An Interim Evaluation Report of Aboriginal Healing Foundation Program Activity

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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.

average - the average is a measure of central tendency (or the "middle") that is used in statistics and is calculated by adding all the values and dividing by the total number of values.

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

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

greatest need - where the 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.

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

inter-generational impacts - refers to the affects that residential schools have had upon the children and grandchildren of those who have attended residential schools.

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

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

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

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

short term - refers to the results that are realistic within a 4 year time frame.

survivors - refers primarily to those who attended residential school; however, for stylistic simplicity, this term is often used to denote those who attended residential school as well as those impacted inter-generationally.

sustain-ability - an indication of longevity beyond the limits of the Aboriginal Healing Foundation either through the financial contributions of others or through voluntary effort.

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

the Legacy - refers to the enduring effects of the physical and sexual abuse suffered in residential schools including inter-generational impacts.

Executive Summary

The Aboriginal Healing Foundation (the Foundation) is a federally funded Aboriginally-run, non-profit corporation created in 1998 to support community-based healing initiatives of Aboriginal people affected by physical and sexual abuse in residential schools including intergenerational impacts (the Legacy). This report is an evaluation initiated and supported by the Foundation with the express purpose of examining the implementation of service delivery objectives to date, as well as the attainment of short term outcomes as a way of being accountable to several primary stakeholders, namely:

- those impacted by the Legacy;
- internal moral authorities[1]; and
- external supporters of the Foundation.

The process evaluation was concentrated upon securing and reporting upon the most relevant information for users (i.e. distribution of resources, target group, team and community characteristics, lessons learned, best practices and greatest challenges) in a position to make decisions about funding policy (AHF Board) and program evolution (communities). The process evaluation was primarily a descriptive exercise reliant upon information already available through internal databases, document files and supplementary information secured through a mail out survey and one-to-one interviews with national stakeholders (AHF Board members and personnel). The impact evaluation has a greater goal orientation and will be done by examining thirteen projects representing the full range of AHF project types. The sample of thirteen projects were also carefully selected to fully represent all target groups, Aboriginal groups, regions and the range of geographic remoteness. The case studies will be examining impact by measuring AHF Board selected indicators (i.e. rates of physical and sexual abuse, children in care, incarceration and suicide) in addition to indicators selected by the community *before* and *after* program implementation (i.e. a within groups repeated measures)[2]. A sample of 36 project files were reviewed and the mail out survey was sent to all 344 projects that were operational at the time (January, 2001) with a 74% response rate. Whenever possible, relevant numerical information from AHF's internal databases

[1]For the sake of clarity, internal moral authority refers to any group which is the accepted and acknowledged "law" making body that holds collective interests at heart and includes traditional examples such as clan mothers and elders councils. Contemporary examples could include survivor, youth or women's groups and health authorities.

[2]When a standard, valid, reliable and culturally appropriate measurement tool or method is used, it is usually used at two points in time: before the program and after the program. This is a popular way to measure program performance in evaluation and is known as a "within groups repeated measures" design or the "before and after" design.

was also used. The following text presents highlights from each of the major chapters of the report.

Who - Participants and Project Teams

According to survey data, a possible maximum of 59,224 participants engaged in AHF-funded activity[3]. When examining quarterly report information, there are proportionately more females than males and more adults than any other age group. First Nations on and off reserve make up the bulk of project participants; however, Métis and Inuit beneficiaries may not be disproportionately represented when considering their representation in Aboriginal populations nationally. When considering target group types, survivors and the inter-generationally impacted represented the vast majority of project participants. From the survey, it is clear there were 48,286 participants engaged in individual healing activity (i.e. healing with a focus on individual progress) with First Nations on-reserve representing the majority (57%), followed by First Nations off-reserve (29%), Métis (11%) and Inuit (3%). Survey data showed that women (44%) and the inter-generationally impacted (45%) were the most well represented target groups followed by men (29%), survivors (27%) and youth (27%). Reasons for withdrawing from healing were most often related to psychological difficulties (e.g. lack of trust, fear, denial, addictions). With respect to training, 10,938 participants were noted with roughly the same representation of First Nations on-reserve (60%), off-reserve (26%), Métis (9%) and Inuit (5%). Trainees were most often women (64%) and those inter-generationally impacted (47%) by the Legacy. Trainees withdrew from the program most often for psychological reasons (e.g. fear, denial, addictions) or to meet competing responsibilities (e.g. family, work, school).

Addictions, victimization and abuse are clearly the most *severe*[4] participant challenges affecting the majority of projects (69%, 58%, and 58%, respectively). Other common challenges which are reported as *severe* by a sizable group (>40%) include denial or grief, poverty, and lack of parenting skills. Healing projects identified **7,589 individuals with special needs** (e.g. suffered severe trauma, inability to engage in a group, history of suicide attempt or life threatening addiction). On average, **thirty-seven percent (median[5]=25%) of participants require greater than normal attention** to deal with their special needs. Projects were most likely to deal with special needs by training some of their employees (61%), enlisting professional support on a monthly or

[3]This figure contradicts the total of 179,639 taken from quarterly reports. See page 17 for a fuller explanation.

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

[5]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, i.e. the median for the following numbers: 1, 2, 3, 4, 5, 6, 7, 8, 1000 is 5.

yearly basis (47%) or relying upon peer support (36%, i.e. those who have special needs help each other). The majority of projects (55%) were able to accommodate all who needed therapeutic healing or desired training but when they could not, they were most inclined to select survivors and their descendants (26%), those at greatest risk (21%) or to target specific groups based upon gender, Aboriginal identity, age, sexual orientation or religion (16%).

AHF projects reported a total of 1,916 paid employees (1,126 full time). Teams were most likely to be composed of administrators, cultural personnel (i.e. Elders, coordinators, teachers), healers and outreach staff. Eighty-eight percent of all positions are occupied by Aboriginal people (n=219, *where **n** represents the number of responses received for that particular survey item*). Survivors occupy fifty percent of all positions. The ability of Aboriginal employees to speak the language was consistently and positively highlighted. Less than half of the project files reviewed conveyed the use of outside resources. Some acknowledged the value of outside resources where prospective community based healers needed therapeutic assistance themselves. When it was used, outside expertise was usually contracted to prepare proposals, conduct needs assessments, draft final reports, offer training or do evaluations.

The most common training opportunities provided (n=226) were: learning about history and the Legacy (69%); professional development[6] (56%); trauma awareness (55%); programs related to family functioning (e.g. child development and parenting skills) (54%); dealing with family violence (54%); crisis intervention (49%) and counselling skills (47%). Over a third (36%) offered advanced training while the remainder offered basic training. Although most (74%) felt that the training offered was adequate, they identified further training needs in the areas of crisis intervention (77%); trauma awareness (76%); counselling skills (74%); dealing with family violence (73%); professional development (71%); family functioning (e.g. child development and parenting skills) (70%); language and culture (69%); learning about history and the Legacy (69%). Most (68%) felt that project personnel would better benefit from advanced training in this area.

In a typical month, over 13,000 volunteer service hours are contributed to AHF projects. Each project enjoys an average of 65 volunteer hours per month. If we assume that the value of this contribution could be remunerated at $10/hour, then volunteer efforts represent an injection of **$130,000 dollars per month or $1,560,000 per year**. The four most favoured volunteer endeavours by all groups included: food preparation (56%), healing circles (54%), workshops (53%), and administration (51%).

[6]This may include conflict resolution, leadership skills, legal information, board training, team building, communication skills, project planning and evaluation, dealing with difficult people and training to facilitate and organize groups or volunteers.

What, Where and When

It is clear that almost half of AHF program resources (47.1%) are being invested in healing. Remaining resources in hierarchical order of value are used for prevention and awareness activities (18.5%), training (9.1%), honouring history (5.2%), building knowledge (4.9%), assessing needs (3.9%), designing and setting up projects (2.6%) and conferencing (.6%). Many projects have very *inclusive* participant criteria; therefore resources do not fit neatly into mutually *exclusive* identity categories (i.e. First Nations only, Métis only or Inuit only). For example, the exclusive Métis budget is $349,200; however, if we examine all budgets where the Métis are included (e.g. Métis and First Nation) as well as all categories which have a more general Aboriginal target, the resources that are available to the Métis could conceivably be as high as $30,634,700[7]. The *exclusive* budgets (i.e. budgets which do NOT include other Aboriginal groups) for First Nations represents 62%, the Métis portion is 4% and for Inuit 1% of the total budget. When looking at the distribution of resources by target group, the same dilemma of categorization holds true. In other words, many projects *target a variety of groups*, so resources do not fit neatly into mutually *exclusive* budgets; therefore, all allocations were added to determine the total amount of resources dedicated (albeit not exclusively) to specific target groups. When this was done, youth, service providers and women were clearly the most commonly named targets, followed by Elders, children, the incarcerated and men. The largest proportion of resources is being invested in what are considered rural[8] (38.2%) communities, followed by urban (24.5%) and semi-isolated (18.4%) environments. At last, remote communities are receiving almost nine percent of AHF resourcing (8.9%) and the greatest number of projects appear to be in Ontario, British Columbia, and Saskatchewan.

Starting with the most pressing need, projects identified pressures to: increase the number of employees and better benefits; encourage survivor involvement; upgrade and expand facilities; improve the project and expand it locally as well as provide training

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[7]This figure includes the finance categories listed below:

Aboriginal, including non-Aboriginal	99,000
First Nation, Aboriginal	1,164,300
Aboriginal	25,655,600
First Nation, Métis	218,600
Métis	3,497,200
GRAND TOTAL	**$30,634,700**

[8] **Remote** - 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 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.

for employees and potential healers. The most expensive of these needs were related to facilities, teams, project expansion, family support, addressing special needs and training. The most common strategies cited to encourage survivor involvement were word of mouth, meetings with individuals and families in the facility where AHF activity is held and newsletters. To guard participant safety, project teams most often conducted formal criminal record checks through the Canadian Police Information Centre; held personal interviews with healers or secured character references. Less formally, many would periodically check with the participant group or use word of mouth to determine healer integrity. The sound majority (67%) were convinced that they were operating in a manner consistent with the Charter of Rights and Freedoms and a sizable portion (42%) said the project has had a dramatic impact upon women. By far, the most favoured approaches to healing were to use either exclusively traditional techniques or blend western and traditional methods. Projects also appeared to favour either age, gender or other special groupings when managing the healing process.

A total of 1,686 communities are being serviced by AHF; the bulk of which are rural[9] (55%) or urban (29%). Ten percent are in semi-isolated areas while six percent are active in remote areas (this is a slightly different pattern than what has emerged from looking at the distribution of financial resources by geographic remoteness). A large proportion (41%) are in communities of 2,000 or more; however, twenty-one percent operate in very small communities with 500 people or less. Projects are delivered in a variety of venues, the most common of which are human service agencies, schools, homes, community gathering places, bush camps and Friendship Centres. Over a third (35%) are facing out-right opposition that usually manifests as denial or fear and over a quarter (26%) are struggling with serious apathy toward project activity. Poor economic conditions, substance abuse, family violence and sexual abuse are serious to moderate challenges facing most of the group (60% or more). Lack of community resources, services and transportation are also serious issues faced by about a quarter of all projects. When projects were asked to identify what might be happening in their communities that would facilitate their efforts, they noted several positive influences including: community support (15%); team strengths (13%); cultural reinforcement (14%) and justice initiatives (10%). However, negative forces were also felt including community instability or tragedy (27%), psychological barriers (fear, denial and addiction (6%), as well as staff turnover and lack of leadership (8%).

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[9] **Remote** - 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 ro 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.

Project Performance

Information has been gathered to determine what impact, if any, AHF-funded activity has had upon:

- influencing individuals and communities;
- establishing partnerships and ensuring sustain-ability;
- meaningfully engaging survivors (including the inter-generationally impacted);
- managing program enhancement;
- ensuring accountability; and
- reaching those in greatest need.

While it is still early in the life of this national initiative, some promising evidence is clear. Data from the mail-out survey showed that projects *are clearly observing immediate, short-term and intermediate outcomes*. So dramatic are the changes that an overwhelming feeling of progress was expressed by many (64%, n= 223), although some (36%) felt it was too early to tell. The increased demand for counselling services, which numerous projects report, suggests that denial and resistance may be decreasing; in some cases, referrals have close to tripled. Document files include comments that can be interpreted as evidence that healing is taking place. For example, community members who first came for services are now giving back to the community as volunteers and they are moving into leadership roles, returning to school or going back to work. Some of the spinoffs are indications of increased community spirit while others suggest a deepening interest in culture and traditions. There is a noted increased sense of hope as walls of silence and denial are dismantled, survivors have reached out to other survivors to encourage them to heal and many more are connected to the healers who will help them achieve their personal goals.

From document review, it is clear that all but one of the thirty-six files reviewed reported established partnerships and survey results show that the majority (72%, n=247) of sponsoring organizations were linked with other healing or training efforts. Relationships are concentrated at the local level and community services are the most likely partners. When questioned about how effective their working relationships with partners were, almost half (49%, n=247) reported very effective. About two-thirds of projects (66%, n=253) report receiving *donations or funding* from other sources but less than half (39%) reported receiving *funding alone*. The funding came from other federal departments, provincial, municipal, hamlet and other Aboriginal governments, as well as private granting foundations and community fundraising efforts. Remarkably,

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

A small group (33 projects in total) reported receiving ***on-going funding*** from federal departments, provincial, municipal, hamlet and Aboriginal governments, as well as private granting foundations and community fundraising efforts. In fact,

a total of $4,090,575 of on-going funding was reported by 33 projects.

Federal and provincial partners have made heftier long term commitments (median of $82,500 and $92,500 respectively) but did not commit as frequently as Aboriginal governments and local fund-raisers. More than half (60%) reported receiving donations of goods or services at an ***estimated value of $7,898,920***. Not only are donations of labour reported by most projects (58%), they are also the most highly valued (median = $10,000). Donations of space (55%; median = $4,500), project materials (44%, median = $1,800), food (41%; median= $800) and transportation (42%; median = $2,000) were also common. ***Community members were rated the most generous donors of goods and services***. Health services were close behind and they were followed by local government and social services.

Survivors are engaged most commonly on a monthly basis as advisory committee members, to evaluate projects or to make decisions regarding program operations. Almost a third of all projects (27%, n=233) indicated that they had an advisory council or a board of directors which included survivors; but some are still struggling primarily because of fear and denial, but also because of mistrust toward the AHF, physical limitations, competing responsibilities and lack of transportation, outreach or effective communication strategies.

Roughly three quarters (74%, n=230) of AHF-funded projects are measuring change in their program participants in some way. Healing projects (n=203) most regularly use informal observations (76%), solicited feedback (64%), evaluations (60%) and formal observations (54%). Some report using unsolicited feedback (32%) and only a few (23%) are using formal assessment. Although projects are required to describe their evaluation plans in their proposals, *clear and specific* methods were articulated by only a few. The most sophisticated evaluation efforts revealed that projects were using standardized, rigorously evaluated, valid and reliable instruments such as the Substance Abuse Subtle Screening Inventory (SASSI), the Myers-Briggs Type Indicator and the Gates MacGinite Test for reading. *It is the results of these instruments that will hold significant weight in* ***quantitatively*** *assessing the impact of AHF-funded activity and it is recommended that future evaluative efforts focus upon those projects which are using such tools*. The majority of indicators cited in project proposals suggest that they would like to impact participant behaviour (e.g. reduced rates of family violence, improved school attendance, increased rates of parental involvement in schools); however, quarterly reports were almost exclusively focussed on the attainment of immediate service delivery objectives.

A small group (15%, n=230) believed that they were definitely reaching those in greatest need. The sizable majority (68%) felt that although they were probably targeting most in greatest need, their efforts could be better and some (7%) were unsure while others (7%) were clear that they were probably not reaching those most affected by the Legacy. Rarely (2%) were projects certain that their efforts were not reaching those in greatest need. When questioned **how many more people could be serviced if the project had adequate time and resources, a total of 56,857 resulted** (n=101). Although national respondents feel that the Foundation is reaching those who need the service the most, they acknowledged that things could be better. They cited community capacity (i.e. ability to prepare proposals and meet AHF reporting requirements) as a major barrier to reaching those in greatest need. Of the two thousand and eight (2,008) proposals received, six hundred and twenty-four (624) have been funded (31%).

Projects learned the *monumental importance of creating safe healing environments* and recognized that creative and unique strategies are required to deal with the emotional intensity related to resistance (i.e. fear and denial); some are *still* at a loss about how to do this best. They felt that screening participants was a valuable exercise with some even recommending addictions treatment or life skills courses as prerequisites to participation in AHF activity. They know that healing will be of a greater intensity and duration than originally anticipated and that ***unique*** approaches tailored to the needs of specific groups (e.g. gender, family, age, healing stage, religious or individual preferences) are needed. They learned that healers need to be fully healed before they begin practice and then require ongoing self-care and peer support. Traditional healing seems particularly effective alone or in combination with western approaches and even seems to work well when merged across Aboriginal cultures. Well over half found that they would have benefited from greater capacity including counsellors specifically trained in residential school abuse, but warned against simultaneous program delivery and training. Sometimes, project teams and beneficiaries were *equally impacted* by the Legacy. Teams discovered that they needed tools or strategies to determine where prospective healers were in their own healing journey. In many cases, a combination of successful recruitment campaigns and community "readiness" magnified service demand, resulting in excessive strain on the healing team. And, while leadership issues were not a dominant theme, it has been suggested that views held by leaders can have a significant impact on community healing. A sizable group reinforced the importance of providing information to the community ***at the outset***. They expressed surprise at how little information and understanding there is about the Legacy, especially for youth and non-Aboriginal human service providers. And, last, but certainly not least, from a national perspective, it is clear that:

- no single strategy will work for what is an ***extremely*** diverse group,
- survivor involvement and strong human resources are essential to success, and
- identifying and addressing inequity, as well as being responsive to community needs works well.

When recounting their best practices, some of the most successful approaches were group focussed healing (e.g. counselling and peer support), family circles, one-on-one counselling, traditional healing alone or in combination with western therapies, home visits, making activities fun, focussing on prevention and role modelling. Projects were also thrilled with their reinforcement of culture; they were certain that using the language, sharing traditions, involving Elders, story telling and retreating to traditional camps facilitated the healing process. Many felt that **raising awareness** was key to the eventual success of any healing endeavour because knowledge of the Legacy provided a social context for what is often viewed as an *individual's* problems. When supporting communities, national stakeholders felt that their best practices were engaging a caring team that respectfully and personally responds to the community; they unanimously acknowledged the work of the Community Support Coordinators in this regard.

The most commonly cited challenges were related to fear, denial, addiction and other related participant issues followed by resource limitations and community opposition. Many document files noted a skills shortage, some so drastic that they were unable to achieve service delivery objectives. Even though highly skilled western practitioners were available, projects lacked someone who could adequately blend western and traditional approaches. When community members were available to act as healers, they occasionally felt too close to clients as relatives, neighbours, life long friends or even enemies. There was also a noted lack of tools or abilities to determine where healers were on their own healing journey so that team leaders could screen for those who were completely healthy. The sheer volume of work was a commonly noted challenge. Many projects indicated that they were ill prepared to develop programs without having an intimate knowledge of survivors' needs and preferences. Communities still minimize the impact of the Legacy, individuals refuse to admit to being survivors, youth continue to feel loyalty towards their abusing families, devout Christians feel criticized when the history is recounted and once trust is achieved, it can be easily annulled with high rates of staff turnover. Some projects noted that provincial agencies continue to refer survivors to western therapists despite the lack of cultural relevance as well as a general ignorance, and even denial, of the Legacy on the part of some practitioners.

Recommendations

From survey data, the most commonly cited recommendations were related to improvement in program or therapeutic approach, cultural reinforcement, management and team issues and community involvement. Of course, each group had their own priorities. For survivors, program or therapeutic approach is most important (58%), while Elders favoured cultural reinforcements (57%). Professionals most frequently said that addressing management and team issues would best serve projects (49%) and sponsors highlighted increased resources (41%). Youth, women, gay/lesbian and

homeless stakeholders all agree that modifications to the program or therapeutic approach would best ensure success and most often this referred to addressing the unique needs of each group. From the 36 document files that were reviewed, it is clear that funding and guideline changes are desired to ensure that resources are spent in Canada; grant recipients make healing available to all, regardless of community-based political affiliations; communities can operate more than one focussed project and survivors are recognized as credible healers free of 'clinical intrusion' from western practitioners. Teams also wanted more time for needs assessment and program development. They were frustrated with the volume of forms and reports required and would like application and reporting requirements significantly streamlined. Projects wanted to share more information formally and informally with the national team and other projects. To that end, they suggested an annual forum for AHF projects to network, attend training workshops, do project presentations and recognize the unique achievements of various activities with an awards ceremony. They wanted AHF to distribute a list of *all* funded projects with contact information, a brief project description and project guideline materials. And, they wanted tools to determine whether or not prospective healers are sufficiently well to lead others on their healing journey.

AHF staff recommended that greater efforts be made to communicate reporting requirements that include information more directly relevant to performance. The national team (staff and Board members) strongly endorsed consultation with survivors during the proposal and project development phases as a way of garnering support for and involvement in the project and to facilitate success. They recognized that they needed to be ever diligent at addressing inequities by ensuring that key groups (e.g youth, the Métis and incarcerated survivors) are drawn in to develop a strategy that would strengthen outreach efforts; educate the public at large; communicate the history and impact of the Legacy; secure long term funding commitments from churches and government and enhance the mandate of the AHF.

At last, the evaluation team recommends that greater emphasis be placed upon reporting the attainment of intermediate outcomes in project monitoring activities. Most importantly, serious consideration should be given to engaging in a meta-evaluation (or a critical analysis of key community evaluations), especially of those projects that are using rigorously tested (i.e. psychometrically evaluated), standardized instruments and a within groups repeated measures design (i.e. testing project participants before and after they engage in program activity). Some thought should also be given to ensuring that participants are counted only once to guarantee that cost effectiveness calculations are valid and reliable.

1. Introduction

1.1 Background

1.1.1 The Need for the Aboriginal Healing Foundation

> *For over 100 years, thousands of Aboriginal children passed through the Canadian residential school system. Begun in the 1870s, it was intended, in the words of government officials, to bring these children into the "circle of civilization." The results, however, were far different. More often, the schools provided an inferior education in an atmosphere of neglect, disease, and often abuse. The residential system was chronically underfunded and often mismanaged, and affected the health, education, and well-being of entire generations of Aboriginal children.*[1]

Residential schools operated under contractual agreement between the government of Canada and the Roman Catholic, Anglican, Methodist (United) and Presbyterian churches with the explicit intent of Aboriginal cultural extinction. Forbidden from using their language, interaction with opposite sex siblings and warm familial connection to parents and grandparents meant that important cultural and psychological influences were stripped from young lives. The militaristic setting where generations of children were raised often extended no affection, personal liberty, privacy or safety which left generations of young Aboriginal people ill equipped for families of their own.

In addition, the physical and sexual abuse at the schools has left a trail of low self-esteem, anger, depression, violence, addiction, unhealthy relationship and parenting skills, fear, shame, compulsiveness, bodily pain and anxiety. The cyclical effects of such unresolved trauma is obvious when the next generation defends itself and copes in the same way. *Breaking the cycle of abuse is essential for Aboriginal communities to be healthy places where children are raised with love.* The Aboriginal Healing Foundation's mission and vision is about stopping this abuse and helping families to learn and support their own well-being.

1.1.2 The Aboriginal Healing Foundation

The Aboriginal Healing Foundation (the Foundation) is a federally funded Aboriginally-run, non-profit corporation that was created on March 31, 1998 to support community-based healing initiatives of Métis, Inuit and First Nations people on and off

[1] Milloy, John.: A National Crime: Canadian Government and the Residential School System, 1879-1986. Winnipeg: University of Manitoba Press, 1999.

reserve who were affected by physical and sexual abuse in residential schools and the intergenerational impacts. The Foundation is a cornerstone of Gathering Strength– *Canada's Aboriginal Action Plan*, a Government of Canada strategy announced on January 7, 1998 to begin a process of reconciliation and renewal with Aboriginal peoples.

The ultimate, long term goal or vision statement is:

"one where those affected by the Legacy of Physical Abuse and Sexual Abuse experienced in the Residential School system have addressed the effects of unresolved trauma in meaningful terms, have broken the cycle of abuse, and have enhanced their capacity as individuals, families, communities and nations to sustain their well being and that of future generations."[2]

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

day to day activities
➥immediate term outcomes
➥longer term outcomes
➥ultimate goal

those who are suffering the Legacy meaningfully resolve their trauma, break the cycle of abuse and have enhanced their capacity to sustain well being.

Now, let's take a more sophisticated look at what activities and intermediate outcomes will help to achieve the goal of ensuring that those who are suffering the Legacy meaningfully resolve their trauma, break the cycle of abuse and enhance their capacity to sustain well being.

1.1.2.1 Activities

The mission is to encourage and support Aboriginal people (i.e. youth, Elders, gay/lesbian, women, the incarcerated) in building and reinforcing sustainable healing

[2]Aboriginal Healing Foundation: Program Handbook, 2nd Edition, page 6.

processes that address the Legacy of Physical Abuse and Sexual Abuse in the Residential School System, including Inter-generational Impacts. A *very wide berth* of eligibility for AHF funding exists: projects are essentially designed to support the community in building, reinforcing and sustaining conditions conducive to healing; developing and enhancing capacity; restoring balance and returning voice to women; ensuring honour and sharing history; promoting awareness; nurturing a supportive public environment; engaging Canadians generally toward reconciliation; encouraging reconciliation between victims and offenders; supporting centre-based healing activity, as well as engaging in research, planning and other knowledge building exercises.

The Foundation's four main program themes for project funding are: Healing (community approaches and healing centres); Restoring Balance; Developing and Enhancing Aboriginal Capacities; and Honour and History.

Healing and Healing Centre projects (where "centre" can range from trauma facility to bush camp):

- incorporate traditional healing methods and other culturally appropriate approaches;
- provide direct healing services (e.g. community therapeutic healing activities and "healing centre" programs);
- fund client referral, access, treatment, case management, follow-up and after care services; and
- meet the standards of therapeutic residential facilities and ethical community based healing activity.

Restoring Balance projects:

- focus on the early detection and prevention of the effects of abuse on all generations of Aboriginal people;
- may be directed toward women, families, youth and Elders; and
- may restore culture and Aboriginal spirituality through awareness and community educational activities.

Developing and Enhancing Aboriginal Capacities projects:

- focus on building a sustainable capacity for the healing process such that appropriate groups and institutions within the community can meet on-going healing needs;
- may include curriculum development and specialized education programs;
- should increase the number of Aboriginal people who provide healing services and provide a supportive environment for those people involved in the healing of survivors;

- must address the Legacy of Physical and Sexual Abuse in the Residential School System, Including Inter-generational Impacts; and
- should be related to specific, individual needs of communities and should support existing and developing Aboriginal programs.

Honour and History projects:

- create historical records of residential school experiences and acknowledge students who did not return home physically, mentally, emotionally or spiritually; and
- may provide funds for a memorial to honour students.

The Foundation also undertakes promotional activities to foster understanding and appreciation of the issues and needs of survivors to create supportive environments for the healing process. And, last, but not least, returning voice to women is a common thread for all the themes and seeks to address the Legacy of Physical and Sexual abuse experienced by women and the negative effects these abuses had on the relationships between women and children.

The practical application of these themes has resulted in AHF funding of activities that fall roughly into the following categories:

- **community services**: community meals; home visits; support networks; transportation;
- **conferences, workshops and gatherings**;
- **cultural activities**: memorials; performing arts;
- **healing services**: day treatment healing services; healing circles; in-patient healing services; centre-based activity;
- **material development**: educational materials; training materials; video productions;
- **planning**: needs assessments; strategic planning;
- **research/knowledge building**;
- **traditional activities, on the land programs**; and
- **training and educational programs**: continuing education; curriculum development; parenting skills; professional training courses.

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

1.1.2.2 Anticipated Outcomes

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

- **increased understanding and awareness** (in both Aboriginal and non Aboriginal communities) of the impact (direct and inter-generational) of the residential school system, healing issues and needs;

- **increased capacity of Aboriginal people to engage in the healing arts/professions**;

- **strengthened positive ties between those suffering the Legacy and those in a position to heal**;

- **increased number and quality of strategic plans with a focus on healing**;

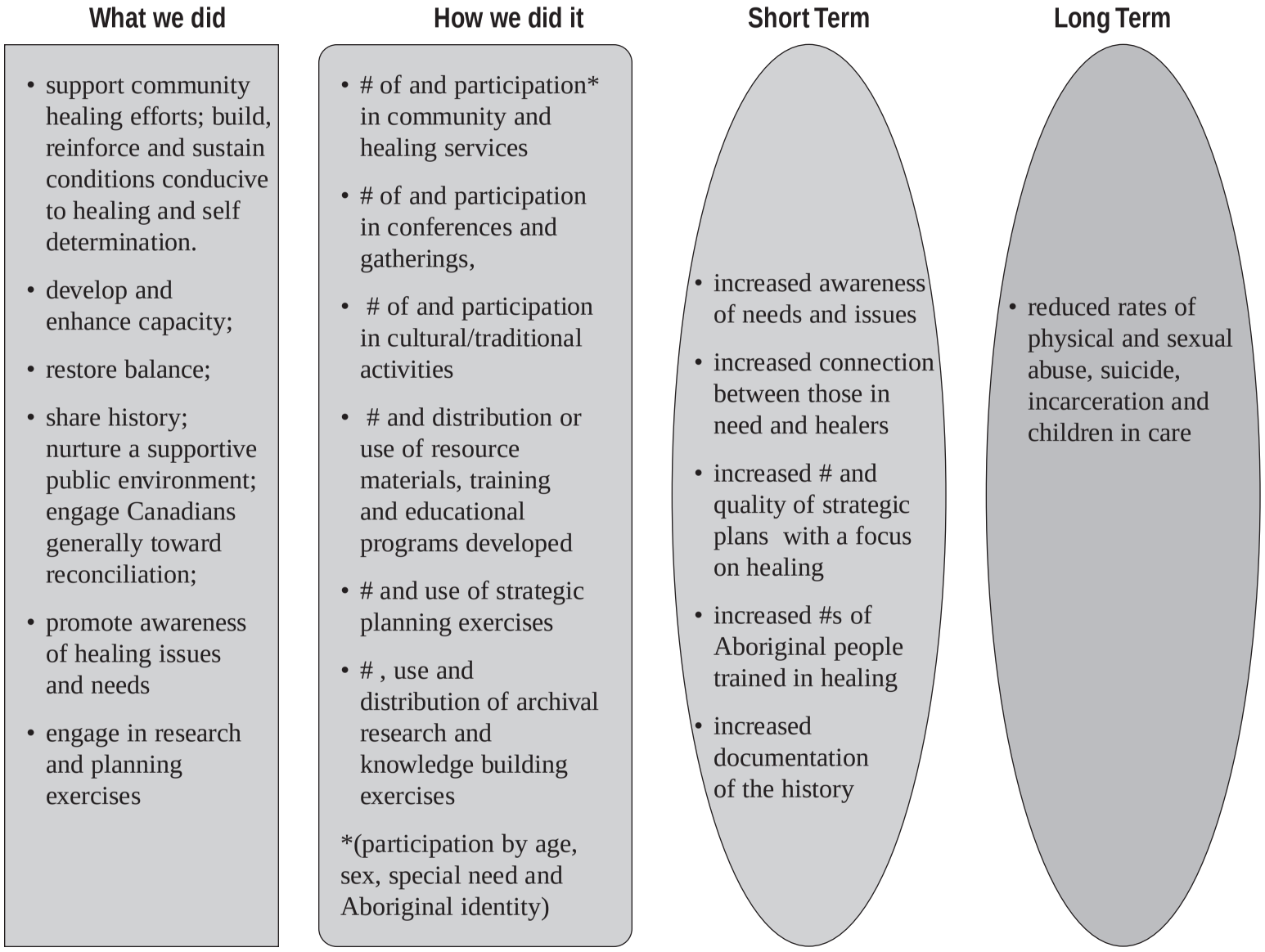
- **increased documentation and publication of the history, increased honour for those who have suffered**;

- **enhanced healing; and**

- **increased reconciliation** between victims and offenders, as well as Aboriginal peoples and Canadians generally.

It is the expressed hope of the AHF that funded efforts will serve as a catalyst to healing and help survivors better cope with the ubiquitous stressors of the Legacy. The logical steps are illustrated in further detail in Figure 1 on the following page that clearly identifies how AHF expects to achieve long term goals. In short, Figure 1 offers the reader a bird's eye view of AHF activities that will lead to a series of outputs (or products and services) that will have an immediate impact believed to set the stage for longer term impacts and, eventually, the ultimate goal.

Figure 1) Aboriginal Healing Foundation: The Logic Model



2. The Evaluation

2.1 Objectives

The following sections outline a *program*[3] evaluation of the Aboriginal Healing Foundation (AHF). Although an organizational evaluation is part of the review exercise for the AHF, it is *not the focus of this report*. Rather, this report highlights the implementation of service delivery objectives as well as the attainment of short term outcomes as a way of being accountable to several primary stakeholders, namely:

- those impacted by the Legacy;
- internal moral authorities[4]; and
- external supporters of the Foundation.

Another primary goal of this report is to provide valuable, relevant information for those in a position to make decisions about AHF funding and program evolution at both the national and community level.

2.2 Approach

The selected approach is really a blend of several techniques which focus upon **goals, decision-making** and **useful information**. The process evaluation was concentrated upon securing and reporting upon the most relevant information for users (i.e. lessons learned, best practices and greatest challenges) in a position to make decisions about funding policy (AHF Board) and program evolution (communities). The impact evaluation has a greater goal orientation and, in the interest of bridging the need for relevance and scientific rigor, all case studies which inform the impact

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

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

Table 1) Five Approchoaches to Evaluation[5]

Approach	Emphasis	Focusing Issues	Evaluator's Role	Evaluation Type
Experimental	Research design	What effects result from program activities and can they be generalized?	Expert/scientist	
Goal-oriented	Goals and objectives	What are the program's goals and objectives and how can they be measured?	Measurement specialist	**Impact**
Decision-focused	Decision making	Which decisions need to be made and what information will be relevant?	Decision support person	**Process**
User-oriented	Information users	Who are the intended information users and what information will be most useful?	Collaborator	
Responsive	Personal understanding	Which people have a stake in the program and what are their points of view?	Counselor/ facilitator	

evaluation are using a quasi-experimental evaluation design (i.e. a within groups repeated measures). Table 1) illustrates the various approaches and highlights the blend selected for the evaluation of AHF.

To determine what information would be most useful to decision makers as well as what goals should be focussed upon, a performance "map"[6] has 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 that can fit on one page.

[5]Reproduced from Stecher, B. M. & Davis, W. A.: How to Focus an Evaluation, Center for the Study of Evaluation, UCLA, Sage Publications, 1987.

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

Table 2) AHF Performance Map

Mission Statement: To support, build, reinforce and sustain the healing process in Aboriginal individuals, families and communities			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short term outcomes**	**longer-term outcomes**
supporting community/centre based healing services and cultural/traditional activities; providing community services; promoting awareness; sponsoring conferences/gatherings; developing capacity; developing resource materials, training and educational programs; sharing history; ensuring honour; engaging in strategic planning, research and knowledge building; engaging key stakeholders in reconciliation; returning voice to women	those suffering from the Legacy of Physical and Sexual Abuse in the Residential School system, those seeking to be healers, broader Canadian public (institutions and individuals)	increased awareness; increased # of strategic plans, 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

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

At last, the resource parameters of this endeavour are difficult to ascertain as a combination of internal and external resources are being used. Externally, $560,000 over a four year period or .16% (.0016) of the total AHF budget of $350 million has been allocated to contract the services of an external evaluator; however, much data and effort has been put into this endeavour by the national AHF team and regional Community Support Coordinators (CSCs) which probably *doubles* the investment in evaluation (or increases the total expenditure to .32% or .0032 of the total budget). To put this into context, a general rule for most national programs is that one percent (.01) of the total budget is allocated to evaluation efforts, although this is highly dependent upon the type of program and its stated goals.

2.3 Process Evaluation Methods

The process evaluation was primarily a descriptive exercise reliant upon information already available through **internal databases**, **document files** and supplementary information secured through **mail out survey** and **one-to-one interviews** with national stakeholders (AHF Board members and personnel). Two Board members and two national team members were selected based upon their proximity to project activity. In other words, those who were considered to have the *most intimate knowledge* of community based activity were selected for interview. The process evaluation reports upon community context, target group characteristics, program teams, service delivery preferences, the distribution of resources and accountability issues.

First, project files were reviewed to determine what information was already available and what supplemental information would be needed. A *sample* of 36 project files were reviewed (See Appendix A for a complete listing). Information was mined from these files according to the document review template in Appendix B and falls broadly into the following categories: project descriptions, capacity building, successes, challenges, target groups, linkages and partnerships, grantee/staff recommendations, lessons learned and evaluation practices. From the review of document files, it was determined that a variety of supplementary information was needed and a mail out survey was developed to fill in the gaps and is included here in Appendix C. The survey was piloted with six AHF sites and revisions incorporated to address most of the noted concerns. Unfortunately, resources did not allow for the translation of the survey into Inuktitut. The survey was then mailed to all 344 projects that were operational at the time (February, 2001) and one follow up phone contact was made from the national office to ensure compliance. At last, the views of key national stakeholders were also solicited through telephone interviews: the national interview schedule is included in Appendix D.

Whenever possible, relevant numerical information from AHF's internal databases were used. When mining important information from document review, all qualitative

data was handled manually and drawn into a document review template (see Appendix B). A manual process was selected over an electronic one in the interests of cost and simplicity. With just 36 files to review, it was felt that the data set was manageable. Once all files were reviewed and templates complete, the raw information was then grouped according to major themes (e.g. successes, challenges). Each theme was then addressed independently so that the strength of trends could be determined.

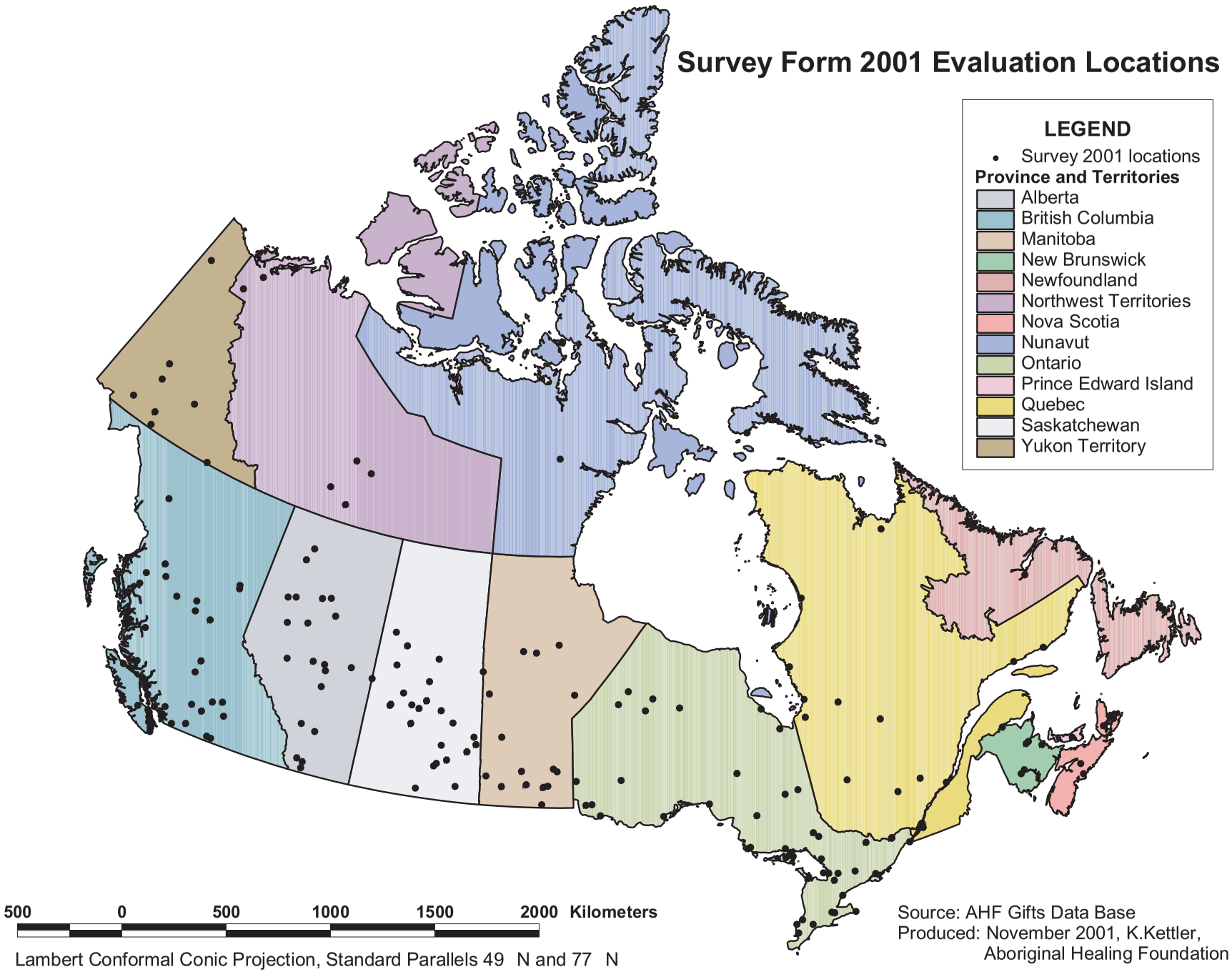
Numerical and categorical data from the mail out survey were analysed using the Statistical Package for the Social Sciences (SPSS) Version 10. Analyses included frequencies, sums and ranges for each question and other univariate descriptive information (e.g. averages and medians). All open ended survey data was categorized and coded and some cross-tabulations were conducted to isolate unique trends. A total of three hundred and forty four (344) surveys were sent to grant recipients representing two hundred and seventy four (274) organizations. See Survey 2001 Locations on the following page for a picture of national distribution. Two hundred and eight surveys (208) were received by AHF representing a response rate of sixty-one percent (61%). However, cases were weighted to account for missing data from organizations with more than one grant. With weighting, the response rate increases to two hundred and fifty-three (253) or seventy-four percent (74%).[7] At last, the framework for organizing all information during data analysis and report writing is included in Appendix E (Information Sources and Organization).

2.4 Outcome Evaluation Methods

The impact evaluation will be informed by thirteen case studies representing each of the project types funded by AHF. Indicators for impact analysis were decided by the AHF Board and include rates of physical and sexual abuse, suicide, incarceration and children in care[8] and, although selected indicators may not always be practically applied

[7]Many organizations (62 in total) received more than one survey because they were administering more than one grant which confused them. As a result, 11 surveys received were duplicative as they were from the same organization and forty-two were from organizations who received more than one survey but chose to submit only one response. It is reasonable to believe that forty-two organizations felt it did not make sense to complete the same survey twice. We have assumed that multiple projects at a single organization have more in common with each other than projects that are hosted by different organizations. From a sampling point of view, projects that are at the same organization are “clustered”. Based on our understanding outlined above, we operated under the assumption that the organizations would have completed a single survey to cover all projects for which they received grants.

[8]These indices may not always be uniformly defined or readily accessible. Therefore, Community Support Coordinators (CSCs) will attempt to secure these rates by examining hospital separation data, police records or incidence and prevalence rates kept by social service agencies and public health officials. Where these statistics are not kept by human service agencies, interviews with key stakeholders and focus group discussions will attempt to estimate the incidence and prevalence (i.e. aggregate information) through indirect, anonymous means or complement social indicators analysis.


Survey Form 2001 Evaluation Locations
LEGEND
Survey 2001 locations
Province and Territories
Alberta
British Columbia
Manitoba
New Brunswick
Newfoundland
Northwest Territories
Nova Scotia
Nunavut
Ontario
Prince Edward Island
Quebec
Saskatchewan
Yukon Territory
500 0 500 1000 1500 2000 Kilometers
Lambert Conformal Conic Projection, Standard Parallels 49 N and 77 N
Source: AHF Gifts Data Base
Produced: November 2001, K.Kettler,
Aboriginal Healing Foundation

to each case study, efforts to secure this information will be conducted and experiences noted in the final report. In addition, a few select indicators chosen by the community will be examined in depth.

It is important to note that no direct measurement of the Board selected indicators was or will be done. In other words, no survivors were or will be questioned directly about their individual histories of sexual or physical abuse. Rather, perceptions, attitudes and social indicators were or will be examined related to the incidence and prevalence of sexual abuse or physical abuse in a community in a way that protected the anonymity of perpetrators and victims. This may include, but will certainly not be limited to, anonymous disclosure rates if such incidence or prevalence rates are being kept by human service agencies or in police records. Alternatively, if such incidence or prevalence rates are not being kept by local officials, then those officials or other key informants were questioned about their *perceptions* regarding the increase or decline in the rates of selected indicators.

The chosen indices (i.e. physical and sexual abuse, children in care, incarceration and suicide) were thoughtfully explored by reviewing the literature to clarify their unique definitions, limitations and interpretations. The *abbreviated* discussion of definitions, limitations and interpretations is found in Appendix F (Definitions, Interpretations and Limitations of Selected Indicators). For a fuller discussion, the reader is referred to the complete report entitled Definitions, Interpretations and Limitations of Selected Indices in the Evaluation of AHF-funded Activity available from the Research Department of the AHF.

Case studies are being used to assess the impact of AHF-funded activity. Methodologically, case studies make sense because the breadth of eligibility for funding is enormous. Many varied strategies with vastly different goals are being supported.

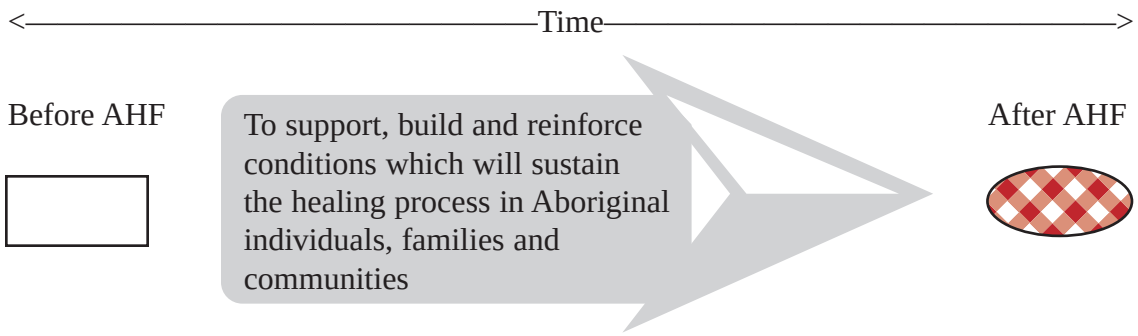
> *Case studies are particularly valuable when the evaluation aims to capture individual differences or unique variations from one program setting to another, or from one program experience to another. . . . . Regardless, . . . a case study seeks to describe that unit in depth, in detail, in context and holistically. The more a program aims at individualized outcomes, the greater the appropriateness of qualitative case methods.*[9]

Each case study is using a within groups repeated measures design. In other words, a "picture in time" will be developed from community needs assessments or other project files and proposals. Board selected indicators (i.e. rates of physical and sexual

[9]Quinn-Patton, M.: How to Use Qualitative Methods in Evaluation, Sage Publications, Newbury Park, California, 1987, page 19.

abuse, suicide, incarceration and children in care) together with two or three anticipated outcomes (decided by the community) will be examined *before* AHF activity begins and again after the program ends in 2003. Schematically represented, a repeated measures design looks like Figure 2 below. The arrows represent what happened over time with respect to AHF-funded efforts. The smaller figures, representing individuals, projects or communities, change in shape from a rectangle to an oval representing the natural and inevitable change in all things over time as a result of the effects of history. The change in *fill* represents the hoped for changes resulting from AHF-funded efforts (e.g. increased awareness, increased capacity, strengthened connection between those in need and healers, etc.).

Figure 2) Indicators Analysis Before and After AHF



Other standard questions in impact evaluation are directly related to program relevance; however, the Foundation has chosen to discuss issues of program relevance in a separate document where the future of the organization will be central.

All data was collected and case studies drafted by the Community Support Coordinators as a way of minimizing costs. At least two, and up to four, site visits may be required. During site visits, the following techniques were/will be used to gather information:

- community observations;
- solicitation of opinions about the program;
- individual interviews with local stakeholders (e.g. project teams, local professionals, sponsors); and
- social indicators analysis: examination of aggregate hospital separation data, police records/statistics and incidence/prevalence reports of human service agencies (e.g. social services and public health).

At last, it is understood that AHF-funded activity is poised to impact major life management and social issues. The Foundation 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 mutually exclusive and focus upon residential

school survivors from each Aboriginal group (i.e. Inuit, First Nation and Métis) in an extremely broad range of circumstances (i.e. isolated, rural, urban, incarcerated). Long term results should be defined in decades as the Legacy will not be erased by short lived remedial efforts. Information is placed in the *context of the times and communities* in which AHF-funded projects are operating so that results can be considered holistically because it is certain that poverty, geographic isolation, environmental issues and lack of economic opportunity will also affect any selected indicators used to measure AHF impact. Therefore, some assessment and discussion of confounding contextual variables has been provided in both case studies and process evaluation reports.

2.4.1 Sample Selection

Thirteen projects were selected to participate in the impact evaluation. A complete matrix of those projects selected as well as the variables used in the selection process is included in Appendix G (Sites Selected for Case Study). Considerations in the selection of this sample included:

Aboriginal identity and special need: Inuit, Métis, First Nation (status and non-status), on and off reserve, women, men, youth, elders, the incarcerated, gay, lesbian and disabled.

Geo-political boundaries: Representation from all regions are included.

Remoteness and community infrastructure Sufficient numbers of both isolated communities with little infrastructure and near urban scenarios were selected.

Project theme area: All project types are represented in the selection of case studies (e.g. community services, conferences/gatherings, cultural activities, healing services, resource development; planning; research; traditional activities; as well as training and education programs).

The identified weakness in sample selection is that *duration of participation* was not considered, meaning that a minimum or maximum amount of time for impact to be noticeable will be more difficult to determine.

3. Process Evaluation Results

The following chapter of this report describes the process thus far by answering the who, what, where and when questions. Information is drawn from several sources including AHF databases, document review, responses from the mail out survey and the opinions of national stakeholders. As a general introduction to this section, let's begin with the opinions of national stakeholders about their relationship with community based projects.

When asked what they would like to share about the process to date, national stakeholders spoke about the ever increasing sensitivity to community needs. To illustrate the Foundation's responsiveness, they cited changes to the proposal review process which was externally driven, inflexible, and sometimes arbitrary to an internally managed, more responsive and supportive approach. Under the current system, when proposals do not meet minimum criteria but ideas are germane, the Foundation works *with* the community by identifying weaknesses (which are often related to proposal writing skills) and affording opportunity for proposal revisions and re-submission. Once funded, the Foundation works to build strengths by helping projects fulfill reporting requirements and has attempted to reduce the administrative response burden associated with reporting requirements by paring quarterly activity reports to biannual submissions (when budgets exceed $50,000) while maintaining quarterly financial statements. At last, national stakeholders believe that the Foundation has taken great care to invest where the need is greatest by closely monitoring project targets and engaging in outreach, when necessary, to ensure an equitable division of resources.

What follows is a *quantitative* picture of the process to date and the reader is forewarned that much of the following information is dense. While it may intrigue some, it can sedate and confuse others. The report includes this information because it answers key questions in the evaluation framework and is important for accountability purposes. To help clarify what all the numbers mean, some explanatory notes are offered here. First of all, as a way of illustrating how many respondents provided information to a particular question, the reader will see in parentheses (n=) where n is the 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[10] (or the middle) have been used: the **average** and the **median**. For simplicity, the average is used in many cases; however, the median or the half way mark is also used where it is believed to be a better

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

measure of central tendency because some responses vary widely, especially when it comes to funding from other sources. When there is such wide variability, the median is a better measure of the "middle" than the average because the average is strongly influenced by even one very high or very low figure. To illustrate this point,the reader is referred to the footnote below.[11] Now, let's look at the data.

3.1 Who

3.1.1 Participant Characteristics

Participant characteristics help planners better understand needs, identify gaps, mediate the environment or restructure the program to facilitate the achievement of desired results. The following information on participant characteristics was drawn primarily from two sources: data from AHF's databases and the mail out process evaluation survey. First of all, let's look at the information available from AHF's database which offers participation rates by age, sex, Aboriginal identity and target group. These data are to be considered estimates as *there is a very sound likelihood that many participants have been counted more than once*[12]; hence, figures may *over-estimate real participation*.

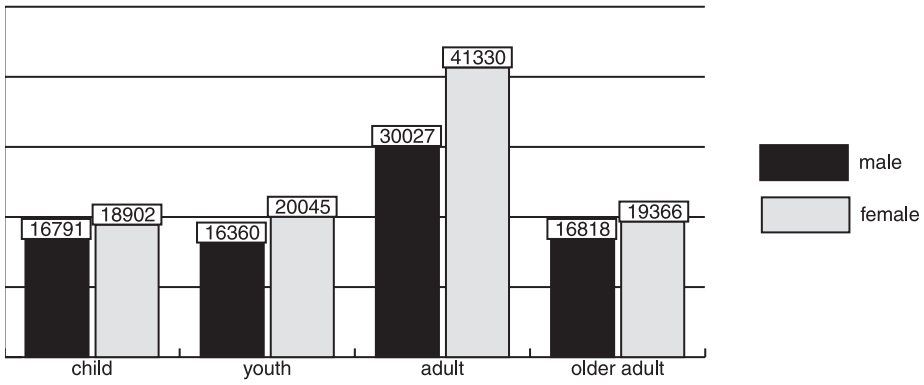
As a way of illustrating this point, let's add together the total number of participants identified by age and sex (because we can assume that age and sex are mutually exclusive categories, that is, a male child would not also be counted as a female Elder) drawn from quarterly reports and compare that number to the number of healing and training participants reported in the mail out survey. The total number of participants reported in quarterly reports (upon which AHF databases are largely dependent) equals 179,639 whereas the total number of healing and training participants reported in the mail out survey is 59,224 (for the sake of illustration, we have assumed that healing and training participants are mutually exclusive although we know that they are not: in other words, the total number of participants is probably less than 59,224). If 100% of the mail out surveys had been returned (the reader is reminded that the survey return rate was 74%), then we might expect this total to reach as many as 80,032, *still half of what was reported in the quarterly reports* (179,639). This figure becomes very important when calculations of cost effectiveness are done. In any case, these data are used as a way of representing the possible distribution of participants by sex, age, aboriginal identity and target group.

[11]Let's say that we want to find the median and the average for the following numbers: 1, 2, 3, 4, 5, 6, 7, 8, 1000. The average would be 115 but the median would be 5. Which is the better measure of the middle or usual response (i.e central tendency)?

[12]It was noted in document review that quarterly reports often cited the exact same participation figures as in the previous three quarters leading the reviewer to suspect that just the final or year end participation rates should be recorded in the companion database.

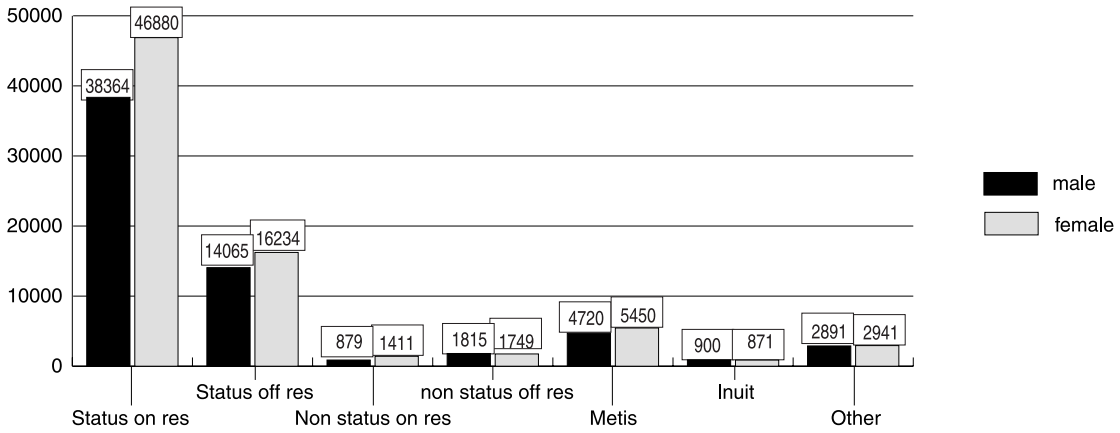
From AHF sources, it appears that females may represent a greater proportion of participants across all ages and that the greatest number of participants fall into the adult[13] category with all other age categories being equally represented. Figure 3 shows the number of participants by age and sex.

Figure 3) Number of Participants by Age and Sex



The vast majority of participants are either status First Nations on or off reserve (85,244 and 30,299 respectively). The Métis (10,170) are the next most populous group followed by those who are classified as "other"[14] (5,832). Non-status First Nations individuals off-reserve (3,564) followed by those on-reserve (2,290) are the next largest groups and the Inuit had the smallest number of participants (1,771). Figure 4 displays the number of participants by Aboriginal identity and sex.

Figure 4) Number of Participants by Aboriginal Group and Sex

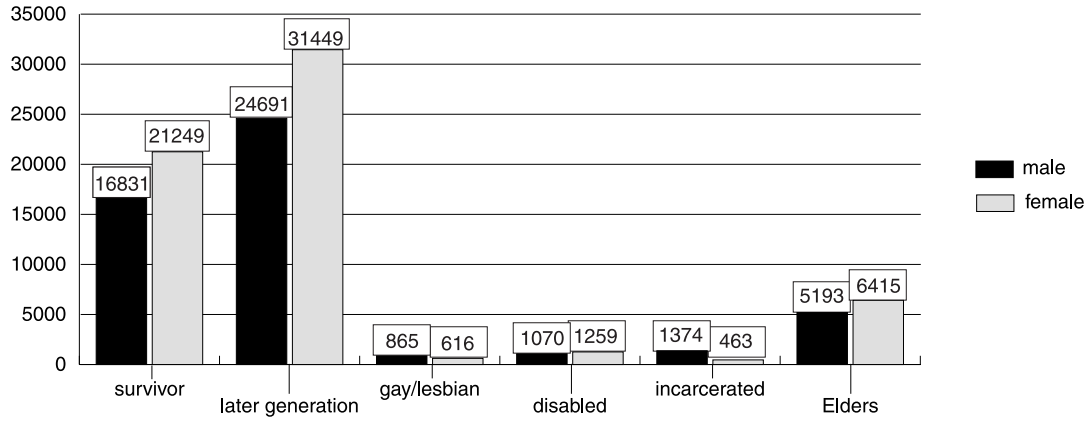


[13]Child - 0-14; Youth - 15-25; Adult - 26-49; Older Adult - 50+.

[14]This can include non-Aboriginal and unidentifiable participants.

When the data are broken down by target group (e.g. survivors, later generations, lesbians, gays, etc) and sex, it is clear the groups with the largest number of participants are later generations (56,037) and survivors (37,880) followed by Elders (11,608), the disabled (2,329), the incarcerated (1,837) and gay or lesbian groups (1,481). Figure 5 illustrates the number of participants broken down by special target group and sex.

Figure 5) Number of Participants by Target Group and Sex



Information about project participants was also obtained from the mail out survey. Because the bulk of AHF investment is in healing and training, the results are profiled to highlight these two project types. Almost half (45% n=253) of projects have a healing only focus while only a few (5%) are training only, but the largest proportion (50%) provide both healing and training. The following sections report on the participant characteristics for these two project categories separately.

3.1.1.1 Healing Project Participation

It is understood that many different kinds of healing activities are taking place: some focus on individual healing with regularly scheduled therapeutic approaches and others have community healing in mind with more sporadic, developmental approaches. In an effort to distinguish between those which focus primarily on the individual or more clinical healing from those who have a more group or community development focus, it was important to take into consideration the degree to which a person is considered a “participant”. In other words, we asked projects to consider whether or not participants were regular beneficiaries (e.g. attended healing circles on a continuous basis) or are they more likely to only attend only irregular events (e.g. pow wows or feasts). A participant’s membership in one of these groups affects their experience of

the project and results in different outcomes. Therefore, projects[15] were asked to differentiate between these two categories of participants when enumerating their participants.

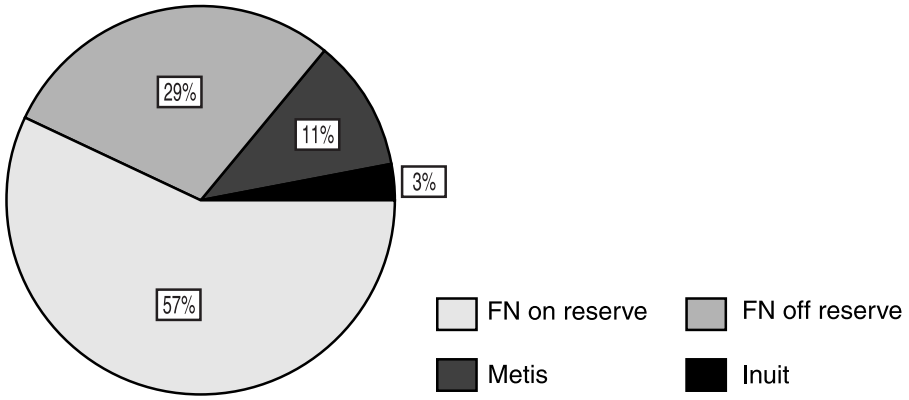
The first category, **individual healing**, refers to regular or more routine participation in a clinical or therapeutic context where the focus is on personal progress. Individual healing activities include any project based therapeutic healing, sharing circles, camps, retreats, ceremonies and counselling. Individually focussed healing projects provide services to an estimated **48,286** (n=221) **participants** with a median of 133 participants per project (average=219). Participants spend an average of one hundred and eighty three (183) hours in healing activity (median = 60 hours, n=162) and can spend as little as two or as many as 2,821 hours in programmed healing activity. The second category, **group healing events**, refers to larger community functions which serve to promote group well being such as feasts, socials, and pow wows. Group healing projects report a total of **39,323** (n=204) attendees with a median attendance rate of 100 (average=193). The reader should note that individual and group healing participants are *not mutually* exclusive. In other words, those who participate in more individualized or clinical types of healing activities (e.g. centre based therapy, healing circles) may also attend group healing events (e.g. feasts and pow wows). Now, let's look at the characteristics of healing activity participants (i.e. those participating in healing where the focus is on individual progress). Proportionately, the largest groups are on and off reserve First Nations (57%[16], and 29% respectively, n=187) followed by the Métis (11%) and Inuit (3%).[17]

[15]For the ease of reading, "project" is used throughout this report to refer to the group of individuals who completed the survey. The survey instructions requested that the following individuals complete the survey: a project deliverer (e.g., a trainer, healer, researcher), a project participant (a beneficiary of the healing or training), and a person who is not directly involved in the project (e.g., nurse, social worker, a Friendship Centre director) whose opinion is important.

[16]The percentage of participants that fell into an Aboriginal group was calculated using the number of Inuit participants, let's say, and dividing by the total number of regular (*individual healing activity*) participants. This proportion or percentage was then averaged over all projects.

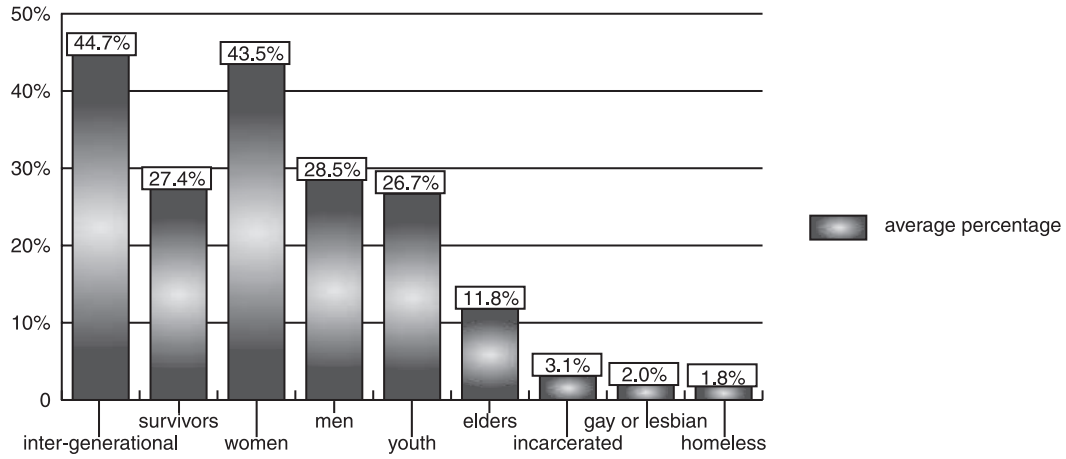
[17]It should be noted that these distributions may reflect national Aboriginal population distributions.

Figure 6) Healing[18] Participation by Aboriginal Identity



When we look at healing participation by target group, the two largest target groups appeared to be inter-generationally impacted (45%[19], n=180) and women (44%), followed by men (29%), survivors (28%) youth (27%) and Elders (12%). Only a few were incarcerated, gay, lesbian or homeless (3.1%, 2.0%, and 1.8% respectively). The reader is reminded that these are *not mutually exclusive* categories. In other words, one participant can fall into many categories (e.g. one person can be a female, incarcerated youth who is inter-generationally impacted). Figure 7 shows healing participation by target group.

Figure 7) Healing Participation by Target Group

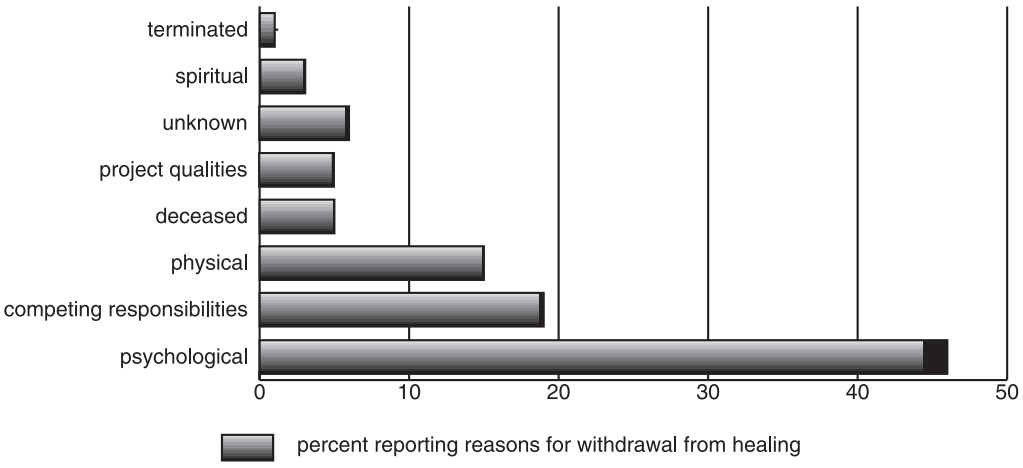


[18]Here healing activity refers to all efforts were progress is on **individual** development and not community development. In other words, this figure refers to participation in healing circles, counselling sessions, centre based activities, retreats etc and not participation in more community focussed healing event such as feasts or pow wows.

[19]The number of participants in a target group (e.g. youth) was divided by the total number of individual healing activity participants. This resulted in a percentage for that target group for every project, then the average was calculated for all projects.

Projects who were finished at the time of the survey (n=83) reported that the vast majority of participants (72%) had completed the healing program. Seventy-six percent of healing projects reported a 50% or better completion rate (n=83) and a 100% completion rate was noted by one third (33%) of completed healing projects. A variety of reasons for withdrawal were offered. Psychological problems (including fear, lack of trust, denial, addiction) accounted for most attrition (46%), followed by competing responsibilities ([19%] e.g. new job, relocation, family crisis or responsibilities) and physical problems ([15%] e.g. poor health or lack of transportation). Five percent reported that participants had passed away or that project qualities (e.g. staff turnover, inability to accommodate varying healing levels and lack of interest in topics presented) accounted for withdrawal. For a small group, participants did not complete the program because of poor cultural or spiritual "fit" (3% e.g. Christian participants looking for an approach other than traditional spiritual practices) or they were terminated (1% e.g. non-compliance). Figure 8 illustrates the frequency of reasons cited for non-completion.

Figure 8) Reasons Why Participants Withdrew from Healing

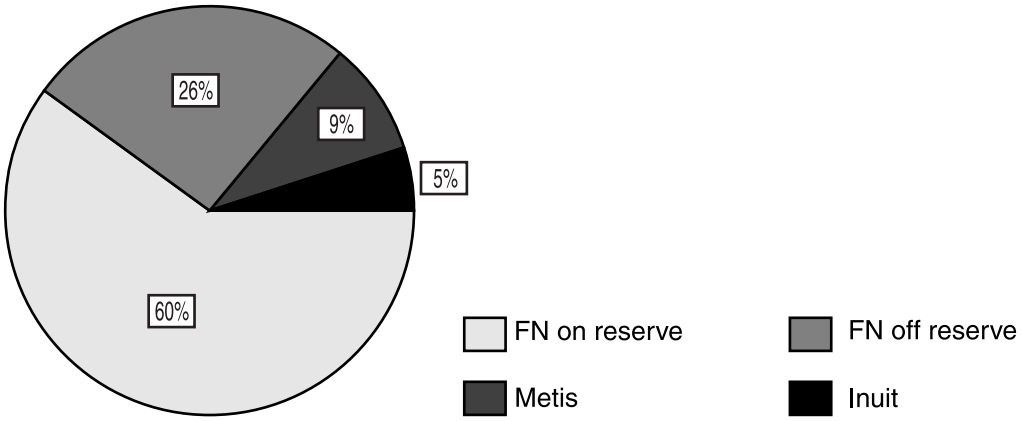


3.1.1.2 Training Project Participation

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 provide services to **10,938** (n=124) **participants** (median = 22 participants per project; average = 88). Trainees spend an average of 193 hours in training (median = 74 hours, n=92). On and off reserve First Nations constitute the majority of training participants (60% and 26% respectively, n=108). The Métis composed nine percent while the Inuit accounted for

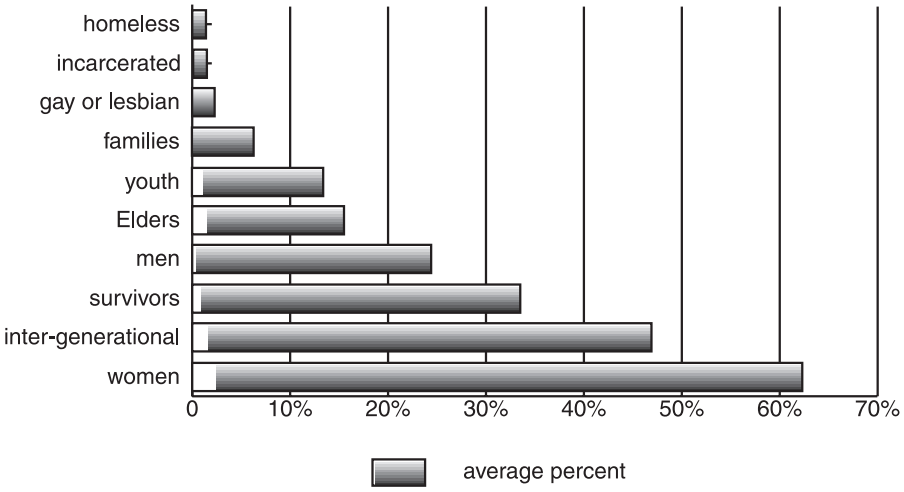
five percent.[20] The distribution of each Aboriginal group participating in training is presented in Figure 9.

Figure 9) Training Participation by Aboriginal Identity



When we look at training participation by target group, it is clear that the inter-generationally impacted (47%) and women (62%) are well represented. Men account for just under a quarter of all training participants (24%) while survivors compose a average of thirty-four percent. Almost as many youth are in training as Elders (average of 13% and 16% respectively), and only a few are incarcerated, gay or lesbian, or homeless (average of 1.4%, 2.3%, and 1.4%, respectively). Figure10 shows the distribution of target groups participating in training.

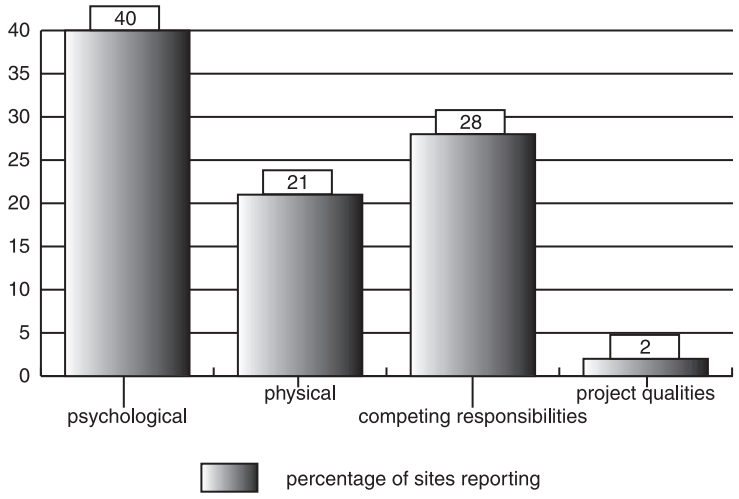
Figure 10) Participation in Training by Target Group



[20]It should be noted that these distributions may reflect Aboriginal population distributions.

For those projects who had *concluded* their training programs at the time of the survey (n=69), seventy-one percent of participants finished the training program. Half the training projects reported an 80% or better completion rate and almost a third (28%) reported that every participant finished the program. A sizable group of projects (40%) cited psychological problems (fear, lack of trust, addictions, lack of commitment) as the primary reason for withdrawal; however physical problems (e.g. poor health) and competing responsibilities prevented some from concluding their studies (21% and 28% respectively). Project qualities accounted for only two percent of the reasons cited for non-completion. Figure 11 illustrates frequency of various reasons noted for participants to withdraw from training.

Figure 11) Reasons Why Participants Withdrew from Training

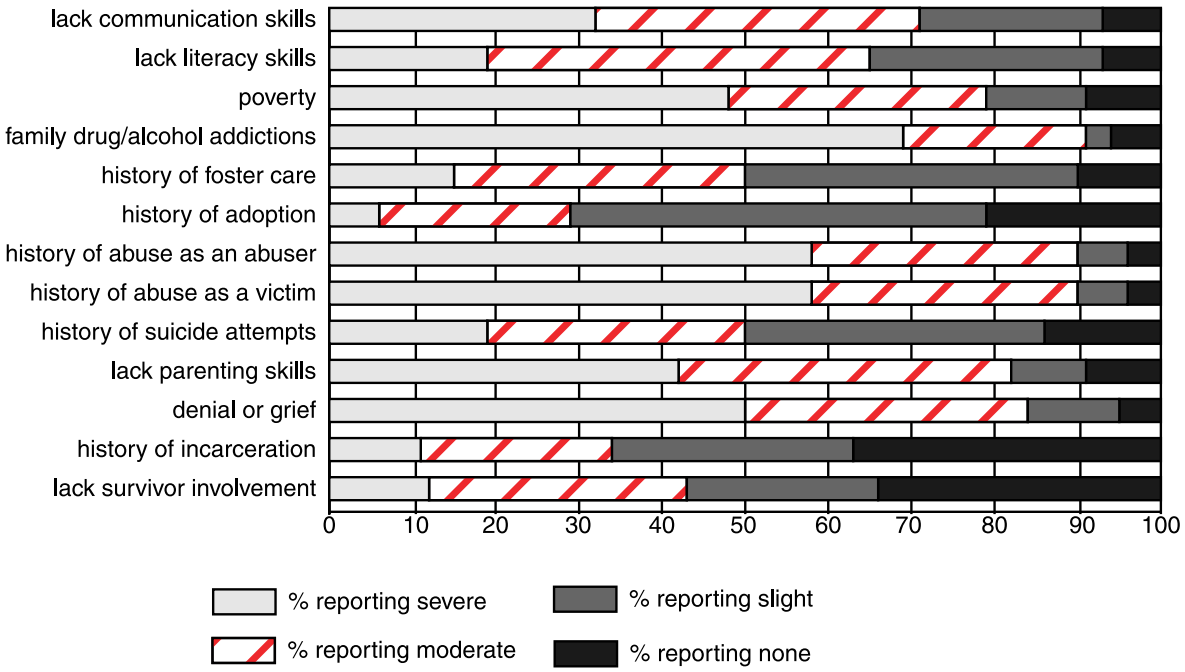


3.1.1.3 Participant Challenges

Addictions, victimization and abuse are clearly the most severe[21] participant challenges affecting the majority of projects (69%, 58%, and 58%, respectively). Other common challenges which are reported as *severe* by a sizable group (>40%) include denial or grief, poverty, and lack of parenting skills. On the other hand, about a third (>30%) reported that survivor involvement and history of incarceration were *not a problem*. Figure 12 illustrates the extent to which participant challenges may affect project operations.

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

Figure 12) Severity and Frequency of Participant Challenges



National stakeholders concurred that a history of addiction, suicide, abuse (i.e. as a victim or perpetrator), adoption, foster care and poverty coupled with denial, fear, grief and a general lack of communication skills were the most significant challenges facing participants. National respondents were inconsistent when estimating how severe the lack of parenting skills might present as a challenge and they believed that this may vary by region. There was also disagreement about the extent to which lack of survivor involvement may present a challenge to AHF projects.

Healing projects identified **7,589 individuals with special needs** (e.g. suffered severe trauma, inability to engage in a group, history of suicide attempt or life threatening addiction). On average, **thirty seven percent (median=25%) of participants require greater than normal attention** to deal with their special needs. Ten percent of projects reported that *all* participants have special needs and thirty-one percent of projects claimed to have *less than ten percent* of their participant population with special needs.[22] It is interesting to note (and clearly reflective of the need for AHF supported activity) that less than one percent of participants (3,585) had previously participated in a similar healing or training program before they began attending an AHF project (n=114).

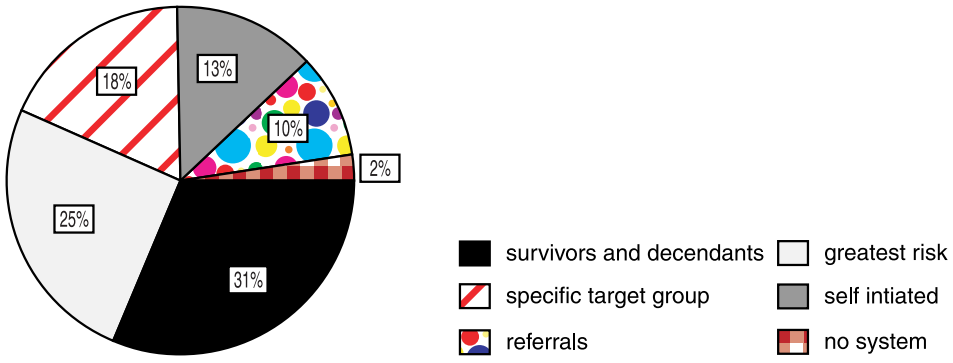
[22]There is a positive linear relationship between *family drug or alcohol addictions, history of abuse as a victim,* and history of incarceration, and the percentage of project participants that have special needs (covariance 0.437, $p<.05$, n=152). In other words, as projects report having more participants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

Projects were asked a series of questions regarding *how* they deal with special needs. Most frequently, projects reported that some employees are trained to deal with serious issues such as suicide, family violence, and addiction (61%, n=242). In some cases, *all* employees are trained to deal with serious issues (25%) but some (9%) report not having any special training, community services or volunteer support to help them in addressing special needs. Other commonly cited strategies included inviting professionals to provide *monthly or yearly* support (47%) with some reporting *weekly* professional support (31%). Projects also frequently relied on peer support (36%) or *trained* volunteers who work one-on-one with individuals and families (19%) although a small percentage (5%) enlisted *untrained* volunteers. Some had no other choice but to make referrals (8%) or engage in case management with another agency (3%) while others used traditional methods (8%) to assist with special needs. On the positive side, a small group (3%) reported that they do not have participants with a condition serious enough to require a different approach.

3.1.1.4 Participant Selection Criteria

The majority (55%, n=234) were able to accommodate all who needed therapeutic healing or desired training. Those who could not accommodate everyone (41%) shared their selection criteria. The most commonly cited priorities were survivors and their descendants (31%, n=104) and those at greatest risk (25%). A few (18%) targeted specific groups based upon gender, Aboriginal identity, age, sexual orientation or religion. Some (13%) reported that they gave priority to those who *self-initiated* their enrollment. A small group (10%) gave priority to referrals and rarely (2%) was there no system for prioritizing participants. Figure 13 illustrates the distribution of project approaches to prioritizing potential participants.

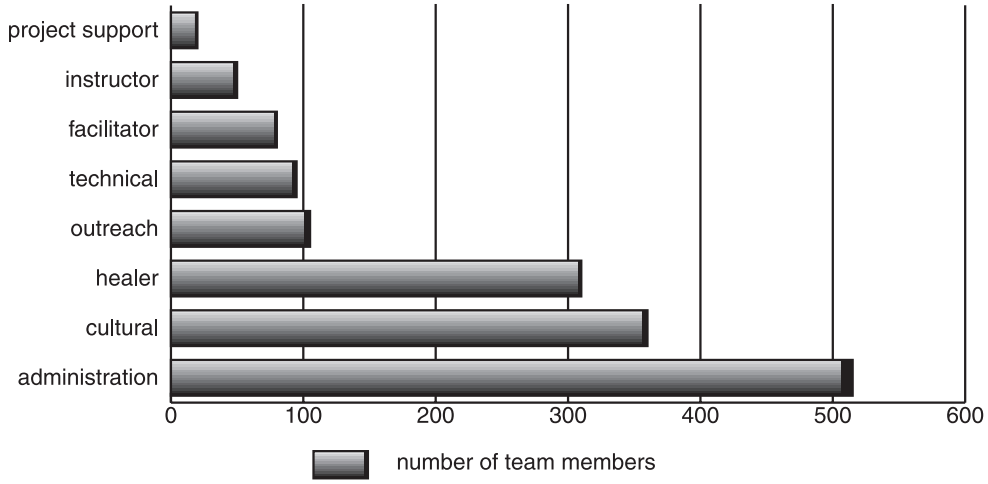
Figure 13) Participant Selection Criteria



3.1.2 The Team - Personnel, Training and Volunteers

AHF projects reported a total of 1,916 paid employees (n=238): 1,126 of which are full time positions (i.e. working more than 30 hours per week on a regular basis). Per site, average team size was 5 full time employees (median = 2) and 4 part-time employees (median = 1) for an average team size of about nine. In hierarchical order, teams (n=206) are most likely to be composed of administrators, cultural personnel (i.e. Elders, cultural coordinators, teachers and therapists), healers (i.e. counsellors, therapists, psychologists, psycho dramatists and acupuncturists), outreach staff, technical personnel (e.g., research coordinator or assistant, technical advisor, security, and support development worker), facilitators, and instructors. Janitors, bus drivers and cooks were also represented in the distribution of team members and are included in Figure 14 as project support.

Figure 14) Number of Team Members by Position



Eighty-eight percent of all positions are occupied by Aboriginal people (n=219). When broken down by position, it is clear that eighty-nine percent of administrative positions are occupied by Aboriginal people, eighty-seven percent of healers are Aboriginal, and eighty-four percent of outreach team members are Aboriginal. The greatest concentration of non-Aboriginal team members exists within project support positions and facilitation roles (making up 23% and 18%, respectively). Survivors occupy fifty percent of positions (n=212). In examining the distribution of survivors among the various positions, it is clear that fifty-six percent of technical positions are occupied by survivors, fifty percent of healers and instructors are survivors, and forty nine percent of administrators, as well as, facilitators are survivors. The greatest concentration of team members who *did not* identify as a survivor within projects are in outreach and project support positions (making up 62% and 55%, respectively).

Document review reinforced these data as it was clear from project files that the majority of employees were First Nations, Inuit or Métis and were directly or inter-generationally affected by the Legacy. The ability of Aboriginal employees to speak the language was consistently and positively highlighted. Less than half of the project files reviewed conveyed the use of outside resources or expertise although some acknowledged the value of outside expertise, when community members felt unable to handle the demands of the client group or were afraid of being seen as an "expert" on the issues. Furthermore, document files revealed that outside expertise was invaluable in scenarios where prospective community based healers needed therapeutic assistance themselves. Outside expertise was usually contracted to prepare proposals, conduct needs assessments, draft final reports, offer training or do evaluations.

Despite the practical benefits to working with external resource personnel, AHF project teams simultaneously resented their presence. They acknowledged that community members were better able to provide insights that facilitated disclosure and that most survivors were generally more comfortable with Aboriginal healers.

> *"Get our own people to heal us. It took me six years for me to talk about my past! I held hurt for fifty years to see the faces of my abusers. It took actual deaths for me to focus on my childhood . . .We need to stop it here for our children! We have to train our people to heal us."*

Notwithstanding the resentment, there was no argument that skills and knowledge were enhanced by the external, professional training provided.

The reader is cautioned to note that the following data are based on an under-reported question (n=29: remember "n" means the number of responses received to the survey question).[23] Forty percent of the personnel included in this analysis hold diplomas or certificates (59 of 147) while about twenty percent hold an undergraduate degree and ten percent have either completed a graduate degree or are traditionally trained. Almost ten percent (10 of 147 employees), are continuing their education. These data must be interpreted with great caution as this is a very small sample of the projects funded by AHF activity. Still, we are able to gain a better understanding of qualifications at AHF projects by examining the years of relevant experience personnel possessed (n=215). On average team members have twelve years of relevant experience in their field (median=10).

[23]We are unable to suggest that the 29 projects represented in this set of data are representative of AHF projects in general.

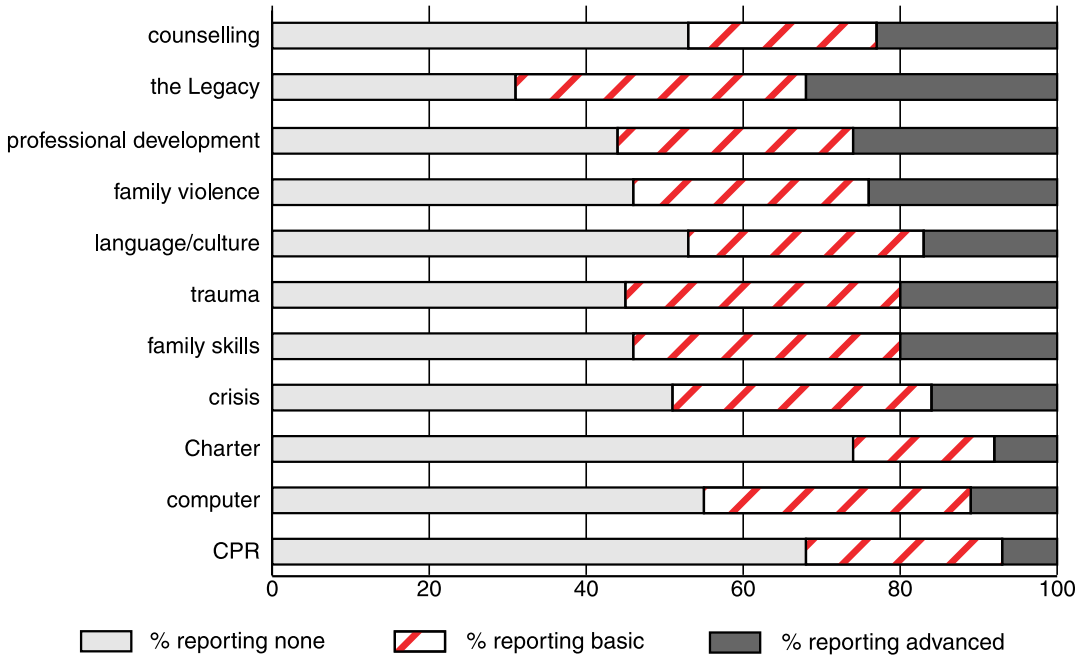
Beyond the training and experience brought to the program by AHF team members, many projects offered training. The most common training opportunities provided (n=226) were:

- learning about history and the Legacy (69%);
- professional development[24] training (56%);
- trauma awareness (55%);
- programs related to family functioning (e.g. child development and parenting skills) (54%);
- dealing with family violence (54%);
- crisis intervention (49%);
- counselling skills (47%);
- Aboriginal language/culture (47%);
- computer/internet training (46%);
- CPR/First Aid (31%);
- learning about the application of the Charter of Rights and Freedoms in the project (26%); and
- "other" training opportunities (1%), including: addictions and alternative therapies.

Thirty six percent of those projects who offered training reported that it was *advanced*: the remaining projects provided basic training (n=226). Projects were just as likely to offer *basic* training on the Legacy (37%) and counselling (24%), as they were to offer *advanced* training in the same areas (32% and 23%, respectively). Advanced training in professional development and family violence were frequently reported (27% and 24%, respectively) while basic training included: computer/internet (35%), trauma awareness (35%) and family skills/functioning (35%). Figure 15 illustrates the percentage of projects offering the type and level of training offered.

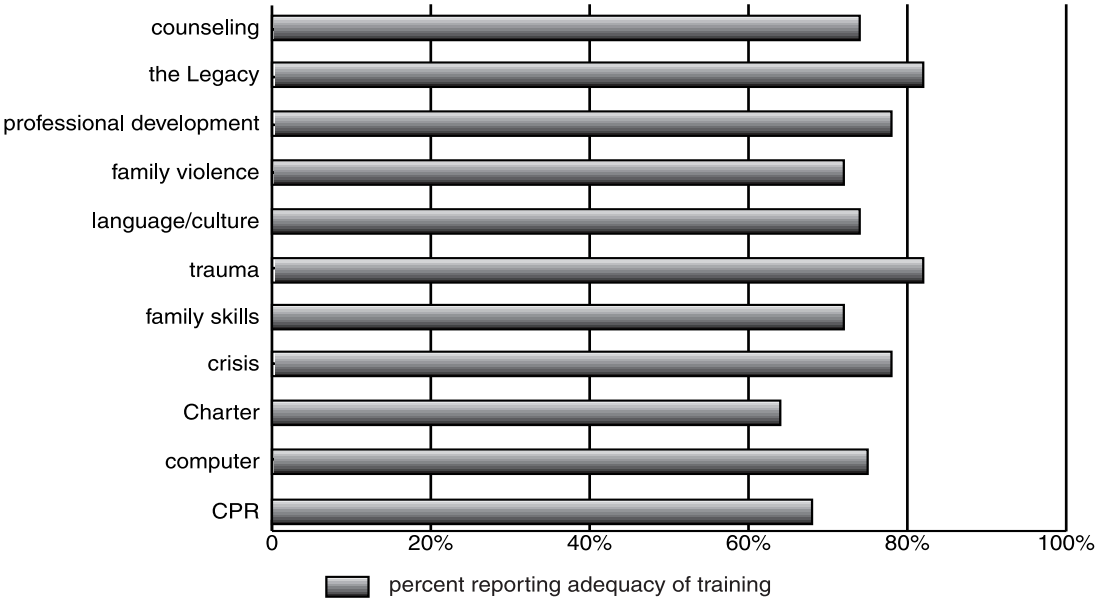
[24]This may include conflict resolution, leadership skills, legal information, board training, team building, communication skills, project planning and evaluation, dealing with difficult people and training to facilitate and organize groups or volunteers.

Figure 15) Training by Type and Level



Overall, seventy four percent believed that the training provided was adequate, while the remainder (26%) felt training was inadequate (n=226). Trauma awareness and learning about the Legacy are reported as adequate most often (81% for both). Learning about the application of the Charter of Rights and Freedoms (37%) and CPR/First Aid (33%) were least likely to be considered adequate. Figure16 illustrates the project perceptions regarding training adequacy by training type.

Figure 16) Assessment of Training Adequacy by Type

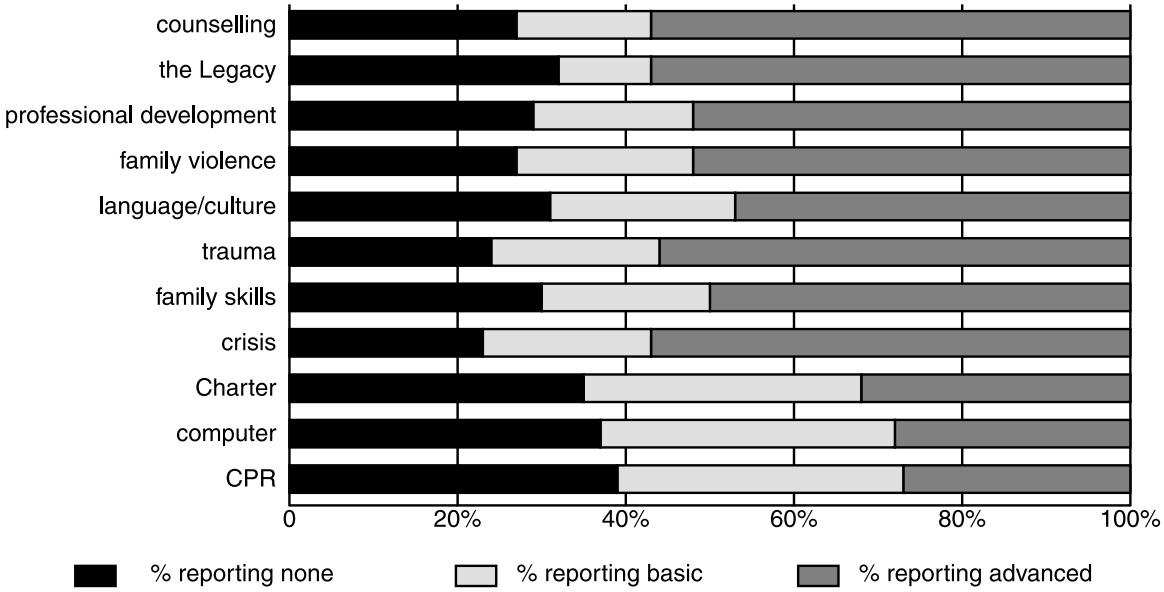


Still, perceived training needs rank highly within the group. Those topic areas most often cited are (n=225):

- crisis intervention (77%);
- trauma awareness (76%);
- counselling skills (74%);
- dealing with family violence (73%);
- professional development training (71%);
- programs related to family functioning (e.g. child development and parenting skills) (70%);
- Aboriginal language/culture (69%);
- learning about history and the Legacy (69%);
- learning about the application of the Charter of Rights and Freedoms in the project (65%);
- computer/internet training (63%);
- CPR/First Aid (61%); and
- "other" training opportunities (16%), including alternative therapies, case management, justice, program development.

Sixty-eight percent of the projects who believed training was required reported that personnel would better benefit from *advanced* training (n=225), while the remaining projects stated that basic training would suffice. Learning about the Legacy, counselling skills, crisis intervention, and trauma awareness are the most commonly cited *advanced* training needs (58%, 58%, 57%, and 56%, respectively). The most frequently reported basic training needs included: CPR/First Aid (33%), Charter application (33%) and computer/internet training (25%). Figure 17 illustrates the percentage of projects reporting whether their personnel require further training by training type and level.

Figure 17) Further Training Needs by Type



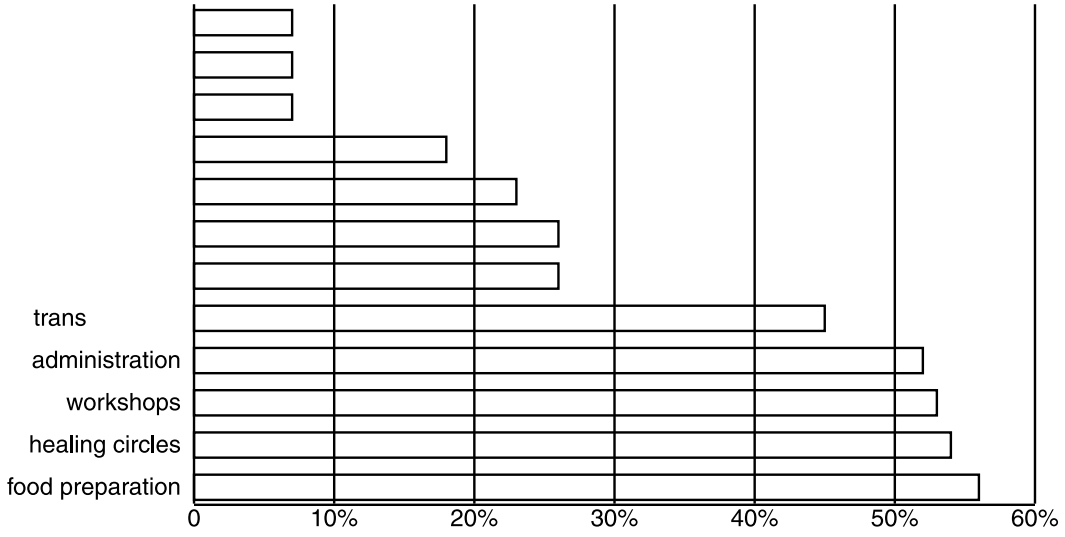
A strong majority of the document files reviewed (93%) revealed that projects provided training of some kind to a variety of targets including leadership, project personnel and community members, generally, as a way of developing healthy and culturally respectful programs. Occasionally, volunteers were trained and sometimes training was collaboratively sponsored with other Aboriginal organizations. Skills were acquired in administration, facilitation, counselling, healing, lifestyle change. There was a noted trend of sharing traditional healing methods at conferences and workshops where participants learned techniques to engage in spiritual counselling, talking circles, sweat lodges, pipe ceremonies and handling disclosures. Some offered instruction as a way of developing community based trainers; however, there was some noted resistance to becoming "the expert" because of the daunting task ahead.

The files suggested training may need to change to better address needs. For example, one project noted that it may be more effective to teach more basic adult child interaction skills before setting out to teach parenting. It was also suggested training be focused upon leadership and project personnel.

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

At last, a discussion about AHF teams would be incomplete without some profile of the enormous volunteer effort. ***In a typical month, over 13,000 volunteer service hours are contributed to AHF projects (n=207)***. Each project enjoys an average of 65 volunteer hours per month (median = 26). If we take a very conservative estimate of what that time might be worth and assume that the value of this contribution could be remunerated at $10/hour, then that represents an injection of **$130,000 dollars per month or $1,560,000 per year**. The four most favoured volunteer endeavours by all groups included: food preparation (56%), healing circles (54%), workshops (53%), and administration (51%). Volunteers were also involved in fundraising (24%), operations (26%), and recruitment (26%). The overall breakdown of volunteer activity and type appears in Figure 18 below.

Figure 18) Volunteer Activity Preferences



* Note to the reader: **"Other"** activities that required volunteers included: traditional healing, sports activities, program development, office assistance, and being a mentor.

3.2 What

The following section describes what happened by looking at the distribution of resources by Aboriginal identity, target group, remoteness, project type and theme as well as region. Identified needs are also profiled in this section along with highlights upon activities of special interest including:

- how projects have engaged survivors,
- ensured participant safety,
- impressions about adherence to the Charter of Rights and Freedoms and ability to return voice to women, and, last, but perhaps most importantly,
- preferred or practised approaches to healing.

Figure K.1) Survivors' Priorities

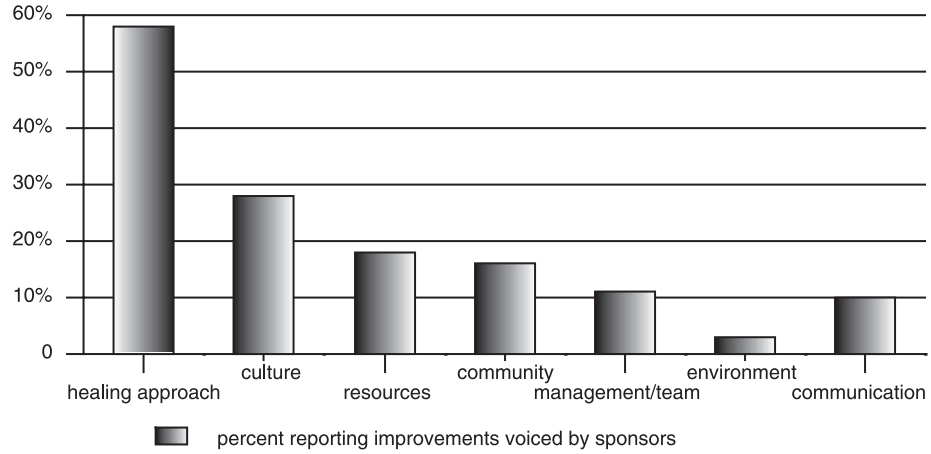


Figure K.2) Elders' Priorities

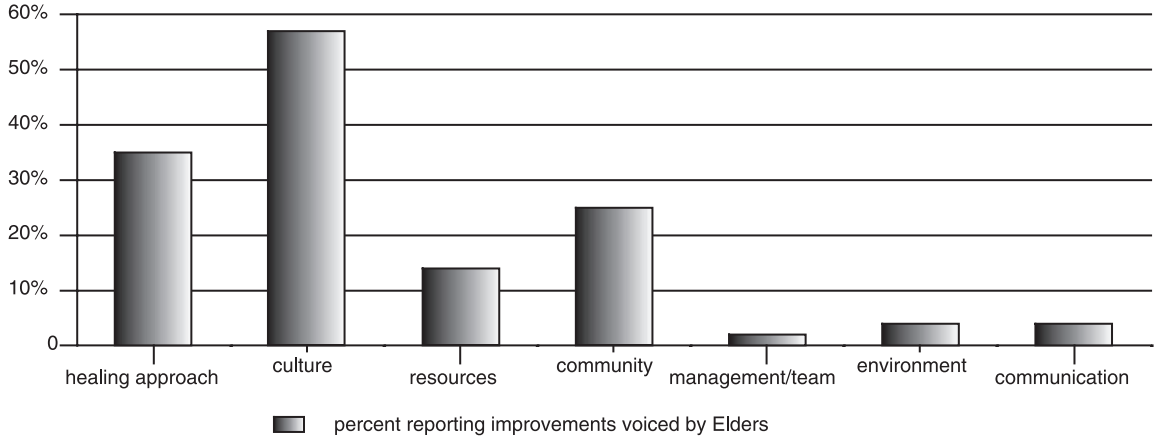


Figure K.3) Professional Priorities

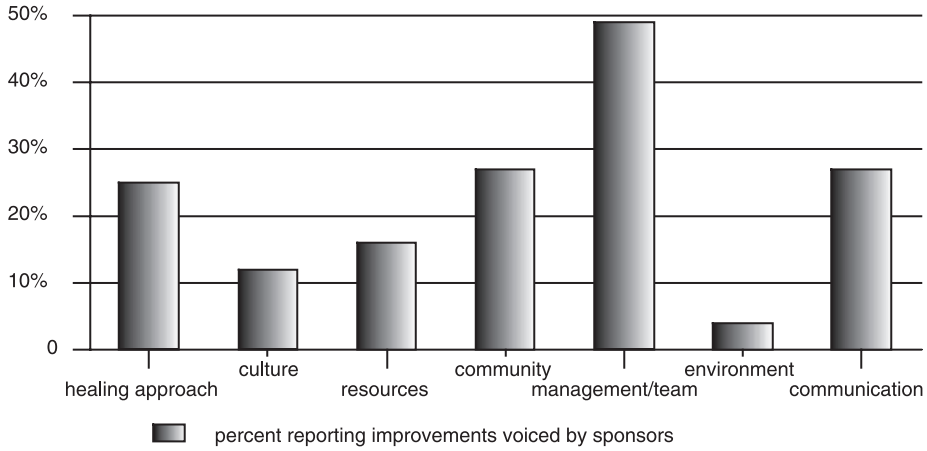


Figure K.4) Sponsor Priorities

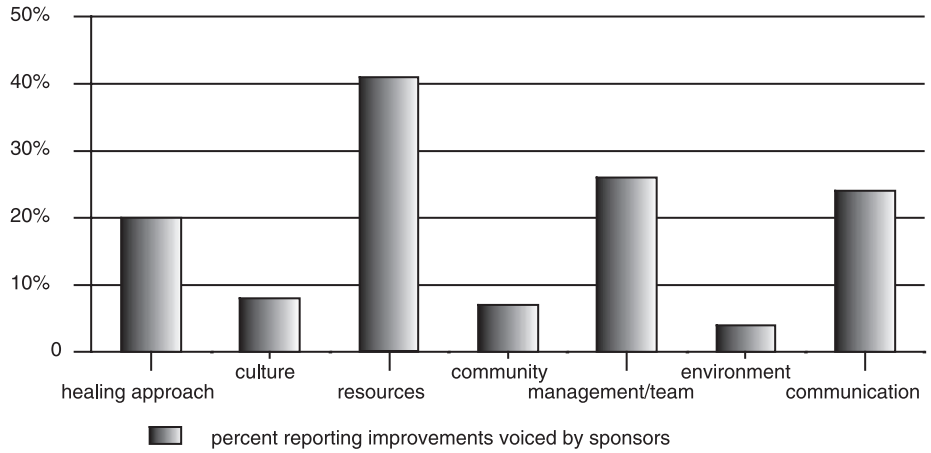


Figure K.5) Youth Priorities

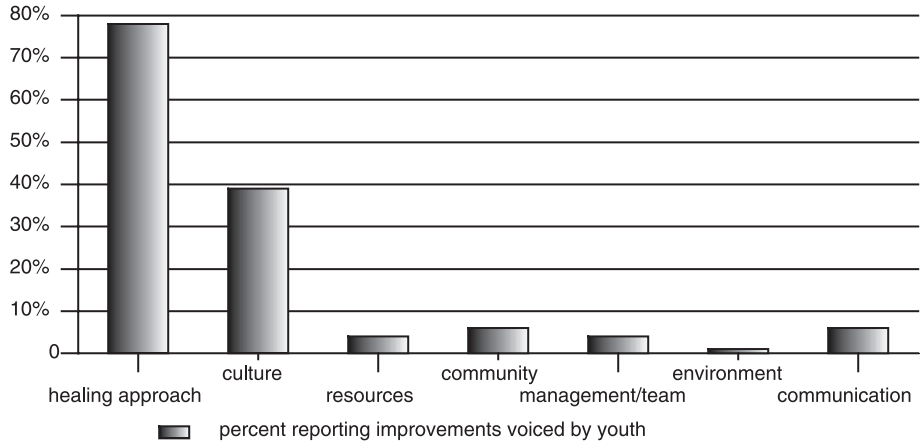


Figure K.6) Women's Priorities

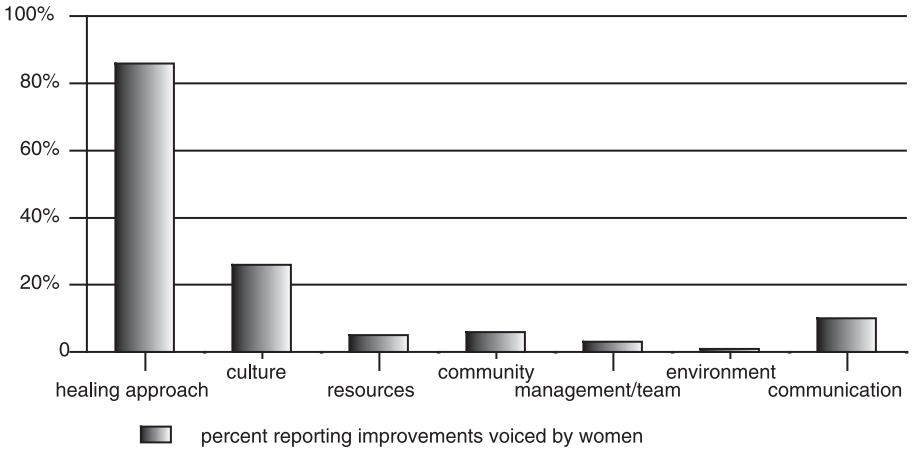


Figure K.7) Gay/Lesbian Priorities

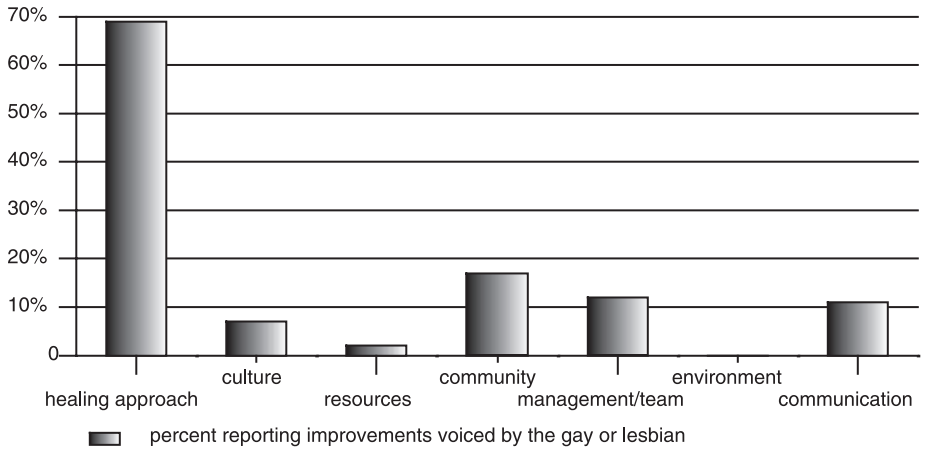
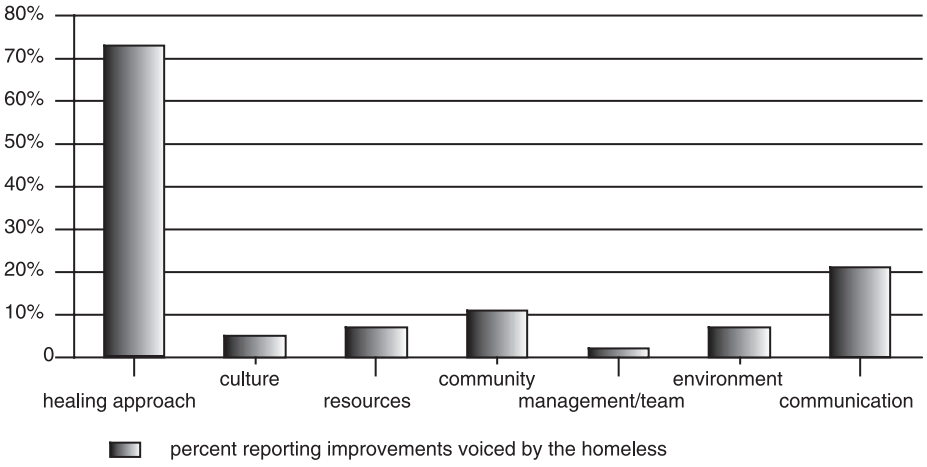


Figure K.8) Priorities of the Homeless



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