Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity

Published by:
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Design & Production:
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June 2003

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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.

amorphous - undefined or indeterminate.

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.

catalyst - a determinant or factor that provokes or speeds significant change or action.

echelon - a group of individuals at a particular level or grade in an organization.

efficacy - efficiency or competence.

emancipated - released (i.e., from parental care and responsibility).

extolled - praised highly or glorified.

genogram - a family therapist's version of a family tree.

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

healing approaches:

> alternative - approaches incorporating all those strategies outside of most regulated and provincially insured western therapies and include, but are not limited to, homeopathy, naturopathy, aroma-therapy, reflexology, massage therapy, acupuncture and acupressure, Reiki, neuro-linguistic programming and bio-energy work.
>
> traditional - approaches incorporating all culturally-based healing strategies including, but not limited to, sharing, healing, talking circles, sweats, ceremonies, fasts, feasts, celebrations, vision quests, traditional medicines and any other spiritual exercises.
>
> western - approaches incorporating all strategies where the practitioner has been trained in western institutions (i.e., post-secondary educational institutions) including, but not limited to, psychologists, psychiatrists, educators, medical doctors and social workers. For the most part, western practitioners are regulated by professional bodies, have comprehensive general liability insurance and professional liability insurance and are state-recognized or their services are covered by provincial health care plans.

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 - the effects of sexual and physical abuse that were passed on to the children, grandchildren and great-grandchildren of Aboriginal people who attended the residential school system.

linear - relating to, resembling or having a graph that is a straight line.

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

machismo - a strong sense of masculine pride, an exaggerated masculinity.

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 question.

nebulous - unclear or obscure.

outcome - intended or unintended result.

output - product or service delivered.

pivotal - vitally important, crucial.

postulates - proposes.

program - or project are used interchangeably and refer to the action taken at the community level that is grant specific.

recidivism - a tendency to relapse into a previous condition or mode of behaviour.

reciprocally - mutually corresponding.

repertoire - the complete list or supply of skills, devices, or ingredients used in a particular field, occupation or practice.

residential schools - the Residential School System in Canada attended by Aboriginal students. It includes industrial schools, boarding schools, homes for students, hostels, billets, residential schools, residential schools with a majority of day students or a combination of any of the above.

reticence - secrecy.

sequelae - an after affect of disease or injury.

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

Survivor - an Aboriginal person who attended and survived the Residential School System.

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

tacit - expressed or carried on without words or speech, unspoken.

the Legacy - refers to the on-going direct and indirect effects of physical and sexual abuse at residential schools. It includes the effects on survivors, their families, descendants and communities (including communities of interest). These effects may include, and are not limited to, family violence, drug, alcohol and substance abuse, physical and sexual abuse, loss of parenting skills and self-destructive behaviours.

univariate - characterized by or depending on only one random variable.

Executive Summary

This report summarizes the research undertaken from September 2002 to May 2003, including results from a second national survey (384 distributed, 176 responses received); individual participant questionnaires (distributed to all active grants [384], 826 responses received representing over 90 projects); a document review of the minutes taken at regional gatherings; information drawn from AHF internal databases; and a focus group discussion with ten projects that show promising success gathered in March 2003. The results are organized based on the key evaluation questions about process, impact and information for users.

Limitations

The data are limited by the fact that roughly half of all operational projects in 2002 (176 of a possible 384 projects) responded to the national survey. Still, when examining respondents from non-respondents, there were no discernible differences on a number of variables. For the first time, the Aboriginal Healing Foundation (AHF) had access to *direct* participant voice, representing participants (including Survivors) from over 90 projects. Still, the total number of respondents (826) remains a very small self-selected sample (out of a possible 129,804 who may have participated last year) with a dominant First Nations perspective.

The instrument used to solicit participant voice was adapted from a feedback tool developed by the clinical team in collaboration with residential school Survivors working with Qul Aun at the Tsow Tun Le Lum Residential Treatment Centre in British Columbia. Although it is not a standardized instrument, no psychometrically evaluated or standardized instrument exists to determine the unique stages of recovery from the Legacy. Administration guides were prepared for both the national survey and the individual participant questionnaire to improve data accuracy.

The lines of evidence include survey responses from project teams, focus group discussions with representatives from 10 selected projects, internal AHF databases and direct feedback from participants. Dissent was encouraged in all data collection, but attempts to secure disconfirming evidence, rival explorations and negative cases were limited to contextual information secured through national surveys and individual participant questionnaires. Similarly, although immediate satisfaction and goal achievement are clearly in the majority, it is not clear what the long-term consequences are of project participation and if they create enduring and healthy changes in participants' lives. In short, the most important information missing is the *longer* term follow-up of participants' progress.

Methods were heavily reliant upon the abilities and willingness of project teams to participate. Lastly, there is a noted dominance of First Nation voice in the participant sample and projects, generally meaning that the unique issues and needs of the Métis and Inuit groups remain elusive.

Who

A total of 59,710 (n=140) participants engaged in healing and less than two per cent had participated in healing before their experience with the AHF. Participants spend, on average, 149 hours in healing (range 2 to 1,225 hours). Training was provided to 11,968 (n=98) individuals and the Métis and Inuit continue to be under-represented in both healing and training (especially training). Denial, grief, history of abuse as a victim, poverty and addictions remain severe challenges affecting more than half of all participants.

In 2002, there were 2,733 paid employees (n=169), of which 931 are full-time. Almost all (90%) full-time and 85% of part-time positions are occupied by Aboriginal people. Both the Métis and Inuit are under-represented in this sample of AHF-funded teams. Survivors (i.e., those who attended residential school) represent 35% of project teams (n=106), 51% of contract workers and those receiving honoraria (n=138) and 51% of all governing or advisory boards (n=139). The intergenerationally impacted are also well-represented and form 58% of project teams (n=128), 29% of those on contract or receiving honoraria (n=139) and 42% of board and advisory committee members (n=124). And last, but perhaps most importantly, characteristics of an effective healer are obvious to the promising projects (focus group) gathered in March 2003. The following are some key characteristics of effective healers that were suggested by the focus group.

- good track record of ethical conduct supported by references
- knows how to defuse negativity
- humble, honest, gentle
- accepts Legacy's reality
- worked through their anger
- complete transition through all stages of grief
- recognized ***by others*** as a healer
- absolute self-acceptance
- recognized as a model of triumphant recovery
- can share their history and healing strategies
- has well-established personal boundaries that protect them from harm or burn-out
- respected in the community
- fearless, unflappable (not easily surprised)
- comfortable and knowledgeable of ceremonies
- present, able to listen intently, hear clearly
- open
- free from the need to control
- unmistakable positive energy
- does not bargain away their actions or the actions of others
- alcohol and drug-free for a minimum two years
- accept, learn from and work with clinical supervision
- understands professional limitations and makes appropriate referrals
- developed a plan for continued wellness
- committed to breaking the cycle of abuse, initiates community action and encourages ownership
- spiritually grounded
- reconciled with Mother Earth
- free of depression, recognizes life goes on

What

The distribution of resources over time by project type is outlined in the following table.

AHF Investment by Project Type (2000/2002)

Project Type	2002	2000	Project Type	2002	2000
Healing	67%	47%	Honouring history	2.2%	5.2%
Prevention and awareness	13%	18.5%	Assessing needs	1.8%	3.9%
Building knowledge	8%	4.9%	Design and set-up projects	1.6%	2.6%
Training	6.6%	9.1%	Conferences	.4%	.6%

Where

The largest proportion of resources continue to be invested in what are considered rural[1] (39.8%) communities, followed by urban (32.1%), semi-isolated (18.7%) and isolated (9.3%) environments. The largest number of communities serviced by AHF are in Ontario (229), British Columbia (222) Saskatchewan (175), Manitoba (128) and Alberta (119). Survey respondents reported, in total, that 1,264 (n=162) communities were being serviced by AHF-funded activity. The solid majority were in communities with a population of 2,000 or more (65%, n=161), a substantial increase from groups surveyed in 2000 (41%, n=233). The remaining projects are in communities of 1,999 or less and some operate in very small communities (15%), with 500 people or less.

1 **Isolated** - a community that cannot be reached by road or ferry service.
Semi-isolated - a community that can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people.
Rural - a community that can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people.
Urban - a community or community of interest that can be reached by road or ferry service and is located within 50 kilometres of a town or city with more than 25,000 people.

When

It is clear that the impact of history has strong facilitative and hindering effects on project performance. Outlined below are the dynamics that help or hinder project goals.

Community dynamics that help

- ✓ *cultural celebration;*
- ✓ *family support (parenting skills);*
- ✓ *inter-agency collaboration;*
- ✓ *student support;*
- ✓ *recreation;*
- ✓ *local access to a variety of services;*
- ✓ *small group who focus on own healing serve as a catalyst for community;*
- ✓ *those who genuinely want healing; supportive leadership;*
- ✓ *access to training;*
- ✓ *children's services;*
- ✓ *awareness of the Legacy;*
- ✓ *youth programs;*
- ✓ *media coverage;*
- ✓ *increased openness facilitated by litigation and associated publicity;*
- ✓ *word-of-mouth communication; and*
- ✓ *public apologies.*

Community dynamics that hinder

- ✓ *"culture" of violence; religious resistance to resurrection of traditional spirituality;*
- ✓ *youth criminal or gang activity;*
- ✓ *crowded living conditions;*
- ✓ *murder and suicide;*
- ✓ *high unemployment;*
- ✓ *addictions (alcohol and drug);*
- ✓ *gossip, denial, "don't talk, don't feel" attitudes;*
- ✓ *political instability;*
- ✓ *imbalanced political priorities (land claims consume all political energies);*
- ✓ *mismanagement of community resources;*
- ✓ *service budget cuts;*
- ✓ *gambling;*
- ✓ *lack of training and skills;*
- ✓ *abuse of prescription medication;*
- ✓ *lack of clinical supervision;*
- ✓ *illness; and*
- ✓ *staff turnover.*

Impact on Individuals

Participants rated project ability to provide respectful, welcoming and safe environments for healing very favourably (>85%, n=761). The majority also felt that their experience in the project helped them to handle difficult issues (71%, n= 726), resolve past trauma (75%, n=726), prepare for and handle future trauma (78%, n=731) and secure support (64%, n=675). Their *personal* goals were most likely to center around self-understanding or awareness, helping other participants (probably family and friends) and acquiring new skills or abilities. When asked about their ability to achieve *personal* goals in the context of AHF-funded projects, about a third indicated that they were able to do so completely or extremely well. About half felt that the project was good or very good at helping them attain personal goals; however, there remains a small group (about 10%) who are only minimally or not having their needs met. Both group and individual counselling sessions were weak when it came to resolving issues related to problems with the law, foster placement and sexual offending. Individual counselling sessions excelled at helping participants improve self-esteem and find individual strengths. Participants credited program qualities, particularly Legacy education and opportunities for learning (relationship skills, processing intense emotions) as most helpful. Bonding or connecting with other participants and cultural celebration were also considered powerful medicine. They were most likely to acquire relationship skills, new and improved ways of relating to self and coping or life skills. More time and greater individual therapeutic attention were participants' most frequent recommendations followed by improved communication (i.e., translation and accessible language), more widespread Legacy education efforts and greater integration of culture.

Impact on Community

In 2002, $1,619,520 worth of volunteer effort was contributed and an estimated $6,195,479 worth of donated goods and services was contributed. A total of $6,921,282 was received from partners during project operations (n=87), with the greatest total amount coming from Aboriginal governments, followed closely by the federal government. A total of $2,589,920 was secured in on-going funding (n=37) with provincial partners followed by Aboriginal governments as the most generous contributors to on-going healing. Some (23%, n=164) are sure that they will not be able to continue once the Aboriginal Healing Foundation funding ends and 56% are unsure about their future.

Over a third (36%, n=166) of the projects who responded to the survey maintain a waiting list and only a small group (11%, n=160) were certain that their efforts were reaching those in *greatest* need. Most (70%, n=160) acknowledged that, although they were probably reaching those in greatest need, their efforts could be better. Some (3%) were unsure, while others (16%) were clear that they were probably or definitely not reaching those most affected by the Legacy. Increasing employee numbers and benefits remains the most important, albeit, most expensive priority need. Other priority needs that are the least costly to meet include improving Survivor and community involvement, increasing family support and access to parenting skills courses.

Best Practices

Forming a relationship through prolonged and informal exchange, meeting people at their current level of need and creating safe, *predictable environments* worked well. Identifying known perpetrators and arresting their activity reflected a serious consideration for safety. Framing activity positively by *"creating opportunities"* for learning, self-expression and cultural celebration was more inviting. Healthy behaviours and relationship patterns are best learned through illustration and exercise—not direction. Role models who can be in direct contact with participants over prolonged periods of time work best.[2] Learning was best received when it included Legacy education, human development and phases of grief. Validate emotions and

[2] Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, N. J.: Prentice-Hall.

acknowledge the ***full** variety* of Legacy manifestations without judgement so that abusers and offenders also feel acceptance. Offer many healing options (traditional and Christian), verbal and non-verbal, quiet and activity-oriented, along with humour and meal-time. Elders, traditional ceremonies and settings are consistently and hugely popular. *Survivors want connection with other Survivors*, especially during Legacy education efforts and appear to respond very well to *client*-driven therapies in more intimate venues (i.e., small groups or one-on-one). Adapting traditional or western approaches allowed for a blend of the best of both worlds to be integrated into therapy. Examples are highlighted below:

Traditions adapted	Western approaches adapted
✓ Sharing circles that allow for exchange; ✓ sweats that are *theme-based* or include genogram charts; ✓ spiritual cleansing partnered with physical cleansing; ✓ story-telling as a way of offering a "diagnosis" or explanation for the Legacy; ✓ train Elders as counsellors; and ✓ medicine bundles wrapped with contemporary self-care products.	✓ Métis wailers in grief counselling; ✓ songs, music, drumming, ritual and ceremony create atmosphere for therapy; ✓ involve western practitioners in ceremonies; ✓ *actively* promote and insist upon cultural integration in western systems; ✓ sentencing circles with Elders; ✓ self-help strategies with features of healing circles; ✓ therapy that emphasizes the current emotions and attitudes of the client, rather than early childhood experiences, and is consistent with traditional teachings; ✓ therapy that emphasizes social development of an individual's developmental experiences *heavily* influenced by traditional knowledge; ✓ attachment theory resonates well in Legacy education; and ✓ Inner Child therapy within the healing circle.

Selecting and caring for the team was a common feature attributed with successful performance. In particular, team members had to be familiar, "*skilled*," well-respected and connected to the community. They had to be able to provide stability, operate *without* a set agenda, be free from the need to control, listen intently, understand and, most importantly, facilitate *independent* decision-making. They held regular debriefings where team strengths, limitations and early signs of stress related symptoms and compassion fatigue were openly discussed and had their own wellness plans. Lastly, little was considered as powerful as Legacy education, not just as a catalyst for healing, but also as a powerful way of engaging and influencing broader-based institutions. Survivor and Elder involvement in governance structures, program decision-making or in less formal exchanges were *highly valued.*

Greatest Challenges

Challenges faced by project teams are directly related to: environmental or contextual factors; the task at hand; and issues related to team care. Isolation, racism, oppression and political interference continue to create hostile environments. In other cases, environmental problems were related to the lack of warm and welcoming facilities. Fear and denial continue to thwart team efforts and where a "culture" of violence permeates community institutions, there is little movement. Crisis, lack of awareness and concern about the Legacy, gossip and anger were considered major roadblocks. While no one who endeavoured to address the Legacy thought it would be a snap job, few really had any idea of the resources and time required to support participants and communities through such a dark time where issues of identity, culture, economy, spirituality, family and education all require investment. Managing an appropriate "fit" between therapeutic approaches and individual participant needs or preferences overwhelms some teams. The sheer volume of work and its emotional intensity has left some front-line workers at risk of exhaustion or burn-out.

Lessons Learned

Project teams are clearly engaged in a "learn as you go" approach where the lessons revolve around several central themes, including: the extent and complexity of the problem; basic requirements of therapy; team strengths; and role of community. Unravelling the tangled Legacy web requires focused energy and effective strategies to deal with identity, culture, relationships, parenting, education, economy and spirituality; all issues that are *deeply rooted* and require a *lengthy recovery*. Teams have learned that healing does not happen all at once or by a neat schedule; it is a delicate progression that needs to be internally driven and externally accommodated. All approaches work better when there is a "readiness" and commitment to healing, personal empowerment is facilitated, self-esteem enhanced and culturally reinforced. Strong team members who are successful models of healing, preferably Survivors who are able to balance their own lives, are well trained and are free from the need to control, rescue, enable or care take, work well. Where a community culture of violence, denial, competing political priorities, religious resistance and individual concern about monetary compensation prevailed, healing goals were thwarted. Several saw Legacy education as "the answer," especially for youth and in the broader Canadian context. They also want partnerships established with educators and tools to help all who are eager to learn.

Recommendations

Since all funding by the Aboriginal Healing Foundation will be committed by October 2003, the following recommendations are directed to all funding agencies who will continue to support healing from the Legacy. These recommendations have been generated from both project team and participant voice, as well as an analysis of the convergent themes identified from data collection associated with the evaluation of AHF activity in 2002.

For Project Teams

- Add Child Abuse in Community Institutions and Organizations: Improving Public and Professional Understanding to Legacy education and individually focused therapies;[3]
- recognize a "readiness" or commitment to healing;
- ensure "fit" between the individual and services offered, train referral agents to make *appropriate* referrals based on the goodness of "fit;"
- address a unique need with a special strategy for a well-defined target group;
- strive only for *realistically* attainable outcomes;
- form a relationship with participants, based on acceptance, trust and safety;
- use therapies that are internally driven or client-directed;
- frame the journey positively by "creating opportunity" for learning, self-expression and cultural reinforcement;
- create opportunities for healthy behaviours, self-understanding and relationship patterns *to be learned through illustration, not direction,* then *exercised*;
- use role models;
- offer a *variety* of healing options;
- take advantage of the good will that humour and meal-time create;
- use Elders, traditional ceremonies and settings;
- examine the utility of attachment theory, theory of psycho-social development, client-directed therapy, Inner Child therapy, psychodrama, genogram charts and active, non-verbal, non-logical approaches, such as art therapy for your group;
- take into consideration special features for unique targets (i.e., youth/children, Elders, men, offenders, Métis and Inuit) that have been identified as promising in this report (see Table 9);
- carefully screen potential healers and consider criteria outlined in this report (see Table 4);
- use group debriefing to diffuse the intense emotion of the work. Recognize compassion fatigue and ensure teams have well-developed boundaries and wellness plans;
- do performance reviews and peer evaluations to improve your work;
- design a training program with sufficient time to absorb material, adequate opportunity for clinically supervised practice and on-going support; and
- secure greater support from granting foundations and municipal governments (see the Aboriginal Healing Foundation (AHF) website at www.ahf.ca).

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[3] Wolfe, D. A., P. G. Jaffe, J.L. Jette and S.E. Poisson (2002). Child Abuse in Community Institutions and Organizations: Improving Public and Professional Understanding. Ottawa: Law Commission of Canada.

For All Funding Agencies

- Provide healing to those who are "ready" and support Legacy education for those who are not;
- develop an adaptable assessment tool for individuals and communities;
- encourage and establish partnerships with educators and publish tools to help *all* who are interested in Legacy education;
- provide guidance for outreach and treatment designed specifically for sexual abuse victims and offenders;
- offer promising strategies for engaging seniors and retaining youth;
- support training that provides sufficient time, clinically supervised practice and arrangements for on-going support;
- a more realistic and detailed vision of the healing journey for participants must be stated;
- make greater use of television and radio for Legacy education (Aboriginal Peoples Television Network, Inuit Broadcasting Corporation). Consider special programming specifically for Métis and Inuit communities;
- develop popular and accessible versions of information gathered that can be shared (common language, audio-visual, hosted chat rooms);
- based on the responses to the survey that Aboriginal and provincial partners are the most generous with respect to on-going funding, it would be helpful for others to match their commitment; and
- secure a purposeful sample in future research and evaluation efforts so that Métis and Inuit voice can be equitably represented.

For Governments and Institutions

- All Canadian professional associations urge members to become well-versed on Survivors' needs, set aside time at annual conferences to address Legacy issues and formulate an enduring commitment to ending the Legacy by engaging or supporting those addressing the Legacy in the community;
- change policy as it relates to disclosures made by incarcerated Survivors. Rather than negatively affecting release time, considered disclosure within a more comprehensive index that measures overall progression;
- all churches, but in particular Euro-Christian institutions, must issue public statements regarding their *encouragement and support of Aboriginal culture and spirituality;*
- any responsible parties who have not done so must issue a public apology: furthermore, it is helpful if the media publicize the apology; and
- all institutions and governments support and reinforce *internal* moral authorities and community-based checks and balances *that prevent highly placed victimizers from using their power to perpetuate the cycle of physical and sexual abuse and shroud it in secrecy.*

Concluding Remarks

Whenever social movements are ignited, it becomes difficult to discern cause from effect. In fact, over time, effects become causes and so the circle goes. For Survivors, their families and their communities who have been introduced to the possibility of a better tomorrow, things will never be the same and, while the evidence suggests that AHF-funded efforts have made a contribution, it is impossible to offer specific credit to a single initiative.

It is clear that those affected by the Legacy are engaged as never before, with the vast majority (>98%) having never participated in a similar healing program and *three times as many participants were identified with special needs* (the term "special needs" used in this report is meant as having some sense of vulnerability) in the current sample of sponsored projects. This may suggest that:

- projects are better able to reach those in greatest need;
- those who fearfully waited on the sidelines initially, became convinced that projects were safe healing places and positive learning environments; or
- project teams are better able to identify those with special needs (e.g., life threatening addictions, risk of suicide, FAS/FAE and other emotional or physical disturbances).

In any case, the extent of participation by individuals who have never engaged in healing before is an indication of the contribution that the AHF has made to increasing the connection between Survivors and healers. In addition, AHF-funded activities increased the capacity of Aboriginal people to provide healing services. There are also a variety of indices that suggest the demand for services and community support may be increasing and resistance to healing decreasing.

Consistently, participants were eager to understand and help themselves, as well as connect with and assist other participants. They credited Legacy education, more general opportunities for learning and connection with other participants as the most powerful elements of healing. In addition, the fruits of AHF-funded activity have also led to greater clarity about:

- protocols and procedures that support participants on their healing journey;
- creative strategies for dismantling denial and fear;
- screening criteria for potential healers (with a special focus on the Survivor as healer); and
- effective blends of western and traditional therapies. Association with project activity, either as a volunteer or in other ways, inspired a major portion of Survivors to engage in healing. Working to address the Legacy was a safe way to determine whether or not healing was right for them.

Still, the influence of community dynamics on project performance is *very strong*. The structural differences between communities that facilitate and those that hinder illustrate community systems are in-extractable from the healing equation. Most projects are still struggling to ensure sustainability, although initial contributions have been received. Lastly, despite living with the aftermath of residential schools for generations, the *extent and complexity* of the Legacy's impact has now become crystal clear for many project teams. Unravelling its tangled web requires focused energy and effective strategies to deal with identity, culture, relationships, parenting, education, economy and spirituality; all issues that are *deeply rooted* and require a *lengthy recovery*.

Measuring change along that journey is complicated by the fact that communities and individuals start their healing at different points in space and time and the progression is a complex interplay between *environment* and *person*. If goals are best achieved by beginning with the end in mind, then a more detailed vision is still required that takes into account the Legacy's complexity and the mandatory time to erase it from Aboriginal life in Canada. Clearly, approaches for addressing the Legacy must be tailored upon community and individual *'readiness'* to heal, framed positively and involve contributions from a broad range of Canadian institutions. Lastly, still missing and vital are the fuller details about long-term consequences of participation in AHF-funded activity and the unique perspective of the Métis and Inuit groups.

1. Introduction

This report is the third in an evaluation series completed for the Aboriginal Healing Foundation (referred to as the AHF). The first report, An Interim Evaluation Report of Aboriginal Healing Foundation Program Activity (2001), focused upon the formative stages of the AHF's work; while the second report, *Journey and Balance, Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity* (2002), concentrated upon the attainment of desired short-term results through case studies of selected AHF-funded projects. A blend of both process and impact evaluation, the primary intent of this interim account, is to highlight *new* information drawn from the second national survey and current data from the AHF's information management system, as well as reinforce a *question-driven framework* for the AHF's remaining work. An abbreviated refresher of the AHF's central activities and desired outcomes are reiterated here,[1] followed by a discussion of methods and detailed information on projects and performance that is structured in a way that answers key questions.

The Aboriginal Healing Foundation is an Aboriginally-run, non-profit corporation that was created on 31st March 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 (herein referred to as 'the Legacy'). The AHF's ultimate, long-term goal or vision statement is to create conditions where Aboriginal people, as key agents of change, build upon their strengths and capabilities to heal:

> *Our vision 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.*[2]

Over time, the AHF has sharply focused its target to projects that 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. The project types eligible for funding included: healing services, prevention and awareness campaigns, training, knowledge building, needs assessments, those who honour history, conferences, as well as project design and set-up. The project activities and types are not mutually exclusive. For example, many healing programs have awareness campaigns as a first step. 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 and professions;

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[1] For a fuller discussion of activities and AHF evolution, the reader is referred to the first two reports in the evaluation series.

[2] Aboriginal Healing Foundation (1999). Program Handbook, 2nd Edition. Ottawa: Aboriginal Healing Foundation, page 6.

- **strengthened positive ties between those suffering from 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. A logical model of the healing path is offered in Figure 1.

Figure 1) Aboriginal Healing Foundation: The Logic Model

What we did

Provided support for:

- community healing efforts; build, reinforce and sustain conditions conducive to healing and self- determination
- developing and enhancing capacity
- sharing history; engaging Canadians generally toward reconciliation
- promoting awareness of healing issues and needs
- engaging in knowledge building and planning exercises

How we did it

Provided funding resources for:

- participation in community and healing services
- participation in conferences and gatherings
- distribution or use of resource materials, training and educational programs
- strategic planning exercises
- distribution of research and knowledge building

<-------- What Happened? ------------------->

Short-term

- increased awareness of needs and issues
- increased capacity of Aboriginal people trained in healing
- increased connection between those in need and healers
- increased # and quality of strategic plans with a focus on healing
- increased documentation and publication of the impact and history of the Legacy
- increased honour for those who suffered
- increased participation in healing journey

Long-term

- those affected by the Legacy 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 with self, family, community and Canadians generally

<------------- What Changed? ------------->

2. Methods

The methods described here are restricted to the primary data sources used for the preparation of this interim report; namely, the second national survey (Appendix 1), individual participant questionnaires (Appendix 2), one focus group discussion with 10 selected AHF-funded projects (Appendix 3), document review of the minutes of the AHF regional gatherings and the use of the AHF's internal database. For a fuller discussion of the conceptual and technical issues associated with the overall evaluation of AHF program activity, the reader is referred to the second evaluation report based on thirteen case studies of selected AHF-funded projects: Kishk Anaquot Health Research (2002): *Journey and Balance, Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity*. Information has been culled to answer the following key questions with a general focus on the attainment of desired short-term outcomes, as well as fruitful material for users and decision-makers (i.e., those addressing the Legacy). The selected approach to the evaluation is a blend between a goal orientation and user-valued approach. Table 1 illustrates the questions that the evaluation has been designed to answer, based on the blended approach:

Table 1) Primary Evaluation Questions

Goal Orientation What evidence is there that AHF has contributed to desired outcomes and experiences?	**What has been the impact on individuals?** ▸ understanding and awareness of the Legacy ▸ healing ▸ capacity as healers **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?

A performance "map"[3] has also been prepared by summarizing project activities, intended target groups, desired short and long-term outcomes, together with potential indicators. The "map" is intended as a simplified, "bird's eye" view of the evaluation effort.

3 Montague, S. (1997). The Three R's of Performance: Core concepts for planning, measurement and management. Ottawa, Ontario: Performance Management Network, Inc.

Table 2) Performance Map

Mission Statement: Our 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.

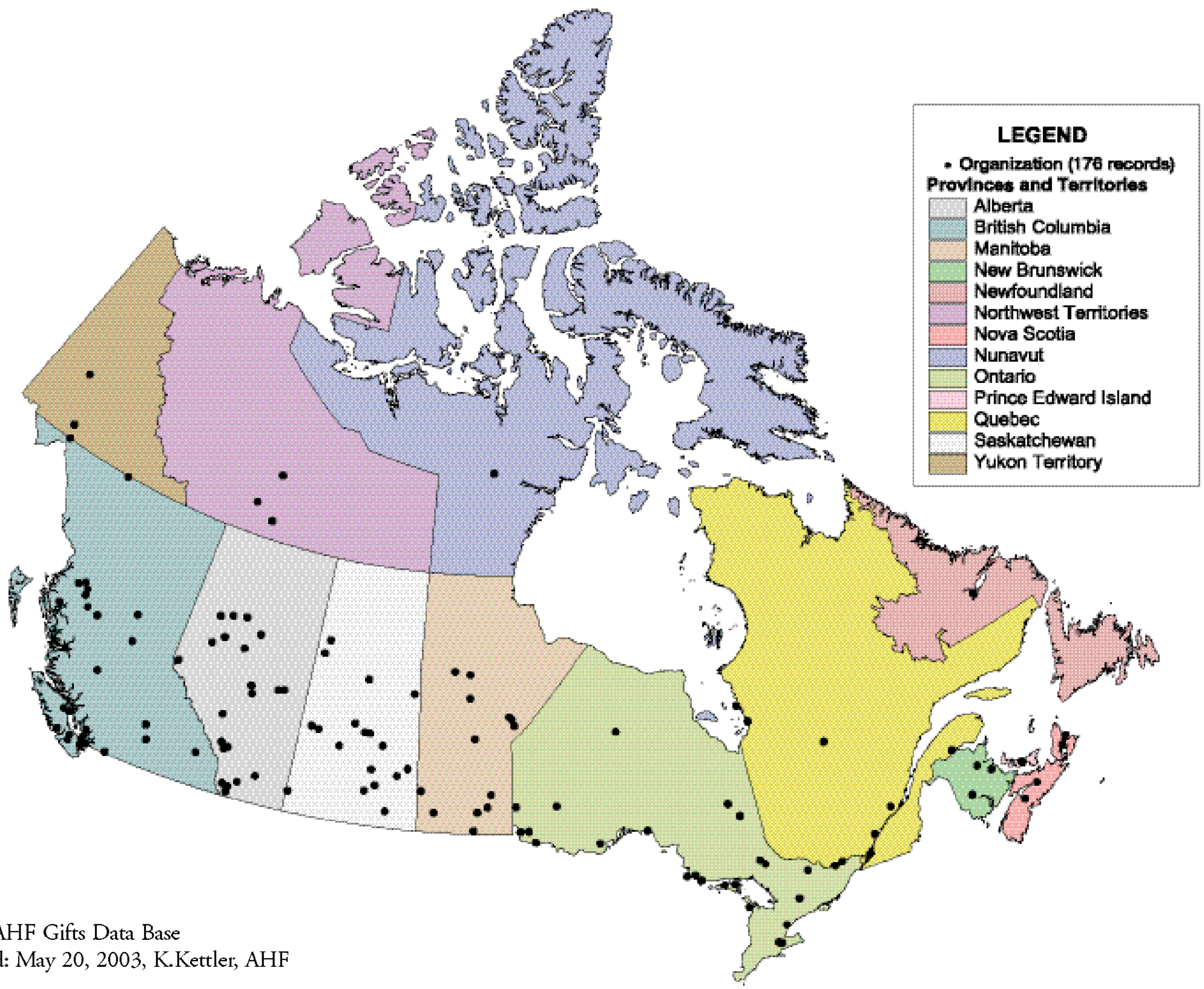
HOW?	WHO?	WHAT do we want?	WHY?
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**longer-term outcomes**
support community healing efforts; build and reinforce conditions conducive to healing and self-determination; develop and enhance capacity; share history; engage Canadians generally toward reconciliation; promote awareness of healing issues and needs; engage in research and knowledge building (develop resource materials, training and educational programs)	those suffering from the Legacy, potential healers, broader Canadian public (institutions and individuals)	increased awareness; increased number and quality of strategic plans with a focus on healing; increased partnership; increased connection between those in need and healers; increased capacity; 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; reconciliation with self, family, community and Canadians generally

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

Resources	Reach	Immediate Measures	Long-Term Measures
one-time grant of $350 million plus interest earned	# 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 people

Whenever possible, relevant numerical information from the AHF's internal databases were used and were the primary source for financial information, which is broken down by target group and geographic situation. A document review was limited to the examination of minutes prepared for the AHF regional gatherings to isolate common issues and questions, as well as the AHF's response to the community. Since 1999, there have been a total of 22 gatherings with 2,880 attendees and five more gatherings are scheduled. Information was secured through a mail-out survey that focused primarily on community context, target group characteristics, program teams, service delivery preferences, the distribution of resources and accountability issues. This survey was based largely upon the first one (conducted in February 2001) and is presented in Appendix 1. The survey was then mailed to all projects that were operational at the time (December 2002) with two follow-up phone contacts to ensure compliance. Lastly, because the short-term impact of funded activity is probably most evident in individual lives, a more discriminating approach to measuring change was attempted through the development of an individual participant questionnaire (IPQ). The questionnaire was adapted from feedback forms used at the Tsow Tun Le Lum Residential Treatment Centre to better reflect the intended goals of the AHF's healing projects and can be found in Appendix 2. A total of 384 surveys and IPQs were sent to all grant recipients who were instructed to reproduce, distribute and administer as many IPQs as needed. Participants were given the choice of returning the IPQs directly to the AHF or submitting them to project teams to be returned in bulk by the coordinator. Figure 2 shows organizations who returned an AHF survey.

Figure 2) Organizations Who Have Returned an AHF Survey,[4] 2002



Source: AHF Gifts Data Base
Produced: May 20, 2003, K.Kettler, AHF

[4] For a breakdown of total numbers for each province/territory, please refer to Appendix 4.

A total of 176 surveys and 826 IPQs representing 94 projects were returned in time for the preparation of this report. The distribution of surveys returned by region are tabulated in Appendix 4. Numerical and categorical data from the mail-out survey and the IPQs were analyzed using the Statistical Package for the Social Sciences (SPSS version 10). Univariate analyses included frequencies, sums, ranges, averages and medians. All open-ended survey and IPQ data were entered (only IPQ qualitative data were coded) and qualitative analyses were done; some cross-tabulations were conducted to isolate unique trends. Lastly, it is understood that AHF-funded activity is poised to impact on major life management and social issues. The AHF acknowledges that the healing journey will be a long, complicated challenge. The picture is further blurred by the fact that program themes and impacts are not specific and focus upon residential school Survivors from each Aboriginal group (i.e., Inuit, First Nation and Métis) in an extremely broad range of circumstance (i.e., isolated, rural, urban, incarcerated).

2.1 Limitations

All research efforts are limited in some way and the information offered here is intended to help decision-makers weigh the significance of this report. The data are limited by the fact that roughly half of all operational projects in 2002 (176 of a possible 384 projects) responded to the national survey. Still, when examining respondents to non-respondents, there were no discernible differences on a number of variables, including: organization type, region, ethnicity, year grant was made, grant amount or project type. Although, for the first time, the AHF has access to *direct* participant voice representing participants from over 90 projects, the total number of respondents (826) remains a very small self-selected sample (out of a possible 129,804 who may have participated last year) with a dominant First Nations perspective. Given the limited resources available to capture Survivor voice nationally, the strength of the sample is directly related to the fact that these 826 participant voices have been drawn from over 90 different projects.

The instrument used to solicit participant voice was adapted from a feedback tool developed by the clinical team in collaboration with residential school Survivors working with Qul Aun at the Tsow Tun Le Lum Residential Treatment Centre in British Columbia. Most adaptations were included to reflect the unique *healing* goals of AHF-funded activity and to isolate the successes and challenges of selected therapeutic approaches. Although it is not a standardized instrument, no psychometrically evaluated or standardized instrument exists to determine the unique healing stages of Aboriginal people recovering from the Legacy of Physical and Sexual Abuse in Residential Schools. Although no training was offered to project teams to help them administer the individual participant questionnaires or the national survey, administration guides were prepared for both instruments to clarify any questions and improve data accuracy. The survey and questionnaires were administered independently in the field.

The lines of evidence include survey responses from, and focus group discussions with, project teams, internal AHF databases and direct feedback from participants. Dissent was encouraged in at least two introductory remarks preceding the individual participant questionnaire completed by participants:

- that there are no right or wrong answers, only answers that are true from your perspective; and

- the report will *not be able to identify who said what*, so please feel free to say things that may cause controversy.

Attempts to secure disconfirming evidence, rival explorations and negative cases were limited to contextual information secured through national surveys and individual participant questionnaires. While it is clear that there are some participants who are not achieving the same level of personal satisfaction, time and resource limitations have prevented further probing of these participants. Similarly, although immediate satisfaction and goal achievement are clear in the majority, it is not clear what the long-term consequences are of project participation and if they create enduring and healthy changes in participants' lives. In short, the most important information missing is the *longer* term follow-up of participants' progress.

Multiple evaluators, both in the field and nationally, were not available within resource limitations. Methods were heavily reliant upon the abilities and willingness of project teams to engage. The information presented here was collected and analyzed by Aboriginal people, some of whom may have also been affected by the Legacy, and their perspectives on healing may have influenced how the information was collected and reported. However, it is imperative that cultural insiders, as well as participants, offer insights that are not available to others. As with the previous national survey effort, much of the information reported here was collected over a five-month period (from mail-out to receipt).

Lastly, there is a noted dominance of First Nation voice in the participant sample and survey respondents, generally meaning that the unique issues and needs of Métis and Inuit groups remain elusive.

3. Who, What, Where and When

This section describes the process indicators by answering the who, what, where and when questions. Because this section focuses heavily upon quantitative information, some explanation is offered as a way of sharing with the reader what the numbers mean. First of all, not all people answered every question in the survey; therefore, the reader will see in parentheses (n =) where "n" is the total number of responses received for that particular survey item. The number of responses becomes *very* important for interpretation when *only a few* projects have answered a particular survey item. In other words, *generalizations about the information presented here can only be made when a sufficient number of responses are noted*. In addition, *two* measures of central tendency[5] (or the middle) have been used: the **average** and the **median**. For simplicity, the average is used in many cases; however, when the *median* is vastly different from the average or when the standard deviation is high, the median or the *half-way* mark is used because it is a *better* measure of central tendency (averages are strongly influenced by even one very high or very low figure[6]).

What do all the numbers mean?

What does n=138 or n=672 mean? This refers to the number of people who responded to a particular question. It is important to know how many people answered a question because it helps to determine how representative or common the statement might be for the whole group. If very few people respond (i.e., 156 out of a possible 826) then the reader must "take this information with a grain of salt" because it may or may not represent the opinion of all 826 people.

Why do the percentages not add up to 100%? In some cases, the percentages do not add up to 100% due to rounding (i.e., making 13.7% into 14% or 2.2% into 2% to keep it simple). Sometimes, percentages do not add up to 100% because some answers were not valid or readable and this information becomes lost. Usually, this represents a very small percentage (almost always <5%) of all answers received for any question.

5 **Central tendency** really refers to the "middle" or attempts to describe what is the typical or the usual response.

6 To find the average for the following numbers: 1, 2, 3, 4, 5, 6, 7, 8 and 1000, add each number and then divide the total numbers (9) to get 115. The median would be the middle number = 5. Which is the better measure of the middle or usual response (i.e, central tendency)?

3.1 Who

3.1.1 Participant Characteristics

Participant characteristics help planners to better understand needs, identify gaps, mediate the environment or restructure the program to facilitate the achievement of desired results. Because the bulk of the AHF investment is in healing and training, the results are profiled to highlight these two project types. Almost half (42%, n=176) of projects have a healing only focus, while only a few (4%) are training only. The largest proportion (48%) provides both healing and training. The following sections report on the participant characteristics for these two project categories.

3.1.1.1 Healing Project Participation

Healing includes a wide variety of activity that is individually and community-focused. To distinguish between the clinical or individually-focused healing and community development efforts, respondents (project teams) were asked to consider only those who attend healing activities on a regular basis (i.e., more than once) and provide their opinion of those participants who *want and need* healing services. Excluded from this group of participants would be casual attendees at a project-sponsored feast or celebration. For this set of AHF-funded projects, an estimated total of **59,710** (n=140) **participants** with a median of 183 participants per project (average= 426) attended healing activities.[7] The participants spend an average of one hundred and forty-nine (149) hours in healing activity (median = 80 hours, n=117) and can spend as little as two or as many as 1,225 hours in programmed healing activity.[8] Proportionately, the largest groups are on and off-reserve First Nations (51%[9] and 29%, respectively), followed by the Métis (11%), others[10] (8%) and Inuit (1%).[11] By comparison, the latest census data reveal that 64% of the Aboriginal people in Canada identify as North American Indians, 31% as Métis and 5% as Inuit.[12]

7 Survey 2000 results show a total of 48,286 participants (n=221; median 133, average 219).

8 Survey 2000 results show an average of 183 hours in programmed healing activity (n=162; median 60, range from 2 to 2,821 hours).

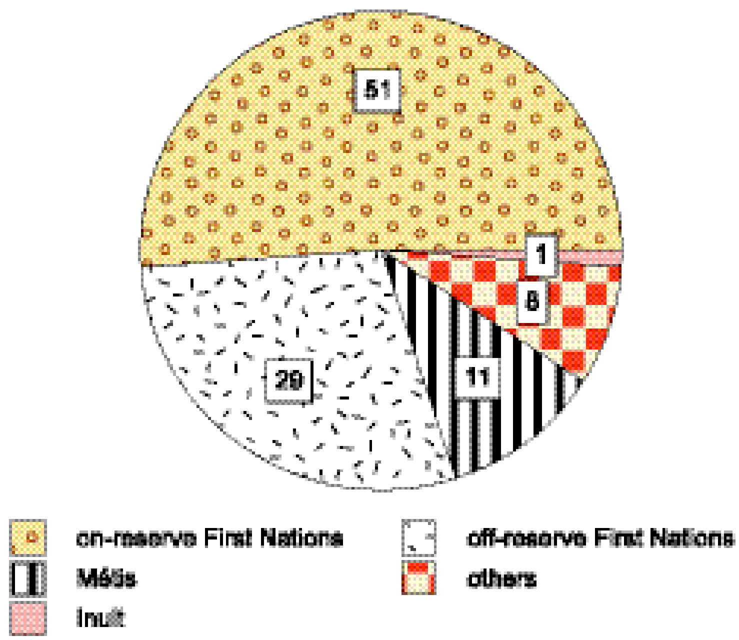
9 The percentage of participants in an Aboriginal group was calculated by using the number of total participants identified by ethnicity as the denominator and the total number within specific Aboriginal identity categories as the numerator.

10 Although the category "others" has not been defined, it is suspected that this includes the non-Aboriginal partners or family members.

11 Survey 2000 results show that on-reserve First Nations = 57%; off-reserve First Nations = 29% (n=187); Métis = 11%; and Inuit = 3% attended healing activities.

12 Statistics Canada (2003). Aboriginal Peoples of Canada: A demographic profile. Ottawa: Statistics Canada.

Figure 3) Healing Participation by Aboriginal Identity as Reported by Survey Respondents

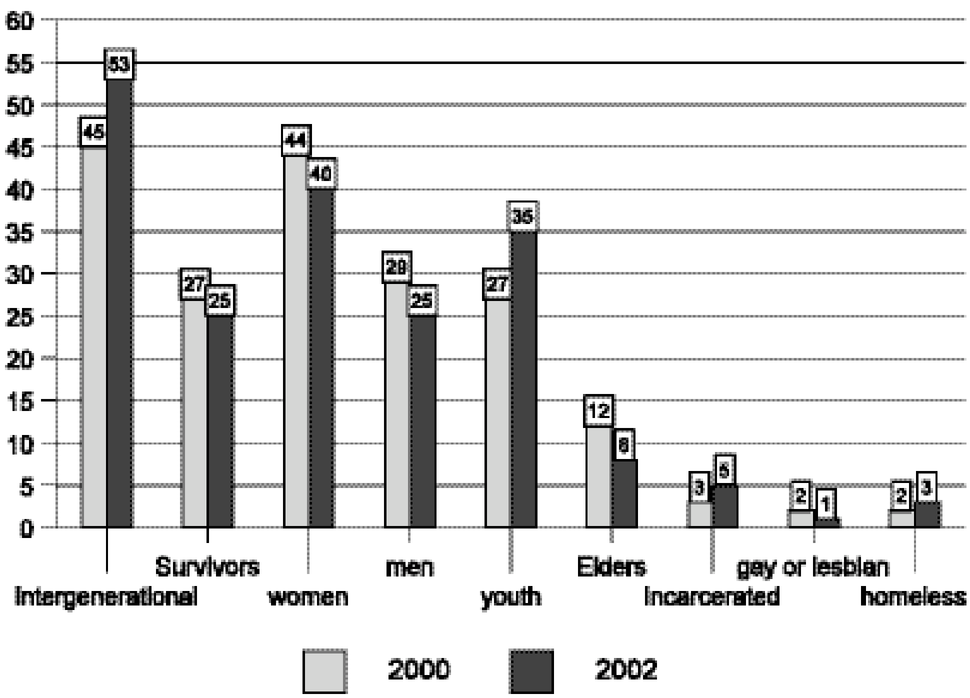


When looking at the healing participation by target group, the two largest target groups appear to be intergenerationally impacted (53%)[13] and women (40%), followed by youth (35%), men (25%), Survivors (25%) and Elders (8%). Only a few were incarcerated, gay, lesbian or homeless (5.1%, 1.4% and 3.3%, respectively).[14] This distribution is starkly similar to the first survey in 2000, although a few trends are noteworthy: there are proportionately more youth, incarcerated, intergenerationally impacted and homeless participants. The reader is reminded that these are *not specific* categories. In other words, one participant can fall into many categories (i.e., one person can be a male Elder who is a Survivor). Figure 4 shows healing participation by target group.

[13] The number of participants in a target group (i.e., intergenerationally impacted) was divided by the *total number* of participants in a healing activity. This resulted in a percentage for that target group for each project. The average was then calculated for all projects.

[14] Survey 2000 results show that intergenerationally impacted (45%); women (44%); men (29%); Survivors (28%); youth (27%); Elders (12%); incarcerated (3.1%); gay or lesbian (2%); and homeless (1.8%) attended a healing activity.

Figure 4) Healing Participation by Target Group (2000 and 2002)



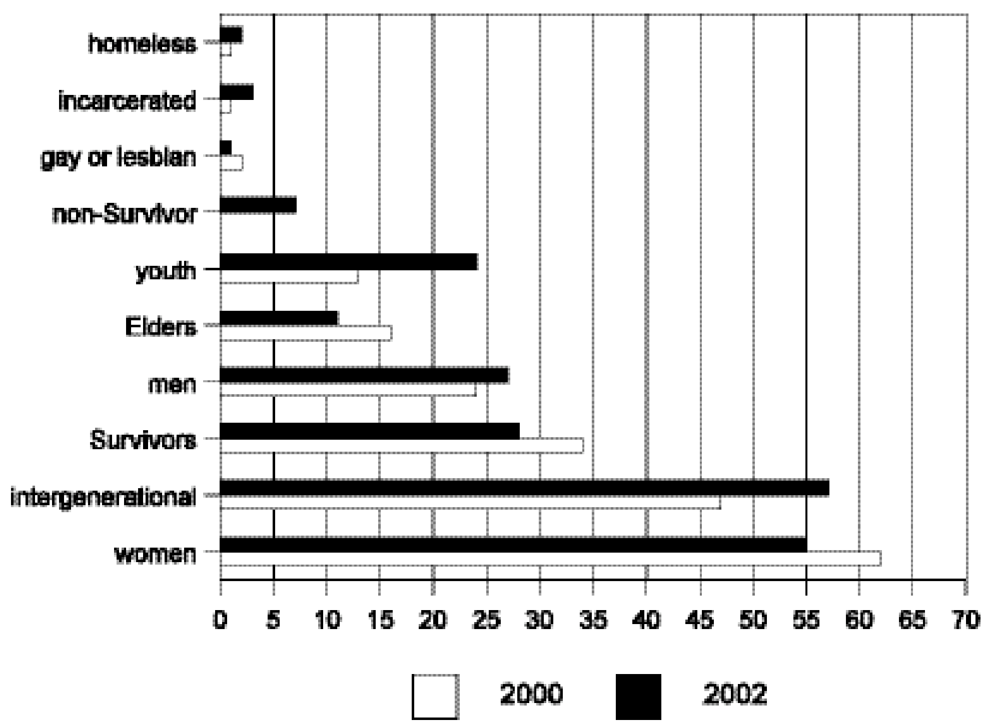
Lastly, it is interesting to note that *less than two per cent* of the participants in healing (or 6,775 out of 59,710) had previously participated in a similar healing program *before* they began attending an AHF-funded project (n=47). This appears to be an enduring trend. In part, this low number can be explained by the few projects that responded to this question. In other words, 140 projects reported having participants in healing, but only 47 projects indicated how many participants had previously participated in healing. Interpretation is then challenged by the fact that so few responded to the question. But, if it is assumed that this proportion of "first-time" participants in healing could be applied to *all* healing projects (n=140), this would still mean that about 20,180 participants in AHF-funded healing projects out of a total 59,710 had previously participated in healing and that a *full two-thirds* or 39,530 (by the most conservative estimate) could be considered "first-time" participants.

Survey respondents report that, although most participants completed their healing programs, some left prematurely because they were not "ready" to heal. Readiness was often defined by project teams as a stable commitment to sobriety and a drug-free life, as well as sufficient trust and a willingness to feel. Survey respondents reported that small community dynamics worked against some who were initially interested, but worried that confidentiality and safety could not be guaranteed. Others, precipitated by crisis, left once the crisis had subsided. Lack of child care and transportation, as well as physical illness, thwarted some participants' continued participation. Competing responsibilities made setting aside time for healing a real struggle. A few left due to "profound philosophical differences" and others were asked to leave because their behaviours presented a risk to other participants.

3.1.1.2 Training Project Participation

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. Training projects provided services to **11,968** (n=98) **participants** (median = 34 participants per project; average = 122).[15] On and off-reserve First Nations constitute the majority of training participants; 58% and 25% respectively. The Métis composed nine per cent, while the Inuit accounted for less than one per cent (.4%) of training participants. Others (presumably non-Aboriginal training participants) represented eight per cent.[16] The distribution of each Aboriginal group participating in training is presented in Figure 5.

Figure 5) **Training Participation by Aboriginal Identity**

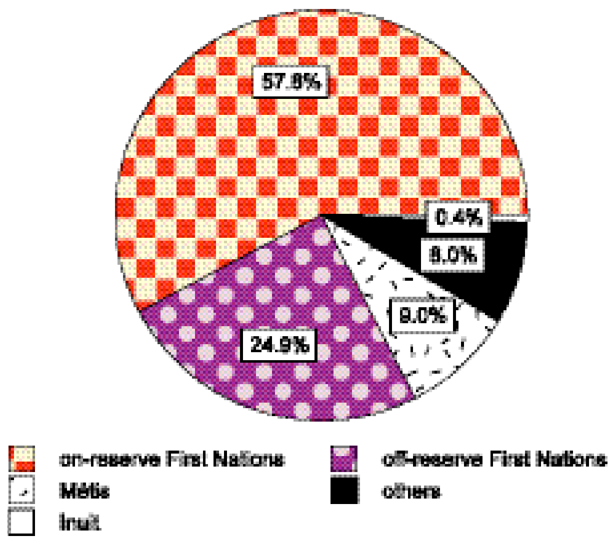


15 Survey 2000 results show that 10,938 participants (n=124; median = 22 participants per project; average = 88), with an average of 193 hours, attended training (median = 74 hours, n=92).

16 Survey 2000 results show the percentage of on-reserve First Nations at 60%; off-reserve First Nations at 26%; Métis at 9%; and Inuit at 5% who participated in training (n=108).

When looking at training participation by target group, it is clear that the intergenerationally impacted (57%) and women (55%) are well represented. Men account for just over a quarter of all training participants (26%), while Survivors compose twenty-eight per cent. Almost a quarter of the training group are youth (24%) and eleven per cent are Elders (11%). Only a few are incarcerated (3%), gay or lesbian (1%) or homeless (1%).[17] Although there have been noted increases in the representation of the intergenerationally impacted incarcerated and homeless training participants over time, youth representation has almost doubled. Figure 6 shows the distribution of target groups participating in training from both the 2000 survey and 2002 survey.

Figure 6) Training Participation by Target Group



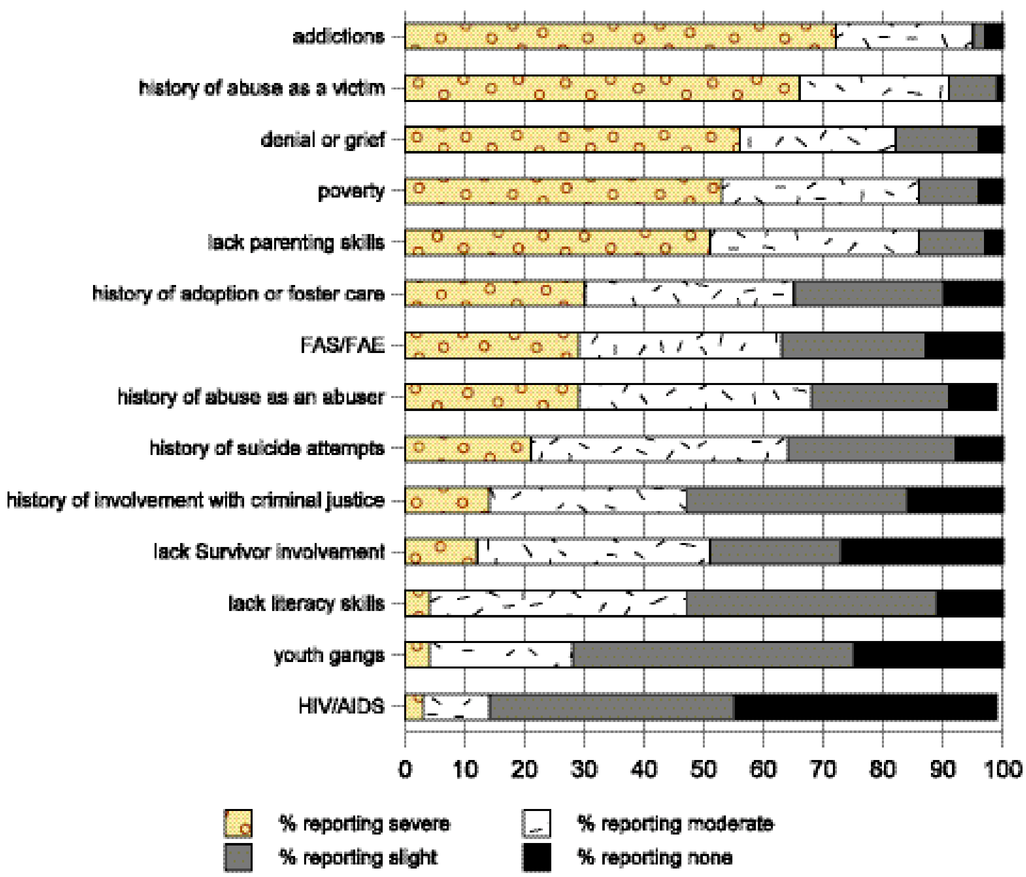
Survey respondents reported that participants withdrew from training because they had competing responsibilities related to job or family or did not feel "ready" to engage because the material re-traumatized them or they felt unable to handle the inevitable demands that their new-found skills would create. In other words, although keen to learn more about how to address the Legacy, some trainees felt the need for more *personal* healing first and were uncertain that they could eventually manage disclosures or provide general support to others. Some trainees lacked the commitment necessary to complete the program, others moved away and still others were incarcerated during their training period. Personal problems were regularly cited as a barrier to training completion as trainees struggled with addictions or poor health. Although rare, a couple of trainees left the program due to a *"profound philosophical difference"* with the training approach. Simple barriers included lack of transportation, child care, inconvenient scheduling (i.e., training offered during day-time business hours) and inadequate remuneration for their participation. Also, a few trainees were asked to leave because they did not comply with project policies.

[17] Survey 2000 results show that the intergenerationally impacted (47%); women (62%); men (24%); Survivors (34%); youth (13%); Elders (16%); incarcerated (1.4%); gay or lesbian (2.3%); and homeless (1.4%) participated in training.

3.1.1.3 Participant Challenges

Addictions, victimization, poverty, lack of parenting skills, together with denial and grief, are the most severe participant challenges affecting over fifty per cent of all projects. Other common challenges that were reported as severe by a sizable group (>25%) included: FAS/FAE, a history of adoption or foster care, as well as history as a perpetrator. More than half of all respondents categorized HIV/AIDS, youth gangs, lack of literacy skills and involvement with the criminal justice system as either a slight problem or no problem. Figure 7 illustrates the extent to which participant challenges may affect project operations.

Figure 7) Severity of Participant Challenges



The projects identified **23,603 individuals with special needs** (the term "special needs" used in this report is meant as having some sense of vulnerability, i.e., suffered severe trauma, inability to engage in a group, history of suicide attempts or life threatening addiction), which increased significantly from the amount reported in 2000 (7,589). If it is assumed that these individuals are in healing projects alone, this represents 39% of the total number of healing project participants (59,710).[18] Respondents to the 2002 survey have a higher number of total participants that could account for

[18] Survey 2000 showed that the results of the median percentage for those with special needs was 25%.

about half of the increase in participants with special needs.[19] Other plausible explanations for this dramatic increase are: "the word is out" that AHF-funded projects are a safe place to heal, that Legacy education is working and denial and fear are being dismantled for individuals who need the service the most. It is also possible that project teams are better able to identify those with special needs, either through training or their prolonged interaction with participants. Respondents felt that special needs were best addressed with more individually focused, longer term, consistent holistic treatment that included appropriate referral, after care and follow-up. Cultural reinforcement, the role of cultural healers, Elders and traditional approaches were all recognized as powerful medicine for special needs. One felt that more needs to be done to encourage support and understanding of the importance of culture as medicine within non-Aboriginal institutions and practitioners. Training was most commonly cited as a solution (76%, n=177). Specific strategies and training were recommended for:

- the treatment of offenders, adolescents and Elders;
- crisis response, debriefing;
- behavioural management;
- sexual abuse; and
- diagnosing FAS/FAE.

A few suggested that *environmental* change would support attention to special needs. More specifically, they recommended the restoration of strong, traditional social organization, as well as improving community conditions so that an improved quality of life could be offered as an incentive to heal. When this was not possible, some felt that having an opportunity to heal *outside* of the community might help. Other ideas included developing a climate of trust and making available traditional lands or sacred sites as healing centres. Supportive environments would eliminate the barriers to healing participation by providing child care, transportation or temporary housing for transient individuals.

Lastly, increased service access either through more developed networks or service organizations locally were consistently cited as a way of dealing with special needs. In fact, the majority (58% and 51% respectively, n=177) felt that increased access to the project team and to visiting professionals were needed. In particular, respondents called for:

- speech therapy;
- educational psychology;
- occupational therapy;
- special education;
- vision therapy;

[19] Because the median number of participants per project was 85 in 2000 and the median number of participants per project was 183 in 2002, this represents a 215% increase in median participation. If it is assumed that rates of participation alone would account for the dramatic increase, then it would be expected that 16,316 individuals would be identified with special needs, leaving an increase of 7,286 to be explained.

- infant stimulation;
- addiction treatment;
- crisis shelter;
- 24/7 intervention;
- literacy programs;
- family facilities;
- couples counselling;
- play therapy;
- psychodrama;
- body work; and
- outreach (especially for the incarcerated and the intergenerationally impacted).

Many felt that these services should be designed and controlled by Aboriginal people.

3.1.1.4 Participant Selection Criteria

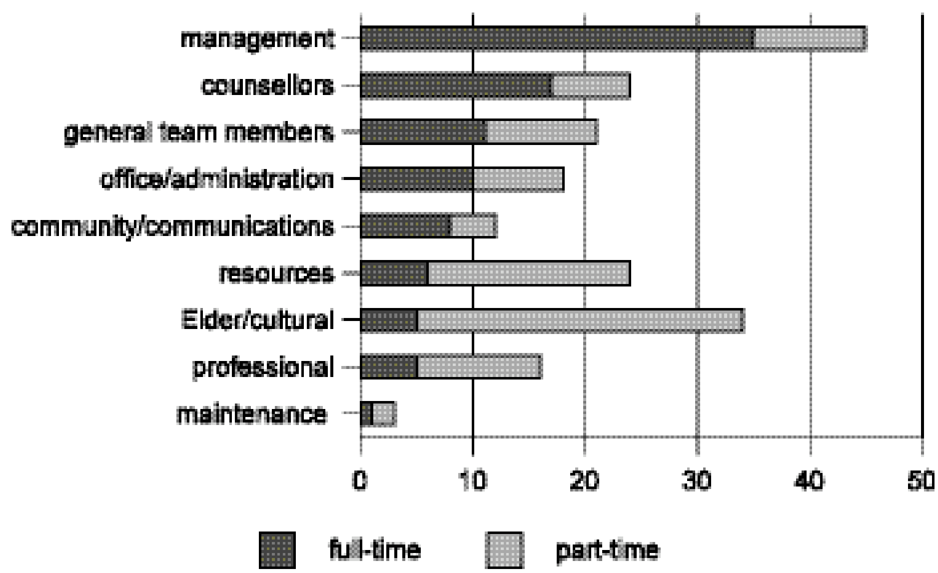
Interestingly, the majority (56%, n=164) claim to be *unable* to accommodate all who need therapeutic healing or desire training.[20] When they had to choose, projects were most likely to select participants based on their level of need or risk and "readiness" to heal or train. "Readiness" was usually characterized as self-motivation, stability, sobriety and a demonstrated interest in and commitment to healing or training. Others placed Survivors at the top of their priority list, while some felt that children and youth or families with children should be first. A few had a "first come, first served" policy, used a random approach or were pressured by the need to maintain geo-political fairness in service access.

[20] Survey 2000 results show that the majority could service demand (55%, n= 234).

3.1.2 The Team

AHF-funded projects reported a total of 2,733 paid employees (n=169); 931 of which are full-time positions (i.e., working more than 30 hours per week on a regular basis). Per project, the average team size was five full-time employees (median = 3) and 10 part-time employees (median = 4) for an average team size of about fifteen. In hierarchical order, teams are most likely to be composed of management positions,[21] Elders and other cultural teachers, resource personnel,[22] counsellors, general project team members,[23] followed by office administration, professionals[24] and communications.

Figure 8) Distribution of Full and Part-Time Team Members by Position



21 Management positions include all directors, assistant directors, managers, assistant managers, supervisors, team leaders, administrators, coordinators and assistant coordinators.

22 Resource personnel include facilitators, instructors, students, guest speakers, workshop organizers and Survivors.

23 General team members include all those identified as helpers, workers, trainees, team members, crime prevention, videographer, front-line worker, support staff, child care worker, social worker, program assistant, program worker, crisis intervention worker, field staff and cook.

24 The professional category included psychologist, therapist, nurse, consultant, researcher, mental health professional, contractor and evaluator.

Ninety-one per cent of all full-time positions and eighty-five per cent of all part-time positions are occupied by Aboriginal people (n=160). Table 3 shows the breakdown of the Aboriginal identity in full and part-time teams.

Table 3) Aboriginal Identity of Full and Part-time Project Teams

Identity	Full-time	Part-time
First Nations	79%	70%
Métis	11%	14%
Inuit	.2%	.9%
non-Aboriginal	9.5%	14.7%

Survivors occupy forty-three per cent of all full-time positions (n=139) and sixty-two per cent of all part-time positions (n=94). Thirty-three per cent of all full-time personnel have a degree, forty-five per cent hold a diploma or certificate, sixteen per cent have other training and six per cent have been trained by AHF-funded projects (n=160). For the part-time group, the distribution is roughly similar with thirty-four per cent having a degree, over one-quarter (28%) hold a diploma or certificate, a third (33%) have other training and five per cent have been trained by AHF-funded projects (n=106). On average, team members have thirteen years of relevant experience in their field (median=10). ***In a typical month, over 13,496 volunteer service hours are contributed to AHF projects (n=154).*** Each project enjoys an average of 88 volunteer hours per month (median = 20). If a very conservative estimate is taken of what this time might be worth and an assumption that the value of this contribution could be remunerated at $10 per hour, then the total hours of volunteer time represents an injection of **$134,960 dollars per month or $1,619,520 per year.**

Lastly, a discussion of team characteristics would not be complete without some focused attention to effective healers. Clearly, healers have many special qualities and can emerge from both traditional or western disciplines. Those who are highly skilled with extensive training and experience and, ideally, *similar* to their target group (i.e., gay or lesbian, teens, female, male, parents or grandparents *and **respected** members of the community*) appear to work well. There was also a high degree of consensus around the character of a healer. Project teams agreed that healers must be caring, committed, nurturing, respectful, non-judgmental, humble, honest, gentle, open, creative, culturally sensitive, patient, out-going and visible in the community. They must be able to make participants feel safe, facilitate *independent* decision-making, bolster self-esteem, avoid assuming the role of rescuer, use humour effectively, as well as maintain their own balance. A healer must be *fully present* to those in their care, able to listen with intent and hear with clarity. As well, they must see, describe and relate to the participant's pain. In the best case scenario, they are also fluent in the language of the community. Although a range of healers are addressing the Legacy, the unique case of a Survivor as a healer has captured much attention.

3.1.2.1 Survivor as Healer

> *The most beautiful people . . . are those who have known defeat, known suffering, known struggle, known loss, and have found their way out of the depths. These persons have an appreciation, a sensitivity and an understanding of life that fills them with compassions, gentleness, and a deep loving concern.*[25]

Many communities are in the unenviable position of engaging in simultaneous healing and training, where many Survivors are now being called upon as healers. But, there is little consensus around how to tell when a Survivor becomes a healer or regarding the amount of time this can take. The answers depend, in part, on the role the individual assumes (i.e., counsellor, healer, Elder, advisor, care giver, facilitator, educator), as the job requirements can vary widely. One area where there appears to be solid consensus when considering all the AHF's evaluation data is that the Survivor as healer is easily recognized as a model of healthy behaviour or successful healing. Their role as a healer is *bestowed* or created through the recognition and respect of others who *believe* in their healing ability. In other words, *caution is wise when dealing with self-proclaimed "healers."*

While few from the focus group gathering of projects that show promising success could offer any definite time for the transition from needing support to providing it, they were certain that several characteristics of a solid Survivor as healer would be clear. Survivors become ready for leadership when: they are free from the need to control others and have well-established personal boundaries that they are able to comfortably maintain, including the ability to handle triggers and remove themselves when exhaustion is imminent. When negativity surfaces, they are skilled enough to defuse it and regain a positive climate for healing. If Survivors are engaged in providing a traditional therapy, they must be entirely comfortable with and completely knowledgeable of traditions, ceremonies and spirituality. Sufficient recovery is usually characterized as fearless and unflappable leadership and complete transition through all stages of grief (i.e., denial, anger, bargaining, depression and acceptance). More specifically, Survivors as healers accept the Legacy's reality, have worked through the anger associated with their loss and do not try to bargain away their actions or the actions of others in an effort to recreate conditions before the loss. They are free from depression and recognize that life must go on. Survivors as healers exude *absolute self-acceptance* and are also able to *demonstrate* healthy functioning by:

- being able to comfortably share their history, healing strategies, as well as a developed plan for *continued* wellness;
- being committed to breaking the cycle of abuse by initiating action and actively encouraging ownership in others;
- offering a good track record of ethical conduct (especially as it relates to maintaining confidentiality) that can be supported by references;

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25 Kubler Ross, E. (n.d.). Selected Quotes. Retrieved on 2 June 2003 from: http://www.elisabethkublerross.com /pages/Quotes.html

- living an alcohol and drug-free lifestyle for a minimum of two years;
- a willingness to learn from, accept and work with clinical supervision;
- understanding the boundaries of their professional ability and making appropriate referrals when needed; and
- regaining respect within the community.

Ultimately, Survivors can only lead others as far as they have travelled on their healing journey. Although they can still be on their own healing journey, they *must demonstrate sufficient resolution to protect themselves and others before they can lead.* When they are not ready to assume leadership roles, they may be engaged in the healing process as helpers or educators. In summation, Table 4 offers a checklist of characteristics recommended by promising project teams to help communities recognize good healers.

Table 4) A Checklist to Screen Potential Healers

A Checklist to Identify Potential Healers	
❏ good track record of ethical conduct supported by references ❏ knows how to defuse negativity ❏ humble, honest, gentle ❏ accepts Legacy's reality ❏ worked through their anger ❏ complete transition through all stages of grief ❏ recognized *by others* as a healer ❏ absolute self-acceptance ❏ recognized as a model of triumphant recovery ❏ able to share their history and healing strategies ❏ has well-established personal boundaries that protects them from harm or burn-out ❏ respected in the community ❏ fearless, unflappable (not easily surprised) ❏ comfortable and knowledgeable of ceremonies	❏ present, able to listen intently, hear clearly ❏ open ❏ free from the need to control ❏ unmistakable positive energy ❏ does not bargain away their actions or the actions of others ❏ alcohol and drug-free for a minimum of two years ❏ accept, learn from and work with clinical supervision ❏ understands their own professional limitations and makes appropriate referrals ❏ developed a plan for continued wellness ❏ committed to breaking the cycle of abuse, initiates community action and encourages ownership ❏ spiritually grounded ❏ reconciled with Mother Earth ❏ free of depression, recognizes life goes on

3.2 What

The following section describes the distribution of resources by Aboriginal identity, target group, remoteness, project type, as well as region. Identified needs are also profiled in this section and, last but perhaps most importantly, preferred or practised approaches to healing.

3.2.1 Distribution of Resources

The financial information shared here was drawn from the AHF's internal databases and has been rounded to the nearest hundred dollars (i.e., $10,512,795 becomes $10,512,800). All data used to prepare Figures 9 to 18 can be found in Appendix 5. These data must be interpreted very carefully as the vast majority of projects accommodate *all* participants, whether or not they are Inuit, Métis, men, women, young, old, incarcerated or on the streets. Similarly, many projects engage in a variety of activities simultaneously (i.e., training and healing, raising awareness and documentation) and, thus, *do not* fall neatly into *only one* project type. To determine what resources are meeting the needs of special cultural groupings, it is important to consider *all* categories of spending where each cultural group is included. In other words, the resources available specifically for the Inuit should be considered with the resources available to the more generic grouping of *all Aboriginal people.* When groups were targeted for other reasons (i.e., because they were young, women or Survivors, etc.), resources were *totalled* to highlight the investment in meeting the needs of unique targets.

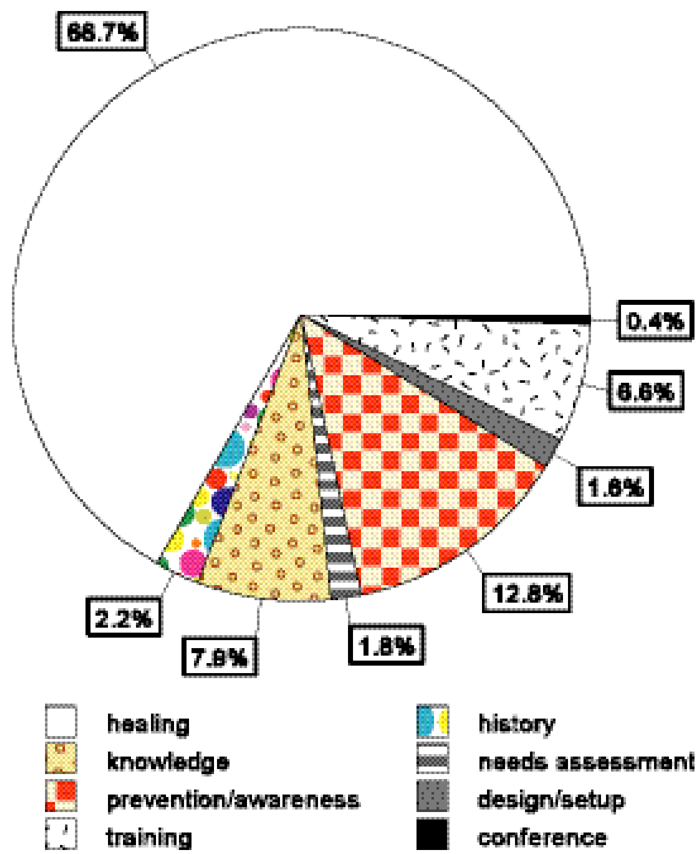
Two-thirds of the AHF program resources (66.7%) are being invested in healing, proportionately much more than allocated in 2000 (47%). Prevention, awareness and knowledge-building also remain important priorities for the AHF. Resources, in hierarchal order of value, are represented in the table below:

Table 5) AHF Investment by Project Type (2000/2002)

Project Type	2002	2000
Healing	66.7%	47%
Prevention and awareness	12.8%	18.5%
Building knowledge	7.9%	4.9%
Training	6.6%	9.1%
Honouring history	2.2%	5.2%
Assessing needs	1.8%	3.9%
Design and set-up projects	1.6%	2.6%
Conferences	.4%	.6%

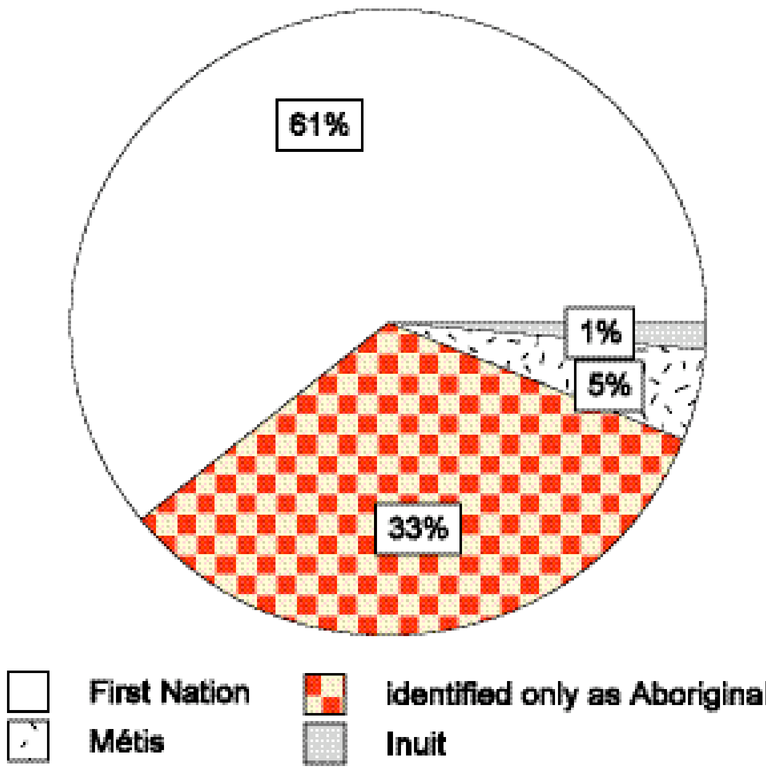
Graphically represented, the distribution of resources by project type for the year 2002 are displayed in Figure 9.

Figure 9) Grants by Project Type (2002)



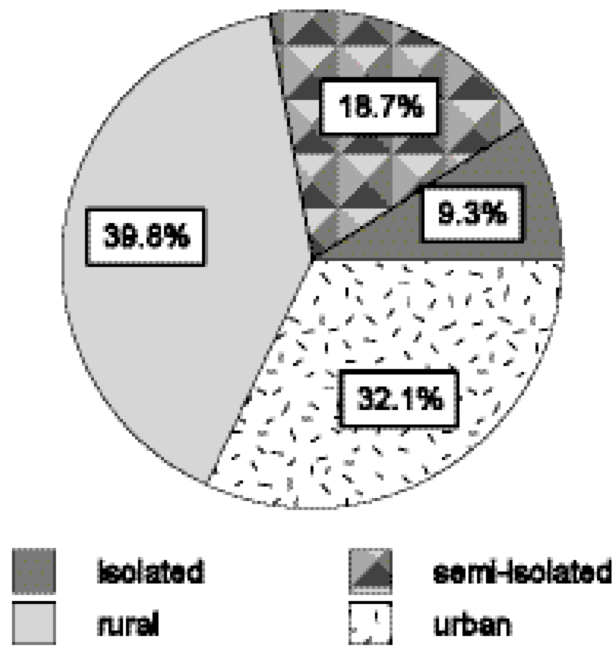
At the time of application, applicants (largely organizations) are asked to choose an Aboriginal identity. Figure 10 shows the percentage of funding committed to grantees who self-identified as Aboriginal (more than one group), First Nations, Inuit or Métis. A small percentage of organizations did not complete this portion of the application.

Figure 10) Distribution of Resources by Aboriginal Organization Type



Looking at the distribution of resources by geographic remoteness, it is clear that the pattern of distribution has remained relatively stable over time. The largest proportion of resources continue to be invested in what are considered rural[26] (39.8%) communities, followed by urban (32.1% up from 24.5% in 2000) and semi-isolated (18.7%) environments. As in 2000, isolated communities are receiving about nine per cent of the AHF resourcing (9.3%). Figure 11 shows how AHF funds are distributed to communities by their degree of remoteness.

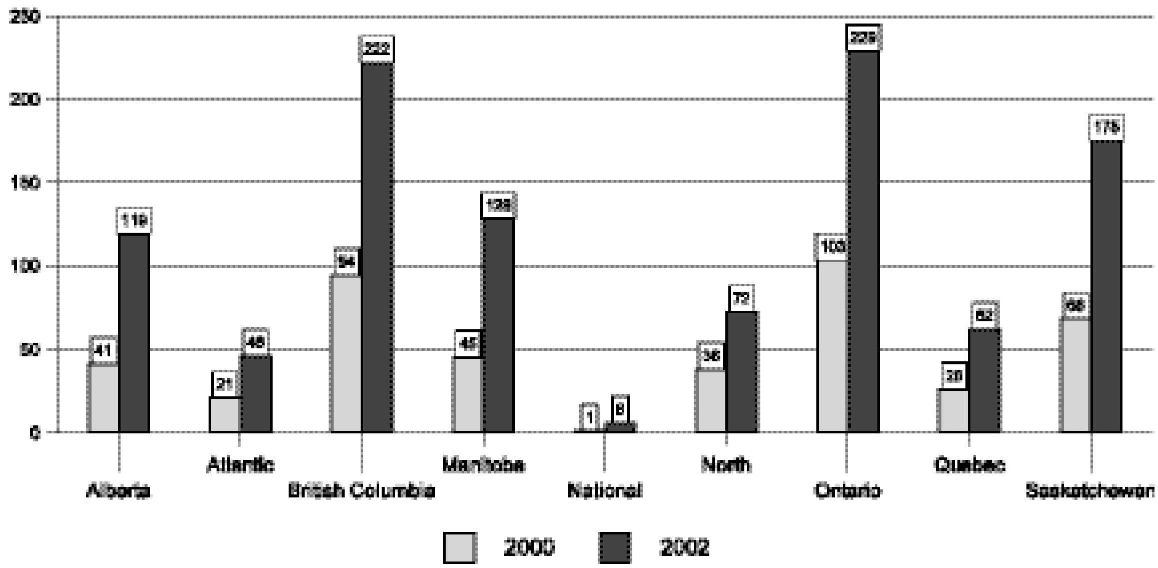
Figure 11) Distribution of Resources by Remoteness (2002)



[26] **Isolated** - a community that cannot be reached by road or ferry service.
Semi-isolated - a community that can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people.
Rural - a community that can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people.
Urban - a community or community of interest that can be reached by road or ferry service and is located within 50 kilometres of a town or city with more than 25,000 people.

Lastly, the largest number of grants funded by the AHF was in Ontario (229), British Columbia (222) and Saskatchewan (175). These were followed by Manitoba (128) and Alberta (119). Figure 12 illustrates the number of projects broken down by region.

Figure 12) Number of Grants by Region (2000 and 2002)



3.2.2 Identified Needs

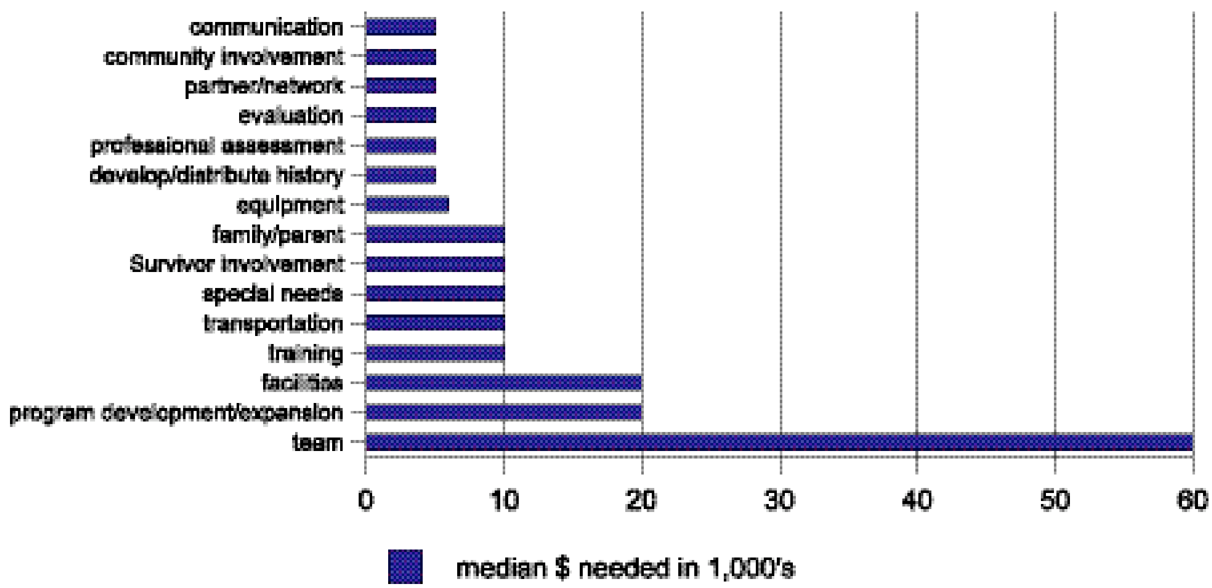
Priority needs have remained relatively stable over the past two years. Increasing the size of the project teams and improving Survivor involvement remain the two most important needs. These are followed closely by project expansion, training, community involvement and family support. Table 6 compares the ranking order of needs in 2002, with the results obtained in 2000. Starting with the most pressing need, the following lists resulted:

Table 6) Needs in Order of Priority (2000 and 2002)

Needs in Order of Priority, 2000	Needs in Order of Priority, 2002
1. Increase employee numbers and benefits; 2. improve Survivor involvement; 3. improve and expand facilities; 4. improve the project and expand locally; 5. provide training; 6. improve family support and parenting skills; 7. encourage community involvement; 8. professional assessments of skill development and healing; 9. resources and professionals to deal with special needs; 10. develop and distribute information on history and the Legacy; 11. improve and offer transportation; 12. improve communication (with community, AHF, Canadians generally); 13. purchase equipment or supplies; 14. enhance partnerships and networks; and 15. project monitoring and evaluation.	1. Increase employee numbers and benefits; 2. improve Survivor involvement; 3. improve the project and expand locally; 4. provide training; 5. encourage community involvement; 6. improve family support and parenting skills; 7. develop and distribute information on history and the Legacy; 8. improve and expand facilities; 9. resources and professionals to deal with special needs; 10. enhance partnerships and networks; 11. improve and offer transportation; 12. professional assessments of skill development and healing; 13. purchase equipment or supplies; 14. improve communication (with community, AHF, Canadians generally); and 15. project monitoring and evaluation.

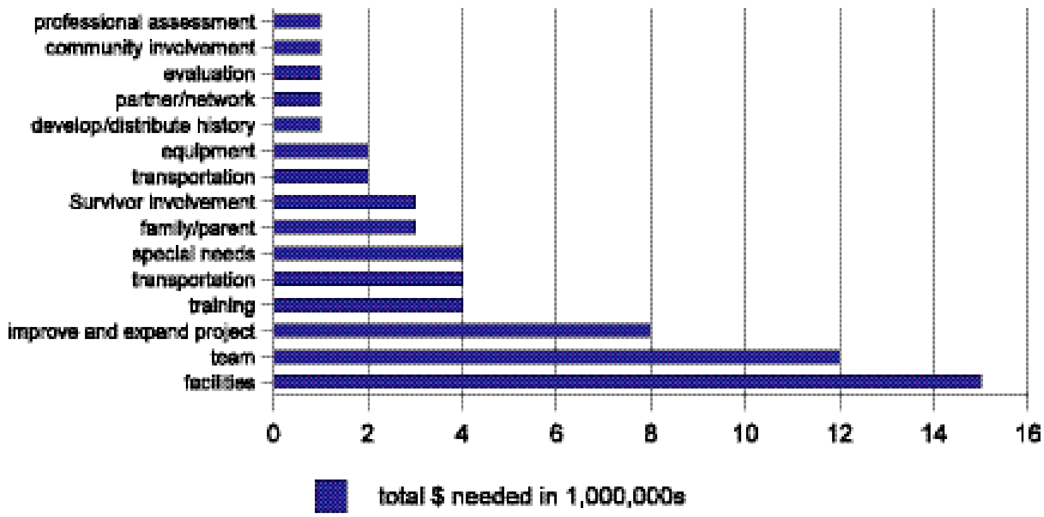
When examining how much each need might cost, a different pattern emerges. The most costly program needs in order are: facility improvements; team expansion; program development or expansion; special needs programming; training; transportation; Legacy education; family support; professional assessments; equipment; evaluation; Survivor involvement; community involvement and communications. Figure 13 reveals the need by *median* cost, while Figure 14 shows the *total* estimated cost. When all the needs are combined, an estimated $60,000,000 would be required to address *current* project needs.

Figure 13) Median Estimated Costs[27] of Program Needs by Type



[27] The reader should note that these costs represent MEDIAN costs or the half-way between all the responses received, which is the better measure of central tendency in this case. For a fuller discussion of what the median means, please see the introduction to the *Process Evaluation Results.*

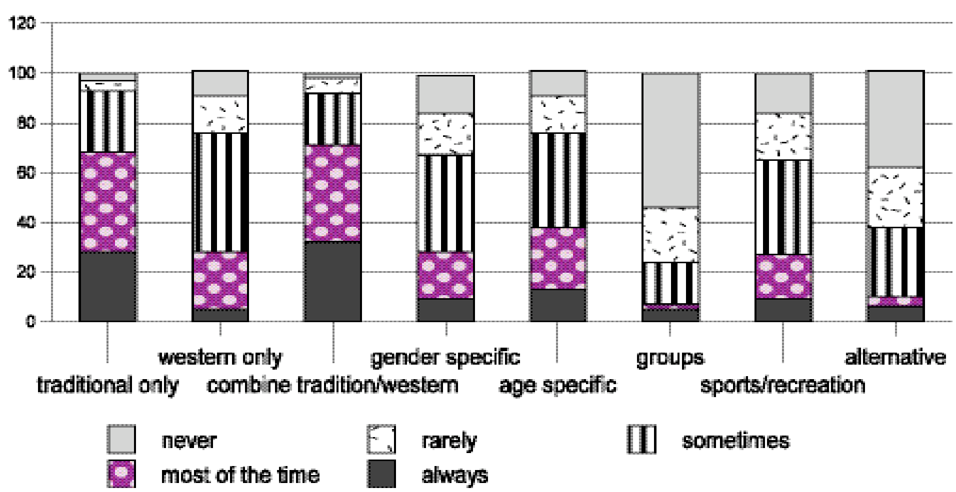
Figure 14) Total Estimated Costs of Program Needs by Type



It is important to note that *improving Survivor and community involvement, together with increased family support and parenting skills courses, were considered high ranking needs and all were identified as some of the least costly to meet.*

Lastly, an answer to the "what" question would be incomplete without a picture of what healing approaches are most commonly used. A very stable pattern with respect to healing approaches has emerged. As in 2000, project teams most commonly used traditional and western therapies in combination or traditional therapies alone. Age and gender specific groups are popular and almost a third (27%, n=160) use sport or recreation on a regular basis (most of the time or always). Figure 15 illustrates how frequently various healing approaches are used.

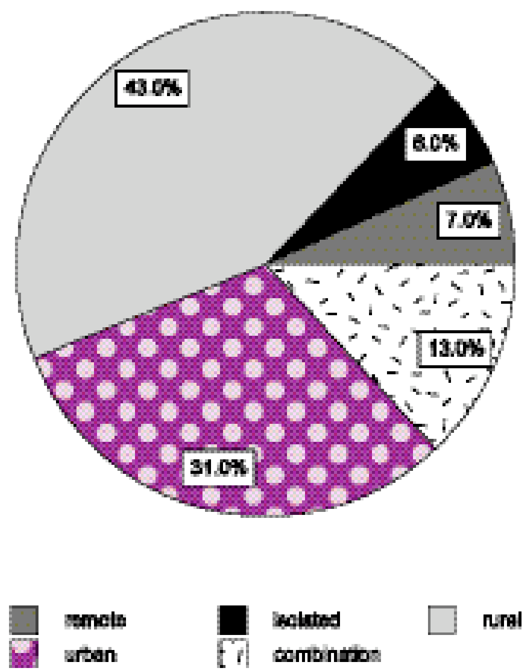
Figure 15) How Often Various Healing Approaches are Used



3.3 Where

A total of 1,264 (n=162) communities were being serviced by those who responded to the survey. Responding projects service a median of two communities (n=162), with about half (47%) serving only one community and almost twenty per cent (17%) serving eleven communities or more. Forty-three per cent (n=177) are servicing rural[28] communities, thirty-one per cent service urban communities, six per cent are in isolated areas, seven per cent are active in remote areas and thirteen per cent service a combination of geographic circumstances (see Figure 16).[29]

Figure 16) Geographic Remoteness of AHF Sites

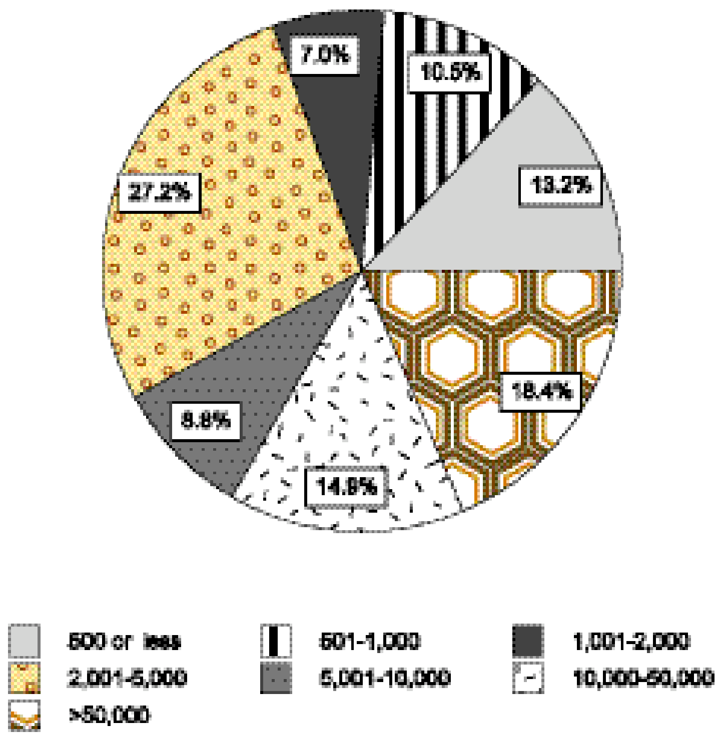


[28] **Isolated** - a community that cannot be reached by road or ferry service.
Semi-isolated - a community that can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people.
Rural - a community that can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people.
Urban - a community or community of interest that can be reached by road or ferry service and is located within 50 kilometres of a town or city with more than 25,000 people.

[29] The 2000 survey results show that 55% were servicing rural communities; 29% were servicing urban communities; 10% were servicing isolated communities; and 6% were servicing remote communities, (n=194).

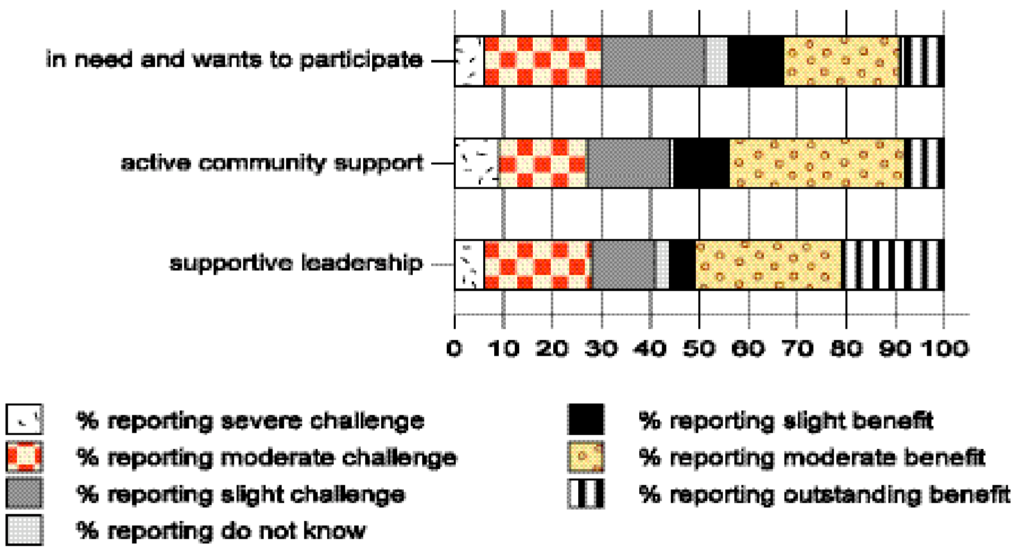
The solid majority were in communities with a population of 2,000 or more (65%, n=161), a substantial increase from groups surveyed in 2000 (41%, n=233). The remaining projects are in communities of 1,999 or less. Some operate in very small communities (15%), with 500 people or less. Figure 17 depicts the distribution of the AHF sites by community size.

Figure 17) Distribution of Projects by Community Size



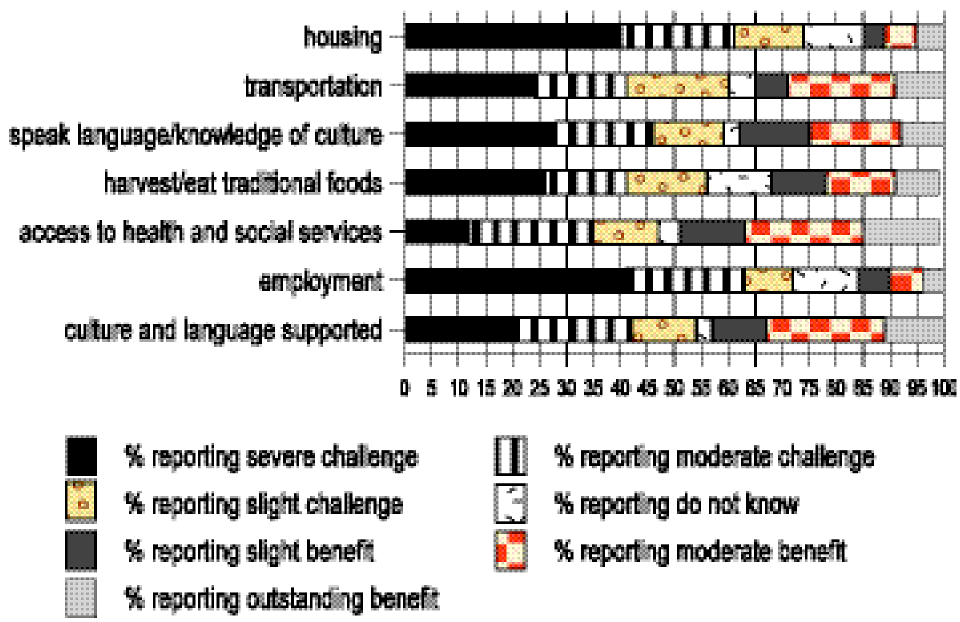
All environments have forces that help or hinder project ability to achieve desired outcomes. Early in the life of the AHF, the majority of projects were facing outright opposition (69%, n=243, 2000 results) with over a quarter (26%, n=243) believing that apathy was a *severe* problem; however, the current sample of survey respondents were not experiencing the same degree of resistance or lack of support. Less than a third of the projects reported that leadership, community support and participation were serious challenges (n=156). *In fact, over half felt that the leadership provided outstanding or moderate support.* Figure 18 illustrates the community response to AHF-funded activity.

Figure 18) Community Response to AHF-funded Activity



Lack of adequate housing and unemployment are severe challenges for a sizable proportion of project teams (40%, n=156). Community contexts that offered access to a range of health and social services, as well as those that supported the integrity of Aboriginal culture and language, were most commonly cited as those that offered benefits to AHF-funded projects. Perceptions of community challenges and benefits are highlighted in Figure 19.

Figure 19) Community Challenges and Benefits



3.4 When

Day to day happenings are as much a product of the times as they are of the players who create them. History sets the stage for current events and the drama that unfolds affects all life. Therefore, it makes sense to examine the times and conditions in which projects operate. The greater world of influence includes community forces, but also extends to provincial and national policy. To better understand the influence of these forces, projects were asked to identify what happened in their world that helped or hindered them. To begin, the facilitating forces will be described, followed by an abbreviated checklist that can be used to supplement the community report card proposed by Four Directions International[30] as a way of measuring change. Following the discussion on what helps, greater focus is directed to the community events and broader structural impediments to healing. Again, a checklist will summarize these forces as a way of highlighting the nature of "special needs" communities.

30 Lane, P., M. Bopp, J. Bopp and 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.

Cultural pride, practice and celebration was commonly considered a supportive force in the community because it affirms and helps in identity formation. Although it is not clear whether or not litigation has a helpful or hindering impact, court cases have simultaneously opened the doors for discussion about the Legacy of physical and sexual abuse, as well as raised the ire of those who believe that public funds for healing are rightfully theirs for personal injury. Inter-agency collaboration and building professional networks contributed by offering complementary services and support to project teams. Easy local access to services, supportive leadership, recreational programming (especially for youth), family support, student support, children's services and team training were also credited with helping projects achieve their goals. When the community culture is one that supports mothers' groups, Elders' gatherings, language immersion opportunities and dry social events, a very ripe climate exists for individual healing. When high profile individuals disclose, responsible parties make public apologies and the media are quick to cover these events, a climate is created for even more disclosure. Increased awareness of the Legacy functions in similar ways. With improved understanding, individuals and families are more likely to break the silence and seek services. And last, but perhaps most importantly, many Aboriginal people and communities are just plain tired. The Legacy's burden has been long lived and heavy, leading many to *genuinely* *want* healing and cultural reclamation.

What helps			
✓	cultural pride, practice and celebration	✓	family support (particularly parenting skills)
✓	inter-agency collaboration and professional networks	✓	student support
✓	easy, *local* access to a variety of services	✓	recreation (i.e., Elders' gatherings, dry social events, youth activities)
✓	training	✓	children's services
✓	awareness of the Legacy	✓	youth programs
✓	media coverage	✓	increased openness facilitated by litigation and associated publicity
✓	word-of-mouth communication		
✓	public apologies	✓	individuals and communities genuinely want healing

The most commonly cited environmental challenge was related to violence, including: youth gang and criminal activity, violent death (murder and suicide), widespread vandalism and an increasingly distorted “culture” of violence. Widespread addictions, not just to alcohol and street drugs, but also an increasing dependence upon prescription medication and excessive gambling, hinder project performance. Such addictions are particularly harmful when they are prevalent in parents or leadership. Lack of employment, crowded living conditions, illness and family dysfunction (particularly a lack of parenting skills) were cited as obstacles to progress. Problems in the political arena included: mismanagement of community resources, instability and the supremacy of land claims negotiations as a political priority. Service budget cuts and relocation prevented much needed complementary support. Staff turnover, lack of skills, training or clinical supervision left some projects feeling overwhelmed. Gossip, denial and a “don’t talk, don’t feel” social norm stall healthy movement. Interestingly, a couple of communities reported that religious groups were working at cross purposes with AHF activities through their attempts to repress the resurrection of traditional spirituality and cultural celebration.

What hinders			
✓	climates where violence is pervasive, tolerated, considered normal	✓	religious resistance to resurrection of traditional spirituality and cultural celebration
✓	youth criminal or gang activity	✓	crowded living conditions
✓	murder and suicide	✓	unemployment
✓	addictions (alcohol and drug)	✓	gossip, denial, “don’t talk, don’t feel” attitudes
✓	political instability		
✓	imbalanced political priorities (i.e., when land claims consume all political energies)	✓	mismanagement of community resources
		✓	service budget cuts
✓	gambling	✓	lack of training and skills
✓	abuse of prescription medication	✓	lack of clinical supervision
✓	illness	✓	staff turnover

4. Project Performance Report

Reporting on project performance usually implies examining the evidence of "success." In the world of evaluation, a viable project strives to successfully achieve its goals and objectives. If the project falls short, failure is implied. The climate in which programs are delivered is not so black and white. People can be inspired by a vision of a healthier, happier life, yet their first steps may be tentative and misdirected. Or, they may charge ahead, full of passion and determination, only to stumble on the first obstacle that crosses their path. Whether speaking about individuals or communities, once a decision has been made to travel down the healing road, the imposition of rigid standards of success can be misleading. The word itself has limited application in evaluation because, in part, it is associated with wealth, fame and prosperity (i.e., a successful entrepreneur), but also because the word "success" hints at an "either or" situation.

> ***success*** *(sckés) n. the accomplishment of what is desired or aimed at, achievement* || *attainment of wealth, fame, prosperity, etc.*[31]

Because of the limitation of the term, other language was explored that more naturally fits the experience of individuals and communities unravelling the Legacy's stronghold on their spirit, families and lives. Building upon popular metaphors for healing in Aboriginal communities (i.e., the healing "journey"), success will be considered in terms of *progression or travel*. Progression and travel both recognize the *process* of change. They imply and embody movement towards a destination. They take into account the need for continuous decision-making about the route to take, the means of transportation, the speed required and the distance to be covered. Travel may require periods of respite, one can get lost, arrive in unexplored territories or circle back towards the beginning and start again. Progress can be swift or slow. The traveller starts at a particular place in time and space (point A) with an intent to reach another point in time and space (point B), no matter if the aim is amorphous. For some, travel is less about the destination than it is about the journey.

The progression in the healing journey is a complex interplay between *environment* and *person*. Well-being is a natural by-product of the balance between core elements of human existence, both internal and external. Individual healing can be facilitated or thwarted by community systems and broad-based institutions not previously thought part of the solution. Similarly, communities and institutions can stagnate or be moved to change by the actions of individuals. *The reciprocal impact of individuals and environments upon each other creates circular causation where effects become determinants.*

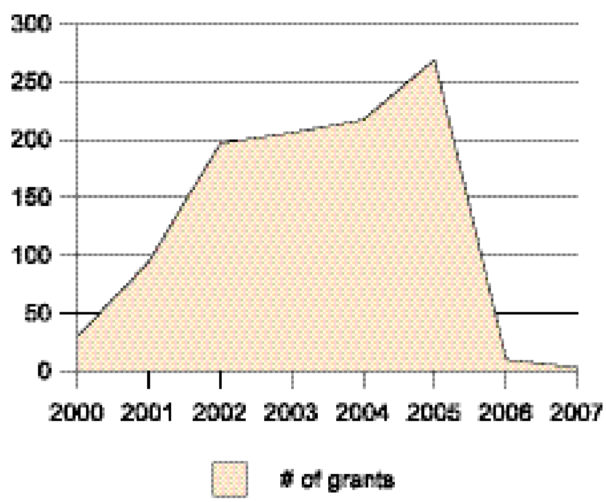
If we consider healing as a journey and measure success as *travel* on that journey, then it is important to consider where the journey begins. In other words, at what place and time have individuals and communities started in their efforts to address the Legacy. For example, if a project is dealing with a convicted murderer whose recidivism record is high, but each infraction is less

[31] Cayne, Bernard S. (1988). The New Lexicon Webster's Encyclopedic Dictionary of the English Language, Canadian Edition. New York: Grolier Educational Associates, Lexicon Publications Inc., page 988.

violent until finally his involvement with the criminal justice system is related to a mere probation violation, does this represent a measure of success? If recidivism is the only measure of success, then valuable information about the nature of the crime history would be missed and an opportunity for a true understanding of the distance "travelled" would be lost. Similarly, if you begin the journey as a teen mother with FAS, a history of childhood sexual abuse and provincial wardship who is at risk of losing her baby, does coming out of your room after three weeks of self-imposed isolation within the context of the family healing home represent success? On a statistical level, no. On a clinical level, it represents an enormous statement of trust and a foundational first step to an improved quality of life.

Communities, like individuals, start the healing journey at a particular place in time and space. The times and the environment are landmarks in their journey and, to best understand the contribution the AHF has made, it is imperative for the reader to bear in mind both the participant and community challenges recounted in this report and previous interim evaluations.[32,33] It is also important for the reader to consider that, although efforts have been undertaken to determine whether or not AHF-funded activity is contributing to desired short-term outcomes, it is *still very early in the life of the initiative* and impact evaluation is arguably premature. In fact, looking at the AHF's momentum, it is clear that efforts have not yet reached peak activity. Figure 20 shows the concentration of activity over the life of the initiative.

Figure 20) Estimated Number of Grants by Year (2000-2007)



32 Kishk Anaquot Health Research (2001). An Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa: Aboriginal Healing Foundation, pages 25-27.

33 Kishk Anaquot Health Research (2002). Journey and Balance: Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa: Aboriginal Healing Foundation, pages 82-88.

Still, some energy has been invested in this interim report to determine what early contributions, if any, AHF-funded activity has made with respect to:

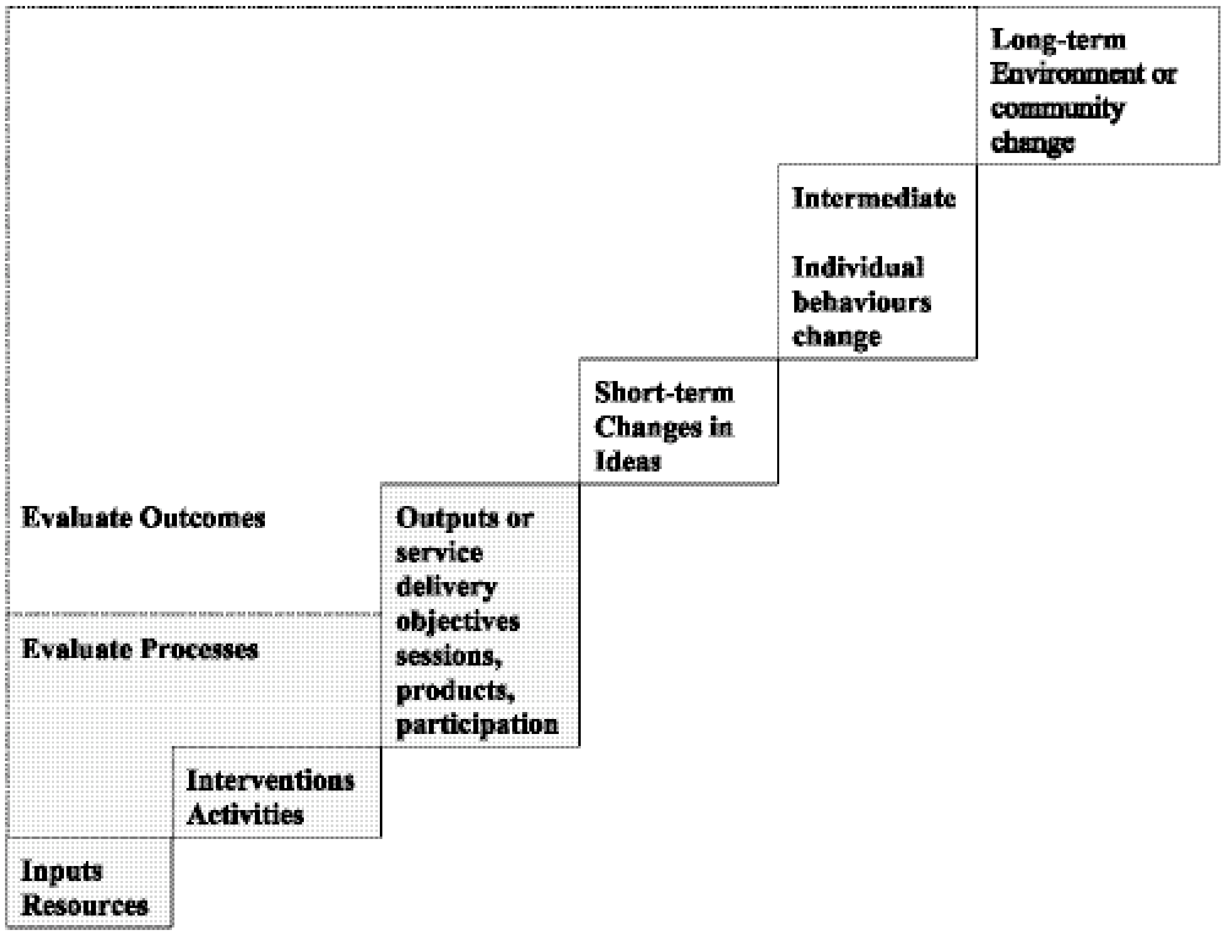
- influencing individuals; and
- influencing communities, particularly:
    - establishing partnerships and ensuring sustainability;
    - meaningfully engaging Survivors and the intergenerationally impacted; and
    - reaching those in greatest need.

This report is unique from other interim reports because, until now, participant voice has been weak due to concerns about respondent care. Although participants' perspectives had been reflected in document files and key informant interviews, this was the first opportunity for direct assessment that was secured with the collaboration of project teams who were in the best position to provide respondent care.

But, before reviewing the evidence, it is important to remind the reader that social change unfolds in fairly predictable patterns. Resources are invested into project **activities** (i.e., offering healing circles or developing a curriculum). Activities, in turn, lead to **outputs** or service delivery objectives (i.e., number of healing circles held, number and types of participants, number of curricula developed, distribution and use of curricula, etc.). As the logic goes, outputs create changes in ideas (i.e., changes in knowledge, attitudes, beliefs, motivation, skills) that, in turn, lead to **behavioural changes** (i.e., going back to school, choosing healthy parenting strategies). When enough individual behaviours change, ultimately, the **environment or community changes** with them (i.e., changes in social or community conditions).

Visually represented, the flow of project activity and desired change looks something like this:[34]

Figure 21) The Predictable Pattern of Change



[34] This figure is an adaptation of the TOP model by Bennett, C. and K. Rockwell (1995). Targeting Outcomes of Programs (TOP); An Integrated Approach to Planning and Evaluation. Unpublished manuscript. University of Nebraska. Lincoln, Nebraska: Obonsawin-Irwin Consulting, Inc.

In addition, greater detail about desired change is helpful as a pretext to a discussion of the early signs of impact. Whenever examining project performance, it is always important to know who will change, what will change about them, when and how will it change and how long will the change last? Table 7 summarizes the answers to these questions with special regard to AHF-funded activity.

Table 7) Change Desired by the Aboriginal Healing Foundation[35]

Ultimate Goal	those affected 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
Source of Change	funded activity (project development, healing, training, knowledge-building, honouring history, assessing need, gatherings and conferences)
Who will change?	Survivors, their families and communities
What will change?	awareness, attitudes, behaviours, social conditions
When will it change?	although unspecified awareness and attitudes should be changing immediately, behavioural and social changes are necessarily longer term
How will it change?	knowledge and awareness will lead to engaging in healing that will improve individual lives and eventually social norms
How much will it change?	awareness and attitudes should change sufficiently to engage Survivors in healing; behaviours should change sufficiently to improve the quality of individual and family life; communities should change sufficiently to see differences in rates of suicide, children in care, physical and sexual abuse, incarceration and disclosure
How long will the change last?	unspecified: may not be able to assume that attitudinal or behavioural change is enduring, but the hope is that change will endure and be sustainable; once the social climate changes, these changes are expected to endure

Because some information about the way individuals and communities will change is nebulous, some assumptions must be made. For example, it is not entirely clear when change will happen, how much change will occur or how long it will last. It is assumed that cognitive change or

35 Grembowski, D. (2001). The Practice of Health Program Evaluation. Thousand Oaks, California: Sage Publications, page 51.

change in attitudes, knowledge, motivation and intention will change immediately. In other words, all projects should be able to detect a change in participant ideas during or immediately after project implementation. Behavioural change is more difficult to predict and varies considerably depending upon the kind of change that is desired. Some participants change their behaviours during their participation in the project and others change some time after participation. Climates, like individuals, will vary considerably in their responsiveness to change.

4.1 Influencing Individuals

What do all the numbers mean?

What does n=138 or n=672 mean? This refers to the number of people who responded to a particular question. It is important to know how many people answered a question because it helps to determine how representative or common the statement might be for the whole group. If very few people respond (i.e., 156 out of a possible 826) then the reader must "take this information with a grain of salt" because it may or may not represent the opinion of all 826 people.

Why do the percentages not add up to 100%? In some cases, the percentages do not add up to 100% due to rounding (i.e., making 13.7% into 14% or 2.2% into 2% to keep it simple). Sometimes, percentages do not add up to 100% because some answers were not valid or readable and this information becomes lost. Usually, this represents a very small percentage (almost always <5%) of all answers received for any question.

Survivor voice, until now, has been limited to what could be obtained indirectly from project files and key informants. Therefore, the Individual Participant Questionnaire (IPQ) was developed as a way of strengthening Survivor voice and gathering information about participant satisfaction, as well as a *self*-reported statement about the achievement of key AHF goals, including:

- increased connection between Survivors and those who can facilitate the healing journey;
- enhanced ability to recognize and deal with the Legacy;
- increased movement toward individual healing goals;
- increased Survivor ability to move beyond the trauma of their past; and
- changes in knowledge and skills that support healing.

A total number of 826 IPQs from at least 90 projects were received. Respondents were as young as 11 years and as old as 93 years (average age 43, n=782) with the solid majority (60%) being female (n=785). Most respondents had completed the healing activity sponsored by the AHF (61%, n=634) and of those who did not complete the program (83%, n=220), claimed it was because the program was on-going. Those who *chose to withdraw*, cited psychological problems (including fear, lack of trust, denial, addiction) (46%, n= 38), followed by competing responsibilities (i.e., new job, relocation, family crisis or responsibilities) (19%) and physical problems (i.e., poor health or lack of transportation). In a few cases, participants had passed away or project qualities (i.e., staff turnover, inability to accommodate varying healing levels and lack of interest in topics presented) accounted for withdrawal. For example, a few participants may not have completed the program because of poor cultural or spiritual "fit" (i.e., Christian participants looking for an approach other than traditionally spiritual practices). Only a couple were terminated (i.e., non-compliance).

Survivors (those who actually attended residential school) represented the majority of respondents (61%, n=723), a solid majority (80%, n=691) had family members (i.e., brother, sister, aunt, uncle) who attended the schools and most respondents claimed that their parents (70%, n=702) and grandparents had also attended residential school (57%, n=609). First Nations formed the bulk of IPQ respondents (87%, n=799), followed by the Métis (8%), non-Aboriginal participants (2%) and the Inuit (1%).

Participants were asked how they got involved in AHF-funded healing and their answers fell into roughly three categories: self-initiated, referred or "mandated" to attend. The reader is cautioned to interpret their responses carefully as it was not clear that the question was always understood.

How they got involved	Further details regarding their motivation to heal
self-initiated (51%, n=826. In other words, 424 out of 826)	Of this group (i.e., the 424 who *chose* to attend), a sizable group (26%, n=424) were inspired to participate in healing after they had volunteered to support AHF or were in some other way associated with the project (16%, n=424). Invitations and advertisements published by project teams accounted for drawing in almost a third of those who were self-referred (28%, n=424) and word-of-mouth drew an additional 10% (n=424). Family members and other participants inspired some (both 6%), friends were the catalyst for a few (3%) and crisis pushed a small minority (1%).
referred (28%, n=826 or 231 of 826).	Of this group (i.e., these 231 Survivors who claimed to have been "referred" to the program), Survivors were most likely to be referred by another program (58%, n=231), but a surprising proportion (13%, n=231) were "referred" by family or friends or responded to an invitation from the AHF-funded project (16%, n=231). A few (9%, n=231) were referred by legal or governmental bodies.
"mandated" (3%, n=826 or 28 of 826)	When they were mandated to attend, the "mandates" originated from a variety of sources, including legal or government bodies (50%, n=28), AHF-funded project requirements associated with training (18%, n=28), Elders (4%, n=28), family members (7%, n=28) or human service workers in related programs (14%, n=28). It is obvious from these sources that the word "mandated" was loosely translated as required or strongly urged to attend.
other reasons (18%, n=826)	The remaining group became involved for a variety of reasons that included being motivated by family, friends and other participants, project invitations, employer encouragement and crisis.

For most (55%, n=755), this was the *first time they had ever participated in a healing program.* Of those who had participated in previous healing (n=362), 44% had engaged in at least one program, 22% in two programs and 33% had a demonstrated investment in healing and had attended three or more different programs before participating in AHF-funded activity.

When considering the types of services used and their perceived efficacy, healing or talking circles, Legacy education, Elders, one-on-one counselling, traditional medicine and ceremony, as well as opportunities for Survivors to gather and bond were most frequently used and most popular. Figures 22 and 23 show service use and preference.

Figure 22) Types of Services Used

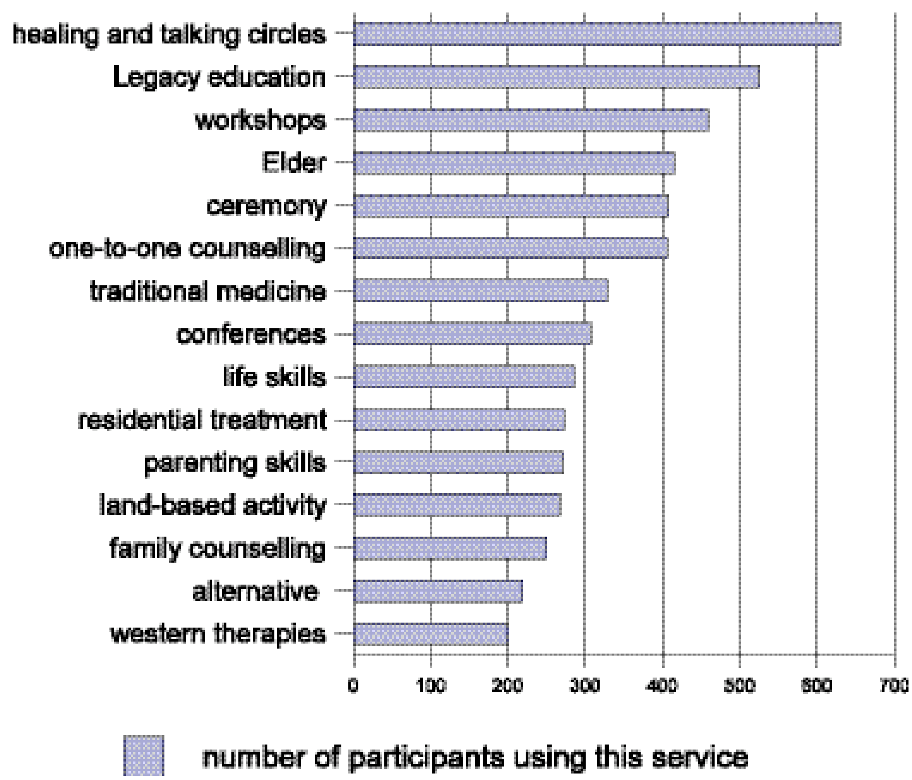


Figure 23) Rating of Types of Services Used

Legend: This figure is best interpreted while taking into account the number of participants who rated service efficacy. Below is a table that highlights how many participants responded to each question.

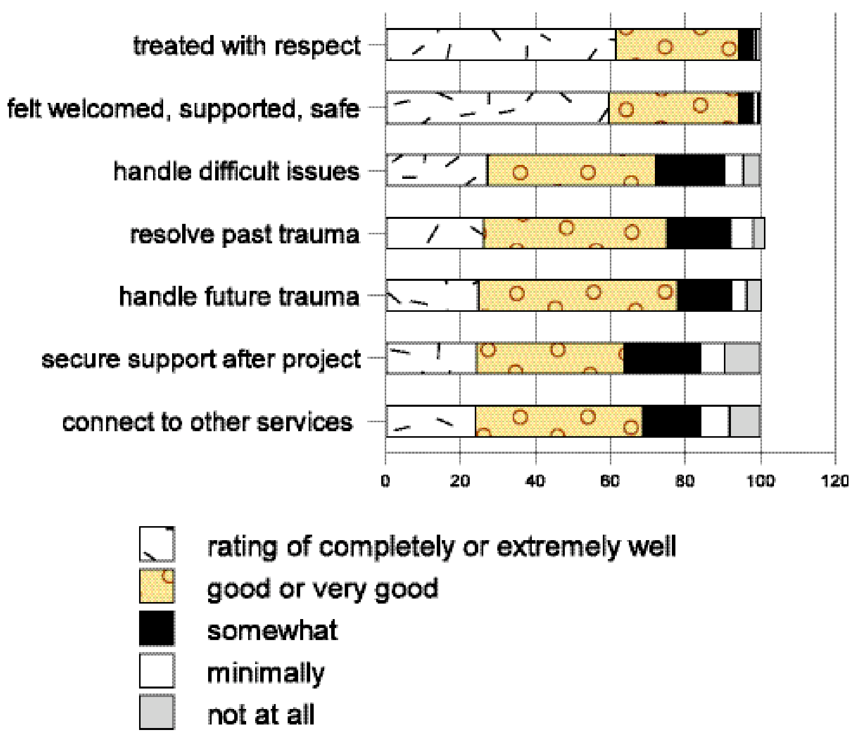
type of service	n =	type of service	n =	type of service	n =
Elder	268	workshops	257	life skills	259
ceremony	377	Legacy education	482	family counselling	218
one-on-one counselling	368	conferences	274	parenting skills	109
healing and talking circles	579	land-based activity	238	alternative	193
traditional medicine	301	residential treatment	251	western therapies	183

Despite the range of activity offered in AHF-funded projects, several goals are shared, including:

- ensuring a warm, welcoming climate of support and safety;
- improved connection between those in need and service providers able to facilitate healing;
- better individual ability to secure support from any source (professional, familial or personal) when it is needed;
- enhanced ability to handle future trauma and resolve past trauma; and
- an overall improved ability to cope or resolve life's difficult issues.

Respondents believed that projects excelled in their ability to provide respectful, welcoming and safe environments for healing. In fact, the vast majority (>85%, n=761) rated these project characteristics favourably. The majority also felt that their experience in the project helped them to handle difficult issues (71%, n= 726), resolve past trauma (75%, n=726), prepare for and handle future trauma (78%, n=731) and secure support (64%, n=675), if needed, once the project was completed.

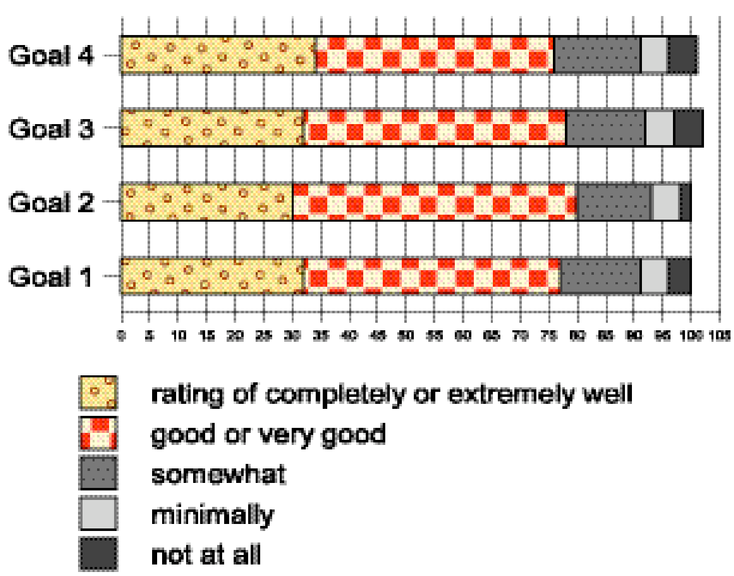
Figure 24) Perceptions of Achievement - General Project Goals



For the future and in order of frequency, participants were most likely to consult a counsellor or therapist (31%, n=733), Elder or traditional healer (26%) or an AHF project team member (25%). A few were planning to rely upon themselves, their families and friends (7%), spiritual leaders (2%), other non-descript helpers (5%) or addictions workers (1%).

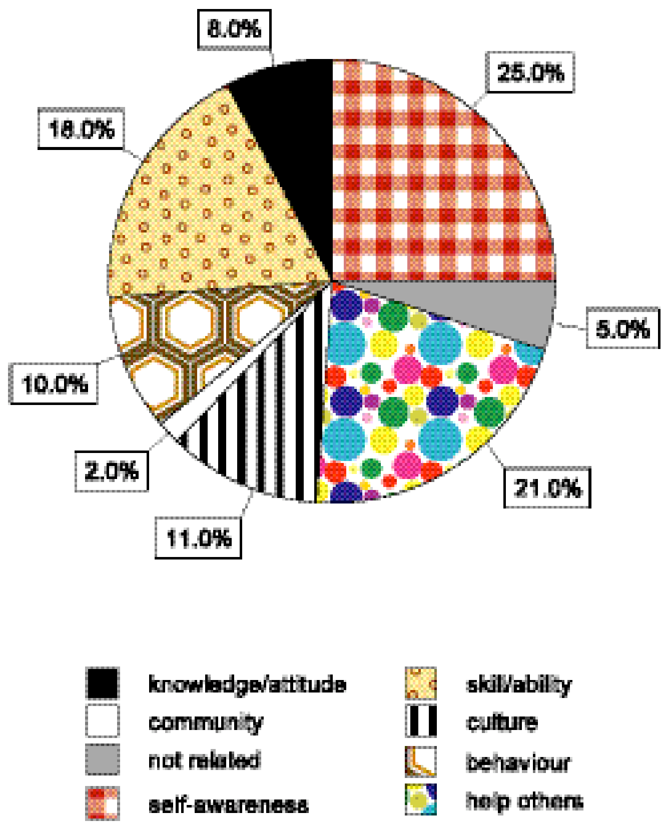
Beyond the goals of AHF-funded activity, participants dreamed of knowing and understanding themselves in ways that helped them to feel better about who they are and what they have to offer. They craved simple solace that comes with firm identity and comforting self-love. They wanted freedom from anxiety, sadness, guilt, self-destructive behaviour and social service interventions. Some just wanted to wake up one morning *without* pain. Participants were eager to learn new skills, generate new ideas and face life with a fresh attitude so that they had the mental and emotional energies required to handle problems, let go of grief, as well as seek and secure healthy relationships. Some sought after the ability to listen intently and communicate effectively so that they could relate to others, trust enough to share, as well as feel heard and understood. They wanted the ability to influence others, hold steady jobs, remain drug-free, find support and forgive those who hurt them. They yearned to be better role models, parents and students. Participants envisioned a brighter future for their communities too, where children were safe, addictions were rare and women were free. They aspired to create communities where a sense of belonging prevailed, morale flourished, culture was celebrated and intergenerational abuse was someone's vague memory. When asked about their ability to achieve these personal goals in the context of AHF-funded projects, about a third indicated that they were able to do so completely or extremely well. About half felt that the project was good or very good at helping them attain personal goals; however, there remains a small group (about 10%) who are only minimally or not getting their needs met in the context of AHF-funded projects. Figure 25 illustrates how participants felt about the project's ability to help them achieve personal goals.

Figure 25) Achievement of Personal Goals



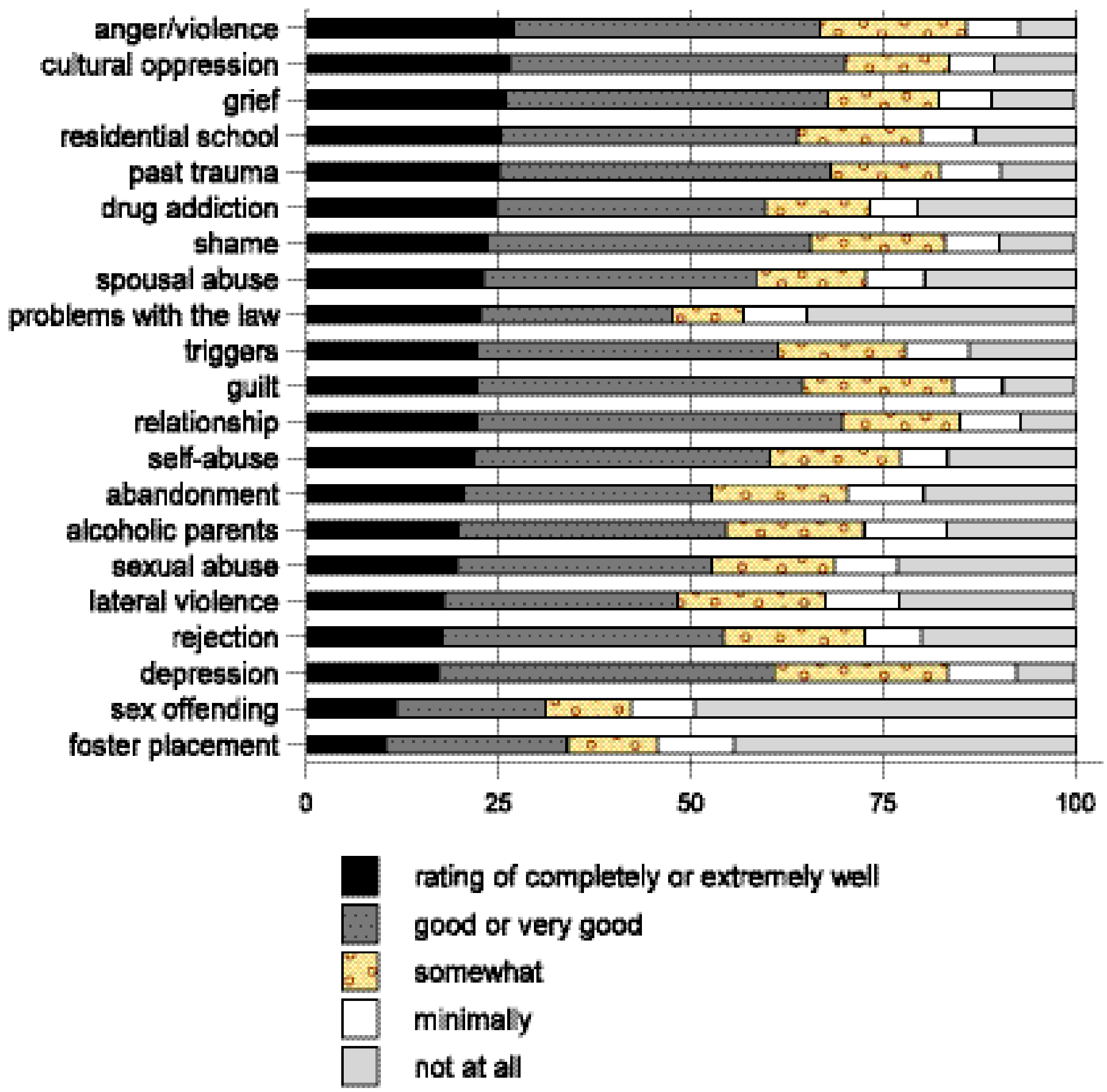
Respondents' goals reflect the primacy of their individual needs and the overwhelming connection that they feel to other Survivors. The most commonly cited goals were self-awareness (25%, n=741), help other Survivors (21%), acquire news skills or abilities (18%), reclaim culture (11%), change behaviours (10%), gain knowledge or change attitudes (8%) and influence the broader community (2%). Respondents' goals by type are illustrated in Figure 26.

Figure 26) Respondents' Goals by Type (2002)



Over sixty per cent gave group counselling sessions a favourable rating when the following issues were addressed: grief, triggers, residential school, depression, anger, violence, shame, guilt, past trauma, cultural oppression and relationship issues. Group sessions were weakest when considering issues such as sexual offending, problems with the law and foster placement. Figure 27 shows the ratings of group counselling sessions secured in AHF-funded projects.

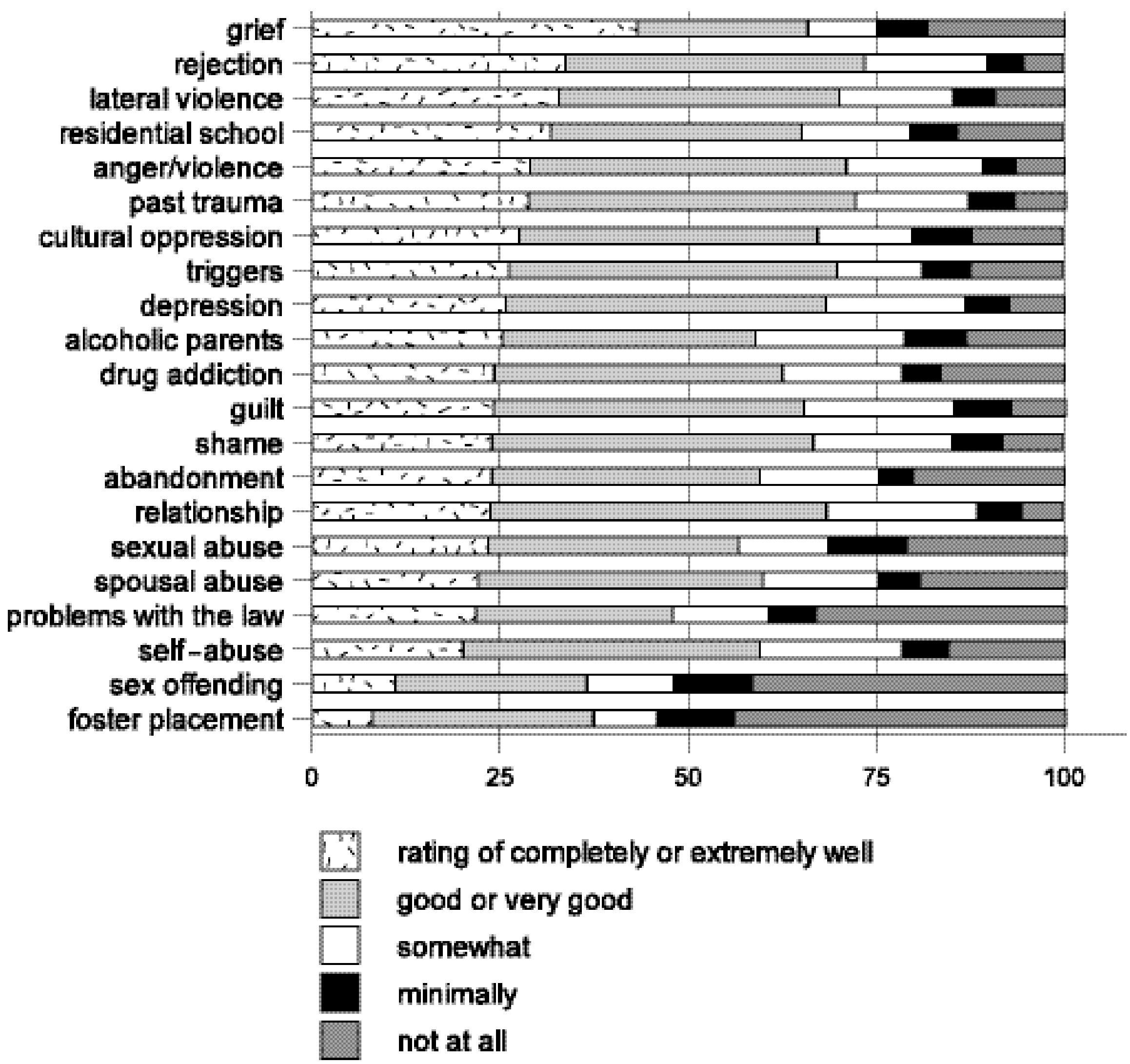
Figure 27) Rating of Group Counselling Sessions



Most, (60%, n=700) claimed that their goals changed over the course of their participation in AHF-funded activity in the direction of improved self-awareness, relationships with others, knowledge and cultural reclamation.

Half of the IPQ respondents had the luxury of individual counselling (50%, n=687) and a fairly similar pattern of approval was noted for these sessions. Over sixty per cent gave individual counselling sessions a favourable rating when the following issues were addressed: grief, lateral violence, triggers, depression, anger, violence, shame, guilt, past trauma, residential school, cultural oppression and relationship issues. Individual sessions were also weak when considering issues such as sexual offending, problems with the law and foster placement. Figure 28 shows the ratings of individual counselling sessions secured in AHF-funded projects.

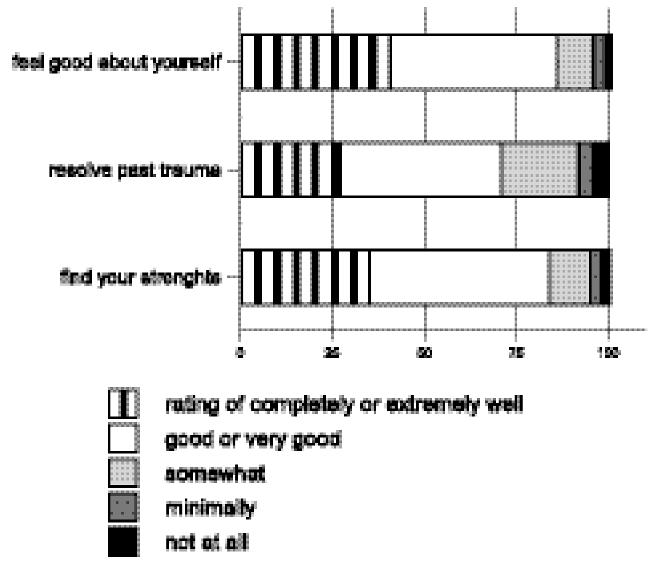
Figure 28) Rating of Individual Counselling Sessions by Specific Issue



On average, participants received eight individual counselling sessions (median = 5, n=247) and, in hierarchical order, were most likely to see: trained counsellors, Elders, psychologists, peer care givers, traditional healers, alternative health practitioners, social workers, psychiatrists or volunteers. Others involved in providing one-on-one services to participants (albeit, not all may be "counselling" sessions) included outreach workers, grandmothers, medical doctors, family members, nurses, sweat lodge keepers, friends, pastors, priests, Reiki practitioners, mentors and addiction workers.

Individual sessions were also assessed with respect to their ability to help participants resolve past trauma (n=431), feel good about themselves (n=434) and find their strengths (n=444). A remarkable proportion of respondents who received individual counselling were pleased[36] with the ability of these sessions to improve their self-esteem, help them to find their strengths (86% and 84% respectively) and work through their past (71%).

Figure 29) Rating of Individual Sessions by General Issue



Most respondents credited *program qualities* as being very helpful on their healing journey, particularly *Legacy education* because it helped them to understand their lives and their families (44%, n=682). They also appreciated *opportunities to learn* about healthy, functional family life, how to process intense emotions and improve their relationships more generally. Bonding with other Survivors was also considered very powerful because it offered a venue for learning how others have reacted to and dealt with the Legacy (30%). Group settings provided feedback, support and the pivotal message that they *were not alone* in their struggles. Cultural celebration and reinforcement (12%) was attributed with giving back what was lost, supporting the reclamation of an identity and instilling pride. Spirituality, whether expressed through Aboriginal traditional or Euro-Christian means, fed participants' souls. Daily prayer, meditation, restored faith or finding their spiritual selves was credited with being most helpful (4%). Lastly, team qualities were recognized as powerful influences on the healing journey (4%). In particular, participants noted safe, respecting, non-judgmental and validating approaches as most supportive on their journey.

36 For example, rated the achievement of these goals favourably or a rating of good, very good, extremely well or completely.

Participants were most likely to acquire *relationship skills* while participating in AHF-funded projects (50%, n=577) including communication and parenting skills. They felt better able to listen, forgive, respect and understand others. Participants believed they were better spouses and friends with increased patience and sensitivity and they were relieved by their new-found abilities to offer and enjoy intimacy. Many (19%) learned new and improved ways of relating to *self* by being more confident, taking time for self-care, revelling in enlightenment and trusting their instincts. A solid group (14%) left with improved coping and life skills, such as remaining alcohol and drug-free and seeking help when it was needed. Some (5%) gained important cultural skills, including but not limited to, drum making, singing, relating to the natural world, respecting Elders and recounting legends. A few were more skilled counsellors (1%), could better engage in spiritual practices (1%) or share the Legacy's impact with others (3%).

Most participants advocated for *more time*, either through program continuity or increased frequency of healing and training sessions (30%, n=642). A surprising proportion felt that better equipment and facilities would improve project functioning (10%) and some referred to changing program qualities (17%), most particularly, having more intimate, smaller group sessions or one-on-one counselling. Others believed that projects could be improved if they focused more on better communication (10%). In particular, they cited translation and popular or common language be used to help draw the community into activities. Legacy education was a key focus in their recommendations for improved communication, awareness and participation. Participants urged for greater integration of culture, Elder involvement, land-based activity and spirituality (8%). They wanted more Survivors and Aboriginal people as healers, greater access to professional resources and an overall increase in the size of the project team (11%).

4.2 Influencing Communities

4.2.1 Establish Partnerships and Ensuring Sustainability

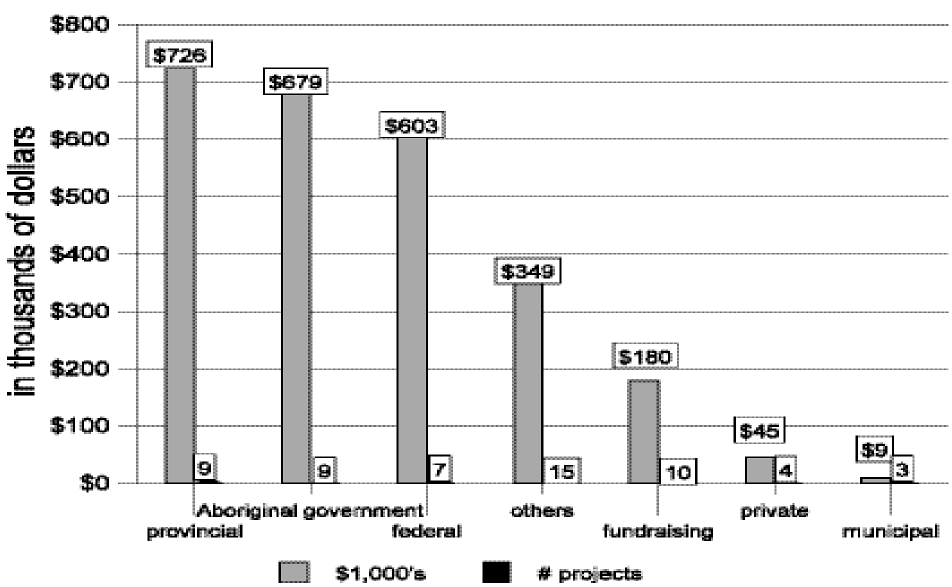
The Aboriginal Healing Foundation was established to serve as a catalyst for community action to address the Legacy. With fixed resources and a definitive time-frame, an end to AHF activity was always clear. Therefore, projects were encouraged to engage longer term sustainable funding from other partners or otherwise develop viable healing strategies. The index chosen to reflect sustainability is the amount of long-term funding secured to date. Partnerships, on the other hand, are represented by all contributions short and long-term (monetary or not), as well as working relationships with complementary service agencies. In the presentation of financial information, totals are used because they more fairly represent what is being contributed *nationally.*

Less than half of all respondents (87 of 176) reported receiving funding from other sources during the operation of their project, down from about two-thirds of all respondents in the first national survey (n=234).

A total of $6,921,282[37] was received from partners during the operation of the 87 projects that reported receiving such funds.

The greatest total amount came from Aboriginal governments ($2,001,270), followed closely by the federal government ($1,963,511). Provincial governments donated $1,181,520, while those gathered in the catch-all "other" category contributed almost a million dollars ($979,710). "Others," by name, included supporters from local health and social service agencies, the United, Anglican and Catholic churches, tribal councils and Aboriginal service agencies, non-insured health benefits, the Métis Nation, local training and employment boards, industry, individual pledges, the United Way, Aboriginal women's associations, the Canadian Conference of Catholic Bishops and fund-raising efforts. Community fund-raising generated over half a million dollars ($543,921), private granting foundations offered $164,530 and municipal governments pitched in $86,820. The distribution of total funds by source is highlighted in Figure 30. As a way of ensuring that each donation is kept into perspective, the reader will note that the number of projects who claimed to receive these contributions is displayed close to the x-axis (bottom horizontal line and on the right side of the graphic bar).

Figure 30) Total Funds Contributed by Source



A small group (37 respondents to the survey) in total reported receiving ***on-going funding*** from federal departments, provincial, municipal, hamlet and Aboriginal governments, as well as private granting foundations and community fund-raising efforts. In fact,

a total of $2,589,920 of on-going funding was reported by 37 respondents to the survey.[38]

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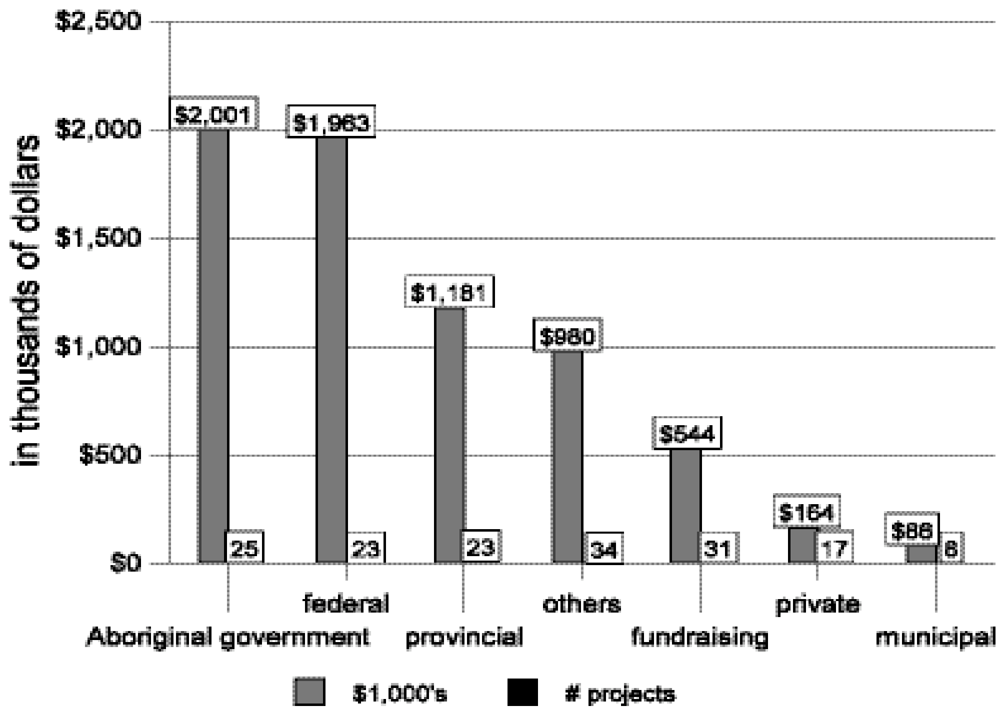
37 The 2002 total is up from $5,619,882 in 2000 (n=99).

38 This figure is down somewhat from the $4,090,575 reported by 33 respondents to the survey in 2000 and is proportionately different. On average, each respondent would have secured about $123,957 in 2000 and currently, on average, they secure $69,997 of on-going funding.

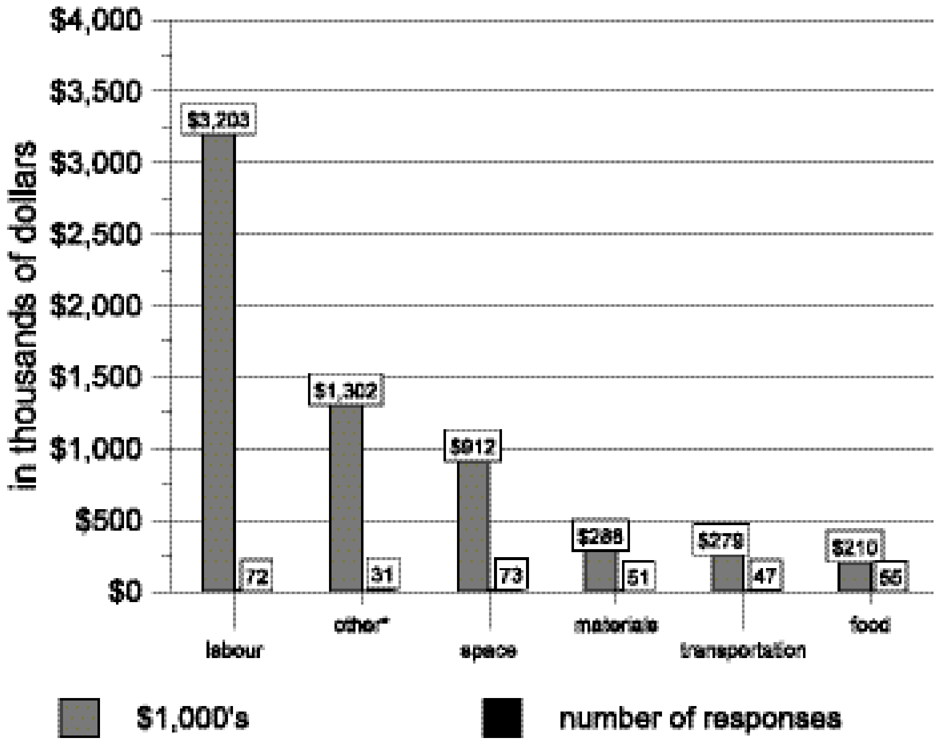
Just over one-fifth (22%, n=164) of the respondents believe that they *will be able* to continue addressing the Legacy beyond the life of the AHF. About as many (23%) were sure that they would be *unable* to continue their healing work and the majority (56%) was unsure. Provincial partners have committed the largest amount to ***on-going*** healing ($725,500), followed by Aboriginal governments ($678,794) and the federal government ($602,962). The generic "other" category, again, has an impressive long-term commitment of $349,075 and includes supporters from local health and social service agencies, the United, Anglican and Catholic churches, Aboriginal governments and service agencies, non-insured health benefits and fund-raising efforts. Again, the reader will note that the number of respondents to the survey who claimed to receive these contributions is displayed close to the x-axis (bottom horizontal line and on the right side of the graphic bar).

Figure 31) Total On-going Funds by Source



More than half (70%) of the respondents reported receiving donations of goods or services at an ***estimated value of $6,195,479.*** Donations of labour were clearly in the lead and valued at $3,203,597, followed by miscellaneous[39] donations totalling $1,302,071. Donations of space ($912,006), project materials ($287,962), transportation ($279,153) and food ($210,690) were also common. The pattern of donations received are depicted in Figure 32. Once more, the reader will note that the number of respondents to the survey who claimed to receive these donations is displayed close to the x-axis (bottom line and on the right side of the graphic bar).

Figure 32) Total Value of Donations by Type

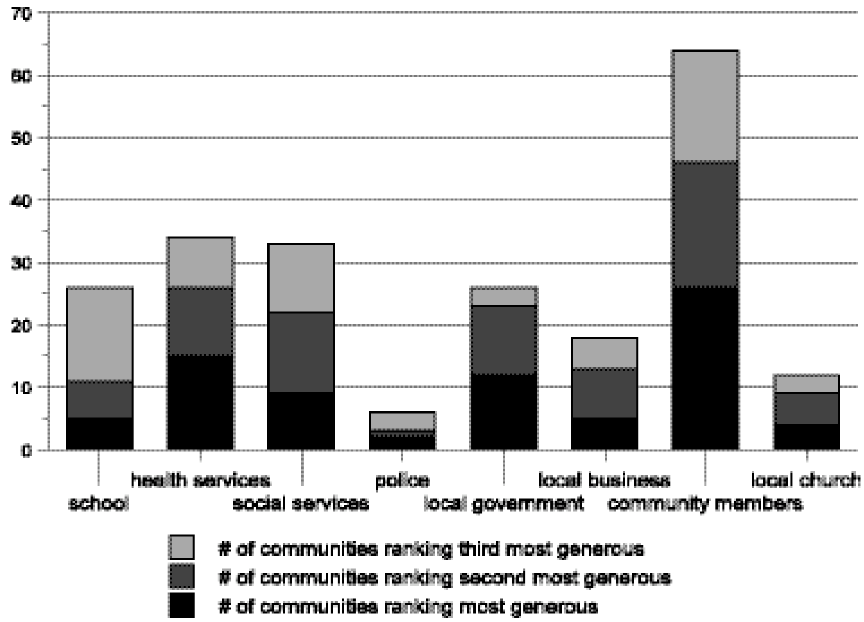


*** "other" includes promotional media, medicine and other miscellaneous items.**

39 The "other" category included items like snow removal, collaborative training opportunities, assessments, clothing, traditional medicine, telephone, accommodation, furniture, utilities, office supplies, advertising and administrative support.

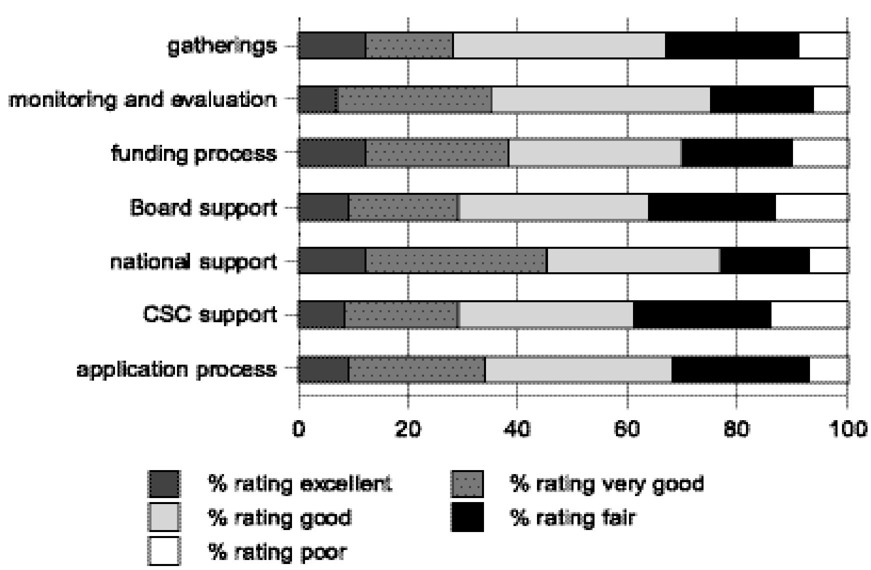
Consistently, community members were rated the most generous donors of goods and services, followed closely by local health and social services. Local governments and schools were important partners too. Figure 33 illustrates project ratings of donor generosity.

Figure 33) Most Generous Donors by Type



Lastly, teams had opportunity to comment upon their partnership with the AHF. Much of the AHF's activity was rated favourably. In particular, they felt very positive about the support they received from the national team as well as the monitoring and evaluation process. Figure 34 shows the distribution of sentiment about AHF processes.

Figure 34) Rating of AHF Activities



Note: CSC = community support coordinator

Beyond securing the support of the community at large, AHF-funded projects have also endeavoured to enlist the active involvement of Survivors and the intergenerationally impacted. The following section reviews their progress to date.

4.2.2 Engaging Survivors

Half of the respondents (51%, n=154) had no difficulty getting Survivors involved. Some (49%) are still struggling for a variety of reasons. Survivors in their communities are elderly with pressing health issues who generally do not want to recount or address their experiences in residential school.

> *Elders have been reluctant to get involved due to beliefs that healing is not possible and to a fear of facing and integrating the past into present day life.*[40]

> *At times, it is difficult because the [S]urvivors are elderly, sick and are not interested with dealing with their pain, not all of them but there are those that we will never be able to help because they don't want to hear, see or talk about their experiences of Residential school.*[41]

Lack of trust, multiple addictions (i.e., alcohol, drugs, gambling), as well as little or no understanding about the Legacy, commonly prevented Survivors from engaging.

> *Many [S]urvivors have trust issues, some have difficulty with people in authority figures, and others are too involved in destructive patterns to become involved in healing projects in any supportive way. Some simply refuse to become involved or even speak of their experiences for any number of reasons.*[42]

> *Survivors are leery of projects because they think that their involvement will jeopardize their financial claim currently in the courts. Survivors feel that they are being used because of their past.*[43]

> *What I found is that people did not connect their behaviour or lifestyle to the past. They did not always understand that it is because they lost their identity that they are lost.*[44]

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[40] AHF National Process and Impact Evaluation Survey 2002, survey respondent #40.

[41] AHF National Process and Impact Evaluation Survey 2002, survey respondent #8.

[42] AHF National Process and Impact Evaluation Survey 2002, survey respondent #139.

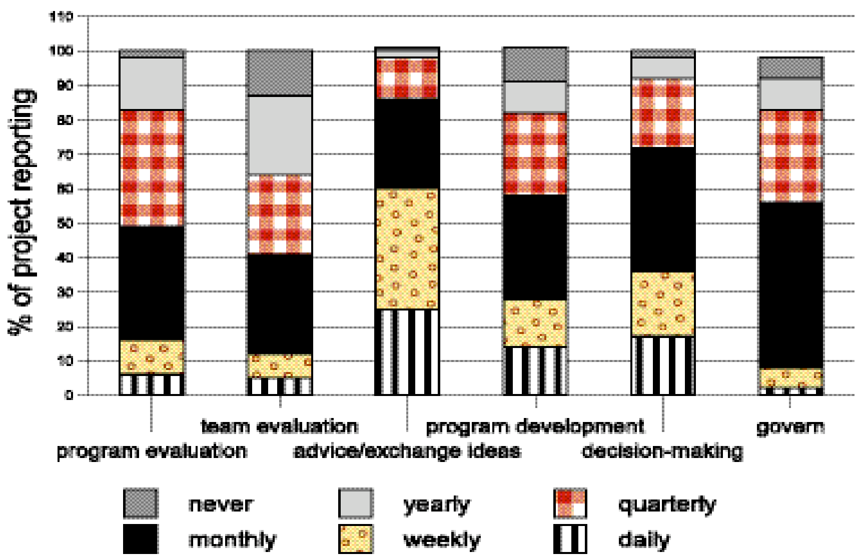
[43] AHF National Process and Impact Evaluation Survey 2002, survey respondent #152.

[44] AHF National Process and Impact Evaluation Survey 2002, survey respondent #144.

Some were thwarted by shame, fear, grief, denial or reticence to be viewed as critical of the church and others have lost hope altogether: *"some have suffered so atrociously that it seems to them no one could ever understand."*[45] Physical and financial barriers include lack of transportation and child care, poor weather, unemployment and insufficient support to engage in healing. In other words, more pressing needs, such as feeding a family, came first when determining where to invest energy.

When they were involved, Survivors were most frequently providing advice, exchanging ideas (60%) and making decisions with project teams at least daily or weekly (n=164). Over half of the project teams (n=161) enlist Survivors in program development activities or within a governing board or advisory committee structure at least once a month. Survivors were also involved in program and team evaluations; however, these activities were more likely to occur on a monthly, quarterly or yearly basis. Figure 35 shows the frequency of Survivor involvement in project management activity.

Figure 35) Frequency of Survivor Involvement in Project Management by Activity



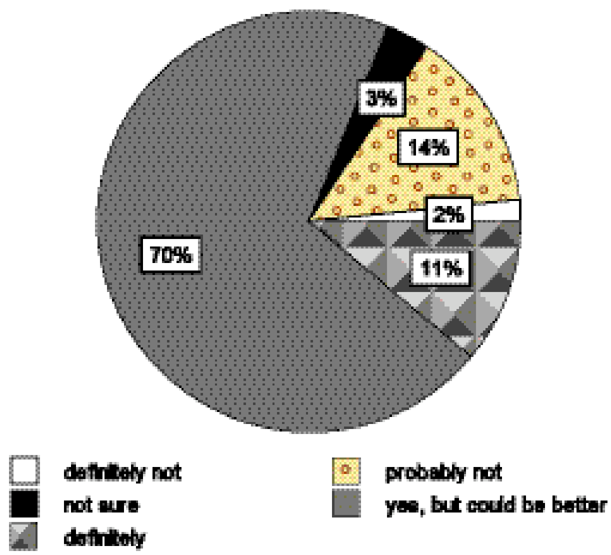
Survivors represent 35% of project teams (n=106), 51% of contract workers and those receiving honoraria (n=138) and 51% of all governing or advisory boards (n=139). The intergenerationally impacted are also well-represented and form 58% of project teams (n=128), 29% of those on contract or receiving honoraria (n=139) and 42% of board and advisory committee members (n=124).

45 AHF National Process and Impact Evaluation Survey 2002, survey respondent #51.

4.2.3 Reaching Those in Greatest Need

Almost half (44%, n=164) claim that they are able to provide healing and training to all those in need. A full fifty-six per cent claimed that they could not and thirty-six per cent (n=166) maintain a waiting list for participation. Only a small group (11%, n=160) were certain that their efforts were reaching those in *greatest* need. Most (70%, n=160) acknowledged that, although they were probably reaching those in greatest need, their efforts could be better. Some (3%) were unsure, while others (16%) were clear that they were probably or definitely not reaching those most affected by the Legacy. Figure 36 illustrates the projects' perceptions regarding their ability to reach those in greatest need.

Figure 36) Ability to Reach Those in Greatest Need



When questioned **how many more people could be serviced if the project had adequate time and resources,** project responses added up to **a total of 68,407** (n=68) people that they could service. This total increased from 56,857 (n=101) in 2000. In other words, *fewer* projects are identifying *more individuals* who would engage in healing or training. To entertain what this might mean, one must consider all 384 operational projects at the time and assume that non-respondents are similar to respondents. This is reasonable because non-respondents and respondents vary little on a number of important variables,[46] which means that there could be twice as many or 136,814 individuals on a national scale who would participate if they could. On average, that would mean 416 people for each project.

46 Source: AHF database.

4.3 Lessons Learned

Although AHF-funded activity is only a part of a broader healing movement and many others have started addressing the Legacy long before the AHF, for many communities, AHF resources represent *their first chance* to systematically address the impact of residential schools. In addition, AHF-funded activity *does* represent the first *national* attempt to undo the specific damage of residential schools. Therefore, without a wealth of documented protocol, easily accessible solutions and historically successful examples, some projects are engaged in a "learn as you go" approach where the lessons revolve around several central themes, including:

- the extent and complexity of the problem;
- the basic requirements of the therapeutic approach;
- team strengths; and
- the role of community.

Extent and Complexity of the Problem

> *Although we knew from the onset how necessary this type of initiative was, it is still overwhelming to hear community members and subsequent generations speak from the heart about their experiences. This has inspired us to do whatever is possible to follow-up with participants and continue with the healing process in the community.*[47]

Despite living with the aftermath of residential schools for generations, the most common lesson learned was related to the *extent and complexity* of the Legacy's impact. For some communities, the solid majority are living with the burden of the Legacy. Unravelling its tangled web requires focused energy and effective strategies to deal with identity, culture, relationships, parenting, education, economy and spirituality; all issues that are *deeply rooted* and require a *lengthy recovery.* Essentially, *people are what they do*: the primary intent of the schools was to erase Aboriginal life-ways and disrupt the very core of their personhood, identity.

> *I think the corruption began from the first day I entered. It was the beginning of a changing world for many of us, we were no longer salmon hunters, buffalo hunters or whale hunters. We had no alternative.*[48]

[47] AHF National Process and Impact Evaluation Survey 2002, survey respondent #108.

[48] Aboriginal Healing Foundation Regional Gathering participant, October 26, 2000 - Vancouver, British Columbia.

Project teams learned that healing is a process, not an event, that calls for the support of a healthy network of professionals or healers *and* adequate material resources. Earning trust, guaranteeing safety, developing unique strategies for different groups, gathering and strengthening front-line teams, integrating with other needed services while simultaneously providing therapeutic and prevention services overwhelmed many. Pressure was created not only by the extent of the need, but also by their knowledge that supporting disclosure ***requires*** follow-up and after care. Opening wounds means there can be *no ethical "sunset"* to the healing they have initiated without an enormously, elevated risk of re-traumatization. Ultimately, in some circumstances, there were more individuals who resisted change than embraced it; "reaching" them or even communicating with them was a Herculean effort. In other situations, establishing trust with interested but hesitant participants required vast resources of creativity and patience. For the longer term, project teams urged a preventive focus on youth.

Basic Requirements of the Therapeutic Approach

Although healing unfolds in fairly predictable ways, teams have learned that it does not happen all at once or by a neat schedule; it is a delicate progression, one that needs to be internally driven and externally accommodated.

> *. . . people are accepting help and support at their pace. Just because we have a timetable doesn't mean the [S]urvivors are ready to move forward at our request. We must accept people where they are and support them as they need it.*[49]

Healers and therapists can be more focused and intervene more appropriately when they recognize a "readiness" and commitment to healing. On occasion, participants can tolerate group work only if it is educational. Participants prefer that healers "walk with them" on their healing journey, not direct them through it.

Therapies must accommodate a variety of starting points in an environment of safety, empathetic understanding and respect that facilitates personal empowerment, enhances self-esteem, accommodates individual and group differences, while reinforcing culture and identity. A few of the uniquely tailored strategies recommended include:

- provide a very structured environment for young people that capitalizes on a variety of activity in short time spans;
- recognizing the unique safety issues of incarcerated sex offenders;
- engage Elders by meeting their needs for connection and socialization; and
- focus on affirmation of identity, especially for the Métis.

[49] AHF National Process and Impact Evaluation Survey 2002, survey respondent #136.

Healing environments must be *free* venues for participant voice, where they are acknowledged and honoured, and where truth prevails and forgiveness is encouraged. Holism must be the underlying foundation for all activity and, for many, individual counselling is preferred over group counselling.

Team Strengths and Care

Strong team members who are successful models of healing, preferably Survivors or the intergenerationally impacted, who are able to balance their own lives, are well trained or obtain the training they need and are free from the need to control, rescue, enable or care take, work well. Obviously, such individuals were difficult to find, especially ones with specific training needed to address the Legacy. Effective teams are consistent, able to work *together* and can ensure positive public relations.

Well-defined, detailed work plans, with sufficient administrative support to ensure that clinical teams are not hijacked by paper work, were essential to maintaining focus. Some projects feel that a professional assessment would help them to meet unique needs and prepare healing plans. Others extolled the value of group debriefing sessions as a way of diffusing the emotional intensity of the work and peer evaluations as a means of improving it. Several reported the value of tracking the performance or the achievement of desired objectives, not just as an accountability tool, but also to establish *new* goals and directions.

Role of the Community

The community culture contributed to the attainment of desired outcomes, especially when there is a genuine desire to engage in healing and where an effective network of culturally-appropriate or sensitive services and a spirit of cooperation or "togetherness" are present. *Increased project momentum led to increased participation and both dynamics reciprocally fed into each other.* Healing goals were thwarted where there is a presence of an internal culture of violence, denial, competing political priorities and individual concern about monetary compensation. Projects described the culture of violence as one where the crimes committed in residential schools have been internalized and considered a normal part of life.

> *The legacy of abuse stemming from Residential school was a hate crime . . . This attitude has been passed on from the initial abusers to the victims and the victims to subsequent generations.*[50]

Sometimes, healing was not a priority for leadership who might be focused on resolving land claims issues. Also, healing may not have been on the minds of community members, in general, who were preoccupied with basic survival issues (food and shelter) or believed that a monetary settlement was all that was needed. Community acceptance or, at a minimum, tolerance of healing activity was key. When the community climate was a hindering force, project teams made it very

50 AHF National Process and Impact Evaluation Survey 2002, survey respondent #42.

clear that *outside help is required.* One community was hindered by several Euro-Christian religious groups who were all struggling for a stronghold on community spirit, without any interest in supporting Aboriginal culture. Several communities saw Legacy education as the answer, especially for youth, not just within the community but also in the broader Canadian context. After all, they claimed that people who do not recognize or understand a problem will not seek to resolve it. Communities want partnerships established with educators and tools to help all who are interested in Legacy education. In one case, they responded to an ever-increasing demand for information with whatever resources were at hand.

> *...from the beginning of this initiative, we have received several requests for information regarding Residential schools and their impact. The requests are coming from health educators, nurses, Ph.D. students, social workers, and media. This has helped us compile a resource list to accommodate these requests.*[51]

Still, many signs of hope were clear in young healers who confidently led the way by offering therapy and ceremony, in the parents who were determined to create a different life for their children and the collective *desire for continued support* on the healing journey.

4.4 Best Practices

Although the term "best practice" is used frequently in the following discussion because it has become a common buzz word that is easily understood, it is important to note that what is being described is really a promising practice or an activity that appears to work well and can easily be adapted to a variety of contexts. In no way is the term "best" to be understood as the *only way* nor should its use engender competition between project teams or communities. Rather, the terms "best" and "promising" are used here inter-changeably for stylistic simplicity.

Over time, some important trends in promising practices have been noted. The current results fall into roughly the same themes reported in previous AHF interim evaluations and include:

- therapeutic approaches;
- the significance of culture;
- team qualities and care;
- providing opportunities for learning; and
- engaging the community.

Before discussing the use of various therapeutic approaches, it is important to clarify some important distinctions between what are collectively known as western, traditional and alternative therapies.

[51] AHF National Process and Impact Evaluation Survey 2002, survey respondent #108.

Western approaches incorporate all strategies where the practitioner has been trained in western institutions (i.e., post-secondary educational institutions) including, but not limited to, psychologists, psychiatrists, educators, medical doctors and social workers. For the most part, western practitioners are regulated by professional bodies, have liability insurances and are state-recognized or their services are covered by provincial health care plans.

Traditional approaches incorporate all culturally-based healing strategies including, but not limited to, sharing, healing, talking circles, sweats, ceremonies, fasts, feasts, celebrations, vision quests, traditional medicines and any other spiritual exercises.

Alternative approaches incorporate all those strategies outside of most regulated and provincially insured western therapies and include, but are not limited to, homeopathy, naturopathy, aromatherapy, reflexology, massage therapy, acupuncture and acupressure, Reiki, neuro-linguistic programming and bio-energy work.

Therapeutic Approaches

Flexibility to accommodate a variety of individual needs and preferences was well served by treating the unique needs of special groups (i.e., gender and age-specific, families, etc.). Evidence suggests that activity-oriented therapies (i.e., arts, crafts, drum making) were popular with those who felt more comfortable in non-verbal forms of expression and humour were *always* a welcomed addition to the therapeutic context. Despite the Legacy's weight, the vast majority of Survivors still have the capacity to appreciate and generate humour.

> *He asked a man his name and the man gave him his Indian name and the Priest couldn't pronounce it so he baptized him as John. John went hunting killed a deer, hung it up, Friday came along and he felt guilty but decided to cut it up and cook it. The Priest came along and found out John was cooking meat. He started really going at him and John said it's okay, don't get too excited. John said remember when you first came around you couldn't pronounce my name, I got this deer and put a stick on it and changed its name to "Fish."* [52]

Ease of access to programs was facilitated by providing home visits, offering transportation and eliminating barriers to participation (i.e., offering child care, food, accommodations). A few projects even provided "incentives" for participation; however, the nature of those incentives were not described. Therapy appears to work best when it was *client*-driven and integrated in a variety of treatment approaches (i.e., western, traditional and alternative). Western practices generally

52 Aboriginal Healing Foundation Regional Gathering participant, October 26, 2000 - Vancouver, British Columbia.

included counselling (individual, group, family and couples), psychotherapy or Christian spirituality; while traditional approaches ranged from sharing circles, sweats, ceremonies and traditional teachings. For some, large group gatherings were preferred because, in part, they offered participants connection and were ideal for early sharing and Legacy education efforts. For others, smaller groups and one-to-one counselling was the preferred strategy because they offer greater privacy, comfort and more personalized care. One project even warned against facilitating or encouraging disclosures in large group venues. Alternative therapies varied significantly and include massage, neuro-linguistic programming, Reiki, time-line therapy and breath work. Examples of the western, traditional and alternative approaches used to address the Legacy are listed in Table 8.

Table 8) Western, Traditional and Alternative Approaches Used to Address the Legacy

Western	Traditional	Alternative
counselling (group, individual, family, couples)	circles	neuro-linguistic programming
psychotherapy	sweats	time-line therapy
life skills	ceremonies (Pipe, Naming, Honour)	massage therapy
mental health promotion	feasts	Huna therapy
art therapy	on-the-land activities	breath work
Christian spirituality	fasting	bio-field (hands-on healing)
psychiatry	Métis wailers	Reiki
Rogerian therapy	cultural celebrations	acupuncture
psycho-social development	traditional food harvesting and preparation	energy release work
Inner Child therapy	speaking the language	vibrational healing
attachment theory	rites of passage	
genogram charts	cleansing	

Often, traditional and western therapies are used consecutively or offered as choices with a great deal of creativity to find and use what works, while recognizing that no one approach will work for everyone. Sometimes, the two approaches are blended in a fairly balanced way or used simultaneously. In other cases, traditions are *adapted* to include western therapeutic elements and the adaptive exchanges appear to be reciprocal.

4.4.1 Adapting Traditional Approaches

For example, in traditional talking or sharing circles, everyone quietly waits and listens while each individual speaks as long as needed. The floor is granted to the speaker symbolically in the form of a feather, rock or other object and circle members listen intently and silently. Interruptions or interference is considered poor protocol; therefore, feedback and group exchange is not a part of the equation. Many projects have *adapted the talking circle to allow for interaction* with peer members or a facilitator/counsellor.

Sweats are one of the most commonly recognized Aboriginal ceremonies of purification and prayer that are also being adapted. Although there are as many ways to conduct a sweat as there are sweat leaders, there are some common features. Sweats are usually held in a sweat lodge made from supple wood, constructed into a half-dome and covered with blankets and tarps. Hot rocks are placed in the lodge where water is poured onto the stones to create steam. The stones represent the ancestors and the leader holds the lodge as a sacred space to help participants with prayer and song. Participants are invited to speak from their hearts about their life and their community concerns as an *open-ended* exploration of spirit. To address the Legacy, sweats are being adapted to be *theme-based.* In other words, the exploration is *directed* to examine a particular issue, such as relationships with others, resolving past trauma or nurturing the inner child.

Sweats have also been adapted to include genogram charts or tools that resemble a family tree with specific information related to the Legacy. When family experiences of residential school are included, the genogram helps clarify and nuance the understanding of the Legacy's impact. When participants are able to see themselves in concert with family patterns, a much deeper understanding can be achieved. Similarly, physical cleansing has been partnered with spiritual cleansing practices, by incorporating a fast or dieting, so that elimination is greater than the intake. The combination of physical and spiritual cleansing is a way of achieving more comprehensive freedom from both environmental and emotional toxicity.

Traditional healing approaches have also blended with the Inner Child therapy, which is a popular approach for many sponsored projects. Essentially, the Inner Child therapy helps participants to reconnect with their last memory of themselves as a happy, carefree child. The loved child who went "inside" or was suppressed by circumstances that led them to grow up too soon and stifle their child-like needs, so that they could always look good or be good, becomes the "inner" child. The inner child develops when he is not loved for who he is rather than what he does, and never has the freedom to play or act childish. This leaves much unfinished psychological childhood business. Continued suppression of the inner child leads to never learning to feel normal, play, have fun, relax, manage stress or appreciate life. It can lead to guilt, workaholism, inability to enjoy family life, social isolation and suspicion of those who do enjoy life. Inner Child therapy seeks to *finish* the psychological business of childhood by reconnecting with the last memories of happiness as a child in the context of family, playmates and school, and relearning how to play, have fun or relax.

Elder involvement is the single most common traditional element of project healing practice that is being adapted. Projects offer Elders training to enhance their competence as counsellors and provide them with the confidence they need to address the Legacy. One of an Elder's most powerful tools, story-telling, has also been adapted as a way of offering a "diagnosis" and explanation for the impact of the Legacy. Although stories may not directly illustrate an idea, they usually touch participants at a base level of feeling and belief, offer a form of vicarious learning, as well as a variety of non-threatening solutions. Another modification includes "medicine" bundles that are wrapped with modern self-care products like a candle, meditation on CDs (computer discs), bath and massage oils. Although some are very strict about not adapting traditional healing approaches, others have a more open attitude: *"Everything is our way if it will make our future brighter."*[53] While traditional healing approaches are changing to include elements of other therapies, western therapeutic practices are also adapting.

4.4.2 Adapting Western Practice

When the overarching framework for healing was grounded in western practice, tradition still influenced and became a part of the wellness repertoire. For example, grief counselling was augmented by bringing in traditional Métis wailers. Historically, the role of the wailer was to come to a wake and cry aloud as a way of releasing grief for the family. In other cases, traditional songs, music or drumming, as well as ritual or ceremony, were used to create an atmosphere for, or as a prerequisite to, contemporary relaxation techniques and massage therapy. Sensitizing western practitioners by involving them in ceremonies was considered a particularly effective way of influencing them to consider, respect or integrate traditional practice with mainstream therapies. Some healers encouraged participants to request more traditional approaches from their non-Aboriginal therapists or actively promoted traditional approaches with western practitioners. In one community, doctors have learned about and are agreeable to permit individuals to exercise the traditional practice of burying the placenta, a funeral director makes a hole in the casket so that the spirit can be released and a local hospital allows "passing over" ceremonies.

Adaptations of western practice have included: Opening and Closing ceremonies that are often used as a way to bridge western therapies within a cultural space; sentencing circles that incorporate Elders who work collaboratively with counsellors; and self-help strategies that are beginning to look a lot like healing circles. Rogerian therapy (named after personality theorist Carl Rogers) was identified as a western approach that fit well into the traditional teachings of self-responsibility. Rogers developed and used a client-centred approach where the client identifies the problem, finds ways of improving it and determines when therapy is done. It is supportive, not reconstructive. It seeks to establish independence and freedom *with responsibility* and not to create an unhealthy dependence upon a therapist. Therefore, client-centred approaches allow individuals to try out their insights on their own, in real life and outside of counselling and therapy. [54]

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53 Participant, AHF Project Gathering, March 28-30, 2003.

54 Boeree, Dr. C. George (1998). Personality Theories, Carl Rogers, 1902-1987, Biography. Retrieved on 1 June 2003 from: http://www.ship.edu/~cgboeree/rogers.html

Symbolism in western therapies appear particularly well-suited to adaptation. For instance, art therapy allows for emotional expression and healing through *non-verbal* means that is well-suited to children or adults who may use words to intellectualize and distance themselves from their emotions. It allows people to overcome barriers to self-expression by using simple materials without any prior art experience or talent and is a non-logical and symbolic approach. Similarly, it is no surprise that Erik Erikson's theory of social development is considered well-suited to Legacy education efforts and traditional healing practices because it is *heavily influenced* by North American Indigenous tribes, namely the Yurok and Sioux.[55] In fact, it was difficult to decide if Erikson's theory was *adapting tradition* or *adapting a western approach.* Essentially, Erikson postulates that each stage of life presents a basic psychological and social conflict that, if resolved, successfully results in virtue. If not resolved, it can result in mal-adaptative behaviour or dysfunction.

Like Erikson's theory of psycho-social development, attachment theory appears to resonate well in healing programs and to validate the traditional role of mother as first educator. Essentially, attachment theory proposes that personality development is heavily influenced by the interaction of child and care giver (usually the mother) during infancy and early childhood. Security and, thus, the ability to explore allows children to become fully emancipated from dependence. When the child and care giver relationship is characterized by a healthy, dependable and loving bond, children can then form mutually contributing relationships with other adults. Residential schools disrupted these fundamental attachments.

> *I went to residential school at 4 1/2 years old, I was fluent in Dogrib and didn't speak any English . . . I stayed in residential school for 10 years after that. The first year I went home . . . Everyone was happy to meet their parents and I was afraid because I didn't know who my mom and dad were until my brother showed me. The thing that helped me to go through this is that my father could speak English and communicate for me with my mother who spoke only Dogrib. When I met my mom I didn't greet her, hug her, because I believed that my mother was a Nun at the school . . . When I saw my mom I wasn't happy at first because I didn't know who she was.*[56]

Sometimes, adaptation was a more simple adjustment, like developing intake forms and staff debriefing sessions that included information about the mental, emotional, physical and spiritual state of individuals or honouring participants by singing an honour song. In other cases, it was using western tools or technology, such as the Aboriginal Peoples Television Network (APTN) to facilitate healing. Although not reflective of traditional healing practices, but certainly a sensitivity to current Aboriginal reality, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV),[57] the main diagnostic reference used by mental health professionals in North America, has

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55 Erikson, E. H. (1985). Childhood and Society. 35th Anniversary Edition. New York: W.W. Norton and Company.

56 Aboriginal Healing Foundation Regional Gathering participant, January 26, 2001 - Yellowknife, NWT.

57 American Psychiatric Association (1987). Diagnostic and statistical manual, 4th edition (DSM-IV). Washington, DC: American Psychiatric Association.

recently recognized the unique features of post-traumatic stress disorder related to residential schools. Beyond the adaptation of western and traditional therapies, other features of programming were considered very promising.

Significance of Culture

Positive self-expression and acceptance was an underlying theme in many efforts to address the Legacy. Undoing the cultural hostility that characterized the schools was most effectively achieved by reclaiming culture, speaking the language, harvesting or eating traditional foods and using art, architecture and the natural environment to surround the participant with environmental clues that offered both explicit and tacit approval for the celebration of *Aboriginal self.* Traditional activities provided *"opportunity for clients to learn who they are,"* [58] where Elders were the best teachers and traditional Aboriginal philosophy could be applied to contemporary life.

Team Qualities and Care

Finding and securing the "best" people was a prescription for success, especially if they were familiar, well-respected and connected to the community and could provide stability to the program. "Best" most commonly implied *"skilled,"* either through experience or training. One project felt that it was important to recognize compassion fatigue through regular debriefings where team strengths, limitations and early signs of stress related symptoms were openly discussed. If any team member was in danger of burning out, management would promote and facilitate self-care. In one case, *daily* debriefings were recommended. In another scenario, all staff had to undertake a wellness plan before addressing the Legacy, in anticipation of the emotional intensity of the work ahead. While the specifics of their training are not always clear, it is understood that good teams are able to maintain confidentiality, reserve judgment, put participants' needs first and speak the language. They had to be sufficiently free from the need to control, able to operate *without* a set agenda, listen intently, understand and, most importantly, facilitate *independent* decision-making. Good team leaders or coordinators with strong leadership skills were also credited with facilitating project goals.

Opportunities for Learning

Legacy education was commonly hailed as a catalyst for healing, but also as a powerful way of engaging broader-based institutions. Relating present behaviour and feelings to past learning and experience makes the world a more comprehensible place; one where cause and effect is clear and solutions can be found. One project's video production was considered their most powerful contribution because it facilitated understanding in an easily accessible and popular format. When community-based understanding is supported, especially for the young, insight creates widespread "movement" toward healing. Beyond the history of residential schools, project teams urged other projects to include learning opportunities where participants could reclaim traditional parenting skills; learn to cope with grief, loss, crisis or life in general; and begin a course of personal development.

[58] AHF National Process and Impact Evaluation Survey 2002, survey respondent #45.

Raising community awareness not only about the Legacy, but also about the variety of healing options and healers, was considered a way of introducing and connecting participants to resources that could help them beyond the life of the AHF. Enlisting local political leaders and securing the commitment of the bright and the talented were considered important best practices. Engaging the community, especially self-help groups who participated in fund-raising, was considered a *practical* strategy that could guarantee sustainability. One community dared to dream about life *without* the Legacy. As a way of promoting their program, they created a "dream wall" or a public space where free imagination could illustrate the possibility and promise of a better tomorrow. One art project initiated their work through joint child and parent activities as a way of enlisting the whole family.

Networking with other communities and special outreach efforts to isolated areas produced the best results for some teams. One community promoted active recruiting of participants, rather than waiting patiently for them to enlist. Service integration and *within*-community collaboration was the key to success for others, especially if it involved contributions from a variety of stakeholders and service providers. Projects were convinced that their ability to secure additional support for their efforts to address the Legacy was related to the synergy created by an interdisciplinary approach. When whole community systems work together and share goals, it reflects a readiness to engage: one that is easily recognized by funders outside the community. Certainly, but not least, Survivor and Elder involvement in governance structures, program decision-making or in less formal exchanges were *highly valued*. Still, some are struggling with a variety of systemic barriers that hinder their ability to achieve desired results and, in some cases, even to implement planned service delivery objectives.

4.5 Greatest challenges

Qualitatively, the challenges faced by project teams have also demonstrated remarkable stability over time and are directly related to:

- environmental or contextual factors;
- the task at hand; and
- issues related to team care and constitution.

4.5.1 Contextual Factors

Geography worked against some communities, especially those in isolated or remote areas where access to technology, trained staff, a network of human services and even infrastructure were in short supply. Sometimes, just the weather was uncooperative. Racism, oppression or the mix of politics and healing in the broader community context made some teams feel like grains of sand against a mighty beating ocean. Sometimes, the physical environment presented the greatest challenge. For example, office environments were considered less than ideal because they are cold, formal and often housed within institutional settings. In one scenario, maintaining consensus and commitment from local agencies was a challenge and, in another, finding and keeping volunteers was a problem.

But, by far, the most commonly cited contextual challenge was related to fear and denial that continue to inhibit participation and, in extreme cases, create outright resistance. Where leadership was still in need of healing, enforced silence, hypocrisy or worse, normalized dysfunction, translated as tacit approval of on-going sexual abuse and created hostile environments for funded projects. Sometimes, the culture of the community has changed so dramatically as a result of the Legacy that violent perpetrators, who would have been ostracized traditionally, rise to the upper echelon of patriarchal systems forcing disclosure underground.

> *. . . regarding disclosure, within our tribe a number of individuals got together and somehow developed a ledger of names of abusers, individuals who were very prominent in the community. What developed is that any time we talk about a healing process it's very hush-hush. The result is that people are more reluctant now to discuss the healing process because they don't want to be seen as taking sides. If information on disclosures is released we would have a heck of a time continuing our existence.*[59]

Teams blamed lack of awareness and concern about the Legacy when there was little or no community involvement in healing. Climates where fear, gossip and anger prevail were also considered roadblocks to establishing trust and enlisting engagement. Crises in the community, especially suicides, always derailed healing or training endeavours. Many teams are eager to learn how other communities were able to cope with fear and denial. The simplest, most direct way of dismantling fear and denial, some projects simply posed the question: *"What do you need to feel ready?"* Other, more complicated and time-consuming solutions are most relevant here.

4.5.1.1 Overcoming Fear and Denial

> *"All healing is based upon relationship."* [60]

Building a relationship under typical conditions *requires time, patience and persistent effort:* it is characterized by prolonged and informal exchange. Trust and intimacy are achieved *indirectly* through opportunities for learning, shared experience, celebration, as well as personal expression. Fear and denial, both natural defences against a threatening situation and entirely predictable reactions to traumatic experience, are best dissipated when ***acceptance and safety*** are first and fundamental elements of the relationship between participant and healer.

Acceptance means finding creative ways to welcome all participants into healing and focusing on what they can contribute to the group by acknowledging their individual strengths. Isolated by their own shame and guilt, as well as the anger of others, offenders are often left without opportunities for normal socialization, healing or re-integration into a harmonious community life.

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59 Aboriginal Healing Foundation Regional Gathering participant, October 26, 2000 - Vancouver, British Columbia.

60 Project team member, AHF Project Gathering, March 28, 2003, Ottawa, Ontario.

If offenders are allowed to exercise their positive strengths or to play a helpful role through the use of a buddy system (i.e., someone is working with them whenever they are in at-risk situations), then the community can benefit from their earnest and helpful contributions. If done successfully, integration and acceptance of offenders can lead them to seek help when they feel the urge to re-offend. Acceptance is also manifested by meeting people at their current level of need and understanding. Working on immediate issues can build trust and lead to a willingness to work on other, more sensitive and deeply-rooted dilemmas over the longer term. Acknowledging and honouring Survivors, recognizing and exercising personal strengths, together with promoting open dialogue, helped to *build solid relationships.*

Reducing resistance meant *creating conditions where those in need felt* ***safe****, physically and emotionally,* where they felt *supported and valued* and where a collective sense of trust and comfort prevailed. Ensuring safety includes clarity and education about client rights, sharing and publicizing guiding principles and rules, being a client advocate first, providing a physical environment that reduces the chance of triggering traumatic memories (especially in residential facilities). Warm, welcoming, *predictable* environments, with clear behavioural codes of ethics (especially related to confidentiality), helped to eliminate fear of the unknown, as well as re-traumatization.

Resistance to healing was generally viewed as a layered emotional wall. On the surface, denial is obvious; but underneath, denial masks shame, guilt, anger and, ultimately, fear. Fear of the unknown, loss, re-traumatization and punitive consequences *is real*, especially in small communities and prisons. Victims may suffer punitive consequences at the hands of violent perpetrators, still at large in the community, with no checks to their power or intimidation. Teams felt that it was important to know *who* was perpetrating and to have checks and balances in place to arrest their activity. In some cases, it is the perpetrator who is fearful of incarceration and reprisal at the hands of violent inmates. Once in jail, some programs confront denial head on with a matter-of-fact non-judgmental statement of the truth. The pretext to a confrontation is to establish a relationship between helper and Survivor based upon *trust* and *trust requires that all parties recognize the truth* and Legacy education facilitates the acceptance of the truth for offenders.

Sometimes, the words "residential school" functioned more to drive people away from project activity than it did to attract them. Likewise, some projects have more success being open to community-wide participation than in targeting Survivors. Focusing peer pressure positively and framing the healing journey as an act of courage and empowerment, and not focusing on weakness, also helped reduce denial because it felt emotionally safer. Framed positively, healing activity was usually called *"creating opportunities"* for learning, self-expression (verbal and non-verbal), as well as cultural reinforcement and celebration.

Learning

Projects were almost unanimous in their high regard for role models. Vicarious learning was considered valuable when the model was an Elder, healer or even a peer, because models are *live* illustrations of the benefits of healing. When people can learn by watching the experiences of others, they are spared all the pain associated with "trial and error." Models are most likely to be imitated if they had *similar* experiences as the observer, and are successful or competent, with admired status and have control over rewarding resources. Although observing positive models in audio visual media or having them symbolically represented in print is helpful, being in *direct contact over prolonged periods of time with live models works best.*[61]

In particular, healthy men with unhealthy histories, who had developed some skills at leading a group or functioning as a healer, seemed very effective in drawing other men onto the healing path. Machismo myths and social constraint hold men hostage in emotional pain that is as vivid and self-destructive as the hurt suffered by adult victims. Essentially, abuse teaches the child that the world is composed of victims and victimizers making the choice to become a victimizer is a form of self-protection and a common male response to childhood trauma.[62]

Ultimately, negative behaviours are learned; therefore, opportunity needs to be created for healthy behaviours and relationship patterns *to be learned through illustration, not direction*, and then *exercised.* Opportunities to learn how to relate as a couple, nurture the self, make use of healing tools (i.e., fasting, singing, writing, spiritual expression, relaxing and meditating) and process emotion were offered as effective examples.

Unpredictability was also best reduced by learning: learning a name for the Legacy's impact, understanding normal reactions to trauma and how community healing might unfold. Being able to name a threat or cluster of reactions gives the individual a sense of control. In particular, understanding the stages of psycho-social development and grief, as well as the role of anger and depression in grief, helped focus therapeutic work and individual resolve to overcome these emotions. While much learning occurs in well-orchestrated campaigns or curricula, projects were very clear that spontaneous, "teachable moments" must also be harnessed. Legacy education is particularly useful when it explains that the reactions to the residential school experience are normal and predictable consequences of institutional trauma and *not* an individual character flaw or weakness.

61 Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, N. J.: Prentice-Hall.

62 Wolfe, D. A., P. G. Jaffe, J.L. Jette and S.E. Poisson (2002). Child Abuse in Community Institutions and Organizations: Improving Public and Professional Understanding. Ottawa: Law Commission of Canada.

Self-Expression

Self-expression flourishes in a climate of acceptance where, without judgement, intense emotions, including shame, guilt and especially anger, are validated. Acceptance is also greatly facilitated when healers acknowledge that there is a *variety* of Legacy manifestations, including murder, sexual violation of children and physical abuse of a spouse, *as a matter of fact.* Anger is a common emotion among Survivors and must be viewed as a natural, necessary part of the grieving and healing process. Anger must be allowed to exist, expressed fully and, in the end, relieved while *accommodating* gender differences in the expression of anger as men may need more intense, aggressive or physical outlets for their anger. When the emotional intensity of a healing session escalates, a buddy system is recommended. In any case, healing teams have to believe that they can handle the manifestation of anger.

Self-expression is supported by a *variety* in healing options where both traditional and Christian Aboriginal people feel they belong. Similarly, different techniques accommodate diverse audiences. Men are particularly responsive to activity-oriented, non-verbal opportunities like physical competitions, warrior yells, music and wood-working because they appear to prefer doing than talking. Another non-verbal strategy hailed as successful included art therapy. Prompting participants to sculpt representations of the Legacy's impact in clay allows issues to be "outside" of the artist (i.e., represented by the clay figures) that, in turn, reduces the direct, emotional drain of the Legacy story. Humour, art, creativity and meal time were also popular ways of lightening the heavy work of addressing the Legacy and greasing the pistons of self-expression. Unfortunately, for the incarcerated, disclosures are inhibited by policies that negatively affect release time, even though disclosures represent emotional progression and self-responsibility.

Cultural Reinforcement and Celebration

Elders are consistently and hugely popular. With or without formal training as counsellors, their life experience and grounding in the culture provide them with the necessary and sufficient qualities to be effective. Elders' projection of honesty, empathy, acceptance and unconditional positive regard for Survivors and honour of Aboriginal culture was considered a powerful way of offering validation for participants. Traditional ceremonies and settings (i.e., land-based camps or sacred sites) provided comfort and assertion that Aboriginal people have a right to be who they are.

4.5.2 The Task at Hand

While no one who endeavoured to address the Legacy thought it would be a snap job, few really had any idea of the resources and time required to support participants and communities through such a dark time. In fact, many indicated that resources did not match the need or they found themselves in a continuous balancing act trying to service competing priorities. For example, assisting single parents without parenting skills who have problems *daily* with their children or their boyfriends is beyond a part-time, short-term program effort. The general weight of colonialism is heavy on the Aboriginal psyche and has created individuals who struggle with dispossession, cultural loss, poverty, long-standing, unresolved trauma and despair so profound that it leads many to life-destroying addictions.

We have developed a very close working relationship with our alcohol and drug abuse prevention program; because of the big role that substance abuse plays in many of these crisis situations. Burnout and active addictions among clients is making it harder to intervene and support.[63]

In part, the task that teams face is one that cannot be untangled from a complicated process of decolonization. In fact, several struggled with gaining and sustaining momentum within the time-lines of their sponsorship and finding financial support beyond the life of the AHF for their continued efforts.

Managing an appropriate "fit" between therapeutic approaches and *individual* participant needs or preferences feel overwhelming to some, especially as it relates to sexual abuse victims and offenders. Engaging seniors and retaining youth was not easy either and teams called for a more focused initiative that would specifically address their needs. In a few cases, the struggle was related to recruitment. Procedures and protocol for finding and reaching out to Survivors was rarely clear and certainly not documented in an operating manual. Maintaining consistency when serving several communities or even within a single community when funding was short-term, insecure or ceased altogether proved difficult. Only a few felt that administrative reports were burdensome, but several cited lack of child care, transportation, translation and cultural education as barriers to participation.

4.5.3 Team Care and Constitution

Several projects described scenarios where they had access to only part-time direction, unstable direction or even had a negative association with management. Lack of training and experience held special difficulties for a number of projects, with several of them citing conflict resolution as a much needed module for training. In some cases, although training was provided, there was insufficient time to really absorb the material or there was insufficient opportunity for clinically supervised practice. Once out in the workforce and without well-planned team care or adequate resources to meet the need, some front-line workers were at serious risk.

I'm concerned about the level of exhaustion and real physical illness that is happening to our front line workers, the leaders, the ones that have been holding so much stress . . . I'm seeing the people that have been holding the fort dying of illness . . . I am totally concerned about the people that are vigilantly focussed on healing. They're tired.[64]

A few healers are experiencing compassion fatigue and finding it increasingly difficult to balance their lives, control their emotions, set boundaries and find the wisdom and care they need to support their quest. In the worst case scenarios, this results in repeated staff turnover and unstable programming.

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63 AHF National Process and Impact Evaluation Survey 2002, survey respondent #139.

64 Aboriginal Healing Foundation Regional Gathering participant, October 26, 2000 - Vancouver, British Columbia.

5. Recommendations

The following recommendations are made with a variety of audiences in mind. Project teams or the internal moral authorities[65] who will use this information to improve project functioning compose the first audience. The second audience includes all funding agencies and the third audience includes Canadian institutions at large (municipal, provincial and federal governments, as well as others who can support community efforts to address the Legacy).

Recommendations directed to project teams

Recommendations for team members fall into two broad categories: therapeutic and team issues.

Therapeutic Issues

Beyond the efforts of project teams, others are drawing some conclusions about the needs of those who have endured institutional trauma that is worth sharing and may be useful to integrate into Legacy education efforts or individual treatment plans for participants. More specifically, it is clear that outcomes resulting from institutional child abuse are heavily influenced by:

> *. . . the significance of the institution to society, the role of the perpetrator within the institution (e.g. teacher, minister), the extent of the child's involvement with the organization, whether the child's involvement with the institution was voluntary or mandatory, and the circumstances following the abuse (e.g., whether or not a full apology for the act was offered . . .* [66]

Similarly, there are fairly predictable consequences, including: shame, guilt, humiliation, fear of or disrespect for authority, avoiding reminders of the abusive experience, and loss of trust and fear of intimacy. Those close to the victim will also experience a kind of "infectious" trauma or vicarious abuse symptoms. Figure 37 illustrates the characteristic after-effects and how the nature of the experience influences them.

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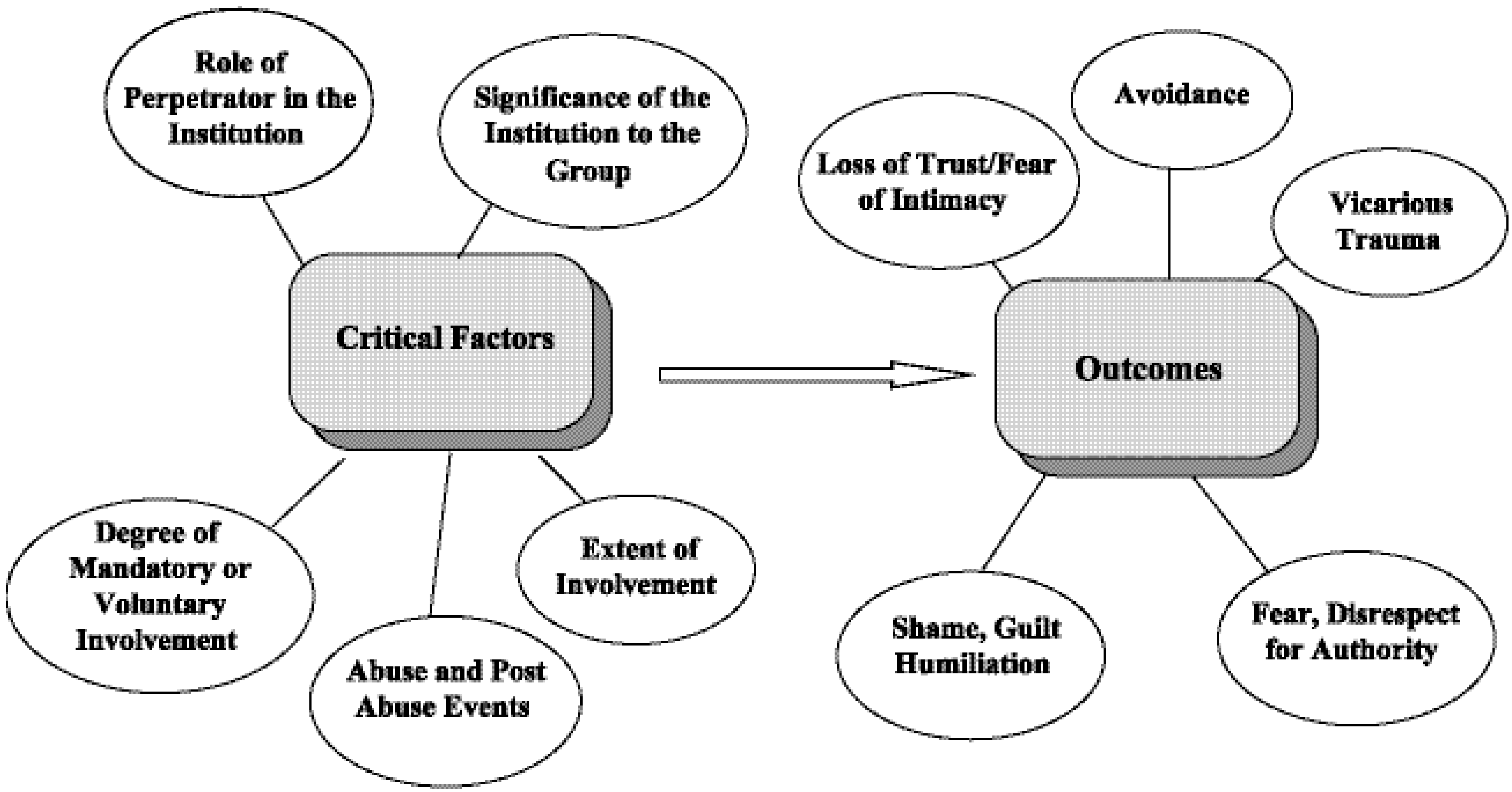
65 An internal moral authority can be defined as an individual or group or organization that functions with collective interests to check unethical or abusive behaviours. Traditional examples of internal moral authorities that held individuals accountable to the group included clan mothers, Elders' councils and tribal councils. Contemporary examples can be restorative justice circles, women's organizations, Elders and healthy, functioning Aboriginal governments. In essence, an internal moral authority ensures that all actions are in the interest of the local collective and that individuals are held accountable to the local community.

66 Wolfe, D. A., P. G. Jaffe, J.L. Jette and S.E. Poisson (2002). Child Abuse in Community Institutions and Organizations: Improving Public and Professional Understanding. Ottawa: Law Commission of Canada, page iii.

Figure 37) Critical Factors Influencing and Significant Outcomes Resulting from Institutional Child Abuse[67]



67 Wolfe, D. A., P. G. Jaffe, J.L. Jette and S.E. Poisson (2002). Child Abuse in Community Institutions and Organizations: Improving Public and Professional Understanding. Ottawa: Law Commission of Canada.

From the efforts of project teams, it is clear that therapeutic interventions work best when teams recognize a "readiness" or commitment to healing. This can be determined through intake assessment or by any other means to determine an appropriate "fit" between the individual and services offered. Referral agents should then be informed, trained or debriefed to make *appropriate* referrals based upon the goodness of "fit" between individuals and the program. In other words, it is important to focus the effort by addressing a unique need with a special strategy for a well-defined target group. *Realistically* attainable outcomes are best conceived when program developers take into account available resources and reasonable target groups.

Form a relationship with participants through prolonged and informal exchange, opportunities for learning, shared experience, cultural celebration, as well as personal expression. Base it on acceptance by welcoming all and focusing on individual strengths. Meet people at their current level of need. Create safety, physically and emotionally; publicize client rights, guiding principles and rules; be a client advocate first; reduce the chance of triggers in the physical environment (especially in residential facilities); and ensure that all environments are *predictable*. Know *who* is still perpetrating in the community and create checks and balances to arrest their activity.

Therapy also appears to work better and feel right when it is internally driven or client-directed and externally accommodated. It is important that reality be encouraged, a trusting relationship be established and Survivors have opportunity to recount past trauma through testimony, site visits, drama or any other means. Survivors are tired of being blamed for the intergenerational sequelae and *want their journey to be <u>positively</u> framed*. Avoid using the terms "residential school" and "healing." Instead, *"create opportunities"* for learning, self-expression (verbal and non-verbal), together with cultural reinforcement and celebration.

Create opportunities for healthy behaviours, self understanding and relationship patterns *to be learned through illustration, not direction*, then *exercised* (i.e., how to relate as a couple; nurture the self; understand grief, the Legacy and healthy psycho-social development; make use of healing tools; process emotion; relax; cope; parent or engage spiritually). Use role models who are most *similar* to the participant, have successfully healed and can be in *direct contact over prolonged periods of time.*[68] Validate emotions, including anger. Offer a *variety* of healing options (traditional and Christian), verbal and non-verbal, quiet and activity-oriented (i.e., sports competitions, warrior yells, music and wood-working, art therapy). Humour and meal-time also eased self-expression. Elders, traditional ceremonies and settings (i.e., land-based camps or sacred sites) provided comfort and are consistently and hugely popular.

In general, when western and traditional practices are used consecutively or blended, they allow for most individuals to find a philosophy that works for them. Of potential interest to therapeutic teams is the relevance of several western therapies including: attachment theory; Erikson's theory of psycho-social development; Rogerian therapy (or client-directed therapies); Inner Child therapy; psychodrama; genogram charts; and active, non-verbal, non-logical approaches such as art therapy. Lastly, Table 9 highlights special considerations for identified target groups.

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68 Bandura, A. (1977). Social Learning Theory. Englewood Cliffs, N. J.: Prentice-Hall.

Table 9) Considerations for Special Targets

Youth and Children	When servicing youth and children, it is recommended that Legacy education efforts be included. Active and non-verbal activities administered by positive role models who understand and can work with the special developmental challenges and phases of youth and childhood are most desirable. Partnerships with day cares and schools are effective and advised. Youth, in particular, appear to benefit from Elder interaction and respond well when their peers and peer culture is woven into project activity.
Elders	It is important for teams to recognize that elderly participants may have other health issues that present barriers to their participation in healing. Special efforts should be made to accommodate their limitations and increase service accessibility. In addition, it is recommended that teams recognize and meet elders' needs for connection and socialization.
Men	Allow men to determine their healing needs and ensure that men are working with men (particularly healthy men with unhealthy histories). Validate emotions and allow for uniquely male ways to handle intense emotions, including anger. Give men the space they may need for more intense, aggressive or physical outlets for their anger. Acknowledge, *in a matter of fact way*, that there are a *variety* of Legacy manifestations, including murder, sexual violation of children and physical abuse of a spouse. Give men opportunity for active hands-on or non-verbal activities and accommodate the differences between those mandated to attend and those who refer themselves.
Offenders	Create opportunities for normal socialization for offenders through re-integration or integration into community life. Use a buddy system (i.e., someone is working with them whenever they are in at-risk situations) if needed. Recognize that offenders have unique safety issues and prepare creative strategies to deal with them, especially in prisons. One method would be to allow for more one-on-one sessions where disclosure will be kept confidential. Lastly, measure their travel on the healing journey through means beyond recidivism.
Inuit	Projects would do well to ensure that Inuit culture, language, traditions and values are fully integrated with, not simply supplements to, the therapeutic approach. Given the dramatic under-representation of Inuit groups in training, it is recommended that greater investment be made in capacity building or skill development.
Métis	For the Métis, it is particularly important to reclaim their identity. Greater investment in reinforcing Métis identity, pride, cultural practice and celebration is warranted.

Team Issues

Carefully identifying potential healers is advised. Some general criteria have been gathered to help projects and are listed below:

A Checklist to Identify Potential Healers

- ❑ good track record of ethical conduct supported by references
- ❑ knows how to defuse negativity
- ❑ humble, honest, gentle
- ❑ accepts Legacy's reality
- ❑ worked through their anger
- ❑ complete transition through all stages of grief
- ❑ recognized by others as a healer
- ❑ absolute self-acceptance
- ❑ recognized as a model of triumphant recovery
- ❑ able to share their history and healing strategies
- ❑ has well-established personal boundaries that protects them from harm or burn-out
- ❑ respected in the community
- ❑ fearless, unflappable (not easily surprised)
- ❑ comfortable and knowledgeable of ceremonies
- ❑ free of depression, recognizes life goes on
- ❑ present, able to listen intently, hear clearly
- ❑ open
- ❑ free from the need to control
- ❑ unmistakable positive energy
- ❑ does not bargain away their actions or the actions of others
- ❑ alcohol and drug-free for a minimum of two years
- ❑ accept, learn from and work with clinical supervision
- ❑ understands their own professional limitations and makes appropriate referrals
- ❑ developed a plan for continued wellness
- ❑ committed to breaking the cycle of abuse, initiates community action and encourages ownership
- ❑ spiritually grounded
- ❑ reconciled with Mother Earth

Team debriefing diffuses the intense emotion associated with the work and performance reviews and peer evaluations improve it. Guidelines for recognizing compassion fatigue and well-developed boundaries and wellness plans will guard teams from exhaustion. Teams would benefit from conflict resolution training, sufficient time to really absorb any training material and adequate opportunity for *clinically-supervised practice and on-going support and advice.* Well-planned team care can save front-line workers from burn-out and programs from repeated staff turnover.

Lastly, private granting foundations and municipal governments appear to be under-utilized resources. The AHF has identified a variety of Canadian granting foundations that have Aboriginal people, community wellness, family violence or support and children as funding priorities. This published document is an on-going effort that has been sent to all current AHF-funded projects and is also posted on the AHF website. Further use of other media (i.e., newsletter, radio, television) should be utilized to better promote this publication.

Recommendations directed to funding agencies who support healing initiatives

As of 31 March 2003, a total of $285 million dollars has been committed by the AHF to support community efforts to address the Legacy and the remaining dollars will be committed by October 2003. The following recommendations are directed to all funding agencies to support continued healing of the Legacy. These recommendations are categorized to address: goal orientation, team support, communications and participant voice.

Goal Orientation

It is clear that *time is required* to establish trust and move through the stages of healing, but it is not clear how much time is needed. In reshaping the vision, the *question of time is still outstanding* and a more realistic vision of the healing journey unstated. Despite living with the aftermath of residential schools for generations, teams told us that the most common lesson learned was related to the *extent and complexity* of the Legacy's impact. Unravelling its tangled web requires focused energy and effective strategies to deal with identity, culture, relationships, parenting, education, economy and spirituality; all issues that are *deeply rooted* and require a *lengthy recovery*. *A much more specific vision that recognizes this complexity and the time required is needed.*

The funding agencies would be well advised to focus healing efforts in communities and with individuals who are *"ready" to heal* and concentrate upon Legacy education in contexts where recipients are not ready for healing. Community readiness and ability to maximize gains are indicated by needs that are well-defined, work plans that are detailed, the collaboration of engaged partners and team or system strengths evidenced by previous experience or success in similar programs. Readiness can also be determined by the extent to which their proposed action to address the Legacy has been informed by Survivors, based on pilot projects or s*pecific* research to meet Survivors' needs. High local *demand* (not to be confused with need) for services is also a prime index of community readiness to heal.

Team Support

Teams were keenly interested in professional assessments that would help them to meet unique needs and prepare healing plans. It might help to develop an adaptable assessment tool for the benefit of all projects, particularly those who do not have one now. Individual readiness to heal and level of need or risk *are* being assessed by many teams and used as a way of determining for whom services will be effective. These parameters should be shared with all projects so that they too can target those who are ready or at risk. In addition, communities want partnerships with educators and tools to help *all* who are interested in Legacy education. Beyond therapeutic assessment, community impact assessments should be informed by the dynamics that help and hinder identified in this report.

Teams want guidance, suggested procedures or protocols for finding and reaching out to participants and ensuring “fit” between therapeutic approaches and individual participant needs or preferences. In particular, they want specific material that will help them with outreach and treatment for sexual abuse victims, offenders, engaging seniors and retaining youth interest. They insisted that training initiatives provide sufficient time to absorb the material, opportunity for clinically supervised practice and arrangements for on-going support from seasoned therapists/healers until confidence is strengthened and expertise assured. Teams also felt that they would benefit from training to address special needs and resolve conflict.

Communications

The role of the Aboriginal People’s Television Network (APTN) should not be overlooked as an incredibly powerful national tool for Legacy education. It would be worth exploring a partnership with APTN and any other television network or broadcasting corporation (i.e., Inuit Broadcasting Corporation). Similarly, because the Métis and Inuit continue to be under-represented, it would be advisable to develop programming specifically for these communities.

Much information has now been accumulated about addressing the Legacy; however, most of it is in an *inaccessible* format for project teams. It is worth producing popular and accessible versions of information gathered that can be shared with communities through a variety of popular media such as common language print, audio-visual productions and hosted chat rooms or plain language links on the AHF website that are distributed or advertised through Aboriginal media networks that speak to the following issues:

- criteria to determine who is an effective healer;
- strategies for addressing special needs and target groups;
- promising therapeutic practices;
- recognizing compassion fatigue, setting boundaries and maintaining balance in the care giver’s life; and
- arresting the unchecked power of victimizers in leadership roles who perpetrate and secure the intergenerational cycle of abuse.

Participant Voice

Although cost effective and national in scope, surveys and individual participant questionnaires yield self-selected samples. In other words, only those who are comfortable or who can complete the surveys and questionnaires do so and the vast majority represented First Nations’ interests. It would be worth considering a *purposeful sample* of selected projects where a more oral tradition of information gathering could occur in the final phases of evaluation/research where Métis and Inuit voice would be equitably represented.

Recommendations directed to Canadian governments and institutions

Recommendations directed to Canadian governments and institutions are related to: enhancing sensitivity, enduring commitment and moral support.

Enhancing Sensitivity

Following the lead of the American Psychological Association, in its revision to the DSM-IV (main diagnostic reference used by mental health professionals in North America), practitioners should become fully versed in the unique features of post-traumatic stress disorder related to residential schools. Professional associations should set aside time in their annual conference agendas for formulating an enduring commitment to ending the Legacy, as well as urge their constituents to work with and support those addressing the Legacy in the community. Beyond changes in practice, there are some glaring and necessary changes in policy, particularly as it relates to disclosures made by incarcerated Survivors. Rather than negatively affecting release time, these disclosures must be considered within a more comprehensive index that measures overall emotional progression and self-responsibility on the healing journey.

Enduring Commitment

It is clear that a variety of expertise is required to address the Legacy and it would be very helpful if specialized professional associations could also offer their expertise or provide training for those dealing with special needs. In fact, each organization could have a "sponsor a trainee" campaign, nationally, regionally or locally, where one professional development seat within their normal training programs is reserved for a community-based healer addressing the Legacy. Alternatively, the organization could annually sponsor a member professional to offer services and training to those addressing the Legacy. In particular, teams cited the need for speech and occupational therapists, as well as educational psychologists. Other services needed to address special needs included: infant stimulation; addiction treatment; crisis intervention; literacy programs; family facilities; couples counselling; play therapy; psychodrama; body work and outreach (especially for the incarcerated). They want more information and training opportunities that will help them to treat offenders, adolescents and Elders, respond during a crisis, manage behavioural challenges, address sexual abuse (victims and offenders) and diagnose FAS/FAE. Long-term commitments of any size by every professional organization in Canada would be a substantive contribution to the enduring efforts to end the abuse.

Lastly, those who responded to the survey reported that Aboriginal and provincial partners have made the most generous funding commitments to on-going healing. Essentially, AHF-funded projects have supported widespread disclosure that *requires* follow-up and after care. Opening wounds means there can be *no ethical "sunset"* to the healing that they have initiated without the risk of re-traumatization. Canadian governments are urged to *continue* addressing the Legacy with groups and communities who are well-grounded in their strategies beyond the life of this highly relevant initiative.

Moral Support

Churches have a particularly important role in supporting Aboriginal culture and spirituality. Public statements should be issued immediately, widely publicized and consistently aligned with internal organizational policies that overtly *encourage and support Aboriginal culture and spirituality*. Public apology and associated media attention to them *appear to play a role in motivating* Survivors to engage in healing. For those institutions who have not yet done so, a public apology is warranted. Lastly, but perhaps most importantly, the substitution of traditional governments with legislated ones has lead to a situation of little or no power for internal moral authorities in many Aboriginal communities. In other words, externally imposed systems of government, as a matter of policy, insist upon and reinforce *external* accountability to bureaucracies, not *internally* to moral authorities who have collective interests at heart. The result is that many perpetrators use their political positions to maintain a strong hold on their communities, allow abuse to continue and thwart efforts to break the cycle. Broader Canadian institutions (governments, corporations and media) must seek every opportunity to support and reinforce *internal* moral authorities and, hence, community-based checks and balances *that prevent high-powered victimizers* from perpetuating the cycle of physical and sexual abuse and shrouding it in secrecy.

6. Concluding Remarks

Whenever social movements are ignited, it becomes difficult to discern cause from effect. In fact, over time, effects become causes and so the circle goes. In the struggle to fit circular causation into a linear model, there is great potential to miss the point. For Survivors, their families and their communities who have been introduced to the possibility of a better tomorrow, things will never be the same. Ultimately, *that is the point.* The nature of change in such scenarios varies from unspoken individual hopes to widespread, unyielding resistance. Although AHF-funded activity has acted as a catalyst in some scenarios, in others it follows a long history of healing activity or joins a cohesive community system of integrated services. Despite much evidence to suggest that things will never be the same, it is impossible to offer specific credit to a single effort.

What is clear and consistent is that Survivors are engaged as never before, with the vast majority (>98%) having never participated in a similar healing program. Even by the *most conservative estimate,* at least two-thirds could be considered "new" healing participants. Other evidence suggesting AHF work remains highly relevant includes the fact that *three times as many participants were identified with special needs* in this sample of sponsored projects. Increased investment in healing can only account for about 40% of this increase. Therefore, the index suggests that:

- projects may be better able to reach those in greatest need;
- those who fearfully waited on the sidelines initially, became convinced that projects were safe healing places and positive learning environments; or
- project teams are better able to identify those with special needs (e.g., life threatening addictions, risk of suicide, FAS/FAE and other emotional or physical disturbances).

In any case, the index serves to support the contribution the AHF has made to increase the connection between Survivors and healers and to increase the capacity of Aboriginal people to provide healing services.

Other indices suggest that the demand for services and community support may be increasing and resistance decreasing. In particular:

- proportionately fewer women and more men received training;
- Survivors and the intergenerationally impacted are well-represented at all levels of project operation;
- the majority of projects who responded are now *unable* to accommodate all who want to participate when previously the majority *could* accommodate all;
- this sample is not experiencing the same degree of resistance or lack of support within the community;
- fewer teams identified more individuals (68,407 up from 56,857 in 2000) whom they could have serviced if they had the resources;
- community members continue to be rated the most generous donors of goods and services; and
- half of the projects who responded had no difficulty getting Survivors involved.

Although there was an incredible amount of stability in the data over time, the most recent sample reported greater representation of youth and the intergenerationally impacted in both healing and training, which could simply be an artifact of sampling or it could represent a trend of increased enthusiasm and engagement of young people. But, the Métis and Inuit may still be under-represented in healing, training, as well as in project teams.

Several data point to the importance of self and other Survivors on the healing journey. Consistently, Survivors were eager to understand and help themselves, as well as connect with and assist other Survivors. Association with project activity, either as a volunteer or in other ways, inspired a major portion of Survivors to engage in healing. Working to address the Legacy was a safe way to determine whether or not healing was right for them. They credited Legacy education, more general opportunities for learning and connection with other Survivors as the most powerful elements of healing. The fruits of AHF-funded activity have also led to greater clarity about:

- protocols and procedures that support Survivors on their journey;
- creative strategies for dismantling denial and fear;
- screening criteria for potential healers (with a special focus on the Survivor as healer); and
- effective blends of western and traditional therapies.

Still, project teams reported that the influence of community dynamics on project performance is *very strong*. The structural differences between communities that facilitate and those that hinder illustrate that community systems are in-extractable from the healing equation. Most projects are still struggling to ensure sustainability, although initial contributions have been received. Lastly, despite living with the aftermath of residential schools for generations, the *extent and complexity* of the Legacy's impact is crystal clear. Unravelling its tangled web requires focused energy and effective strategies to deal with identity, culture, relationships, parenting, education, economy and spirituality; all issues that are *deeply rooted* and require a *lengthy recovery.*

Measuring change along that journey is complicated by the fact that communities and individuals start their healing at different points in space and time and the progression is a complex interplay between *environment* and *person*. Some begin in *very difficult* circumstances. Such landmarks are *fundamental clinical indices* for understanding the contribution the AHF has made. Although many signs of hope are clear, it is still very early in the life of the initiative and the real contribution of the Aboriginal Healing Foundation is yet to unfold. If goals are best achieved by beginning with the end in mind, then a more detailed vision is still required that takes into account the Legacy's complexity and the mandatory time to erase it from Aboriginal life in Canada. Clearly, approaches for addressing the Legacy must be tailored upon community and individual '*readiness*' to heal, framed positively and involve contributions from a broad range of Canadian institutions. Lastly, still missing and vital are the fuller details about *long-term* consequences of participation in AHF-funded activity and the unique perspective of the Métis and Inuit groups.

AHF National Process and Impact Evaluation Survey 2002

DESIGNED TO BE FILLED OUT WITH YOUR GUIDE

If you received more than one grant from the Aboriginal Healing Foundation, please complete *only one survey which describes your experience over the total time that you have been involved with or supported by the Aboriginal Healing Foundation.* It is not necessary to complete a survey for each grant that you received. Instead, only one survey should be completed which describes all activities that have been supported by the Foundation

Organization Name:	
Location:	
Region:	
Total # of Years/Months of Receiving AHF Funds:	

(Please include the total length of time you received funding from the AHF.)

This survey is intended to be completed **by a group** if possible. The group should include at least:

- one PROJECT deliverer (trainer, healer, etc)
- one survivor or someone affected by intergenerational impacts who has participated in the decision making process about the PROJECT
- one community service provider who has been involved indirectly by either accepting or providing referrals (e.g. the public health nurse or local social worker).

If you have any questions about how a particular question should be answered, please consult your Survey Guide. All terms which have been defined in the guide are capitalized (e.g. the term PROJECT in question 1). If time does not allow the gathering of a group to complete this survey, please have a community member who is most familiar with the project/s, fill out the questionnaire.

1. How many communities does this PROJECT serve? ________________

2. Describe your community or most of the communities that you serve.
(Please check only one).

- ❏ **Remote** - a community that cannot be reached by road or ferry service.
- ❏ **Isolated** - a community that can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people.
- ❏ **Rural** - a community that can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people.
- ❏ **Urban** - a community that can be reached by road or ferry service AND is located within 50 kilometres of a town/city with more than 25,000 people.

3. How many people live in your community? If your PROJECT serves more than one community, what is the total population of those communities? If you are unsure, ask your local government. Please consult your Survey Guide to complete this question.
________ # of people in the community OR total number people in all communities combined

A. WHO
Participants

A.1 Is your PROJECT ...
- ❏ a healing PROJECT? If your PROJECT has healing activities, answer questions A.2 through A.4, otherwise proceed to A.5.
- ❏ a training PROJECT? If your PROJECT has training activities, answer questions A.5 to A.7
- ❏ both healing and training? If your project has both healing and training activities, answer questions A.2 through to A.7.
- ❏ other - neither healing or training (e.g. video production, history documentation)

If your PROJECT has HEALING activities, answer questions A.2 to A.4.

A.2 **How many *individuals* have participated in healing activity who want and need healing services** (includes centre-based therapeutic healing, sharing circles, camps and retreats, etc.) ***Each participant should only be counted once** and this total **does not include*** community members *who are not seeking healing services* but who may have attended large scale community healing or social events such as feasts, conferences and pow-wows.

_____ total # of people who have participated *who want and need healing*
- ❏ Not sure
- ❏ Not applicable (e.g. video production, research or documentation)

A.3 How many individuals who participated/are participating in AHF-funded **healing activity who want and need healing services** are in the following categories? (Provide the best estimate).

_____ First Nations on reserve
_____ First Nations off reserve
_____ Métis
_____ Inuit
_____ Other

A.4 How many individuals who participated/participating in AHF-funded **healing activity who want and need healing services** are in the following categories? (Provide the best estimate).

_____ SURVIVORS
_____ intergenerationally impacted
_____ those who do not identify as Survivors or intergenerationally impacted

From the above total estimate, please indicate how many are in the following categories?

_____youth
_____ women
_____ men

Also from the above total estimate, please indicate how many are in the following categories? (If applicable)

_____ gay or lesbian
_____ incarcerated
_____ Elders
_____ homeless (see Guide for definition)

If your PROJECT has TRAINING activities, answer questions A.5 to A.7.

A.5 How many ***individuals*** have participated in **training as trainees** (includes workshop participation, formal classroom training, etc.)?

_____ total # of people who have participated in training.
❑ Not sure
❑ Not applicable (e.g. video production, research or documentation PROJECTs)

A.6 How many individuals who have participated in AHF-funded **training** are in the following categories? (Provide the best estimate).

_____ First Nations on reserve
_____ First Nations off reserve
_____ Métis
_____ Inuit
_____ Other

A.7 How many individuals who have participated in AHF-funded **training** are in the following categories? (Provide the best estimate).

_____ SURVIVORS (actually attended residential school)
_____ intergenerationally impacted (i.e. children and grandchildren of Survivors)
_____ those who do not identify as Survivors or intergenerationally impacted

From the above total estimate, please indicate how many are in the following categories?

_____youth
_____ women
_____ men

Also from the above total estimate, please indicate how many are in the following categories? (If applicable)

_____ gay or lesbian
_____ incarcerated
_____ Elders
_____ homeless (see Guide for definition)

A.8 To what extent do the following participant characteristics present challenges/difficulties you must deal with in operating your AHF PROJECT? (Indicate the extent of the challenge by checking the appropriate box.)

		Severe	Moderate	Slight	No Problem
(a)	lack of Survivor involvement	❑	❑	❑	❑
(b)	history of involvement in the criminal justice system	❑	❑	❑	❑
(c)	denial, fear, grief	❑	❑	❑	❑
(d)	lack of parenting skills	❑	❑	❑	❑
(e)	history of suicide attempts	❑	❑	❑	❑
(f)	history of abuse as a victim	❑	❑	❑	❑
(g)	history of abuse as an abuser	❑	❑	❑	❑
(h)	history of adoption or foster care	❑	❑	❑	❑
(i)	HIV/AIDs	❑	❑	❑	❑
(j)	addiction (for example: alcohol, drugs, gambling)	❑	❑	❑	❑
(k)	poverty	❑	❑	❑	❑
(l)	can't read or write	❑	❑	❑	❑
(m)	participation in youth gangs	❑	❑	❑	❑
(n)	FAS/FAE	❑	❑	❑	❑
(o)	Other: Please specify ____________________	❑	❑	❑	❑

Notes or comments: ____

A.9 How many of the people participating in your **healing PROJECT** require **greater attention** because of special needs (e.g. severe trauma suffered, inability to open up in a group, history of suicide attempt or life threatening addiction, etc.)?

requiring greater than normal attention______________________________

A.10 What do you think should be done to address the special needs of participants counted in question A.9 (we understand that more resources are needed, what we want to know is HOW should those resources be used? Check all that apply)

❑ training
❑ increase the project team
❑ improved facilities
❑ improved networking
❑ better access to services locally
❑ visiting professionals

Other: Please Specify____

A.11 Is your PROJECT able to accommodate all the people who need therapeutic healing or who desire training?

❑ Yes If yes, proceed to question A.13
❑ No If no, proceed to question A.12

A.12 If your PROJECT found it **could not/cannot** enroll all who want to participate, how would you/do you choose participants? In other words, who is given first priority?

____

A.13 In the opinion of the group gathered to answer this survey, is the PROJECT reaching those who need the service the most? Please check only one response.

5	4	3	2	1
_________	_________	_________	_________	_________
Yes Definitely	Yes But could be better	Not sure	Probably Not	Definitely Not

If the group answered probably not or definitely not, offer an explanation for why they feel this way.
____

A.14 How many more people in need of therapeutic healing/training could you serve if you had more space/qualified human resources/money?
_______ (# of people seeking healing services/training)
_______ unsure

A.15 Do you have a waiting list (formal or informal) for those who want to enroll in therapeutic healing/training?
❏ Yes If yes, proceed to Question A.16
❏ No If no, proceed to Question A.17

A.16 If a waiting list is maintained (formal or informal), what is/was the maximum number of people on that waiting list at any given time?_________

A.17 How many people currently participating in therapeutic healing/training have participated in **another similar** healing/training PROJECT (**not funded by AHF**) **BEFORE** they came to your PROJECT? (*Please consult your Survey Guide to be clear about what is meant by another similar healing project or program.)*

❏ None
❏ Unsure
# of people who have participated in previous healing PROJECTs

Personnel and Volunteers ***(Please see your Guide to answer questions A18 to A23.)***

A.18 Please think about the total duration of your PROJECT (**i.e. from the first time you received AHF - funding until now**). Over that time period, how many **full time** (who work **30 hours per week** ***or more***) paid *positions* (not individuals) did/do you have in total? Note: This includes employees, contractors and those who receive honoraria. _________

A.19 Please think about the *total duration* of your PROJECT (**i.e. from the first time you received AHF - funding until now**). Over that time period, how many **part time** (who work **less than 30 hours per week**) paid ***positions*** did/do you have in total? Note: This includes employees, contractors and those who receive honoraria. _______

A.20 Again, please think about the *total time you have been operating an AHF project* (**i.e. from the first time you received funding until now**) and *all the people involved*. Please indicate how many of the people involved have been SURVIVORS (i.e. attended residential school) or intergenerationally impacted (i.e. children and grandchildren of those who went to residential school).

Roles	Total #	# of SURVIVORS	# of intergenerationally impacted
employees			
volunteers			
contractors or those who receive honoraria			
board or advisory committee members			

A.21 How often does your AHF PROJECT engage SURVIVORS in the following PROJECT management activities?

		Daily	Weekly	Monthly	Quarterly	Yearly	Never
(a)	Developing PROJECT materials or content	❑	❑	❑	❑	❑	❑
(b)	Decision making	❑	❑	❑	❑	❑	❑
(c)	Informal communications to seek advice/exchange ideas	❑	❑	❑	❑	❑	❑
(d)	Evaluating progress or performance of PROJECT	❑	❑	❑	❑	❑	❑
(e)	Evaluating progress or performance of AHF team members	❑	❑	❑	❑	❑	❑
(f)	As part of an advisory or governing committee	❑	❑	❑	❑	❑	❑

A.22 Do SURVIVORS participate in staff hiring/evaluation decisions?

❑ Yes

❑ No Why not____

Question A.23

Please complete this table for all **full time** and **part time** positions. Make extra copies of this page if necessary. *To complete this question, **please refer to your survey guide.***

FULL TIME *Position or Role*	*Aboriginal Identity**				*Survivor (yes or no)*	*Inter-generational (yes or no)*	*Type of degree, certificate, training*				*# of years relevant experience*
	FN	*M*	*I*	*NA*			*Degree*	*Certificate Diploma*	*AHF Training*	*Other training*	

PART TIME *Position or Role*	*Aboriginal Identity**				*Survivor (yes or no)*	*Inter-generational (yes or no)*	*Type of degree, certificate, training*				*# of years relevant experience*
	FN	*M*	*I*	*NA*			*Degree*	*Certificate Diploma*	*AHF Training*	*Other training*	

** FN – First Nations, M – Métis, I – Inuit, NA – Non–Aboriginal*

A.24 In a typical month, estimate the number of hours of volunteer service contributed to the PROJECT. ________

B. WHAT

If your PROJECT has healing activities, answer questions B.1 through B.4, otherwise proceed to B.5.

B.1 If your PROJECT is *focused* on **healing** (i.e. most [more than 50%] of the resources and time are spent on healing), estimate how many hours an INDIVIDUAL participates in healing activity from the beginning of the healing project to the end? Please consult your Survey Guide to answer this question. ____________

B.2 How many individuals completed **healing** activities as they were planned? ______

B.3 How many individuals did NOT complete the **healing** activities? ______

B.4 Why did they not complete the **healing** activities? Please explain. __________________________________

If your PROJECT has training activities, answer questions B.5 through B.9, otherwise proceed to the next section.

B.5 Please estimate how many hours INDIVIDUAL participants have attended **training** sessions. You may wish to consult your Survey Guide to answer this question. ________________________

B.6 What is the maximum number of trainees you can enroll in your **training** PROJECT in a given year?_____ (# of trainees)

B.7 How many completed the **training** PROJECT? ______

B.8 How many did not complete the **training** PROJECT? Provide your best estimate ________

B.9 Why did they not complete the **training**? Explain. ____

B.10 To what extent do the following characteristics describe or impact upon your community? (Please indicate the nature of the impact by checking the appropriate box)

		Severe Challenge	Moderate Challenge	Slight Challenge	Don't know	Slight Benefit	Moderate Benefit	Outstanding Benefit
(a)	Supportive leadership	☐	☐	☐	☐	☐	☐	☐
(b)	Aboriginal language and culture supported by local institutions (e.g. schools, hospitals)	☐	☐	☐	☐	☐	☐	☐
(c)	Active community support	☐	☐	☐	☐	☐	☐	☐
(d)	Those in need want to participate	☐	☐	☐	☐	☐	☐	☐
(e)	Employment	☐	☐	☐	☐	☐	☐	☐
(f)	Access to health and social services	☐	☐	☐	☐	☐	☐	☐
(g)	Ability to harvest and eat traditional foods	☐	☐	☐	☐	☐	☐	☐
(h)	Community members speak the language, know the culture	☐	☐	☐	☐	☐	☐	☐
(i)	Transportation (local bus, vehicles, etc.)	☐	☐	☐	☐	☐	☐	☐
(j)	Housing	☐	☐	☐	☐	☐	☐	☐
(k)	Other (please specify)________________	☐	☐	☐	☐	☐	☐	☐
(l)	Other (please specify)________________	☐	☐	☐	☐	☐	☐	☐
(m)	Other (please specify)________________	☐	☐	☐	☐	☐	☐	☐
(n)	Other (please specify) ________________	☐	☐	☐	☐	☐	☐	☐
(o)	Other (please specify) ________________	☐	☐	☐	☐	☐	☐	☐
(p)	Other (please specify) ________________	☐	☐	☐	☐	☐	☐	☐

B.11 What is happening (or has happened) in your community that might have influenced your results? Try to think of *everything* (e.g. suicides, reawakening of culture, children's programs, political problems, court cases, increased funding for health services, new treatment centre, new road access, relocation, etc)

Please explain ____

B.12 What are the key features of your healing PROJECT? (i.e. centre-based, sharing circles, retreats, one-to-one or family counselling, or any other type of healing?) (Check one box for each item indicating how often each approach is used.

		Always	Most of the time	Sometimes	Rarely	Never
(a)	Use of traditional approaches only (e.g. healing/sharing circles, consultations or free time with Elders, cultural teachers, traditional people, spiritual guides; Aboriginal celebrations, ceremonies, dances, songs, story telling, fasting, sweats; land, bush or camp based activity)	☐	☐	☐	☐	☐
(b)	Use of a western therapeutic approach only visiting professionals (e.g. those trained in western institutions such as psychologists, psychiatrists, educators, trainers)	☐	☐	☐	☐	☐
(c)	Use of a combined approach including both traditional and western therapeutic methods	☐	☐	☐	☐	☐

		Always	Most of the time	Sometimes	Rarely	Never
(d)	Gender specific treatments (i.e. separate groups for men and women)	☐	☐	☐	☐	☐
(e)	Age specific treatments (i.e. separate groups for children, youth, Elders, etc)	☐	☐	☐	☐	☐
(f)	Any other grouping based upon ______________ (i.e. gay/lesbian, incarcerated)	☐	☐	☐	☐	☐
(g)	Sport, recreational activities (i.e. music, drama)	☐	☐	☐	☐	☐
(h)	Alternative therapies (i.e. homeopathy, naturopathy, aromatherapy, reflexology, massage therapy, Reiki, etc)	☐	☐	☐	☐	☐
(i)	Other, please specify ________________________________	☐	☐	☐	☐	☐
(j)	Other, please specify ________________________________	☐	☐	☐	☐	☐

C. PROJECT Finances

C.1 Take some time to think about ***realistic*** needs of your PROJECT. In the left hand column, rank order your most important PROJECT needs by putting a 1 by the most important need, a 2 by the second most important and so on. In the right hand column, estimate how much money would be *realistically* required to address this need.

			$
(a)	____	Increase employees numbers and benefits	____________________
(b)	____	Improve the PROJECT and expand it locally	____________________
(c)	____	Provide training for employees and potential healers	____________________
(d)	____	Offer, increase or improve transportation	____________________
(e)	____	Improve and expand our building	____________________
(f)	____	Develop/distribute information on the history and impact of residential school	____________________
(g)	____	Purchase equipment or supplies	____________________
(h)	____	Special needs (resources, professionals)	____________________
(i)	____	Solicit and establish partnerships/networks	____________________
(j)	____	Improve communication (with community, AHF, Canadians generally)	____________________
(k)	____	PROJECT monitoring and evaluation	____________________
(l)	____	Obtain professional assessments of skill development and healing	____________________
(m)	____	Improve Survivor involvement	____________________
(n)	____	Improve family support and parenting skills	____________________
(o)	____	Encourage community involvement	____________________
(p)	____	Other (please specify) __________________________	____________________
		Grand Total	____________________

C.2 Are you addressing the Legacy of Physical and Sexual Abuse with other agencies or organizations?

- ❏ No
- ❏ Yes, Please explain ____

C.3 How much funding did you receive from other sources while operating the PROJECT? (i.e. from the date you first received funding from AHF until you stopped receiving funding OR if you are still receiving funding, to the present date) How much have these same partners committed to ***on-going*** funding of healing, training, service or research PROJECTs or any other AHF related activity?

	Funder	Contributions made during PROJECT operation	Amount of *on-going* commitment to funding
(a)	Other federal departments, branches or divisions	$__________.00	$__________.00
(b)	Provincial or Territorial governments	$__________.00	$__________.00
(c)	Municipal or Hamlet governments	$__________.00	$__________.00
(d)	Aboriginal governments	$__________.00	$__________.00
(e)	Private granting foundations	$__________.00	$__________.00
(f)	Community fund raising efforts	$__________.00	$__________.00
(g)	Other (please specify) _______	$__________.00	$__________.00
(h)	Other (please specify) _______	$__________.00	$__________.00
(i)	Other (please specify) _______	$__________.00	$__________.00
(j)	Other (please specify) _______	$__________.00	$__________.00

C.4 Will you be able to continue with your activities when the AHF is gone?

❏ Yes
❏ No
_____Not sure

C.5 What is the estimated value of donated goods or services (in-kind contributions) you have received (i.e. from the date you first received funding from AHF until you stopped receiving funding OR if you are still receiving funding, to the present date) for the following? (Please estimate APPROXIMATE VALUE.)

			Cannot Estimate
(a)	Transportation	$__________.00	❏
(b)	Food	$__________.00	❏
(c)	PROJECT materials	$__________.00	❏
(d)	Labour (including volunteers)	$__________.00	❏
(e)	Space for PROJECT	$__________.00	❏
(f)	Other (please specify):	$__________.00	❏
(g)	______________________________	$__________.00	❏
(h)	______________________________	$__________.00	❏
(i)	______________________________	$__________.00	❏
(j)	❏ None		

C.6 Who **donates** the largest amounts **of goods and services** to your PROJECT? Identify the most generous partners by putting a 1 by the most generous, 2 by the next most generous partner and so on.

a) ___ school
b) ___ health services
c) ___ social services
d) ___ police
e) ___ local government
f) ___ local businesses
g) ___ community members
h) ___ local church
i) ___ other, please specify____
j) ___ other, please specify____

D. Learning

D.1 What are the most important lessons that you have learned? Please specify ____________________

D.2 What were your best practices? Please specify ____

D.3 What were your greatest challenges? Please specify ____

D.4 Has it been difficult to get SURVIVORS involved?
❑ No
❑ Yes. If so, what are the barriers to Survivors being more involved? In other words, why has it been difficult to involve Survivors? ____

D.5 Has it been difficult to get men involved?
❑ No
❑ Yes. If so, what are the barriers to men being more involved? In other words, why has it been difficult to involve men? ____

D.6 To complete this question, the group must gather information from reliable sources where it is available or *estimate to the best of your ability* how many (or what percentage of) community members can be described by the list of characteristics in the left hand column during the year *just before the project* and then again in the year *just after the project.* ***Please*** **refer to your guide to complete this question accurately.**

Characteristics of Healing	Before project began	After project was complete (or now)	Does not apply	Don't Know	Comments
% of the Aboriginal participants who are trying to address the Legacy of Physical and Sexual Abuse					
% of community households with persistent violence					
% of youth/children at risk and *without* adequate support					
% of Aboriginal community are aware of and understand the impact of the Legacy of Physical and Sexual Abuse					
% of local NON-Aboriginal service providers (i.e. health, justice, etc) who are aware of and understand the impact of the Legacy of Physical and Sexual Abuse					
% of Aboriginal community members with a positive attitude toward healing					
Number of sexual abuse disclosures					
Number of reported sexual assaults					
Number of attempted suicides					
Number of reported cases of spousal abuse					
Number of physical assault charges					
% of SURVIVORS and the inter-generationally impacted who are involved or committed on a personal healing journey					
number of Aboriginal people *able to lead others in healing*					
# of documents or productions (i.e. educational videos) on the history of residential schools					
# of strategic plans with a focus on healing					
% of those in need who are connected to those who can facilitate healing					

D.7 Rate each of the following aspects of the Aboriginal Healing Foundation activity on a scale of 1 to 5, where 1 = poor, 2 = fair, 3 = good, 4 = very good, and 5 = excellent.

		poor	fair	good	very good	excellent
(a)	application for funding process (principles, guidelines, support in completing application)	1	2	3	4	5
(b)	Support and assistance from the Community Support Coordinators	1	2	3	4	5
(c)	Support and assistance from the national team (head office staff)	1	2	3	4	5
(d)	The support and representation provided by the national board.	1	2	3	4	5
(e)	Funding processes (e.g quarterly monitoring reports, cash flow and renewal)	1	2	3	4	5
(f)	Monitoring and Evaluation process	1	2	3	4	5
(g)	Gatherings	1	2	3	4	5
(h)	Other (please specify)____________________	1	2	3	4	5
(i)	Other (please specify)____________________	1	2	3	4	5
(j)	Other (please specify)____________________	1	2	3	4	5

Please offer an explanation for any rate of 2 or lower on any item

____

Survey Contacts: Who coordinated the completion of this survey (this name will be used only if we need to ask you what a certain answer means) (PRINT OR TYPE.) Please also secure a sponsor's signature who has reviewed the answers presented in this survey.

The PROJECT deliverer participating in the completion of this survey:

(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

The Survivor participating in the completion of this survey:

(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

The Community Service provider participating in the completion of this survey:

(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

Other interest parties participating in the completion of this survey:

(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

Appendix 2

Your Experience on the Healing Journey

Filling out this form is **voluntary**. ***All* project participants** are being asked to fill this form out so that we can learn from your experience. This information may be used for a community evaluation and will be used for the national evaluation. All information will be kept confidential. No one will be able to identify your comments in any reports; therefore, you can feel free to say things that may cause controversy or things that you think the project team may not want to hear. The information will help us to *improve* the services we offer to you and others. If you choose to answer only some of the questions and not others, it will not effect the services provided to you. *There are no right or wrong answers, only answers that are **true for you.***

Today's Date_________________________

Name of AHF Project that you participated in__________________________________

Age ❑ Male ❑ Female

AHF Project Healing Activity Start Date_________________________________

AHF Project Healing Activity Finish Date________________________________

Healing Activity completed ❑ Yes ❑ No

If healing activity was not completed, what were the reasons?

1. a) I attended residential school ❑ Yes ❑ No
   b) My brother/sister/aunt/uncle attended residential school ❑ Yes ❑ No
   c) My parents (mother, father or both) attended residential school ❑ Yes ❑ No
   d) My grandparents attended residential school ❑ Yes ❑ No

2. The Nation I belong to:____
   (Métis, Inuit, Anishnabe, Kanienke'ha:ka, non-Aboriginal, etc.)

3. I got involved in the personal healing offered by the AHF Project because I

   ❑ learned about it and came (self-referred)
   ❑ was referred by ____________________________________ (please specify the title of the person or service and not the person's name)
   ❑ was mandated (or forced) to attend by __________________ (please specify the title of the person or service and not the person's name)
   ❑ Other, please specify _________________________________

4. Is this the **first** time that you have participated in a healing program?

   ❑ Yes (Go to question #6) ❑ No (Go to question #5)

5. Please list your **previous** involvement in healing programs: The first three rows are provided as an example.

Healing Program	Month and year started	Month and year completed
e.g. addictions treatment	November 1998	January 1999
e.g. individual counselling	June 1997	July 1997
e.g. family therapy	May 1993	December 1993

6. Please take some time to think about the impact that residential schools have had on you, your ability to speak your language, your knowledge of your culture, your ability to be a parent and so on. Please rate the impact that residential schools have had on these areas of your life.

   If this question does not apply to you, please move to question 7.

	Life Areas	NEGATIVE			No Impact	POSITIVE		
		Dramatic	Moderate	Slight		Slight	Moderate	Dramatic
a)	language	☐	☐	☐	☐	☐	☐	☐
b)	culture	☐	☐	☐	☐	☐	☐	☐
c)	parenting	☐	☐	☐	☐	☐	☐	☐
d)	identity	☐	☐	☐	☐	☐	☐	☐
e)	family	☐	☐	☐	☐	☐	☐	☐
f)	relationship skills	☐	☐	☐	☐	☐	☐	☐
g)	mental health	☐	☐	☐	☐	☐	☐	☐
h)	addictions	☐	☐	☐	☐	☐	☐	☐
i)	self image/esteem	☐	☐	☐	☐	☐	☐	☐

7. What did you hope to gain or achieve by participating in this healing activity? Briefly describe what you hoped you would get from your participation in the AHF Project. In other words, what were your goals and expectations?

   Goal #1 ____
   Goal #2 ____
   Goal #3 ____
   Goal #4 ____

8. Did these goals or expectations change during the healing activity?

❑ Yes ❑ No If yes, please say how they changed.
Comments

____

____

9. To what degree were your goals met? **Please check box or circle your response.**

	Not at all	Minimally	Somewhat	Good	Very Good	Extremely Well	Completely
Goal #1	❑	❑	❑	❑	❑	❑	❑
Goal #2	❑	❑	❑	❑	❑	❑	❑
Goal #3	❑	❑	❑	❑	❑	❑	❑
Goal #4	❑	❑	❑	❑	❑	❑	❑

10. The AHF Project you attended wants to help you move beyond the traumas of your past. To what degree did you experience this goal?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

11. Did the AHF Project you attended assist you to feel welcomed, supported and safe?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

12. Were you treated in a way that was respectful of your beliefs, values, language and culture?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

13. How motivated are you to heal? Please circle your answer below. Number one is not motivated at all and number seven is very highly motivated.

Not Motivated						Very Motivated
1	2	3	4	5	6	7

14. How much support do you have on your healing journey? Please circle your answer below. Number one is no support at all and number seven is all the support you expect you will need.

No Support						All the support I need
1	2	3	4	5	6	7

Questions 15 to 15b **Group Healing Experience**

15. If you participated in any ***group healing***, which of the following issues did you work on and how satisfied were *you* with the progress that *you* made on each issue? Please only check boxes on the issues that you worked on and rate how well those issues were resolved by checking only **one** of the boxes in that row.

	Not at all	Minimally	Somewhat	Good	Very Good	Extremely Well	Completely
drug addiction	❑	❑	❑	❑	❑	❑	❑
spousal abuse	❑	❑	❑	❑	❑	❑	❑
self-abuse	❑	❑	❑	❑	❑	❑	❑
relationship problems	❑	❑	❑	❑	❑	❑	❑
problems with the law	❑	❑	❑	❑	❑	❑	❑
cultural oppression	❑	❑	❑	❑	❑	❑	❑
abandonment as a child	❑	❑	❑	❑	❑	❑	❑
effects of past trauma	❑	❑	❑	❑	❑	❑	❑
guilt	❑	❑	❑	❑	❑	❑	❑
shame	❑	❑	❑	❑	❑	❑	❑
anger and violence	❑	❑	❑	❑	❑	❑	❑
depression	❑	❑	❑	❑	❑	❑	❑
child of alcoholic parents	❑	❑	❑	❑	❑	❑	❑
sexual abuse	❑	❑	❑	❑	❑	❑	❑
foster placement experience	❑	❑	❑	❑	❑	❑	❑
residential school concerns	❑	❑	❑	❑	❑	❑	❑
sex offending	❑	❑	❑	❑	❑	❑	❑
identifying triggers	❑	❑	❑	❑	❑	❑	❑
rejection	❑	❑	❑	❑	❑	❑	❑
lateral violence	❑	❑	❑	❑	❑	❑	❑
grief work	❑	❑	❑	❑	❑	❑	❑
other______________	❑	❑	❑	❑	❑	❑	❑
other ______________	❑	❑	❑	❑	❑	❑	❑

Comments

____

____

15a) Did the AHF Project you attended help you to resolve difficult issues in your life?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

15b) Did you find ways to get support once the project is over?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

Questions 16 to 22 **Individual Healing Experience**

16. Did you receive individual healing sessions in the AHF Project you attended?
❑ Yes ❑ No If not, please go to Question 23.

17. How many one-to-one sessions did you have? ___________________________

18. Please tell us how many sessions you had with each type of healer listed below:

Number of sessions	Type of healer
	psychologist or psychotherapist
	psychiatrist
	alternative health practitioner (e.g. massage therapist or naturopath)
	trained counsellor
	care giver/peer counsellor
	volunteer
	social worker
	traditional healer
	Elder
	other, please specify______________________
	other, please specify______________________

19. Did the individual sessions help you find or develop your strengths?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

20. Did the individual sessions help you move beyond the trauma of your past?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

21. Did your individual sessions help you to feel good about yourself ?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

22. Which of the following issues did you work on in the ***individual sessions*** and, if so, to what extent were you pleased with the experience? Please rate only those issues that were addressed in your individual sessions.

Issues	Not at all	Minimally	Somewhat	Good	Very Good	Extremely Well	Completely
drug addiction	❑	❑	❑	❑	❑	❑	❑
spousal abuse	❑	❑	❑	❑	❑	❑	❑
self-abuse	❑	❑	❑	❑	❑	❑	❑
relationship problems	❑	❑	❑	❑	❑	❑	❑
problems with the law	❑	❑	❑	❑	❑	❑	❑
cultural oppression	❑	❑	❑	❑	❑	❑	❑
abandonment as a child	❑	❑	❑	❑	❑	❑	❑
effects of past trauma	❑	❑	❑	❑	❑	❑	❑
guilt	❑	❑	❑	❑	❑	❑	❑
shame	❑	❑	❑	❑	❑	❑	❑
anger and violence	❑	❑	❑	❑	❑	❑	❑
depression	❑	❑	❑	❑	❑	❑	❑
child of alcoholic parents	❑	❑	❑	❑	❑	❑	❑
sexual abuse	❑	❑	❑	❑	❑	❑	❑
foster placement experience	❑	❑	❑	❑	❑	❑	❑
residential school concerns	❑	❑	❑	❑	❑	❑	❑
sex offending	❑	❑	❑	❑	❑	❑	❑
identifying triggers	❑	❑	❑	❑	❑	❑	❑
self-esteem	❑	❑	❑	❑	❑	❑	❑
grief work	❑	❑	❑	❑	❑	❑	❑
other, please specify							
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑
	❑	❑	❑	❑	❑	❑	❑

23. What was most helpful to you on your healing journey?

____

____

24. Who would you use in the future if you felt the need for more healing work (please provide the person's job title and not the person's name)

____

____

25. How much did the project prepare you for handling future trauma?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

26. Were you helped in connecting to other services that you needed?

❑ not at all ❑ minimally ❑ somewhat ❑ good ❑ very good ❑ extremely well ❑ completely

27. How could we improve the program?

____

____

28. What new skills did you learn or build during the program?

____

____

29. Which services or activities in the AHF Project you attended did you use? *(Check **all** services used)*. Which service or activity was **most effective** for you? Which services or activity was not effective? Please rate only the services or activities that you attended.

Type of Service	I used this service	Least effective	Slightly effective	Moderately effective	Most effective
healing/talking circles/group counselling	❑	☹	❑	❑	☺
land-based activities or healing camps	❑	☹	❑	❑	☺
alternative therapies (e.g. Ricki, massage, naturopathy)	❑	☹	❑	❑	☺
ceremonies	❑	☹	❑	❑	☺
traditional medicines (herbal)	❑	☹	❑	❑	☺
family counselling	❑	☹	❑	❑	☺
one-to-one counselling	❑	☹	❑	❑	☺
parenting skills education	❑	☹	❑	❑	☺
learning about history of residential schools	❑	☹	❑	❑	☺
residential treatment program for residential school Survivors	❑	☹	❑	❑	☺
life skills education	❑	☹	❑	❑	☺
visits with an Elder	❑	☹	❑	❑	☺
workshops	❑	☹	❑	❑	☺
conferences	❑	☹	❑	❑	☺
western therapies (e.g. psychoanalysis and psychiatry)	❑	☹	❑	❑	☺
Other *(Specify)* ________	❑	☹	❑	❑	☺

Mail completed form to:

Aboriginal Healing Foundation
801 - 75 Albert Street
Ottawa, Ontario
K1P 5E7
Attention: Research

Aboriginal Healing Foundation
Healing Project Voices: Focus Group Discussions
March 28 - 29, 2003

PRIMARY GOAL - bring more *in-depth* information to what projects have already told us about:

- How do you dismantle fear and denial?
- What western and traditional therapies work well *together*?
- How do you know when someone is a good 'Healer'?

Table 1) Dismantling Fear and Denial

Projects have told us that dismantling fear and denial requires:	**How else has denial been successfully dismantled?**
a lot of time because you must first build a relationship and establish trust; providing education on the Legacy of Physical and Sexual Abuse in Residential Schools, especially when it explains that the reactions to the residential school experience are normal and predictable consequences of institutional trauma and *not* an individual character flaw or weakness; ***confronting the truth head on;*** * framing the healing journey as an act of courage and empowerment and not weakness; and ***ensuring safety;*** * (we know it includes clarity and education about client rights, sharing and publicizing guiding principles and rules, being a client advocate first, ensuring a physical environment that does not trigger the client especially in residential facilities).	Do men need a different approach? If so, what? Do men have different safety issues? If so, what are they? Is outreach done in communities still overcome with denial? How?

Table 2) *Blending* Traditional and Western Therapies

Projects have told us that:	**What western and traditional therapies work well when they are *blended* together?**
They use both western and traditional therapies/tools (including but not limited to art therapy, psychodrama, massage, relaxation, cognitive and behavioural therapies in groups and one-on-one; peer support groups; healing and sharing circles, ceremonies, sweat lodges, smudging, cleansing, story telling, retreating to land-based traditional camps together, harvesting and preparing country foods, cultural celebration, especially those that provided opportunity for song, food and dance). **Some examples of the blends that we have discovered:** Myers Briggs used as a self-awareness tool and integrated with Medicine Wheel teachings; combining imagery of the natural world of creation and the Inuit life practices to present an understanding of personal growth through life crisis; and Inner Child Therapy *integrated* with traditional Attikamek therapies.	Beyond simply using both approaches does anyone ***select*** western techniques based upon ***how well they already fit within the culture***? If so which ones? Have any western approaches been adapted so that they were more intricately woven into traditional cultural healing approaches? Or have any traditional therapies been selected and woven ***into*** a western approach? Have either western or traditional therapies been *modified or adapted* to fit into a blend of the two?

Table 3) Identifying a Good Healer

Projects have told us that good healers are:	**How else is a good healer identified?**
highly skilled with lots of training and experience; (specifically in residential school issues) ***survivors who could model successful healing***; ✶ fluent in the language; are *like* their target group (i.e. gay or lesbian, teens, female, male, parents or grandparents ***and respected members of the community***); outgoing and visible in the community; caring and nurturing, respectful, non-judgmental, culturally sensitive, patient; ***committed;*** ✶ able to facilitate *independent* decision-making in a way that supported self-esteem; able to make Survivors feel safe; able to maintain their own balance through organizational support, family support and self-care; and able to help navigate others on the healing journey *without* assuming the role of rescuer.	How can you tell if a Survivor is 'healed enough' to lead others on a healing journey?

Appendix 4

Region	# of Surveys Returned
British Columbia	29
Alberta	28
Saskatchewan	28
Manitoba	25
Ontario	37
Quebec	8
Atlantic	11
North	9
Yukon	1

Appendix 5

Distribution of AHF Resources

Type of Location	Total Number of Grants	Total Amount Funded
Isolated		
Isolated	81	$13,813,323.03
Isolated, Rural	2	$248,484.53
Isolated, Rural, Semi-Isolated	3	$468,269.48
Isolated, Rural, Urban, Semi-Isolated	1	$832,785.00
Isolated, Semi-Isolated	5	$1,873,252.96
Isolated, Semi-Isolated, Rural	1	$902,206.00
Isolated, Semi-Isolated, Rural, Urban	1	$378,842.00
Isolated, Urban	1	$240,175.00
Isolated, Urban, Rural	1	$85,310.00
Isolated, Urban, Rural, Semi-Isolated	5	$3,482,880.52
Rural, Isolated	2	$275,150.00
Rural, Isolated, Semi-Isolated, Urban	2	$1,650,724.39
Rural, Semi-Isolated	5	$716,369.00
Rural, Semi-Isolated, Isolated	2	$1,263,460.00
Rural, Semi-Isolated, Isolated, Urban	1	$127,500.00
Rural, Urban, Isolated	1	$203,952.00
Rural, Urban, Semi-Isolated, Isolated	2	$500,768.00
Semi-Isolated, Isolated	5	$567,093.87
Semi-Isolated, Isolated, Rural, Urban	1	$682,350.00
Semi-Isolated, Rural, Isolated	1	$872,000.00
Urban, Isolated, Semi-Isolated	1	$145,200.00
Urban, Isolated, Semi-Isolated, Rural	1	$66,000.00
Urban, Rural, Semi-Isolated, Isolated	1	$172,339.05
Urban, Semi-Isolated, Rural, Isolated	1	$346,502.50
Total	127	$29,914,937.33
Semi-Isolated		
Isolated, Rural, Semi-Isolated	3	$468,269.48
Isolated, Rural, Urban, Semi-Isolated	1	$832,785.00
Isolated, Semi-Isolated	5	$1,873,252.96
Isolated, Semi-Isolated, Rural	1	$902,206.00
Isolated, Semi-Isolated, Rural,	1	$378,842.00

Type of Location	Total Number of Grants	Total Amount Funded
Urban		
Isolated, Urban, Rural, Semi-Isolated	5	$3,482,880.52
Rural, Isolated, Semi-Isolated, Urban	2	$716,369.00
Rural, Semi-Isolated	5	$1,650,724.39
Rural, Semi-Isolated, Isolated	2	$1,263,460.00
Rural, Semi-Isolated, Isolated, Urban	1	$127,500.00
Rural, Semi-Isolated, Urban	1	$981,176.00
Rural, Urban, Semi-Isolated	1	$500,768.00
Rural, Urban, Semi-Isolated, Isolated	2	$500,768.00
Semi-Isolated	130	$39,439,411.86
Semi-Isolated, Isolated	5	$567,093.87
Semi-Isolated, Isolated, Rural, Urban	1	$682,350.00
Semi-Isolated, Rural	7	$1,150,658.57
Semi-Isolated, Rural, Isolated	1	$872,000.00
Semi-Isolated, Rural, Urban	3	$818,612.52
Semi-Isolated, Urban	2	$175,255.00
Semi-Isolated, Urban, Rural	1	$50,000.00
Urban, Isolated, Semi-Isolated	1	$145,200.00
Urban, Isolated, Semi-Isolated, Rural	1	$66,000.00
Urban, Rural, Semi-Isolated	2	$1,391,466.00
Urban, Rural, Semi-Isolated, Isolated	1	$172,339.05
Urban, Semi-Isolated, Rural	1	$325,000.00
Urban, Semi-Isolated, Rural, Isolated	1	$346,502.50
Total	187	$59,880,890.72
Rural		
Isolated, Rural	2	$248,484.53
Isolated, Rural, Semi-Isolated	3	$468,269.48
Isolated, Rural, Urban, Semi-Isolated	1	$832,785.00
Isolated, Semi-Isolated, Rural	1	$902,206.00
Isolated, Semi-Isolated, Rural, Urban	1	$378,842.00
Isolated, Urban, Rural	1	$85,310.00
Isolated, Urban, Rural, Semi-Isolated	5	$3,482,880.52
Rural	383	$94,031,739.46
Rural, Isolated	2	$275,150.00
Rural, Isolated, Semi-Isolated, Urban	2	$716,369.00
Rural, Semi-Isolated	5	$1,650,724.39

Type of Location	Total Number of Grants	Total Amount Funded
Semi-Isolated, Urban, Rural	1	$50,000.00
Urban	315	$75,898,102.17
Urban,Isolated,Semi-Isolated	1	$145,200.00
Urban, Isolated, Semi-Isolated, Rural	1	$66,000.00
Urban, Rural	13	$4,293,544.38
Urban, Rural, Semi-Isolated	2	$1,391,466.00
Urban, Rural, Semi-Isolated, Isolated	1	$172,339.05
Urban, Semi-Isolated, Rural	1	$325,000.00
Urban, Semi-Isolated, Rural, Isolated	1	$346,502.50
Total	385	$103,077,517.48
Unspecified	47	$6,458,288.31

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