) Transformation
Driving Forces	Problems identified (addictions, suicide); key individuals (often women) engaged in healing; key organizations work to address the "crisis"; leaders create enabling climate.	Growing awareness of the scope of the problem; recognize underlying trauma as root causes (e.g., residential school trauma, sexual abuse).	Progress has been dramatic but maintaining momentum presents challenges; professional capacity grows but healing becomes more institutionalized.	Limitations of current approaches recognized; a shift from healing as "fixing" to healing as "building"; growing participation by community members in the wider economy.
Success Indicators	People engaged in personal healing; informal support networks forming; growing number of people seeking help for a particular problem (e.g., drinking); sSuccess and failure are measured in stark terms (e.g., sobriety versus drinking).	More sobriety; increased number of people on a wellness path; a growing sense of hope, momentum, transformed vision – people believe community healing is possible.	Increased participation, support for healthy activities; negative behaviours (violence, abuse) not publicly tolerated; new programs support individual and family healing; more people seeking education; increase in cultural awareness, practices.	Increased community control of services; links between community economic development, community development and health; networks and alliances with outside groups.
Restraints	Denial; fear; opposition.	Lack of service capacity and trained employees; lack of resources; inability of service providers to work together; political support absent or token; resistance to healing by some groups within the community.	Lack of holism: inter-agency conflicts, isolated funding pockets, difficulties linking funding sources to community agenda; pressure to produce "results"; burnout; vested interests oppose healing; new problems emerge, especially among youth.	Ongoing effects of trauma; competent leaders drawn to employment outside community; community governance may maintain divisions and disunity; outside government policies geared to maintain dependency and external decision-making.
Link with Desired Outcomes for AHF- Funded Projects	Funding application submitted (e.g., recognition of a problem and desire to address it). Funded projects fulfill service delivery objectives.	Increased awareness and understanding of the Legacy; increased documentation of history; evidence of individual healing and increased number of people engaged in healing; increased hope; capacity-building is underway; increased ties between Survivors and healers.	Increased partnerships; increased capacity to facilitate healing (access to services and healers); development of strategic plans with a focus on healing (multi-agency, community level planning with support of community members and leaders).	Reduced rates of physical and sexual abuse, suicide, children in care and incarceration; reconciliation.

Figure 7) Community Healing Journey



Viewing community healing as a process with four distinct stages provides a lense to help understand where the case study communities fall on the healing journey. In reality, individuals and communities are always more complex than models can portray – events tend not to unfold in a linear fashion and there may be more progress in some areas than others. However, as a tool, this model helps to explain and perhaps legitimate the community experience with healing. An understanding of the challenges and successes of each stage can reduce frustration when processes are not moving quickly enough and concrete results seem out of reach. In fact, as the Four Worlds paper points out, *"The healing journey is a long-term process, probably involving several decades."*[41]

The following discussion attempts to illustrate how projects fit into the four stages of community healing,[42] but the progress achieved by individual projects can in no way be measured by how far they are along the healing path at a particular point in time. In fact, the authors of *Mapping the Healing Journey* acknowledge the benefits and limitations of their proposed model:

> *Taken together, these stages form one type of "map" of the healing process, which can be useful both for understanding the current dynamics of the community healing process and determining future actions and priorities. It must be stressed at the outset that these stages are only approximate models of complex real-life events.… They also do not take place in a linear way. They are more like ripples unfolding in a pool, where each new circle contains the previous one.*[43]

4.2.1 Stage One: The Journey Begins

Earlier, it was noted that the majority of case study sites report high levels of physical and sexual abuse and addictions. Other community-level problems include high rates of incarceration, suicide and children in care. Moreover, economic and social environments contain challenges associated with poor economies, inadequate housing, high rates of unemployment, racism and even homophobia. While each community is unique and there is a high degree of variability in the nature and extent of community-level challenges (and strengths), it is fair to say that those communities and organizations who apply for AHF funding have recognized the need to take action and identified an approach or action plan. The diversity of approaches is evident in the following excerpts from funding applications:

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[41] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada, page 43. This is one of seven "Lessons about healing and the healing journey."

[42] The examples presented in this section are drawn primarily from the case studies, but the evidence is also supplemented with material from the document review and national survey that were part of the 2001 interim evaluation report.

[43] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada, page 62.

Honouring Residential School Survivors: A Theatrical Production
People who have difficulty normally expressing their feelings will often allow the emotions to happen in a darkened theatre. … The theatrical production will give the audience an opportunity to view, through its characters and family relationships, the generational impacts of the childhood trauma of physical and sexual abuse. … The project will work with each host community to make sure there are counsellors available for each performance to provide immediate support, and also to ensure that people, particularly Survivors, are aware of where they can get on-going support in the community.

Cape Dorset: Healing and Harmony in Our Families
[The project was seeking support for healing activities which began for some women in the community in 1995.] *We know that there are other individuals, men and women, who have yet to start their healing journey to recover from the abuse experienced in residential schools or institutions in the South. Many of our people feel powerless and useless and need to learn to heal their spirit. The spiritual destruction of Inuit resulted when White Government came north and relocated Inuit into the communities, destroyed our dogs and way of life, took over educating our children and started looking after all our needs by providing housing, health care and welfare. Toxic shame is intergenerational. We need to learn more about our spirituality and know again in our heart that we are equal to other cultures of people in the human race.*

Tsow Tun Le Lum: Qul Aun Healing Initiative
The Healing Initiative Program (Qul Aun) is a holistic, balanced program of therapeutic and traditional methodologies. The program addresses emotional, mental, physical and spiritual health and well-being. The experienced and trained staff guide participants through therapeutic processes which include: healing circles, role playing, psychodrama, men's groups, women's groups, individual counselling sessions, daily journals and physical activities. In addition, Elders, healers and others lead traditional methodologies which include traditional ceremonies, traditional rituals (sweat lodges, pond, cedar cleansing, etc.) identify restoration and spiritual reclamation. The development of the program began and will continue with direct input from Survivors and adaptation to constantly changing needs. It will provide a safe, sensitive and caring environment to address blocked and unresolved trauma.

In applying for AHF funds, potential grantees must show how they intend to address the Legacy, how they will work with other community programs and services (including letters of support), and how they will be accountable to the community. Application forms require setting out a detailed account of the proposed purpose, activities, goals, objectives, and evaluation plans as well as an explanation of how the project will meet the needs of the community.[44] The amount of work required to complete an application and the clarity with which they must identify problems and interventions place projects firmly within the first stage of healing. Other aspects of the application process propel them further along the path: for example, commitments to address the Legacy can

[44] It should be noted that the Foundation's community support coordinators are available to assist communities in developing their funding proposals.

move communities into stage two (Gathering Momentum). It is recognized, of course, that communities enter the Foundation's constellation of funded projects at various stages of development and, also, that progress is not uniform, even within a single project.

Individual engagement in healing is an essential component of the community healing journey. As reported earlier, *many people are engaging in healing and training activities for the first time and less than one percent of all project participants had previously participated in a similar program.*[45] Informants in two of the case study projects (Big Cove and the Urban Native Youth Association's Two-Spirited Youth Project) specifically referred to their project as filling a service gap. Also, it is clear that a greater proportion of participants are women than men. While the problems associated with lower levels of male involvement are addressed elsewhere in this report, it is reassuring to find that the first stage of community healing is often driven by a core group within the community and this group is frequently comprised of women. This was certainly the case for Cape Dorset, Tawow Healing Home, I da wa da di, and the Kikinahk Parenting Program and the Atikamekw communities.

In Willow Bunch, Saskatchewan, the Métis Local undertook a project aimed at giving a positive awareness of the history of the Willow Bunch Métis to the community and increasing pride in being Métis. This may not at first appear to be related to community healing, but racism has been a common feature of the social climate in Willow Bunch and Métis were shunned from institutions such as the credit union, community councils and organizations. Not everyone was positive about the project (anywhere from less than 10% to 50%), but a core group of people worked to build momentum. Those who were positive included Métis involved with the Local, students, people with an appreciation for history, many of the Elders, those with a broad world view and those who had left Willow Bunch and experienced other environments and different cultures. Resistence and denial (obstacles common in the first stage of healing) were more common among older residents and those who felt threatened by an accurate history, changes in school language laws and economic development funding for the Métis: *"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."*

The Willow Bunch project led to numerous activities that had never taken place before: workshops, Métis cultural activities, work within the school, visits from other Métis organizations, newspaper articles and interviews about Métis history. Overall, respondents believe 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. ….I think most of the history of this area has come from a Euro-centric perspective up until the healing project."* In carrying out these activities and meeting its service delivery objectives, this project has changed the social environment in a small but important way: the conditions now exist for a community healing process to begin.

[45] Kishk Anaquot Health Research (2001). An interim report of Aboriginal Healing Foundation program activity. Ottawa: Aboriginal Healing Foundation, page 29. A total of 3,585 participants had never participated in a similar program.

4.2.2 Stage Two: Gathering Momentum

The second stage of community healing is characterized by an increase in healing activity, both at the individual and organizational levels. More people are participating in programs as well as volunteering. Programs and services are developing and evolving in response to the need. It is also at this stage that underlying trauma related to residential school abuse begins to be understood as a root cause of problems such as suicide and addictions. At the same time, there is an increase in healthy behaviours and a growing sense of hope in the community. Obstacles relate to a lack of resources, service capacity and trained staff and, in some instances, a lack of political support and continued resistance and denial among some sectors of the community.

The Cape Dorset healing project exhibits many of these characteristics. The project was designed 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.[46] A nineteen member Community Healing Team (CHT) planned and coordinated healing and training activities as well as participated in them. The CHT was composed almost entirely of Inuit women (one non-Inuk, two men). Key informants were asked to give an example of how the community has benefitted from the project. Several described an increased skill level among community caregivers and an increased capacity to deal with crisis. One person spoke about how her personal growth has led others to approach her to discuss their problems. The collective impact of having a number of individuals involved in healing who live and work in the community is evident in the following response:

> [There's] *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 affect. Kids will learn this stuff too.*

Among the challenges facing the project, key informants identified continued resistance to remembrance and mourning by individuals and certain segments of the community, including some of the church members who believe that forgiveness and reconciliation can occur without adequate processing of past trauma. Yet progress was clearly realized on a number of fronts:

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

Looking to the future, one person commented, *"One goal is to have all community organizations and agencies come together as one, with no barriers."*

The experiences of the Koskikiwetan project in the Atikamekw communities of Opitciwan, Wemotaci and Manawan also fit well here. Many more recognize the connection between their

[46] The Tsow-tun-le-lum Society's Qul Aun project has a similar philosophy in that it *"believes that healing begins with the individual, extends to the family and moves out into the entire community."*

experiences at residential school and current rates of social distress resulting in more individuals seeking help, much less tolerance for violent behaviour and increased reporting of sexual and physical abuse. Although there was stark disagreement about rates of children in care, respondents did note enhanced collective and parental responsibility for children. The challenges faced by Koskikiwetan included securing sufficiently skilled human resources, enlisting Survivors who have healed enough to lead others into healing, uncertainty about future support for the healing process initiated and revitalization of Atikamekw solidarity.

4.2.2.1 Awareness and Understanding of the Legacy

The second phase of community healing is where the focus shifts to recognizing the root causes of addictions and abuse. As noted earlier, a personal understanding of the Legacy can be a pivotal first step towards the success of the healing endeavour. When history is shared, a social context is created for what was previously viewed as an individual problem. A similar process occurs at the community level. Over the past four years in La Ronge (Kikinahk), 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. Hearing the radio talk show in Cree made it okay for individuals to talk in other venues with those in the 40-50 year old category appearing much more willing to talk than those who were older. For the Nisichawayasinhk Cree Nation (Pisimweyapiy Counselling Centre), more open discussion about and different attitudes toward the Legacy, together with public acknowledgement of high profile perpetrators, suggest that the climate has changed. Recommended program improvements included building on this initial success by enlisting partners in Legacy education.

While the I da wa da di project served Aboriginal women from across Ontario, its training sessions for front-line workers were held in partnership with particular community agencies. These workshops were especially successful in increasing participants' knowledge of the Legacy, and this new understanding was used in their healing work with clients. Qul-Aun (Tsow-tun-le-lum Society) also has a province-wide catchment area, but there is some evidence that the program also influenced the community surrounding the centre. Respondents were asked about their attitude regarding the local community's understanding of the Legacy. They unanimously noted that change was obvious (n=13). However, they did not believe that the entire community had been affected. Many (11) felt that at least half of the community, if not more, now has a better understanding of the impact of the Legacy. Two people felt that the change in knowledge and understanding of the Legacy was restricted to a small group (<20% and <10%). The impact of Qul-Aun on all communities of origin (e.g., where participants reside) was not measurable within the resources allocated. However, the outreach component played a major role in getting 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.*[47]

[47] Tsow Tun Le Lum Society, Qul Aun Program, Project #HC-36-BC/67-BC, 5th Quarter Project Monitoring Transfer Sheet, May 31, 2001, page 8.

Every Warrior's Song was built around the experiences of Survivors and it involved them in the research phase and as advisors throughout the project. This project documented residential school history and impacts, albeit in a theatrical venue. The following comments were made by key informants on how communities are able to deal with residential school issues differently:

- *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.*
- *I saw an impact on frontline workers, development and education, even for the leadership.*
- *Survivors did an honouring at each performance. The community now sees their strength and how Survivors can make contributions to the community.*
- *I know that Survivor support groups were started, even a theatre group in Merritt was started. I know one Friendship Centre is now running training for counsellors.*
- *Frontline workers at each performance got more understanding of trauma. We recognize basic*
- *alcohol and drug counselling isn't enough.*

While some respondents felt that sexual abuse issues were adequately addressed by Kikinahk Parenting Project's awareness campaign, they were not convinced that such abuse was adequately linked to residential schools. In Big Cove, it remains unclear how well the project is addressing the Legacy. It is a youth project and the residential school in Shubenacadie, Nova Scotia, where First Nations children in the Atlantic region were sent, has been closed for almost forty years. Yet, many of the community's youth are inter-generational Survivors and the project's goals include developing personal, social, mental and physical well being to combat the effects of unresolved trauma originating from the Legacy. Big Cove is discussed in greater detail under the third stage of community healing. This community exhibits many of the characteristics of a community well along the healing path, but it appears not to have explicitly addressed this issue, at least not as part of this youth initiative. Other community organizations may, in fact, be dealing with the Legacy.

4.2.3 Stage Three: Hitting the Wall

By the third stage of community healing, a great deal of progress has been made, but momentum is beginning to stall. The community's service capacity has grown and an increasing number of individuals have pursued education and training and are now employed. On the other hand, the hope and excitement often evident in the second stage has dulled, healing becomes more institutionalized and frontline workers are beginning to burn-out. While more of the community's adults are pursuing healthy lifestyles, previously undisclosed abuses may be brought forward. New social problems, such as gambling, prescription drug use and youth crime may arise. According to *Mapping the Healing Journey*,

> *What appears to have been a wall may in fact be a long plateau. One of the characteristics of a plateau is that not much seems to be happening and you don't seem to be going anywhere, but it is actually where the foundation for all future advances are being laid.*[48]

[48] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada, page 64.

Some aspects of the Big Cove Youth Initiative may be seen as reflective of the activity that takes place in stage three of community healing. The project targets youth between the ages of ten and twenty-nine and offers a wide range of sports and other non-alcoholic activities, support groups, and cultural and spiritual events. The project team includes young people who work with representatives of other community agencies (e.g., social services, psychological services, alcohol and drug prevention and treatment) on a Youth Advisory Board. The Board is connected to the Big Cove First Nation Wellness Committee, which is a good example of inter-agency partnering that brings together social and health services with economic development, police, community leadership and Elders. Informants felt support from leadership was strong.

The Youth Initiative was one way the community responded to the high incidence of youth suicide. The crisis peaked in 1992 and for eight years since then, Big Cove's annual suicide rate was 116 per 100,000 with a total of twenty-one deaths. By comparison, the Canadian suicide rate during this period was 13 per 100,000.[49] The project coordinator confirmed that in the years surrounding 1992, all community service agencies were essentially doing crisis management. This resulted in burn-out 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 pro-active approach.

Social indicator analysis suggests that suicide and attempted suicide, physical and sexual abuse, and alcohol and drug use remain high. Vandalism and break and enters were identified as common crimes committed by youth. According to a youth survey[50] conducted early in the project, 91% of respondents felt alcohol and drug use was the greatest problem facing youth today, followed by peer pressure (45%) and unwanted pregnancy (35%). Figures cited in a study of special educational needs[51] showed that of the 157 students at Big Cove School, one-fifth had been exposed and affected by alcohol and drugs prenatally. Interestingly, when this case study was completed, a copy of the report was sent to the project team and they contacted the author because they felt the data under-represented the problem of sexual abuse. Additional material was provided, including a study on family violence completed in 1992 which indicated between sixty and ninety percent of the Big Cove population being directly or indirectly affected by sexual abuse. This was an important development in that the case study report led to a decision to publicly disclose additional information about the seriousness of sexual abuse based on the contention that the problem could not be addressed unless it was acknowledged.

These figures suggest the community is still in crisis, yet the case study also shows that significant progress has been made. For example, the Youth Initiative appears to be playing a major part in closing the service gap. One informant stated *"there had been no suicide training for youth before*

[49] Canadian Institute for Health Information (CIHI) (1996). Community health indicators: definitions and interpretations. Ottawa. Reprinted 1996, 1997, page 146.

[50]The Youth Initiative Survey was conducted during the second quarter (April 1 - June 30, 2000). A total of 141 community members responded to the survey.

[51] Cox, Dr. Lori (1998). Special education needs assessment. Page 51. The study included a survey of sixteen teachers and fifty-six parents.

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 a more cooperative, pro-active, multi-agency approach is now in place.

Key informants described a number of other benefits of the project:

- 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;
- project staff work well as a team;
  facilitates cooperation among community service providers;
- develops self-esteem and new skills; and
- provides a safe place for youth.

The investment in the Youth Initiative's team, 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, perhaps new leaders will emerge from this group. The project is having a positive influence 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 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 broaden the perspective of the young project team and allow them to be guided and nurtured by people who have a wealth of experience and expertise to offer.

4.2.3.1 Increasing Capacity to Facilitate Healing

Capacity-building is part of an ongoing and dynamic process. Every community initiative, from healing to economic development, has the potential to hire and train community members (AHF projects have contributed greatly in this regard). Individuals may leave the community for education or employment and return at a later time. Increasingly, Elders and traditional healers are viewed as educators and trainers in their own right. As momentum builds during the second stage of healing, more community members are attracted to opportunities to increase their knowledge base and skills, and by the third stage, there is great potential for this personal growth to positively influence the community environment. There are a variety of examples of this trend in the case studies.

Big Cove is focussing its efforts on building capacity and skills among youth, while I da wa da di is providing training to women. As a result, more women and Elders are 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.

Respondents from the Kikinahk Parenting Program (KPP) case study reported strong administration, a few dedicated team members, adequate training and education, and a clear long-term vision as contributing to the project's success. However, the need for ongoing education and skill development is probably reflected in the fact that not everyone was completely satisfied that KPP was able to deal with sexual abuse issues in a *clinical* capacity. Qul Aun, on the other hand, provided all team members with *twelve weeks of core training* as well as internships for trauma counselors and other professional development workshops. The purpose of training all staff was to ensure a fully qualified team to work with Survivors. The twelve week core training, in particular, prepared the Qul Aun team for the implementation of the five week treatment program.

The national survey found that only a few (5%) projects have a training-only focus, but half (50%) provide both healing and training. Training projects provided services to 10,938 participants and trainees spend an average of 193 hours in training.[52] In addition to building skills through training, AHF projects are employing Aboriginal people. The national survey found a total of 1,916 paid employees, eighty-eight percent of whom are Aboriginal. Clearly, AHF-funded projects provided community-level employment and training opportunities not previously available. Large numbers of Aboriginal people have been hired and trained and are now participating actively in community healing initiatives. This represents a significant contribution to building a healing capacity within participating communities.

4.2.3.2 Establishing Partnerships and Ensuring Sustainability

The Foundation has placed considerable emphasis on developing partnerships and cooperative relationships. For example, the funding application asks how projects will coordinate with other community services and quarterly activity reports include a section asking about any new partnerships established. There are good reasons for this. The Foundation does not wish to foster dependency on a fund with a ten-year life span, and partnerships are one way of promoting longer-term sustainability. There is also a well-established body of literature that supports a coordinated, holistic approach to health and healing through community development.[53] One of the consistent lessons learned from experiences with healing initiatives in Aboriginal communities is that *"Community healing requires personal, cultural, economic, political, and social development initiatives woven together into a coherent, long-term coordinated strategy."*[54] The number, type and quality of partnerships were

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[52] Kishk Anaquot Health Research (2000). An interim evaluation report of Aboriginal Healing Foundation program activity. Ottawa: Aboriginal Healing Foundation, page 20.

[53] The need for a holistic approach to health and healing is well developed in the Report of the Royal Commission on Aboriginal Peoples, as well as various publications by the World Health Organization. Also, Health Canada supports a population health model which recognizes the impact of non-medical determinants on individual and community health, including income, social support networks, education, employment, social and physical environments, coping skills, culture, healthy child development, health services and gender. The funding guide for Health Canada's Population Health Fund states, *"Collaboration across sectors is essential to successfully address the determinants of health. Existing partnerships should be strengthened, and new ones created, with organizations whose mandate or activities have a direct or indirect impact on health."* (1999:3).

[54] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada, page 43.

explored in the document review and national survey, while the case studies provide further insight into how cooperative relationships influenced projects.

From the document review, all but one of the thirty six files reviewed reported established partnerships, and survey results show that the majority (72%, n=247) of sponsoring organizations were linked with other healing or training efforts.[55] Relationships are concentrated at the local level and community services are the most likely partners. Overall, AHF-funded projects developed significant working relationships with a variety of service providers and agencies in their communities and regions, primarily as a way of expanding service range.

An interesting finding is suggested with respect to the influence of community relationships on projects. In some instances, active coordination and inter-agency work appear to have created conditions conducive to initiating an AHF project. For example, Red Deer has a reputation as a hostile environment where landlords are reluctant to rent to Aboriginal people and employers are reluctant to hire them as well. In the past fifteen years, Aboriginal organizations and services in Red Deer have grown and formed an interdisciplinary team of integrated services. New initiatives include funding for the homeless, community supported housing, opening of the Red Deer Aboriginal Employment Centre and a new Aboriginal council that oversees all programs affecting the community. In addition, cultural awareness education for all agencies dealing with Aboriginal people is required. The Tawow Healing Home entered this animated environment and filled a gap by providing the only culturally based, non-mandated therapeutic program for Aboriginal children and adolescents and their families at risk of intervention by social services.

In the case studies, examples of a variety of approaches to partnerships are found. In one case, a strong inter-agency committee provides guidance to the project (Big Cove). In others, the project team includes individuals who work for, or are members, of an assortment of community agencies and organizations (e.g., Cape Dorset and the Atikamekw communities of Opitciwan, Wemotaci and Manawan). In Willow Bunch, while no formal partnerships were created, external linkages were established with provincial organizations (Métis Addictions Council of Saskatchewan, Gabriel Dumont Institute and Métis Nation of Saskatchewan). Key informants discussing the Pisimweyapiy Counselling Centre credited locally established partnerships and networks, among other factors, with an increase in the number of couples seeking counselling over the lifespan of the project. The centre had established working relationships with local native media, regional Survivors' programs, leadership, the Métis community, a local college and a variety of human service organizations. Tsow Tun Le Lum's Qul Aun program is reported to have established credibility with Corrections Services Canada in providing services to inmates ready for parole and it receives a per diem for each bed inmates occupy.

The Aboriginal Peoples' Justice Circle in Ottawa encouraged membership from the Aboriginal community as well as from the mainstream justice system, including representatives of the Crown Attorney, police and the judiciary. While interview respondents did not agree on the level of support community partners gave the project, there was some evidence of progress with respect to

[55] Kishk Anaquot Health Research (2000). An interim evaluation report of Aboriginal Healing Foundation program activity. Ottawa: Aboriginal Healing Foundation, Table 4 and Figures 40-43.

increased awareness and acceptance of Aboriginal values and practices. The project's third quarterly report stated that the Assistant Crown Attorney, as a member of the circle, had been *"instrumental in having Aboriginal persons diverted away from the mainstream justice system."* One respondent communicated that justice officials *"have begun to listen and learn and to accept our teachings … this type of networking allows us to gain credibility and more respect and there is more willingness to learn our ways."* In fact, it was reported that smudging is now allowed and respected in court.

Two of the projects travelled to communities: one to present a play, *Every Warrior's Song*, and the other to deliver training workshops (I da wa da di). In both cases, host communities and organizations took on organizational responsibilities. The funding application for the theatrical production listed six initial partnerships with bands, treatment centres and residential school committees. The play was presented in twelve sites across the province, and in the final report, thirteen additional partnerships were named. Host communities provided facilities with a stage and an area large enough to house their anticipated audience plus marketing, transportation for the audience, a feast, a counsellor, pre and post action plans for participant support, and roving counsellors during the performance. I da wa da di training workshops were sponsored by three different agencies who provided local promotion and outreach as well as meals and refreshment breaks. Included in these partnerships are the traditional healers and Elders who came from different regions to the training workshops and the annual gathering to share their teachings and wisdom on healing.

The case studies addressed the issue of sustainability primarily by asking key informants about the project's potential for continuing after AHF funding had lapsed. Two of the projects are no longer operating – the theatrical production and the Two-Spirited Youth Project. Two others felt they could not sustain project activity beyond the life of the AHF, at least not without the support of a strong partner. In one case, this was due to the unique service provided: Tawow (referred to above) is the only whole family, non-mandated family service option in the region. If the organization accepts funding from social services, the program will have to change to adhere to their guidelines and may lose its unique approach. It was observed that the difficulties in establishing partnerships, caused primarily by differing philosophies and practices with child welfare agencies, decreases Tawow's chances of sustainability. When Justice Heals operated without funds both before and after the termination of Foundation funding.

While concerns were expressed about the long-term sustainability of many of the projects, there was also a determination to carry on, although activities might have to be scaled back. One informant insisted that even if new sources of funding could not be found, *"people will not stop pursuing their healing, they have just gotten a taste of the 'Good Life!'"* number of projects have or are in the process of identifying alternative funding sources. One of the clear benefits of AHF funding is that service gaps are being filled and new and innovative programs, like Tawow, have been created. This flexibility and responsiveness to community needs is clearly a strength, but it also presents a sustainability challenge for projects that do not easily fit into existing programs and criteria. However, as the following information from the national survey shows, projects are attracting both funding and non-monetary donations:

> *About two-thirds of projects (66%, n=253) report receiving donations or funding from other sources but less than half (39%) reported receiving funding alone. The funding*

came from other federal departments, provincial, municipal, hamlet and other Aboriginal governments, as well as private granting foundations and community fundraising efforts. Remarkably,

> ***a total of $5,619,882 were received from partners during the operation of the 99 projects that reported receiving such funds.***

There is a greater probability that projects will receive funding from an Aboriginal government or community fundraising than from any other source. Although the largest median donations were received from local health and social service agencies ($30,000): only nine projects reported receiving such donations.[56] *By comparison, twenty-five communities reported receiving a median of $27,621 from federal sources making federal governments the most generous donors, and almost a quarter received funding from private sources (22%).*

Only 33 projects had secured a long-term financial commitment from their partners.

4.2.3.3 Strategic Planning

AHF-funded projects invested varying efforts in strategic planning. Some included this as a project objective (Cape Dorset) while others were initiated following a lengthy planning cycle (Qul Aun). Others could have benefitted from an increased focus on planning (Two-Spirited Youth). *Mapping the Healing Journey* recommends that every community in recovery develop a comprehensive (5 to 10 year) plan that weaves together community healing and development.[57] This approach refers to strategic planning at the community rather than project level. Over the long-term, the involvement of AHF-funded projects in community-level strategic planning may contribute to the sustainability of healing initiatives as well as their integration into community plans.

4.2.4 Stage Four: Transformation

Stage four of the community journey is where healing becomes more integrated with other community development initiatives and the focus shifts from fixing problems to transforming systems. Volumes have been written about the debilitating effects of poverty and unemployment on individual and community health. A study of Hollow Water's Community Holistic Circle Healing asks, *"What good is the healing if it can't be sustained in its physical component?"* and it quotes a community member on the issue:

> *It doesn't make sense to get people well without sustaining that wellness. The long-term*

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[56] Refer to the section of the interim report on "Establishing partnerships and ensuring sustainability," including Appendix J for a chart which summarizes the median, minimums, maximums and sums for each category.

[57] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada, page 74.

vision must address the unemployment in our community. It's an essential part of holistic healing. … Treatment and employment go hand in hand. … With our next generation of kids, economic development must be factored in. Opportunities for our children will help them. Otherwise, there is a chance of them getting into trouble.[58]

It is during the fourth stage of community healing that significant reductions in rates of physical and sexual abuse, children in care, incarceration and suicide are most likely to occur. As noted at the beginning of this section, it is still too early to assess the contribution of AHF-funded projects by measuring improvements in the environment based on these social indicators. It is, however, never too early to gather baseline data and all projects should be encouraged to do so.

In closing, it is important to remember that while the journey is long and often arduous, progress is being realized. A respondent in one of the case studies spoke about changes in the way some people are speaking about "community":

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.*

4.3 Managing Program Enhancement

Several observations and recommendations have emerged from the case study exercise that are supplemented by findings from the document review and the national process evaluation survey that relate directly to program enhancement.

Case study project files were *rich* in detail regarding the achievement of service delivery objectives and some did *formally* collect feedback from participants that was invaluable to adding participant voice to this report. Informal feedback was a common strategy used to assess participant satisfaction. Although all projects submitted evaluation plans, many selected for case study did not have the expertise, time nor the appropriate tools to carry out their evaluations. It is also possible that project teams may have confused their investment in completing project monitoring and evaluation forms requested by the Foundation as sufficient to meet evaluation requirements.

The document review (36 project files) revealed that team impressions were abundant in the project monitoring reports; but, *clear and specific* evaluation methods were articulated by only a few and only a handful had completed evaluation reports. Those who did engage in evaluations as planned provided stellar examples of community based, participatory self evaluation including defensible evidence related to participant life satisfaction, observable changes in self-sufficiency, effectiveness of project management and the degree to which the project was able to become financially self sustaining. Data collection methods varied and included participant evaluation, community questionnaires,

[58] Native Counselling Services of Alberta (2001). A cost-benefit analysis of Hollow Water's Community Holistic Circle healing process. Ottawa: Solicitor General Canada, page 44.

focus groups, key informant interviews and some claimed to be using standardized, rigorously evaluated instruments. *It is the results of these instruments that will hold significant weight in assessing the impact of AHF-funded project activity*. Project teams encountered difficulties when assessing the contributions their efforts made toward desired goals that indicate the sensitive nature of AHF program activities and a need for community based evaluation training.

> *Field workers found out that the majority of people were afraid to do the questionnaires. We as a team concluded the fear came from the unknown and un-dealt issues within each individual's life.*
>
> *Incomplete data collection – frustrating outcome given the time and energy invested in completing the Achenback Child Behaviour Checklist and Teacher Report forms during pre-group phase.*

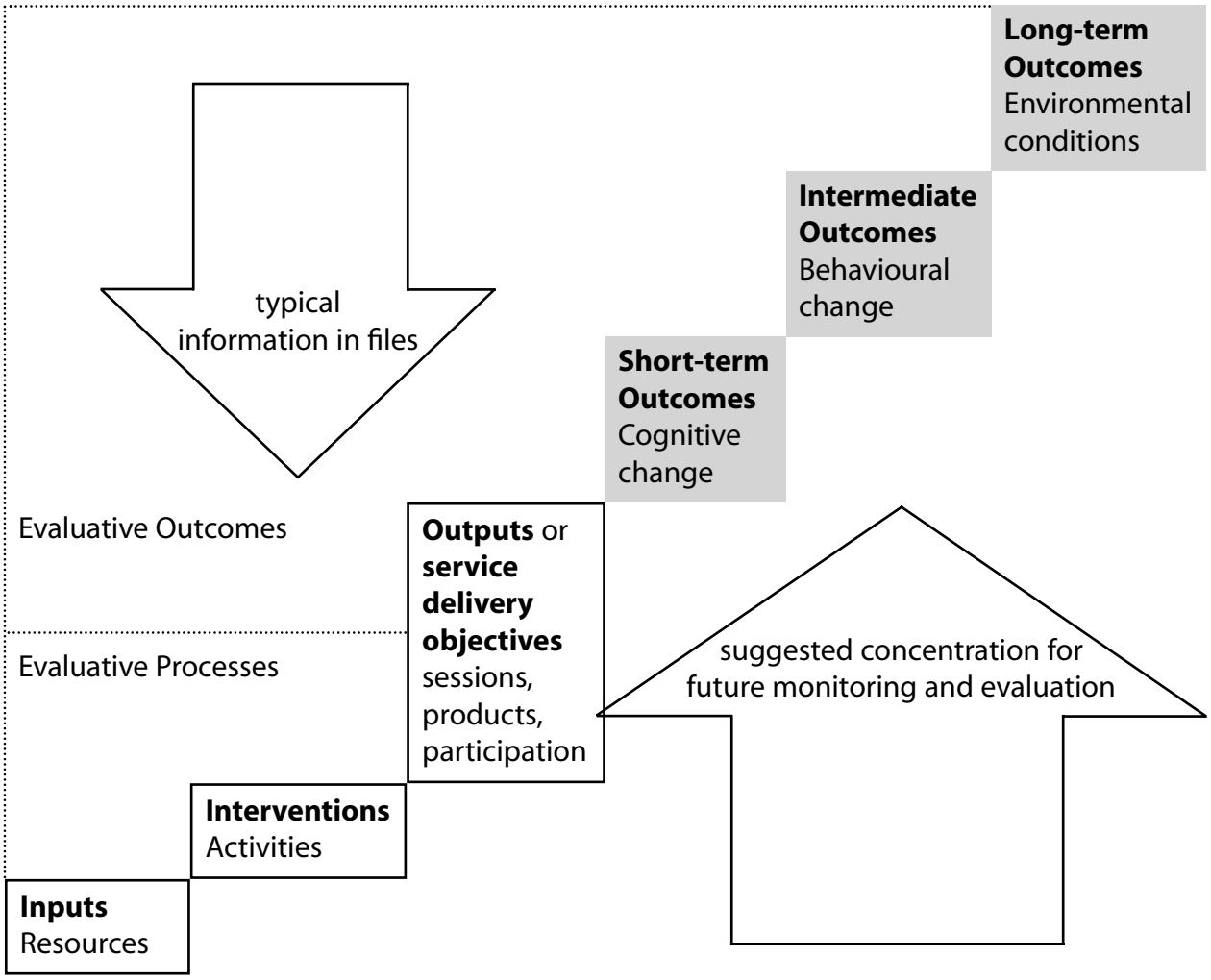
Sometimes reports indicate positive participant feedback without any submission of the participant evaluation forms (e.g., raw data). In other cases, raw data is included in progress reports (e.g., participant satisfaction forms) but no analysis or synthesis of participant voice is included. Sometimes, there were claims of high participation rates or service demand without corresponding details regarding the proportion of Survivors within the community who are engaged. Possible explanations for the lack of evaluative information in the files include therapeutic demands upon project teams as well as community capacity.

From the process evaluation survey, it was clear that roughly three quarters (74%, n=230) of AHF-funded projects are measuring change in their program participants in some way; however, rarely (2%) do projects use after care or follow up practices as a way of measuring enduring change. With respect to training projects, the majority (77%, n=137) are measuring skills and knowledge acquisition and proportionately more (5%) are using follow up strategies to determine if knowledge or skills acquired during training have been applied. What follows are recommendations for improving program enhancement efforts that address the distinction between outputs and outcomes, an appropriate and sufficiently sensitive target for analysis, useful measurement tools and suggested evaluation designs.

4.3.1 Outputs versus Outcomes

More clarity on the difference between the ability to measure *implementation objectives* (e.g., what we did or *output*) and *real change* (e.g., what we wanted or *outcome*) is needed. In other words, while it is important to report the achievement of service delivery objectives or immediate outputs (e.g., documents, participation, meetings and conferences), a more powerful statement can be made if the effort focuses upon whether or not any *changes* have occurred in ideas, intentions, behaviours or conditions (e.g., the outcomes). The suggested focus of future project monitoring and evaluation efforts are shaded in Figure 8.

Figure 8) Focussing Efforts on Change



In addition, it would be helpful if projects were encouraged to strive for more realistically attainable goals that can be articulated in finer detail so that the theory underlining each effort is clear. Table 8 is offered as a way of ensuring that programs are designed in a way that allows them to be evaluated.

Table 8) Key Questions for Measuring Performance[59]

Ultimate Goal of AHF	create sustainable healing
Source of Change	program activities identified here
Who will change?	who *specifically* (targets tend to be very broad)
What will change?	awareness, knowledge (specific learning outcomes) attitudes, motivation, behaviours, community conditions (more specificity needed as well as more realistic expectations)
When will it change?	usually unspecified, assumed at the end of the program
How will it change?	reduce, increase
How much will it change?	also usually unspecified
How long will the change last?	almost never specified: may not be able to assume that change is enduring

For example, Legacy education campaigns would be much easier to assess if a clearly articulated set of learning outcomes were identified. A sample of specific learning outcomes designed for Legacy education has been provided in Appendix E. Furthermore, Legacy education campaigns would also be well served by collecting information on indicators traditionally used to evaluate similar efforts[60] to estimate the amount of perceived change in:

- community awareness;
- attitudes toward healing;
- behavioural intentions to heal;
- interpersonal communications (e.g., talking with others about Legacy); and
- current service access and use trends.

Program participation statistics should include a summary at the end of the project to get a more accurate reflection of the number of individuals involved (current quarterly reporting systems are probably counting individuals more than once over the life of the project and therefore cannot be totalled). Project monitoring and evaluation should also consider using qualitative data processing software and coding key segments of quarterly reports for quick retrieval of information. Sections that are of particular value as well as suggested modification to the wording of quarterly reports have been singled out with highlighted commentary in Appendix F. Another essential dilemma in evaluating funded activities is selecting an appropriate target for study.

[59] Adapted from Grembowski, D. (2001). The practice of health program evaluation. Thousand Oaks, CA: Sage Publications, page 51.

[60] Health Canada. Still making a difference: interim report: the impact of the Health Promotion Directorate's social marketing campaigns 1992-1993, page 4.

4.3.2 Individuals versus Communities

Social indicators give a reasonably objective, "big picture," bottom-line evidence: a broad picture is always valuable and the sooner the better.[61] Key indicators were selected based upon their relevance to healing and included community or provincial rates of children in care, incarceration, suicide as well as physical and sexual abuse. Only during data collection did it become clear the extent to which they would be available, ***sufficiently sensitive***, accurate and possible to collect. In other words, while focussing on changes in community conditions is honourable and ambitious, it may not be well suited for early evaluation efforts. Therefore, creative strategies that are ***adequately discriminating*** must be developed to ensure *direct* measurement of change in individuals because the appropriate target for study is not always communities and is most certainly not provinces. When individuals are the appropriate unit of analysis, they should be followed over the long-term, especially when the sponsoring organization is not entirely dependent upon the AHF (e.g., community councils, treatment centres, Friendship Centres, etc.) ***and some effort should be made to determine how successful participants differ from those who are not successful in the short and long-term***. Once follow up data is secured, it can be analyzed and reported by an external evaluator. The report should contain broad based follow up efforts only to those scenarios where the community is the appropriate unit of analysis and where community information was secured on key social indicators (e.g., physical and sexual abuse) like Big Cove, New Brunswick and Red Deer, Alberta.

In a perfect world, participants would be followed for as long as possible (e.g., longitudinally), even after they have stopped participating. There may be a need to start new groups (or cohorts) of participants to help assess the changing nature of activity. In other words, projects will change, some will end, and others will start. Introducing new groups of participants into the evaluation would allow for the comparison of impacts on participants before and after significant changes in the approach. Participants in the sample should be selected based on the amount of time spent in healing activity (measured by total number of hours or days over a specific period of time) so that evaluators can determine what appears to be a minimum or maximum amount of time to be spent in the program before impacts are noticeable. Remoteness and community infrastructure should also be accommodated in the analysis by including sufficient numbers of participants from both isolated communities with little infrastructure and near urban scenarios. If longitudinal assessment is possible, sample selection should consider the length of follow up and a large enough sample size to accommodate attrition.

Recognizing the liabilities associated with direct assessment of individuals, it is recommended that additional support (beyond the Community Guide to Evaluating AHF Projects) be provided to project teams in the form of a measurement directory that would identify either an ideal tool, or a series of tools that could be used to measure healing from sexual abuse, self esteem enhancement, employability and other desired life outcomes. Because direct assessment or direct observation of

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[61] Fawcett, S.B., A. Paine-Andrews, V.T. Francisco, J. Schultz, K.P. Richter, R.K. Lewis, E.L. Williams, K.J. Harris, J. Berkley, J.L. Fisher and C.M. Lopez (n.d.). Work group evaluation handbook: evaluating and supporting community initiatives for health and development. Work Group on Health Promotion and Community Development. Lawrence, KA: University of Kansas.

participants is ideal, a sample consent form is presented in Appendix G and must be used to gain informed consent prior to observation or administration of any assessments. Supporting materials must be made available to participants to explain what, when, why and how they would be assessed and why AHF needs to be evaluated. Participation in the assessment would be quite important for validity; however, participation would be voluntary.

4.3.3 Suggested Measurement Strategies and Tools

Longer term follow-up of those participating in healing programs should include personal, educational, vocational, criminal and treatment histories as well as level of functioning in the home, as a partner in a romantic relationship, in the workplace, with their own children, friends and parents. These data could be collected during intake, as a baseline measure, then again at the end of the program, six months and one year later during after-care. More specifically, these data might include the following items listed in Table 9.

Table 9) Suggested Intake and Follow Up Information on Individuals

Personal information	Age, sex, how referred, source of income, motivation level; personal healing goals, life satisfaction, degree of self-sufficiency
Legal status	Marital status, stability of living situation, number of family members in the home and roles; child care arrangements; rating of family and other social support; the history, frequency and intensity of family problems, participant family members' life satisfaction
Family and living situation	Current or pending charges, hearings, recognizance, probation, parole, conditional or temporary release
Substance use	Current use, ability to abstain
Residential school history	direct Survivor or inter-generationally impacted; perceived intensity of Legacy impact on language, culture, parenting, identity, family, relationship skills, mental health, addictions
Treatment history	Other treatment programs attended/completed (specify dates) before and since participating in AHF-funded projects

Furthermore, answers to the following questions (with suggested indicators) in Table 10 adapted from the evaluation plan submitted by Qul Aun should be considered in any longer term follow up of healing project participants.

Table 10) Evaluation Questions and Possible Indicators in Assessing Individual Progress

Evaluation Question	Possible indicators
Do clients achieve an enduring sense of peace and resolution of specific traumas and issues?	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?	stability/place of living situation (e.g., marital home, with friends, boarding, transient on the street); use of routine in day to day life (e.g., life has regularity, structure and rules, constructive management of family, work and leisure time, stress management)
Are community aftercare support systems developed to facilitate reclamation of a healthy productive and stable life (e.g., one year)?	access and appropriate use of local services and support networks
Do individuals develop and implement life plans and goals?	employment, attendance at school, relationship quality, degree of client commitment and achievement of life plan and goals; degree to which client copes with stressful situations without utilizing alcohol/drugs
Do individuals develop a social and therapeutic network of friends and counselling support such that they are not alone and can get help when needed?	existence of family/social support network; involvement in other counselling; attendance at Narcotics Anonymous or other self-help groups
Do clients develop improved self esteem, realistic ideas about who they are and what they can contribute? What other benefits do clients achieve in the areas of work, family life, educational upgrading and health?	degree to which client is able to see self clearly and realistically; degree to which client wants a higher quality of life; extent to which client participates in community

For youth development programs, the Foundation may want to support projects in ***adapting*** tools developed by others. For example, the growing popularity of the concept of resiliency in youth development programs has led to a comprehensive measure of positive youth development. It addresses caring relationships, high expectations, opportunities to participate in meaningful activities, social competence, autonomy, sense of meaning and purpose. Items assess attitudes toward school, family background, communication, community conditions and involvement in positive

activities (a copy of the California Healthy Kids Survey for resilience assessment is included in Appendix H).

Of particular interest to those addressing the Legacy would be the work of Mary Jane Alexander, Ph.D.[62] ***who is developing a reliable and valid instrument to assess healing from sexual abuse trauma*** (a copy was unavailable at the time of this report). Other more general healing programs that attempt to strengthen life skills in adults may want to consider using Antonovsky's sense of coherence scale (See Appendix I).[63] Lastly, more community-wide endeavours would be well suited to use the community wellness report card suggested by Four Worlds[64] (included in Appendix J). In short, a variety of instruments already exist that are reliable, valid, rigourously tested, standardized and widely accepted measurement tools; and while, for some situations and project goals, they may have to be adapted, they may also be readily useful in other projects. Their use together with a strong evaluation design would lend more strength to any statements about the plausible association between funded project activity and outcomes.

The evaluation forms currently in use should be revised to capture more details about the skills and knowledge gained in training workshops and other benefits to participation. In other words, greater specificity is required to determine what skills and knowledge have changed as a result of participating in training. In some scenarios, regular community surveys (once or twice a year) should occur to gauge how the community views the project and its activities including key representatives from community agencies. Finally, these case studies should be shared with projects and referral agents as well as the community at large.

4.3.4 Suggested Evaluation Designs

Because the Foundation will be coming to a close soon, it is clear that a within groups repeated measure design (see page 14 for a schematic representation of this quasi-experimental design) is no longer practical. However, there are select case studies where a repeated measures design should continue if other research or evaluation resources can be secured (e.g., Qul Aun, Pisimweyapiy, Big Cove, Cape Dorset, Tawow Healing Home). Because a repeated measures design was no longer feasible, case studies were redesigned as post-test only. In other words, communities and individuals were assessed after their participation in the project. The new design is graphically represented in Figure 9. The arrow represents funded activity over time and the shaded oval represents the group (community or individuals) who participated.

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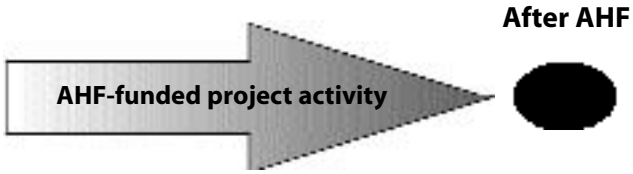
[62] Research Scientist with the Nathan Kline Institute: 140 Old Orangeburg Rd.,Orangeburg, NY 10962, Phone: 845-398-6584, Fax: 845-398-6592.

[63] Antonovsky, A. (1987). Unravelling the mystery of health: how people manage stress and stay well. London, UK: Jossey-Bass.

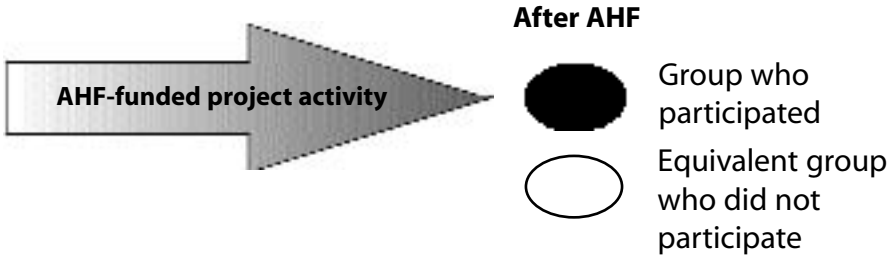
[64] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada.

Figure 9) Post Project Only Design



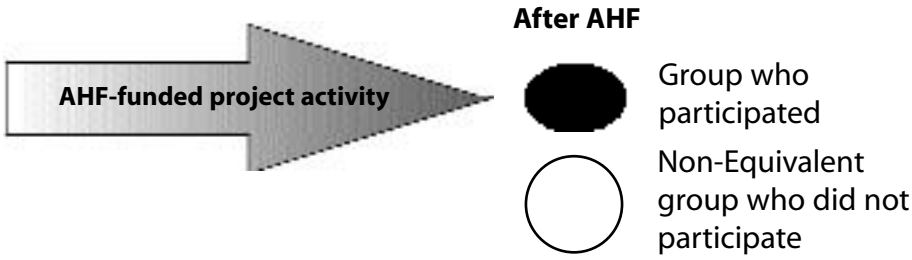
In an ideal world, the Foundation could compare two groups selected at random (either communities or groups of individuals) that were identical on important characteristics (e.g., age, sex, socio-economic status) and *differed only in their participation in AHF-funded project activity*. In such a case, it would be safer to assume that the differences between these two groups could be "attributed" to project activities. One possible design that would offer such strength might look something like Figure 10.

Figure 10) Post Project Only Equivalent Comparison Design



Because finding an *equivalent* comparison group can be difficult or costly, non-equivalent comparisons are often used. An evaluation design where non-equivalent groups are compared is depicted in Figure 11.

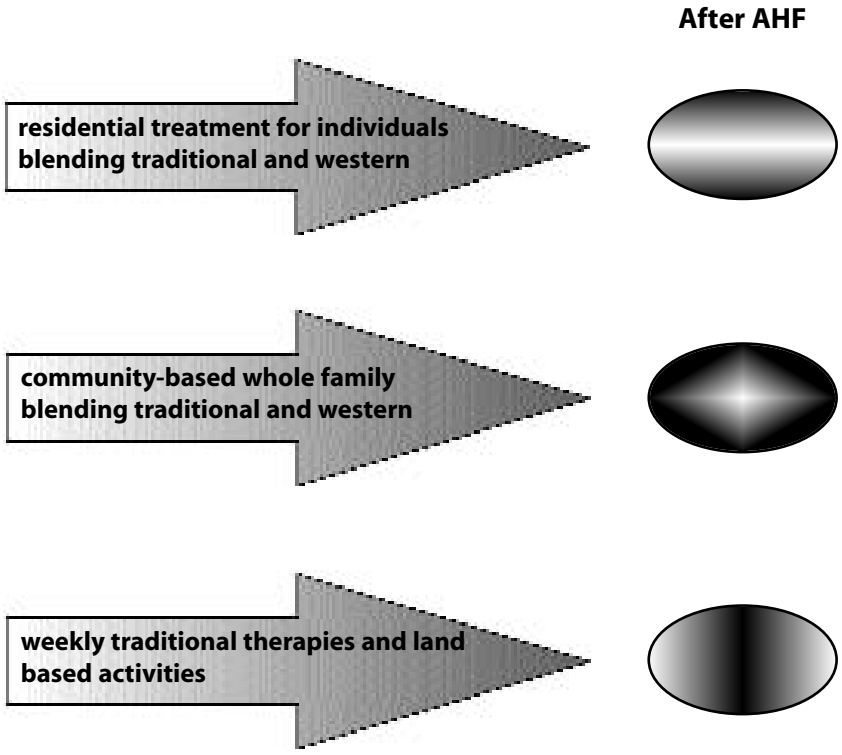
Figure 11) Post Project Only Non-Equivalent Comparison Design



Of course there are *ethical issues to consider in the use of comparison group*s which have already been addressed in the methods section. Therefore, *before the use of comparison groups is seriously considered, **funding policy would have to be changed to ensure that any group enlisted as an equivalent or non-equivalent comparison would eventually be funded to address the Legacy at some later point in time.*** After all, is it right to involve a community or individual in a comparison group if they really need the intervention but are not likely to get it at any point in time?

To compare interventions to one another, the Foundation may also want to consider a post program only design using a variety of different approaches to healing or training. This design is schematically represented in Figure 12.

Figure 12) Post Program Only Comparing Different Healing Approaches



Of course, there are other evaluation designs that are valuable and strong, but they also tend to be costly and perhaps impractical for a variety of other reasons. What has been offered here are the simplest, most practical design solutions to strengthen the Foundation's analysis of the contribution that projects have made toward healing.

4.4 Accountability to Community and Survivors

Three of the four urban case study projects – Two-Spirited Youth Initiative, When Justice Heals, and Tawow Healing Home – struggled with issues of community participation and Survivor involvement. The fourth project, Building A Nation, reported a large majority of Survivors among project participants, Survivor involvement on an advisory committee and creative strategies to engage the community, such as monthly feasts. It may be that extraordinary efforts are required to engage Survivors and community members in urban areas where the community is geographically dispersed among a larger non-Aboriginal population. Moreover, the definition of "community" may itself be a challenge in the urban context. In Ottawa, for example, the Inuit community does not necessarily identify with a generic "Aboriginal" community. At the very least, the meaning and definition of "community" is more diffuse in cities than in smaller geographic communities.

Four of the remaining case study projects appear to have achieved high levels of Survivor and community engagement, while the others had mixed results. Koskikiwetan is a stellar example of a Survivor-driven project – over half of the fourteen-member multi-disciplinary team that developed the project proposal were Survivors. Survivors directed the project and delivered the therapy. This had a cathartic effect on local workers as participants because Survivors can share experience, model healthy behaviour, truly understand and empathize, and appear to be more effective at shattering the silence that surrounds abuse. The project ensured collaboration between various partners either by directly involving them or by informing them regularly on the progress of ongoing activities. Team members also took advantage of meetings organized by health and social services, education and police services to provide reports on activities. As well, the project was promoted during an Elders' conference and reports were presented to the Atikamekw Nation Council.

Qul Aun was also an outstanding example of Survivor involvement. Survivors were enlisted as peer partners with psychologists and other counsellors during the long program development period. In addition, Qul Aun's formalized system of participant feedback ensured that information was regularly gathered and used as a basis for program evolution. In contrast, the NPES found that Survivors were least likely to be involved in the development of program content or materials while they were most commonly enlisted as advisory committee members.[65] *Every Warrior's Song* also involved Survivors early in the project. In fact, the play was based on the experiences of Survivors interviewed during the research phase. Survivors and Elders participated throughout. Their involvement was credited to sustaining the project's momentum.

The Pisimweyapiy Counselling Centre in Nelson House involved Survivors and Elders on the project team and board of directors and the residential school advisory group provided support to the project team. Accountability to the community was highly rated and a solid majority of case study respondents felt the project needed little or no improvement in this regard. Accountability was fulfilled through local radio, community presentations, monthly newsletters and residential school advisory committee meetings, as well as posted program activity schedules. Table 11 provides a summary of the various ways that case study projects attempted to achieve accountability and engage Survivors.

[65] Kishk Anaquot Health Research (2001). An interim report of Aboriginal Healing Foundation program activity. Ottawa: Aboriginal Healing Foundation, page 65.

Table 11) Overview of Accountability and Survivor Engagement in Case Study Projects

Project	Location	Accountability to Community	Engaging Survivors
Healing and Harmony in Our Families	Cape Dorset, Nunavut	Project team recognized the need for more outreach and feedback from the community.	Good involvement from female Survivors of sexual abuse but involving male Survivors remains a challenge. Project team includes large percentage of Elders
Two-Spirited Youth Program	Vancouver, BC	The project reported having no advisory committee, no needs assessment, no formal avenues for participant feedback and tenuous links with Aboriginal gay/lesbian groups.	No advisory committee or Survivor involvement in the program.
Every Warrior's Song	Chase, BC	Debriefing with audience after each performance and ensuring arrangements are in place for follow-up counselling. Follow-up meetings with communities to attain feedback.	Survivors involved in initial research and as advisors throughout the project. Project team included Elders and Survivors.
Qul Aun Program	Lantzville, BC	Formal and informal feedback gathered from participants, staff and community referral workers (e.g., surveys, questionnaires, groups discussions).	Elders are engaged as teachers and peer support counsellors. Some team members are Survivors.
Tawow Healing Home	Red Deer, Alberta	The extent of communication with the community was unclear. No written reference to regular newsletters, meetings or feasts were reported, other than in the quarterly reports which referenced the open house and the Aboriginal Community Council monthly meetings.	The project was able to engage Survivors in project development but could not sustain their involvement in more continuous program operations. Some Survivors were involved as volunteers.
Building A Nation	Saskatoon, Sask.	Various strategies including monthly feasts to gather community together for information sharing and feedback. Outreach to Aboriginal communities outside city. Information management strategies, strategic planning at Board level.	Approximately 80% of participants are Survivors. An advisory committee includes Survivors, but the project does not appear to be Survivor-driven.
Willow Bunch Healing Project	Willow Bunch, Sask.	Communication with the community through sharing the year two workplan. Informal communication with school, museum, historical committee, and Métis institutions. Also, use of media through press releases, public announcements and interviews.	Not really applicable. Project addressed the suppression of Métis culture and identity, not physical and sexual abuse. Métis individuals and community actively involved in project development and administration.

Project	Location	Accountability to Community	Engaging Survivors
Kikinahk Parents of Teens	La Ronge, Sask.	Information sharing methods include radio, brochure and newsletters. School officials need more formal opportunities to provide feedback.	Lack of Survivor involvement was a noted challenge.
Pisimweyapiy Counselling Centre	Nelson House, Manitoba	Accountability to community rated high by respondents. Methods include local radio, community presentations, monthly newsletter, residential school advisory committee meetings, and posting a schedule of program activities.	Two of four team members are Survivors and Elders are involved in the project. One member of the board of directors in a respected community Elder and a
I da wa da di	Toronto/ Six Nations, Ontario	Formal participant feedback process (written questionnaires). Feedback summaries included in reports to participants and the community.	Survivor. Residential school advisory group and Survivors committee provides support to project team.
When Justice Heals	Ottawa, Ontario	Lack of community participation and support were recognized as challenges.	No board, advisory committee or formal means of involving Survivors, except as participants in training and healing activities.
Koskikiwetan	La Tuque, Quebec	Progress reports to a conference of Elders (2001) and meetings organized by social services, health, education, police and the Atikamekw Nation. Regular updates to project partners.	Respondents were divided on the level of Survivor involvement in the project. Over half of initial 14-member team were Survivors and Survivor involvement on team remains high.
Our Youth, the Voice of the Future	Big Cove, New Brunswick	Community survey/needs assessment early in project. Involvement of leadership through Community Wellness Committee. Youth Advisory Board.	Survivor involvement in program development. Elders involved in teaching arts and crafts and traditional activities, but project reports that greater Survivor involvement is required.

4.5 Addressing the Need

This discussion highlights project ability to address the need ***within*** *their communities or target groups*. Specific examples and issues are drawn from case studies with reinforcing information from process evaluation survey results. While there is much evidence to suggest that projects are addressing the needs of Survivors, teams face challenges associated with needs that exceed resources and abilities. In addition, some target groups remain difficult to engage and information about barriers to participation remains unclear.

For Big Cove, it was estimated that roughly seventeen percent of the target group (900 youth) participated. With adequate resources and more active outreach, informants claimed that they *could have served as many as five-hundred youth*. As a starting point, the youth initiative has established a clear platform for abuse issues to come into the open. In Cape Dorset, women's and teen girls' healing groups appear well-established. Elders also participate in healing and training, but men continue to be under-represented. For well-developed healing and training projects with regional target populations, the costs of travel and child care enabling participation are unclear. Still, regional programs do have representation from a wide range of communities suggesting solid communication strategies and the ability of some participants to overcome or be supported in their travel and child care needs. Overall, the majority of projects (55%, n=234) were able to accommodate all who needed therapeutic healing or desired training.

Sometimes it became clear that Survivors' needs were beyond team capabilities and *professional* counselling was recommended. In other words, while teams may have been well equipped to strengthen parenting skills, they felt ill prepared to address FAS/FAE, serious chronic addiction, dissociative disorders and other psycho-social symptoms associated with post-traumatic stress. More generally, healing projects identified 7,589 individuals with special needs (e.g., suffered severe trauma, inability to engage in a group, history of suicide attempt or life threatening addiction). On average, thirty seven percent (median=25%) of participants require greater than normal attention to deal with their special needs.[66] As a result, some Survivors had to be referred elsewhere.

Suggested strategies to address the need included increases in team membership and a more comprehensive and phased approach to healing. In other words, perhaps some issues (e.g., self destructive behaviours) need to be resolved *before* other areas (e.g., parenting skills, employability) can be managed. In other cases, the sheer volume of service demand made it difficult for teams to address the need. Under those circumstances, increased resources and enhanced partnerships may have worked well to achieve greater results.

Some Survivors start their healing journey and then slip through the cracks because they are not prepared to face their issues or their needs do not 'fit' with the approach. Accommodating them has been difficult because little is known about this group, other than many of them may have been

[66] There is a positive linear relationship between *family drug or alcohol addictions, history of abuse as a victim, history of incarceration* and the percentage of project participants that have special needs (covariance 0.437, p<.05, n=152). In other words, as projects report having more participants in any of the categories named (e.g., history of incarceration), they also report having a higher percentage of special needs participants.

mandated to attend. More information about those who start but do not finish is necessary before their needs can reasonably or adequately be addressed. Similarly, although community wide education on the Legacy was met with enthusiasm, there is evidence that denial *persists*. Most respondents felt there was room for improvement in reaching those in greatest need with more active, creative and enduring outreach efforts. Legacy education was consistently cited as one strategy to engage Survivors in healing. Influencing women was considered one avenue to the eventual participation of men.

Addressing the need was also defined as filling a service gap (e.g., providing services to gay and lesbian youth, offering a non-mandated, culturally sensitive blend of traditional and contemporary parenting skills, whole family therapy or celebrating and reinforcing Métis culture). In one case (e.g., the Pisimweyapiy Counselling Centre) the AHF-funded team has been so effective at addressing the needs of Survivors that the health services team is considering adopting its approach and protocols. Lastly, creating an environment for reclamation of cultural identity, documenting an *accurate* history and using this information to re-educate the community has addressed a long standing need for an improved relationship between non-Aboriginal and Aboriginal members of the community.

4.6 Lessons Learned

An analysis of the case studies provides insight into the healing process in four specific areas. The first relates to team characteristics. The second issue revolves around gaps in knowledge and practice with respect to gender and therapeutic healing. The third area is also related to gaps. We know that many projects have effectively incorporated a combination of western and traditional approaches, but there is little information about *how* that blending takes place. The fourth category of learning is more project-specific. It focuses on the practical experiences of implementing and delivering programs and services.

4.6.1 Team Characteristics

Projects were almost unanimous in their praise for well trained, Aboriginal healers who were like their target group (e.g., male, female, gay, lesbian, parents or members of the community) and were well supported through various team care efforts while they led others on the healing journey. To ensure such a team was created, many projects struggled with simultaneous training and healing efforts. On the one hand, the rationale for selecting Survivors to lead the healing journey are obvious:

- it takes advantage of the influence of role models;
- communities can rely upon 'home grown' expertise;
- it ensures that Aboriginal solutions are found to address the Legacy; and
- it guarantees moral independence in, and longevity of, healing endeavours.

In fact, Pisimweyapiy Counselling Centre participants had solid praise for their Survivor/healer. On the other hand, Survivors and healers are human and *there are no guarantees* that in helping others, they will not be triggered to relive their own trauma. In Koskikiwetan, one Survivor/therapist was unable to maintain enough composure or strength to facilitate a healing session leaving others open

with no one to guide them. Several community informants felt that the Survivor-therapists were not receiving adequate clinical support to deal effectively with their issues. Framed within the stages of individual healing, the Survivor- therapists had not fully reclaimed stable, healthy, functional lives before they had embarked upon efforts to heal others. Within the context of community healing, the Atikimekw communities, like many others, were just gaining momentum on their healing journey and were faced with the dilemma of having to simultaneously develop local capacity and deliver much needed therapies. When a community is just gaining momentum, *there is still a serious shortage of individual Survivors who have fully healed and can function as leader/healers without setbacks*. Becoming aware of repressed personal issues and collective problems is part of the healing process and emotional turbulence is to be expected. While the reasons for selecting community members to lead the healing process are clear, being thrust into the role of Survivor/healer can lead to unintended and potentially harmful consequences. Koskikiwetan's experience in this regard raises important questions for those addressing the Legacy. In short, *what risks are tolerable* when moving forward with simultaneous training and healing? Does the need for *community based* healers (who are also Survivors) mean that some parameters need to be defined for scenarios where training and healing are simultaneous? How will Survivors safety be guaranteed in such scenarios?

4.6.2 Gender and Healing

More women than men participate in healing.[67] Moreover, some of the therapeutic healing projects have specifically identified low male participation as a challenge. The Cape Dorset case study, for example, identified difficulties attracting male participants, but it also noted that the word *healing*, when translated into Inuktitut, was problematic for some community members. One dimension of this problem involves language and cultural interpretation, but there is also a possibility that healing itself has negative connotations. In fact, there is some evidence to suggest that entering healing may be viewed as a weakness by both men and women:

> *The Survivor frequently resists mourning, not only out of fear but also out of pride. She may consciously refuse to grieve as a way of denying victory to the perpetrator. In this case it is important to reframe the patient's mourning as an act of courage rather than humiliation.*[68]

Sex-role stereotyping may mean that such feelings are even more pronounced among men:

> *Although abuse of power is the fundamental dynamic behind all forms of victimization, many male victims do not report feeling powerless and do not see themselves as "victims."* [69]

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[67] When we look at healing participation by target group, the two largest target groups appeared to be inter-generationally impacted (45%, n=180) and women (44%), followed by men (29%), Survivors (28%) youth (27%) and Elders (12%). Only a few were incarcerated, gay, lesbian or homeless (3.1%, 2.0%, and 1.8% respectively). However, these are not mutually exclusive categories. One participant can fall into many categories (e.g., one person can be a female, incarcerated youth who is inter-generationally impacted). (Kishk Anaquot Health Research, 2001:22).

[68] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 188.

[69] Mathews, Frederick (1996). The invisible boy: revisioning the victimization of male children and teens. National Clearinghouse on Family Violence. Ottawa: Public Works and Government Services Canada. Retrieved from: http://www.hc-sc.gc.ca/hppb/familyviolence/html/invisible.htm

Thus, the therapeutic healing process itself may be threatening to men to the extent that even considering the need for help forces an unwilling identification with victims. As noted above, if mourning (or even acknowledging the abuse) is seen as granting victory to the perpetrator, all Survivors (especially men) may have difficulty breaking through denial. The ways in which healing, counselling and therapy are framed and the terminology used require further discussion, especially by men.

Building a Nation (BAN), which succeeded in engaging men in healing, offers a number of possible explanations for its success. The first relates to the client base and the nature of the services provided. BAN offers services geared to individual needs and various *layers* of support are provided, such as help looking for parents or apartment hunting. Clients include those with problems related to addictions, homelessness and conflict with the law. More men than women may be coming from these life circumstances. In addition to providing individual and group counselling, healing activities include traditional celebrations and ceremonies, continuing support (e.g., drop-in center, client advocacy for those involved with the justice system, child custody) and social gatherings. Traditional ceremonies, teaching men to be door-keepers, to collect rocks or wood for the sacred fire and sweat lodge, are jobs meant to be done by men and consequently, they attract and engage men. Lastly, they also have more male counsellors and Men's Circles, all of which contribute to the higher rate of male involvement.

With respect to children, there are very real differences between boys and girls who are sexually abused and the types of abuse they suffer.

> *Sexually abused boys, compared to sexually abused girls, are:*
>
> - *younger;*
> - *more often physically abused as well;*
> - *more often abused forcefully;*
> - *less often alone when the abuse takes place;*
> - *less willing to tell;*
> - *more often physically injured;*
> - *more often subjected to masturbatory abuse;*
> - *more often subjected to anal abuse; and*
> - *less often subjected to non-contact abuse.*[70]

These differences, along with male attitudes toward victimization, have implications for the treatment of male Survivors. A Canadian study that reported similar gender differences also stated, *"boys and male teens remain on the periphery of the discourse on child abuse."*[71] Moreover, *"male victims frequently find that therapists, counsellors or other types of caregivers trained with female-centred*

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70 Nyman, Anders and Borje Svensson (1997). Boys sexual abuse and treatment. London: Jessica Kingsley Publishers, page 161.

71 Mathews, Frederick (1996). The invisible boy: revisioning the victimization of male children and teens. National Clearinghouse on Family Violence. Ottawa: Public Works and Government Services Canada, page 1. Retrieved from: http://www.hc-sc.gc.ca/hppb/familyviolence/html/invisible.htm

models of victimization are unable to help them."[72] The literature on treating male Survivors of sexual abuse points decidedly to the need for more research, more gender-specific treatment programs, more male therapists and more understanding of the effects of therapy on men and boys.

In light of the Legacy, one of the more disturbing consequences is the potential for male Survivors of unresolved sexual trauma and abuse to commit sexual offences themselves. While the links between victimization and offending are not fully understood, male victims of child sexual abuse are at greater risk of offending than non-victims, although most child victims do not become offenders.[73] A paper on Aboriginal sexual offending prepared for the Foundation estimates that there are *"150,000 Aboriginal sexual offenders in Canada,"*[74] although low reporting rates mean that most offenders have never been charged. The paper concludes that the criminal justice system does not work for Aboriginal sex offenders. Since more offenders are not incarcerated, but are in the community, more community-based programs are needed. It also presents evidence that voluntary participation (among other factors) is linked more closely to successful outcomes. The primary lesson gleaned from the literature (as well as the evidence that AHF-funded healing activities attract fewer men than women) is the need for greater understanding of the therapeutic healing needs of male Survivors and intergenerationally impacted men and boys. This is a precondition to creating effective programs that engage male participants.

4.6.3 Culture as Good Medicine

The interim evaluation reported that many projects affirmed the value of traditional healing and the need to increase the use of traditional healers, Elders and cultural teachings, either alone or in collaboration with other methods. While only a few of the case study projects combine traditional and western approaches to healing, the Qul Aun experience is enlightening because it provides details about methods not available elsewhere.

Tsow tun le lum (Qul Aun Program) is an in-patient treatment centre based on a blend of traditional healing activities and centralized residential care. It prides itself on the traditional decor of its facility, which includes a sweat lodge, traditional healing pond and First Nations arts and crafts from the local community. The experienced and trained Qul Aun program team guide participants who are dealing with unresolved trauma through a therapeutic in-patient program which includes traditional ceremonies, rituals (sweat lodge, pond, cedar cleansing), healing circles and reclaiming traditional spirituality. Western therapies focus on psychodrama, post-traumatic stress therapy, reading assignments, journal work, men and women's groups (focus on abuse and abandonment issues), anger management, inner child work, and individual and team sports. A balance of cultural ceremonies and rituals, with support of resident Elders, provides a culturally sensitive environment.

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[72] Mathews, Frederick (1996). The invisible boy: revisioning the victimization of male children and teens. National Clearinghouse on Family Violence. Ottawa: Public Works and Government Services Canada, page 2. Retrieved from: http://www.hc-sc.gc.ca/hppb/familyviolence/html/invisible.htm

[73] Phaneuf, Gordon F. (1990). Adolescent sexual offenders. National Clearinghouse on Family Violence Fact Sheet. Ottawa: Public Works and Government Services Canada. Retrieved from: http://www.hc-sc.gc .ca/hppb/familyviolence/html/adosxof.htm

[74] Hylton, John (2001). Aboriginal sexual offending in Canada. Ottawa: Aboriginal Healing Foundation, page 77.

Two highly skilled Aboriginal counsellors (one male and one female) have the most constant contact with the participants throughout their five-week stay and help to create a family-type setting and role model healthy boundaries. One of the counsellors is a residential school Survivor. Respondents indicated that the traditional practices honoured at the treatment centre probably accounted for the increase in cultural pride they saw among participants. Those who saw little change believed that participants may have already had a strong cultural base before arriving for treatment.

Another healing project includes facilities with a circular room for healing circles and workshops, a herb room, art work that illustrates the teachings found within Mohawk culture, and a circular garden divided to represent the four directions and four aspects of the individual. Beyond the garden are four small lodges where fasting retreats take place. The healer is a respected traditional Mohawk woman, a herbalist and Elder with more than twenty years of healing experience.

Activities include healing circles, fasting retreats, healing retreats, training workshops for service providers working with Aboriginal women Survivors, and an annual "Awakening the Spirit" gathering. It is through traditional teachings (prayer, ceremony, songs, healing circles, dance, drumming, fasting and medicines) that the project helps women address the Legacy. Key informants in the case study stated that there was more discussion of traditional healing, people were attending more ceremonies and seeking out medicine and personal counselling. An interesting comment by one of the informants demonstrates a 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.'"*

Looking beyond these two projects, more specific and detailed information is required about the blending of traditional and western approaches and how this actually works in the therapeutic environment. For example, which specific traditions and western approaches work well together, in what ways have they been blended, in what proportions and with what results? Given the significant variation in Aboriginal cultures and communities and the corresponding variation in western therapies, a great deal more needs to be known about integrating these two approaches.

For many of the case study projects, culture and tradition played a supportive rather than therapeutic role. Schools were reported to be very interested in finding Elders who are knowledgeable in traditional ways. Some projects also incorporated on-the-land excursions and camps, while social activities such as feasts and dances brought people together. A *neck bones and bannock supper* organized by Elders was considered a great success. Another project was delighted to discover that *Cree culture was better medicine than originally anticipated*. Shared celebration of the community history and culture was seen as a potential way of overcoming conflict among different sectors of the community. Overall, it is clear that cultural activities enhance personal and community pride and well-being, as well as providing a solid base for healing.

4.6.4 Programs and Services

The case studies allowed project teams and community informants an opportunity to reflect and comment upon what they had learned from their experience. When considering these lessons, it is important to remember that learning often occurs under unique circumstances and is influenced by a project's goals, objectives, services, target groups, team characteristics, and length of operation.

What is obvious to one team may take months of trial and error for another to discover, or it may simply be inappropriate in another setting. As such, the lessons represent a combination of what has been learned along the way, what could have or should have occurred and what worked well. In spite of their singularity, the sharing of such learning across projects can reduce the need for trial and error in responding to sometimes universal challenges.

The case studies reveal that a great deal of project-specific learning took place. For example, one group found that improved networking among the directors of health services led to more coordinated, complementary programs. Another discovered that bringing tough issues into the open led to new partnerships and initiatives to *"face problems head on."* The Aboriginal Peoples' Justice Circle wondered if non-Aboriginal partners and members should have advisory rather than decision-making roles. In each of these cases, the learning about networking and partnerships was unique to the project's experience.

Other lessons had a more universal tone. Many of the projects appear to have underestimated the time and effort required to organize, to reach target audiences, to find the right people for the job, to interview older people, and to break through denial and guilt at the personal and community level. Team members learned to go slower and to focus their efforts:

> *I learned a lot about accountability and going slower – being better prepared.*
>
> *Awareness efforts could have been more strategically delivered by reducing the number of education and awareness activities.*

Other examples of learning identified in the case studies are summarized below:

- whole family therapy and traditional ways have been key to keeping families together;
- for some clients in in-patient treatment, bunk beds and the use of flashlights on night patrol are clear triggers;
- family of origin discussions are essential to breaking through self-blame;
- there is a clear need for behavioural boundaries in treatment;
- male-female training teams and experienced male group facilitators may increase the participation of men in healing;
- there is a critical need for training/healing Aboriginal caregivers;
- find the right people for the job, exhaustive criminal records checks are absolutely essential;
- guard against team burn-out;
- community participation and regular communication and information sharing are components of successful projects; and
- follow-up with clients and families is required.

Finally, a respondent in one of the case studies reminds us of the importance of simply making an effort: *"What have I learned? That we are not always going to win, but at least when you participate, you give it a shot."*

Table 12 attempts to categorize the program-specific learning that took place among the case study projects.

Table 12) Lessons Learned

	Healing and Harmony in our Families	Two-Spirited Youth Program	Every Warrior's Song	Qui Aun Program	Tawow Healing Home	Building a Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Team characteristics													
· gender issues (more male-female teams; men working with men)	●	●										●	●
· high-quality, trained *Aboriginal* healers and caregivers	●							●		●		●	
· do background checks before hiring			●					●				●	
· team care				●				●			●	●	
· challenges associated with simultaneous healing and training						●						●	
Culture as good medicine													
· cultural practices and teachings (including camps, Elders in school)	●			●	●	●	●	●	●	●	●	●	
· physical environment reflects culture				●						●		●	
Therapeutic Approach													
· importance of whole family therapy					●			●					
· include family of origin discussions				●									
· screen participants				●	●						●	●	
· need for behavioural boundaries				●									
· identify and eliminate triggers				●									
· blend traditional and western approaches	●			●	●			●		●			
Administration													
· improve communication and networking				●				●	●		●	●	
· avoid creating service dependency								●					
· focus the reach (e.g., target youth, specific communications)						●	●	●					
· increase service and team capacity	●	●	●		●			●			●	●	
· importance of participant evaluation										●	●		
· enormous time and effort required	●	●	●			●	●	●			●	●	●
· need for client follow-up											●		
· need to engage community											●		

4.7 Best Practices

Best practices have been defined here as those activities that work best and feel right for Survivors and their families. *"A best practice should be able to provide the tools and the flexibility necessary for communities and regions to respond appropriately to local conditions."*[75] The evidence suggests that there are a few broad categories under which best practices fall including:

- Legacy education;
- team characteristics;
- creating a healing environment;
- therapeutic approach;
- project administration; and
- networks and partnerships.

4.7.1 Legacy Education

Legacy education was commonly recognized as a catalyst for healing. When it became clear that the burden of the Legacy of physical and sexual abuse was no longer a puzzling personal flaw, but a normal and predictable reaction to institutional trauma, movement to reclaim a life of balance was considered an act of empowerment and courage, not weakness. Acknowledging the suffering, resiliency and strength of Survivors in Legacy education campaigns gave them dignity. Sometimes Legacy education was part of more comprehensive teachings about the processes of colonization and decolonization which offered more in-depth insight on individual and community dynamics. Secondly, awareness campaigns *felt safe* to the majority prompting further action to address the Legacy, *often before* a crisis. Communities also recognized that Legacy education set a strong foundation for training and service improvement. It filled a gaping hole for those in general Canadian agencies.

> *The opportunity to educate non-Aboriginal people of the long-term effects of the residential school system has been both rewarding and astounding. Shocking in the sense that the feedback that I have received from the workshops is that most people never really looked at the residual effects of such a system.*

Some of the most widely regarded Legacy education strategies included radio broadcasts in an Aboriginal language and visual and active strategies such as theatre and psychodrama. Many felt that schools were particularly important partners in this regard and that greater efforts with students should be undertaken.

4.7.2 Team Characteristics

Selecting and developing a strong project team often meant having highly skilled Survivors, fluent in their language who could model successful healing. If they have successfully resolved past trauma, their ability to understand and support others who are experiencing similar challenges seems particularly

[75] Archibald, L. and P. Bird. (2001). Innovation in First Nations and Inuit health systems: models, structures and approaches: a discussion paper prepared for First Nations and Inuit Health Branch. Winnipeg: unpublished.

astute. Furthermore, healers who were *like* their target group were easier to identify with and relate to which made them more approachable. Depending upon the unique needs of the group, that sometimes meant selecting team members who were gay or lesbian, teens, female, male, parents or grandparents *and **respected** members of the community*.

When teams were linked with key service providers and maintained presence in the community, informal opportunities were created which allowed Survivors to become familiar and comfortable with healers *at their own pace* in less threatening venues. In other words, team members that were outgoing and visible in the community through their active involvement with other agencies or through outreach efforts, were more likely to engage participation. Once engaged, Survivors favoured teams that were respectful, non-judgmental, culturally sensitive, patient, committed role models able to facilitate *independent* decision-making in a way that supported self esteem. They had to be caring and nurturing with an ability to make Survivors feel safe. Elders were consistently recognized as valuable.

Finally, teams were only as good as their own ability to maintain balance. In other words, keeping team members well meant continuity and momentum were maintained, not only for individuals at a critical time of establishing safety, but also for communities who were experiencing floods of disclosure and service demand. Team care included preparatory work to help navigate on the healing journey *without* assuming the role of rescuer, as well as continuous processing of the intense emotional nature of their work and regular professional development opportunities.

4.7.3 Creating a Healing Environment

When serving a regional population, using an already established centre of healing worked to lend credibility to AHF-funded projects. When servicing a community, it may be more important for projects to have an identity and location of *their own* to avoid the stigmatization of being associated with an alcohol or drug treatment facility. Sufficient space and private facilities with sound proof rooms for one-on-one counselling sessions were considered basic essentials. An environment that reinforced cultural identity (e.g., flying the Métis flag, showcasing the Red River cart, displaying Aboriginal art, land-based traditional camps, natural surroundings) was silent but powerful medicine for a variety of project goals. It was as though physical representations of culture created safety to be who you are as an Aboriginal person both emotionally and spiritually. One woman described how the careful creation of a physical environment helped her to feel 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.*

In one case, creating an environment for healing actually meant returning to residential schools which some found effective for remembrance, mourning, cleansing and closure. In another, it meant offering whole family therapy in a country home setting with a large yard for play, other families on the same journey and an air of comfort and warmth provided by a Cree grandmother who could model traditional parenting skills.

4.7.4 Therapeutic Approach

Therapy was best initiated with some clarity and education regarding client rights. When codes of ethics, guiding principles and team rules were developed, publicized and shared one-on-one with prospective clients, it helped to establish safety. Being a client advocate first, without feeling the obligation to adhere to government agency-based policy created a feeling of safety (especially for incarcerated and homeless individuals). An Aboriginal team, some of whom speak the language together with Aboriginal control of programming in an *urban* area where few other similar services exist, was also believed to contribute to an environment conducive to healing. Developing whole programs or specific activities to meet the unique needs of special groups (e.g., trans-gender youth, teens, men, parents, women, Elders, students) appeared to maximize program influence. Sometimes, *unique* solutions were created based on *individual* needs. One-on-one counselling functioned well in this regard. Special guidance and support for individuals were dependent upon program flexibility and team skill (especially when handling special needs). On occasion, responding to the unique needs meant holding special circles for higher risk periods (e.g., before Christmas).

Emphasizing personal responsibility together with self trust was at the core of effective therapy. In one case, this involved doing family history work allowing individuals to examine what patterns they learned and emphasize their role in choosing to replicate or NOT replicate the pattern. Recognizing and using the power of choice especially in parenting, communication and anger management were considered essential to address the Legacy and fit well with culturally appropriate treatment.

> *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.*[76]

The *blend* of traditional healing and western therapies was also very popular. Informants were certain that healing circles, ceremonies (e.g., sweat lodges, smudging, cleansing), story telling, retreating to land based traditional camps together with harvesting and preparing country foods contributed to healing supported by western therapies. Cultural celebration, especially those that provided opportunity for song, food and dance offered a welcomed balance to the heavier, more emotional work done in counselling or combatting racism. In a few cases, the blend of western and traditional healing was beyond simple combination to more active selection of western techniques based upon *how well they would fit* ***within*** *the culture*. Once selected, the approaches were more intricately woven into the culture through the use of the language and Elders.

> *We use the modern therapeutic approaches that fit within the Inuit values and approaches. Our pair of trainers were Inuit 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*

[76] Building A Nation Family Healing Centre Inc., Healing the Multigenerational Effects of Residential School Placement - Urban Access Program, Project #1256-SK, Year II, First Quarterly Report, page 17.

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.

Of course, traditional healing was also recommended as a stand alone approach for those open and willing to engage in cultural reclamation. Traditional healing was not always warmly welcomed by those who held more Euro-Christian spiritual beliefs.

Fun was an important element in the healing equation especially with teens. Light-hearted family outings offered important bonding experiences not only between team members and participants but also between participating family members and other participants. Those bonds helped support the more arduous work of healing, not only during the project but after. Connecting and sharing with others was often cited as a best practice and included examples such as conferences, active outreach, healing circles and whole family treatment. Connecting helped Survivors feel supported in a way that one-on-one sessions could not.

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.

Included in some of the most successful connecting approaches were group focussed healing (e.g., counselling and peer support), family circles, home visits and role modelling. Connection was also facilitated by *voluntary* services where Aboriginal people could empower one another.

4.7.5 Project Administration

Putting the target group in a decision-making role was consistently cited as a best practice. Advance planning with noted "experts", namely Survivors, was the best way to ensure that programs would be based on their reality and not distantly developed theoretical assumptions. Again, depending upon the target group, this also meant that decision makers should be selected based upon their age, sex and family status. In other words, teens were best able to decide what might work for teens, men best able to develop programs for men, and so on. Beyond planning, continuously and formally soliciting feedback was a way to ensure that project activities *remained relevant and evolved to best suit participant needs*. When evaluative information was collected from participants, it became clear what activities were well received, powerful and workable. Team building was facilitated by group decision making and a range of accountability practices kept the team in line with community aspirations. Where community climates were not hospitable, administration through the establishment of a wellness committee gave projects' moral independence from agency politics or an apathetic local government.

Ensuring participants are well screened and selected from those who *genuinely want personal transformation* set fertile ground for growth in clinical programs (e.g., those focussed on *individual* progress). Informants spoke about a "readiness" to heal that included:

- an understanding of the commitment required;
- clarity about the healing process itself; and
- a general freedom from serious self destructive behaviours including addiction.

Some even felt that participants should be able to demonstrate some form of support system (e.g., counselling opportunities, participation in self help) beyond the life of the project although this sentiment was not universal.

Several strategies were used to ensure service access. Scheduling evening and day sessions offered opportunity for those employed during the daytime to participate. Promoting services *in and out* of the community meant that more Survivors could travel from nearby communities which were not addressing the Legacy. Finally, service access was also facilitated by providing childcare for parents so that they could attend healing activities.

4.7.6 Networks and Partnerships

Schools were often mentioned as powerful allies not only in Legacy education but also as institutions which could guard Aboriginal cultural integrity. Of course, project teams recognized that a *range* of partnerships was beneficial. Establishing working relationships with complementary services meant more holistic care could be provided. This also offered an avenue for Survivors to continue to engage in healing, even if their needs exceeded the expertise of the project team. Having weekly clinical supervision from professional consultants (psychologist, medical doctor, dietitian, nurse) as well as involving Alcoholics Anonymous sponsors and parole officers worked very well in one context. These same alliances were important when it came to planning and ensuring adequate aftercare. Open communication and involvement with local agencies have improved trust, working relationships and access to information. Sometimes communities had to rely upon facilitators or trainers from *outside* the community to work with or develop the capacity of local caregivers. When community members were reluctant to be viewed as an "expert" or were involved in therapeutic situations that were too close emotionally, outside expertise was considered invaluable. Lastly, but perhaps most important, *supportive leadership played a pivotal role in contributing to desired outcomes*, not only because project teams did not have to spend time challenging political resistence, but also because leaders could often find ways to supplement budgets, develop consistent policy, provide facilities and transportation or lend credibility to the endeavour.

Table 13 illustrates where shining examples of best practices can be found. It is important for the reader to note that best practices are not applicable in all cases as some would not be relevant for project goals. For example, a historical documentation project would not need to consider whole family treatment. The table is provided as a way of referring the reader to the entire case study available from the Research Department of the Aboriginal Healing Foundation, or the summary provided in Volume II of this report.

Table 13) Best Practices

	Healing and Harmony in our Families	Two-Spirited Youth Program	Every Warrior's Song	Qul Aun Program	Tawow Healing Home	Building a Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Legacy education			●	●		●			●	●		●	
Team characteristics													
· have team members that participants can identify with (role models)	●	●	●	●	●			●	●			●	●
· outgoing, visible, able to engage in active outreach		●	●			●							●
· skilled, caring, respectful team			●		●	●		●		●			
· team building/care		●	●										
Healing Environment													
· carefully select setting (home like, established, land based, unique for Survivors)				●	●			●	●	●		●	
Therapeutic Approach													
· strategies which reinforce feelings of safety	●			●	●	●			●	●			
· unique services to meet unique needs	●	●			●	●	●	●		●		●	●
· blend traditional and western approaches	●			●	●	●				●	●	●	
· non-mandated parenting skills option					●			●					
· whole family treatment					●			●				●	
· engaging Elders	●		●	●		●		●				●	
· connecting and sharing with others (conferences, group work)				●	●		●	●		●		●	
· engaging in remembrance				●	●				●				
· emphasize personal responsibility, choice, self trust				●	●	●			●				
· fun light hearted activity	●					●	●	●					●
· continuity of service						●							
Project Administration													
· adequate planning and preparation		●							●				
· screening participants				●									
· Survivor involvement (target group as decision makers)			●	●								●	●
· soliciting and responding to participation feedback				●					●	●		●	
· ensuring service access	●					●			●				
Networking and Partnerships													
· work with school							●					●	
· ensure complementary service access				●	●	●			●				
· involve leadership									●				
· use outside expertise appropriately	●			●		●	●						●

4.8 Challenges

Much can be learned from the difficulties facing projects as from their successes. Where a particular challenge comes up again and again (e.g., denial, lack of resources), a pattern emerges that can point to areas of remedial action. However, care must be taken not to discount unique obstacles faced by individual projects. For example, the Two-Spirited Youth Initiative found dealing with homophobia an ongoing challenge. While this problem was not raised in other projects, this may be simply because gay/lesbian issues were not addressed.

It should also be noted that obstacles are related to community and participant characteristics. Rural, urban and remote communities face different hardships and have a range of differing strengths to support healing. A lack of community services in remote areas may be balanced by high levels of language retention and a vibrant culture. It is critical to remember that a range of social and economic conditions and individual and community strengths stand behind every project. Challenges identified by projects may in fact be reflections of a community's commitment to address and overcome serious and deep-rooted problems. As such, they are indicative of the strength of the community or key people within it. The following excerpt from one of the case studies is an example of the importance of placing challenges within a community context.

> Pisimweyapiy Counselling Centre (PCC) – *a community-based therapeutic program located on Nisichawayasihk Cree Nation (NCN):*
> *Hunting, trapping and fishing form the economic base of the community and traditional sharing of wealth is still practised through harvest donations to community Elders.... Although NCN is covered by the provisions of the Northern Flood Agreement, hydro development has caused significant disruption to traditional Cree harvesting, homelands and consequently social and familial well-being. While little was obtained on social indicators, what was clear is that all physical assault and domestic abuse in the community as well as most crime committed in Thompson is associated with substance abuse, and children (8-12 years) are abusing. Still, the community is described by outsiders as one with initiative, that it is organized and advanced, with a variety of measures to minimize crime and deal with social problems.*

The challenges identified in this case study are summarized below:

- *The project was housed in a trailer, which became too small to accommodate all who wanted to participate, and the paper thin walls stressed confidentiality in one-on-one sessions.*
- *Some people believe PCC 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 PCC's identity from the Medicine Lodge. This would eliminate reluctance to participate due to 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.*
- *On the other hand, a clearly competing priority is the ever burgeoning participant group. Some expressed fear that many are still hurting and 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.*
- *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 PCC profile would have helped in this regard.*

Thus, the project is impeded by a variety of factors ranging from inadequate facilities to a therapeutic approach – involving the whole family – that appears not to have been totally embraced by participants' families. Other challenges relate to the need for a continuum of care in the community, including outreach and aftercare. The counselling centre also needs to establish an identity *separate* from the sponsoring addictions service. Surveyed on their own, these challenges appear daunting. Yet, viewed in context, one becomes aware of the strengths the project has to work with: a community with strong ties to its culture, language and values, which is viewed from outside as independent, organized and fully capable of dealing with its social problems. This added contextual information suggests that the challenges identified above are within the project's power to address. With time, this project can establish itself as a viable therapeutic service, overcome individual and community resistence, and become part of an effective network. In this light, the challenges point to the ongoing work required to support this intervention program. Even the way the challenges are presented points to solutions. For example, the belief that more Legacy education and a higher profile would help in preventing relapses and that outreach could benefit from greater media activity and work in the school.

Another challenge identified in the Pisimweyapiy Counselling Centre study – *the failure to engage mandated clients* – highlights a problem that other projects may also be experiencing. Simply stated, people cannot be forced to heal. For Survivors, there may actually be good reasons for resisting mandated participation since the same feelings of powerlessness and helplessness that occurred in the traumatic experience can be recreated in therapy.

> *Patients who suffer from a traumatic syndrome form a characteristic type of transference in the therapy relationship. Their emotional responses to any person in a position of authority have been deformed by the experience of terror.*[77]

For urban-based agencies, many challenges centred upon cultural ignorance, inconsistency and even hostility. During the first year of Building A Nation's operations, mainstream agencies kept referring Aboriginal clients to non-Aboriginal service providers who were *not familiar with a traditional Aboriginal worldview*. Some improvement was noted in the second year as referrals increased. In one public presentation on the Legacy, a Catholic high school principal asked, *"Where is Jesus in the medicine wheel?"* [78] Other cultural tensions included the fact that mainstream agencies were mandate centred while Building A Nation was *client* centred.

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[77] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 136.

[78] Building A Nation Family Healing Centre Inc., Healing the Multigenerational Effects of Residential School Placement - Urban Access Program, Project #1256-SK, Year I, Second Quarterly Report.

Our 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.[79]

Merging with provincial agencies to provide seamless service was also a challenge.

We 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.[80]

Respondents in the When Justice Heals project were open about the problems they confronted in their various roles within the project and with the Aboriginal Peoples' Justice Circle (APJC). Some members of the APJC held conflicting views about alternative justice, sentencing circles and the role of mainstream justice personnel in the project. For example, at least one respondent mentioned not agreeing that offenders had to plead guilty and a couple of others raised concerns about being too closely associated with the courts. However, these practices are integral to sentencing circles as opposed to other alternatives, such as pre-charge diversion. The extent to which such issues were discussed and debated within the APJC and the community is not clear. Three-quarters, or six of the eight respondents referred in some way to a lack of community support and involvement. Other identified challenges included lack of training for APJC members, lack of resources, administrative difficulties including an ambiguous relationship with the sponsor, systemic obstacles related to the mainstream justice and social service systems, and pressures on circle members. With respect to the latter, interviewees mentioned the long hours required by volunteers, high levels of stress and the high potential for burn-out. It appears that circle members were open to criticism because they had access to information about clients they could not share with the community, as well as information about the community that could not be shared with justice officials:

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 family of the accused. How can you be completely impartial? The committee was constantly under a microscope.

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[79] Building A Nation Family Healing Centre Inc., Healing the Multigenerational Effects of Residential School Placement - Urban Access Program, Project #1256-SK, Year II, First Quarterly Report.

[80] Building A Nation Family Healing Centre Inc., Healing the Multigenerational Effects of Residential School Placement - Urban Access Program, Project #1256-SK, Year II, First Quarterly Report, page 17.

4.8.1 Resistence and Denial

As reported elsewhere, breaking through individual and community resistence through Legacy education sets the stage and provides momentum for healing. Yet, resistence and denial were reported in many of the projects. In one case, it was observed that Elders would rather not talk about their experience in residential school, while the men and women in their forties and fifties are more willing to share. Key informants 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, although this initiative is being taken more by women than by men. The case study concluded that despite progress, a wall of denial and silence persists.

Another project found the community was still struggling with the issue of residential schools and most could or would not admit to being a Survivor. Some suggested that awareness was best accomplished by increasing Survivor involvement in programs and planning. Some key informants spoke about both individual and community resistence to healing, and in one case church resistance was mentioned. One project proposed that guidelines be developed to creatively dismantle denial in communities and individuals.

Breaking through denial at a personal level is a courageous act. Some people involved with the t heatrical production felt that the emotional nature of the subject matter made *"getting people to come out"* a challenge. Also, some of the actors and stage crew found dealing with their own emotions and "getting over or looking at our own issues and experiences" difficult. Even months later, during the interview process, at least two informants became emotional requiring the interviewer to pause. One team member said, *"My Dad is a Survivor and a really tough guy; it's difficult to get someone like him to talk about these sensitive issues."*

4.8.2 Inadequate Resources

Most of the case study projects experienced some resource limitations either in the present or in anticipating a future without AHF funds. There were concerns regarding the high level of uncertainty over funding as well as problems related to a lack of resources. Often, it was human resources that were required. For example, the Qul Aun project found that more than one staff person is required for the night shift. This is when many participants could be triggered, as most abuse in residential schools happened during the night when students were alone. The Two-Spirited Youth Program operated with only one employee. This employee worked as a counsellor and facilitator and provided workshops on the Legacy and gay/lesbian issues to frontline agencies, service providers, schools, universities and Aboriginal organizations. The study concluded that this stretching of human resources may have impacted the project's sustainability, as well as contributed to the isolation experienced by the counsellor/facilitator – especially since the project served a very high needs group. Severe participant challenges included denial, fear, grief, family drug or alcohol addiction, cultural self-hatred and internalized homophobia.

Resource restraints were cited as influencing projects in a number of other ways: less access to complementary resources and services, less ability to meet growing demands, insufficient outreach, inability to train referral workers, lack of pre/post care, and reduced public education and community

information activity. In one case, prolonged uncertainty about funding created fear of losing excellent team members. Another simply stated that *limited resources spelled limited results*.

Where programs are in their infancy, it is expected that with appropriate resources, they can establish credibility and effectiveness and integrate more fully into existing networks of community services. Many AHF-funded projects serve to fill gaps in community services. In some cases, demand clearly outstrips capacity (a challenge which indicates the tremendous need for programs). Others are struggling for community acceptance. Key informants in the two projects with province-wide catchment areas (Qul Aun and I da wa di di) were concerned about aftercare and support for participants when they returned to their home communities. In one case, that concern was not just about formal community services, but also about the critical informal support of family and friends as *"supports must come from a place of health and healing, otherwise the environment would not be supportive for ongoing healing."*

4.8.3 Responding to the Need

Time and time again, the case studies point to the high level of need among project participants. This not only places a burden on the ability of projects to meet the demand for services, it also challenges their professional capacities. For instance, meeting the unique needs of those still struggling with addiction or suffering from FAS/FAE challenged a number of projects. One project with clearly developed intake criteria found that inappropriate referrals (e.g., still abusing substances) still slipped through. According to local respondents in another case study, FAS/FAE is a big problem. As a result, almost all participants were affected and required greater than normal attention within the program. Specialized skills and training may be required for projects to deal internally with some of the special needs of clients. Alternatively, access to appropriate outside professionals is necessary. Many projects found that tremendous effort is required to address such high level needs and the challenges associated with maintaining momentum are severe. Certainly, staff burn-out is one of the consequences of the need to expend extraordinary efforts. Burn-out was definitely a challenge for When Justice Heals which relied almost entirely on volunteers.

4.8.4 Healers and Healing

Some projects are dependent upon *one person*, who can only lead so many workshops, training and healing sessions. This not only limits the number of participants, but it also raises questions about the project's sustainability if that one key person was no longer involved. Since the goals include increasing the number of healers and developing their skills, this challenge is relatively short-lived, but it highlights a number of broader issues. The success of many of the projects has been attributed to highly skilled individuals and teams, but *there is a need for even greater numbers of Aboriginal healers with recognized skills and reputed practices*. **Lower male participation in healing may, in part, be addressed through developing *more* male healers, facilitators and role models**. Yet, it is not universally clear how to determine when a healer has gained sufficient skills and experience or is sufficiently healed to lead others into healing. The great need for healers must not take precedence over the safety needs of Survivors. *But, the need for community-based healers does require that some tolerable risks are identified for proceeding with simultaneous* training and healing. In other words, under what conditions can Survivors move into leadership roles, engage in capacity building and delivery services when their own healing journey is not complete?

Lastly, while lack of time was not explicitly highlighted as a challenge among the case study projects, the need for more time was often recited as a lesson learned. In reality, the issue of timing is a compelling and pervasive challenge to all healing projects at both the individual and community level:

> *Building strong families and strong communities is a long-term process. Short-term, ill-conceived responses can do more harm than good. In particular, if victims are encouraged to disclose the abuse they have suffered, adequate and appropriate services must be available for victims and offenders. If not, many will be left even more severely damaged. A strategy that builds knowledge, trust and community capacity over time will be much more effective in the long-term.*[81]

Healing from the Legacy is *not* a quick fix, and more than a five-year band-aid is required. The psychological literature is clear that the failure to provide clients with adequate time and support to heal is irresponsible:

> *Piecing together the trauma story becomes a more complicated project with Survivors of prolonged, repeated abuse. … Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered.*[82]

At the project level, the scarcity of time left many in a crucial balancing act, creating situations where *"when the number of active clients is high, the public awareness and education activity suffers."* Similarly, one challenge identified by a respondent speaking about an in-patient program was the difficulty of balancing sexual abuse treatment and other residential school impacts – not to mention their substance abuse and foster care issues. The amount of time and effort the healing journey requires must be recognized so that when the Foundation's mandate has expired, a simple lack of time does not become the peg on which Canadian society hangs its collective hat and says, "sorry, we tried …." As one project stated:

> *We 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.*

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[81] Hylton, John (2001). Aboriginal sexual offending in Canada. Ottawa: Aboriginal Healing Foundation, page 192.

[82] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 184.

Table 14) Challenges

	Healing and Harmony in our Families	Two-Spirited Youth Program	Every Warrior's Song	Qul Aun Program	Tawow Healing Home	Building a Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Individual resistance/denial	●				●		●	●				●	
Community resistance/denial	●				●		●	●	●			●	
Dealing with homophobia		●											
Uncertainty over funding/inadequate funds, resources, facilities	●		●	●	●			●	●	●	●	●	●
Community challenges (addictions, economy, lack of services)	●							●	●	●			●
Hostile policy or cultural environments						●					●		
Programming issues													
Low attendance, lack of time, extent of services, etc.		●		●				●			●		
Personnel issues (lack of staff; finding right people, turnover)	●	●	●	●				●			●	●	
Service need/demand exceeds capacity					●	●		●		●			
Reaching men (low male participation rates)	●							●	●			●	
Misunderstandings between/among agencies, partners					●		●				●		
Inability to deal with special needs; high needs target group		●			●			●					●
Evaluation issues (lack of expertise, time, personnel)	●	●		●	●			●			●	●	
Lack of involvement by Survivors, parents, volunteers					●			●	●		●		●
Need for outreach, after-care				●					●	●	●		
Insufficient number of community based healers												●	
Conflicting views among team											●		
Administrative difficulties											●		
Lack of training											●		

5. Conclusions

awareness and understanding of the Legacy

Perhaps the most obvious contribution that AHF-funded project activity has made is related to Legacy education. By providing a social context for what has historically been viewed as individuals' problems, Legacy education created a climate that facilitated movement toward healing *without* first facing crisis. Legacy education also provided a constructive framework for addressing Survivors' needs. In fact, open discussion about and different attitudes toward the Legacy have led to public denouncement of powerful, high profile perpetrators. While AHF-funded project activity did raise awareness and understanding of the Legacy, informants were *clear* that their work was not complete because ignorance, denial and silence persist.

capacity of Aboriginal people to heal others

Many felt more intimately familiar with and capable of responding to Survivors' needs borne of the Legacy. They believe they had acquired skills to support healing within their family and community and to effectively manage crisis. Still, many are not able to address serious special needs alone and embracing hard to reach groups will be an ongoing challenge. For others more resistant to change or suffering from severe conditions, more training or a different approach may be required. Although training was a logical and ultimately effective place to begin because it helped others understand and ***do*** what works, there is a continued need to upgrade skills to allow community counsellors to work more skillfully with Survivors.

connection between Survivors and healers

The vast majority were able to overcome or reduce denial sufficiently to have the program operate to capacity; many could not meet the demand. Success in this regard may be due partly to the fact that Survivors finally felt there was an adequate 'fit' between their unique needs and *appropriate* services designed by them for them. In fact, it is estimated that only one percent of all participants had engaged in a similar healing program before AHF supported efforts to address the Legacy. Evidence of an expanded network of Survivors on the healing journey includes healthy participation rates, service demand and increased spin off healing activity (e.g., conferences and gatherings of Survivors not funded by the AHF). Funded activity has also contributed to enhanced trust and pride in traditional healing methods. Still, on occasion, the connection between Survivors and potential healers was not the best fit because Survivors' needs exceeded team capacity (e.g., FAS/FAE or serious chronic addiction).

strategic planning with a focus on healing

There are examples among the case studies selected which indicate that *years* of development and careful attention to Survivors' wants and needs were undertaken to develop a strategic therapeutic plan. In another case, funded activity was credited with contributing to a shift from crisis management to more effective long-term wellness planning and community development. A pro-active and coordinated approach to Survivors' issues often functioned to reduce gaps in services with some commanding widespread respect for their service delivery standards and success rates. *In fact, one health service agency will be modelling its efforts on the practices and protocols of an AHF project!* Still, a plan is dependent upon a long-term commitment to its support and most projects are *at risk* because they

they have been unable to secure long-term financial commitments. Sometimes, difficulty establishing partnerships was caused by philosophical differences. In other words, where some projects have enjoyed moral independence and self directing freedom under the support of the AHF, other agencies expect adherence to regulations which may thwart bold, creative, culturally appropriate approaches.

participation in the healing journey

Indicator data show that suicide, physical abuse, sexual abuse, children in care 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 about how participants' families and partners have benefited. Within projects, there appear to be large differences between individuals. While some move quickly toward desired outcomes, others apparently do not. It is still unclear what the differences are between these groups. Therefore, while some statements can be made about what approach seems to work well, little can be said about whom it works for and who requires something different. The only real "lead" in this direction is that current approaches may work well for women and the inter-generationally impacted (as they represent the majority of participants) and another approach may be required for older Survivors, children and men.

Although it is premature to conclude that activities have developed *lasting* healing from the Legacy, it would be safe to say there is tremendous instant gratification for up to three months after completing a program. Participants credited their project with helping them to achieve their personal goals, deal with historical trauma and daily stress. Some Survivors have successfully transformed childhood trauma to healing and empowerment as well as decreased their participation in unhealthy survival patterns. They claimed to have overcome powerlessness and hopelessness.

In some communities, progress is slow because projects are reaching only a small number of their target group. There is also a clear difference between those who are ready to face and heal from the Legacy and those who are not. While initial efforts should focus on those who are ready, some guidelines should be offered on how to creatively dismantle denial where it exists, not just in a community context, but also for individuals. It has been repeatedly demonstrated that inviting and attracting women to participate can act as a catalyst within the family but *other* unique, *pro-active*, appealing and non-threatening strategies are needed for men who are consistently under-represented in healing programs.

documentation, history and honour for Survivors

Drama worked well in both a community and therapeutic context to recount history and honour Survivors. Historically accurate accounts of Métis contributions to society contributed to increased Métis identification, attendance at Local meetings and broader community celebration of Métis history and culture. Honouring Survivors facilitated understanding of the Legacy, disclosure and ultimately counselling. For others, reviewing history was a method of engaging in remembrance and mourning, an essential stage of healing from trauma.

5.1 Explaining Results

A variety of reasons have been offered or discovered to account for the changes observed. Some credited participant motivation or the therapeutic approach. Others believed that team characteristics and community dynamics played a role and no effort can discount the contributions of the broader context and historical events.

Individual change was often credited to personal motivation that was sometimes characterized as simply wanting their children's lives to be better than their own. Consistently, those who *chose* to participate with hopes for a better life left with more than those who were *mandated* to participate. An approach which granted freedom to exercise decision making skills with supportive, non-judgmental guidance in a culturally sensitive environment of *acceptance* where Aboriginal people could empower one another worked very well.

> *Therapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather than force, mutuality rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience.*[83]

Also credited with contributing to success are a safe healing environment, combining group lectures with one-on-one counselling, accessible scheduling, blending western and Aboriginal healing, supportive leadership, complementary partnerships, community commitment to, and readiness for, healing; and Survivor involvement in program development. Teams composed of Survivors from the community who are skilled counsellors, successful on their own healing journey, gentle, committed and professional without being imposing were consistently most effective. Partners who offered complementary services were also given credit for contributing to desired outcomes.

It is unclear to what extent the role of referring agencies and broader community development contributed to noted change. Some suggested that simultaneous efforts *to change the environment* (e.g., by changing practice and policy) were needed to support efforts which focus on *changing individual behaviour*. After all, individual and community healing is *nonlinear*. In other words, human services don't just do one thing at a time. Instead, many interrelated activities occur at the same time and success in one area usually breeds success elsewhere. Informants were convinced that creating supportive climates had important implications for maintenance of aftercare.

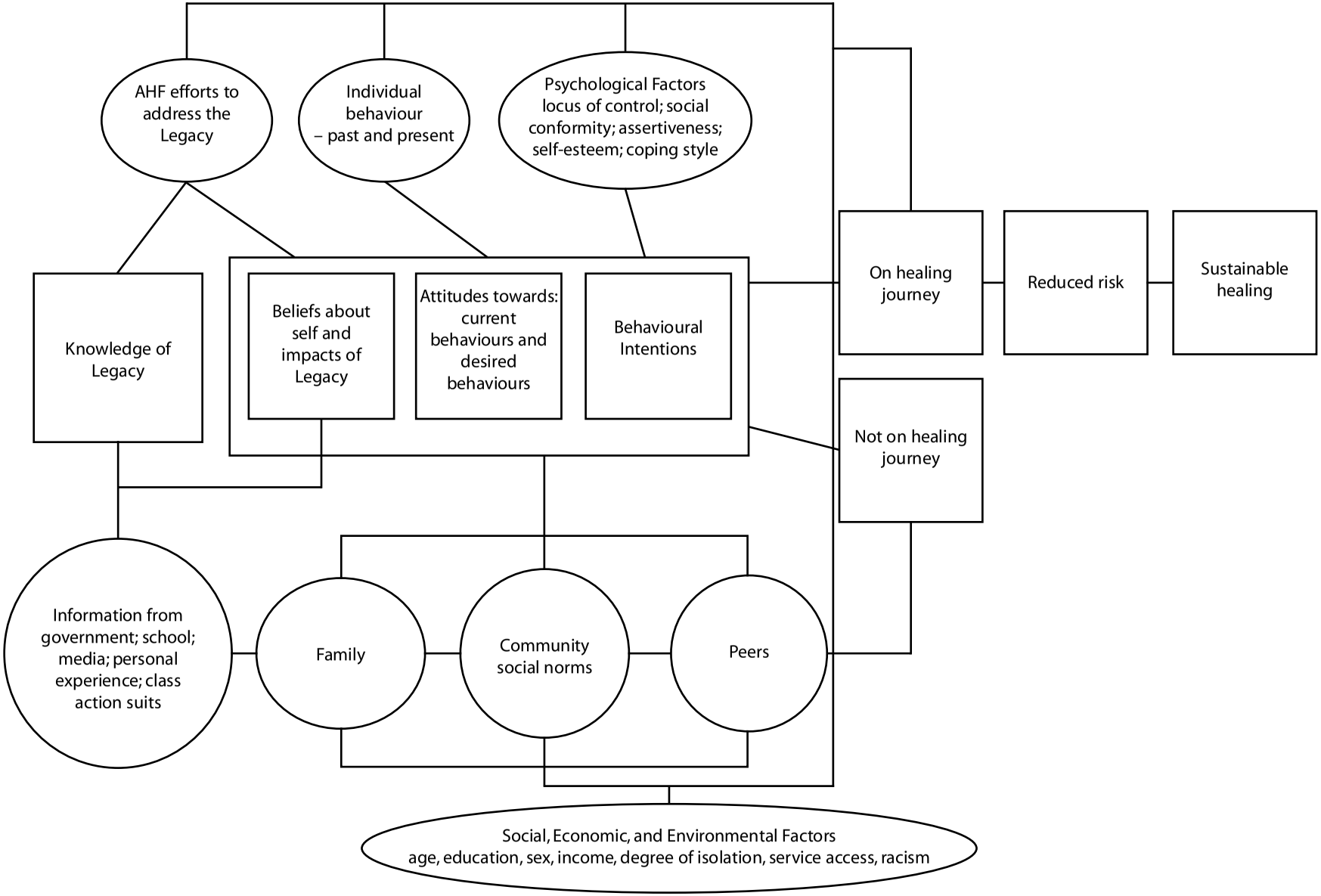
There is also substantial evidence that *something beyond the life of the AHF is definitely happening* as evidenced by steadily increasing enrollment of Aboriginal students in post secondary education, a virtual explosion of Aboriginal entrepreneurship, strengthened focus on Aboriginal issues after the Oka crisis and policy change following the report of the Royal Commission on Aboriginal Peoples. While colonialism still thrives in many circles, no longer are Aboriginal people merely a backdrop to colonial history, but are now featured in prime time media as thriving, contemporary members of Canadian society. Increased local control over a variety of services, shared resource

[83] Herman, J. (1997). Trauma and recovery: the aftermath of violence – from domestic abuse to political terror. New York: Basic Books, page 136.

management agreements, the resurgence of culture and language, restorative justice initiatives, federal early childhood development programs and provincial investment in Aboriginal health all contribute. Media attention to Mount Cashel, Alfred and, more recently, pedophilia within the Catholic Church cannot be discounted. In fact, the Aboriginal Healing Foundation represents a small segment of time in what has been described as an Aboriginal healing movement.

Informants described a community climate of widespread poverty, addiction, family dysfunction, occasional clashes between Aboriginal spirituality and Christianity, as well as community elements who are resistant either because they benefit from the status quo or they are paralyzed by fear. In fact, there are a variety of individual factors and community dynamics which not only play a role in the decision to heal but also in how well healing progresses and is maintained. Those factors are represented in Figure 13 which offers a conceptual model of the myriad of influences affecting the decision to engage on the healing journey.

Figure 13) Factors Influencing the Decision to Engage in the Healing Journey



Lastly, healing from institutional trauma is not well understood. Community initiatives are complex and some goals (e.g., improved quality of life) can be difficult to measure. In fact, research scientists haven't yet come up with *reliable* and *valid* ways to measure healing from physical and sexual abuse or institutional trauma in Aboriginal populations. Many more *immediate* outcomes need to be identified. Precise information on what happened, who it happened to, and for how long the intervention occurred were not always available. *Without tracking individuals and communities over time, it will never be clear how enduring the changes noted thus far will be nor to what extent they are life-altering*.

6. Recommendations

The following recommendations are not presented in order of importance or frequency. Rather they should be viewed as equally important in addressing the Legacy of physical and sexual abuse in residential schools.

Recommendation 1
Shape the vision

Although the Foundation has a vision of ending the cycle of abuse and creating sustainable healing, it is strongly recommended that more clarity be offered to help shape the vision. A new vision statement should be clear that the journey is complicated, unfolds in fairly predictable stages, each dependent upon the preceding phase and *will take a long time*. The vision should be clear about what kind of time is needed for dismantling denial, team training and strengthening exercises as well as community healing. It must also reflect what is known about individual and community phases of healing and emphasize *support and guidance beyond the first stages to ensure that Survivors and communities work through the longest and most arduous tasks of reclamation and transformation.* A vision with clarity that incorporates what is known about the journey will help both funders and communities assess movement toward desired outcomes, anticipate common problems and promote understanding.

Recommendation 2
Develop creative, effective and unique strategies for men

Men are under-represented in healing activities. There is a need for greater understanding of the therapeutic needs of male Survivors and of the effectiveness of gender-specific programs and having male counsellors and healers available to work with men. Men in the community should be asked directly about their healing needs and preferences. Securing gender balance in project teams may increase opportunities for men and boys to bond and identify with at least one staff member, especially if they have gender issues.

Recommendation 3
Continue and reinforce efforts to dismantle denial and reduce fear

Informants recognized that many individuals and communities are still heavily impacted by the Legacy but dominated by denial or fear. While it is safe to assume that a ripple effect will occur, depending upon the contagious influence of successful healing is a passive approach and will NOT

likely break the cycle in families or communities that endure very isolated social conditions whether they are self or geographically imposed. To effectively and completely break the cycle of physical and sexual abuse, creative forms of active outreach and continuous, reinforced efforts in Legacy education are required. Audio visual methods and school partnerships are logical places to begin; however, sharing between projects will also be necessary because a dialogue is needed to explore methods of gaining the trust and involvement of "hard to reach" populations. Honouring Survivors works particularly well to dismantle fear. Consideration should be given to substituting the word 'healing' with a word or phrase that accurately reflects the courage to engage in a process of reclamation or transformation; one that suggests the process is about boldly exercising an inherent right to a life of peace and balance.

Recommendation 4
Profile the healer

More information is needed about the team members who were highly regarded by Survivors. Those who were hailed as effective and remarkable examples of what a healer should be must be studied in greater detail so that other projects may be able to screen or detect potential team members with the *same experience and skill*. We know that Survivors who have modelled a successful healing journey are non-judgmental, culturally sensitive, respectful *and could guard participant safety* were hugely popular. But more practical details are required about their qualities as well as their role and responsibilities so that others can be trained to address Survivors' *unique* needs. It would also be important to know what factors enabled them to make long-term commitments to their work and what professional development opportunities and support are required to manage and process the intense emotional nature of their work. And finally, when communities are faced with simultaneous training and healing, it would be important to define the parameters under which a Survivor can simultaneously assume the role of a healer and engage in capacity building.

Recommendation 5
Strengthen and maintain partnerships

Partnering agencies, including local Aboriginal AIDS organizations, probation services, schools, social and health services, Aboriginal political organizations and community leaders, are a great source of strength and support. Inter-agency coordination effectively expands influence and reach in addressing the Legacy and in meeting the healing needs of individuals and communities. It also helps efforts to secure the use of facilities and increase the potential pool of volunteers. Partnership with agents who are secure enough to support a morally independent approach are best.

Recommendation 6
Support the achievement of results

In order to support the achievement of results, it is important to identify what is different about those for whom the program *worked* versus those for whom the program *did not work*. We need to learn what distinguishes mandated from self motivated participants. There is a need to formally document healing initiatives with unique strategies for specific target groups within the community as well as for the community as a whole. Additionally, we need to be clear about the distinction between activities and outcomes and offer projects defensible tools and methods to assess change that is relevant to their unique goals (e.g., resiliency, healing from sexual abuse, self esteem). Furthermore, it is important to offer a quick and universal measurement tool for all projects that address the short-term outcomes of the Foundation as a whole. While informal and oral methods of evaluation are effective for local project enhancement, they are not easily shared with others. The projects should set aside sufficient time to summarize oral reports into a written format. And finally, in order to support the achievement of results, we need to explore the nature of the blend between western and traditional therapies and determine under which circumstances the impact is maximized.

Recommendation 7
Focus

Impact was maximized when unique needs were addressed with special strategies. Projects should *be encouraged to aim for realistically attainable outcomes* in reasonably restricted target groups. The projects should amend or develop intake processes to determine participant readiness and "fit" with program resources and make appropriate referrals when necessary. Alternatively, where participant needs outstrip demand, projects should be encouraged to undertake needs assessment and, if necessary, to focus their reach.

Recommendation 8
Share the good news

Much has been learned in the process and these lessons are valuable for others. Some of these lessons included the importance of facilities that are adequate and appropriate in size, structure and location with an identity distinct from other services, the widespread popularity of cultural practices and teachings, as well as the unique and appropriate blending of traditional and western therapies. Other lessons learned included the power of treating the individual in the context of family; and supporting service access through the provision of child care, transportation and effective outreach. An essential part of this campaign could include *honouring the leaders* who have passionately supported the effort. And finally, stories about the rewards of the healing journey need to published.

Summary of Case Studies

Table of Contents

Summary of Case Studies

Volume II of this report includes summaries of thirteen case studies selected for the impact evaluation of the Aboriginal Healing Foundation. These studies are listed below:

Case Studies Selected for the Impact Evaluation of AHF-Funded Activity

Project Name/Sponsor	Location
Healing and Harmony in Our Families / Hamlet of Cape Dorset	Cape Dorset, Nunavut
Two-Spirited Youth Program / Urban Native Youth Association	Vancouver, British Columbia
Every Warrior's Song / George Manuel Institute	Chase, British Columbia
Qul Aun Program / Tsow Tun Le Lum Society	Lantzville, British Columbia
Tawow Healing Home / Shining Mountains Living Community Services	Red Deer, Alberta
Healing the Multigenerational Effects of Residential School Placement - Urban Access Program / Building A Nation Family Healing Centre Inc.	Saskatoon, Saskatchewan
Willow Bunch Healing Project / Willow Bunch Métis Local	Willow Bunch, Saskatchewan
Kikinahk Parents of Teens / Kikinahk Friendship Centre	La Ronge, Saskatchewan
Pisimweyapiy Counselling Centre / Nelson House Medicine Lodge	Nelson House, Manitoba
I da wa da di / Centre for Indigenous Sovereignty	Toronto, Ontario
When Justice Heals / Odawa Native Friendship Centre	Ottawa, Ontario
Koskikiwetan / Conseil de la Nation Atikamekw	La Tuque, Quebec
Our Youth, the Voice of the Future / Big Cove First Nation	Big Cove, New Brunswick

In some cases, the summaries represent only fifteen percent of the original text; therefore, the reader should be mindful that rich detail about the context, participants, lessons learned, best practices and challenges can be found by referencing the original case studies available from the Research Department of the Aboriginal Healing Foundation. To preserve anonymity, quotations drawn from informants have been italicized and indented but not referenced.

Hamlet of Cape Dorset: Healing and Harmony in Our Families (AHF Project # CT-411-NT/32-NT)

Project Description

This project takes place in a remote Inuit community seeking to provide healing and training to a core group of individuals on the Community Healing Team (CHT). The healing strategy is based on a "heal the healer first" approach. The objectives were summarized in the funding proposal as follows:

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

The Hamlet of Cape Dorset sponsored the project.

Target Groups: Specific target groups were (Inuit) women, youth, Elders, men and caregivers in Cape Dorset. In addition, all members of the community were invited to participate in an awareness session and on-the-land camps. Membership on the CHT was open to the entire community, as were all activities.

Funding: The project received $121,080 of the $126, 080 allocated for the period 01 May 1999 to 30 April 2000. At the time of writing this case study, the project was in its second year of operation.

Project Team

The nineteen people on the CHT during the case study period were almost entirely Inuit women (one non-Inuk, two men). A project coordinator was employed but the position changed hands several times. The project reported eight part-time and no full-time employees. The CHT and interested community caregivers received training in trauma awareness, counselling skills, dealing with family violence, family functioning and sexual abuse. The need for advanced training in counselling skills and dealing with family violence was noted. Volunteer service was identified as being 534 hours in a typical month, with the majority of time devoted to two key areas: administration (planning and management) and workshops.

Participant Characteristics

All 46 participants in healing activities were Inuit, as were 21 of 22 training participants. Over one-third of healing participants and two-thirds of training participants were Elders. Most (89.1%) of the participants in healing were women and almost one-third were youth. In this

project, the term "Survivor" refers to survivors of sexual abuse (rather than residential school Survivors), and 87% identified as Survivors. With respect to training, 86.4% of participants were women while 13.6% were men. None of the training participants were youth. A community awareness session attracted over 60 individuals, all Inuit.

Context

Cape Dorset is a remote community on Baffin Island in the Nunavut Territory. It has a population of approximately 1,200, with a high proportion (almost 50%) under the age of twenty. Projected population growth is 46% over a 15-year period. The community is 93% Inuit and Inuktitut is the primary language spoken, followed by English. Community services include a primary and secondary school, health centre, RCMP detachment, adult education centre, two churches, a visitor centre, post office, community hall, arena, airport, two large retail stores, three convenience stores, a fire department, local radio station, water and sanitation services, two hotels with restaurants/coffee shops and one coffee shop/bakery. In addition to municipal affairs, the Hamlet of Cape Dorset is responsible for social services, probation and public works.

Cape Dorset is well known in the art world for its print making and carvings, with estimated earnings in the range of a few million dollars. However, unemployment rates remain high – between 22.8% and 42.6% depending on the criteria used. The serious impact that physical and sexual abuse had on some female community members who attended southern institutions was mentioned in the project proposal, as well as the impact of a male teacher who sexually abused male students in the 1980s. 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, while below the territorial average, is still noteworthy.

Outcomes and Measures

Project activities included weekly healing circles for women and teen girls; individual counselling; on-the-land camps for youth, Elders and women (one each during the summer); monthly planning meetings; seven training sessions using facilitators from outside the community; and a community awareness workshop. The men's healing circle was not firmly established. Desired short-term results focused on building skills and capacity among community caregivers in order to promote healing in families and the community (see performance map).

Cape Dorset Healing and Harmony in Our Families Performance Map CT-411-NT

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.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Provide healing and support through weekly healing circles; provide on-the-land camps; and provide training and support through various workshops and a healing strategy.	Women, youth, Elders, caregivers and men.	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.	Restored balance and harmony in families and community.
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**
$126,080 per year	# of people in Cape Dorset participating and impacted by this program.	# 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 on training and skills acquired; evidence of a healing strategy developed and implemented; increased participation of men; and key informant views of effectiveness of CHT.	Reduced rates of physical and sexual abuse, suicide, incarceration, children in care; and evidence of changes in community attitudes: seen by participation in community by healthier role models built upon Inuit culture and spiritual ways.

Influencing individuals and communities

Service delivery objectives were met and there was evidence of progress towards achieving the following 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; a strong, effective CHT; overcoming powerlessness and hopelessness; and an increased sense of pride in culture and spirituality as it relates to healing. However, the healing and training participants were primarily Inuit women, and the objective of reaching men was not achieved. The project was designed to *heal the healers first*, an approach that only benefited those the core group came in contact with – family

members, community members, clients in professional roles. While the project only received AHF funding for the last two years, there were prior efforts on a smaller scale since 1995, allowing greater time for an impact on individuals and the community.

Impact on Individuals

Nine of ten respondents reported seeing changes in the knowledge, attitudes, and skills of project participants. Examples of observed changes include:

- growing up emotionally;
- dealing with issues in a new way (*"not just crying and crying anymore"*);
- people are happier, more able to cope in their personal lives;
- people being more stable and fun to be with;
- improvements in how participants see their worthiness and employability;
- a court Elder said: *"I used to be scared to do these jobs until I took healing."*

One hundred percent of respondents observed the following changes in participants who attended **healing** activities: healthier coping patterns; better self-esteem; understanding sexual abuse; and dealing better with depression. Ninety percent (90%) observed changes in youth self-esteem, talking about suicide, community support for Elders and a stronger CHT; and eighty percent (80%) reported changes in participants not attempting suicide, victims getting help for violence and abuse, and getting support from Elders. In general, these are issues that can be dealt with through positive, supportive measures and through the provision of information (education and training). Lower levels of improvement were observed for men getting treatment[84] (30%), women getting treatment (60%), abusers getting help to stop physical abuse and violence (40%), and men dealing with violent behaviour (50%).

Examples of skills learned in the **training** workshops included the following:

- listening skills were most often mentioned: *"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;"*
- being able to recognize when another is in pain;
- breathing exercises and massage;
- making healthier choices, such as not committing suicide;
- learning about what their children may be going through as sexual abuse victims;
- being more confident because of the training;
- becoming more aware of being a role model for younger people;
- increased self-awareness to making better life choices;
- being able to share what they learned with others; and
- *"I'm worth something. I'm a better parent."*

[84] Treatment refers to alcohol and drug treatment and the low numbers may, in part, be due to the closing of a treatment centre in Iqaluit.

Respondents also observed the following behavioural changes: increased participation in the teen girls' healing circle and increased openness on the part of the girls; and, in a crisis, the CHT works together and supports each other. Some key informants spoke about personal changes, such as healing from sexual abuse, stopping alcohol consumption and gaining new jobs, which directly attributed to their healing journey.

Impact on Community

A number of individuals involved in the CHT have key roles within the community (e.g., court Elders, probation officer, school counsellor) and their involvement in healing activities may be allowing personal growth to influence their professional roles. Also, several key informants described an increased skill level or an increased capacity to deal with crisis – they now have the tools to deal effectively with crisis and the ability to identify when people need help. There are more capable people to address problems that arise. One respondent captured the multiple impacts of the project on families and the community:

> *[There's] 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 affect. 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.*

The project led to an increased number of traditional activities available in the community (on-the-land camps) and provided opportunities for community members to be involved in concrete supporting roles, such as transporting people and supplies to the camps.

Social indicator data collected in the study represent incidents or rates of physical and sexual abuse, suicide, incarceration and children in care at a particular point in time and there were no data to suggest how rates may have changed since the project began. Most key informants did not know whether rates of sexual abuse and children in care had changed. Over half felt that incarceration rates (a community problem identified in the funding application) had stayed the same, and half believed physical abuse and suicide rates had decreased. However, the RCMP reported 195 common assault incidents over a 23-month period. There were 12 sexual assaults against adults and six involving minors over the same period. For suicide, half the respondents also said rates had gone down. Yet again, both RCMP and social services report high figures – one or two completed suicides per year and up to ten attempts per month.

Establishing partnerships and ensuring sustainability

Nineteen people were listed as being members of the Community Healing Team with the following agencies represented: Uquajjigiaqtiit Justice Committee (six members, including the chairperson and justice specialist); social services; Tukkuvik Women's Shelter; school counsellors; Anglican Women's Auxiliary (lay person caregivers); two land guides; and two people were listed without any

affiliation. A number of these organizations, as well as the RCMP, the hamlet (municipality) and the health centre, provided letters of support for the initial funding proposal. Community members were the largest donators of goods and services along with the hamlet and the justice committee. The estimated value of donated goods and services is $2,000 in food and $24,000 in space for the project.

Five of eight respondents either agreed the project was sustainable or said it would continue, *"if there is a strong desire to continue with it on a voluntary basis, and/or to seek funding elsewhere."* 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 version or operating with volunteers.

Meaningfully engaging Survivors (including the inter-generationally impacted)

The history of residential schools in Inuit regions of the north differs significantly from that in southern Canada. The project application states that some female community members experienced sexual abuse at residential schools in the south while young men in the community were victims of a male teacher who sexually abused a significant number of children while teaching in the community. The term "Survivor" was used in project reports and by respondents to refer to survivors of sexual abuse. In this context, the project had Survivor involvement from women, but the lack of male involvement was identified as a significant challenge.

Managing program enhancement

The project did not appear to have a clearly laid out evaluation and monitoring process. Although the CHT participated in monthly planning and evaluation meetings, efforts appeared to be focused on planning. Some workshop evaluations were collected, but it was not clear if and how they were used by the project.

Best Practices

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. Practices identified as successful include the following:

- a blend of traditional and western approaches;
- engaged in active outreach;
- built local capacity (use of local facilitators);
- safety was promoted through the development of a mission statement, goals and objectives, code of ethics, guiding principles, and CHT rules;
- healing was geared to unique needs (e.g., teens);
- childcare for women so they could attend healing activities;
- Inuktitut was used in healing circles; English-speaking trainers used simultaneous interpretation; and
- Elders are part of the CHT.

One of the project reports highlighted the important role of Elders and Inuit culture in the training workshops:

> *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.*

Challenges

Reaching men was consistently raised in the interviews as a challenge, as well as project documentation. Some responses suggested the men's group had started, but not without a struggle. It was not clear whether this was a recruiting problem (e.g., 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?)

Another problem noted was that one of the churches was opposed to or divided on "healing." It was suggested the church's opposition was based on its focus to seek repentance for sins rather than on the need to heal from the traumas experienced.

Other challenges mentioned by key informants in response to an open-ended question included: resistance to healing (individual); community or church resistance to healing; uncertainty over funding; programming issues (e.g., low attendance, finding the right trainers for training workshops); and public scrutiny of community facilitators.

Ensuring accountability

The project received an average score of only 2.8 out of 6 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.

Reaching those in greatest need

In rating the project's ability to meet previously identified needs, the average score was 4.75 out of 6 – this ranks just below category 5, defined as *"very well, but needs minor improvements."* Project files and interview responses confirmed that women's and teen girls' groups were well-established and Elders were represented on the CHT and participated in healing and training activities.

While most respondents felt the project's methods, activities and processes worked reasonably well, there was a recognized 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."*

Lessons Learned

Whether it was a lesson learned before this project began or after, the fourth quarter report stated that the CHT wanted to "remain focused on building community capacity." Other lessons were mentioned in interviews and project reports:

- bring in more male-female training teams;
- heal the healers first - the project recognized they had to deal with personal issues first (personal growth);
- hesitant to start a men's group unless men can get healing and training to support the group;
- the men wanted experienced group facilitators;
- one person cannot heal the community, it takes a team approach;
- *"we 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;"* [85]
- the word *"healing"* creates some division. Whether the term is misunderstood may be partly at issue, as three informants observed that there was public resistance to radio announcements about healing. The announcements were amended and fewer people seem to be resisting the concept.

Conclusions

A review of the project's short-term outcomes suggest 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.

The 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 spirit behind this project is strong and often was reflected through the personal testimony that came from key 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 new jobs which they directly attributed to their healing journey. The Elder who inspired the title of this study, said:

[85] Project's fourth quarter final report submitted to the AHF, Section VII, Page 10.

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.

Programming Recommendations

- Greater efforts should take place to partner with probation services to: a) gain wider access to men in a captive audience; and b) 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 healing;
- until such time that enough interest is generated to begin a men's group, more male facilitators should be brought into the community;
- men in the community should be asked directly about their healing needs and preferences;
- There was some community and church resistance to using the word "healing" ('mumisuq"), and the project responded by amending their radio announcements. Opportunities should be pursued to engage in broader discussions on the most appropriate Inuktitut word for healing and culturally appropriate ways of promoting the concept of healing;
- improved reporting is recommended, which captures and reflects age and gender breakdowns; and
- a healing strategy should be formalized into a document. 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.

Evaluation Recommendations

- Workshop evaluations need to be collected on an ongoing basis;
- the evaluation forms currently in use should be revised to capture more details about the skills and knowledge gained in training workshops including other benefits to participation;
- regular community surveys (once or twice a year) should occur to gauge how the community views the project and its activities;
- community agencies should also be surveyed; and
- this study should be provided to key 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.

Urban Native Youth Association: Two-Spirited Youth Program (AHF Project # CT-302-BC)

Project Description

This project was designed to provide gay, lesbian, bisexual and transgendered Aboriginal youth in Vancouver with peer support and healing through individual and group counselling. It also introduced two-spirited and residential school issues in presentations to social service providers, students and educators. Activities included weekly drop-in groups, individual counselling, outreach to community service providers and street youth, workshops and public education sessions. The host agency for this project was the Urban Native Youth Association (UNYA) in Vancouver. The UNYA was incorporated in1989 and administers a wide range of programs and services, including a safe house for street youth, life skills training, a drop-in centre, alcohol and drug treatment, and various prevention and outreach services. Shortly after this case study began, the project was informed that it would not be renewed.

Target Groups: The primary target group was Aboriginal youth (especially street-involved) who self-identified as being two-spirited, gay, bisexual, lesbian or transgendered. Community agencies, local First Nations, schools and universities were identified as a secondary target group.

Funding: The project received $81,420 in funding for the period of 1 July 1999 to 30 June 2000.

Project Team

The project employed one full-time counsellor, an Aboriginal man with a psychology degree who identified himself as two-spirited. He was able to participate in a wide variety of training workshops ranging from advanced crisis intervention, counselling and suicide prevention to proposal development. The program was coordinated by UNYA's community developer. There was no advisory committee. In place of this, the staff member relied on the executive director, the project coordinator, and other gay/lesbian staff at UNYA.

Participant Characteristics

The National Process Evaluation Survey (NPES) showed a total of seventy people were reached in individual and group healing activities: 85.7% were First Nations, 14.3% were Métis and all were youth. The majority were male (71.4%), followed by women (21.4%) and transgendered (7.1%). Over three-quarters (78.6%) identified as gay, lesbian or questioning their sexual identity. Project files suggested lower participation rates: five to twenty-nine youth in drop-in groups, and between six and fifteen participating in individual counselling. Community awareness and educational activities reached over two hundred people.[86]

[86] Project files and the National Process Evaluation Survey differ with respect to the number of people the project reached in public awareness and educational activities. The NPES reported two hundred individuals. Project files report a reach of 40 organizations in the first quarter and 177, 144 and 137 people in the following three quarters.

Context

Based on the 1996 Census, Metropolitan Vancouver has a population of 1,831,665, of which there are an estimated 31,140 Aboriginal people. The number of street-involved people is difficult to estimate as this is an especially migratory population. In its year-end report on the program (1999-2000), UNYA stated, *"40% of the street youth population in Vancouver self-identified as gay, lesbian, bisexual, transgendered or questioning youth … 40% of the total street population were Aboriginal."* [87] The downtown east side, where many of the target population live, is known for high rates of injection drug use, poverty, unemployment, homelessness, sexual exploitation and incidence of diseases such as HIV/AIDS and Hepatitis C. One local study found suicide rates among First Nations to be twice that of the rest of the population.[88] Another noted that incarceration rates for Aboriginal youth were eleven times the provincial rate and five times the national rate.[89] A review of a safe house program for Aboriginal youth found that twenty-six of the fifty-three youth who accessed the safe house were known to have been sexually exploited.[90] The project recognized their target group as a high needs and hard-to-reach population.

The project's response to the NPES supports the view that the target population faces a number of severe challenges, including: 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 (e.g., local bus, vehicles).

Outcomes and Measures

The project anticipated achieving short-term results with respect to two distinct populations: the youth they worked with and the community at large. Among youth, the objectives focused on healing. Specific issues included sexual abuse, suicide, low self-esteem, depression, coping with sexuality issues and homophobia. In addition, there was a desire to increase awareness of the intergenerational impacts of residential school abuse among the youth and the community service providers who worked with them. Also, there was a more general desire to increase understanding and support in the community-at-large.

The project's ability to achieve these outcomes was measured by:

· sustained and/or increased levels of participation in group meetings and individual counselling;

[87] Urban Native Youth Association, Annual Report 1999-2000, Two-Spirited Youth Program Year-End Report.

[88] Vancouver Richmond Health Board (1999). Healing Ways. Aboriginal Health & Service Review, October, page 32. Suicide rates were reported for status Indians at 3.7 per 10,000 and for the remainder of the population at 1.4 per 10,000.

[89] UNYA, Annual Report 1999-2000.

[90] Vancouver Native Health Society, 2000 Annual Report, page 33.

- observed and self-reported increases in peer support;
- reduced rates of substance abuse, depression and the number of gay/lesbian youth on the streets;
- increased number of referrals from outside agencies; and
- evidence that media and key informants in other agencies have an understanding of the intergenerational impacts of residential schools and of gay/lesbian issues (see performance map).

Urban Native Youth Association Performance Map – CT-302-BC

MISSION: Gay, lesbian, bisexual and transgendered Aboriginal youth are free of the abuses that have been damaging their lives – they are traveling down the long road to recovery and gaining realistic hope for a healthier lifestyle for the future.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Provide peer support/ healing through regular group meetings and healing through individual counseling; establish contact with youth agencies, 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).	Gay/lesbian youth; agencies, community, etc.	Increased healing (reduced incidence 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; increased awareness of the intergenerational impacts of residential school abuse and gay/ lesbian youth issues (reduction in homophobia and increase in community understanding and support).	Gay/lesbian youth are off the streets and engaged in healthier lifestyles free of abuse, depression, suicide and sexual exploitation.

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**
$81,420	# of participants from gay/lesbian youth community; community-at-large	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); numbers of gay/lesbian youth living on street; evidence that media and other agencies understand the intergenerational impacts of the residential school system and the extent to which the Legacy is acknowledged and openly discussed in counselling and group work; level of homophobia in schools and agencies.	Reduced rates of suicide and attempted suicide; reduced numbers of gay/lesbian youth living on the streets and engaged in abusive behaviours (alcohol and drug abuse, sexual exploitation).

Impact on Individuals

There were not enough data to reach conclusions on the impact the project had on its participants. The few feedback forms collected offered no insight into how participants were changing their attitudes, knowledge, behaviours or if there was progress in the area of peer support. Interviews with six key informants revealed: five of six observed changes among participants in facing homophobia, dealing with their sexuality and making personal changes in their lives; four of six observed progress in dealing with depression; and half observed changes in self-esteem, understanding the Legacy and facing alcohol or drug usage. However, six interviews do not provide enough evidence on which to base solid conclusions. In terms of concrete changes, four gay/lesbian youth were reported to have been reunited with their families and communities.

Impact on Community

Using a scale of one to five (1 low, 5 high), a clear majority of key informants felt the program was 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.

There were numerous references to homophobia in the project files and in the interviews. In fact, this was the reason the program pulled out of networking with other AHF-funded projects in the city. The counsellor/facilitator's response to how he saw other AHF 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, since the interviewer did not approach other projects. In searching relevant Aboriginal data for the greater Vancouver area, it was found that a number of AHF-funded projects exist in the same area, but none 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 in the absence of evaluation material, this is merely speculation.

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 were part of this case study. When asked what level of support community agencies have provided, Aboriginal respondents rated support much lower than non-Aboriginal respondents. The three Aboriginal informants identified resistance from the Aboriginal community around *hearing about* gay/lesbian issues as the biggest challenge. Three

respondents said things had improved when questioned how partnering agencies dealt with residential school issues differently as a result of the project. However, when asked what changes were made in the way they do their work, two of three partnering agency representatives said they made no changes. There was a sense that an education and awareness process was taking place among the key informants themselves, but further support and awareness were required. One person stated, *"I talk more openly about two-spirit issues."* This individual, including two others who spoke of becoming more vocal, were the Aboriginal informants.

Establishing partnerships and ensuring sustainability

The final project monitoring sheet listed linkages with thirty-one agencies in addition to the partnering programs and four media outlets (radio, television, newspapers). Workshops were presented to bands, schools, youth groups, parole officers, and gay and lesbian groups. However, it is difficult to determine the effectiveness as there were few participant evaluations to rely on. Direct linkages were established with sixteen Aboriginal and mainstream service agencies. Three external agencies and one program by UNYA were directly involved with the gay/lesbian youth program. This involvement included providing space for drop-ins or group activities. Four of six respondents said that agencies who had partnered with the program became more aware of the Legacy.

The program operated with a single staff person and no advisory committee was in place. This may have impacted the project's sustainability, as well as contributed to the isolation experienced by the counsellor/facilitator.

The estimated value of donated goods and services (food, labour, space for group meetings) over a period of eighteen months was $14,400. Donations came from social services, health services, a local youth resource centre and community members.

Meaningfully engaging Survivors (including the intergenerationally impacted)

There was no advisory committee or Survivor involvement in the project.

Managing program enhancement

Efforts were made to form an advisory committee to oversee the project, but it did not materialize. In addition, there was no systematic participant evaluation process or needs assessment, so there was little concrete information to help support or guide the direction of the program.

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.

Best Practices

Three things are deemed to have worked well for this program:

- the counsellor/facilitator was an Aboriginal gay/lesbian person, increasing the likelihood that clients would identify with them;
- the program linked with key agencies serving the Aboriginal community and maintained a presence at drop-in groups. This provided gay/lesbian youth with opportunities to become familiar and comfortable with the counsellor/facilitator at their own pace; and
- 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 addition, several of the respondents mentioned the quality and dedication of the counsellor/facilitator.

Challenges

Severe participant challenges included denial, fear, grief, family drug or alcohol addiction, cultural self-hatred and internalized homophobia. Interviews and project files indicated the program faced a number of other challenges. In particular, the program had targeted a high needs, hard-to-reach population. Low participation rates could be expected when trying to work with *"kids that don't want to be reached."*

Other identified challenges included:

- dealing with homophobia; and
- given the high needs surrounding the target group, the program could have foreseen the difficulties one person would face. Almost all those interviewed repeatedly indicated the need to expand the program to have more than one staff.

Ensuring accountability

When asked about how well the project had been accountable, similar responses were given including, *"we've put out a lot but are not getting a lot of feedback coming in. People don't express why they aren't utilizing the program. If they did, maybe we could respond."*

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.

Not working with the Aboriginal gay/lesbian community seemed a weakness. There was an assertion of 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.

Reaching those in greatest need

This is a high-needs target group and the issues being addressed ranged from overcoming substance abuse to healing from sexual abuse to coping with one's own sexuality in a homophobic society. The project reported in the NPES that, *"five clients have been actually referred elsewhere, due to dual diagnosis, treatment programs, etc. But, in reality, I would say all clients suffer from some form of inability to open up in group and deal with severe trauma, e.g.,, sexual abuse, racism, sexism, etc."* While it was unclear if the project actually reached those in greatest need (Aboriginal gay/lesbian youth), it clearly attempted to fill a service gap. However, one key informant mentioned 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?"*

Lessons Learned

The following were identified as lessons learned during the course of the project:

- most informants interviewed suggested 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 his 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 pm to 7 am and the youth know that. I really live my job;"*
- two respondents mentioned how they speak more openly and frequently about gay/lesbian issues; and
- some non-Aboriginal agencies that linked with the program indicated no substantial change 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.

Conclusions

There is some indication that the program had an impact on increasing knowledge and awareness on both residential schools and gay/lesbian issues through numerous workshops and presentations. Without participant evaluations, it is difficult to know what was learned from these workshops. Further benefits of the program 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 who reconciled with his/her family. Moreover, the program was just beginning. Since *"street-involved youth have experienced a series of losses: family, housing, innocence,"* [91] it seemed another loss was dealt them when the gay/lesbian youth program ended.

[91] Youth Safe House Program Review, Vancouver Native Health Society, May 2001, Page 15.

Programming issues have been stated elsewhere in this study, such as no advisory committee and only one staff to serve a significant high needs population. The absence of an evaluation process and needs assessment meant little concrete information to guide the direction of the program. Also, not working with the Aboriginal gay/lesbian community seemed a weakness.

Recommendations

Although the project was no longer operating by the time the case study was completed, the following recommendations were presented for the benefit of other projects:

- 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 was felt the budget was sufficient to hire at least one full-time position 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 opportunity for clients to bond with at least one staff member, especially if they had gender issues.
- An advisory committee should 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 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. Involving healthy Elders who are compassionate to the needs of youth and who were not homophobic was felt to be all that was necessary.
- Partnering with appropriate Aboriginal agencies could have provided links into the Aboriginal community. For example, 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.
- Implementing the evaluation plan outlined in the proposal may have allowed for revising the workplan to place emphasis where it was needed most and/or where it would have been most effective.

George Manuel Institute: Honouring Residential School Survivors: A Theatrical Production (AHF Project # HH-88-BC)

Project Description

The project involved researching, writing, producing and delivering a play that addressed the Legacy of Physical and Sexual Abuse, Including Intergenerational Impacts. 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 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 project was sponsored by the Neskonlith Indian Band and the George Manual Institute, located near Chase in the interior of British Columbia.

Target Groups: The target groups included the general public, both Aboriginal and non-Aboriginal, Survivors, their families and communities, actors, project staff, volunteers and the twelve communities that hosted the play.

Funding: The project received $147,366 in funding for the period of 1 January 2000 to 31 December 2000.

Project Team

The project team included six staff members, six actors, and twelve other support staff who received honorariums for various duties. Staff positions included: a project coordinator (replaced once), production manager, playwright/director, stage manager (replaced once), dramaturge and choreographer. The twelve support staff included Elders and Survivors who advised, taught songs, gave teachings and drummed.

A key factor was hiring actors who were on a healing path. In addition to the staff and actors, there were forty roving counsellors and thirty volunteers who supported the development and delivery of the theatrical production. The roving counsellors were provided by the host community to gauge how the audience was responding and to intervene and provide counselling if someone expressed or showed a need. The playwright/director facilitated debriefing sessions at the end of each performance, which required a lot of skill and experience. The debriefing sessions were also utilized to work with actors and staff to prepare for and process the intensely emotional subject matter. Several actors stated that the person who provided this guidance was exceptional and that, without her, they would never have tackled this type of theatre job.

Volunteers donated their time and effort as follows: hall set-up, food preparation, healing circles and transportation. Communities who hosted a performance took efforts to prepare feasts, promote the event, set-up, tear down, clean up the halls, make media contacts, secure Elders and leaders for opening prayers and provide staff to oversee any follow-up referrals and counselling needs.

Participant Characteristics

An important aspect of participant recruitment applied to **who** worked on the project. During the early stages, the playwright/director was asked by Elders, Survivors and one treatment director to ensure those who worked on the project be *"in sobriety and working on healing."*

The project's first quarterly report showed forty individuals directly involved in the project: 5% were under the age of twenty-five, 35% over the age of fifty and the remaining 60% falling in between. Most (80%) were status on-reserve, 17.5% were status off-reserve and 2.5% were Métis. All were Survivors or later generations (82.5% Survivors and 17.5% later generations). Males and females were equally represented. The number of participants dropped in the third quarter to 19, likely because interviews with Survivors had been completed. The statistical profile showed fewer Elders (21% over the age of 50) and an almost equal balance of Survivors and later generations.

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 the last person made no mention of being a descendant. The age of the actors ranged from seventeen to forty-five years old, with the majority being under the age of thirty.

The theatrical production held twelve performances throughout the province of BC, including two performances for clients only at treatment centres. The project files reported reaching an estimated 4,000 people. Many interviewees reported standing room only at the facilities where the performances were held.

Context

According to Statistics Canada, the Aboriginal population in BC in 1996 was 139,655. Persons registered under the Indian Act living both on and off-reserve were listed as being 93,835. In keeping with similar Aboriginal demographics across the country, almost half of BC's Aboriginal population, or 57,645, were under the age of nineteen. Adding the next age group (20-24), this figure rises to 69,595. Combined with the next age group (25-34), the figure rises to 93,845 of the Aboriginal population in BC, which means a significantly young Aboriginal population in BC. These figures (1996 Census) 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 that closed (last one to close in BC was St. Mary's Mission in 1985). The 1996 Census also cited 26,000 Métis persons living in BC.

Populations of Centres which held performances

Location	General Population**	Aboriginal Population
Vancouver (two centres)	1,831,665 (Metro)	31,140 **
Round Lake Treatment Centre (Armstrong)	5,322 (Armstrong District)	36 bed facility
Nenqayni Treatment Centre (Williams Lake)	38,552 (Williams Lake agglomeration)	4 Family Units plus 10 Youth beds
Interior Friendship Centre ***	84,914 (Kamloops)	undetermined
Kelowna Friendship Centre ***	136,541 (Kelowna)	undetermined
Tillicum Haus Friendship Centre ***	85,585 (Nanaimo)	undetermined
Neskonlith First Nation * (Near Chase. Kamloops Service Centre)	2,460 (Chase) 84,914 (Kamloops)	543
Lytton Band *(Merritt Service Centre)	7,631 (Merritt)	1665
Bonaparte Band * (Near Cache Creek. Kamloops Service Centre)	1,115 (Cache Creek) 84,914 (Kamloops) 719	719
Coldwater First Nation (Near Merritt)	7,631 (Merritt)	282 **
Bridge River Band * (Near Lillooet. Kamloops Service Centre)	84,914 (Kamloops)	379

* First Nations Profiles, Indian & Northern Affairs Canada, July 2001
** Statistics Canada, 1996 Census
*** Friendship Centres serve largely urban populations and satellite First Nations

Outcomes and Measures

The project's desired short-term outcomes include: increasing levels of knowledge and awareness of residential school issues; involving Survivors in the production to ensure accurate, true portrayals of the original experiences of Survivors; honouring the resilience of Survivors; appropriate guided dialogue after each performance; and appropriate wellness and safety plans for all involved or working on the project (see performance map).

Neskonlith Indian Band/George Manual Institute Performance Map

MISSION: A creative, interactive process of healing for Survivors, their families and communities that stays true to the original experiences of residential school Survivors.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Research and write a play in consultation with Survivors; recruit staff; hold auditions to recruit actors based on skills and familiarity with residential school issues; produce and deliver performances locally, provincially and possibly elsewhere in Canada; engage, debrief and interact after each performance with the audience; and provide closure to staff and actors.	Residential school Survivors, family and community members, actors, staff and volunteers, community staff and leaders.	Increased knowledge and awareness on 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.	Restored balance and honour of Survivors with their families and communities.

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, 6 actors, 6 project staff, 12 support staff, 40 roving counsellors and 30 volunteers.	Through dialogue after each performance: to gauge # of audience members staying for discussion, reports of audience reaction, length of time people would stay, discuss and listen to issues; perceptions by actors, staff, volunteers on what changes have been seen in Survivors, their families and communities; self-reported and key informant views on how the performance has impacted those directly involved with the project; and evidence of increased awareness of residential school issues within communities.	Increase in Survivor healing, as seen through a sense of belonging, validation, utilization as a resource, family and community reconciliations; decreased rates of physical and sexual abuse due to education, awareness and willingness to acknowledge and intervene in these areas; and decreased rates of suicide, children in care and incarceration.

Influencing individuals and communities

This project can be deemed a success. It met all of its stated requirements and managed challenges with commitment and dedication.

Impact on Individuals

The cast and crew of the theatrical production, *Every Warrior's Song*, were asked to describe the impact on themselves regarding residential school issues as well as examples of impact on others. The following responses suggest both cognitive and behavioural changes occurred:

- *I felt like I was reliving a part of my past when I was drinking and drugging and on the skids.*
- *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 behaviour.*
- *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.*
- *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 [before] and now she does.*
- *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.*

Other examples of positive action actors were taking included making decisions to go back to school and several stated they were going into counselling or therapy. Also, two mentioned not using alcohol and drugs and how this seemed to be a part of character-building for them. One person said, *"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."*

The impact on audience members was indicated by the following quotes from key informant:

- *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 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.*

In follow-up telephone calls, communities were asked about the number of clients and families who sought counselling following the performance. After five performances, forty-one individuals and fourteen families sought counselling and four individuals were referred elsewhere.

According to informants, every performance honoured Survivors by recognizing their strength and resiliency. Notable quotes from key informants regarding impact on Survivors include:

- *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.*
- *the 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.*

Impact on Community

A majority of the key informants from the project team and sponsoring community organizations believed there will be an impact on the long-term social indicators the Foundation hopes to positively influence. In fact, 95% of respondents stated the project will have "a lot" or "some" impact on sexual abuse and 90% believed the same about physical abuse. The following comments were made by key informants on how communities dealt with residential school issues differently or whether services had 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.*
- *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.*
- *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.*
- *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.*

Establishing partnerships and ensuring sustainability

The funding application listed six initial partnerships with bands, treatment centres and residential school committees. In the final report, 13 additional partnerships were named.

Host communities were expected to provide facilities with a stage and area large enough to house their anticipated audience, marketing; transportation for the audience, a feast, a counsellor, pre and post action plans for participant support and roving counsellors during the performance.[92]

Meaningfully engaging Survivors (including the intergenerationally impacted)

Residential school Survivors were involved throughout this project, as interviewees in its research phase and as advisors throughout the project.

Best Practices

Both in the application and throughout the interview process, several people mentioned the safety or non-threatening nature of theatre, which appears to have worked well. This is supported by informants who made reference to witnessing many first-time disclosures. The fact that disclosures took place in the presence of family, community members, roving counsellors, and a skilled facilitator who led a debriefing session after each performance, suggested a supportive, safe climate was established to process these revelations.

More specifically, best practices include the following:

- 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 end of project;
- having Survivors identify themselves and acknowledging them at performances allowed roving counsellors to tag people for follow-up if required;
- the highly skilled facilitator (playwright/director) appeared to have benefited all involved; and,
- the involvement of Survivors and Elders, in all stages, allowed for sustained momentum and adequate support.

[92] Project's fourth quarter report submitted to the AHF, Section III, Identifying successes and barriers, Part v.

Challenges

A number of key informants stated "getting people to come out" was a challenge, especially since the production dealt with such an emotional subject. (In spite of this, performances were reportedly well-attended.) Two 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.

Budgetary problems were mentioned. For example, the application under-estimated certain costs. Because project funds were limited, this prohibited the ability to travel to more communities. In addition, 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."* Also, a vacuum was created when the original contact person from the host organization departed early.

The recruitment process for the cast posed some challenge. A key requirement became not so much their acting experience, but their commitment to personal wellness. *One informant mentioned the challenge of "finding actors with a grassroots understanding of culture, spirituality and tradition, then develop that into the play."* Lastly, reference was made to the subject matter itself and how certain individuals may have found it difficult to hear or talk about these issues.

Ensuring accountability

Accountability was enhanced through debriefing the audience after each performance, ensuring roving counsellors were present at performances and that arrangements were in place for follow-up counselling. The project reported it met with members of the linkage communities to attain feedback and to perform follow-up with the counselling staff.

Lessons Learned

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

- *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. One person mentioned being 'more conscious of the people they hire, know their backgrounds, etc.'*

The final report stated one lesson learned was that the project did not allow enough time for the final meeting where closure took place, thereby going over-schedule. The project also indicated they would allow themselves more time to plan.

Conclusions

This project can be deemed a success. It met all of its stated requirements and managed challenges with commitment and dedication. General comments from the final report included an observation of a need to upgrade the skills of community counsellors to a level that would allow them to work more skilfully with residential school Survivors. On the other hand, some organizations were said to have brought their entire trauma team to a performance. Also, an advanced trauma training course was initiated after the project ended.

One informant, a Survivor, rightly observed *"the spirit of the play will move in the direction it wants to. [We] 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 Friendship Centre:

> *With anxiety and curiousness, I went to Kelowna to watch the play....Not knowing what to expect, but realizing past pains [and] 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.*

Recommendations

There were no recommendations as the project was completed.

Tsow Tun Le Lum Society: Qul Aun Program (AHF Project # HC-36-BC)

Program Description

This case study reported on the progress on Qul Aun Program (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. It is the extension of the two-year pilot for residential school Survivors originally funded by Health Canada and includes: individual daily activity (reading assignments, exercise journal work), men's and women's groups focussing on abuse and abandonment, anger management, inner child work, psychodrama, healing circles, team sports and traditional ceremonies with support of resident Elders. The implementation objective was to develop an in-patient program. This would provide a healing opportunity for those who have issues caused by abuse trauma that contributed to substance abuse relapse and an inability to deal with life stresses in the areas of self-care, parenting and relationships. The main goals were lasting healing and well-being, cultural pride and capacity to address the Legacy. Because the focus of this evaluative effort was on individual treatment, the specific phases of activity are highlighted below:

- **Connecting**: consisted of Welcoming Home ceremony, orientation, techniques for grounding, building trust and safety, identifying resiliency and strengths, triggers, validation and support, Elder visit and attend drug and alcohol activities;
- **Discovering**: included circles and sweat lodge, examine the definition of post-traumatic stress disorder, family of origin, early childhood development, relationship, shame and guilt, history of residential schools and effects of unresolved trauma (cultural oppression, shame, sexual abuse, and residential school). Elder visits were also part of week two activities;
- **Reclaiming**: introduced psychodrama and essentially allowed participants to role play scenarios of unresolved trauma in order to heal past hurts; and
- **We Made It Through**: is a continuation of circles, sweat lodge, teachings on resiliency and empowerment, self-care plan, after-care plan, re-entry to community and Elder visits.

Target Group: Qul Aun Program focused on providing treatment services for all Aboriginal (Métis, Inuit, First Nations, on or off-reserve) adults 19 years and older, inclusive of incarcerated males ready for parole. Participants were mainly from British Columbia and the Yukon but the program had accepted clients from as far as Alberta, Saskatchewan, Manitoba, and Seattle, Washington.

Funding: The Aboriginal Healing Foundation (AHF) continued to fund the project as a pilot for one year in the amount of $459,560. The project received an extension, which increased the contribution agreement to $689,340 for a seventeen-month program. Plus, in-kind contributions from the substance abuse program in the amount of $235,000 raised the actual total to $924,340. The majority of funding was invested in healing.

Context

Qul Aun is administered by the Tsow Tun Le Lum Society in the central Vancouver Island region, although clients arrive from all over British Columbia. The Society has operated programs for those

for those suffering from addiction, sex offenders and sexual abuse survivors and "believes that healing begins with the individual, extends to the family and moves out into the entire community." The Society's main funding source is the First Nations Inuit Health Branch of Health Canada. However, some resources do come from Corrections Canada for treatment beds assigned to inmates that participate in Qul Aun. The centre prides itself in the traditional decor. The building is complemented by a sweat lodge area and a traditional healing pond located in the natural forest that surrounds the centre. The centre has accumulated over fifty partners who continue to contribute to referrals and after-care.

Outcomes and Measures

To assess performance toward goals, several key questions were answered about activities, short and long-term desired outcomes, resources, reach and possible indicators of change. The answers to those questions have been neatly categorized in the following performance map. While all project activities and goals are presented in this map, the focus of this case study was exclusively on healing where the greatest investment of resources was made.

PERFORMANCE MAP - Tsow tun le lum Society "Qul Aun Program"

MISSION: The primary mission of the Healing Initiative will be to strengthen the ability of Aboriginal People to live healthy, happy lives and the affirmation of pride in the Aboriginal identity.

HOW?	WHO?	WHAT do we want?	WHY?
Resources	**Reach**		
activities/outputs		**short-term outcomes**	**long-term outcomes**
Counselling services (e.g., psychodrama, post-traumatic stress therapy, healing/talking circles, traditional ceremonies), solicit feedback, monitor outreach and review after-care.	Aboriginal adults (> 19 yrs, status blind, on or off reserve) residing near vicinity of TTLL, Vancouver, Yukon and inmates from Corrections.	Increase in pride in Aboriginal identity, confidence, feelings of empowerment, community knowledge of Legacy and personal capacity to address Legacy; and reductions in abuse and feelings of victimization.	* Restoration of the emotional, mental, physical and spiritual health and well-being for participants, families and communities; broken cycle of abuse; and lasting healing.
Hire team; review other treatment material for relevance; establish community contacts; held open house; mass mail-outs; news ads; and on-going staff meetings to review programming.	Not applicable		
Core training for all staff; internships for trauma counsellors; workshops; promote awareness of program; implement special session for front-line workers; and evaluation.	Team delivering trauma treatment.	Increase knowledge and skill to address Legacy.	

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

Budget	Reach	Short-term Measures	Long-term Measures
$459,560 (12 months) $680,157 (17 months) plus $235,000 (in-kind)	* 123 utilized the program	Observed and indirectly (self) reported changes in substance abuse, violence, use of healthy parenting skills, cultural pride, feelings of empowerment and victimization, understanding of self, knowledge and understanding of Legacy, awareness of needs and issues of Survivors by leadership and referral network, # of community organizations seeking education on the Qul Aun Trauma program, service demand for residential trauma treatment and measures of skill or capacity to address Legacy.	Need and rate of participation in treatment programs; observed and self-reported changes in parenting skill; reduced rates of children in care; family violence and suicide (including attempts).
budget for development $18,000	Not applicable	Awareness of the residential school impacts; # of partnerships established (either by formal protocol or informal networking opportunities) between front-line workers addressing impact of the Legacy; documents on issues and needs of residential school Survivors; Survivor feedback on quality of trauma treatment program.	
budget for training $16,000	12 staff trained	Self-report and observed changes in skills, knowledge, treatment application, awareness of needs and issues of Survivors in trainees; solicited feedback from participants about quality of trainee's ability to facilitate healing.	

Participant Characteristics

Groups to date are predominately women and sometimes the female to male ratio is 7/3 or 6/4. There is a maximum of thirteen participants per session. Disabled clients are also accepted and accommodated into the program and one to three incarcerated males attend each session. Participants must meet the following criteria:

- substance-free for six months inclusive of any active/mood altering drugs;
- demonstrated pre/post treatment support;
- mentally stable, able to participate in intense individual and group counselling;
- 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 that would occur during the program such as physician or court appearances.

Parole ready inmates **must** attend the addictions program prior to entry.

At least ninety percent of all participants (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 percent have attempted suicide and twenty percent have suffered from incest or have a criminal record. The vast majority are First Nations (94%) and some are Métis (3%). There are no Inuit participants at Qul Aun. An overwhelming majority are residential school Survivors (19%) and, congruent with most other AHF programs nationally, women outnumber men by almost two to one. A small number of Elders (16) and incarcerated individuals (12) have also participated in treatment. Worthy of note is that some of the participant group are also service providers (10).

Project Team

The project is overseen by an active board of directors. There are two full-time Aboriginal counsellors (one is counsellor/coordinator) who handle the day-to-day activities of the treatment program with periodic assistance from Elders. Also, there is a therapist and psychologist for one-on-one counselling, a psycho dramatist who comes in during week three only, an outreach worker, a cook, am intake and night counsellors. The two Aboriginal counsellors have the most constant contact with participants throughout their five-week stay and who create a family type setting and role model healthy boundaries.

Impact

Because the service delivery area is very broad geographically, it is unfair and difficult to focus on one community for changes in rates of suicide, sexual abuse, physical abuse, incarceration or children

in care. Therefore, what follows are the sentiments of Qul Aun's participants regarding the efficacy of the treatment approach when addressing these issues.[93]

Almost 80% of Qul Aun's participants have a **history of foster care**. Over 70% were completely or extremely satisfied with Qul Aun's various approaches (e.g., group and individual therapies) to abandonment issues. Forty-four percent felt that group therapy addressed foster care issues either extremely well or completely, but many more (75%) rated *individual* therapy highly effective.

The vast majority of Qul Aun's group (>90%) had suffered as victims of **sexual abuse**. For those participants for whom sexual abuse was a relevant topic in group sessions (n=45), a slight majority (53%) felt either completely or extremely satisfied. For those in individualized sessions who addressed sexual abuse (n=38), a greater proportion of them (68%) felt completely or extremely satisfied. It is possible that such stigmatized behaviours lend themselves better to individualized treatment for some who feel uncomfortable addressing or expressing the full impact of sexual abuse on their lives in a group. There is a ***clear preference for those who have a history of sexual offence to prefer individualized counselling*** (88%, n=11) ***than to group treatment*** (50%, n=12). This is understandable given the stigmatization of the offense. Also, they may be part of the explanation of why men were not attracted to the group healing contexts.

Almost all (>95%) Qul Aun participants had a history of **physical abuse** or family violence. Physical abuse, anger, violence and spousal abuse were addressed in treatment. There appeared to be an even distribution of the level of satisfaction in the treatment of these issues in both group[94] and individualized settings.[95]

Again, there is a clear preference for those who have a history of **conflict with the law** to prefer *individualized* counselling (75%, n=8) to group treatment (54%, n=11). The stigmatization of illegal activity may be part of the explanation why men were not attracted to group healing contexts.

Almost half (46%) of Qul Aun participants have a history of **suicide** *attempt*. 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) but were also satisfactorily addressed in the group context by the majority (n=49: self abuse, n=46: depression).

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[93] The reader will note that (n=#) is included in many statements. The "n" refers to the total number of participants who voiced an opinion on the topic.

[94] (n= 46: anger and violence, 74% felt treatment addressed the issue either completely or extremely well; n=28: spousal abuse, 69% felt treatment addressed the issue either completely or extremely well).

[95] (n=35: anger and violence, n=21: spousal abuse, 57% felt either group or individual settings worked completely or extremely well).

Accountability to the Community

Qul Aun has gathered much feedback from the project participants, staff and community referral workers. They have done this through client experience surveys after each session, follow-up client experience surveys, informal referral source questionnaires completed by phone and informal program self-evaluations through group discussions using a SWOT analysis (e.g., looking at strengths, weaknesses, opportunities and threats). Of all case studies conducted, Qul Aun was the most methodical and conscientious about collecting participant feedback and was the only project to engage in longer term follow-up.

Impact on Individuals

It was recognized that a substance-free lifestyle allowed participants to stay focused and complete treatment sessions. Clients who had prior counselling and understand healing techniques achieved the most (based on referral workers statement), and often required minimal after-care. The clients who come in with minimal understanding of healing techniques often require longer after-care/counselling and most of the time need a refresher course or second session. Therefore, it is safe to assume that the five-week session works best if participants have demonstrated a solid commitment to heal, as well as have a support system.

The following were the summarized responses of one-to-one interviews with Qul Aun team members (4), community referral workers (7) and administration (2), making a total of thirteen people. Discussion highlighted the opinions of these key informants regarding change in the Qul Aun participants and in the community. While the Qul Aun team was unanimous that an increase in **cultural pride** had occurred (n=4), referral workers (n=6) did not all uniformly share that optimism; however, eighty percent agreed that a change was noticeable. Respondents most often indicated that they observed changes in individual attitudes toward spiritual beliefs and cultural practices evidenced by individuals taking up crafts where there was no interest before. However, they did not believe that all participants had been affected. When asked to estimate how many participants changed, most felt that fifty percent or more of the participant groups had enhanced feelings of cultural pride. One felt that such change was restricted to less than ten percent of the group. Respondents most often attributed changes in individuals 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 already have a strong cultural base before arriving at treatment.

When respondents were asked about noted positive changes in **coping patterns**, **self-worth and life skills**, they unanimously agreed that changes were visible (n=13). When asked 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% of the participants had more confidence, feelings of empowerment, personal capacity to address the Legacy and reduced feelings of victimization. At least two respondents felt positive changes in improved life skills were restricted to a small group (<10% and <20% of the total number of participants). 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.

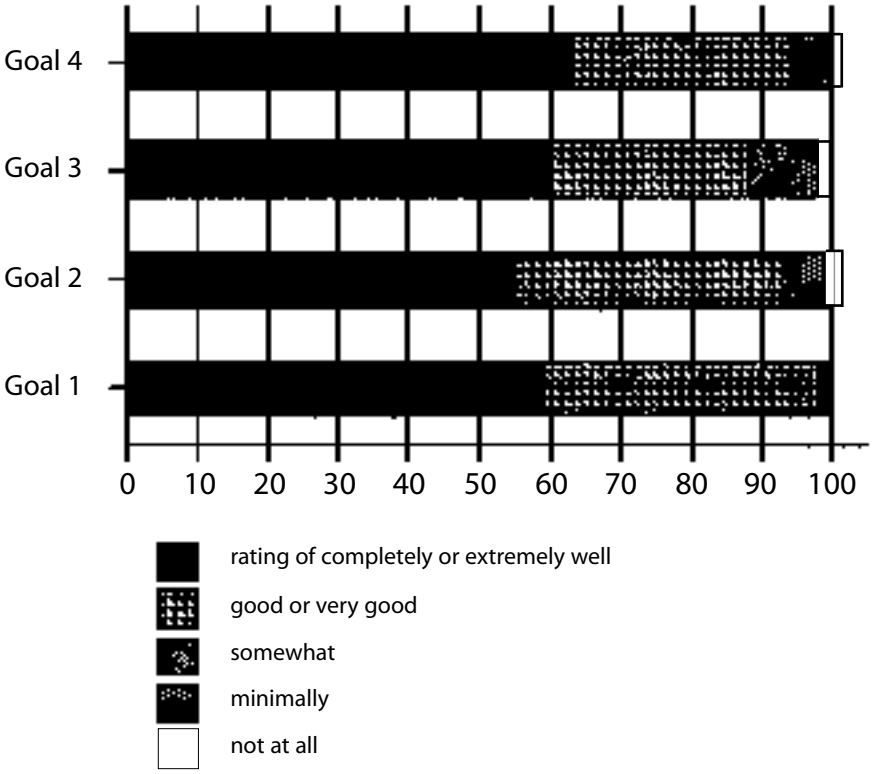
Referral workers noted that many clients **continue with external counselling and self-support groups**; however, staff did not share this analysis. Some believed that participants, who go back to the correctional facility or to remote regions, did not get the support they required. Although most felt that fifty percent or more of the participant groups had maintained after-care, one felt that such change was restricted to less than ten percent of the group. Respondents most often attributed client maintenance of after-care to after-care planning, although community isolation or incarceration presented challenges to after-care. Those who saw little change believed that participants may already have a strong support system prior to arriving for treatment.

When respondents were asked about participant **understanding of the Legacy**, they unanimously felt that change was obvious (n=11), although most felt that increased understanding was restricted to about 75% of the participant group. Respondents 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.

Results from the follow-up survey of clients (three months after Qul Aun) show some promising endurance. While characteristics of these respondents were not obtained, it is known that the majority (70%, n=23) reported that Qul Aun helped them to act upon their strengths and did so completely or extremely well (22% of these respondents reported that the impact was very good). When asked if the program had made a difference in their lives, over three quarters of the group (78%, n=23) reported that it did so completely or extremely well. Respondents were also asked to comment on the program's ability to prepare them for handling future trauma. Most (78%, n=23) reported that it did so completely or extremely well.

In addition, at three months follow-up, participants are asked to what degree their personal goals were met by Qul Aun. The majority indicated extremely well or completely (n=59, from five different Qul Aun sessions). The following figure illustrates the distribution of opinions with respect to the achievement of *personal* goals.

Achievement of participant's personal goals



With respect to the *program-driven* goal of assisting participants to move beyond the trauma of their past, 76% of respondents (n=49) noted that they experienced this program aim either completely or extremely well.

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 (n=13). However, they did not believe that the entire community had been affected. Many (11) felt that at least half of the community or more now has a better understanding of the impact of the Legacy. Two people felt that the change in knowledge and understanding of the Legacy was restricted to a small group (<20% and <10%).

Respondents attributed change in participants' understanding of the Legacy to the combined influences of program elements (e.g., the Welcoming Home Ceremony), efforts of the program team, publicity in the media, activity in the courts and greater involvement of schools in educating students about the Legacy. For those who see little change in community understanding of the Legacy, strong efforts to increase awareness of the impact of the Legacy by schools and community services were recommended.

The impact of Qul Aun on all communities of origin (e.g., where participants reside) was not measurable with the resources allocated to this effort, nor was it appropriately discriminating. What is known is that 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.[96]

Respondents have noted that people are asking more questions, there is an increase in the amount of referrals to Qul Aun, as well as increased participation in other Aboriginal Healing Foundation programs and health related programs.

Partnerships and Sustainability

Qul Aun had established credibility with Correctional Services Canada in serving inmates who were ready for parole and was funded per diem for each bed inmates occupied. However, this would not be substantial to run a full program. The centre was reviewing other methods of funding to ensure they continued to meet 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. The only volunteer element of Qul Aun is the Board of Directors who give generously of their time and knowledge. The ability to sustain Qul Aun activity beyond the life of AHF is in question.

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 Qul Aun addressed physical and sexual abuse issues reasonably or very well and that only some improvement may be needed. However, there are still some clients slipping through the system who are not prepared to address these issues.

Best Practices

Among Qul Aun's best practices are:

- engaging Elders as teachers and peer support counsellors;
- having team members who are Survivors and can model healing;
- using a blend of traditional approaches and western approaches (most particularly psychodrama);
- ensuring team is well trained, thoroughly healed, professional, compassionate and able to create a safe environment;
- treating participants equally and consistently;
- educating about the Legacy and client rights;
- ensuring participants are well screened with adequate after-care;
- using an already established centre of healing;
- ensuring participants are selected based upon their commitment to heal, a healthy support system (counselling) and sometimes attendance in the substance abuse treatment program prior to Qul Aun;

[96] Project's 5th Quarter AHF project monitoring transfer sheet, May 31, 2001, page 8.

- doing genograms with each individual, which allows them to walk through their own history to clarify what patterns they learned and emphasize that they have a choice to NOT repeat this pattern; and
- having weekly clinical supervision from professional consultants (psychologist, medical doctor, dietician, nurse, Alcoholics Anonymous sponsors and a parole officer).

Challenges

Regular difficulties associated with programming include:

- additional team members are required to cover during 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 clients and keep the community informed;
- efforts to increase awareness are needed not only to cover a large region but also to help overcome denial;
- prolonged uncertainty about funding created fear of losing excellent team members;
- need to include an interdisciplinary, full team complement to discuss what worked and did not work;
- finding the balance between treatment for sexual abuse and insufficient time for healing – what should take priority and how should the resources be balanced to address residential school and inter-generational impacts of substance abuse and abandonment issues;
- inappropriate referrals (e.g., clients still abusing substances) do slip through the intake process;
- more than one team member 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;
- not having client satisfaction questionnaires summarized for each session, as well as the lack of group identifiers (e.g., age, gender, front-line workers), limited the ability to make note of trends for unique groups. There is a need to simplify the client satisfaction questionnaire so that the client can fill out the form independently and to reword questions and answers to avoid social desirability biases; and
- although part of the Qul Aun public relations/communications plan, the creation of a video on trauma treatment has been delayed. It is recommended that the program be funded and supported to create this video to increase awareness.

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 participants from coming. Other triggers of in-patient treatment are related to food quality, which is not always optimal in institutional environments. Qul Aun has also 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.

Conclusions

Although it is premature to conclude that Qul Aun has developed lasting healing from the Legacy, it would be safe to say there is tremendous instant gratification for up to six months after completing the program. Participants credit Qul Aun in helping them to achieve their personal goals, deal with historical trauma and face the ever present stressors of life. 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.

Recommendations

It is clear that Qul Aun cannot, on its own, significantly influence any 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 proposal. These identify the 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 indicator: 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 a regular time, goes to work at a certain time);
- Are community after-care 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., to 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, 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 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; and
- 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 would be the most valuable information to secure to determine the long-term impacts of Qul Aun.

Shining Mountains Living Community Services: Tawow Healing Home (AHF Project # 1397-AB)

Project Description

The project addressed here is the Tawow Healing Home delivered by the Shining Mountains Living Community Services (SMLCS) of Red Deer, Alberta. The primary purpose of the project is to provide a culturally-based, non-mandated therapeutic home environment for Aboriginal children/adolescents and their families at risk for involvement with protective services. The project was selected for a case study because it covered services in an *urban* context which strengthens *parenting skills* using *traditional* approaches and *land-based activities*. Key components of the project were 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);
- the use of traditional teaching, recreation, values and parenting methods;
- a safe, comprehensive cooperative approach working with community resources;
- service specific to the unique needs and beliefs of the Aboriginal person; and
- after-care.

The project's main goals, as stated in the application for AHF funding, were:

- to build independent parents with significance, power, competence and virtue;
- to provide a healing environment, which is specific to the unique needs and beliefs of the Aboriginal person; and
- to provide a *non-threatening*, *voluntary* process for family healing.

Target Groups: The target group was all Aboriginal groups that included youth, men and women.

Funding: Co-funding for this project was provided by the Métis Local #84, SMLCS and through private donation. 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 Tawow Healing Home, located 20 minutes north from downtown Red Deer, 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.

The Project Team – Personnel, Training and Volunteers

SMLCS, established in 1995, has experience administering and delivering a variety of programs[97] and shares facilities with four other Aboriginal agencies. The Tawow Healing Home has three team members. A large portion of program responsibilities are shared by the executive director and the bookkeeper. The director has extensive experience in addiction, rehabilitation, crisis, family and life counselling. The third team member, a live-in house mother, had the most contact with participants by providing motherly care in a holistic, traditional Cree way. Four Elders visited the project and provided consultation and traditional wisdom and received honoraria for this service. Volunteers consist of three Survivors who gave support and circle guidance to SMLCS team members and participants; two youth who attended yard care and provided support to the younger children in recreational pursuits; and one parent/grandparent who offered transportation, social interaction and yard care. The number of board members seemed to fluctuate from four to six and included both Aboriginal and non-Aboriginal community members. Political posturing had caused some complications for the board.

Participant Characteristics

The Tawow Healing Home focused on youth/adolescents and their families at risk for involvement of protective services. The majority of parents were single women (7 out of 8), under 25 years of age (range 22 to 40) who previously attended some form of substance abuse treatment (6 out of 8) and had their children apprehended at one time or another. Lack of parenting skill and substance abuse were considered their most significant challenges. The majority of children were under 10 (range infant to teen). Most (63%) were referred by the Kasohkowew Child Wellness Society (KCWS) in Samson First Nation in Hobbema and the others were self referred or encouraged to attend by their families. Participants were assessed to determine their commitment to change. Intake evaluations were completed for both youth and parents and, once accepted, a healing plan was developed. The length of stay was self-determined to a maximum of four months. All Aboriginal groups were eligible to participate as *"the project will not discriminate against any who are not of Aboriginal descent."* At the time of writing, thirteen were status First Nations, four were non-status First Nations and six were Métis. Occupancy for the Tawow Healing Home had been full: many families have been turned away.

Community Context

Red Deer, Alberta is an urban community located halfway between Calgary and Edmonton with a population of 68,308.[98] The city is known for its growing agriculture, oil and gas industries which feed increases in employment and population growth, but also creates a zero percent vacancy rate. Red

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[97] These include conflict resolution, cross cultural awareness, family violence prevention and women's anger management. Also, SMLCS is currently planning to undertake a post alcohol and drug treatment safe haven for individuals who are at risk of homelessness and a mobile outreach unit.

[98] The city of Red Deer, Alberta Municipality. Population. Retrieved September 2001 from http://www.city.red-deer.ab.ca

Deer has a reputation as a hostile environment: landlords are reluctant to rent to Aboriginal people and employers are reluctant to hire them as well. A highly transient population means many homeless youth fall victim to prostitution and substance abuse. On a more positive note, in the past fifteen years, Aboriginal organizations and services in Red Deer have grown and formed an interdisciplinary team of integrated services where SMLCS is the only *non-mandated* family service option. While there is an unknown number of Survivors in the area, there were three residential schools around Red Deer: 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.[99]

Outcomes and Measures

Tawow provided a structured 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-modeling and participation in parenting classes; increase their knowledge of culture and language through participation of traditional activities; seek employment/training or education; as well as dialogue with their family, SMLCS 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 following performance map.

[99] An AHF list of residential schools is a document that is under development.

Shining Mountains Living Community Services Performance Map

MISSION: Tawow Healing Home project seeks to restore, rebuild and reunify our children, families, and communities in physical, emotional, intellectual and spiritual health.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Provide a cohesive, adaptable and welcoming program of family care; provide opportunities for family growth and parenting skills development during residence through modeling, positive encouragement and genuine partnership between the parent(s) and healing helper(s); utilize traditional teaching, recreation, values and parenting methods; provide 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; provide healing environment services specific to the unique needs and beliefs of the Aboriginal person; maintain safety and security of the family; build independence in parenting and self-sufficiency based on significance, power, competence and virtue (the 4 bases of self-esteem and traditional educational practices).	Aboriginal children/ adolescents and their families at risk for involvement with protective services.	Reduce occurrences of family violence within participant families; increase involvement of participant families in community activities, traditional activities, counselling sessions and education or employment; reduce the contributory factors which lead to family breakdown with our target population; increase awareness of services available to assist family function in the community; increase independence in parenting and self-sufficiency.	Create a self-supporting healing community.

How will we know we made a difference? What changes will we see? How much change has occurred?			
Budget	**Reach**	**Short-term Measures**	**Long-term Measures**
$150,000	14 Aboriginal children and their families (9 adults) at risk with protective services in Red Deer, Hobbema and Rocky Mountain House.	Participation in co-parenting, traditional activities, community activities, counselling sessions, employment and education; reduced occurrences of family violence; observed changes in awareness of available services; observed changes in parenting behaviour and self-sufficiency.	Reduced rates in family violence, children in care and incarceration; change in number of families involved in community.

Impact on Individuals

Most respondents noted some change in **parental involvement**. Some observed that parents were more aware of the issues influencing their parenting style, motivated to change daily routines (e.g., homework and household duties) and better able to manage anger. Parents attended classes with the children (e.g., mental health and Family Life Improvement Program (FLIP)) and shared their thoughts with the house mother. Half of the respondents (4/8) felt that these changes were obvious in all parents, while some (3/8) felt that only half the parents exhibited these changes. One respondent felt that three quarters of the parents demonstrated desired change.

Parent child interactions were characterized as more patient, confident and nurturing, as evidenced by parental investments in 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. For most respondents (7/8), this change was obvious in all participants to some degree. Many respondents believed that **parenting skills** had improved because most participants were making decisions independent of social services. Many parents, who entered the program with a lot of aggression, left better able to discuss issues with respect and not just *"fly off the handle."* Most informants (6/9) felt that changes in parenting skill were obvious in all participants. Direct feedback forms and interviews (collected by the project team from Tawow participants), revealed that participants came away with a more positive approach to caring for their families and a more positive approach to life in general.

With respect to **self-sufficiency**, some participants (who were not doing so before their participation in Tawow) decided to seek or secure employment, training or educational opportunities. Informants observed that participants started to do things more on their own without asking for help and that 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.)* It was noted that participants were increasingly able to resist the confining regulations imposed by social services and become more assertive by asking for what they need. 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 the ones who have already gone through the program, rely partially or wholly on social assistance). One problem noted was that participants relied heavily on SMLCS team members to get them to their appointments and classes due to the home being outside the city. All respondents felt that at least half of participating families increased their level of independence and self-sufficiency.

Furthermore, the majority of respondents felt that participants were seeking treatment (10/12) and accessing more services (10/14) as a result of their participation. All participants are still in contact with the project which shows a genuine appreciation of the investment made in their personal growth.

Changes in individual participants were credited to:

- the healthy role model provided by the house mother whose parenting style created less stress and conflict and whose support and feedback motivated parents to improve;
- parental motivation and commitment to keep the family together;

- an emphasis on planning;
- parental expectations of improved stability in their lives, enhanced self worth and increased confidence;
- parental freedom to exercise decision making skills with non-judgmental guidance;
- the combination of traditional approaches to parenting and parenting skills classes;
- a program environment of acceptance where healthy living patterns were the norm; and the fact that
- Aboriginal women were helping Aboriginal women.

Tawow's **team** felt more knowledgeable about traditional approaches to parenting, Cree language and how to start on their own spiritual journey.

Impact on Community

Before considering Tawow's impact on the community, it is important to highlight major developments to improve services to the Aboriginal community over the past couple of years. Some of these include: funding for the homeless; community supported housing; opening of Red Deer Aboriginal Employment Centre; opening of a new Aboriginal council that oversees all programs affecting the Aboriginal community; and the implementation of cultural awareness education mandated to all agencies' personnel dealing with Aboriginal people. As a way of facilitating the potential long-term impact of Tawow on Red Deer, key social indicators have been examined to provide a baseline for future evaluative efforts including **physical and sexual abuse, children in care, suicide and incarceration.**

The project estimates that there are 1,240[100] (11.3%) Aboriginal community members in Red Deer suffering from **physical abuse**.[101] Out of 13 respondents, 7 (53.8%) felt that there was a decrease in the rate for physical abuse and that 6 (46.2%) were unsure. This perception was supported by data on *reported* assaults obtained from the RCMP detachment in Red Deer. It was clear that there was an overall decrease in assault cases in 2001, which may have been affected by the increase in employment opportunities, new programs or a highly migratory population. The following table reveals indicator data on physical abuse.

[100] SMLCS response to the AHF Supplementary Survey, July 2001.

[101] Defined as 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. Source: www.gov.ab.ca/just/crimeprev/family _violence.

Reported Complaints of Physical Abuse[102]

Crime Code	January 1 -August 31, 2000	January 1-August 31, 2001
Assault (level 1)	590	481
Assault weapon/bodily harm	60	32
Aggravated assault	5	3
Assault causing bodily harm	2	3
Total	658	520

The project estimates that there are 360[103] (3.3%) Aboriginal community members in Red Deer suffering from **sexual abuse**.[104] Only 4 of 13 (30.8%) respondents felt that the rate for sexual abuse had decreased and the rest (69.2%) were unsure if there was any change. The table below indicates the number of *reported* sexual assaults and may or may not include Aboriginal people. Although the numbers indicate very few attacks, it is *very likely* that a much greater number is undisclosed. These data are clearly in contrast to the opinions of respondents to the AHF Supplementary Survey.

Reported Complaints of Sexual Abuse[105]

Crime Code	January 1 -August 31, 2000	January 1-August 31, 2001
Aggravated sexual assault	0	1
Sexual assault with weapon	0	1
Total	0	2

The following figure shows the rates for Aboriginal children placed in care for the areas that Diamond Willow Child and Family Services Authority services for the 2000/2001 period.

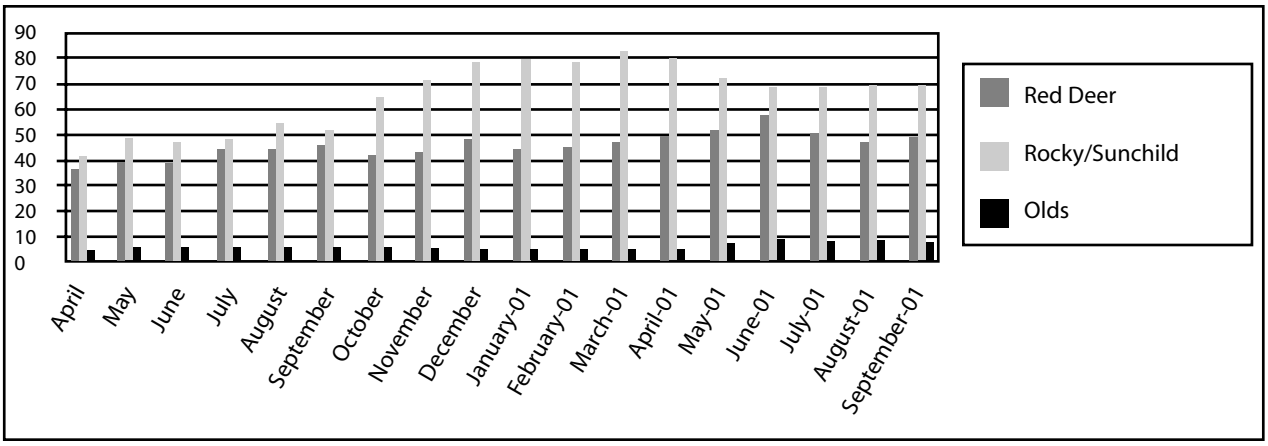
102 Compiled by Red Deer City RCMP detachment and includes both Aboriginal and non-Aboriginal.

103 SMLCS response to the AHF Supplementary Survey, July 2001.

104 Sexual abuse is making victims do any sexual acts they do not want to do. Retrieved in September 2001 from: www.gov.ab.ca/just/crimeprev/family_violence

105 Compiled by Red Deer City RCMP detachment and includes both Aboriginal and non-Aboriginal.

Total Number of Aboriginal Children in Care (Red Deer, Rocky/Sunchild, Olds)[106] for 2000/2001



The current total population for Red Deer is 68,308. If we assume that roughly 3.45%[107] of the population is Aboriginal, then it is estimated there were 825[108] Aboriginal children under the age of 15 living in Red Deer in 2001. The project estimated there were 454[109] children in care in the Red Deer area, which probably included rates from Hobbema and Rocky Mountain. Looking at children from Red Deer alone, a total of 286 Aboriginal children were placed in care (temporary and long-term care between 1 January 2001 to 4 October 2001) through the intervention of the Red Deer Native Friendship Society (RDNFS).[110,111,] Caution is required in interpreting this information because no information could be obtained on the exact number of children who were in and out through a 'revolving door' child care system. In other words, one child could be counted more than once in the total number of children placed in care. When questioned about whether or not rates of children in care had changed, opinions from respondents differed slightly. About half the respondents (46.2%) felt that there was a decrease in the rates for children in care, 15.4% felt there was an increase, 7.7% felt there was no change and 30.8% were unsure.

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[106] Census 1996 lists the total population for Sunchild Reserve at 435 with 255 (58.6%) under the) age of 20; total population for the town of Rocky Mountain House was 5,805, Aboriginal population was 255 (4.4%) and 1,945 under the age of 20; total population for the town of Olds (located between Red Deer and Calgary) was 5,700, Aboriginal population was 95 (1.7%) and 1,675 under the age of 20.

[107] Based on 1996 Census percent distribution.

[108] Based on 1996 Census data, it was estimated that Aboriginal children accounted for 35% of all Aboriginal people. Statistics Canada, Aboriginal Peoples in Canada - Profile Series, June 2001.

[109] SMLCS response to the AHF Supplementary Survey, July 2001.

[110] Red Deer Native Friendship Society only delivers services to those children living in the city of Red Deer.

[111] This information was gathered through the RDNFS Community Care Coordinator in charge of the program that intervenes when an Aboriginal child who is a resident of Red Deer is involved.

The project estimated that 125[112] (1.1%) Aboriginal community members have been **incarcerated**. Out of 13 respondents, one felt there was an increase and one felt there was a decrease in the rates for incarceration. The rest of the respondents were not sure. The project estimated there were 42[113] (0.4%) Aboriginal people who either attempted or committed **suicide** within the past year.

Although it was already mentioned that there was an increase in suicides in Hobbema during the past summer (one respondent said there were a total of four suicides), 46.2% still felt that, overall, there was a 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. But the majority, 53.8% could not decide whether rates had changed. The table below shows a slight decrease in the number of Aboriginal suicides for the province of Alberta. The following tables were prepared with statistics provided by the Office of the Chief Medical Examiner of Alberta.

Number of Deaths by Suicide by Aboriginal Identity in Alberta

	2000		**2001**	
	Status/Non-Status	Métis	Status/Non-Status	Métis
Totals	35	8	33	2

The next table shows that 11.6% 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 that year. It also shows that 31.4% of Aboriginal suicides in Alberta 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.

[112] This information was gathered through the RDNFS Community Care Coordinator in charge of the program that intervenes when an Aboriginal child who is a resident of Red Deer is involved.

[113] SMLCS response to the AHF Supplementary Survey, July 2001. Rates were for one year, but it was unclear if it was for 2000 or from June 2000 to July 2001.

Number of Aboriginal Suicides by Age for 2000

	Red Deer				Hobbema				Rocky Mountain House				
	2000		2001		2000		2001		2000		2001		2000
Age	M	F	M	F	M	F	M	F	M	F	M	F	Unknown
Under 15						1		2					
15-19								3					
20-24					1		2	2					
25-44			1				1						
Unknown													3
Total	0	0	1	0	1	1	3	7	0	0	0	0	3

The only estimates that were available on family violence were provided by the AHF Supplementary Survey of July 2001, which stated that 1,650 (15% - based on the project's belief that there are approximately 11,000 Aboriginal people living in Red Deer as of July 2001) Aboriginal community members suffer from family violence. This number may also include acts against children, as it is not certain how the project defines the term '*family violence.'*

Partnerships and Sustainability

The project showed to those who were involved with the project that there are people who care and there is hope. However, without an established **partnership** with KCWS in Hobbema or any other private or public backing, Tawow will cease to exist when the AHF closes its door. If SMLCS accepts funding from social services, the program will have to change to adhere to their guidelines and may lose its unique approach. The primary and most successful working partnership has been with the Family Life Improvement Program (FLIP) that all Tawow participants attend on a voluntary basis.

Successes and Best Practices

Voluntary, parenting skills development services operating in a home environment where both traditional and western approaches allowed for greater opportunity for Aboriginal people to empower one another. Program flexibility meant *unique* solutions were created based on *individual* needs. Much credit went to the house mother whose patience, commitment, traditional parenting skill, as well as her ability to facilitate independent decision-making, encouraged confidence. Participants clearly respected and admired her.

Challenges

- Service need and demand exceed capacity: many families have been turned away;
- misunderstandings between Tawow and social services created much angst as social services viewed Tawow as 'child protection,' which needed to follow regulation. Lack of cooperation and a strained relationship inhibited communication that might have appeased any safety concerns on the part of social services;
- a country location may not have encouraged enough *'street smarts;'*
- smoking was allowed in the home, raising health concerns for children;
- inability to deal with special needs (e.g., FAS/FAE);
- reduced funding meant lost team members (capable of evaluating), less access to Elders, as well as other programs and activities that were planned;
- sustaining Survivor involvement;
- young parents did not always appreciate, accept or feel comfortable around visiting Elders; and
- struggling with denial: most could or would not admit to being a Survivor.

Addressing the Need

Almost half the respondents felt that the project was addressing the Legacy, but they also felt that victims of physical and sexual abuse may require *professional* counselling, which was beyond the team's capabilities. Aside from a referral strategy, respondents felt that increases in team membership may address the need better. With respect to achieving enduring, desired results, most respondents (7/10) were unsure and felt it was too soon to tell.

Lessons Learned

The importance of whole family therapy and traditional ways has been key to *keeping* families together. It was recommended that hands on bush experience was needed. The project team felt the need to modify intake forms and referral processes to better detect FAS/FAE, as well as to clarify whether or not to accept FAE participants. It was 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.

Conclusions

As a ***whole family, non-mandated***, culturally sensitive therapy facilitated by cultural insiders in a home setting, Tawow appeared to be having a positive influence on most who participated (although not all responded to the same degree). Also, this service was well received by the community. SMLCS Tawow Healing Home appears to be having an impact on the majority of participants. It is clear that the program is not able to address serious special needs alone. It is not clear how enduring the changes noted thus far will be, nor to what extent they are life-altering. It is also unclear to what extent the role of referring agencies, broader community development and established partnerships contribute to these changes (e.g., FLIP). 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.

Recommendations

The following recommendations are suggestions to enhance administration and evaluation of the program:

- 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 AHF that the project is addressing the Legacy and needs that were set out in the 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 (e.g., FAE).

With respect to the continued evaluation of Tawow, it is recommended that the intake form be used as a baseline measure. It is also recommended that the project team summarize **all** participants' information regarding personal, educational, vocational, criminal and treatment histories, as well as level of functioning in the home, as a relationship with husband/wife/partner, in the workplace, 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 after-care. 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 (e.g., children in care, sexual and physical abuse, suicide, incarceration) in 2007 to determine trends over time.

Building A Nation Family Healing Centre Inc.: Healing the Multi-generational Effects of Residential School Placement – Urban Access Program (AHF Project # CT-2429-SK/1256)

Project Description

This case study was selected to reveal the unique challenges facing urban based projects with First Nations, Métis, homeless and incarcerated beneficiaries from a western geographical perspective. The project which forms the basis for this case study is titled "Healing the Multi-generational Effects of Residential School Placement – Urban Access Program." (AHF Project # CT-2429-SK/1256). The program, more commonly known as Building A Nation or BAN provided healing activities and continuing support. A review of quarterly reports show that two key training programs were offered (Aboriginal Parenting Skills and Counselling First Responders). The latter became known as A.C.C.E.S.S., which stands for 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) and social gatherings. Training was considered part of the continuing support to help individuals manage personal and familial crisis independently.

Target Groups: Aboriginal people in the city of Saskatoon, Saskatchewan and surrounding Aboriginal communities. Special groups reached in this project included homeless and incarcerated individuals. It is the only case study where men outnumbered women in a healing activity.

Funding: The project was funded from 1 May 1999 to 30 April 2000 with a contribution in the amount of $210,229. In its second year, which operated from 1 June 2000 to 31 May 2001, a further amount of $222,800 was secured.

Project Team

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

BAN Project Team

Year One Title	# of positions	Year Two Title	# of positions
Counsellor/Case Worker	1	Psychologist	1
Youth Worker	1	Traditional Therapist	1
Mental Health Therapist	1	Case Manager	1
Theater Project Coordinator	1	Youth Worker (1 male & 1 female)	2
		Legal Advocate	0.5
		Executive Director	1
		Financial Comptroller	1
		Receptionist	1
		Public Relations Officer	0.5
		Office Manager	1
		Women's Therapist	1

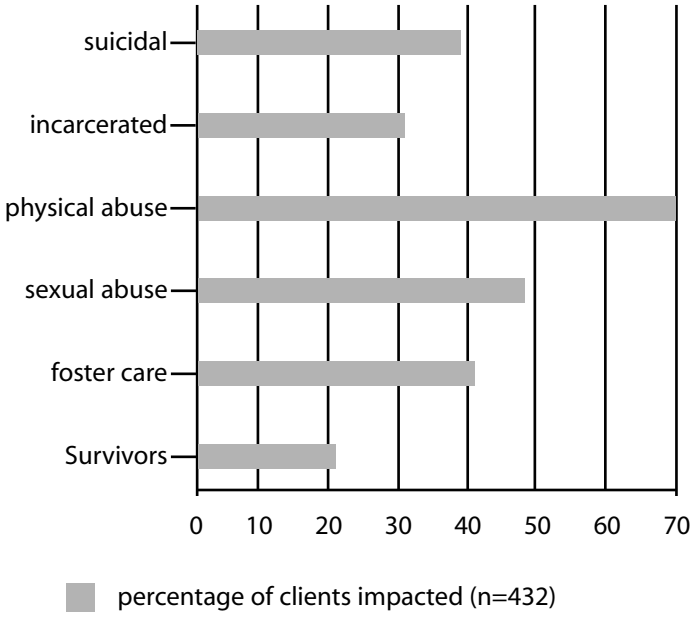
In addition to the project team, an advisory board was established with designated Survivors. The *"Advisory Board will have direct input to the design of data gathering instruments, analysis of data, and both formative and summative evaluation phases of project management and reporting."* [114]

Participant Characteristics

Participants 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."* The vast majority (70%) have experienced physical abuse and many (slightly less than 50%) are sexual abuse victims with a history of suicide attempts and ideation. Just over forty percent have been wards of the province.

[114] BAN's year two application for project funding to the AHF, Part F, Project Monitoring and Evaluation.

Participant Histories



The percentage of *direct* Survivors (e.g., those who attended residential school) remained at or near the eighty percent mark. It should be noted that virtually all were dependent upon social assistance and *men appeared to have higher participation rates in healing activity than women*.[115] Severe participant challenges (more than 80%) were identified as: lack of Survivor involvement; incarceration; denial, fear, 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.[116]

Context

Very little information was found on the indicators selected (e.g., suicide, children in care, physical abuse, sexual abuse and incarceration) for the Aboriginal population in *Saskatoon*. Figures for the province and for the non-Aboriginal population are intended *only* to provide a general context. Saskatoon has a population of between 193,647 and 219,056, of which 16,160[117] are Aboriginal.

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[115] In a follow-up call to BAN, it became clear why more men were involved. For example, with some Traditional ceremonies, teaching men to be door-keepers and to collect rocks or wood for the sacred fire and sweat lodge, are jobs meant to be done by men. Also, there tended to be more men involved in court advocacy hearings and supporting clients psychologically and emotionally who may be going through residential school claims. Lastly, BAN also had more male counsellors and men's circles, all of which contributed to the higher number of male involvement. To some degree, homelessness and street-involvement factored in as well, as more men may be coming from these life circumstances.

[116] Ban response to the NPES completed March 2001, question A.10.

[117] Statistics Canada. 1996 Census, Fact Sheet, Community Profiles.

The project estimates the Aboriginal population at about twice this number or 30,000 and the urban environment provides little to guard Aboriginal cultural integrity.

> *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.*[118]

The following unemployment figures showed Saskatoon had a 7.5% rate, slightly higher for males at 7.7% than females at 7.4%.[1191] In Saskatchewan, as of 31 March 1999, there were 3,392 families receiving child protection services with 2,710 children in care and 65% were First Nation and Métis. According to the Saskatchewan Social Services annual report for 2000-2001, the two main causes for child protection involvement were *"physical neglect and lack of parenting ability."*[120] Sexual assault figures for all of Saskatchewan were 1,525[121] in the year 2000. For Saskatoon, there were 347 sex offences in 1991 and 274 in 1996.[122] Saskatoon had 722 major assaults and 1,523 common assaults[123] in 1996, an increase of about 37% over previous years.[124] In 1999, Saskatchewan had *"1,144 inmates in provincial custody"* [125] with a clear over-representation of Aboriginal offenders. In Canada as a whole, Aboriginal over-representation is greatest in the Prairie provinces.[126] Further information showed that *"Aboriginal peoples represent 2.8% of the Canadian population, but account for 18% of the federally incarcerated population."* [127]

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[118] BAN year two application for project funding to the AHF, Part C, Community Profile, Question 13.

[119] Statistics Canada. 1996 Census, Fact Sheet, Community Profiles.

[120] Statistics Canada. 1996 Census, Fact Sheet, Community Profiles, Page 28.

[121] Statistics Canada. Canadian Statistics - Crimes, by type of offence, Canada, the provinces and territories, CANSIM II, table 252-0001 and catalogue no 85-205-XIB.

[122] Correctional Services of Canada (1996). Community profile, Saskatoon SK, page 5.

[123] 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 which cause much less harm.

[124] Correctional Services of Canada (1996). Community profile, Saskatoon SK, page 5.

[125] Statistics Canada. Canadian Statistics - Crimes, by type of offence, Canada, the provinces and territories, CANSIM II, tables 255-0001 and 255-0002. Last modified 22 February 2002.

[126] Statistics Canada. Canadian Statistics – Crimes, by type of offence, Canada, the provinces and territories. Last modified February 22, 2002, page 45.

[127] Correctional Services of Canada. Aboriginal Offender Statistics, Facts and Figures. Updated 25 February 2002.

In addition, the number of young offenders in Saskatchewan, regardless of ethnicity, have been steadily increasing annually since 1992 by about 6%.[128] In 1992-1993, there were 291 young offenders in custody in Saskatchewan and in 1998-1999, the figure was 398.[129] The three-year national average rate of suicide for First Nations people was 38 per 100,000, about three times higher than the national average.[130] Over a four-year period, suicide accounted for 23%[131] of injury and poisoning deaths in Saskatchewan for First Nations people.

Outcomes and Measures

The logical link between BAN's activities, what they hope to achieve in the short-term, and the desired long-term outcomes, as well as performance measures have been summarized and presented in the table on the following page.

[128] Saskatchewan Social Services. Annual Report, 1998-99, page 35.

[129] Saskatchewan Social Services. Annual Report, 1998-99, page 36.

[130] Health Canada, First Nations & Inuit Health Branch. Statistics Fact Sheet: Death Rates due to Injury & Poisoning by Cause.

[131] Health Canada, First Nations & Inuit Health Branch. Statistics Fact Sheet: Death Rates due to Injury & Poisoning by Cause. Statistics for 1989-1993, showed 479 deaths among First Nations people in SK.

Building A Nation - Logic Model (File# CT-2429-SK)

Activities	Therapy/Healing Activities	Continuing Support
How we did it	Ongoing individual and group counselling, powwow, cultural camp, sharing circles, sweat lodge ceremonies, cultural industries, cultural teachings, develop an appropriate assessment and evaluation strategy and seek avenues to ensure BAN sustainability.	Drop-in center; 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, housing support, public speaking, outreach, inter-agency partners and exposure to healthy role models.
What we did	# of individuals counselled, # of individual counselling sessions, # of groups in counselling, # of common interest circles (e.g., family, volunteers, parolees), 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.	# of training courses, # of community release plans and client support appearances (court, child custody), # of presentations and curriculum development on residential school history and recovery.
What we wanted	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, social assistance), increased use and understanding of traditional healing methods, increased access to culturally appropriate services and sustainability.	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.
How we know things have changed short-term	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 to BAN activity).	
Why are we doing this	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.	
How we know things have changed long-term	Rates of lateral abuse, incarceration, children in care, sexual abuse, suicide and attempts, participation and volunteerism in community events and dependence upon social assistance.	

Impact on Individuals

While the more detailed impact of BAN intervention on individual lives (see logic model for list of indicators) remained unclear, the project did offer opportunity for individuals to move toward reclamation of a healthy, stable, functional life *without* any 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 appropriate human services. BAN's inclusive, family orientation has led to a reduced risk of child apprehension, which they attributed to their ability to provide *skilled* support during crisis and more general support for lone parent households. Some participants have developed sufficient leadership skills, such that they now manage the administrative details associated with group events (e.g., advertising, scheduling). Overall, respondents felt that BAN was able to achieve desired results reasonably well. This belief was based on the fact that the project receives unsolicited calls from referral agents and clients who say so. They also felt that the comprehensive and ***voluntary*** nature of their services (e.g., culturally appropriate healing, advocacy and support as well as life skills reinforcement that emphasizes self-responsibility) helped. Ideally, the evaluation plan to measure individual and family impact should be implemented.

Some young offenders represent a third or fourth generation dependent upon social assistance. When they become teen parents, as many of them do, the cycle continues. But, like other teens, *"All they want is love, they need a comfort zone....We have positive activities, they take it all in, absorb all of it."* Informants believe that a bond, based on trust, has developed between young people and the BAN team. Evidence of this relationship is 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, which the team credited to the cultural components of the program (e.g., impulse control taught in sweats).At last, BAN represents a new system with various layers of support not offered elsewhere (e.g., help looking for parents or apartment hunting).

Part of BAN activity included a ten-week theatre program (Circle of Voices) to help all youth (ages 12 to 26) feel safe to creatively express themselves, build self-esteem, as well as learn about theatrical production.Over time, it became clear that this young group became dependent upon each other for support and encouragement, 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.The 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 as evidenced by their voluntary attendance at daily workshops, involvement in talking circles and support for the theatrical production.Some parents even motivated their children to continue in the performing arts industry.

One hundred and fifty-three people completed the Counselling First Responders training from the start of the project until March 2002.However, it was not clear to what extent participants acquired the necessary knowledge or skill to effectively manage crisis in their lives.However, the BAN team felt that training provided them 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,

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.

Impact on Families

While it was unclear to what extent family therapy led to ultimately desirable outcomes, respondents *were* clear that the challenges facing families were many (e.g., poverty and addiction). It should be noted that virtually all participants were dependent upon social assistance. If family members were not victimized directly, they witnessed horrific acts of violence and *client needs often exceeded program capacity*. 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 that healing came first and justice issues came later. In part, this philosophy helped establish trust that was critical to engaging families in a way that would facilitate results. Such trust was also credited to BAN being Aboriginally owned, with a team majority of First Nations and Métis, as well as a sensitivity to Legacy issues and cultural understanding.

Impact on Community

BAN's team has a *good* reputation. They are 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. The informant acknowledged that the history was not always pleasant, but felt that enlisting allies might require a less threatening approach.

Referral agents have noted that some of the clients shared with BAN became involved (in BAN) as a result of their own initiative, resulting in increased access to advocacy services. Sometimes, referral agents were frustrated by the lack of progress in *their own* approach. Even with the support of various provincial departments, agents have referred several clients to BAN and believe they need to refer *more*.

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

Building A Nation's board is comprised of First Nations, French speaking people, Métis 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.[132]

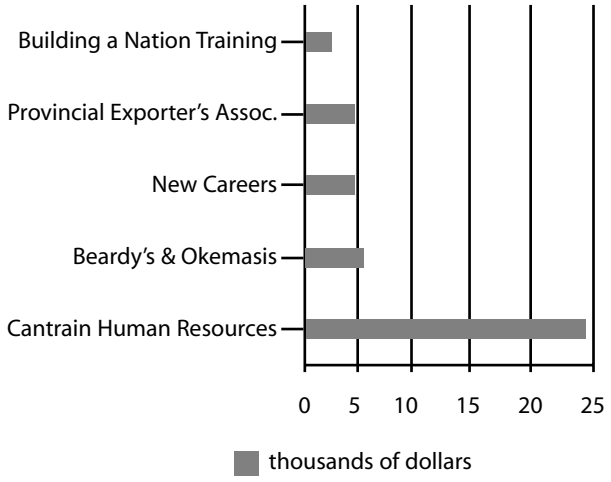
[132] The Times Observer (2001). Building A Nation: Aboriginal community leader appeals to educators to build cultural bridges, September, page 3.

Finally, there was a noted increase in 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 can receive certification. Also, court referrals for community release programs managed by BAN have increased over time. Saskatoon courts recognize BAN as an "alternative sentencing" program, possibly the result of more culturally sensitive staff in these agencies.

Partnerships and Sustainability

Although BAN has a plan and is hopeful about long-term funding beyond the life of the Foundation, no formal agreements have been obtained. While no dollar figure was provided, the project believed that it enjoyed *generous* donations of goods and services, including an estimated $14,000 that was secured through fund-raising. In addition, the figure below illustrates the generous funding received from partners (totaling $42,100).

Funds Donated by Partners



The Circle of Voices youth theatre production was supported by the Westmount Community School, Dark Horse Studio, Blue Hills Productions and the Saskatoon Fringe. Some external informants, although not all, felt that their organization benefited from the work done by BAN. BAN had many formal referral systems with other organizations. Many have taken BAN training, including the Saskatoon Police's Aboriginal cultural coordinator. Each school year, roughly fifty children come for an information session on the Legacy, including social services and the program coordinator at a local youth group home. Some referral agents felt that BAN facilitated 'bridge building' between agencies with different world views and that the cultural orientation and Legacy education was definitely needed.

Accountability

Although informants felt that BAN was engaging in clear and realistic communication with the community, they acknowledged that it was a challenge with their target group (e.g., homeless or incarcerated individuals who could be highly transient). Their most successful strategy is to use

monthly feasts 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. 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.

Addressing the Need

All felt the program was addressing the needs of participants 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) continued coming, even if only sporadically. In other words, no clients were 'lost.' Informants believe that their efforts to cultivate trust and offer client centered support with counsellors sensitive to Legacy issues are the reasons for program popularity. When improvements were suggested, they were related to the time and support required to move through all healing phases.

Best Practices

- Medicine wheel-based counselling encourages self directed learning and growth;
- role modelling was an effective strategy for creating healthy lives for beneficiaries;
- being a client *advocate*, first and foremost, without feeling the obligation to adhere to governmental agency-based policy was a highly regarded philosophical foundation;
- an Aboriginal team, some of who speak an Aboriginal language, was believed to contribute to desired outcomes;
- Aboriginal control of Aboriginal programming in an urban area where few other similar services exist; and
- BAN attempts to offer clarity in the therapeutic process by helping individuals to identify their strengths and weaknesses. They do this by blending western tools (e.g., the Myers-Briggs) within culturally appropriate framework for analysis (e.g., the Medicine Wheel). This exercise was done solely for the expressed purpose of offering clients insight, which apparently worked very well to create self awareness, establish trust and integrate western and traditional approaches.

Challenges

Merging with provincial agencies to provide seamless service was a challenge due to a lack of understanding about the Legacy, the dis-empowering nature of mainstream services and cultural domination. Some external agencies were resistant to the restorative nature of BAN's clinical and adjunctive programming.

Many participants came from harsh circumstances, often experiencing *several* layers of difficulties. Service demand, burn-out, 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 counselling was overwhelming. Furthermore, community release plans increased pressure for more adjunctive activities, *(e.g., support related to housing,*

employment, life-skills development). Being unfamiliar with the justice system also posed a barrier early in the project's mandate. Also, administrative costs, such as accountant's and lawyer's fees, became burdensome.

Programming issues listed as barriers included: transportation during daytime hours as *"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. 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 valuation skills and requirements. The planned evaluation appeared to have been only used for the theater production.

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 had affected not only their lives, but the undercurrent of rage in their communities. Some had no idea of the extent of the abuse, family breakdown or level of hurt. BAN *finally offered a social explanation* for the impact of the Legacy that other individual and symptom-focused treatment programs had not.

Insufficient attention had been paid to establish on-going funding commitments. Some felt that the strength of partnerships needed to extend beyond financial support to include an integrated service network. The team also warned against simultaneous training and program delivery. Training cannot occur when you need a team that must deliver services immediately. But, the combination of having skilled traditional and clinical therapists working together meant prompt movement from assessment and planning to healing.

Conclusions

BAN is proving to be a resource for a significant amount of Aboriginal people living in Saskatoon. Referrals and client numbers have increased steadily and most return for ongoing counselling and support. The project has created an environment where participants feel they belong and are respected. Positive results were most often attributed to the *culturally appropriate* services offered. When change was not immediately apparent, the team acknowledged that the stresses of undergoing healing and training while maintaining economic self-sufficiency, was a harsh reality that was a struggle for some participants. Referral agents also acknowledged that the target group (especially incarcerated and homeless individuals) were a challenging group to maintain. The project has created a better understanding of Aboriginal culture within mainstream service agencies in Saskatoon. Finally, it can be stated that BAN is clearly filling a need by offering a continuum of services where previous gaps existed.

Recommendations

- *Focus* the effort either by reducing the target or identifying *more realistically attainable* outcomes for such a broadly based and multi-challenged beneficiary group;
- provide more clarity about how western and traditional healing methods complement each other or blend together;
- *following through with the plan to develop a 'Survivor's assessment protocol' adapted or blended from widely recognized tools and well suited to the cultural context;*
- partnerships should continue to be nurtured to provide needed support for adjunctive services. Also, partnerships should be strategically selected so that efforts to raise awareness in and train external agents to address the Legacy are sufficiently resourced with detailed curricula and time;
- merge program databases to provide one record; and
- revisit the evaluation plan to gauge the effectiveness of key program components,[133] which included collecting information on:

    - measurable change in participant life satisfaction;
    - measurable degree of satisfaction of participant family members;
    - observable change in self-sufficiency;
    - effectiveness of project management; and
    - degree to which the project builds longevity past AHF funding,

[133] BAN application for project funding to the AHF, page 15-16.

Willow Bunch Métis Local #17: Willow Bunch Healing Project (AHF Project # 1176-SK)

Project Description

The Willow Bunch Healing Project delivered by the Willow Bunch Métis Local #17 of Willow Bunch, Saskatchewan (AHF Project # 1176-SK) intends to *"give a positive awareness of history of the Willow Bunch Métis to the community....[and] increase pride in being Métis."*[134] This case study covers the following project types and targets: Métis, rural, West, materials development.

Target Groups: The target group includes Métis and others living in Willow Bunch, Saskatchewan.

Funding: 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 Team

The Métis Local (referred to as "the Local")was established in the 1940s, but has never received core funding nor delivered services from an established location until it was supported by the AHF. It existed solely through membership fees and the elected board participated on a voluntary basis. Although the process evaluation survey stated the project had four full-time employees, two part-time employees and a number of volunteers who contributed approximately forty 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 ten years old and returned years later to settle in the community. He was president of the Willow Bunch Métis Local #17 from 1996 to 2000. He stepped down as president in order to become the project coordinator. Since 1996, he has been involved in various Métis and community issues. The project consultant (co-coordinator for current AHF-funded year) is also Métis, with familial ties to Willow Bunch who has offered consulting services on many projects for a number of Aboriginal organizations and governments. The researcher/writer holds a Ph.D, M.Ed and a B.A. She has completed an extensive list of reports for a number of Aboriginal organizations, both national and provincial. According to the project coordinator, 30-35 volunteers contributed to the Local office set-up. One Elder, whose family members are prominent ranchers, is involved. Involvement of youth seems limited as there is only one youth volunteer at present. The advisory committee for the AHF-sponsored project is also the board of directors for the Local.

[134] Project proposal for AHF funding, February 2000.

Participant Characteristics

Activities where participation was estimated included:

- the Métis fiddle dine and dance (150-300 people attended);
- a workshop on Métis identity (50 people attended and all were Métis from Assiniboia, Wood Mountain, Rock Glen and Willow Bunch); and
- a cultural day event at school (120 participants if whom 110 were students).

All other activities that occurred did not indicate participant estimates or gave further details on participant characteristics.

Context

The town of Willow Bunch, Saskatchewan is located at the southern end of the province. Many homes and buildings are empty with long-standing 'for sale' signs out front, giving the town an almost abandoned look. Services include a garage, motel/restaurant, tavern, gas station, town hall/fire hall, rural municipality building, co-op store, post office, library, school, retirement home, museum/community centre/day care centre and the Métis Local.

Agriculture and mining of non-mineral resources are the major industries and the farming community is struggling with a three-year drought. Economic growth dollars trickle into the community and are limited to small grants, such as the one from Quebec to improve tourism and from the Saskatchewan government for its commitment to Métis education and other Métis initiatives. In 1998, Métis Local #17 received a grant from the Clarence Campeau Development Fund, which is a Métis-controlled economic development funding agency.

The population of the town is 400 with 50% Métis.[135] The project team believes that approximately 90% are Métis but do not identify or do not know. In July 2001, there were 395[136] people living in Willow Bunch compared to 431[137] in 1996, which is indicative of the economic turmoil this small rural town faces. Many high school graduates leave the community for opportunity or education and never return. Racism has also been a common feature of the social climate in Willow Bunch. Métis were shunned from institutions such as the credit union, parish councils and other organizations.

> *They could be part of the parish . . . . not any of them that sat on parish council or school boards . . . . I remember playing with a French boy and we were getting along fine and the nun come over . . . . 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."*

[135] Project response to the AHF Supplementary Survey (July 2001).

[136] Taken from the Saskatchewan Bureau of Statistics internet site.

[137] Statistics Canada 1996 Census.

Métis were considered intellectually inferior. To gain opportunity, a Métis would have to forego his or her identity. The following excerpt is from a history book that is still held in the Willow Bunch school library and was used as reading material for history class. In it, the Métis were defined as

> *Irascible, inconsistent, wasteful and love alcoholic beverages. They cannot work consistently nor can they adapt as [sic] 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.*[138]

Finally, social indicator analysis revealed 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.

Outcomes and Measures

The main program activities expected to produce change in the contributing 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, newsletters, use all media to inform and promote a positive image;
- re-educate the Métis and non-Métis community about true history;
- work with schools, museum, 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 in a new positive image.

These activities would then lead to the production of:

- booklets, brochures, posters on Métis contributions to the area;
- book or publication of healing process; and
- book or publication on the Willow Bunch Métis.

[138] Willow Bunch Healing Project final report of its first year funding to the AHF, October 2001, page 1.

Which then would ultimately create conditions where there would be:

- an increased 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 would develop.

The relationship between activities and selected outcomes is set out in the following performance map, which shows what measures will be used to note change. This "map" was used to determine what information should be gathered.

Willow Bunch Healing Project - Performance Map

<table>
<tr><td colspan="5">MISSION: Give a positive awareness of history of the Willow Bunch Métis to the community; increase pride in being Métis; and community to begin the healing process.</td></tr>
<tr><td colspan="2">HOW?</td><td>WHO?</td><td colspan="2">WHAT do we want?</td><td>WHY?</td></tr>
<tr><td colspan="2">Resources/Activities/Outputs</td><td>Reach</td><td colspan="3">Results</td></tr>
<tr><td colspan="2"></td><td></td><td colspan="2">short-term outcomes</td><td>long-term outcomes</td></tr>
<tr><td colspan="2">Communicate/Educate: Develop communication plan; re-educate community; regular public meetings, use all media to inform and promote; revive and appreciate traditional Métis activities (e.g., Aboriginal Day, Riel Day, fly Métis Nation flag); work with schools, museum, provincial Métis agencies and organizations to promote positive Métis history; work with community leaders to promote a new image.</td><td>The whole community of Willow Bunch.</td><td colspan="2">Increase # of Métis participation in cultural activities, interviews, meetings, increase awareness of true Métis history.</td><td>Ensure a positive portrayal of the history of the Willow Bunch Métis and increase pride in being Métis.</td></tr>
<tr><td colspan="6">How will we know we made a difference? What changes will we see? How much change has occurred?</td></tr>
<tr><td>Budget</td><td>Reach</td><td colspan="2">Short-term Measures</td><td colspan="2">Long-term Measures</td></tr>
<tr><td>$109,200</td><td># of Métis who participated in cultural activities and # of participants who attended meetings.</td><td colspan="2"># participating in cultural activities, # who shared stories and # aware of true Métis history.</td><td colspan="2"># who are proud to be Métis and # of people who are aware of the true history of Métis in the community.</td></tr>
</table>

Results

The desired outcomes that were examined focused on: impact on the individual including project awareness, Métis involvement and identification; impact on the community including response to the project; access to information on the Métis; community knowledge of Métis; and community relations. Results are almost exclusively based on the opinions of key informants. It should be noted

here that some planned outputs were not realized. No book was produced or distributed due to the difficulty obtaining a sufficient number of stories and interviews and no *formal* communication plan was developed. Furthermore, there was no evidence of any brochures, pamphlets or posters produced by the project.

Impact on Individuals

The majority of respondents were aware of the project, although most saw it as a Local activity rather than an AHF-funded project activity. While most were clear about the central message, some thought the project's intent was job creation or to start another museum. Local membership stands at 250 (from Willow Bunch, Coronach, Rockglen and Bengough) up 150 from four years ago. *"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."* Respondents have observed increased attendance at Local meetings, increased discussion about Métis identity, a dramatic increase (over 80%) in participant knowledge of accurate Métis history, as well as involvement and pride in the Métis culture.The Métis flag is flown on all occasions and more community members wear the Métis sash with pride. Respondents also felt there was a moderate to dramatic increase (40% plus) in participant knowledge of Métis culture and Métis identification. In fact, it became clear that some in the broader community *"didn't even know that there were Métis. They didn't even know that there was an organization or a nation. No, it is there, as in there were Métis people or a Métis Nation that there could be a membership."* But, they know now.

Impact on The Community

Not everyone was *positive* about the project (anywhere from less than 10% to 50%). Those that were positive were Métis involved with the Local, students, people who have an appreciation for history, many of the Métis Elders, those with a broad world view and those who have left Willow Bunch and experienced other environments and 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 . . . . 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*

Others who showed *enthusiasm* included the mayor, librarian, nuns at the rectory, kinsmen club and the local principal. The Local is also gaining ground with the museum board who have resisted changes to the existing displays. The less enthusiastic (estimated at 10-50%) were older, more closed minded, felt threatened by an accurate history, changing of school language laws and resented economic development funding for the Métis.

> *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.*

Many activities were possible over the past year that have never been done before: 10-12 workshops were open to the general public; 8-10 Métis cultural activities were sponsored; the Local worked within the school; other Métis organizations visit the community; newspaper articles and reports on Métis were published; and interviews regarding history were held. Most communication has occurred mainly through open discussion with animated displays of Métis culture. These seemed to work well, albeit limited to a smaller audience. The team believes that Métis history and culture, rich with life and colour, is better related through demonstration. 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:

- Local 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;
- recognizing Métis contributions in a positive, non-threatening way;
- having a physical presence in the community (e.g., the building);
- having articles about the Métis for distribution; and
- the Saskatchewan government's education policy that encourages Aboriginal history to be incorporated into school curriculum.

Increased community involvement and curiosity in Métis culture (especially among youth), an informal agreement made between the historic village committee and the project,[139] and increased hiring of Métis all suggest that something is happening. 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, open discussion about Métis issues and the steadfast enthusiasm, congenial approach and firm vision of the project team.

To determine how much knowledge the community has on the Métis, respondents were asked what it means to be Métis. 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; and*
- *I don't really know. As far as I'm concerned I'm a Canadian, Canadian-Métis. . . . 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 . . . . it hasn't changed me at all but I'm glad to see the way things are going.*

[139] It should be noted that this agreement was done as a draft letter, but was never formalized.

Although there was some disagreement about the extent of change, respondents did believe that some non-Métis people have better knowledge of *accurate* Métis history. Respondents credited a variety of actions and conditions for this noted change including:

- 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, which are focused upon reconciliation (not blame), most particularly, a Métis dine and dance where about 150-300 attended
- the existence of the Métis Local facility, as well as their increased participation with Métis Nation Saskatchewan affiliates.

Overall, respondents believe 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 . . . . I think most of the history of this area has come from a euro-centric perspective up until the healing project.*

Establishing Partnerships and Sustainability

No *formal* partnerships have been established and sustainability is at risk. Still, *informal* partners are plenty and include the local leadership, school staff, kinsmen club, parks and recreation department, postmaster, town council and rural municipality whose support was considered helpful and earnest. However, trust issues are still an undercurrent in the relationship between the Métis and others in the community. Some suspect that other overly enthusiastic "partners" may be clamouring for Métis-specific funding without any intent of sharing power with the Métis. External linkages have also been established with the Métis Addictions Council of Saskatchewan Inc. (MACSI), the Gabriel Dumont Institute (GDI) of Native Studies and Applied Research and the Métis Nation of Saskatchewan (MNS). AHF is the Local's only funding source: they will be looking at Heritage Canada, Gabriel Dumont Institute and the Clarence Campeau Development Fund for future funding.

Accountability

One team member believed that the Métis leadership is constantly monitoring and evaluating activities. Even though the project stated they were using feedback forms to evaluate and monitor,[140] 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 workplan for year two of the project, constant informal communication with the school, museum, historical committee and other Métis institutions, as well as press releases, public announcements and live interviews.

[140] AHF Project Monitoring Report, 4th quarter.

Addressing the Need

By examining the loss, reclaiming Métis identity, documenting an accurate history and using this information to re-educate the community, the project has set a foundation for an improved relationship not only with others, but also within the Métis community.

Successes and Best Practices

Open communication and cultural celebrations that provide opportunity to taste, see and hear Métis food, song and dance have been very well received. Involvement of local agencies in project activities has improved trust and relationships. Linking with other Métis organizations has increased access to information. Having a constant physical presence (flying the Métis flag and showcasing the Red River cart), a voice in the community and cultural activities at the school were all considered best practices.

Challenges

The project identified difficulty dealing with some Métis Elders who were reluctant to relate their experiences. Some relations in the community are strained, especially with the older set who continue to show dominance and hostility, but with a sense of complete normality. Changing such attitudes will take more than two years. The project also had difficulty convincing people that it is trying to *improve* community relations.[141]

Lessons Learned

More time is needed to interview older Métis. The guilt and denial they feel about their heritage required that they first develop trust and comfort. New resources for Métis initiatives are causing some resentment by those feeling left out of the resource loop. Creative ways of working together in shared celebration of the community history and culture may overcome these sentiments. Targeting efforts at youth who are more open may be the best use of resources. The tenacity of those who are threatened by a new social order where Métis value is recognized was unanticipated and under-estimated. Changing their minds will be a longstanding endeavour.

Conclusions

Although the project's first year plan was to complete an accurate historical account of the Métis of Willow Bunch, only one quarter of the book was complete. However, work with the museum committee to improve the Métis displays is well underway. While the extent and magnitude of change is not entirely clear, "something" beyond physical changes, is apparent in Willow Bunch. Métis identification is on the rise. More Métis people attend Local meetings and the broader community is more involved in the celebration of Métis history and culture, *especially* the school.

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[141] Project response to the AHF National Process Evaluation Survey, 2001.

Contributing factors include:

- community desire to learn;
- influence of provincial education policy and enthusiastic partnership with school leadership;
- legislative changes that benefit the Métis (e.g., economic development and education funding);
- open and friendly cultural events;
- physical presence (e.g., Métis flag, Red River cart display, cultural events, Métis Local facility is evident, all *for the first time*);
- participation from and support of other Métis organizations;
- workshops, use of media; and
- the project team's non-threatening approach.

Nonetheless, there is a community element who are resistant (estimated at 10-50%) this element is composed of those who benefited from the historical social hierarchy, have never left the community and are threatened by changes to school language laws (English rather than French is the primary language of instruction in Saskatchewan schools). Also, some older Métis are still reluctant to share their stories.

Recommendations

The following recommendations are suggestions to enhance administration and evaluation of the program. Program recommendations include:

- increase information on Métis (open discussion and *written materials*); continue celebration 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 include:

- develop a participant feedback form to guide improvements; and
- develop and conduct a community survey to determine extent of Métis knowledge and rate of racial discrimination.

Kikinahk Friendship Centre: Kikinahk Parenting Program (AHF Project # RB-67-SK)

Project Description

This case study examines the Kikinahk Parenting Program (KPP) in a rural community, which combines western and traditional approaches. 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. KPP hopes to accomplish this goal via a parenting skills program where a blend of traditional parenting models, together with opportunities to learn modern expectations of parents are offered. KPP combined an informal, voluntary, "drop-in" approach with more active recruitment. It seemed that encouraging people via word-of-mouth was the most effective way of enlisting participation. One-on-one counselling, weekly scheduled support groups, conferences, family evenings and special events with Elders (camping, harvesting traditional foods, sharing traditional knowledge) were some of the activities undertaken by KPP.

KPP is being delivered by the Kikinahk Friendship Centre (KFC) in La Ronge, Saskatchewan, a rural area with a population of about 7,000. It is closely linked to a variety of other programs within the Friendship Centre and the community such as the Lac La Ronge Indian Band, local women's shelter, social services, mediation and diversion program, young parent program, head start, outreach, child care co-op, youth service, recreation and prenatal nutrition. Perhaps the closest working relationship is with the Piwapan Women's Shelter, who have a similar program for parents.

Target Groups: The project targets Survivors, whether they are First Nation, Métis, gay/lesbian, disabled, men, women, youth or Elders, who are living in La Ronge, Saskatchewan and surrounding area.

Funding: KPP's budget this year was $186,190.

Outcomes and Measures

The following performance map identifies activities, desired outcomes and performance measures used in this case study.

Kikinahk Parenting Program Performance Map

MISSION: To strengthen the family bonds of Survivors and those intergenerationally impacted by residential schools, so that First Nations/Métis families in La Ronge and surrounding area can enjoy a happy and functional family life.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources/Activities/Outputs	**Reach**	**Results**	
		short-term outcomes	**long-term outcomes**
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, support group meetings, evening activities (e.g., supper, dance), traditional activities (e.g., camping, harvesting traditional foods), conferences, culture week activities, group activities, parenting weekend in the bush and neck bone and bannock supper with the Elders.	Residential school Survivors and those who have been affected intergenerationally, whether they are First Nation, Métis, gay/lesbian, disabled, men, women, youth or Elders living in La Ronge and surrounding area.	Increase involvement of parents and teens in community activities, improved communication and attachment between Survivors and their offspring, reduced abuse, increase awareness of family issues, increase awareness of issues for community to better support and understand the legacy of residential school resulting in reduced denial of the problem.	Confident and responsible parents raising children in non-violent homes and protecting their children from abuse and ongoing healing process and increased awareness of issues related to the Legacy.

How will we know we made a difference?		**What changes will we see?**	**How much change has 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, individual service demand for healing and community demand for education on the Legacy.	Reduced rates of abuse, family violence, children in care, child/teen suicide and evidence of change in community support systems for Survivors and their families.

Project Team and Participants

The KPP team consisted of a finance officer, project coordinator, Elder grandparent team and part-time bus driver. 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 of traditional parenting were highly regarded, well skilled and tirelessly motivated.

Most participants were First Nations (both on and off-reserve) and intergenerationally impacted young, single parents. These were mainly women from ages 20-40 years, who accessed the program by dropping in or were referred by Mental Health Services or the Piwapan Women's Shelter. Forty individuals participated on a regular basis in all or most of the events sponsored by KPP, but more

than one hundred individuals have participated in at least one group event associated with healing (e.g., family evenings, conferences, feasts, sharing with Elders). 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. Women had out-numbered men at this event with a ratio of four to one.

Context

KPP operates mainly in the gym at the Friendship Centre, but the Elder grandparents have their own office where they meet with participants one-on-one or where they teach traditional activities. Boardrooms are used for day or evening activities and a family room is used where parents can bring their children and still be involved with the program (babysitters are provided so that parents could actively attend). Sometimes, traditional activities are organized off site at an island cabin.

The town of La Ronge sits on the western shore of Lac La Ronge in northern Saskatchewan and is really a combination of three communities: the town, Air Ronge and the Lac La Ronge Indian Band. Acculturation has been swift, pervasive and accompanied by some stressful social dynamics that include racism and a class structure based upon a cash economy. There is also a pronounced tension between Euro-Christian followers and those who practice traditional Aboriginal spirituality. According to responses to the National Process Evaluation Survey (NPES), KPP team members recognize the following community challenges to be severe (e.g., affecting 80% or more of the population): poor local economic conditions, substance abuse, fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE), as well as family violence. La Ronge and surrounding Aboriginal communities are also plagued by housing shortages. In some cases, they are 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 (< 25 years) who may have been thrown out or who have left due to violence in the home. It was clear that the solid majority (71%) of mental health clients were First Nation and many (41%) were youth (13-18 years old). The most common problems, in order of frequency, were related to: relationships, suicidal ideation, depression, anxiety and behavioural problems. Finally, of all assault charges laid, many were of a sexual nature and *an alarming proportion of sexual assault charges involve youth and children as victims!*

This case study will evaluate changes in the individual participant and in the community. More specifically, the evaluation questions were:

- Was the KPP effective at teaching traditional and current parenting skills?
- Did the community's awareness and understanding of the Legacy change?

Interviews were prepared to secure perceptions regarding change on a variety of short-term indicators. Actual interviews were conducted by one AHF team member and most of the agencies in La Ronge that serviced Aboriginal people were interviewed or contacted.

Impact on Individuals

From the KPP team's perspective, participant characteristics certainly changed over time. Initially, only women were coming to the program. Eventually, they brought their husbands and teenagers. In fact, the level of participation surprised the KPP team. *"There are fathers who, for the first time in their lives, are having an emotional family outing with their sons."*[142] Parents became increasingly comfortable to share insights and ask questions. Some even 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 to do things *with* their teens when before they could not. One respondent noted that mothers who have participated in KPP are not accessing services as often as those who have not been to the program. Respondents saw greater enthusiasm and motivation was evidenced by increased teen participation in activities and knowledge of traditional practices. A few were thinking about going back to school and some have decided to stay in school.

From the periphery, success was not always clear. While some did note that at least a few have "straightened out" their lives by getting jobs, going back to school and improving their relationships, not everyone heard evidence about parents sobering up, upgrading skills or getting their children back. In short, a respondent was quick to clarify that while dramatic change was observed in some participants, there were *"absolutely no changes"* in others. Also, it was not clear to what extent any changes endured beyond the life of the project.

Impact on Community

There was a clear difference in opinion about whether or not KPP was able to facilitate an increased understanding of the Legacy. While some argue that many are still in denial, others notice an increased willingness to discuss the Legacy, albeit superficially. 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 represented a *distinct environmental difference from even just five years* ago. Also, age appeared to play a role with those in the 40-50 years old age category who appear much more willing to talk about the Legacy than those who were older.

There was 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 KPP, there was a serious lack of participation. However, other respondents indicated that the number of drop-in visitors and telephone inquiries about KPP activities increased over time. In fact, one team member recounted that community members *would not wait* to receive information about scheduled traditional activities sponsored by KPP, but *actively sought* information. Engaging in harvesting and preparing traditional foods, especially caribou hunting and smoking fish, brought participants back to a *fond* time in their childhood. This created an obvious and eager anticipation in the community.

With respect to any changes over time in board-selected social indicators, one key informant noted that rates of domestic violence remain high and victims, including children, have been threatened

[142] AHF Project Monitoring Second Quarterly Report, 2000, Objective # 2.

after their disclosure. Key informants were also clear that primary (directly abused) and secondary (witness to the abuse) sexual abuse victims were getting younger. Rates continue to be high and silence ensures maintenance of the status quo. While some respondents felt that sexual abuse issues were adequately addressed by KPP's awareness campaign, they were not convinced that such abuse was adequately linked to residential school, nor were they completely satisfied that KPP was able to deal with sexual abuse issues in a *clinical* capacity. Again, there was a noted inconsistency in opinion regarding whether or not rates of children in care have changed. Some feel the rates have increased and have observed that the community's ability to accommodate these children has been saturated. At last, while respondents believe that the community is in a better position to intervene earlier, most did not believe that suicide rates have changed from what is an unacceptably high rate. *"In Stanley Mission, there were 125 attempts in one year out of 1,200 population."*

About half of all respondents felt that KPP 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 the Legacy was addressed well did so because they saw an increase in willingness to seek information and, ultimately, help. Other respondents felt that there was a misunderstanding about what KPP had to offer. In other words, not everyone in the community was entirely clear that KPP was a *healing* program and not a child and family service organization or a class action suit.

Accountability to the Community

Although the majority (80%) felt that KPP 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. School officials felt that they should have had a formal opportunity to provide feedback. KPP's steering committee did not meet due to the fact that most members were professional people whose schedules conflicted with their involvement.

Outside of project files, records of participation and AHF reports, it was not clear how KPP was evaluated, if at all. There was no evidence that KPP was able to follow through with its evaluation plan. In fact, in many of the reports submitted to the Foundation, it was clear that KPP administrators confused means with ends. In other words, most responses to questions about expected outcomes (e.g., changes in participants) focused almost exclusively on the attainment of implementation objectives (e.g., project participation).

Explaining Results

It's clear that parenting education and traditional activities, facilitated by skilled Elders who have long-thirsted after the opportunity to right the wrongs of residential schools, set a solid footing for those who are eager to end the Legacy's impact on their lives. While KPP could not reach everyone in need or have an impact on all those who participated, the information suggests that at least an immediate, if even 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. What is not clear is whether or not the desired change has had a *lasting* impact on KPP 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 on:

- participant characteristics, particularly what is it about those for whom the program works and does not work?
- do any differences endure six months, a year or two years later? and
- what are the current rates of physical and sexual abuse, children in care, suicide and incarceration for the target group?

The Elder grandparents who facilitated KPP during its first year of operation won widespread allegiance, as evidenced by some participants who dropped 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 KPP had an impact. Group dynamics and Legacy education also won credit as powerful change makers. As 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, but just parents lacking skill and support.

Change was also commonly attributed to participant motivation or a "readiness" for change. KPP teaches relationship skills, which 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."* Focussing on communication skills, "quality" time with loved ones, home visits and the power of effective role models were important program elements contributing to change. Finally, but perhaps most importantly, participants felt respect from the team, which facilitated a climate of trust. For young people, feeling heard and understood, as well as establishing friendships among their peers, made KPP a pleasant place to be.

There were a myriad of explanations for those families and individuals who did not experience life altering changes as a result of their participation in KPP. 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, support programs, personal challenges related to addictions, literacy and poverty, as well as racism and classism may also play a role.

Partnerships and Sustainability

KPP worked closely with other programs of the Friendship Centre, as well as local institutions and resource people. However, respondents were almost unanimous in their opinion that KPP could not sustain activity beyond the life of the AHF.

Addressing the Need

It was clear that the majority of participants at KPP were young, single mothers and that community wide education on the Legacy was met with sparked enthusiasm. As a non-mandated, culturally relevant program, with access to Cree Elders and traditional parenting skills education, KPP was also filling a service gap. Still, respondents felt that the need exceeded KPP resources and

that partnerships might have worked well to achieve greater results. Furthermore, there is evidence that denial *persists* in La Ronge. Eighty percent of all respondents felt there was room for improvement in KPP's ability to target those in greatest need.

Successes and Best Practices

The presence, experience and character of the Cree grandparents were consistently credited with any positive changes 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" was credited with opening dialogue about painful social issues. Establishing working relationships with complementary services and keeping team members well were also considered best practices. The project's location, leadership and community support also helped to create conditions where change was possible. Strong administration, a few dedicated team members, adequate training and education, as well as a *vision* for the long haul was clear.

Challenges

Kikinahk faces the following day-to-day challenges:

· inadequate services to meet demand;
· lack of community involvement and soliciting program participation particularly for youth;
· "drop-in" nature may have been viewed as a babysitting service;
· limited resources spelled limited results;
· the board was opposed to the use of traditional spiritual practices;
· high staff turnover;
· lack of expertise and support for evaluation;
· lack of transportation to off-site events; and
· lack of paternal commitment.

Poverty and lack of parenting skills were severe challenges (affecting 80% or more of participants). Lack of Survivor involvement, denial, fear, grief, history of abuse as a victim or in foster care, family drug or alcohol addictions, lack of literacy and communication skills were considered moderate challenges (affecting 40-80% of participants).

Denial was also a barrier to progress, which respondents believed could be resolved by increased Survivor involvement in program planning. More involvement from parents of youth would also facilitate KPP'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 KPP, which was also considered very low.

Lessons Learned

In point form, some of the lessons learned by the KPP team include the following:

- find the *right* people for the job;
- exhaustive criminal record checks are ***absolutely essential***;
- avoid creating service dependency;
- you can't tell Elders what to do;
- guard against team burn-out;
- traditional feasts and teen dances are popular social gatherings;
- more rigorous screening of professional credentials and abilities;
- bringing tough issues out in the open could 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;
- anticipate and quash efforts by lawyers to secure Survivors' names as a way of boosting participation in class action suits; and
- focus the reach.

Conclusions

Was KPP able to make parents feel more comfortable about their role and send them off with new skills? Well, for some participants, that was the case. For others more resistant to change, a different approach may be required. KPP appealed more to women than men and, while it did spark an interest in Legacy education and increased community understanding of the impact, a wall of denial and silence persisted. Several important ingredients have been credited with the progress that KPP was able to achieve and that included:

- 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; as well as
- a community and program climate, which placed individual struggles within the context of a social injustice.

But, like any healing process, the development of parenting skill takes time. It may require years of investment before KPP could create lasting healing from the Legacy in the La Ronge area.

There was was clear difference between those who were ready to face and heal from the Legacy and those who were 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, and not just in a community context. We know Legacy education works well in this regard, but it could also work well on an individual basis. It has been repeatedly demonstrated that inviting and attracting women to participate can act as a catalyst within the family. However, unique strategies are needed for men who are consistently and significantly under-represented in healing programs.

Recommendations

The program delivery recommendations are classified under three major headings: team building, project delivery and evaluation issues.

Team Building Issues

- Select steering committee members who *commit* to the life of the project;
- hire dedicated teams with education and skills that are in for the long haul; and
- consult Survivors in the hiring and program development processes.

Project Delivery Issues

- Have ***vision*** - emphasize continued services (e.g., 10-25 years);
- get local schools involved in Legacy education;
- refer serious issues to the appropriate agencies upon disclosure;
- focus on target groups;
- build capacity and human resources; and
- break down the barriers of denial and enlist the participation of men in healing programs.

Evaluation Issues

- Use client satisfaction questionnaires and formal evaluation;
- be clear about the distinction between activities and outcomes;
- direct assessment is best. Enlist projects and help them to get and use tools or information to determine changes in project participants and community. Samples of measures used to assess consumer satisfaction, parenting skills, healing from sexual abuse, self-esteem, employability and other dimensions of change required by projects be secured and available for project use. Structure the evaluation so that project teams can collect the raw data which can be analysed externally;
- increase efforts to explore rival explanations;
- profile those for whom the program seemed to work. 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? and
- make adherence to the evaluation plan as stated in the proposal a condition for funding, as well as for long-term follow up.

Nelson House Medicine Lodge:
Pisimweyapiy Counselling Centre (AHF Project # CT-373 MB)

Project Description

The Pisimweyapiy Counselling Centre[143] (AHF Project # CT-373 MB) 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."*[144] The objectives outlined in the project's brochure are:

- provide a safe, structured, nurturing environment for *direct therapeutic support* and strengthen the *network of local support*;
- develop resource material that covers the therapeutic process, client management and work schedules;
- foster and strengthen communication and relationship skills;
- maximize pride, self-responsibility and acceptance; and
- reduce the number of deaths, family destruction and cultural genocide resulting from the Legacy.

The Pisimweyapiy Counselling Centre (PCC) is purposefully designed and structured to operate as an out-patient community-based therapeutic program. Methods and activities include:

- case management: assessment and treatment planning, individual and family therapy, after-care planning and follow-up;
- men and women's healing circles, self-help groups, workshops (e.g., sexual abuse, parenting, family, residential school syndrome, suicide intervention and post vention, communication skills, anger management, grieving and loss);
- traditional teachings and ceremonies;
- field trips to residential schools and to pick medicines;
- regular physical exercises and nutrition; and
- home visits to conduct family sessions.

The Pisimweyapiy Counselling Centre is situated on the Nisichawayasihk Cree Nation and operates out of a house trailer on the grounds of the Nelson House Medicine Lodge (NHML). While the trailer is conveniently located, lack of space and privacy are concerns (e.g., walls are not soundproof and participants are grouped too close together).

Target Groups: The target group includes all local Aboriginal (Métis, Inuit, First Nation, on or off reserve) adults, youth and families affected by residential schools in the area.

Funding: Pisimweyapiy Counselling Centre is an addition to the existing services of the

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[143] This case study covers the following project type and targets: First Nations, rural/remote, west, healing circles, traditional activities and professional training courses.

[144] NHML project proposal for funding to the AHF, February 2000.

NHML 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 focus of this case study.

The Project Team

The executive director serves as a working group member of the Treatment Centre, holds a Masters degree in Social Work and has experience as a senior counsellor. The 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. One is a trained social worker with fifteen years of experience in counselling and corrections dealing with First Nations people. Another is a Survivor with an Applied Counsellor Certificate who has worked as a counsellor at the Medicine Lodge. The third therapist is a Survivor certified in Community Social Development, as a community education facilitator, radio broadcaster and life skills coach and has extensive experience working with older and young adults both in the education field and social services. Elders are in constant use by the project. One member of the board of directors is a respected community Elder and Survivor. Staff training included computer skills, supervision/management, time management, therapeutic change and development, as well as working with families and couples.

Participant Characteristics

The most significant challenges facing the participant group included physical abuse, which affects virtually all participants, and alcohol abuse (90%). Most (>60%) are also dealing with a history of sexual abuse, family violence, criminality and lack of basic life skills. While there is roughly an even distribution between the sexes, women still outnumber men and the bulk of participants are in the 25-45 year age category. Almost all are First Nations on reserve and a large percentage (85%) are intergenerationally impacted.

Community and Regional Context

Nisichawayasihk Cree Nation (NCN), is located on the northern shore of Footprint Lake west of Thompson and northeast of The Pas in northern Manitoba. Hunting, trapping and fishing form the economic base of the community and traditional sharing of wealth is still practiced through harvest donations to community Elders. Local businesses include the trappers' association, forest industries, air service, housing development, department and food stores, as well as a convenience store/gas station. Also, there are local taxi and bus services and a day care. The community development corporation owns and operates a motor hotel and tavern, both located in Thompson. Local facilities and services include a band office, a community hall, a recreation building, a pool hall, a nursing station, policing and a school (grades K-12). Most houses have water and sewage, some have cisterns and trucked septic service and three have no plumbing or sewage services. Health programming in the community includes the Nelson House Medicine Lodge (an alcohol and drug treatment facility) and a variety of integrated health services.

Although NCN is covered by the provisions of the Northern Flood Agreement, hydro development has caused significant disruption to traditional Cree harvesting, homelands and, consequently, social and familial well-being. While little was obtained on social indicators, what was clear is that all

physical assault and domestic abuse *in the community*, as well as most crimes committed *in Thompson*, is associated with substance abuse and children (8-12 years) who are abusing. Still, the community is described by outsiders as one with initiative, that it is organized and advanced, with a variety of measures to minimize crime and deal with social problems. Although there have been no suicides for a long time, there are fatal accidents, usually alcohol related, that may be questionable. Also, the director of child and family services reported sixty-two family cases that were open and involved 229 children. Of the 2,058 residents living on the reserve, it was estimated that 242 are residential school Survivors (not counting those affected intergenerationally).

Outcomes and Measures

PCC has undertaken to develop a network of support by providing individual, group and family therapeutic services (one-on-one sessions, healing circles that are gender and age specific, self-help groups, home visits, field trips, after-care and continuing care). They have introduced and practiced 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. The desired short-term results included:

- 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 accidental death and suicide rates, rate of family destruction and reverse cultural genocide.

A long-term outcome is for participants and their families to 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 how to live independently and have found their spirit. The following "performance map" provides a bird's eye view of the project's mission, resources, target, objectives and goals and highlights what sources of information will be used to note change.

Nelson House Medicine Lodge Performance Map

MISSION: Enhancing and empowering the personal and social functioning of students of residential schools and their families, thereby contributing to the overall health and wellness of our community.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources/Activities/Outputs	**Reach**	**Results**	
		short-term outcomes	**long-term outcomes**
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, after and continuing care, introduce and practice new and healthier ways of life, individual and group/family therapy, self-help and community beautification.	Survivors, family and community members and intergenerationally impacted in Manitoba.	Overcome/reduce denial sufficiently to have the program operate to capacity; increase transformation of childhood trauma to healing and empowerment; decrease participation in unhealthy survival patterns; improve family functioning; increase life empowering behaviours; initiate healing; reduce unhealthy coping; and expand self-reclaimed network of Survivors healing.	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.
Staff training and professional care.	Community staff and leaders.	Increase capacity to deal with the Legacy; increase knowledge and understanding of the Legacy; and increase access and participation in expanding network of support which is familiar with and capable of responding to those suffering from the Legacy.	

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**
$464,526 one year only	# of participants from within community (3 intakes per year)	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; and observed and self-reported changes in coping skills and transformation of childhood trauma.	Rates of suicide and attempted suicide, dependency on welfare, homelessness, substance abuse as measured by alcohol or drug-related criminal offences and participation in treatment.
Training budget?	# of trainees	Observed and self-reported changes in understanding and capacity to deal with the Legacy and feedback from referral agencies regarding changes in access to services skilled to aid and appropriate for Survivors.	

Impact on Individuals

There was disagreement about the extent and magnitude of change in coping patterns. Evidence of change included some participants who appeared better able to maintain sobriety, seek employment, disclose past trauma, be out-going, seek spiritual fulfilment and recruit others to participate. Participants shared that they felt increasingly comfortable over the duration of the program. Counsellors who were non-judgmental, sincere, trustworthy, gentle, respectful, committed and culturally sensitive clearly facilitated healing. Equally important was a combination of group lectures, one-to-one counselling and a *safe* environment.

All respondents felt that there was a moderate change in understanding of the Legacy among participants. However, they were in stark disagreement about how many participants have experienced this change. One felt strongly that it may be too early to expect major changes in understanding while others noticed an increased openness when discussing the Legacy. Change was facilitated by leadership support, Survivor participation and emphasis on Legacy education. The team agreed that participants left with enhanced self-esteem, even if they did not agree about the magnitude of change or the percentage of participants who experienced this outcome. Behavioural evidence that was cited included changed facial expressions from sadness to peace, securing gainful employment and comfortable displays of physical affection. Again, they credited Legacy education, framing therapy in the context of Cree culture, focussing on responsibility and *choice*, as well as emphasizing self-trust for the observed changes. The team also believed that training helped them to skilfully address the Legacy and help Survivors.

While no agreement was clear about how many experienced increased cultural pride or the degree of that change within individual participants, the team was sure that some change was obvious. The majority of participants were clearly excited about culture teachings and eager to learn more, but some were resistant. PCC felt that their program, together with reinforcement from the Medicine Lodge, was responsible for such change and believed that group dynamics strengthened the impact. When questioned about participant risk for physical abuse, sexual abuse, provincial wardship and suicide, the team concurred that risk for physical abuse and suicide may have decreased but were not sure about sexual abuse and provincial wardship because of the extent of community denial. Although there were no suicides in the community since the program began, they felt it was still too soon to see a difference in sexual abuse and children in care.

The majority of participants (11 of 19) 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 of their needs. The majority of participants (15) were very satisfied and the remainder were mostly satisfied with the service. Very few had suggestions to offer. Those who did make suggestions, offered the following:

· have a larger meeting room;
· improve attendance by mandated participants;

- include more women's groups and cultural teachings;
- offer home visits in addition to centre-based therapy as a form of after-care;
- offer smaller workshops on addictions; and
- increase counselling sessions to a duration of four or five hours.

The majority of participants had an overwhelming amount of positive praise for program content and the project team. Their voice is captured below:

- *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 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 . . . . 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 got so much out of it. I realize my problems areas . . . . I especially enjoyed the trip to my former residential school. It has brought some closure to some sad and bad memories over there . . . . I will continue to seek counselling after this program.*
- *Only wish that my two sisters would come. Encourage mother to speak to them to come, it is terrific program!!*

Impact on Community

Sixty-seven of a possible seventy-five participants were engaged and nineteen graduated from the program, representing an 89% participation rate and a 28% completion rate. Each successive intake showed increasing enrollment so that by the fourth intake, they exceeded capacity and had outgrown their trailer. Usually, intake is fifteen participants and the fourth intake accommodated 20. Eventually, *participants engaged without being referred*. Their only obstacle appeared to be getting family members involved in phase two of the therapeutic programming; however, over the lifespan of the project, an increasing number of couples started coming to PCC. They credited positive changes to the partnerships and networks established locally, the confidential setting, peaked community curiosity, team skills, project visibility and the example set by recent graduates/ participants. 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.

To create a network of support, PCC formed self-help groups, enlisted Elders to make themselves available and contracted therapists. Mandated referrals were being made to PCC, but roughly eighty percent of those mandated did not complete the program. Also, the residential school advisory group, Survivors' committee and the board of the Nelson House Medicine Lodge provide support to the PCC team. The team and community informants held different opinions about the extent of change in the community's understanding of the Legacy. There was an acknowledgement that denial is not completely dismantled; however, when change was clear, it included increased anticipation of monthly newsletters, open discussion and clarity that PCC is a *healing* (not compensatory) effort. The rate of disclosures have also precipitated fundamental and structural acknowledgment 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 from the Legacy;
- efforts of the PCC (e.g., conferences, field trips to residential schools, public relation campaigns);
- PCC team members who are skilled Survivors able to inspire healing and make others feel safe; and
- Elder involvement.

One of the spin-offs is the Residential school Survivors from the community and other organizations around Thompson had successfully hosted a five-day conference at Troy Lake. Another conference was planned for March 2002 for care-givers who work with Survivors. They also planned for another summer conference in 2002.

PCC got high marks for its accountability to the community. The solid majority felt the project needed little or no improvement in this regard. Accountability is fulfilled through local radio, community presentations, monthly newsletters and residential school advisory committee meetings, as well as posted program activity schedules. About half of the respondents felt that the PCC was addressing the Legacy very well, requiring little or no improvement. Some felt that the program could better address the Legacy and a small percentage felt that PCC was struggling in this regard.

Partnerships and Sustainability

Working relationships have been formed with the local native media, regional Survivors' programs, leadership, the Métis community, a local college and a variety of human services. However, the PCC did not receive any other funding. Possible funding sources include interest from the 4.5 million dollars from hydro, fundraising, outreach to other communities, charging a fee for services, integration with another program, government assistance or forming partnerships with other programs. There is concern about program sustainability.

Successes and Best Practices

Success of the program had been credited to a team that was well respected, non-judgmental, respectful, committed and culturally sensitive who are community members and are also *Survivors* with skills. Supportive leadership, community partners and participants who genuinely want personal transformation set 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 and anger management, worked well. Some respondents felt that the combination of group lectures, one-to-one counselling and a *safe* environment created conditions for change. Specific activities that are planned to continue because of their resounding success are:

· healing/sharing circles (for unique groups);
· using Cree culture as medicine;
· bringing in presenters from the outside;
· networking and sharing with other programs and organizations;
· working with the Elders;
· field trips to residential schools brought closure for Survivors;
· continuing professional development;
· promoting services in and out of the community;
· soliciting participant feedback;
· Legacy education;
· light-hearted, fun activities; and
· scheduling evening and day sessions.

Challenges

The trailer eventually became too small and paper thin walls stressed one-on-one sessions. Pisimweyapiy Counselling Centre also needs an identity *separate* from the Medicine Lodge to eliminate a reluctance to participate due to fear of stigmatization as a substance abuser. Pressure to more actively engage in outreach efforts did not always win over the competing priority of supporting an ever-burgeoning participant group. Also, efforts to include family in the therapeutic process did not materialize as the team had hoped. Those who were mandated to participate came once or twice and then most (80%) dropped out. Finally, 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 relapse, but were not as fully developed as anticipated. Informants believed that more Legacy education and a higher PCC profile would help in this regard.

Addressing the Need

PCC has been so effective at addressing the need, the Health Services Division is considering adopting its approach and protocols. Respondents were evenly divided between believing that little or no improvement was needed (50%) and believing that some improvement would be beneficial (50%). Whole family therapy and outreach efforts to dysfunctional families were recommended. More generally, the proposal writing requirement of the Foundation has caused communities in greatest need, who do not have the human or financial resources, not to participate in such a screening process. It was suggested that AHF's efforts be more proactive, outreaching and supportive to those communities who suffer the most.

Lessons Learned

More community involvement in program development, through the use of "coffee nights," would be beneficial. Cree culture was better medicine than originally anticipated. Also, improved networking, especially among the directors of health services, would guarantee program complementarity.

Conclusions

Nineteen of sixty-seven participants have completed the program at PCC (28%), with clearly enthusiastic impressions about their healing experience. Contributing factors include:

- a safe, culturally sensitive, therapeutic process that combined group lectures with one-on-one counselling;
- accessible scheduling of services;
- 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 and readiness for healing; and
- Survivor involvement in program development.

The program was able to operate at almost full capacity (89%). Most of those mandated to attend dropped out and all have suffered from physical abuse. Ninety percent of these participants suffer from addiction and the majority (>60%) have experienced family violence, conflict with the law and lack basic life skills. Informants described a community climate of widespread poverty, addiction and family dysfunction. Phase two of the therapy program (when the family gets involved) did not go as well as planned, which probably had more to do with pervasive social problems than the skills or commitment of the team. Other events, which may have influenced the program's ability to achieve the magnitude of change it desired, included:

- clashes between Cree spirituality and Christianity;
- the socio-economic disruption caused by hydro flooding;
- low self-esteem; and
- widespread dependence upon social assistance.

More open discussion and different attitudes toward the Legacy, together with public acknowledgement of high profile perpetrators, suggest that the climate has changed. Recommended improvements included: a bigger facility with a distinct identity (separate from the NHML), enlisting partners in Legacy education, treating the individual in the context of family and *ensuring continuing care*. Outside forces that may have had a facilitative influence included: Cree systems of restorative justice, conditional sentencing and a regional resurgence of culture. Sustainability is in question.

Recommendations

Team Issues

- Select teams with *experience*, train them to address Survivors' unique needs;
- whenever possible, enlist recognized Survivors who have modeled a successful healing journey; and
- counsellors should be non-judgmental, culturally sensitive, respectful and make participants feel safe.

Project delivery

- Ensure that facilities are adequate/appropriate in size, structure and location with an identity distinct from other services;
- ensure after-care with home visits and centre-based out-patient therapy;
- increase time available for counselling;
- assess special needs, develop unique treatment plans or make appropriate referrals;
- learn differences between mandated and self-motivated;
- strategize how to support and engage mandated participants to complete the program;
- boost Legacy education and outreach efforts by enlisting community-based partners (schools, radio, television);
- include more women's groups and cultural teachings;
- encourage family participation with "family" night or family fun activities;
- maintain Elder involvement; and
- maintain evening and day sessions.

Evaluation issues

Referral, intake and follow up information could be adapted to include:

- **Personal information**: Age, sex, how referred, source of income, motivation level, personal healing goals (follow-up would rate the extent to which they were able to achieve their personal goals);
- **Family and living situation**: Marital status, stability of living situation, number of family members in the home and roles; child care arrangements; rating of family and other social support; the history, frequency and intensity of family problems (follow-up would focus on changes in any of these);
- **Legal status**: Current or pending charges, hearings, recognizance, probation, parole, conditional or temporary release;
- **Substance use**: Current use, ability to abstain while attending PCC;
- **Residential school history**: Survivor or intergenerationally impacted; perceived intensity of Legacy impact on language, culture, parenting, identity, family, relationship skills, mental health, addictions (other follow-up data collection efforts would assess the impact of the program on these areas); and
- **Treatment history**: Other treatment programs attended/completed and specify dates (follow-up would include other programs attended since participating in PCC).

Centre for Indigenous Sovereignty: I da wa da di
(AHF Project # RB -268- ON)

Project Description

I da wa da di (Mohawk for "We should all speak") provides a range of traditional services to Aboriginal women who have suffered the Legacy of Sexual and Physical Abuse in Residential Schools, Including Intergenerational Impacts. Activities included: healing circles, fasting retreats and healing retreats; training workshops for women who work with Survivors; and an annual gathering for one hundred women Survivors, counsellors and healers. The retreats and circles are held at the beautiful Earth Healing Herb Gardens & Retreat Centre on the Six Nations reserve next door to Brantford, Ontario. The centre, which is neither incorporated nor run as a business, is a result of twenty years of dedication to healing on the part of the project coordinator. It is open to all Aboriginal woman who seek healing. The project is sponsored by the Centre for Indigenous Sovereignty (CFIS) as it *"seems to fall between the cracks of your [the Foundation's] applicant eligibility criteria."* [145]

This project has been meticulous in gathering feedback from participants through post-activity evaluations and the results are included in project reports submitted to the AHF. Other sources of information used in this case study include interviews with key informants and the project's response to the National Process Evaluation Survey (NPES).

Target Groups: The project targeted adult Aboriginal women in the province of Ontario.

Funding: The project received pilot year funding of $191,532 (1 December 1999 to 30 November 2000). 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 31 December 2001.

Project Team

The coordinator/healer is a well-reputed traditional Mohawk woman. She is an herbalist and Elder who worked as a traditional healer at health centres in Hamilton, Brantford and Toronto. She has taught at the University of Toronto, McMaster University, and Mohawk College (Brantford). She is the project's only full-time employee and there is one part-time employee (clerical). Approximately fifteen people helped in the preparation and delivery of the annual gathering. The volunteer services were estimated at fifteen hours per month covering administration, food preparation, maintenance, transportation and cultural/traditional activities.

Participant Characteristics

The project reached two hundred and twenty-three people from sixty-two First Nations and urban/rural communities in Ontario. Eight people were from another province or living outside of Canada. Participants were primarily women (97%); one quarter were Elders and 6.7% were youth.

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[145] Peters, Gordon (CFIS) (1999, March 30). Letter to the Aboriginal Healing Foundation.

Almost three-quarters (74.4%) identified as intergenerationally impacted, while 14.3% identified as Survivors and 11.2% were either not impacted or they did not know. In terms of Aboriginal status, 46.2% were First Nations on-reserve, 47.1% First Nations off-reserve, 3.6% Métis, 0.4% Inuit, 2.2% identified as non-status off-reserve and 0.4% were identified as "other".

Context

The Department of Indian and Northern Affairs reported 146,113 registered Indians, 127 First Nations and 207 reserves in Ontario as of December 1998. Nationally, Aboriginal women constituted 51% of the total Aboriginal population in 2000. The largest populated age group was between the ages of 5 to 29. The Ontario Native Women's Association web site reports the following four "Facts About Aboriginal Women:" there are 40,959 working age Aboriginal women in Ontario; its 1989 study, *Breaking Free*, found that eight of ten 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.[146]

The healing centre is located on Six Nations territory, ten miles southeast of Brantford in southwestern Ontario. The community is abundant in resources with numerous programs and services, as well as over 300 small businesses owned and operated by community members, five elementary schools, its own police service, fire and emergency medical services, newspaper and radio station.

Outcomes and Measures

The project's short-term outcomes focused 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 such things as the number of women seeking healing services and changes in participants' self-esteem, coping skills and knowledge of traditional teachings (see performance map).

[146] Ontario Native Women's Association. Retrieved from: http://www.onwa.org/index_body.htm

Centre for Indigenous Sovereignty: I da wa da di Performance Map

MISSION: Aboriginal women, the life givers and teachers of our society, will live in healthy relationships based on an intolerance of abuse, cultural pride and sobriety.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources/Activities/Outputs	**Reach**	**Results**	
		short-term outcomes	**long-term outcomes**
Begin the process of healing from the Legacy of Physical and Sexual Abuse in Residential Schools, Including 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.	Aboriginal women and Aboriginal women healers/helpers.	Increased coping skills, positive self-images, physical, mental, spiritual and emotional well-being; traditional healing environment for women to begin the process of healing from the Legacy; stabilize women in crisis; decreased isolation and increased networking among Aboriginal women involved in healing work; and increased traditional and cultural healing skills among Aboriginal women who work with Survivors of abuse.	Aboriginal women living healthy lifestyles free of physical and sexual violence; women will have a strong sense of community and identity and there will be more women fulfilling the traditional role in all areas of community living, leadership, etc.

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**
$ 191,532	223 Aboriginal women.	Self-reported and observed changes in self-esteem, self-image, coping skills, 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, fasts, gatherings); # of women in shelters; and self-reported knowledge of traditional teachings, ceremonies, etc. among community members.	Reduced rates of physical and sexual abuse/violence; reduced number of women incarcerated; reduced levels of children in care; reduced incidence of depression among women, as well as a reduction in suicide rates; increased number of women living healthy lifestyles and more involved in community leadership and decision making roles; and evidence of revitalized Aboriginal culture.

Influencing individuals and communities

All proposed activities were successfully completed; thus, the project has shown an ability to achieve its service delivery objectives.

Impact on Individuals

Post-activity evaluations and key informant interviews point 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 NPES states the project had *"some influence"* on empowering individual women participants. This was evidenced by the fact that some women 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."*

Increased Knowledge and Understanding of Residential School Impacts: The project's third quarterly report submitted to the AHF stated that thirty-one of thirty-four participants (91.2%), who completed evaluation forms after a training workshop, felt the information presented had increased their awareness and understanding of the impact of residential schools on Aboriginal people, families and communities. Moreover, thirty of the thirty-four respondents identified ways the workshop would help them in working with residential school Survivors and later generations. The comments suggest that participants' increased understanding will be passed on to clients and family members and that it will allow them to be more empathetic, supportive, compassionate, and non-judgmental in their work with clients.

Of the seventy people who filled out evaluation forms at the annual gathering,[147] fifty-three (75.7%) agreed that it helped them address residential school or intergenerational trauma. Many stated that this gathering gave them a feeling of empowerment that enabled them to seek help in dealing with these issues. Other responses focused on intended behavioural changes, such as becoming more attentive to their families, passing on cultural teachings, spending more time with Elders, and starting or continuing the healing journey. The following comment exemplifies how a combined knowledge of the 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."*

Increased Knowledge of Traditional Healing: When asked how they knew people were more knowledgeable of traditional healing practices than they were twelve months ago, seven of eight key informants stated that there was more discussion of traditional healing, people were attending more ceremonies and seeking out medicine and personal counselling.

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[147] Of the 120 participants, 20 were residential school Survivors, 75 identified themselves 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. I da wa da di Project, Awakening the Spirit Gathering, September 28, 29, 30th, 2000, Report of Participant Evaluations, page 4.

Increased Healing Skills: Participants spoke about concrete tools or skills that they gained as a result of their participation in the gathering. In fact, 90%, or sixty-three of seventy 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, the importance of sharing, self-evaluation tools and fasting. Evaluation summaries for one of the training workshops indicated that ten of eleven participants felt it had met their learning goals and expectations.

Evidence of Healing: Examples of observed behaviour change include more people attending ceremonies in the long-house and an increase in the number of women seeking personal counselling to further their healing. One woman shared that she had left an emotionally and psychologically abusive relationship/marriage of 20 some odd years. 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.

In addition to changes in their own lives, key informants observed changes in attitude and behaviour in the project participants. Most notable changes were in levels of self-confidence and self-worth. Other changes include developing a stronger sense of identity and pride, and a stronger commitment to personal wellness. Examples of attitudinal change provided by gathering participants include strengthening their own identity, feeling less alone and, for some, a shift in attitude to one of forgiveness towards a parent or an abuser. With respect to behavioural change, key informants reported that a couple of participants have returned to school to obtain a higher education; others have made movement in their careers, engaged in drumming and singing the traditional songs, are making their own traditional clothing, and have joined the healing movement by facilitating workshops in the community and sharing their own healing journeys.

Impact on Community

Key informants and participant evaluation reports suggest that women are feeling less isolated and more involved in community life. Key informants observed that women were 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.

Key informants in the community of Six Nations noted that there were more young people in mentorship with healers than in previous years. Also, comments were made that older people had been afraid of stepping out. Now, more Elders are taking an active role in the community and people are more readily able to make a commitment to the long house. Also, people have developed the ability to question what they do not think is right or what they do not understand.

Another person mentioned that women were more active in the community and that a number of external services (e.g., catering, small businesses) are managed by women. As well, there was an increase in the number of women who volunteer, such as programming for children and after school theater. It should be noted, however, that in the project's response to the NPES, 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.

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. Aboriginal men's roles, on the other hand, are remaining static or losing ground – especially in areas of high unemployment and where traditional economic activities are no longer practiced. Moreover, men tend to be less involved than women in healing projects.

Establishing partnerships and ensuring sustainability

The centre operated without financial assistance prior to AHF funding. It has been 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. The value of volunteer labour was estimated at $2,160.

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

Key informants were asked if the project would be able to operate when funding from the Foundation ends. A 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 was that the project will continue, but not to this extent. When asked what would improve the project, the response included more staff, more training, expanded facilities, and evaluation by resource people who help in the program delivery.

Meaningfully engaging Survivors (including the intergenerationally impacted)

The project has no board of directors or advisory committees and there are no formal mechanisms in place to engage Survivors (other than as participants). Data from the NPES revealed that thirty-two of two hundred and twenty-three participants were residential school Survivors and one hundred and sixty-six have been impacted intergenerationally. It is evident from the discussion of the project's impact on individuals that it is addressing the Legacy, including inter-generational impacts. Survivors and their descendants are involved at all levels of this traditional healing program.

Managing program enhancement

Very informative and extensive evaluation questionnaires were completed by participants at the end of each activity. The gathering generated seventy questionnaires, which represented 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 it assisted them in developing their program design. The evaluation 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 Foundation, 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.

Best Practices

It is clear that one of the project's best practices is the safe environment it has been able to create. Over 95% of those who responded to the Awakening the Spirit evaluation said they felt safe at the gathering.

Other best practices that were identified are outlined below:

- sharing stories enlightened participants that they were not alone and were connected by different things in many different ways. The majority of respondents (87.1%) felt that group sharing was supportive;
- the project did well in addressing The legacy. The focus on historical and contemporary impacts of the Legacy appeared to establish a constructive framework for healing and training activities; and
- the project's data collection and evaluation tools were outstanding. Informative and extensive evaluation questionnaires were completed by participants at the end of each activity.

The project identified the following best practices in the NPES: 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.

Challenges

One of the challenges this project faced was responding to the demand or need for its healing services – 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 limit as 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.

Another challenge noted by key informants was the need to work collaboratively, by developing a more structured network around participants. In fact, it was clear that efforts must be made in providing support to participants to continue their healing journey. Key informants were asked what other supports, other than the support received by the project, do people needed on their healing journey. They gave high importance to the extended family, immediate family and friends. Participants' comments 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 upon. 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, which is the reality of Aboriginal communities.

One potential challenge related to the ability of the project to sustain itself at current levels after funding from the AHF. 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 that, *"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 Foundation began funding its activities. There is a good possibility it will continue to operate after this particular source of funding ends.

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 gender they are. There are not enough women chiefs, although many women work behind the scenes.

One of the strengths of this project is the experience and skills of the coordinator/healer. However, one person can only lead so many workshop, training and healing sessions. This could limit the number of participants, but it also means that the project is dependent upon this one person. If the coordinator was no longer involved, could the objectives be transferable to another individual, group or centre? It should be noted that one of the project's goals was to increase traditional and cultural healing skills among Aboriginal women. In training sessions, skills were being passed on to women participants. Another goal is to build a network to increase the number of healers.

Ensuring accountability

Comprehensive evaluation questionnaires were completed by participants at the end of each activity. The evaluations were included in regular reports to the Foundation, as well as in reports to the community and participants.

Reaching those in greatest need

The healing programs are open to all Aboriginal women and the target area is the entire province. It was unclear, however, whether participation was hampered by the cost of travel or child care. On the other hand, *"Gathering the Spirit"* participants were from forty-four communities across Ontario. This suggested that information about the project was reaching Aboriginal communities and that a good number of people had the means to travel to the Six Nations reserve. The gathering aimed to attract one hundred participants and the actual attendance was one hundred and twenty.

This is a small project with one woman to lead the healing and training activities. There is enough evidence to conclude that the project was having a positive impact on participants, but further research would be required to determine if it was reaching those in greatest need.

Lessons Learned

The project coordinator 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.

Conclusions

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 Legacy of residential schools appeared to establish a constructive framework for healing and training activities.

This project used and promoted the tools found within Aboriginal traditional systems. Traditionalism is part of the need for Aboriginal people to form a strong identity. 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.

Recommendations

The project's tracking of participant feedback provides a solid basis for assessing its impact on participants. ***In terms of measuring longer 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.***

Odawa Native Friendship Centre: When Justice Heals (AHF Project # 1291-ON)

Project Description

The Aboriginal Peoples' Justice Committee (APJC) was established to provide alternatives to the mainstream justice system for Aboriginal people in the Ottawa region. Through healing and sentencing circles, the APJC hoped to help Aboriginal individuals caught in the justice system to reintegrate into the community. Activities of the project included meeting with mainstream justice officials, establishing separate support groups and healing circles for offenders and victims, and referring clients to needed services and treatment facilities. Overall, the project was intended to break the cycle of incarceration and involvement with the justice system and to establish positive life patterns and relationships with families.

Target Groups: The primary target group was Aboriginal people in the Ottawa region who are in conflict with the law.

Funding: The project was funded from 1 October 2000 to 30 September 2001 with a grant in the amount of $ 71,165. It operated without funds both before AHF funding (beginning in 1997) and afterwards.

Project Team

The project team, as identified in the application for funding, consisted of ten 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 representatives from the justice system, while the Aboriginal volunteers were representatives from Aboriginal support organizations and the education sector. Individual volunteers fluctuated over time. At one point, non-Aboriginal members outnumbered the Aboriginal members. The National Process Evaluation Survey (NPES) estimated over 100 hours per month of volunteer time.

The APJC team consisted of two co-chairs (one male and one female), a circle keeper and the circle volunteers. One coordinator was employed with the funding received from the Foundation, although there was a time lapse of approximately seven months before the coordinator's position was filled.

Training workshops for the APJC members were to be offered during the course of the project. The project recognized the need for training, especially for the circle keeper and conflict mediation. While this training was not provided, Aboriginal Legal Services of Toronto conducted a general training workshop. The NPES reported that basic and advanced training was needed in the areas of crisis intervention, trauma awareness, counselling skills, Aboriginal language/culture, the history and impact of the residential schools, learning about the *Charter of Rights and Freedoms*, dealing with family violence and 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."*

Participant Characteristics

Potential participants were recruited largely through the mainstream justice system. In order to qualify, offenders had to be found guilty, plead guilty or admit responsibility for their actions. At least two community members had to agree to support them throughout the process. Applications were considered from both adult and young offenders. 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, their case would be returned to the mainstream justice system.[148]

The healing process took approximately nine months and up to a year in some cases. Participation rates ranged from two to five, with the NPES reporting that one woman and two men participated in AHF-funded project healing activities and two completed the process. One participant was a residential school Survivor, while the remaining two were intergenerationally impacted.

Context

According to Statistics Canada, the Ottawa population was 774,072 and the Ottawa-Hull region was approximately 875,100 in 2001.[149] Population statistics for Aboriginal people in the National Capital Region (NCR) vary from one Aboriginal organization to another and estimates range from 11,090 to 40,800, with 35,000 being a commonly reported figure.[150]

Aboriginal people come to urban centers for a variety of reasons, including seeking a better life for themselves and their children and pursuing post-secondary education or employment. Some Aboriginal people came to the city after their release from prison, foster care or hospitals and many were unable or unwilling to make their way back to their home communities. Once here, they 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.[151] Housing shortages and high rents in Ottawa are creating serious problems for low income individuals and families, and Aboriginal people are over-represented among the poor. In 1996, the poverty rate for Aboriginal people living in Ottawa was 51.2%.[152]

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[148] Aboriginal Peoples' Justice Circle (2001). Application for Sentencing and Healing Circles, undated; Sentencing and Healing Circles Guidelines, APJC, January; Information Letter to Community, APJC, undated.

[149] Statistics Canada. Retrieved from: http://www12.statcan.ca/english/Profil01/Details/details.cfm

[150] Approximately twenty applications for funding from various Aboriginal organizations in the Ottawa area were reviewed for population statistics. Source: confidential internal AHF proposals.

[151] Royal Commission on Aboriginal Peoples (RCAP) (1993). Aboriginal peoples in urban centres. Ottawa: Ministry of Supply and Services, page 2, 65-90.

[152] Lee, Kevin K. (2000). Urban poverty in Canada: a statistical profile. Canadian Council on Social Development. April, page 40. Retrieved from: http://www.ccsd.ca/pubs/2000/up/

The NPES reported the following severe challenges facing the community: history of suicide attempts, history of abuse as a victim, history of abuse as an abuser, and drug or alcohol addictions.

Outcomes and Measures

The project's desired short and long-term outcomes are set out in the following performance map along with indicators of how change will be measured. The desired short-term outcomes focus to provide an alternative to the mainstream justice system, bringing more cultural relevance to the mainstream system, and working more effectively with both victims and Aboriginal people in conflict with the law. The desired long-term outcomes are related to impact on the cycle of incarceration and to establish positive life patterns.

Odawa Native Friendship Centre "When Justice Heals" Performance Map

MISSION: To provide an Aboriginal specific alternative to incarceration in the mainstream justice system in the Ottawa-Carleton region.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Hold regular support circles for offenders while in custody, healing circles for offenders, families and victims and sentencing circles; 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 re-integrate into the community; provide training to the APJC staff and volunteers; provide referrals to treatment services; and assist in the victim/offender reconciliation process.	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.	To provide an alternative to the mainstream justice system and work more effectively with Aboriginal people in conflict with the law; to make the justice system more culturally relevant; to assist in reconciliation with victims; to help offenders face their behaviours; to restore relationships wherever possible; to assist offenders regain a positive sense of themselves and their culture and re-integrate into the community; and to increase the skills, capabilities and effectiveness of the APJC and other interested volunteers.	To break the cycle of incarceration and involvement with the justice system and establish positive life patterns and relationships with families.

How will we know we made a difference? What changes will we see? How much change has occurred?			
Budget	**Reach**	**Short-term Measures**	**Long-term Measures**
$ 77,165	Number of Aboriginal offenders, victims and families participating in the program; number of APJC members; number of Aboriginal service providers and mainstream justice personnel involved with project.	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, number of applicants and court referrals, and number of committed Elders and volunteers involved with APJC); 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; reduced rates of suicide among participants; self-reported and observed changes in knowledge, capabilities and skills of APJC members and in the Committee's contributions to the community.	Reduction in incarceration rates and number of Aboriginal people in conflict with the law; reduced rates of addictions, physical and sexual abuse, family violence, self-abuse, homelessness and suicide.

Impact on Individuals

In light of the small number of participants (three to five in total; two completed 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."*

The majority of respondents felt that participants were *less likely* to be in conflict with the law as a result of the project. Although 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 and those without a long history of involvement with the law. 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.

When asked to describe any changes they observed in participants' attitudes, knowledge, skills and behaviour, three respondents noted a greater awareness and knowledge of culture and traditions. There were also references to 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 is going back to school. Other changes noted by key informants include the fact that clients express themselves better at the end of a circle. Clients 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 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."* 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. Others spoke about the value of the teachings and role of Elders.

Respondents were asked if they noticed if victims and their families were more likely or less likely to participate in alternative justice initiatives over the course of the project. Interestingly, there was no consensus and only two of eight people felt it was more likely. It appeared that victims were not necessarily Aboriginal, and non-Aboriginal victims were not particularly interested in alternative justice processes.

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 (e.g., protection against re-victimization and further harm by the offender) to some degree, although a few were not sure and one person said the project is not addressing the issue at all. 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.

Respondents were also asked how well social services and justice-related services ensured the overall safety and well-being of the offender (e.g., safe from community retribution or ostracization).

Respondents were divided almost evenly between those who felt some level of safety was in place and those who felt service delivery agencies were struggling or not addressing the issue (one person was not sure).

Impact on Community

All the interviewees recognized the advantages that the project brought to the Ottawa region, especially in light of the growing Aboriginal population. *"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."* When asked how the project made the mainstream justice system more culturally relevant and responsive, it was reported that awareness sessions at the courthouse were a sensitizing process for the mainstream justice personnel. 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."* Another respondent reported greater respect for the medicines and that smudging is now allowed in the courtroom. The number of referrals from the mainstream justice system was cited as another indicator of 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 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 community. 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 *"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 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."*

Establishing partnerships and ensuring sustainability

The application for AHF funding listed three sources of community support: Tungasuvvingat Inuit, Wabano and the Post Charge Diversion of the Ottawa Police Service. Partnership information contained in the NPES cited two key community agencies linked with the project. One was the Bimadiszi Inuujujut Lodge that offered fast track counselling services to APJC clients and victims and the other was the Aboriginal Women's Support Centre (AWSC) that offered victim support. Agency partnerships identified in the quarterly reports submitted to the AHF included the Wabano Centre for Aboriginal Health, the Centre for Treatment for Sexual Abuse and Childhood Trauma, Pinganodin Lodge, House of Hope, the Crown Attorney's office and the police liaison offices.

Respondents did not agree on the level of support that 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. With respect to Aboriginal partners, one person was concerned that not enough Aboriginal people were involved and another felt there was no sense of ownership by the Aboriginal partners.

The issue of sustainability was addressed separately in the NPES where it was reported that the value of donated labour from community agencies, including the Crown Attorney, was approximated $9,500. In addition, the court provided a meeting room for the sentencing circles. *When Justice Heals* continued to operate after the second year application for funding was declined by the AHF. Despite the fact that many of the respondents reported major problems with the project, including its accountability to the community and the lack of training for the APJC, most believe that it is a viable program and merits ongoing support.

Meaningfully engaging Survivors (including the intergenerationally impacted)

Two different views were expressed regarding the involvement of Survivors. Most respondents reported Survivors were involved, especially in the planning phase, and one said the involvement was *"significant."* 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 addressed the Legacy of Physical and Sexual Abuse, Including Intergenerational Impacts, half of the respondents were not sure. One person stated the project was not addressing the Legacy at all and another felt it was doing poorly. The remaining two reported that the project was doing reasonably well. One of these respondents noted that, while the issue was not dealt with directly, *"it gets addressed when we talk about the person's experience about their culture."*

Managing program enhancement

Responses were split regarding how well the project's methods, activities and processes outlined in the AHF funding agreement led to desired results. Five people were unfamiliar with the funding agreement and, therefore, were 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. The NPES reported the project measured change in participants through formal (written and recorded) observations and solicited feedback, but the files do not contain these documents. Project 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.*

Best Practices

When asked to describe the project's successes, respondents spoke of improvements in the lives of clients. There was a big change in how a client dealt with his children and spouse, was smudging for the first time and enrolled in a Native Studies course. One person felt there was an increase in the community's knowledge of the justice process, and a number of examples were given of successful interactions with the mainstream justice system, including strong partnerships with the police and courts.

The third quarterly report 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 suggested 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"* and *"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."*

The NPES identified the following 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."*

Challenges

Interviewees were especially open about the problems they confronted in their various roles within the project. These challenges are summarized below.

Conflicting Philosophies: Within the APJC, there were differing views about alternative justice. Some supported the community council model used by the Aboriginal Legal Services of Toronto (ALST) and felt 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.

Lack of Community Participation and Support: Three-quarters, or six of the eight people interviewed, referred in some way to a lack of community support and involvement.

Lack of Resources: The project team was composed entirely of volunteers, except for a paid coordinator during five of the twelve months the project received AHF funding. As a result, the volunteer workload was extremely high. 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.

Administrative Difficulties: 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 and 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."*

The quarterly reports submitted to the AHF stated that, as a volunteer committee, there was no formal management structure. A report prepared for the APJC identified the need for greater clarity with respect to the roles and structure of the APJC and the need to revise the terms of reference, to review the circle process and to clarify Odawa's role with respect to the APJC.[153]

Lack of Training: It appeared that the only training provided was based on ALST's community council model and this was controversial with some members. The need for training for circle members and circle keepers was reiterated in the four quarterly reports submitted to the AHF prepared by the project. The interviews confirmed that training was an unfulfilled need. Only two of eight respondents rated the training received as either very good or reasonably good, yet even these two followed up with comments that called their ratings into question: one mentioned insufficient training dollars to meet the need and the other stated that available training was not specific enough. One respondent rated the training as fair, two stated that no training was provided and three were unsure.

Systemic Challenges: One person spoke about how defence lawyers did 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. Also, non-Aboriginal service agencies showed a reluctance to take on court-mandated clients. Another person stated that *"lawyers would approve a conditional release in a heart beat because then someone else would have the responsibility."* This approach may have added to the burden of Aboriginal services in the Ottawa region.

Pressures on Circle Members: Interviewees mentioned the long hours required by volunteers, high levels of stress and the high potential for burn-out. Moreover, circle members had access to confidential information that could not be shared with the community and this created difficulties *"because of the confidentiality aspect of our work, we were criticized. The committee took unfair abuse."* There was also pressure felt by the Aboriginal circle members that related to the information 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:

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[153] 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.

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.

Ensuring accountability

There were significant concerns about the lack of community participation and support. Only one of eight respondents felt the project was reasonably accountable (e.g., engaged in clear and realistic communication with the community, as well as allow community input); the rest said it was struggling, not addressing it at all or they were unsure.

Reaching those in greatest need

In the NPES, the project reported that it was reaching those who need the service the most, although it could be better. It was stipulated as a qualification that the offender must make an application to the APJC. 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. 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 and another said very well. One respondent claimed that the project was doing reasonably well for those clients who made an application, although it was struggling to address the needs of those who did not know about the project.

Lessons Learned

The majority of respondents recognized the need for full participation of the community, both Aboriginal and non-Aboriginal, through regular communication and information sharing. Training was also identified by one respondent who said, *"we needed more specific training so that we could fine tune our processes."* Other suggestions outlined by respondents or recorded in the project's quarterly reports submitted to the AHF included:

· develop an information package for new volunteers;
· re-evaluate and re-structure 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 burn-out;
· bi-monthly reports to the committee;
· should have a paid committee;
· regular circle meetings are vital;

· develop 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 in the following quote: *"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."*

Conclusions

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 that 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 barriers through their work with judges, lawyers and other justice system personnel.

Nevertheless, this case study identified a number of substantive challenges. These included 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 were 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.

Recommendations

· The APJC should begin to engage 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 were 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 should 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 structure, management structure, policies and procedures should be formalized and to pay close attention to safety, de-briefing and burn-out prevention for the APJC members. Moreover, job descriptions for both volunteers and paid staff and formalized roles for a board/advisory or steering committee and an Elder.
· The 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. Training opportunities should be ongoing to ensure access by new members and volunteers.
· The 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.

· Recognizing the difficulties involved in implementing the above recommendations when the APJC is operating on a volunteer basis and without operational funds, the 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.
· A process should be put into place for client and victim follow-up and to track after-care progress.

Council of the Atikamekw Nation: Koskikiwetan (AHF Project # 1311-QC)

Project Description

The project addressed in this case study is titled "Return to our source" or Koskikiwetan (1311-QC), a continuation of the pilot project entitled Miromatisiwinik. The project activities included:

- training local front-line workers and counsellors in intervention techniques related to sexual abuse, the Legacy, crisis intervention and group facilitation. Trainees were also invited to commit themselves to a therapeutic process in order to be able to provide training to others;
- group therapeutic process involving six on-the-land sessions (15-day canoe expedition, two per month, one for adult Survivors and one for youth) in Atikamekw territory. The winter site at Lac Flamand has eight cabins and the summer site on Roy Island is accessible only by canoe with accommodation in canvas tents. A meeting of the adult and youth groups was planned at the end of each month; and
- individual psychosocial intervention offered through the use of community front-line workers and counsellors, who were accessible throughout the process and gave pre-therapy sessions to prepare participants and offered post-therapy sessions to those who opted to attend.

Several other activities were organized in each community, such as sharing circles and more general Legacy education to include as many people as possible in the healing process.

Target Groups: The target group included members (particularly families) of three Atikamekw communities: Opitciwan, Manawan and Wemotaci. Participants included non-status Indians living on and off-reserve, Metis and Inuit. The project served participants with special needs and who belonged to the following social groups: residential school Survivors, their descendants who were affected, homosexuals, disabled individuals, non-Aboriginals and Elders.

Funding: This study focused on the period of operation beginning 1 July 1999 and ending 31 October 2001 with a budget of $1,056,682.

Project Team

The Koskikiwetan team is composed of a project manager, a regional coordinator, three local coordinators, a clinical supervisor, local front-line workers and therapists. There were also support personnel (cook, maintenance person) who worked in collaboration with the Council of the Atikamekw Nation (Atikamekw Sipi) (e.g., education, social services, administrative and consulting services). Before requesting AHF support, a 14-member team, including a psychologist and a lawyer, was gathered to submit a proposal adapted to Survivors' needs. More than half of this initial team were residential school Survivors. The project also benefited from volunteer Elders from the three communities who offered their spiritual guidance and sat on various committees. The project was conducted in collaboration with the regional council for education and language, Atikamekw teaching services, the Atikamekw Language Institute (Wasikahikan) and Atikamekw Nation Documentation Services.

Participant characteristics

The Atikamekw Nation has a young population: 60% are less than 25 years old. In the Opitciwan community, children from 0 to 14 did not participate in the healing activities. But in the other two communities, Wemotaci and Manawan, they did. It is worth noting that women participants from the three communities outnumbered men. During the first year, the majority of participants were registered Indians residing on-reserve. The total number of non-Aboriginal participants in Manawan were higher than the other two communities. By the second year, there was an increase in participants aged 50 and over. The number of non-Aboriginal participants showed a marked decrease in the second year. Overall participation decreased by 3%. On the other hand, the participation of residential school Survivors increased by 1%. Elder participation remained the same for both years. From the beginning of the project, involving the population was an arduous and lengthy process (and still is). Many are still reticent.

Context

The three communities of the Atikamekw Nation, where the Koskikiwetan project took place, are situated in the regions of Haute-Mauricie and of Lanaudière. Most members of the Atikamekw Nation live in one of the three communities. The Atikamekw Nation has been colonized by the French and the Catholic, and some communities are accessible by dirt road only. The Atikamekw Nation administers a school system to promote Atikamekw education, language and culture, and to implant a bilingual teaching system (Atikamekw and French) in each community. A total of 119 children from the community of Opitciwan, 212 from Wemotaci and 125 from Manawan attended residential school (almost a *third* of all community members belonging to the Atikamekw Nation) and went to either the Amos or Pointe-Bleue residential schools.

The healing process began *within* Atikamekw communities *before* the creation of the AHF. It is a *community*-initiated quest, a response to the inordinate illness burden carried by the Atikamekw. The Mikon Project was a study on mortality in the Atikamekw communities that was done in 1999. In the three Atikamekw communities under study, suicides were between 3.5 to 5 times higher than in the population of Quebec or Canada. Suicide rates were clearly highest in Wemotaci (103.09 per 100,000).[154] ***Almost three-quarters (67.7%) of the individuals in Wemotaci have attempted suicide in their lifetime***. The Mikon project revealed that the adolescent population was at highest risk of committing suicide. From 1977 to 1998, the age of suicides in Wemotaci ranged from 16 to 42 years of age: 75% were male and 25% were female. In Manawan, the range was the same; however, there was a greater population of suicides among females(33%). In Opitciwan, the age range for suicides was greater than in the other two communities (from 10 to 65) and the gender proportion was similar to that noted in Wemotaci (75% male and 25% female). In Opticiwan, individuals 35 to 49 years of age showed the highest rate of suicide attempts (75%) followed by individuals between 25-34 years of age (50%). Men and women attempt suicide with the same frequency, but elevated risk was associated with living as a couple, higher income and education. In summary, violence and suicide represented a significant proportion of the general mortality in the Atikamekw communities: 32.6% of deaths were due to violence and 7.8% of deaths were due to

[154] Coloma C., Mikon Project. Mortality in the Atikamekw Communities 1999.

to suicide. Death due to violent acts was particularly evident among male individuals in the three communities: 69% in Opitciwan, 83% in Wemotaci and 64% in Manawan. Violent death affected individuals between the ages of two months and 57 years, with ***32% of the victims being children (between the ages of two months and 11 years).***

In general, women were physically assaulted more than twice as often as men. Young adults between 25 and 34 years of age were more likely to endure physical assaults. Those at a higher income and education levels were more likely than others to be assaulted.[155] Women endured almost twice as much sexual abuse as men in the Wemotaci community; while in the community of Manawan, it is about one-third more. In the other age groups, it was individuals between 35 and 39 years of age who endured the most abuse in both communities. The rates of sexual abuse and physical abuse were just as alarming: 46.3% had experienced sexual abuse and 32.2% had experienced physical abuse in Wemotaci. In Opitciwan, the rates of sexual assaults and physical assaults were lower.[156] In Wemotaci, almost one-quarter of the individuals who suffered sexual abuse had an annual income of less than $12,000 and 40% have an annual income greater than $30,000.[157]

Outcomes and Measures

The following performance map illustrates how activities were intended to lead to desired results and includes three areas of activity, which corresponds to the three phases of the Koskikiwetan project.

[155] Council of the Atikamekw Nation La vie quotidienne et adaptation des Atikamekw de Wemotaci à la modernité, 1997.

[156] ANC, Vie quotidienne et adaptation des Atikamekw de Wemotaci à la modernité, 1997, L'adaptation des Atikamekw d'Opitciwan à la modernité, 1997a.

[157] Vie quotidienne et adaptation des Atikamekw de Wemotaci à la modernité (1997:102) and Problèmes sociaux, solidarité et entraide à Manawan (Social Problems, Solidarity and Support in Manawan) (1996:115).

Koskikiwetan Performance Map

MISSION: The Atikamekw Nation project seeks to restore the individual and collective harmony of its members, in order to give them back the pride and dignity that was totally lost in the residential school institutions			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources/Activities/Outputs	**Reach**	**Results**	
		short-term outcomes	**long-term outcomes**
Legacy education; training front-line workers in suicide prevention, grief work, and supportive counselling, crisis management, group facilitation, sexual abuse; "Inner Child" therapy for future front-line workers; and individual and collective therapy and psychosocial and cultural interventions.	Front-line workers in the three communities, Survivors and their descendants.	Increased ability to respond adequately to the psychological, psychosocial and cultural needs of Survivors and increase number of healing participants.	Support network established; culturally appropriate service access and need; and restoration of lost identity and family and community harmony.

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**
$ 672,290	Adults and youth in the three communities.	Increase in the psychological and psychosocial services; increase in cultural activities; and re-establishment of family, intergenerational and community relations.	Reduced rates of suicide, alcohol and drug use, family violence, sexual and physical abuse, children in care and unemployment; and improved family, intergenerational and community relationships.

Influencing Individuals and Communities

Most respondents believed that there was an increased awareness and a decreased tolerance for physical abuse, particularly among those who took part in the more intensive land-based therapies:

- *In general, it is less hidden, women are more inclined to report it.*[158]
- *There is an 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.*

Very few respondents believed that sexual abuse had decreased, but they did note an increase in the reporting of sexual abuse:

- *The silence is shattered, people are talking about it more and more.*
- *There is more reporting of sexual abuse, but that does not mean that there is more sexual abuse.*

[158] All quotes were translated from French to English.

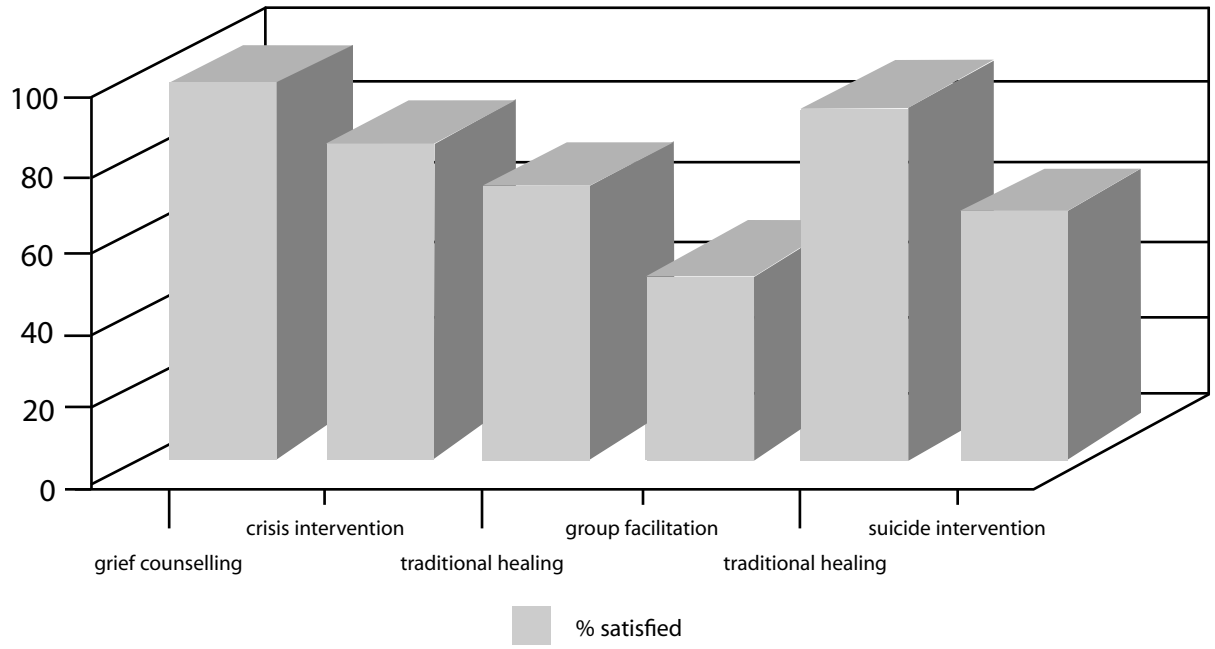
There was no agreement about the rate of children in care; however, most respondents perceived an increase in parental awareness of their roles and responsibilities, together with a noted trend towards collective responsibility for children. Most respondents were not certain if incarceration rates had changed and some felt that it was too early to tell. Others were in disagreement about changes in incarceration and suicide rates. Several pointed out that, in January 2002, there were three suicides, ***the youngest being 11 years old.***

Those who participated in training believed that they were better able to:

- recognize and understand the impact of the Legacy, early warning signs of suicide, as well as the characteristics of assault;
- deal with powerlessness;
- be open and share experiences;
- give and receive compliments;
- hold children in their arms;
- perform interventions, listen and offer help;
- facilitate a group;
- used adapted work tools;
- discipline the spirit; and
- live rather than survive.

Still, Koskikiwetan evoked diverse reactions. During the first year, there was a great deal of uncertainty and distrust. Year-to-year funding caused significant staff turnover; however, some team members remained faithful to the project despite job uncertainty. These individuals *understood* the impact of the Legacy and appeared to have improved community relations. Team members also had opportunity to explore traditional healing practices in-depth and made use of these practices. Overall, the majority were satisfied with the training they received, especially counselling and crisis intervention. The following figure reveals the percentage of trainees who reported being satisfied with various training components.

Percent of Individuals Satisfied with Koskikiwetan Training by Training Type



Most of the team was composed of Survivors who directed the project and offered therapy. Informants believe that having Survivors in key roles created a climate of genuine empathy for participants and facilitated project impact through role modeling. Still, Survivor-therapists are human and some in Koskikiwetan were unable to maintain enough composure or strength to facilitate a healing session, leaving others open with no one to guide them. Several informants felt that Survivor-therapists were not receiving adequate clinical support to deal effectively with their issues. Framed within the stages of individual healing, the Survivor-therapists had not fully reclaimed stable, healthy, functional lives before they had embarked upon efforts to heal others. In part, the healing process involved becoming aware of repressed personal issues and collective problems. Because the Atikamekw communities were just gathering momentum on their healing journey, there is still a *shortage* of individual Survivors who had fully healed and could function as leaders without setbacks. Emotional explosions were to be expected in the healing process, which could create upheaval in family and community solidarity, as well as interrupt the healing process.

A regular participant evaluation was done one month after therapy and recommendations were made by local committees monthly. Participation rates, as well as self-reported ease of suffering and improved quality of inter-generational relationships, spoke well for the project. But, Koskikiwetan team members admitted that they were only touching the tip of the iceberg. *"Breaking the silence, healing and proceeding with reconstruction requires a lot of time, energy and resources of all kinds, because the whole nation is affected down to its soul."*

The project staff also encountered some difficulties during the first therapy-expeditions. There were several mistakes and shortfalls in the first therapy-expedition: youth mistakenly thought it was a vacation camp and there was a shortage of coaches. Both shortfalls were corrected during the second therapy-expedition. The front-line workers encountered resistance from some to identify as a Survivor, but all participants affirmed that they were very satisfied with the therapy and that they would recommend the therapy to others. The skills of the therapists were unanimously recognized by participants.

A new awareness of the Legacy's impact was evident among children, as it clearly created more communication between generations. People were more inclined to openly communicate within families and communities about physical and sexual abuse, which led to an increase in the number of interventions and follow-ups. To meet this need, the project staff trained thirty front-line workers to support sexual abuse victims during the first two years of the project. Still, there was no *real* consensus about the project's ability to reduce denial and several suggested that overcoming denial is most difficult with older community members, most of whom are direct Survivors. Informants believed there was a moderate increase in understanding of the Legacy and community spirit, but were fearful that open wounds would not be given sufficient time to heal. They noted greater community participation in project activities and increased numbers of family members providing support to participants during closing ceremonies. But, re-establishing *strong* families would take more time than the duration of the project. Early signs of positive movement in this regard, however, had been noted and included increased parental involvement in their child's scholastic activity, improved rapport between parent and child and parental insistence that children who were apprehended now *stay* in the community with their extended family.

Best Practices

The use of culturally appropriate therapies in land based environments were credited with the improvement of self and cultural esteem, as well as the personal commitment to engage in a longer term healing process. Audio and video productions were considered effective Legacy education tools that led to some dismantling of denial and increased the number of disclosures of physical and sexual abuse. Koskikiwetan was particularly diligent in soliciting feedback from participants and team members and then making necessary program adjustments based on suggestions offered. For the most part, Survivors directed and delivered the project, which on one hand was considered a best practice because:

- took advantage of the influence of role models;
- relied upon 'home grown' expertise and not imported professionals;
- ensured that *Atikamekw* solutions would be found to address the Legacy; and
- guaranteed moral independence and longevity of healing endeavours.

Challenges

On the other hand, moving forward with Survivors who had not healed sufficiently did, at least on one occasion, leave those in therapy open and lost because the Survivor/therapist broke down emotionally during a healing session. Unfortunately, there was an insufficient number of people who completed their healing journeys in the community to offer a wide selection of healers, therapists or counsellors. Koskikiwetan, like other projects, was faced with the dilemma of having to simultaneously develop local capacity *and* deliver much needed therapies. While the reasons for selecting community members to lead the healing process were clear, being thrust into the role of Survivor/healer could lead to unintended and potentially harmful consequences. Koskikiwetan's experience in this regard raised an important question for others addressing the Legacy. In short, what risks are tolerable when moving forward with simultaneous training and healing? After all, Survivors are human and there are no guarantees that in helping others, they will not be triggered to relive their own trauma. Does the need for *community-based* healers mean that some parameters need to be defined for scenarios where training and healing are simultaneous? How will Survivors safety be guaranteed in such scenarios?

Other challenges experienced by the Koskikiwetan team included:

- lack of expertise to intervene with adolescents;
- difficulty creating solidarity within the community and the Atikamekw Nation;
- insufficient time to support and guide individuals/communities through ***all*** phases of healing; and
- the fear that an abrupt cessation of healing support would aggravate Survivors' trauma.

Partnerships and Sustainability

In each community, there was a support group made up of people working in education, health, police and social services. Managers allowed their teams to participate in therapeutic activity and, although new funding partnerships had not been formally established, pursued future relations with

various service agencies was a primary objective of continued activity. Community informants believed that the momentum created by Koskikiwetan will survive beyond the life of the Foundation.

Addressing the Need

Pre-therapy activities were intended to prepare and select individuals with the greatest needs. Unfortunately, the details regarding pre-therapeutic evaluation had not been secured.

Accountability

Project partners were either directly involved or regularly informed on project progress. Although screening procedures were in place for selecting team members, they admitted to being confused and unable to respond to questions about AHF requirements regarding the CPIC (Canadian Police Information Centre) clearance for employees. Community-wide communications included presentations at a conference of Elders held in Opitciwan, local meetings organized by the social, health, education and police services, as well as regional meetings of the Atikamekw Nation. At one point, the team realized that local front-line workers were not sufficiently informing the community-at-large and the situation was corrected by using community radio and television, as well as publishing articles in local papers. The video production Miromatisiwinik (Wind from the North), together with sharing circles, proved to be very effective means of Legacy education and raising awareness of project activity.

Evaluation

The project engaged in a review process involving the therapeutic team, local front-line workers, the regional coordinator and other resource people that continuously assessed training and therapy, implemented necessary short-term changes and reviewed the therapeutic approach. Several adjustments were made including greater integration of Aboriginal culture, traditional healing, spirituality and "Inner Child" therapy. They also adapted training to fit better with *individual* needs and accommodated trainees by allowing more time for them to address their issues. This resulted in more active participation and greater satisfaction among participants.

Lessons Learned

The project team recognized deficiencies in their ability to intervene with adolescents, as well as engage in post-therapy and follow-up with people *outside* the community. They learned that trainees needed to be screened to ensure their 'readiness' for training and acknowledged the extensive effort required to sustain healing momentum by reducing the number of land based therapy sessions. They knew that a *reliable and competent* team who *can set limits* to ensure effectiveness and continuity was needed. They believed that such a team included a clinical supervisor, therapists, front-line workers, volunteers and support personnel. The team was convinced that Survivors need guidance and support *over several years* (at least three). In addition, *"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."*

Post-therapy was performed in groups or individually, depending on participant preferences. Parent/child dynamics created some difficulties at the beginning of the post-therapy activities. The front-line workers noted that these parental links became less of an obstacle when the post-therapy was undertaken as a group.

Conclusions

The Atikamekw Nation demonstrated its commitment to the healing process by breaking the cycle of living conditions marked by abuse and violence, a process that began *before* AHF was created. The AHF-funded project, Koskikiwetan, facilitated the Nation's ability to gather momentum on the healing journey by increasing skill, community understanding of the Legacy and the number of individuals participating in therapy. The demand for continued therapy and disclosure rates of physical and sexual abuse were growing steadily. Koskikiwetan has provided opportunity for traditional methods and land-based therapies to be offered in Atikamekw and to be integrated with other services. The project was credited with reinforcing cultural pride, practice and motivation to learn more about traditional Atikamekw life. But fundamental and enduring change takes several years of constant personal and collective investment. The Atikamekw envision a day when acculturation will only be a bad memory. With increased understanding of the Legacy, young people have gained insight about their relationships with parents and grandparents. Still, resistance is strong and high rates of staff turnover inhibit progress. The diversity and creativity of Legacy education strategies were particularly successful, including the video production Miromatisiwinik, radio talk shows, teleconferences, theatrical work and meetings with high school students and primary school teachers. At last, although continuous and regular self-examination led the project to make many corrective actions quickly, the team was keenly aware that improvements still needed to be made. *"Continuing training sessions seem to us to be a necessity." "We are also of the opinion that support [e.g., clinical support for the Survivor therapist] must be given to the local workers and workers in the other sectors so that they can be in a better position to provide support for their clients. The activities to raise awareness about the impacts of the residential school experiences must also continue."*

Recommendations

Safety and individual well being

- Ensure that the work of all team members is clinically supervised by a well- trained and seasoned counsellor/therapist;
- ensure criminal history checks are done with all front-line workers; and
- support front-line workers with vacations/cultural holidays, as well as briefings and debriefings before and after each therapy session.

Organizational development

- Ensure that project teams are introduced to local inhabitants;
- improve communication between regional and local offices, especially during land-based therapy sessions;
- ensure that the regional office provides clear program direction;

· create an organizational chart;
· enlist the support of a cook and a camp assistant for land based therapies; and
· select teams trained to intervene with adolescents.

Therapeutic activity

· Screen individuals for therapy;
· register clients at least one week in advance;
· organize pre-therapy information sessions with guest speakers on Atikamekw culture and spirituality as a pre-requisite;
· modify the application form so that sufficient information is gathered to improve therapeutic follow-up;
· promote regular physical activity to facilitate healing; and
· weave culture into post-therapy and group activities.

Cooperation and networking

· Participate in the community on issues (regarding education, health, police, etc.);
· make decisions through local and regional interaction;
· develop team spirit;
· increase opportunities to meet with all teams (local and regional);
· establish a protocol to promote interaction.

Evaluation

· Create a participant satisfaction questionnaire (adapt the model provided in the "Community Guide to Evaluating Aboriginal Healing Foundation Activity");
· commit to formal planned evaluations and long-term follow-up;
· distinguish between activities and results; and
· identify the differences between those for whom the program worked and those for whom the program did not work.

Big Cove First Nation: "Our Youth, the Voice of the Future" (AHF Project # RB-175-NB)

Project Description

The Big Cove Youth Initiative provided the community's youth with support and opportunity to develop personal, social, mental and physical well-being to combat the effects of unresolved trauma originating primarily from the Legacy of residential schools. Activities included: organize and implement a youth council and youth advisory board; develop ongoing activities for youth (with youth input in the planning); organize a support group night; develop an alcohol and drug awareness program; establish substance abuse workshops; provide an outreach and rehabilitative program for alcohol and drug abusers through cultural and spiritual events, alternative activities, traditional values and making referrals; and, provide after-care and follow-up for alcohol and drug abusers.

Target Groups: The project targeted Big Cove youth between the ages of ten and twenty-nine.

Funding: The pilot year funding of $189,300 was received for the period 3 January 2000 to 31 December 2000. Bridge funding furthered the project to 31 March 2001, and a second phase was funded to 31 December 2001 (AHF project # 1822).

Project Team

The project team included the young people hired by the project, as well as key individuals within community agencies. Together, these individuals made up the Youth Advisory Board and there were connections through agency representatives to the Big Cove First Nation Wellness Committee. Represented on the advisory board were the directors of the community's major health and social service organizations (health services, child and family services, Lone Eagle Treatment Centre and alcohol and drug prevention). Also involved was the coordinator of psychological and community development, who acted as the project coordinator. Four of the board members were from Big Cove and fluent in their language. Some have been directors of their programs for over a decade.

The project coordinator is a registered psychologist who worked in the community of Big Cove since the early 1990s. There were six full-time staff members on the project: one youth development worker; three youth workers and two field workers. Three of the six staff members spoke Mi'kmaq fluently. The two field worker positions required 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.

All the full-time staff were female. Five of the six positions were filled by individuals of First Nations origin. There were also six part-time staff members: security, arts and crafts facilitator, youth spiritual circle facilitator, jingle dance instructor and two fund-raising assistants. All were First Nations, two were both Elders and Survivors, and the related experience of the group ranged from five to twenty-five years.

Staff training included suicide intervention, first aid/CPR, leadership, work plan development, restorative justice, personal empowerment, medicine wheel teachings, stress management and a "stop bullying" program. Individual staff members also attended workshops, such as one attended the Youth Action Network (Toronto, ON) and two attended the Environmental Network (Truro, NS). Approximately thirty hours per month of volunteer service was noted. Volunteers donated their time in: food preparation, fund-raising, healing circles, transportation and traditional activities.

Participant Characteristics

Participation rates based on gender were about even for most activities, with the exception that sports-oriented activities tended to attract more males than females. As well, some activities were targeted to one gender (e.g., the "Girls in the 90's" program). Others, such as the Santa Claus Parade, sought community-wide participation. Twenty-four distinct programs and activities were reported, including weekly sports, arts and crafts, dance lessons and support groups. The program held monthly sweats, summer and March break programs and one-time events, such as a youth rally. The number of participants in each activity ranged from 9 to 530 and the Santa Claus parade had the most participants.

The project completed the National Process Evaluation Survey and reported that healing and training activities reached approximately 150 people, 69 of which were youth. However, *"reports for the final quarter of 2000 estimate the project was reaching approximately one hundred and fifty youth and children on a weekly basis."* [159] One-time events, such as conferences or gatherings, were attended by up to three hundred people.

Context

Big Cove is the largest First Nation in New Brunswick with the tribal affiliation being Mi'kmaq. Big Cove's population, as stated by Indian and Northern Affairs Canada in April 2001 was 2,458, with an estimated growth rate between 3.1 percent and 3.5 percent. Over half (57.4%) of the population was under the age of thirty, and more than one-quarter (27%) were between fifteen to twenty-nine years, as of 31 March 2000. Coupled with the population growth, the need for housing continued to outstrip the ability to meet the basic human need and demand for proper shelter. Recent figures put the number of houses needed at five hundred and fifteen.

Big Cove is located in Kent County, New Brunswick. It is in a location with high unemployment rates that fluctuate with seasonal employment. The surrounding region is primarily French-speaking (70%), further hindering the community of Big Cove, which is largely Mi'kmaq-speaking with English as their second language. A needs assessment cited the unemployment rate at 80-85%. According to the 1996 Census,[160] the unemployment rate in New Brunswick was 15.5% and in the community of Big Cove (Richibucto 15 Indian Reserve) the rate was three times greater at 46.2%.

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[159] Project's fourth quarter report to the AHF (2000) Part V, Question iii, Page 7.

[160] Statistics Canada. 1996 Census, statistical profile: income and work statistics for Richibucto 15 (Indian reserve), New Brunswick.

The issue of suicide in this community created extensive media attention and an added burden on community service providers. This was especially true during 1992 which saw the rate of suicide peak. The project coordinator confirmed that during that period, all community service agencies were essentially doing crisis management. This resulted in burn-out 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 were able to shift from crisis mode to a more pro-active approach.

Between 1975 and 2000, there were thirty-four deaths as a result of suicide. Since 1992, Big Cove's annual suicide rate was 116/100,000, with a total of twenty-one deaths as a result of suicide. The age for completed suicides varied, clustering in early or late twenties, then early thirties. Overall, the age range was between 16 to 34. The crisis centre in Big Cove, which staffs a help-line and outreach program, documented an average of three to five attempts per week, suggesting between 150 to 200 attempted suicides each year.

RCMP statistics showed a significant number of assault and sexual assault investigations in 1998 and 1999. However, there were few indications of the actual rates of physical and sexual abuse since reported rates tend to under-represent the problems. When the case study was completed, a copy of this report was sent to the project team. They subsequently contacted the author to provide additional data on sexual abuse. They included a study on family violence completed in 1992, which indicated *"between sixty and ninety percent of the Big Cove population being directly or indirectly affected by sexual abuse."* Furthermore, the director of Psychological Services expressed a willingness to go on record to state that child sexual abuse was one of the core dysfunctions underlying the problems of suicide, attempted suicide, family violence, children in care, and addiction. This was an important development in that the case study report led to a decision to publicly disclose additional information about the seriousness of the problem of sexual abuse in this community.

No figures were available on incarceration rates for this community. Vandalism and break and enters were identified as common crimes committed by youth. According to a youth survey[161] conducted early in the project, 91% of respondents felt 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%). Figures cited in a study of special educational needs [162] showed that one-fifth of the 157 students at Big Cove School had been exposed and affected by alcohol and drugs prenatally. Both parents and teachers who were surveyed provided almost equal observations on the extent of alcohol and drug abuse. Parents estimated that 71% of students had 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 twenty-five years, especially during pregnancy.[163]

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[161] The Youth Initiative Survey was conducted during the second quarter (1 April - 30 June 2000). A total of 141 community members responded to the survey.

[162] Cox, Dr. Lori (1998). Special Education Needs Assessment, page 51. The study included a survey of 15 teachers and 56 parents.

[163] Cox, Dr. Lori (1998). Special Education Needs Assessment, page 16.

A second AHF-funded project existed in the community – the "Outreach Program for the Suicidal at Risk Clients of Big Cove." The community also has a project called "Nurturing our Youth," as well as a restorative justice initiative implemented early in 2000. These last two initiatives were *not* funded by AHF, but have related or similar goals and have liaised with the AHF-funded project.

Outcomes and Measures

The following performance map was used as a one-page reference guide to collect information. It linked 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, youth crime; an increase in education and skill levels; and an increase in overall community well-being (reduced rates of physical abuse, sexual abuse, incarceration, children in care). Short-term outcomes and indicators are similarly mapped. In this way, the performance map identified significant measures of change.

Big Cove Performance Map

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.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources/Activities/Outputs	**Reach**	**Results**	
		short-term outcomes	**long-term outcomes**
Provide programs and support for youth, including sports, arts and crafts, babysitting course, activity nights, "Girls in the 90s-2000s" course, youth support group and traditional activities; provide alcohol and drug awareness, outreach and after-care, alcohol and drug-free activities and interagency networking; and provide training for project team and develop Youth Advisory Board and Youth Committee.	Youth; project team and community.	Increased skill levels, knowledge, self-esteem, health of youth; increased 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; creating the Youth Council and Youth Advisory Board; and progress towards establishing the Youth Centre.	Youth in the community have the support and opportunities they need to develop personal, social, mental and physical well-being and healthy youth equals a healthy community.

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**
$189,000	# of youth participating and impacted by programs.	Youth satisfaction with activities (participant feedback forms); # of youth participating in alcohol and drug services, including treatment and after-care; level of participation in alcohol and drug-free activities and events; rates of alcohol and drug use among youth; perceptions of key informants and self-reported changes in self-esteem, leadership skills, attitudes of youth; evidence of peer support; steps taken toward establishing a Youth Centre ($ 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, interactions between youth and Elders; and evidence of improved community spirit.	Increase in healthy youth as evidenced by reduced rates of attempted and completed suicides, alcohol and drug use, youth crime and an increase in education and skill levels; increase in overall community well-being (reduced rates of physical abuse, sexual abuse, incarceration, 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.

Influencing individuals and communities

The project met the majority of its service delivery objectives by providing a wide variety of activities and programs for youth, as well as staff training and establishing a youth advisory board. In addition to the knowledge and skills gained in training, project staff spoke of learning from their involvement with community leaders on the advisory board.

Impact on Individuals

Overall, there was an indication that changes took place during the course of the project, such as knowledge and skill levels (leadership, cultural awareness, goals setting, social skills), attitudes (self-esteem) and behaviour (parental involvement, mother/daughter communication, family relations and peer support). The highest area where change was noted was in cultural awareness. This was supported by project files, which show that youth sweats and other cultural activities were well attended.

Observed changes during the previous twelve months

	1	2	3	4	5	# of responses
	Little or no change →				Significant change	
Youth self-esteem			3.7			14
Parental involvement		2.8				14
Mother/daughter communications			3.7			14
Family relations			3			14
Youth leadership			3.6			14
Peer support			3.5			14
Cultural Awareness				4		13
Goal setting			3.4			13
Social skills			3.3			13

An example was cited of how youth were showing leadership by being assertive enough to challenge traditions. In Mi'kmaq communities, wakes are almost always held in the homes of the family. Youth members of the project team took steps to hold the wake of a suicide victim at the drop-in centre, which they helped to staff on a twenty-four hour basis for about one week.

Key informants noted that youth *"don't fight and throw things"* as much as they first did. One person mentioned how project staff seemed to have greater control over the youth, even more than the teachers. Others pointed out that youth were being both listened to and encouraged more. Another noted that the youth showed up on time when they had activities to attend, thereby demonstrating responsibility and suggesting that the activities were relevant and of interest to them.

Some staff spoke of youth confiding in them, that bonding took place and that children are stopping them in the streets to say hello. Since this was relatively new behaviour, they concluded that young people and children were coming out of their shells and began to talk more. One teacher noted how some youth were volunteering, which she said was a big thing. Project staff also noted that older youth were now helping to watch the younger ones.

The youth support group showed steady and good attendance, and almost two-thirds of respondents (64.3%) said there were now better opportunities to deal with alcohol and drug issues than in the past. Also, just over one-third (35.7%) of respondents observed a greater willingness for youth to seek treatment.

Impact on Community

The Youth Initiative appeared to be playing a major part in closing the 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 respondents spoke about a greater awareness of suicide, a new openness to talk about it and the fact that there was 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 a more cooperative, pro-active, multi-agency approach was now in place. Without a doubt, the Youth Initiative had a role in allowing other agencies to take a pause from the crisis situation that resulted from the rash of suicides in the community.

Key informants described a number of benefits of the project:

- 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;
- project staff work well as a team;
- facilitates cooperation among community service providers;
- develops self-esteem and new skills; and
- provides a safe place for kids.

Establishing partnerships and ensuring sustainability

The Youth Advisory Board was comprised of the project staff (who were youth themselves) and representatives of five community agencies. These agencies, along with representatives from economic development, education, police and the band, were members of the working group of the Big Cove First Nation Wellness Committee. The Wellness Committee is a good example of the inter-agency partnering that benefited the Youth Initiative. The Chief and Council supported the youth project through a band council resolution, and key informants felt support from leadership was high. The project was also linked to other youth projects through its membership on the community's justice panel.

The project partnered with the schools (both on and off-reserve) in many ways through coordinating and delivering alcohol and drug awareness, but also through utilizing the Big Cove School to deliver activities. However, the relationship with the school may require further work. The interviews revealed that communication between the project and the school could be better.

Meaningfully engaging Survivors (including the intergenerationally impacted)

It remained unclear how well the project was 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 forty years, but many of the community's youth are intergenerational Survivors. Respondents reported that Survivors were involved in proposal development and some sit as Elders, teach arts and crafts to youth, or participate in fund-raising. Two people involved in delivering traditional activities as volunteers/part-time members of the project team are both Elders and Survivors. Key informants did state that many Survivors were 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.

Managing program enhancement

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).

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;
- the project 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).

Challenges

Lack of parenting skills, poverty, lack of literacy skills and lack of Survivor involvement in the project were identified as severe participant challenges. With respect to project activities, key informants mentioned the following challenges:

- the need for their own building;

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

Ensuring accountability

A wide range of activities for and by youth were initiated and the staff on the project team increased their capacity to carry out their jobs through participation in a variety of training initiatives. The community survey conducted by the project in the summer of 2000 served as both a needs assessment and an evaluation tool. A youth advisory board was created.

Reaching those in greatest need

While the exact number of youth participants in this project remained unclear, there was an estimate made of one hundred and fifty youth and children per week. This meant that the project was serving 16.7% of the estimated target group of nine hundred youth. In fact, the National Process Evaluation Survey completed by the project stated that with the proper resources, it could serve five-hundred youth.

Some informants specifically mentioned hard-to-reach youth and one person said this was 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 is needed as it is a complex issue and, as the name implies, this group is *hard-to-reach.*

It remained unclear how well the project was addressing the Legacy. The project was not intended to address physical and sexual abuse directly, as it is *"an integrated prevention, early intervention and after-care initiative."* Indirectly, however, there may be increased opportunities for these issues to come into the open as the children and youth are reportedly bonding with staff, confiding in them, talking more and seemingly gaining higher levels of confidence and self-esteem.

While the project had an open-door policy, recruitment priorities were identified as follows: youth aged twelve to eighteen years, most needy and first-come, first-serve. Events were promoted through local radio, cable TV station, a newsletter and word of mouth.

Lessons Learned

One major lesson learned was the under-estimation of what effort was actually needed to organize the youth.

Conclusions

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 the project begins slowly to raise self-esteem, confidence and skill levels, perhaps new leaders will emerge from this group. The project was having a positive impact in other ways as well. We know, for instance, that it 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 pro-active and coordinated approach to community issues taken by this project was also part of the capacity building among youth. Having a seat on the Wellness Committee and liaising with other initiatives could be seen as short-term changes, which can broaden the perspective of the 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. Without the intervention and prevention efforts being offered through this project, these issues will continue to outpace the ability to meet the challenges.

Recommendations

- Efforts should be made to secure a male worker and young male volunteers to complement the six female youth members of the project team 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 (e.g., suicide and sexual abuse);
- a dialogue is needed to explore methods of gaining the trust and involvement of the "hard-to-reach" population and lead 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; and

· 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 the 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.

Appendices

Criteria Used to Select Case Studies

Appendix A

PROJECT	Métis	Inuit	FN	Non-Status	Youth	Men	Women	Gay/ Lesbian	Incarcerated	Elders	Urban	Rural/ Remote	North	French	East	West
NORTH																
Hamlet of Cape Dorset Community Healing		●											●			
BC																
Urban Native Youth Association					●			●			●					●
George Manuel Institute			●									●				●
Tsow-Tun Le Lum Society						●					●					●
ALBERTA																
Shining Mountains Living Community Services					●	●	●				●					●
SASKATCHEWAN																
Building a Nation Family Healing Centre Inc.					●	●	●		●	●	●					●
Willow Bunch Métis Local	●											●				●
Kikinahk Parents of Teens Assistance Program	●				●		●					●				●
MANITOBA																
Nelson House Medicine Lodge Inc.			●		●	●	●					●				●
ONTARIO																
Centre for Indigenous Sovereignty			●				●				●				●	
Odawa Native Friendship Centre	●		●	●					●		●				●	
QUEBEC																
Conseil de la Nation Atikamekw			●											●	●	
NEW BRUNSWICK																
Big Cove First Nation			●		●							●			●	

PROJECT	Community Services	Conference/ Gatherings	Performing Arts	Health centre (residential care)	Camp/retreat (away from community)	Day program (in community)	Healing circles	Materials development	Research/ knowledge planning	Traditional activities	Parent skills	Professional taining	$	N
NORTH														
Hamlet of Cape Dorset Community Healing		●			●	●	●			●			121,080	CT-411-NT/32-NT
BC														
Urban Native Youth Association	●					●							81,420	CT-302-BC/237-BC
George Manuel Institute (write/produce play)			●										147,366	180-BC
Tsow-Tun Le Lum Society				●			●			●			459,560	HC-36-BC/67-BC
ALBERTA														
Shining Mountains Living Community Services					●		●			●	●		150,000	1397-AB
SASKATCHEWAN														
Building a Nation Family Healing Centre Inc.	●				●	●	●			●	●	●	222,800	1256-SK
Willow Bunch Métis Local (book)								●					109,200	1176-SK
Kikinahk Parents of Teens Assistance Program					●					●	●		186,190	RB-67-SK/364-SK
MANITOBA														
Nelson House Medicine Lodge Inc.							●			●		●	464,526	52.01-MB
ONTARIO														
Centre for Indigenous Sovereignty		●				●	●			●		●	191,532	RB-268-ON/455-ON
Odawa Native Friendship Centre												●	77,165	1291-ON
QUEBEC														
Conseil de la Nation Atikamekw		●							●				517,317	1311-QC/28-QC
NEW BRUNSWICK														
Big Cove First Nation (outreach aftercare program, youth at risk	●					●	●			●			189,300	RB-175-NB/412-NB

Appendix B

Process Evaluation Methods

The process evaluation was primarily a descriptive exercise reliant upon information already available through **internal databases**, **document files** and supplementary information secured through **mail out survey** and **one-to-one interviews** with national stakeholders (AHF board members and personnel). Two board members and two national team members were selected based upon their proximity to project activity. In other words, those who were considered to have *the most intimate knowledge* of community-based activity were selected for an interview. The process evaluation reports upon community context, target group characteristics, program teams, service delivery preferences, the distribution of resources and accountability issues.

First, project files were reviewed to determine what information was already available and what supplemental information would be needed. A *sample* of 36 project files were reviewed. Information was mined from these files according to a document review template and falls broadly into the following categories: project descriptions, capacity building, successes, challenges, target groups, linkages and partnerships, grantee/staff recommendations, lessons learned and evaluation practices. From the review of document files, it was determined that a variety of supplementary information was needed and a mail out survey was developed to fill in the gaps. The survey was piloted with six AHF sites and revisions incorporated to address most of the noted concerns. Unfortunately, resources did not allow for the translation of the survey into Inuktitut. The survey was then mailed to all 344 projects that were operational at the time (February 2001) and one follow up phone contact was made from the national office to ensure compliance. And finally, the views of key national stakeholders were also solicited through telephone interviews.

Whenever possible, relevant numerical information from AHF's internal databases were used. When mining important information from the document review, all qualitative data were handled manually and drawn into a document review template. A manual process was selected over an electronic one in the interests of cost and simplicity. With just 36 files to review, it was felt that the data set was manageable. Once all files were reviewed and templates completed, the raw information was then grouped according to major themes (e.g., successes, challenges). Each theme was then addressed independently so that the strength of trends could be determined.

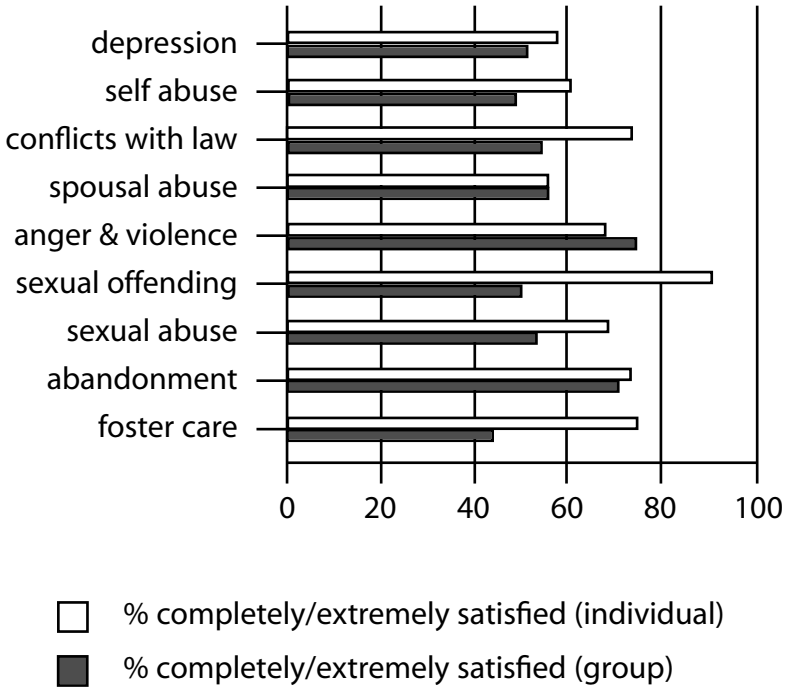
Numerical and categorical data from the mail out survey were analysed using the Statistical Package for the Social Sciences (SPSS version 10). Analysis included frequencies, sums and ranges for each question and other univariate descriptive information (e.g., averages and medians). All open-ended survey data were categorized and coded and some cross-tabulations were conducted to isolate unique trends. A total of three hundred and forty-four (344) surveys were sent to grant recipients representing two hundred and seventy-four (274) organizations. Two hundred and eight surveys (208) were received by the AHF representing a response rate of sixty-one percent (61%). However, cases were weighted to account for missing data from organizations with more than one grant. With weighting,

the response rate increased to two hundred and fifty-three (253) or seventy-four percent (74%).[164] To view the list of the 36 project files reviewed, document review template, National Process Evaluation Survey 2001, national interview and framework for organizing the information, see *An Interim Evaluation Report of Aboriginal Healing Foundation Program Activity*, June 2001, Appendices A to E.

[164] Many organizations (62 in total) received more than one survey because they were administering more than one grant which caused confusion. As a result, 11 surveys received were duplications as they were from the same organization and forty-two were from organizations who received more than one survey but chose to submit only one response. It is reasonable to believe that forty-two organizations felt it did not make sense to complete the same survey twice. We have assumed that multiple projects within a single organization have more in common with each other than projects that are hosted by different organizations. From a sampling point of view, projects that are within the same organization are "clustered." Based on our understanding outlined above, we operated under the assumption that the organizations would have completed a single survey to cover all projects for which they received grants.

Appendix C

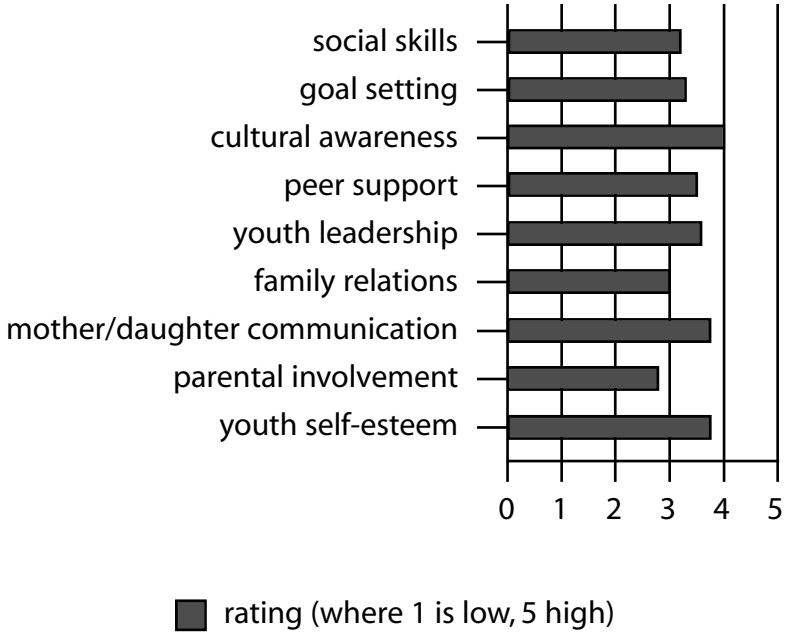
Figure C.1) Satisfaction Rating of Group and Individualized Treatment Approaches (Qul Aun Program)*



* foster care group n=14 individual n=18
abandonment group n=51 individual n=41
sexual abuse n=45 individual n=38
sexual offending group n=11 individual n=12
anger and violence group n= 46 individual n=35
spousal abuse group n=28 individual n=11
self abuse group n=49 individual n=28
depression group n=46 individual n=29

Appendix D

Figure D.1) Respondents' Attitudes about Change in Big Cove



Appendix E

Specific Learning Outcomes Targeted by Legacy Education

Learn history	· demonstrate ability to identify colonial mentality (stereotyping, bias,) in action; · know schools where family or community members attended; how students were enlisted to attend, general conditions and academic standards; · know the experiences of family or community members; · able to identify problems in family and community associated with the Legacy.
Understand the impact of the Legacy	· new impression of parents and grandparents leading to forgiveness; · identify personal behaviour that is shaped by family and peers; · emerging self image; evaluation of coping strategies; use Legacy knowledge as a basis for self discovery; · make informed choices that will contribute to physical, mental, emotional, and spiritual well-being; · set appropriate goals for their healing journey, make realistic plans, and keep track of and evaluate their progress.
Apply understanding to address the Legacy	· offer creative and critical suggestions for action designed to end the Legacy; · perform an activity that demonstrates awareness of their responsibilities as healing Survivors (e.g., share with others, teach, participate in anti-racism programs); · demonstrate concern and care for other Survivors; · use a variety of forms, media, and languages to communicate knowledge and understanding of Legacy.

Appendix F

How to use Project Performance Reviews for Evaluation
Suggested Revisions for Greater Utility

Note to the reader: what follows are selected sections from various versions of the project monitoring and evaluation forms. The selected section is reproduced here in its entirety and the highlighted text is added commentary highlighting how the information can be used in evaluation as well as some suggested changes.

ABORIGINAL HEALING FOUNDATION
PROJECT PERFORMANCE REVIEW FORM

Version #3

2. Addresses the legacy of physical and sexual abuse in residential schools, including inter-generational impacts. *(In summary, provide a brief description of the project as it relates to the Legacy of Physical/Sexual Abuse in Residential Schools including Intergenerational Impacts.)*
Take information from this section and code for statement on accountability.

3. Accountability: How is the project accountable to: a) the community where the project is taking place; b) people who have survived the residential school system; and c) the target group who will benefit from the project
Take information from here to develop statement on accountability.

SECTION II - PROJECT OBJECTIVES

What are the project objectives for this reporting period according to the Workplan submitted in Part G of your Contribution Agreement? Please let us know the outcomes. It is important that the Foundation has an understanding of successes or barriers that projects are experiencing. This will not affect future funding. Reporting lessons learned will contribute to an overall positive performance review outcome for the project.

Here the objectives and outcomes are not clearly differentiated. An objective is a specific and measurable activity or output or the means to an end. The outcome is the *result* of that activity – or *the end* goal – the *desired change* in knowledge, attitudes or behaviour.

OBJECTIVE # 1 *State objective in your project workplan.*	**Was Objective Achieved? YES_____ NO _____** *Please explain how you determined that this objective was achieved, or was not achieved.*
LIST ACTIVITIES FOR OBJECTIVE # 1: Please list any barriers or successes that your project experienced Information from here should be summarized into best practices and greatest challenges.	

ABORIGINAL HEALING FOUNDATION
PROJECT PERFORMANCE REVIEW FORM
Please use this form to report your Project's

2nd Quarter (4-6mos) & 4th Quarter (10-12mos)

Version #3

SECTION II – PROJECT OBJECTIVES

What are the project objectives for this reporting period according to the Workplan submitted in Part G of your Contribution Agreement? Please let us know the outcomes. It is important that the Foundation has an understanding of successes or barriers that projects are experiencing. This will not affect future funding. Reporting lessons learned will contribute to an overall positive performance review outcome for the project.

OBJECTIVE # 1 *State objective in your project workplan.*	**Was Objective Achieved? YES_____ NO _____** *Please explain how you determined that this objective was achieved, or was not achieved.*
	Again, watch for confusion between reporting on what was done or outputs and reporting on what has changed. These are two different statements.
LIST ACTIVITIES FOR OBJECTIVE # 1: Please list any barriers or successes that your project experienced Information from these sections can be drawn into a report on best practices (successes) and greatest challenges (barriers).	

SECTION III Identify successes and barriers	i) What activities would you continue based on the response of participants and staff? The information contained here can be brought together to form part of the section on **best practices**. ii) Was there anything that you would not do the next time? Please explain. This information can be brought together to form a section on **lessons learned**. iii) Did you provide any training during this reporting period? If so, please provide details. (e.g., crisis intervention, suicide intervention, computer skills, etc.) Information can be drawn from this section for a statement on capacity building. Remember, just because a training program has been offered, it is not clear that knowledge and skills have changed. Offering training may represent the achievement of a service delivery objective but the end goal of training is to change knowledge and skills. More simply, training is the means to the end of having a more skilled, knowledgeable workforce - look for any information that talks about how knowledge and skills have changed as a result. In other words, what practices or policies have changed, what about confidence, knowledge and skill level of trainees? iv) Who has your project worked with and what new partnerships were established this quarter? Please describe the initiatives taken to support these partnerships. Information from this section can be summarized in a statement about partnerships. v) Are there any support systems/safety nets in place for community members and staff involved in your project? If so, please describe. (e.g., debriefing sessions, in-house counsellors, in-house Elders, etc.)
SECTION IV Accountability	This information should also be summarized and added to a statement on accountability. i) Have you reported your findings to the community? How and in what form? Please provide details. (e.g., presentations, questionnaires, surveys, evaluations, t.v., radio, newspapers, etc.). ii) Please describe how you are involving Residential School Survivors and their descendants in your on-going programming. iii) Do you have a C.P.I.C. (Canadian Police Information Centre) policy, (as required by Section 5(d)(vii) of the Contribution Agreement) in place for staff and volunteers who are involved with your project? Please describe.

SECTION V Project Monitoring & Evaluation	i) Are there any **barriers** that your project might be experiencing that are preventing you from meeting the time frame in your workplan. If so, please explain. This should also be included for **greatest challenges** ii) Are there any changes that you would make in the developmental or implementation stages of your project? Please describe. This should be coded for **lessons learned**. iii) What impact did your project have in addressing the Residential School Legacy of Physical and Sexual Abuse and/or Intergenerational Impacts? Please describe in detail. (e.g., we trained 20 frontline workers and provided counselling for five families, etc.) The example provided here *misleads* the project to report the achievement of or completion of project **outputs** and not the **outcome or impact**. This example talks about what was done, not what happened as a result of what was done. Remember: activities or outputs are the *means* to the end (not the end by itself) and include things like providing therapy, producing a video or document, distributing pamphlets. An **outcome or impact** is what *changed as a result of the activity or output* and refers to things like *changes* in ideas, attitudes and behaviour or community conditions. What support or evidence do they have that such changes have taken place (see below) iv) How are you evaluating your program? Please provide details. (e.g., questionnaires, feedback, surveys, statistical information, etc.) Here we want to ask for **copies of these tools and statistical information as well as summaries of their results** or even the raw information (e.g., all the participant feedback forms even if they are not summarized) and a description of their methods (e.g., how was the feedback collected, confidentiality guaranteed, etc)
SECTION VI Other Results – Observations – Comments	i) Please provide thoughts and observations on spinoffs or spontaneous activities created by clients or staff outside of your program. This might include such events as community pot lucks, recreational group gatherings, peer counselling or support, teen bonding, etc. This is also **evidence of impact** and should be included in any statement about impact.

SECTION VII General Comments	i) Are there any activity(s) or approach(es) that you think other projects or the Foundation would find useful – either because it worked very well or didn't work at all? The Foundation is particularly interested in strategies that address the Legacy of Physical and Sexual Abuse in the Residential School System; the needs of Survivors; and/or Inter-generational Impacts not only among individuals but the community as a whole. Please provide your recommendations below: Again, more information for **best practices and greatest challenges**. i.i) Please list commonly asked questions by clients or staff about the Aboriginal Healing Foundation, or recommendations by your project on dealing more effectively with program development and support at the community level This is the voice of the community on recommendations. It should be included in a report on foundation activities.

Appendix G

Informed Consent

Dear Participant,

We are trying to gather information that will help us to evaluate our efforts to heal from the Legacy of physical and sexual abuse in residential schools in (name your community) and we believe that the best information would be the (pick your favourite tool or method) to see if there are differences over time. All information will remain confidential and results will be grouped together so that no individual participant can be identified in the evaluation. In other words, we will be talking about the results in terms of percentages (e.g., 80% showed improved self esteem) and not by individual (e.g., Mary showed improved self esteem). If you agree to allow us to use your information to be included in the group, please sign below:

_____ Date_____)

Appendix H

California Healthy Kids Survey
Section B

For each of the statements below, please mark your answer sheet to show whether you feel that it is not at all true, a little true, pretty much true, or very much true.

	I have a friend about my own age …	Not at all True	A Little True	Pretty Much True	Very Much True
B1	who really cares about me	A	B	C	D
B2	who talks with me about my problems	A	B	C	D
B3	who teases me too much	A	B	C	D
B4	who helps me when I'm having a hard time	A	B	C	D
	In my home, there is a parent or some other adult …				
B5	who expects me to follow the rules	A	B	C	D
B6	who is interested in my school work	A	B	C	D
B7	who believes that I will be a success	A	B	C	D
B8	who is too busy to pay much attention to me	A	B	C	D
B9	who talks with me about my problems	A	B	C	D
B10	who always wants me to do my best	A	B	C	D
B11	who listens to me when I have something to say	A	B	C	D
B12	I feel bad when someone gets their feelings hurt	A	B	C	D
B13	I do fun things or go fun places with my parents or other adults	A	B	C	D
B14	I try to understand what other people go through	A	B	C	D
B15	When I need help, I find someone to talk with	A	B	C	D
B16	I know where to go for help with a problem	A	B	C	D
B17	I try to work out problems by talking or writing about them	A	B	C	D
B18	My friends get into a lot of trouble	A	B	C	D
B19	I do interesting activities at school	A	B	C	D
B20	My friends try to do what is right	A	B	C	D
B21	I do things at home that make a difference	A	B	C	D
B22	My friends do well in school	A	B	C	D

		Not at all True	A Little True	Pretty Much True	Very Much True
B23	I help make decisions with my family	A	B	C	D
B24	At school, I help decide things like class activities or rules	A	B	C	D
B25	I do things at my school that make a difference	A	B	C	D
	Outside of my home and school, there is an adult …				
B26	Who really cares about me	A	B	C	D
B27	Who tells me when I do a good job	A	B	C	D
B28	Who notices when I am upset about something	A	B	C	D
B29	Who believes that I will be a success	A	B	C	D
B30	Who always wants me to do my best	A	B	C	D
B31	Whom I trust	A	B	C	D
	At my school, there is a teacher or some other adult …				
B32	Who really cares about me	A	B	C	D
B33	Who tells me when I do a good job	A	B	C	D
B34	Who notices when I'm not there	A	B	C	D
B35	Who is mean to me	A	B	C	D
B36	Who always wants me to do my best	A	B	C	D
B37	Who listens to me when I have something to say	A	B	C	D
B38	Who believes that I will be a success	A	B	C	D
B39	I can work out my problems	A	B	C	D
B40	I can do most things if I try	A	B	C	D
B41	I can work with someone who has different opinions than mine	A	B	C	D
B42	There are many things that I do well	A	B	C	D
B43	I enjoy working together with other students my age	A	B	C	D
B44	I stand up for myself without putting others down	A	B	C	D
B45	I try to understand how other people feel and think	A	B	C	D
B46	I feel like I am all alone in the world	A	B	C	D
B47	There is a purpose to my life	A	B	C	D
B48	I understand my moods and feelings	A	B	C	D

		Not at all True	A Little True	Pretty Much True	Very Much True
B49	I understand why I do what I do	A	B	C	D
B50	I am part of clubs, sports teams, church/temple or other group activities away from school	A	B	C	D
B51	Outside of my home and school, I help other people	A	B	C	D
B52	I am confused about what I want out of life	A	B	C	D
B53	I have goals and plans for the future	A	B	C	D
B54	I plan to graduate from high school	A	B	C	D
B55	I plan to go to college or some other school after high school	A	B	C	D

Appendix I

Sense of Coherence Scale

A. Antonovsky (1987). Unravelling the Mystery of Health: How People Manage Stress and Stay Well, Jossey Bass: London, UK.

1.When you talk to people, do you have the feeling that they don´t understand you?	1 Never	2	3	4	5	6	7 Always have this feeling
2. In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it:	1 Surely wouldn't get done	2	3	4	5	6	7 Surely would get done
3. Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?	1 You feel that they're strangers	2	3	4	5	6	7 You know them very well
4.Do have the feeling that you don't really care about what goes on around you?	1 Very seldom or never	2	3	4	5	6	7 Very often
5. Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well?	1 Never happened	2	3	4	5	6	7 Always happened
6.Has it happened that people whom you counted on disappointed you?	1 Never happened	2	3	4	5	6	7 Always happened
7. Life is:	1 Full of Interest	2	3	4	5	6	7 Completely routine
8. Until now your life has had:	1 No clear goals or purpose at all	2	3	4	5	6	7 Very clear goals and purpose
9. Do you have the feeling that you're being treated unfairly?	1 Very often	2	3	4	5	6	7 Very seldom or never

10. In the past ten years your life has been:	1 Full of changes without your knowing what will happen next	2	3	4	5	6	7 Completely consistent and clear
11. Most of the things you do in the future will probably be:	1 Completely fascinating	2	3	4	5	6	7 Deadly boring
12. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?	1 Very often	2	3	4	5	6	7 Very seldom or never
13. What best describes how you see life:	1 One can always find a solution to painful things in life	2	3	4	5	6	7 There is no solution to painful things in life
14.When you think about your life, you very often:	1 Feel how good it is to be alive	2	3	4	5	6	7 Ask yourself why you exist at all
15.When you face a difficult problem, the choice of a solution is:	1 Always confusing and hard to find	2	3	4	5	6	7 Always completely clear
16. Doing the things you do every day is:	1 A source of deep pleasure and satisfaction	2	3	4	5	6	7 A source of pain and boredom
17. Your life in the future will probably be:	1 Full of changes without your knowing what will happen next	2	3	4	5	6	7 Completely consistent and clear
18. When something unpleasant happened in the past your tendency was:	1 "To eat yourself up" about it	2	3	4	5	6	7 To say “ok that’s that, I have to live with it" and go on

19. Do you have very mixed-up feelings and ideas?	1 Very often	2	3	4	5	6	7 Very seldom or never
20. When you do something that gives you a good feeling:	1 It's certain that you'll go on feeling good	2	3	4	5	6	7 It's certain that something will happen to spoil the feeling
21. Does it happen that you have feelings inside you would rather not feel?	1 Very often	2	3	4	5	6	7 Very seldom or never
22. You anticipate that your personal life in the future will be:	1 Totally without meaning or purpose	2	3	4	5	6	7 Full of meaning and purpose
23. Do you think that there will always be people whom you'll be able to count on in the future?	1 You're certain there will be	2	3	4	5	6	7 You doubt there will be
24. Does it happen that you have the feeling that you don't know exactly what's about to happen?	1 Very often	2	3	4	5	6	7 Very seldom or never
25. Many people – even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?	1 Never	2	3	4	5	6	7 Very often
26. When something happened, have you generally found that:	1 You overestimated or underestimated its importance	2	3	4	5	6	7 You saw things in the right proportion
27. When you think of the difficulties you are likely to face in important aspects of your life, do you have the feeling that:	1 You will always succeed in overcoming the difficulties	2	3	4	5	6	7 You won't succeed in overcoming the difficulties

28. How often do you have the feeling that there's little meaning in the things you do in your daily life?	1 Very often	2	3	4	5	6	7 Very seldom or never
29. How often do you have feelings that you're not sure you can keep under control?	1 Very often	2	3	4	5	6	7 Very seldom or never

The Sense of Coherence is, according to Antonovsky, "…. a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence." (2). Each subscale is described below.

(1) Comprehensibility subscale (C): "…. the stimuli arriving from one's internal and external environments in the course of living are structured, predictable and explicable." (2). Sample item: "Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well?" Scale: 1=never and 7=always.

(2) Manageability subscale (MA): "…. the resources are available to one to meet the demands posed by these stimuli." (2). Sample item: "Do you have the feeling that you're being treated unfairly?" Scale: 1=never and 7=always.

(3) Meaningfulness subscale (ME): "…. these demands are challenges worthy of investment and engagement." (2). Sample item: "Until now your life has had:" Scale: 1=no clear goals or purpose and 7=very clear goals and purpose.

It is important to note that SOC is not a personality test and that a person's SOC scores change during the lifetime, for example, during psychological stress, anxiety or depression.

Sample Community Wellness Report Card[165]

Issue	Last Report	This Report	Comments
% of households with persistent alcohol and drug abuse ongoing	79%	62%	Summer work projects gave some adults a focus.
% of youth at risk and without adequate support	84%	51%	Outdoor camps and cultural activities have engaged a significant number of youth.
% of families living in overcrowded and unhealthy housing	45%	45%	No change
% of working age adults unemployed and on welfare	88%	82%	Summer work programs have employed some people, the basic problem is not being addressed
Number of sexual abuse disclosures and reported sexual assaults	0	0	Sexual abuse is still not acknowledged as part of a community reality, though it comes up frequently in counselling cases.
Number of (known) attempted suicides	4	0	Suicide prevention workshops and new youth buddy system has helped.
Number of reported cases of spousal abuse	6	2	Less alcohol abuse and more work has made for less stress in families.
Number of people participating in healing circles	21	56	Our June recruitment has involved an additional 30-40 people in circles
% of community residents involved or committed on a personal healing journey	15%	26%	New people have joined the healing spring workshops, new healing circles attracting some
Number of people volunteering for anything	81	126	Summer roundups is always a popular venue for volunteers, but overall annual numbers the same

[165] Lane, P., M. Bopp, J. Bopp and J. Norris (2002). Mapping the Healing Journey: The final report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Four Directions International research commissioned by the Aboriginal Healing Foundation and the Aboriginal Corrections Policy Unit. Ottawa: Solicitor General Canada.

Aboriginal Healing Foundation
75 Albert Street, Suite 801, Ottawa, Ontario K1P 5E7
Phone: (613) 237-4441
Toll-free: (888) 725-8886
Fax: (613) 237-4442
E-mail: programs@ahf.ca
Website: www.ahf.ca