Final Report of the Aboriginal Healing Foundation

Volume II
Measuring Progress: Program Evaluation

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Published by:
Aboriginal Healing Foundation
75 Albert Street, Suite 801, Ottawa, Ontario K1P 5E7
Phone: (613) 237-4441
Toll-free: (888) 725-8886
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E-mail: programs@ahf.ca
Website: www.ahf.ca

Design & Production:
Anishinabe Printing (Kitigan-Zibi)
Kanatiio Communications (Kanesatake)

Reprinted by:
Anishinabe Printing (Kitigan-Zibi)

ISBN 1-897285-23-X

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Final Report of the Aboriginal Healing Foundation

Volume II

Measuring Progress: Program Evaluation

Prepared by

Kishk Anaquot Health Research

2006

Schubenacadie Indian Residential School
Photo: Library and Archives Canada

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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.

Aboriginal people or Aboriginal - includes Métis, Inuit and First Nations, regardless of where they live in Canada and regardless of whether they are "registered" under the *Indian Act* of Canada.

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 or promising practices - models, approaches, techniques and initiatives that are based on Aboriginal experiences; that feel right to Survivors and their families; and that result in positive changes in people's lives.

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

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

Community support coordinator (CSC) - Aboriginal Healing Foundation (AHF) regional staff whose role is to provide advice at the program development proposal level; put communities in touch with other communities doing similar work; support applicants in setting up links and partnerships; and provide information on AHF program materials or research, services, programs and other funding sources already in existence.

Efficacy - the power to produce a result; efficiency or competence.

Genogram - a technique used to identify and increase understanding of the impacts of intergenerational trauma and often used in conjunction with psychodrama.

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

Healing Approaches:

Alternative - approaches incorporating all those strategies outside of most regulated and provincially insured Western therapies and include, but are not limited to, homeopathy, naturopathy, aromatherapy, reflexology, massage therapy, acupuncture, acupressure, Reiki, neurolinguistic programming and bioenergy work;

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

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

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

Holistic healing - healing of the mind, body, spirit and emotions.

Individual healing - is focussed upon personal growth and not community development.

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

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

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

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) - refers to the number of responses received on a survey question.

Outcome - intended or unintended *result.*

Output - product or service delivered.

Pivotal - vitally important, crucial.

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.

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

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

Residential schools - the residential school system in Canada attended by Aboriginal students. This may include industrial schools, boarding schools, homes for students, hostels, billets, residential schools, residential schools with a majority of day students or a combination of any of the above.

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

Survivor - means an Aboriginal person who attended and survived the residential school system.

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

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

Univariate - characterized by or depending on only one variable.

Photo: Fred Cattroll

Introduction

This volume is the consolidation of a series of annual evaluation reports, examining both process and impact, published over the period 2001 to 2003. The first report, *An Interim Evaluation Report of Aboriginal Healing Foundation Program Activity* (2001), focussed on the formative stages of the Aboriginal Healing Foundation's work (hereinafter referred to as the AHF). The second report, *Journey and Balance: Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity* (2002), concentrated on the attainment of desired short-term results. The *Third Interim Evaluation Report of the Aboriginal Healing Foundation Program Activity* (2003) was a blend of both process and impact evaluation, with the primary intent to highlight new information as well as reinforce a question-driven framework for the evaluation.

1.1 Background

1.1.1 The Need for Healing from Residential Schools

Residential schooling for Aboriginal children was a favoured approach to "civilizing" the original inhabitants of Canada from the 1830s, on the initiative of Christian missionaries. The residential school system was introduced as Canadian government policy, following a report in 1879 on the working of industrial schools in the United States by Nicholas Flood Davin under a commission from then Prime Minister Sir John A. MacDonald.

Residential schools operated as a joint partnership between the government of Canada and church entities, primarily the Roman Catholic, Anglican, Methodist (United) and Presbyterian churches. Residential schools were also operated by the Mennonite and Baptist churches and the Salvation Army. These schools operated with the explicit intent of Aboriginal cultural extinction. As stated by Prime Minister John A. Macdonald: "The great aim of our legislation has been to do away with the tribal system and to assimilate the Indian people in all respects with the other inhabitants of the dominion, as speedily as they are fit for the change."[1] Aboriginal people were forbidden from using their language, interacting with opposite sex siblings, and having warm familial connections to parents and grandparents, which meant that important cultural and psychological influences were stripped from young lives. The austere, institutionalized setting where generations of children were raised often extended no nurturing, personal liberty, privacy or safety that, in turn, left generations of young Aboriginal people ill equipped for families of their own.

Recognition that the experience of residential schooling had long-lasting damaging effects on Aboriginal children has emerged slowly in the consciousness of Canadians. Aboriginal people themselves, in many cases, have been unaware of the connection between the deprivation, humiliation and violence that they experienced in residential schools and subsequent challenges to their physical, social, emotional and spiritual well-being. Stories of isolation from family, hunger, and harsh discipline from teachers and supervisors, had circulated within families, sometimes interspersed with tales of resistance.

Although the schools are often referred to as Indian residential schools, Métis children were recruited to fill places in them throughout their history. From 1955 to 1970, residential schools and hostels for Inuit students were operated in the North under federal authority. Before 1955, Anglican and Roman Catholic churches in the Arctic operated residential schools with federal subsidies. After 1970, schools came under the authority of the government of the Northwest Territories. In 1969, the Government of Canada ended

its partnership with the churches in the management of residential schools and adopted a policy aimed at dismantling the system.[2] Between the 1800s and the 1990s, over 130 church-run residences, industrial and boarding schools and northern hostels existed at one time or another, the number peaking at 80 in 1931.[3] The last federally run residential school closed in 1996.[4]

Until the 1980s, a veil of silence concealed thousands of stories of residential school Survivors. There were the uncounted numbers of students who died shortly after discharge from the schools in poor health or who were buried on school grounds, victims of malnutrition and disease. There were others who sought to deny their Aboriginal roots as best they could, becoming lost in unfriendly cities or forming families in which they never spoke of the past. And there were those who emerged from the schools carrying an intolerable burden of anger and shame and disconnection from society. In the final decades of the twentieth century, the silence of residential school Survivors was broken and the link between early abuse and later distress was acknowledged in public discourse. More recently, Aboriginal people have recognized the relationship between the intergenerational impacts of residential schools and cycles of abuse.

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 (intergenerational impacts) of such unresolved trauma is obvious when the next generation defends itself by coping in the same way. Breaking the cycle of abuse is essential to Aboriginal people in dealing with pressing social issues and for Aboriginal communities to be healthy places where children are raised with love. The AHF's mission and vision is stopping the abuse and helping families to learn and support their own well-being.

1.1.2 The Aboriginal Healing Foundation

The AHF is a federally funded, Aboriginal-run, not-for-profit corporation that was created on 31 March 1998 to support community-based healing initiatives of Métis, Inuit and First Nation people on- and off-reserve who were directly or intergenerationally affected by physical and sexual abuse in residential schools. The AHF is a cornerstone of *Gathering Strength—Canada's Aboriginal Action Plan* (announced on 7 January 1998), a government of Canada strategy to initiate the process of reconciliation and renewal with Aboriginal people. The mission is to encourage and support Aboriginal people (i.e., youth, Elders, gay/lesbian, women, the incarcerated, etc.) in building and reinforcing sustainable healing processes that address the legacy of physical abuse and sexual abuse in the residential school system (hereinafter referred to as the Legacy), including intergenerational impacts. The AHF's approach views Aboriginal people as key agents of change and builds on their strengths and capabilities to heal. The ultimate goal is:

> [O]ne 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.[5]

1.1.2.1 Activities

Initially, a wide range of eligibility for funding existed under the program themes of healing, restoring balance, developing and enhancing Aboriginal capacity, honour and history. Early in the process, a greater

investment in needs assessment, program development and set up were made. This approach allowed communities to start addressing the Legacy at its outer layers. As the AHF evolved, support was more sharply targeted to fund those projects that could optimize impact on the community, ensure sustainability, as well as address the healing needs of those who suffer most from physical and sexual abuse through the use of safe healing practices. The project types eligible for funding are presented in Table 1.

Table 1) Project Types Funded by the Aboriginal Healing Foundation

Healing Services	provide direct healing services through either traditional or Western approaches; focussed either on the community, family or individual; and meet the ethical standards of therapeutic care and community-based healing
Prevention/Awareness	activities aimed at raising awareness of the Legacy, early detection and prevention of the effects of abuse
Conference	gatherings that include speakers, sessions and participants from a wide geographic area
Honouring History	memorials, genealogy and other projects related to remembrance
Training	providing instruction or specialized education for potential healers and curriculum development to build sustainable capacity for the healing process
Knowledge-Building	research in program design and capacity building
Needs Assessment	assessing the healing needs of the community
Project Design and Setup	projects that only address start-up and have not initiated the provision of other services

These project types are not to be construed as mutually exclusive; rather, they are offered to bring more specificity, clarity and organization to a continuum of supported activity.

The AHF designed strategic approaches to deal with the many challenges that arose since its inception. When it was established in 1998, the AHF faced the challenges of establishing a process to fund community-based healing projects that address the Legacy on the basis of quality, capability and equity. In addition to developing this process, the AHF faced the complexity and enormity of unawareness and resistance in many Aboriginal communities; building a knowledge base related to healing the Legacy; educating the Canadian public; and the confusion associated with healing and compensation. To meet these challenges, the AHF developed strategic approaches that fostered access to funding and responded to the healing needs expressed by communities. For the first year only, AHF instituted a Project Development Assistance (PDA) program that provided funding to communities to help them develop relevant and workable project proposals. In the early days of the process, the AHF also hired community support coordinators (CSCs), who held workshops across the country to explain the funding process to Survivors and community groups. This program was phased out in August 2003 with the exception of the North, where there is one CSC

available to Inuit communities.

The AHF also initiated regional gatherings in an effort to be accountable to Aboriginal communities. Twenty-seven regional gatherings have been held across the country to hear the concerns of Aboriginal communities and to report upon the activities and finances of the AHF. In response to three impact evaluations and the expressed needs of Survivors, communities and projects, the AHF processes of application and monitoring have been streamlined over the years, and the funding priorities have been continually refined. In six years, the AHF has published three application handbooks, each of which was more understandable and focussed with respect to funding priorities that emerged from three national surveys, 13 case studies and other research undertaken for evaluation purposes that established timely funding priorities.

1.1.2.2 Anticipated Outcomes

The underlying assumption is that funded activities will create experiences that will address the healing needs of Survivors who attended residential schools and the intergenerationally impacted, and will lead to:

- increased understanding and awareness of the Legacy, as well as Survivors' healing issues and needs;
- increased capacity of Aboriginal people to engage in the healing arts/professions;
- strengthened positive ties between those suffering from the Legacy and those in a position to heal;
- more strategic planning with a focus on healing;
- increased documentation and publication of the history, increased honour for those who have suffered; and
- enhanced healing, which is broadly defined as a reclamation of all that was lost caused by the effects of attending residential school.

In turn, these short-term outcomes are believed to create conditions that will facilitate *sustainable* healing activities and end the intergenerational cycle of physical, sexual and other forms of abuse. The logical relationship between activities, outcomes and long-term goals is illustrated in Figure 1.

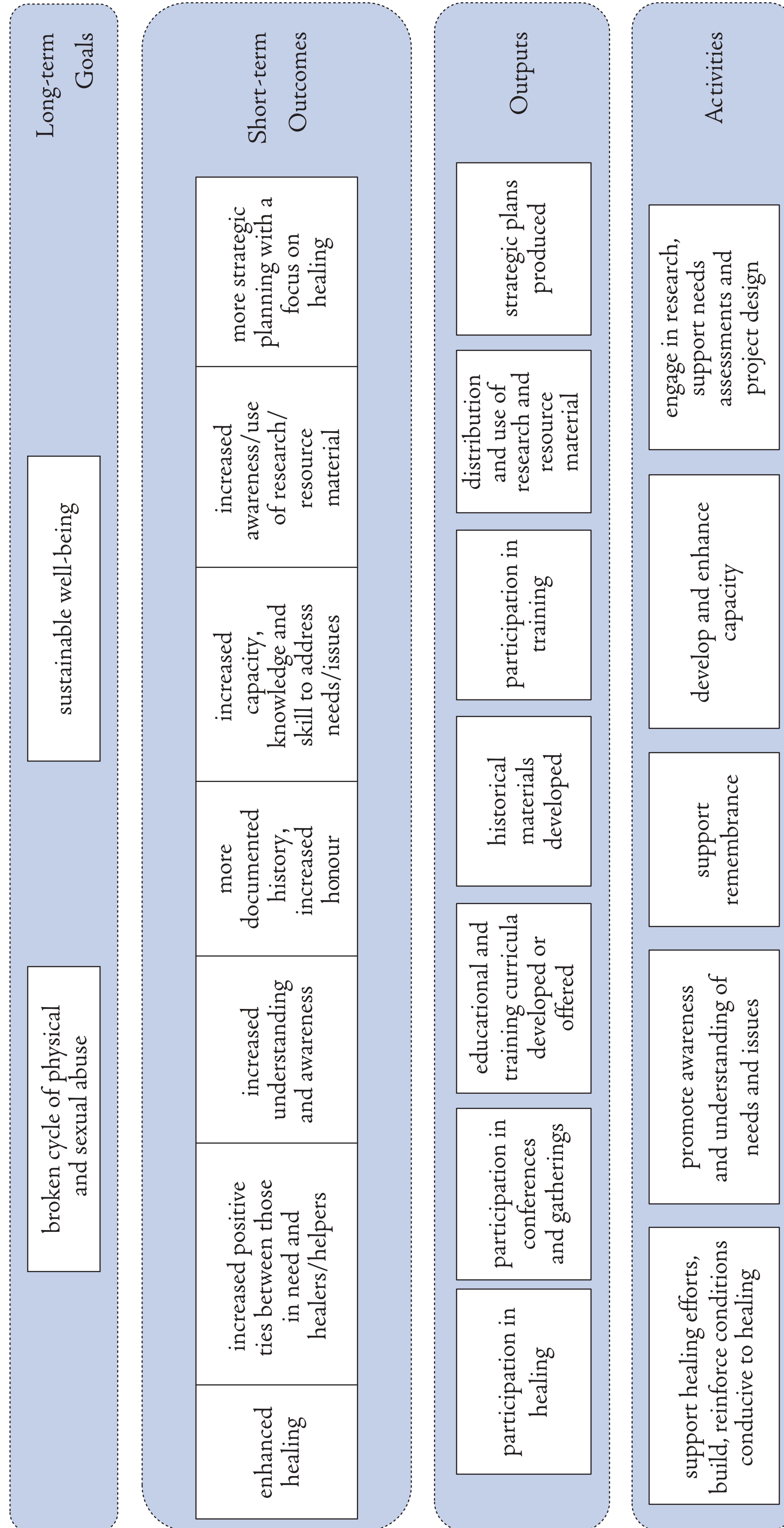
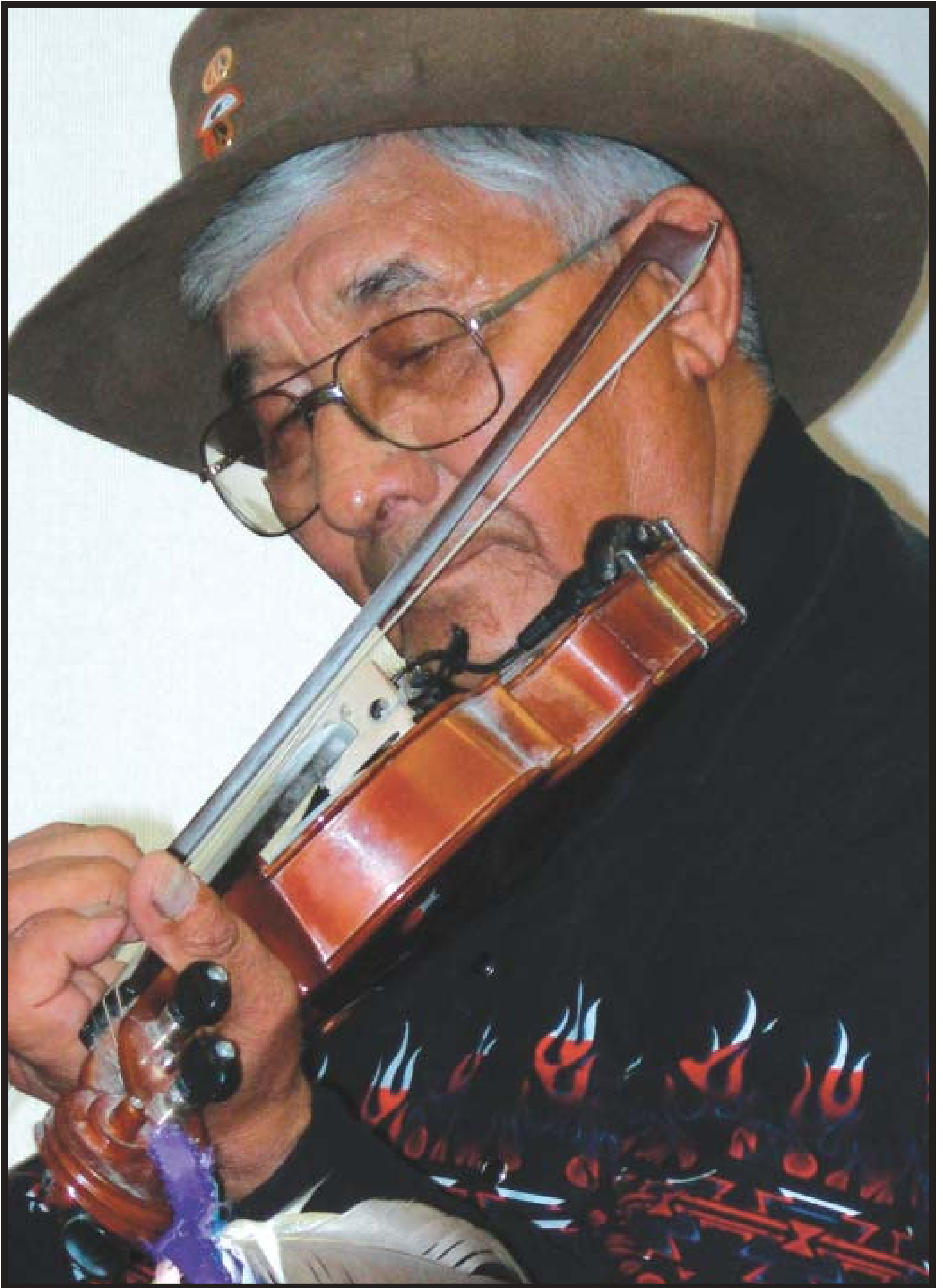


Figure 1) The Aboriginal Healing Foundation Logic Model



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The Evaluation

2.1 Conceptual Issues

At the outset, it is important to be clear that this volume describes the AHF's *program*[6] evaluation efforts as a way of being accountable to primary stakeholders; namely, those affected by the Legacy (i.e., Survivors, their families and communities), partners, supporters, and funders—including the government of Canada—who have an interest in the realization of desired goals. Other primary purposes are to determine the AHF's contribution to the attainment of *immediate* goals and objectives, offer insight to decision makers and information users, and to share the learning and experience of those addressing the Legacy. Table 2 illustrates the key features of the blended evaluation approach used.

Table 2) Five Approaches to Evaluation[7]

Approach	Emphasis	Focussing 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-focussed	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		Which people have a stake in the program and what are their points of view?	Counsellor/ facilitator	

Dialogue with project teams and Survivors has been used to produce knowledge, guide action and assess the effort's worth, while improving motivation and capacity to manage for results.

Political considerations include the fact that the AHF is an independent Aboriginal entity, operated and administered by Aboriginal people, and represents public recognition of the institutional trauma and the intergenerational aftereffects resulting from the internment of Aboriginal children in residential schools. The AHF Research and Evaluation Committee oversaw the work of the evaluation team, which included an external national facilitator. Kishk Anaquot Health Research was contracted to do the evaluation since it specializes in "decolonizing" evaluation practice by balancing the need for confidence with tactics that are, first and foremost, accountable to Survivors and their families, along with other internal moral authorities in which qualitative information features prominently. Unfortunately, the evaluation was not conducted in the Aboriginal language of choice; however, a popular version of the report will be prepared. Resources for the evaluation included joint efforts of external facilitators and AHF staff. It is anticipated that this report will be judged by the extent to which it offers communities a voice and shares considerations for future direction in addressing the Legacy. The primary evaluation questions are presented in Table 3.

Table 3) Primary Evaluation Questions

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

These questions have been framed to determine what have been the most immediate impacts of AHF-funded effort. The assessment of long-term impact is inappropriate at this stage of the initiative.

2.2 Technical Issues

Methods of inquiry included record review, national surveys, one-to-one telephone interviews, focus groups, case studies and direct assessments.

Record Review

In 2000, a sample of 36 AHF-funded project files were randomly selected, which included two Inuit and one Métis project to ensure fair representation (see Appendix A for a complete listing of project files reviewed). Information was drawn from the files according to a predetermined format essentially designed to answer primary evaluation questions (see Appendix B), as well as determine what information was readily available. More specifically, information was culled for evidence of impact, promising practices, target group characteristics, challenges, lessons learned, evaluation strategies, quotations, recommendations and capacity building efforts. In addition, minutes prepared for 27 gatherings were also reviewed to isolate common issues and concerns. In total, there were 2,537 attendees at these gatherings who responded to an open invitation through advertisements in newspapers and on radio. Invitations were also delivered by mail and facsimile with a follow-up telephone call. At last, information was drawn from AHF databases to profile the distribution of financial resources by project type, target group and geographic location.

National Survey

Once the initial record review of 36 project files was complete, a mail-out survey was developed to address information gaps. The first version of the national survey was piloted in six sites and revised according to the feedback received. The second version of the survey was modified to capture impact information without success,[8] while the third version was significantly reduced to focus on key variables, namely:

- participation in healing and training by target;
- geographic circumstance;
- team composition;
- special and outstanding needs;
- partnerships;
- Survivor involvement; and
- sustainability.

Three national surveys were sent to operational organizations in English and French with follow-up phone contact to encourage response. The first national survey (sent January 2001 for the year 2000) was mailed to 344 active agreements within 274 organizations. A total of 208 surveys from 195 organizations were received. However, cases were weighted to account for missing data from organizations with more than one grant. With weighting, the response rate increases to 253 or 74 per cent. The second national survey (December 2002) was mailed to 384 organizations with active agreements who were asked to complete a single survey and include information for all their active agreements at the time; there were 176 responses. The third national survey (August 2004) was mailed to 447 organizations with contribution agreements ending on or after 31 March 2004, and again were asked to complete a single survey to represent all simultaneous agreements. A total of 209 responses were received. All three versions of the national surveys are included in Appendix C and the geographic distribution of the self-selected sample is depicted in Figure 2. (A map of all funded locations is shown in Figure 3.)

Figure 2) Organizations Who Have Returned an AHF Survey, 2001 - 2004

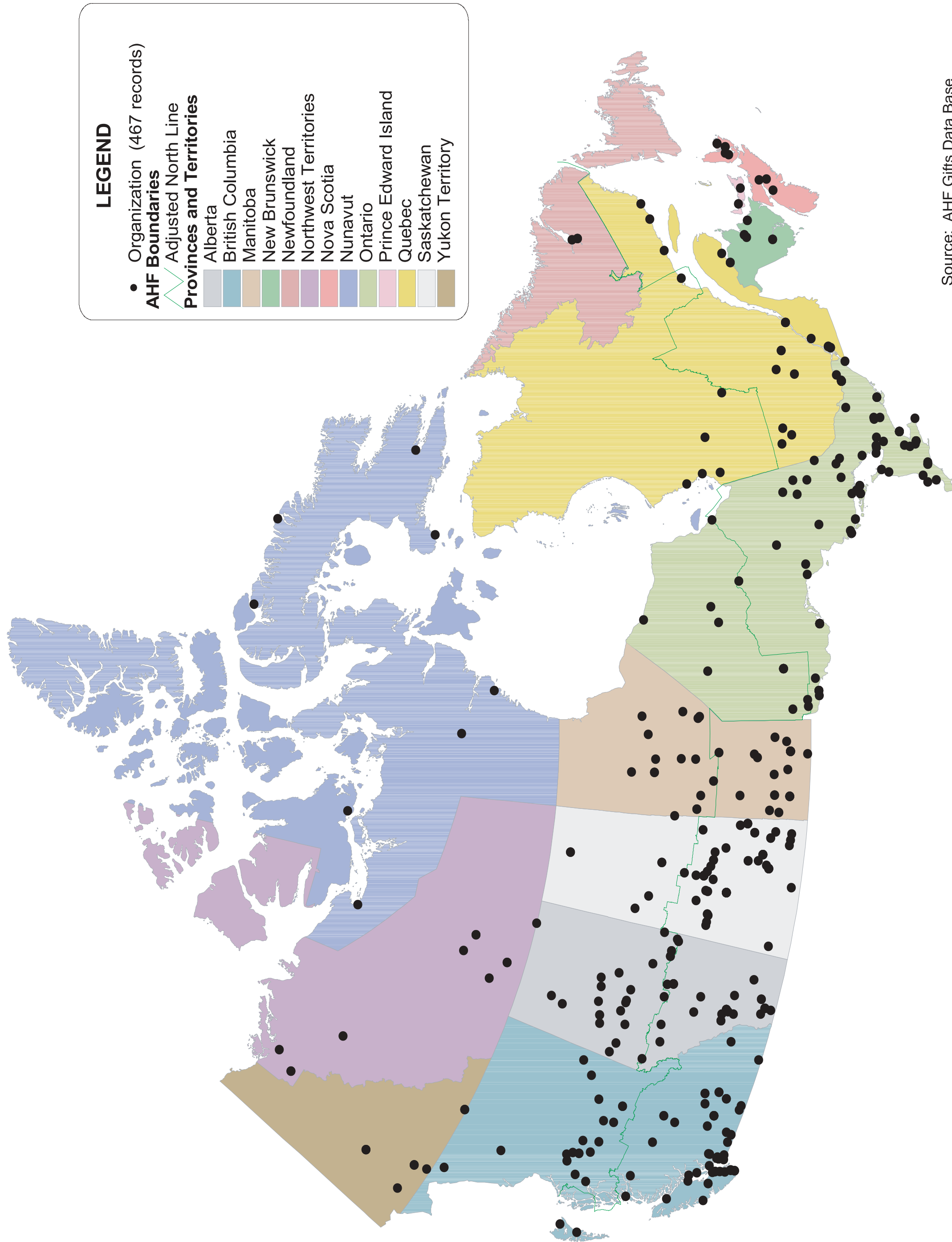
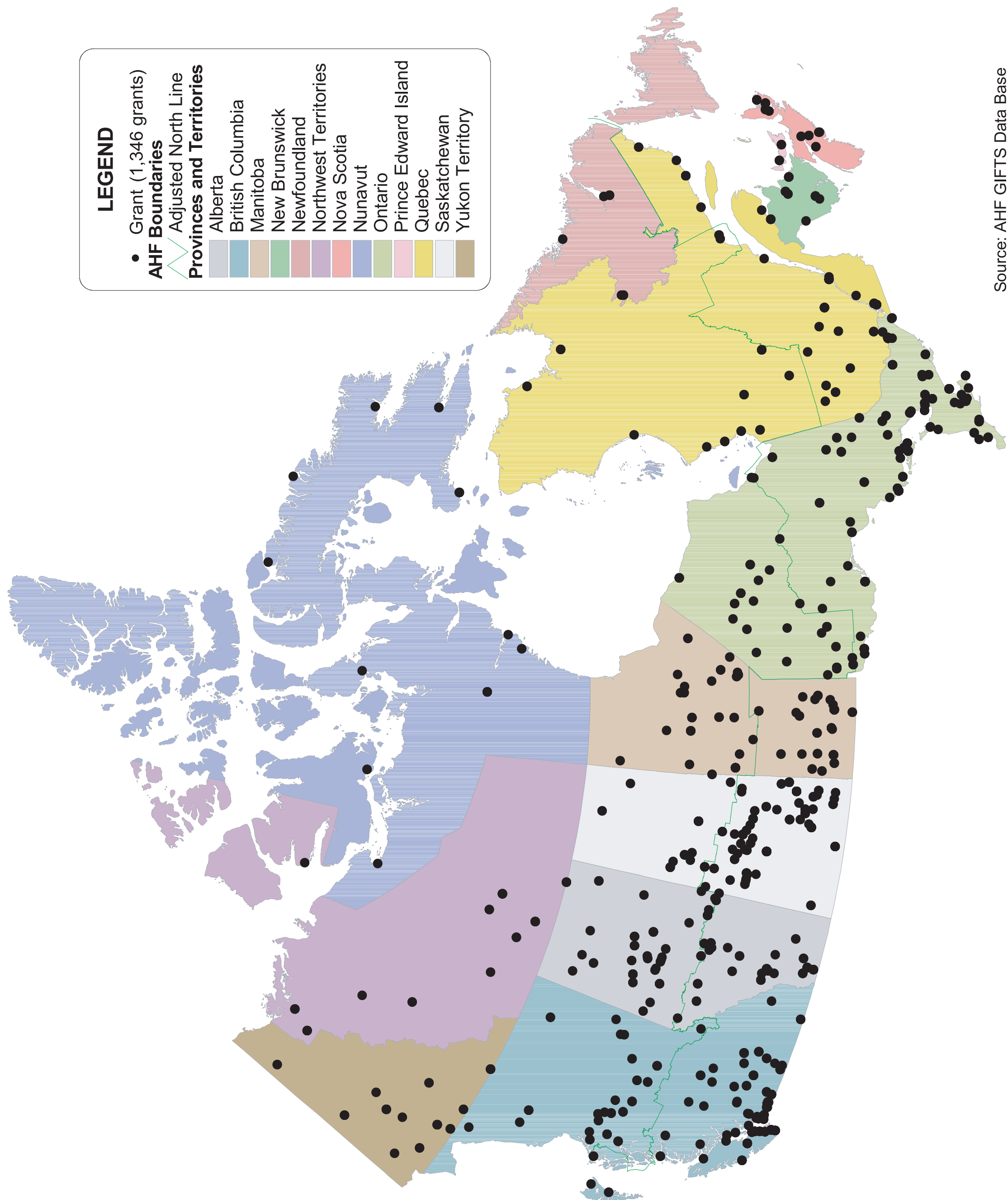


Figure 3) Approved Grants, June 1999 - March 2005



One-to-One Telephone Interviews

One-to-one telephone interviews with AHF board members and personnel, who were selected based on their intimate knowledge of community-based activity, were conducted. The national interview schedule was designed to gather opinions about the distribution of resources, outstanding needs, lessons learned, challenges and recommendations. The interview questionnaire is included in Appendix D.

Focus Groups

A purposeful sampling strategy was used for five national focus groups with "promising"[9] projects, including one national gathering. The teams were provided with a summary of learning to date related to healer qualities, therapeutic approaches, readiness to heal, and community indicators of change. They were then questioned for further details about each area of interest to isolate trends and uniqueness. The framework for discussion in the national focus groups is presented in Appendix E.

Case Study

Case studies were used to assess the impact of AHF-funded activity, since many varied strategies to address the Legacy were supported.[10] A maximum variation sampling strategy was used to ensure that cases selected would include representation from all Aboriginal groups, special need categories, and communities that varied in geographic remoteness and infrastructure, as well as a full range of project types. Table 4 gives a description for each project selected for the case studies. The project selection criteria and the case study summaries are presented in Appendix F.

Data was collected and reports drafted by the community support coordinators (CSCs) of the AHF who conducted one site visit for each case study to gather information through direct observations, individual interviews with local stakeholders, and requests to local police and other human service agencies for social indicators when accessible.

Table 4) Case Study Project Descriptions

Organization / Project	Description	Community	Target Group
Hamlet of Cape Dorset (now Municipality of Cape Dorset) / Healing & Harmony in Our Families	Healing and training a core group of community caregivers	**Cape Dorset**, Nunavut: 1,200 (remote)	Inuit
Urban Native Youth Association / Two-Spirited Youth Project	Peer support and healing activities for gay, lesbian, bisexual and trans-gendered youth	**Vancouver**, BC (urban)	gay/lesbian youth
George Manuel Institute/Neskonlith Indian Band / Honouring Survivors Theatrical Production (Every Warrior's Song)	Researching, writing, and delivering a play that honours Survivors and addresses the legacy of physical and sexual abuse in residential schools	**Chase**, BC: performances throughout region (rural)	Aboriginal, primarily First Nations
Tsow-Tun Le Lum Society / Qul-Aun Program	In-patient healing centre based on a blend of traditional healing and centralized residential care	**BC** (province-wide); healing centre on Nanoose First Nation: 151 (Vancouver Island)	Aboriginal, primarily First Nations
Shining Mountains Living Community Services / Tawow Healing Home	Culturally-based, non-mandated therapeutic home for children/ adolescents and their families at risk of involvement with protective services	**Red Deer**, Alberta: 68,308 (urban)	First Nations, Métis
Building a Nation, Life Skills Training Inc. (now Building A Nation, Inc.) / Healing the Multi-generational Effects of Residential School Placement - Urban Access Program	Training for beneficiaries to better manage crisis, cross-cultural training, Legacy education, healing services and adjunct services (e.g., client advocacy and support related to child custody, justice and social service, housing, life skills)	**Saskatoon,** Saskatchewan: 200,000; Aboriginal population: 30,000 (urban)	Urban Aboriginal people
Willow Bunch Métis Local #17 / Willow Bunch Healing Project	Activities to increase awareness of Métis history and pride in being Métis	**Willow Bunch**, Saskatchewan: 400 (rural)	Métis
Kikinahk Friendship Centre Inc. / Kikinahk Parenting Program	Parenting skills program combining traditional and Western models and approaches	**La Ronge**, Saskatchewan: 7,000 (rural)	First Nations, Métis
Nelson House Medicine Lodge Inc./ Pisimweyapiy Counselling Centre	Nine-week, community-based out-patient program for Survivors and their families	**Nisichawayasihk Cree Nation**, Northern Manitoba (rural)	Aboriginal, primarily First Nations
Centre for Indigenous Sovereignty/ I da wa da di	Healing circles, fasting and healing retreats for Aboriginal women; training workshops for service providers who work with Survivors	**Ontario**-wide, host organization in Toronto, healing centre in Six Nations	Aboriginal women
Odawa Native Fridenship Centre / When Justice Heals	An urban alternative justice project that incorporates healing and sentencing circles	**Ottawa,** Ontario: 875,100; Aboriginal population: 35,000 (urban)	Aboriginal
Conseil de la Nation Atikamekw Inc. / Koskikiwetan	Training of community workers and counsellor, establishment of a support network, Legacy education and land-based healing activities	**Opitciwan, Wemotaci, Manawan,** Quebec: Atikamekw Nation	Primarily First Nations, on- and off-reserve, but includes non-status Indians, Métis, Inuit and non-Aboriginal family members
Big Cove First Nation /Our Youth, the Voice of the Future (Big Cove Youth Initiative)	Activities to support the personal, social, mental and physical well-being of youth	**Big Cove**, NB: 2,458 (rural)	First Nation youth

Direct Assessment

Because short-term impact is probably most evident in individual lives, a more discriminating approach to measuring change was attempted through the development of an individual participant questionnaire (IPQ) (see Appendix G). This questionnaire was adapted from a tool developed by the clinical team in collaboration with residential school Survivors working with the Qul-Aun Program at the Tsow-Tun Le Lum Society, a residential treatment centre in Lantzville, British Columbia. Most adaptations were included to reflect the unique healing goals of AHF-funded activity and to isolate the successes and challenges of selected therapeutic approaches. More specifically, the IPQ captured history of personal and familial experiences in residential school, nature and level of motivation for participation, history of participation in healing programs, therapeutic goals and their achievement, individual experience of the therapeutic environment, extent of external support, skills acquisition and service preferences. A total of 384 IPQs were sent to all grant recipients (December 2002) who were asked to reproduce and distribute them to willing participants as needed. Participants were given the choice of returning the IPQs directly to the AHF or submitting them to project teams to be returned in bulk by the coordinator. From December 2002 to June 2004, 1,479 IPQs were received and analyzed for this volume.

The types of data collected, their source and methods of collection are profiled in Appendix H.

2.2.1 Analysis and Design

A content analysis of the open-ended responses, interviews and the documents contained in project files was conducted. While the process of data analysis was largely inductive (e.g., themes, patterns and categories emerging from the data), some themes (or organizing principles) were also imposed by the evaluation questions. In particular, qualitative information was examined for impact on individuals and communities, as well as issues related to sustainability, partnerships, meeting the need, promising practices, challenges and lessons learned. Numerical and categorical data resulting from the national surveys and IPQs were analyzed using the Statistical Package for the Social Sciences (SPSS version 10), and univariate analyses included frequencies, sums, ranges, averages and medians. Cross-tabulations were done to answer specific questions about participation and impact and extrapolations were calculated to determine population estimates. While comparisons would have been valuable, the AHF is on an unprecedented course of supporting Aboriginal communities to heal from institutional trauma; thus, many initiatives (e.g., substance abuse treatment or family violence counselling) seemed conceptually ill-suited for comparison. Instead, evaluation resources have been concentrated to ensure a restorative and capacity building exercise.

Initially, "a within groups repeated measures design"[11] was selected for the impact evaluation to allow for comparisons over time; however, with a rapidly approaching AHF sunset, a repeated measures design was no longer feasible and case studies were redesigned as "post-test only" or one-time only measurement. Selected social indicators to be used for impact analysis initially included rates of physical and sexual abuse, incarceration, suicide and children in care. Deemed insufficiently discriminating, these indices were substituted as signs of intermediate community change by the following:

- Survivor action and involvement;
- the establishment of partnerships and sustainability;
- the existence of *appropriate* services for Survivors and their connection to them;
- general understanding and awareness of the Legacy's impact;
- community-based team capacity to address the Legacy's impact;
- evidence suggesting healing (e.g., changes in participation, disclosure rates, and community cohesion to support healing); and
- intent to continue healing efforts made obvious by community plans or visions.

Over time, it also became clear that the most sensitive way to assess change in the immediate-term was to directly assess individual participants. The development and distribution of the IPQ allowed project teams to collect information directly from their participants; thus, the units of analysis included both *communities* and *individuals*.

2.2.2 Data Quality, Accuracy and Limitations

Attempts to ensure data quality and accuracy included securing information that was relevant and triangulating[12] sources and methods. Surveys and individual participant questionnaires were self-report instruments heavily reliant upon the abilities and willingness of respondents to engage. Although no training was offered in the administration of national surveys and IPQs, reference guides were developed and distributed to clarify outstanding questions and to facilitate accurate self-reports. Some individuals may have had help from project teams to complete the IPQs and teams were directed to call AHF Research if they had outstanding questions. All surveys, interview schedules and IPQs were reliant upon face validity and no tests were done to measure reliability. While the IPQ is not a standardized instrument, it is clear that no psychometrically evaluated instrument exists to assess cognitive or behavioural indices of healing from the Legacy (institutional trauma) for Aboriginal people. Other standardized tools, while arguably relevant, have not been normalized for a North American Indigenous population. Although the first national survey was piloted, all other instruments were not due to time constraints. This may have caused the apparent misunderstanding of some questions that resulted in some lost data.

Attempts to secure all evidence, both positive and negative, were limited to information obtained through national surveys and IPQs. While it is clear that some are not achieving the same level of personal satisfaction from their participation, time and resource limitations have prevented in-depth exploration of this group. Although immediate satisfaction and goal achievement are clear in the majority, it is not clear what the long-term consequences are or if AHF-funded projects create enduring change in their participants. In short, the most important information missing is the *longer* term follow-up of participants' progress. Similarly, the identified weakness in sample selection is that duration of participation was not considered, meaning that a minimum or maximum amount of time for more enduring impact is more difficult to determine.

Quantitative information included national surveys, IPQ data and the AHF's internal records. National survey response rates ranged from 74 per cent in 2001 to 46 per cent in 2004. When examining respondents to nonrespondents, there were discernible differences on a number of variables, including organization type, region, ethnicity, year grant was made, grant amount and project type; therefore, extrapolations are to be viewed with caution and considered rough estimates of the population. The number of IPQ respondents (n=1,479) remains a very small, self-selected sample with a dominant First Nations perspective; however,

the strength of the sample is directly related to the fact that these voices have been drawn from, at least, 143 different organizations representing a variety of project types in diverse communities. Still, there is a noted dominance of First Nation voice in both the participant and survey samples, meaning that the unique issues and needs of Métis and Inuit groups require further scrutiny.

With respect to project files, it is important to note that they tended to focus more on positive aspects than on the negative. There was also wide variability in the detail and sophistication in these reports; some refer to the use of standardized instruments, external evaluations or raw data, but few included their reports or aggregate information. Many projects either were not able to do the evaluation as planned or believed their project monitoring reports were adequate to meet evaluation requirements. Although many report progress related to activities and products, very few are reporting the desired change that may have resulted from their activity.

Several field guides and training sessions were offered to the community support coordinators (CSCs) before embarking upon case studies in order to reduce bias and ensure conformity in methods, thereby enhancing reliability. Respondents were encouraged to answer honestly—even if their comments would cause controversy—in at least two introductory remarks preceding interview questions to reduce bias. Multiple evaluators were not available within resource limitations; however, case study analysis done internally by CSCs was verified by an external evaluator that may have reduced bias. Half the time, the CSC role as a public relations and support arm of the AHF allowed for extended and multiple contacts with informants before the evaluation, which helped to increase familiarity and comfort in the data collection phase. CSCs were reliant on information that was most readily available. In addition, because direct assessment was problematic for AHF personnel, the perceptions of key informants were weighted heavily in case studies.

Lastly, the statements and findings reported here will speak to the contribution[13] that the AHF has made to addressing the legacy of physical and sexual abuse arising from residential schools. This report will provide users and decision makers with guidance for developing programs that work better and feel right based upon what are "plausible associations"[14] between activities and outcomes. The process is concentrated upon meeting the multiple goals of confidence, sharing the understanding and experience of Aboriginal-controlled efforts to address the Legacy, and bolstering Aboriginal capacity to enhance program management.[15]

Photo: Bob Mesher

Who, What, Where and When

This chapter focusses primarily on quantitative information related to process or program implementation obtained from national surveys and AHF internal databases. A core set of data (e.g., participation rates, team characteristics, partnerships and extent of outstanding need) is based upon the merger of survey information from distinct organizations over time (i.e., surveys one, two and three and, unless otherwise stated, the results reported here refer to this longitudinal and merged data set, n=467).[16] Other, more specific data (e.g., number of hours spent in healing activity or training and outstanding training needs) are replicated from either the first survey (indicated here by S1) or the second survey (identified as S2), since most information was removed from the third survey to streamline data collection efforts. In addition, because the merged survey data is based upon a sample of 467[17] distinct organizations, and more than 725 organizations have been supported by the AHF to 1 September 2004, extrapolations[18] are offered as a way of highlighting the potential impact of funded activity and are prefixed by the following denotation: [Ext:].

Because this section paints a quantitative picture of national activity, there are many numbers reported that require explanation. First, each survey question was not answered by all potential respondents; therefore, the number of respondents is indicated in parentheses (n=) where "n" is the total number of responses received for that particular survey item.[19] Second, there are *two* measures of central tendency[20] used: the average and the median. For simplicity, the average is used in many cases; however, when the *median* is vastly different from the average or when the standard deviation is high, the median or the *half-way* mark is used because it is a *better* measure of the "middle" (averages are strongly influenced by even one very high or very low figure[21]).

3.1 Who

Participant characteristics help planners to better understand needs, identify gaps, mediate the environment or restructure the program to facilitate the achievement of desired results. Since the bulk of AHF investment is in healing and training, the results are profiled to highlight these two project types. Many projects (43%, n=467) had a healing-only focus, while only a few (4%) were training only. The largest proportion (49%) provided both healing and training and a few offered neither healing or training (4%). The following sections report on the participant characteristics for these healing and training project categories only.

3.1.1 Participants

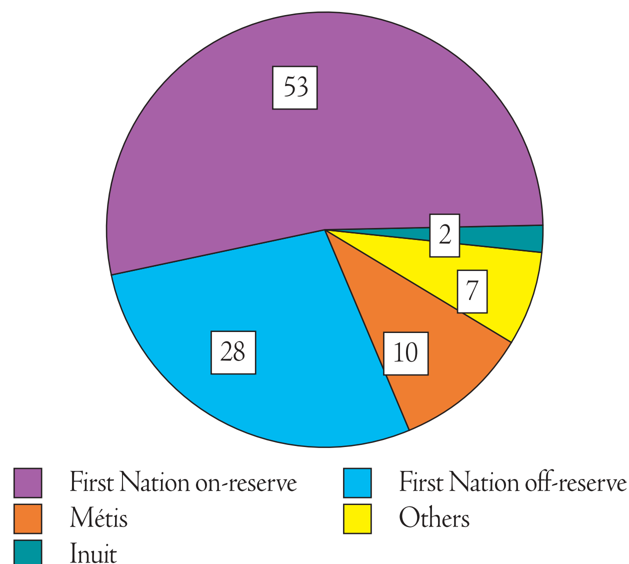
3.1.1.1 Healing Project Participation

Respondents understand healing to involve *individual* healing and *group* healing events. Individual healing involves regular or more routine participation in clinical or therapeutic contexts that focus on personal progress. Group healing events are larger community functions that promote group well-being and include feasts, socials and pow wows. While attempts were made to distinguish between individually focussed healing and group healing events, respondent ideas about healing were more inclusive.

An estimated total of 111,170 (n=394) participants with a median of 122 participants per project (average=282) attended healing activities for this set of AHF-funded projects [Ext - 204,564: n=725]. Participants spend an average of 149 hours in healing activity (median=80 hours, n=117, S2) and can

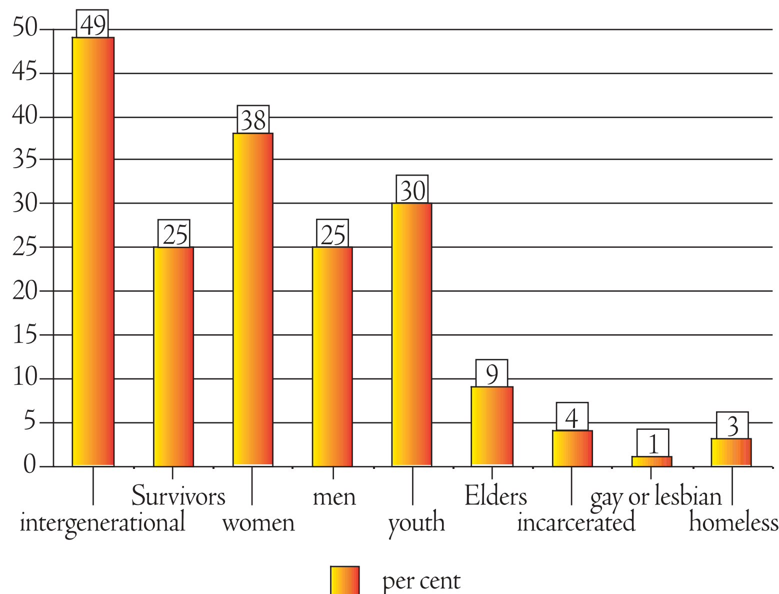
spend as little as two or as many as 1,225 hours in programmed healing activity.[22] Proportionately, the largest groups are on- and off-reserve First Nations (53% and 28%, respectively), followed by the Métis (10%), others[23] (7%) and Inuit (2%).[24] By comparison, the latest census data reveal that 62 per cent of the Aboriginal people in Canada identify as North American Indians, 30 per cent as Métis and 5 per cent as Inuit.[25]

Figure 4) Healing Participation by Aboriginal Identity (2004)[26]



When looking at the healing participation by target group, the two largest target groups appear to be the intergenerationally impacted (49%) and women (38%), followed by youth (30%), men (25%), Survivors (25%) and Elders (9%). Only a few were incarcerated, gay, lesbian or homeless (4%, 1% and 3%, respectively).[27] It is important to note that these are *not* exclusive categories. In other words, one participant can fall into many categories, such as a male Elder who is a Survivor. Figure 5 shows healing participation by target group.

Figure 5) Healing Participation by Target Group (2004)



Interesting to note is that 11,325 participants had previously participated in a similar program before they began attending AHF-funded activity (n=145). If we assume that this group refers to healing participants and consider them against the total number of healing participants identified in these same projects or 34,953 (n=138),[28] it is possible that approximately 33 per cent may have previously participated in a similar program. In other words, the data suggest there are a sizeable proportion of participants who are engaged in addressing the Legacy who have never engaged before.

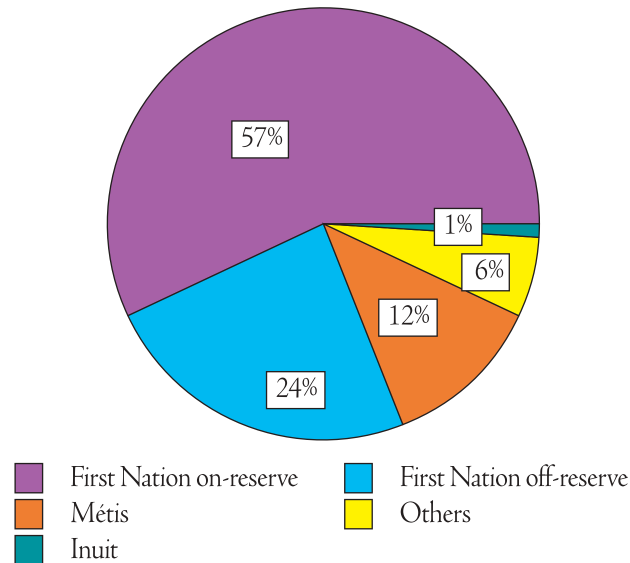
Survey respondents report that, although most participants completed their healing programs, some left prematurely because they were not "ready" to heal. Readiness was often defined by project teams as a stable commitment to sobriety and a drug-free lifestyle, as well as sufficient trust and a willingness to feel. Survey respondents also report that small community dynamics worked against some people who were initially interested, but remained unconvinced that confidentiality and safety could be guaranteed. Some began healing programs during a crisis then left when the crisis was over. Lack of child care and transportation, as well as physical illness, thwarted some participants' continued involvement. Competing responsibilities made setting aside time for healing a common struggle. A few left due to "profound philosophical differences" related to poor cultural or spiritual "fit" (e.g., Christian participants looking for an approach other than traditional spiritual practices). Some participants were asked to leave because their behaviours presented a risk to others.

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* skill acquisition. Training projects provide services to 28,133 participants (n=246; median=31.5 participants per project; average=114 [Ext - 49,095: n=429[29]]). Trainees spend an average of 193 hours in training (median=74 hours, n=92, S1). On- and off-reserve First Nation people constitute the majority of training participants

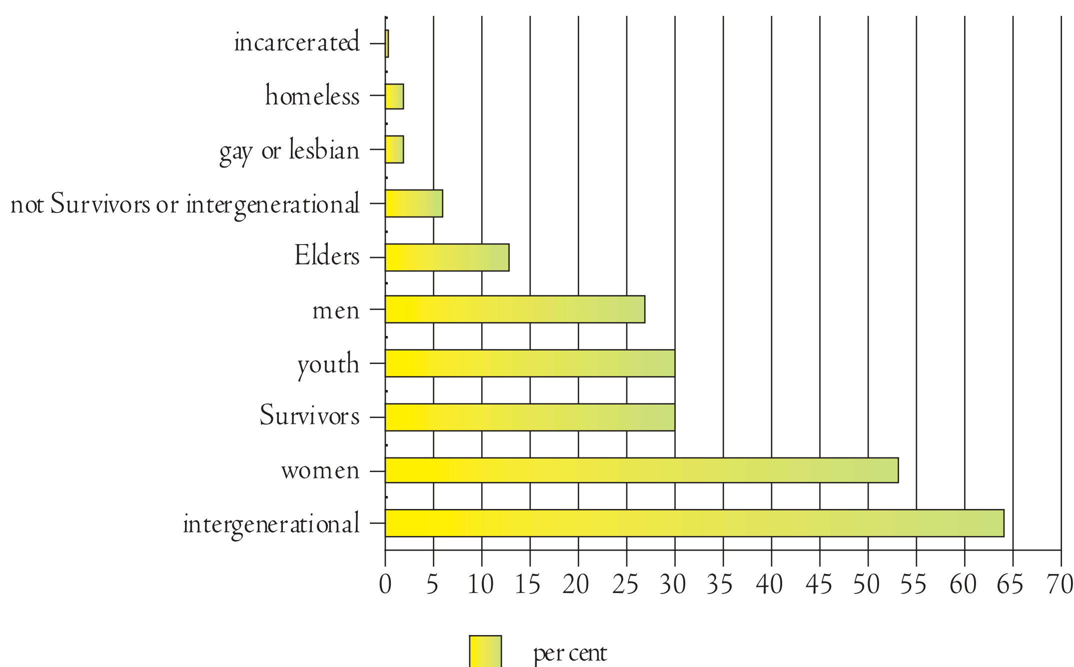
(57% and 24% respectively, n=246). The Métis composed 12 per cent, while the Inuit accounted for 1 per cent.[30] The distribution of each Aboriginal group participating in training is presented in Figure 6.

Figure 6) Training Participation by Aboriginal Identity (2004)



When looking at training participation by target group, it is clear that the intergenerationally impacted (64%, n=246) and women (53%) are well represented. Men account for just over a quarter of all training participants (27%), while Survivors compose 32 per cent. Almost a third of the training group are youth (30%) and 13 per cent are Elders. Only a few are incarcerated (3%), gay or lesbian (2%) or homeless (2%). Although there are slight changes in this distribution at different measurement periods, the relative proportions remain similar.[31] Figure 7 shows the distribution of target groups participating in training.

Figure 7) Training Participation by Target Group (2004)

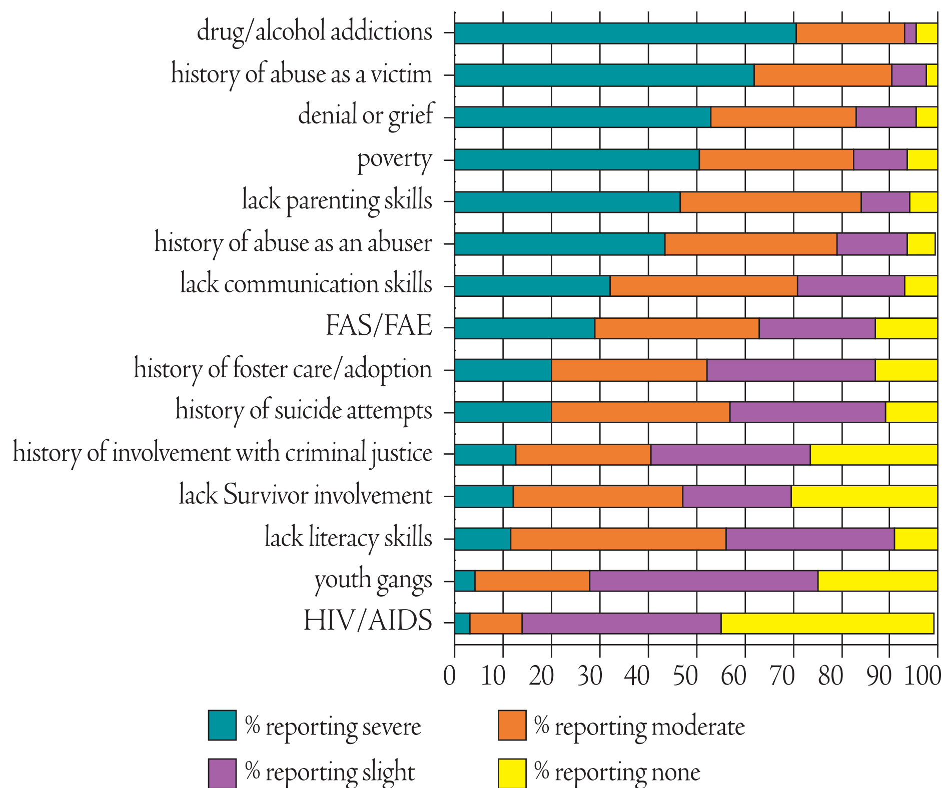


Survey respondents reported that participants withdrew from training for the following reasons: competing responsibilities related to job or family; did not feel "ready" to engage because the material re-traumatized them; or they felt unable to handle the inevitable demands resulting from their newly acquired skills. Although they were keen to learn more about addressing the effects of residential school experiences, some trainees thought they needed *personal* healing first and remained uncertain about their abilities to manage disclosures and provide general support to others in the future. Some trainees were not committed to complete the program(s), others moved away and some were incarcerated during their training period. Personal problems were regularly cited as a barrier to completing the training program(s) as trainees struggled with addictions or poor health. On rare occasions, a couple of trainees left their program(s) because of "profound philosophical differences" with the training approaches. Logistical barriers included lack of transportation, child care, inconvenient scheduling (i.e., training offered during daytime business hours) and inadequate remuneration for their participation. Finally, a few trainees were asked to leave because they did not comply with project policies.

3.1.1.3 Participant Challenges

Addictions, victimization, poverty, denial and grief are the most severe participant challenges reported by over 50 per cent of all projects. Other common challenges that were reported as severe by a sizeable group (>25%) included poor parenting skills, history of abuse as a perpetrator, poor communication skills and FAS/FAE. More than half of all respondents categorized HIV/AIDS, youth gangs, lack of literacy skills and involvement with the criminal justice system as either a slight problem or no problem. Figure 8 illustrates the extent to which participant challenges may affect project operations.

Figure 8) Participant Challenges (2004)



Healing projects identified 27,855 individuals with special needs (n=267, e.g., suffered severe trauma, inability to engage in a group, history of suicide attempt or life-threatening addiction) [Ext - 75,636: n=725]. On average, 37 per cent (median=25%, n=152, S1) of participants require greater than normal attention to deal with their special needs.[32] 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 more serious issues such as suicide, family violence and addiction (61%, n=242, S1). 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 address 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. On the positive side, a small group (3%) reported they do not have participants with a condition serious enough to require a different approach.

Respondents thought that special needs were best addressed with more individually focussed, longer term, consistent holistic treatment that included appropriate referral, aftercare and follow-up. As a way to address special needs, teams consistently cited increased service access, either through more developed local networks or service organizations. In fact, the majority (58% and 51% respectively, n=177, S2) thought that increasing access to the project team and to visiting professionals were needed. In particular, respondents called for:

- speech therapy,
- educational psychology,
- occupational therapy,
- special education,
- vision therapy,
- infant stimulation,
- addiction treatment,
- crisis shelter,
- 24/7 intervention,
- literacy programs,
- family facilities,
- couples counselling,
- play therapy,
- psychodrama,
- body work, and
- outreach (especially for the incarcerated and the intergenerationally impacted).

Many recommended that these services be designed and controlled by Aboriginal people. Cultural reinforcement, the role of cultural healers, Elders and traditional approaches were also recognized as effective ways to address special needs. One thought that more effort to encourage support for cultural practices within non-Aboriginal institutions and among their practitioners was warranted. Specific strategies and training were most commonly cited as solutions (76%, n=177, S1) to treat the special needs of offenders, adolescents and Elders; adequately respond and debrief during crisis; skilfully manage behavioural challenges; successfully resolve sexual abuse trauma; and diagnose FAS/FAE.

A few suggested that *environmental* change would bring attention to special needs. More specifically, they recommended the restoration of strong, traditional social organizations, as well as improving community conditions, so that an improved quality of life could be offered as an incentive to heal. Individual healing, they claimed, must be coupled with a broader community development approach where improvements could be measured at a variety of levels and where the "healed" individual could find opportunity and adequate housing. When this was not possible, some suggested that an opportunity to heal *outside* of the community might help, but the issue of aftercare, follow-up and long-term support would have to be addressed. Other ideas included developing a climate of trust and making available traditional lands or sacred sites as healing centres. Supportive environments would also eliminate the barriers to participation for those with a high level of need by providing child care, transportation or temporary housing for transient individuals.

3.1.1.4 Participant Selection Criteria

The majority (56%, n=164, S2) claim to be unable to accommodate all who need therapeutic healing or desire training.[33] Faced with this dilemma, teams that reported selection criteria in the second survey were most likely to select participants based on their level of need or risk and "readiness." Readiness was usually characterized as self-motivation, stability, sobriety and a demonstrated interest in, and commitment to, healing or training. Others gave Survivors and their descendants high priority, while some thought that children and youth or families with children should be first. A few had a "first come, first served" policy,

used a random approach or were pressured by the need to maintain geopolitical fairness in service access. The distribution of participant selection criteria from respondents of the first survey is depicted in Appendix I.

3.1.2 Team Characteristics and Training

AHF-funded projects reported a total of 4,833 paid employees (n=330) [Ext - 10,618: n=725]; 2,004 of which are full-time positions (i.e., working more than 30 hours per week on a regular basis) and 2,829 are part-time [Ext - 4,403 full-time: 6,215 part-time: n=725]. The average project team size was six full-time employees (median=3) and 11 part-time employees (median=4) for an average team size of about 15. In order of frequency (S2), teams were most likely to be composed of management positions,[34] Elders and other cultural teachers, resource personnel,[35] counsellors, general project team members,[36] office administration, professionals[37] and communications (see Appendix J).

Aboriginal people occupy 91 per cent of all full-time positions and 85 per cent of all part-time positions (n=160, S2). Table 5 shows the breakdown of the Aboriginal identity in full- and part-time teams.

Table 5) Aboriginal Identity of Full- and Part-time Project Teams

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

By position, 89 per cent of administrative positions, 87 per cent of healers and 84 per cent of outreach team members are occupied by Aboriginal people (n=219, S1). The greatest concentration of non-Aboriginal team members exists within project support positions and facilitation roles (making up 23% and 18%, respectively). Survivors (those who attended residential schools) occupy 32 per cent of all employee positions (n=185, S3) and the intergenerationally impacted occupy 60 per cent. Of the volunteer group, 43 per cent (n=129, S3) were Survivors while 57 per cent were intergenerationally impacted. Those on contract or who receive honoraria were almost evenly divided between Survivors (47%) and the intergenerationally impacted (44%, n=163, S3). Governance structures (board and advisory committees) are composed of 51 per cent Survivors and 43 per cent intergenerationally impacted (n=176, S3). Most of the time, Survivors are involved in hiring and team evaluation decisions (73%, n=357).

Survey findings confirmed results obtained from document review: the majority of employees were First Nations, Inuit or Métis and were directly or intergenerationally affected by experiences at residential schools. In addition, the fact that some Aboriginal employees speak their respective Indigenous languages was consistently highlighted. Although some acknowledged the value of outside expertise, less than half of the project files reviewed indicated the use of outside resources or expertise. Usually, outside expertise was drawn upon to meet client group needs when community members felt they were unable to do so or were afraid of being seen as “experts” on the issues. Further, outside expertise was deemed to be invaluable where

potential community-based healers needed therapeutic assistance themselves. Outside experts were usually contracted to write proposals, conduct needs assessments, draft final reports, offer training or undertake evaluations. Despite the practical benefits of engaging external expertise, AHF-funded project teams simultaneously resented their presence, stating that community members are better able to facilitate disclosure and that most Survivors are 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 (Anonymous).

Notwithstanding this resentment, community members acknowledged that training provided by external experts enhanced their abilities to meet Survivors' needs.

Beyond the training and experience brought to the program by AHF-funded project team members, many projects offered training. The most common training opportunities provided (n=226, S1) were:

- learning about history and effects of abuse experienced at residential schools (69%);
- professional development[38] 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%); and
- computer/internet training (46%).

Overall, 74 per cent thought that the training provided was adequate, while the remainder (26%) thought training was inadequate (n=226, S1). Perceived training needs most often cited were (n=225, S1):

- 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 impacts of residential schools (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, and program development.

Of the projects who believed training was required, 68 per cent reported that personnel would better benefit from *advanced* training (n=225, S1), while the remaining projects stated that basic training would suffice.

The majority of projects reviewed in document files (93%, n=36) provided training to a variety of target audiences, including community leadership, project personnel and community members, in efforts to implement 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 and lifestyle change. There was a noted trend of sharing traditional healing methods at conferences and workshops where participants exchanged knowledge about techniques of spiritual counselling, talking circles, sweat lodges, pipe ceremonies and handling disclosures. Some offered instruction as a way of developing community-based trainers.

The modification of training approaches on an ongoing basis is needed. For example, one project noted that teaching more basic adult-child interaction skills should precede teaching parenting skills. Also suggested was that training should be focussed upon leadership and project personnel.

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

A discussion about team characteristics would be incomplete without mention of the generous contributions made by volunteers. In a typical month, over 23,660 volunteer service hours are contributed to AHF-funded projects (n=263) [Ext - 36,704: n=408[39]]. Each project enjoys an average of 90 volunteer hours per month (median=28). Assuming that volunteer time would be remunerated at $10 per hour, a conservative estimate of the dollar value for volunteer time would be $236,600 dollars [Ext - $367,704] per month or $2,839,200 per year [Ext - $4,412,448].

3.2 What

This section describes the distribution of resources by project type, self-identified Aboriginal organization type, remoteness, as well as region. Identified needs are also profiled along with preferred or practised approaches to healing.

3.2.1 Distribution of Resources

Clearly, the bulk of AHF resources (committed by October 2003 with 72 per cent transferred to projects as of 1st September 2004) has been invested in healing services (70.9%). Prevention and public awareness activities received the second highest amount (11%). Remaining resource allocations, in descending order of value, were for training (7.1%), knowledge building (6.6%), honouring history (1.7%), assessing needs (1.2%), designing and setting up projects (1.1%) and conferences (.4%). It is important for the reader to understand that many projects also engaged in a variety of activities simultaneously (i.e., training and healing, raising awareness and documentation). Therefore, although Figure 9 offers a rough guide for investment, activities do *not* always fit neatly into only one project-type category.

Figure 9) AHF Investment by Project Type (1999–2004)

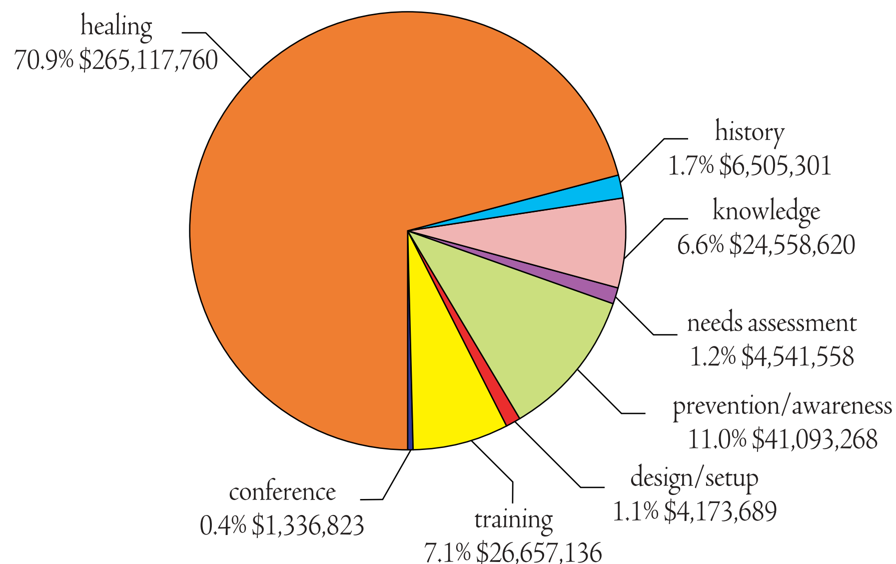
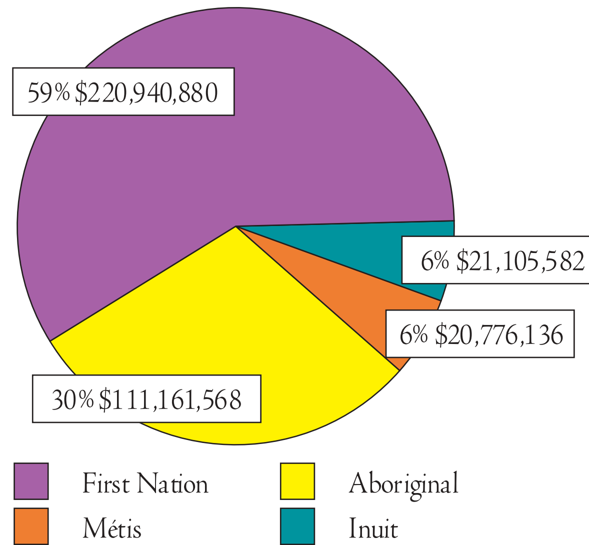


Figure 10 shows the percentage of funding committed to organizations that self-identified as Aboriginal,[40] First Nations, Inuit or Métis. A small percentage of organizations did not complete this portion of the application and therefore their affiliation is unknown.

Figure 10) Distribution of Resources by Aboriginal Identity of Recipient Organization (2004)[41]



3.2.2 Identified Needs

Priority needs of AHF-funded projects have remained relatively stable over the measurement period 2000–2002. Increasing the size of the team and improving Survivor involvement have been the two most important needs. These are followed closely by project expansion, training, community involvement and family support. Table 6 compares the ranking order of needs in 2002 with the 2000 results. Starting with the most pressing need, the following lists resulted.

Table 6) Needs of AHF-funded Projects in Order of Priority (2000 and 2002)

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

A different pattern emerges on examination of the costs associated with need. The most costly program needs, in order, are facility improvements, team expansion, program development or expansion, special needs programming, training, transportation, education about the impacts of residential schools, family support, professional assessments, equipment, evaluation, Survivor involvement, community involvement and communications. Figure 11 reveals the average *median* cost from both national surveys (2000 and 2002), while Figure 12 shows the average *total* estimated cost from both national surveys. When all the needs are added together, an estimated $111,375,920 (n=282, S1, S2) [Ext: $140,855,595, n=573][42] would be required to address these project needs.

Figure 11) Averaged Median Estimated Costs[43] of Program Needs by Type

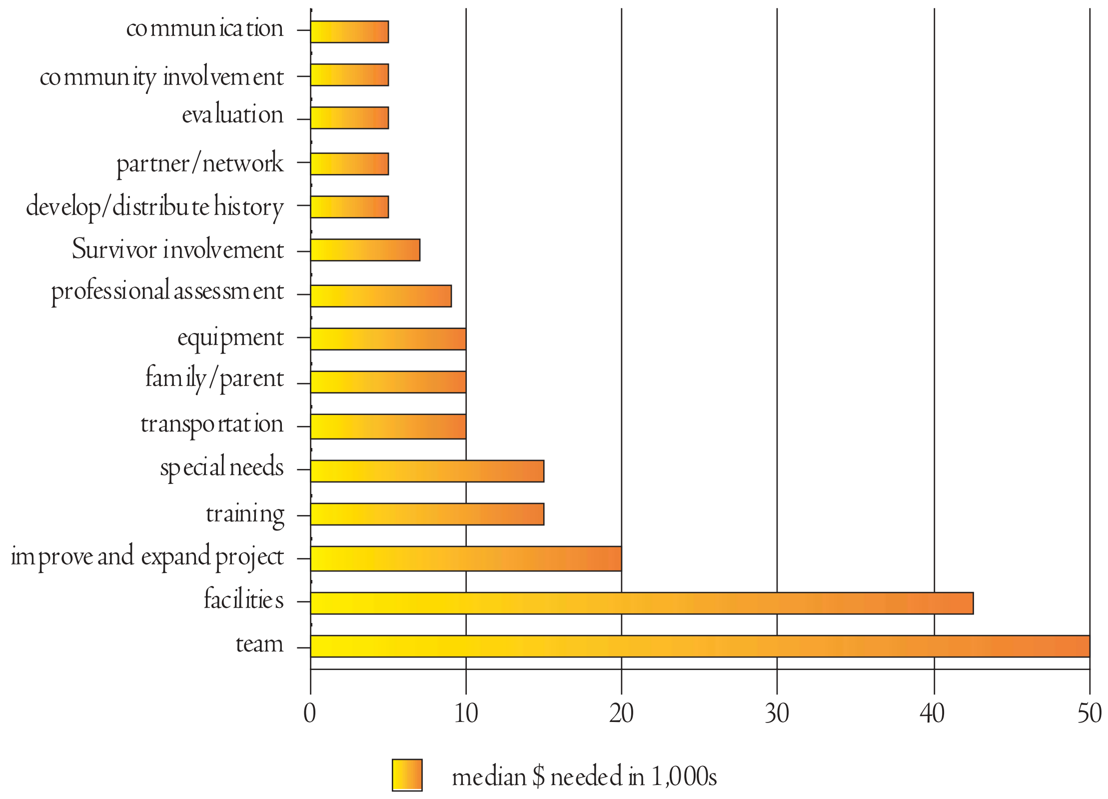
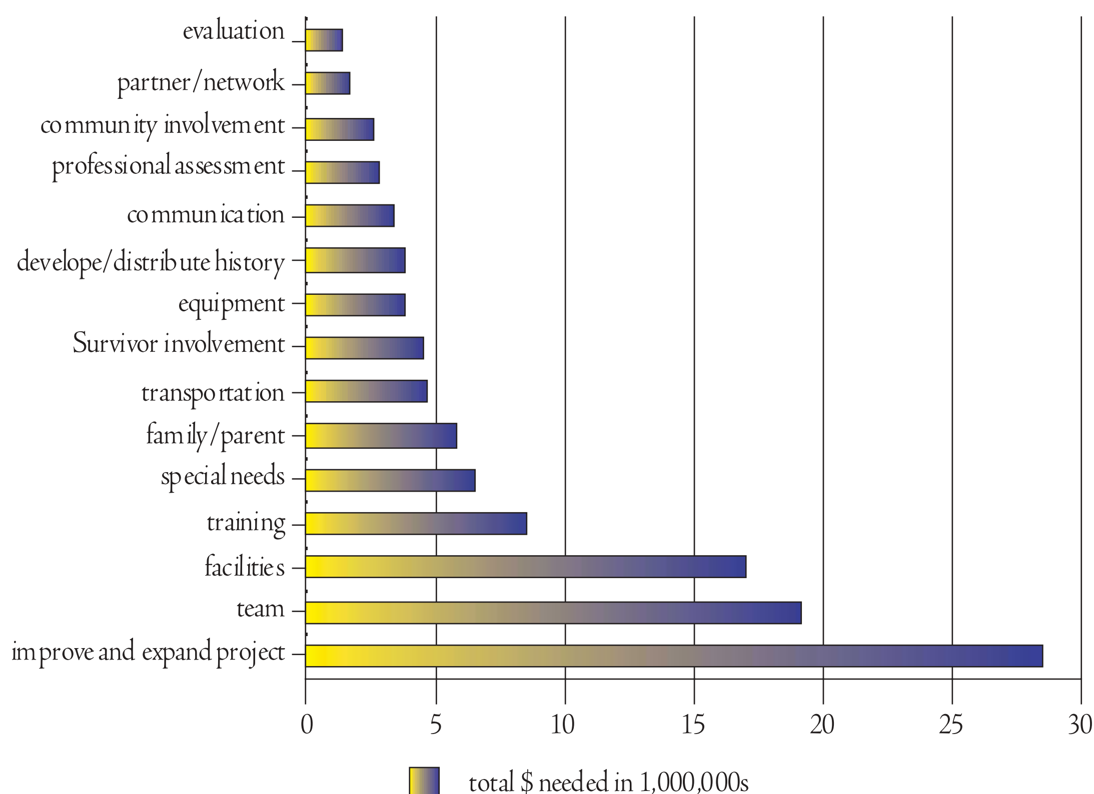


Figure 12) Averaged Total Estimated Costs of Program Needs by Type

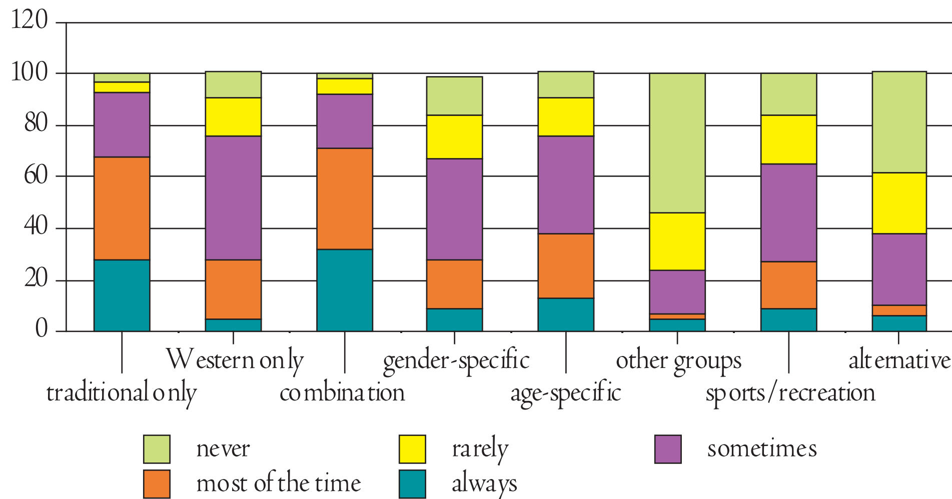


It is important to note that improving Survivor and community involvement, together with increased family support and parenting skill courses, were considered high-ranking needs and all were identified among the least costly to meet.

When asked to rank project needs, respondents from across Canada consistently identified improving and encouraging Survivor and community involvement as the highest priority. From a national perspective, top-ranking needs were improved communication with the community, Canadians generally and the private sector, particularly communications on the impacts of residential schools; improved family support and parenting skills courses; securing partnerships and networks supporting the effort; and professional assessments of skill development and healing. One national respondent identified the following priorities in order of importance: resources to deal with special needs, program development and expansion, transportation, enhanced project teams and benefits, facilities, equipment and evaluation.

Finally, a snapshot of the healing approaches that are most commonly used is presented. Grouping by age and gender is popular and almost a third (27%, n=160, S2) use sport or recreation on a regular basis (most of the time or always). Figure 13 illustrates how frequently various healing approaches are used.

Figure 13) How Often Various Healing Approaches are Used



3.2.3 Strategies Used to Enlist Survivor Support

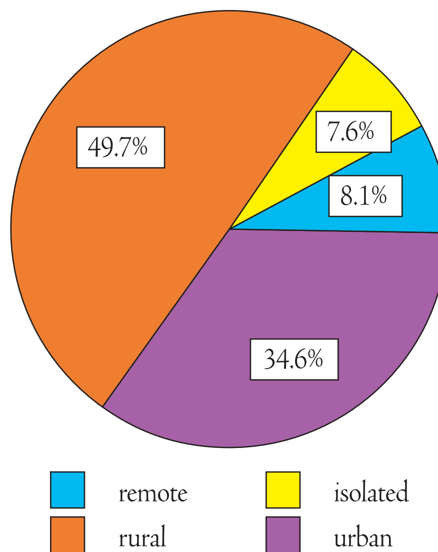
This section highlights the strategies used to garner participation in projects, as reported in the 2000 process evaluation survey. Regardless of project focus, it is the AHF's expressed intention that all projects will actively engage Survivors to participate. While many diverse strategies have been used to engage Survivors, these are the most common (n=240, S1): word of mouth (89), meetings with individuals and families in the project facility (37), newsletters (27), telephone campaigns (24), pamphlets or brochures (20), advertisements (19), interagency groups (16), home visits (14), community bulletin boards (13), involvement in all areas of human service delivery (7), interviews and inviting individuals and families to visit the project (6), and "beat the street" types of outreach efforts (2). Appendix K presents the most commonly used strategies for enlisting Survivors' involvement.

To ensure participant safety, projects used a variety of strategies (n=243, S1), such as criminal record checks through the Canadian Police Information Centre (CPIC) (194), personal interviews (173), character references (168), periodically checking with the participant group to ensure their safety (155), word-of-mouth (119), and consulting with other service beneficiaries (119). Some methods were directly related to individual project policies and procedures (51), requiring healers to sign a code of conduct (85) or make another formal commitment to guard participant safety (19). Also, participants worked to protect each other (10). Appendix L illustrates how teams have guarded participant safety.

3.3 Where

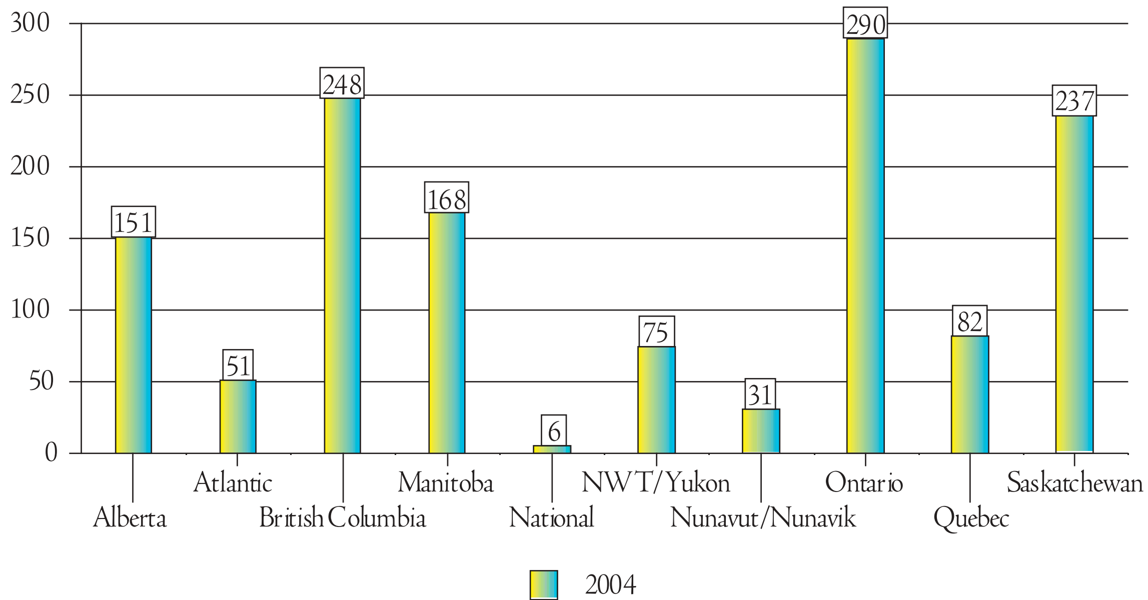
The largest proportion of respondents continue to service rural[44] communities (49.7%, n=384), followed by urban (34.6%), isolated (7.6%) and remote (8.1%) environments. Figure 14 shows the distribution of respondents by degree of remoteness.

Figure 14) Distribution of Respondents by Remoteness (2004)



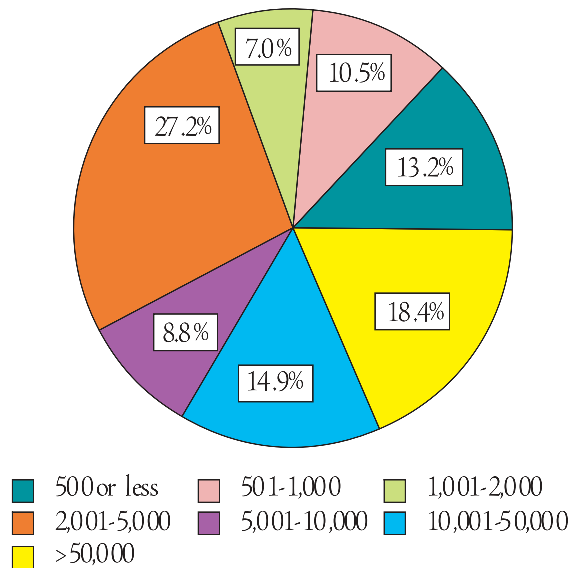
The largest number of grants were to projects in Ontario (290), followed by British Columbia (248), Saskatchewan (237), Manitoba (168) and Alberta (151). Figure 15 illustrates the number of grants broken down by region.

Figure 15) Number of Grants by Region (2004)



The solid majority were in communities with populations of 2,000 or more (65%, n=161, S2). The remaining projects are in communities of 1,999 or less. Some operate in very small communities (15%) with 500 people or less. Figure 16 depicts the distribution of the AHF-funded project sites by community size.

Figure 16) Distribution of Projects by Community Size



Projects are delivered in a variety of venues, the most common of which are health centres or human service agencies, local schools, home settings, community gathering places, bush camps and friendship centres. Less common environments include Aboriginal government administration offices, colleges or universities, former residential schools and correctional centres (S1). Project environments are shown graphically in Appendix M.

All environments have elements that either facilitate or hinder projects in achieving desired outcomes. Early in the life of the AHF, the majority of projects were facing outright opposition to addressing the Legacy (69%, n=243, S1) with over a quarter (26%) believing that apathy was a *severe* problem; however, over time, survey respondents experienced less resistance and enjoyed more support—a finding that reinforces the assertion that healing takes a long time. In other words, it is entirely possible that initial inaction, disinterest or apathy was merely a predictable and early phase of confronting a traumatic past. Less than a third of the projects reported that leadership, community support and participation were serious challenges (n=156, S2). In fact, over half felt that the leadership provided outstanding or moderate support. Lack of adequate housing and unemployment are severe challenges for a sizeable proportion of project teams (40%, n=156, S2). Communities that offer a range of health and social services, and those which support the integrity of Aboriginal cultures and languages, were most often cited as those that offered benefits to projects. Perceptions about community challenges and benefits are highlighted in Appendix N.

3.4 When

Day-to-day happenings are as much a product of the times as they are of the players who create them. History sets the stage for current events and the drama that unfolds affects all life; therefore, it makes sense to examine the times and conditions in which projects operate. The greater world of influence includes community forces, but also extends to provincial and national policy. To better understand the influence of these forces, projects were asked to identify what happened in their world that helped or hindered them. To begin, the facilitating forces will be described, followed by an abbreviated checklist that can be used to supplement the community report card proposed by Four Directions International[45] as a way of measuring change. Following the discussion on what helps, greater focus is directed to the community events and broader structural impediments to healing. Again, a checklist will summarize these forces as a way of highlighting the nature of "special needs" communities.

Cultural pride, practice and celebration were commonly considered to be supportive forces in communities since they affirm and help in identity formation. The effects of litigation on the impacts of healing projects cannot be stated with absolute certainty, however, some trends are associated with litigation. First, litigation has engaged Aboriginal people, the federal government, church entities and the legal community in dialogues about residential schools—specifically physical and sexual abuse. Second, the court cases have raised the ire of those who believe that public funds for healing should instead be used to compensate personal injury.

Interagency collaboration and building professional networks contributed by offering complementary services and support to project teams. Teams that are comprised of deeply committed people who regularly debrief on this emotional subject also contribute greatly to project success. Easy local access to services, supportive leadership, recreational programming (especially for youth), family support, student support, children's services and team training were also credited with helping projects achieve their goals. Similarly, crime prevention and restorative justice initiatives are complementary programs. When the community culture supports mothers' groups, Elders' gatherings, language immersion opportunities and alcohol-free social events, a very ripe climate exists for individual healing. When high-profile individuals disclose, responsible parties make public apologies and the media are quick to cover these events a climate becomes conducive for more disclosure. Increased awareness of the impacts of residential schools functions in similar ways. With improved understanding, individuals and families are more likely to break the silence and seek

services. Most importantly, many Aboriginal people and communities are just plain tired. The burden of residential school experiences has been long lived and heavy, leading many to *genuinely want* healing and cultural reclamation.

What helps

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

The most commonly cited environmental challenges relate to violence (including violent deaths such as murder and suicide): youth gang and criminal activity, widespread vandalism and an increasingly distorted "culture" of violence. Widespread abuse of alcohol and street drugs, increasing dependence upon prescription medication and excessive gambling hinder project performance. Substance abuse by parents and leaders is especially harmful. Lack of employment, crowded living conditions, illness and family dysfunction (particularly a lack of parenting skills) were cited as obstacles to progress. Next are the problems in the political arena: mismanagement of community resources, instability and healing as a low political priority. Service budget cuts and relocation prevented much-needed complementary support. Similarly, projects having to cope with poor facilities and inclement weather experienced greater challenges than others. High staff turnover, lack of skills, training or clinical supervision, and a lack of mental health initiatives left some projects feeling overwhelmed. Gossip, denial and a "don't talk, don't feel" social norm stalls healthy movement. Interestingly, a couple of communities reported that religious groups were working at cross purposes with AHF-funded activities by attempting to repress the reclamation of traditional Indigenous spirituality and cultural celebration.

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

Respondents from across Canada also identified several initiatives that would *facilitate* the work of AHF-funded projects including early intervention programs, such as Aboriginal Head Start (AHS), and efforts to curb fetal alcohol syndrome and fetal alcohol effects. They believed that several other federal efforts also complement AHF-funded projects such as youth justice initiatives, advances in substance abuse treatment and employment programs. The lack of mental health initiatives was thought to impede progress in healing efforts.

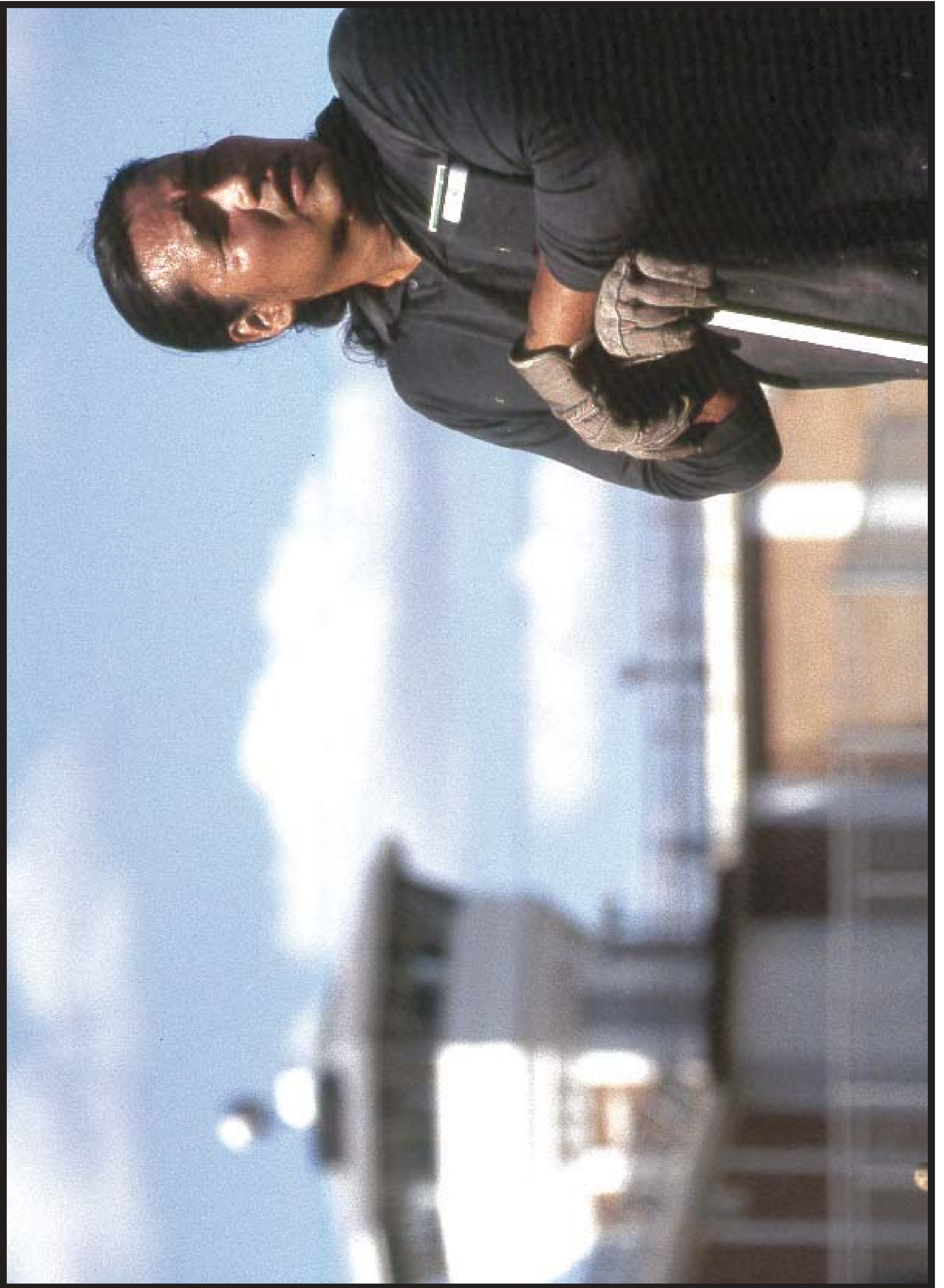


Photo: Fred Cattroll

Sharing Experience and Learning

Although AHF-funded activity is part of a broader healing movement, for many communities, these resources represent their *first* chance to address the legacy of physical and sexual abuse in residential schools. Without a wealth of documented protocol and easily accessible solutions, many are engaged in a "learn-as-you-go" approach. This chapter shares their experiences by weaving together their challenges and the creative ideas generated as a result. Much of this information and the themes generated were drawn from focus group discussions, case studies and the stories relayed in regional gatherings and project monitoring reports. The emphasis was on profiling the *quality* of experience and learning, not its quantity. (The tables in Appendix O outline the frequency of noted lessons learned, best practices and challenges from 13 case studies related to the themes identified here.) Whenever data were available, quantities or proportions are cited, but the bulk of this section relays shared ideas. The lessons learned have evolved into practices that are effective, easily adapted[46] and feel right to Survivors and their families. Although the term "best" practice is used because it is easily understood, it should not be viewed as the *only* way, nor should it create competition; rather, the terms "best" and "promising" practice are used interchangeably for stylistic simplicity.

It is important to remember that learning often occurs under unique circumstances and is influenced by a project's goals, objectives, services, target groups, team characteristics, community context and length of operation. What is obvious to one team may take months of trial and error for another to discover or it may be inappropriate in another setting. In spite of their singularity, sharing the learning and experience across projects can reduce the need for trial and error in responding to, sometimes, universal challenges. Although difficult to classify since many tests have been met with complex and multifaceted strategies, the knowledge acquired from their experiences fall roughly into the following categories:

- engaging participation and support;
- team issues, qualities and care;
- program and therapeutic approach; and
- partnerships and sustainability.

4.1 Engaging Participation and Support

In many scenarios, the community culture contributed to the program's success; it is most effective when there was a genuine desire to engage in healing, where there was an effective network of culturally appropriate or sensitive services and there was a spirit of cooperation or "togetherness."[47] Increased project momentum led to increased participation and the dynamics fed into each other. Projects described the culture of violence as one where the crimes committed in residential schools have been internalized and considered a normal part of life.

> The Legacy of abuse stemming from Residential school was a hate crime … This attitude has been passed on from the initial abusers to the victims and the victims to subsequent generations.[48]

Sometimes, healing competed unsuccessfully with other political priorities for leadership energy and attention. Community acceptance or, at a minimum, tolerance of healing activity was key. Healing goals were thwarted when there was an internal culture of violence,[49] outright opposition to AHF-funded healing

effort,[50] and individual concern about monetary compensation. When the community climate hindered efforts, project teams made it clear that *outside help is required*.

One of the most commonly cited barriers to engaging the community was related to denial of the Legacy.[51] Communities habitually minimize the impact of the Legacy and individuals refuse to admit to being Survivors. Therefore, teams spend extra time and energy dismantling fear and denial while sensitively convincing people to engage.

When leadership was still in need of healing, enforced silence and normalized dysfunction translated as expressed approval of ongoing sexual abuse and created hostile environments for project teams.[52]

> [A] number of individuals got together and somehow developed a ledger of names of abusers, individuals who were very prominent in the community ... people are more reluctant now to discuss the healing process because they don't want to be seen as taking sides. If information on disclosures is released we would have a heck of a time continuing our existence.[53]

The reluctance to engage in healing was generally viewed as a layered emotional wall where surface denial masks shame, guilt, anger and, ultimately, fear of the unknown, loss, re-traumatization and punitive consequences. In communities where violence is socially acceptable and students are at risk *even at school*, nurturing interest and involvement sometimes led to working with participants who were violent, pessimistic, emotionally closed or suffering from serious addiction and poor impulse control. Barriers were also created by the loyalty that youth felt toward their abusive families and the suspicion generated for devout Christians when history was recounted. Climates where gossip and anger prevail were also considered roadblocks to establishing trust and enlisting participation, especially when the focus on monetary compensation for the Legacy outweighed a desire for healing.

Community crises, especially suicides, *always* derailed community action.

Geography works against isolated or remote communities where access to technology, trained staff, a network of human services and even infrastructure are scarce. Some teams promoted their services to Survivors in nearby communities that were not addressing the Legacy.

Poverty and racism offer challenges to community participation. Being poor narrows people's options. Healing was not always a priority with community members preoccupied with basic survival issues (e.g., food and shelter). If it is a choice between paying for child care, groceries or utilities or pay transportation to participate in healing, the choice is clear. Still, teams used numerous strategies to improve access, including varied scheduling (e.g., evening sessions for those employed during the day), providing home visits, offering transportation and eliminating barriers to participation (i.e., offering child care, food, accommodations).

Some case studies revealed that a facility was not ideal if it was cold, formal or housed in institutions that reproduced the initial trauma induced by the Legacy, or it was too closely associated with stigmatizing services (e.g., alcohol and drug treatment) to allow for comfortable involvement. Some facilities (e.g., trailers) lacked privacy to allow for confidential consultations or they were too small for large groups to meet. One team suggested that to properly service a community the program should have its own facility.

Occasionally, the words "residential school" drove people away from activities. Teams had more success being open to community-wide participation than targeting Survivors.

Furthermore, while AHF-funded projects are beacons of cultural reclamation, celebration and reinforcement, the broader Canadian context does not safeguard Aboriginal cultural integrity (e.g., translation services, culture and language education, or the integration of Aboriginal worldviews and philosophies in policy and practice).

Understanding the impact of the Legacy is perhaps best indicated by program demand. Some projects that were still struggling with denial *did not* operate to full capacity, although many projects did. Most others could not meet service demand, especially as momentum was gathered and participants began reaching out to others to encourage them to heal. Youth and Elder dynamics seemed particularly successful in this regard. Team creativity shone brightly in enlisting participation and support. While the most promising practices have limited influence on lack of adequate infrastructure and systemic barriers, such as racism or poverty, they were excited about how they could engage those resistant to participation.

Building Relationship

Teams operated on the principle that all healing is based upon relationship. The importance of relationship was a consistent theme in focus group discussions, gatherings and case studies. Building a relationship requires time, patience and persistent effort and is characterized by *prolonged and informal* exchange. Trust and intimacy are achieved *indirectly* through opportunities for learning, shared experience, celebration, as well as personal expression. Team members that were outgoing and visible in the community, through their active involvement or outreach efforts, were more likely to engage participation. This created casual opportunities that allowed Survivors to become familiar and comfortable with healers *at their own pace* in less threatening venues. Fear and denial, both natural defences against a threatening situation and entirely predictable reactions to traumatic experience,[54] are best dissipated when *acceptance and safety* are primary elements of the relationship.

Acceptance means welcoming *all*, acknowledging strengths, honouring Survivors, and meeting people at their current level of need and understanding so that trust can be established to work on more sensitive and deeply rooted dilemmas over the long-term. In focus group discussions, project teams believed that when sexual violation of children, spousal abuse and other extremely violent acts are acknowledged as "matter of fact" manifestations of the Legacy, people will accept help. Without judgement, intense emotions—shame, guilt and especially anger—are validated, expressed fully, viewed as *natural and necessary* for grieving and, ultimately, skilfully handled and relieved by therapeutic teams. Differences in the expression of anger among the genders must be accommodated. When the emotional intensity of a healing session escalates, grounding techniques[55] and a buddy system were used and recommended by one team.

To some people, the word "healing" implies that a flaw must be corrected or overcome. When translated into Inuktitut, "Mamisaq" is usually meant as "physical" healing; thus, the word "healing" has a problematic cultural interpretation and may be viewed as a weakness by both men and women.

> The Survivor frequently resists mourning, not only out of fear but also out of pride. She may consciously refuse to grieve as a way of denying victory to the perpetrator. In this case it is important to reframe the patient's mourning as an act of courage rather than humiliation.[56]

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

> Although abuse of power is the fundamental dynamic behind all forms of victimization, many male victims do not report feeling powerless and do not see themselves as "victims."[57]

Thus, "healing" may force an unwilling identification as a victim and the ways in which healing, counselling and therapy are framed require further discussion, especially by men. Focussing peer pressure positively, structuring the healing journey as an act of courage and empowerment and refraining from focussing on weakness provided a greater feeling of emotional safety. Framed positively, healing is creating opportunities for *learning, self-expression* (verbal and nonverbal), as well as *cultural reinforcement and celebration.*

Opportunities for Learning and Expression

In focus group discussions and case studies, it became clear that learning healthy behaviours and relationship patterns was best facilitated through illustration, not direction, and then exercised. How to relate as a couple, nurture self, make use of healing tools (i.e., fasting, singing, writing, spiritual expression, relaxing and meditation), and process emotion were offered as relevant and effective lessons. Unpredictability was also best reduced by learning: learning a name for the Legacy, understanding normal reactions to trauma and recognizing how community healing might unfold. Being able to name a threat or cluster of reactions gives the individual a sense of control over their emotions and environments. In particular, understanding childhood development and grief helped focus therapeutic work and individual resolve. While much learning occurs in well-orchestrated campaigns or curricula, a few teams were very clear that spontaneous, "teachable moments" must also be harnessed.

Legacy education is particularly useful when it explains that the reactions to the residential school experience are normal and predictable consequences of institutional trauma, and not an individual character flaw or weakness. Vicarious learning was considered valuable when the model was an Elder, healer or even a peer, since models are living proof of the benefits of healing. When people can learn by watching the experiences of others, they are spared the pain associated with "trial and error" learning. In particular, healthy men with unhealthy histories who had developed some skills at leading a group or functioning as a healer seemed very effective in drawing other men onto the healing path (this was heard consistently from all projects that serviced men and that participated in focus group discussions and case studies).

Teams learned the value of community involvement in program planning, promotion and delivery, as well as in creating awareness of the Legacy; suggesting that community cohesion and empowerment were important indicators of healing. A sizeable group reinforced the importance of providing information to the community *at the outset.*

Legacy education was almost always recognized as a catalyst for healing from every source (i.e., project files, gathering minutes, six of 13 case studies, focus groups and national surveys). When it became clear that the burden of the legacy of physical and sexual abuse was no longer a puzzling personal flaw, but a normal and predictable reaction to institutional trauma, movement to reclaim a life of balance was considered an act of empowerment and courage, not weakness. Acknowledging the suffering, resiliency and strength of Survivors in Legacy education campaigns gave them dignity.

Most participants desired to know and understand themselves through supported self-examination and expression that takes gender differences into consideration and offers spiritual comfort regardless of faith. Nonlogical, nonverbal methods of self-expression were hugely popular.

> Expecting the client always to express in words what he feels and senses is like requiring a huge "translation effort" .… This is often not even possible, especially in the case of "early" types of experiences.… It is for this very reason that verbal therapy too often excludes many of a person's most significant spheres of experiencing. That's why it can be very enriching to recognize and know how to support and accompany change processes non-verbally.[58]

When focus group participants were specifically probed about their strategies to engage men, they were full of good ideas. Men are particularly responsive to activity-oriented, nonverbal opportunities for expression like physical competitions, warrior yells, music and woodworking, since they appear to prefer this to talking. Art therapy—popular in several projects invited to focus group discussions—allows participants to create representations of the Legacy "outside" of the artist that, in turn, reduced the direct, emotional drain of the Legacy story. Other forms of creativity, including humour and mealtime, were also popular and comfortable ways in which to express self that functioned to lighten the heavy work of addressing the Legacy. Focussing therapy,[59] used in at least one scenario, replaces verbal expression with action; clients are asked to *do* rather than to *tell* what they are experiencing through gestures or behaviour. However, some policy climates present barriers to self-expression. For the incarcerated in some institutions, disclosures from offenders are inhibited by policies that negatively affect release time, even though they represent significant expression, measurable emotional progression and self-responsibility.

Cultural Reinforcement and Celebration

Regardless of the data source, teams and Survivors recognize the value of cultural reinforcement and celebration as a way of reclaiming what was lost personally, spiritually and linguistically. Clearly, Elders were hugely popular in cultural activities and interventions. With or without formal training as counsellors, their life experience and grounding in the culture provide them with the necessary and sufficient qualities to be effective. Elders' projection of honesty, empathy, acceptance, unconditional positive regard for Survivors and honour of Aboriginal culture was considered a powerful way of offering validation for participants. An environment that reinforced cultural identity (e.g., Métis flag, Red River cart, an Inuksuk, displaying Aboriginal art, land-based traditional camps or natural surroundings) was silent but powerful medicine. Consistently, teams reported on the value of traditional healing and the need to increase the use of traditional healers, Elders and cultural teachings, either alone or in collaboration with other healing methods.

Traditional approaches appear to work well with Western and Eastern approaches—even when merged across Aboriginal cultures.

So it has become amply clear that some of the most promising practices to enlist participation and support are to build a relationship based on acceptance and safety, offer opportunity for learning both healthy patterns and history, expressing self and celebrating culture. Beyond dismantling fear and denial, or more general resistance to how the journey has been framed or the variety of appropriate interventions, teams also recognized that there were two key variables that determined successful engagement: "readiness" and "fit."

4.1.1 "Readiness" or "Fit"

Although some teams, especially those in residential treatment facilities, rigorously assess "readiness" or "fit," others used a variety of priority-setting strategies. For a number of teams (31%, n=104, S1), Survivors and their descendants were at the top of their list, and they were accepted without assessment. Others (25%) identified those at greatest risk as top priority and a few (18%) targeted specific groups based on gender, Aboriginal identity, age, sexual orientation or religion. Some (13%) reported that they gave priority to those who self-initiated enrollment, and a small group (10%) gave priority to referrals. A very small group (2%) had no system to identify priorities and used either a "first-come, first-served" basis or a random approach. At least two teams felt that children and youth, or families with children, should be the priority to receive service first, and a couple of others were pressured by the need to maintain fairness in service access to all regions and territories and, in the case of tribal councils, consideration of service to all community members.

Of course, not all programs have intake criteria or do formal assessments to determine who can or cannot participate. At least one team that participated in focus group discussions operated on a harm reduction model in the hope that an improved relationship with self will emerge over time. This project team did not deny those participants who are making their first attempt to change their lives since helpers recognized that passively listening to others lays the groundwork for more active participation later on. In any case, a supportive network of referral agents who were able to meet clients at their current level of need was crucial to more inclusive criteria for participation.

Teams participating in case studies and focus group discussions regularly described a "readiness" to heal, and some have developed both formal and informal ways of determining who *genuinely* wants growth and transformation. Some use intake assessments and others depend upon a more casual exchange by inquiring about previous participation in healing or directly asking "why do you want to participate?" or "do you know yourself?" When these questions precipitate a fearful response, then it is clear that the individual is not "ready." If the use of the term "ready to heal" is closely examined, it refers to the "fit" between participants and service interventions that projects offer.

In assessing "readiness," project teams are basically determining who will benefit the most from the program being offered. When talking about therapeutic or healing interventions related to the legacy of physical and sexual abuse in residential schools, participants are considered "ready" if they:

- are self-motivated, interested and *willing* participants with a track record of regular, ongoing or previous participation in healing;
- are clear about and committed to the healing process, including addressing trauma, examining and communicating feelings, questioning themselves, reviewing lifestyles and changing behaviours;
- have a reasonably stable and at least moderately generous relationship with themselves, characterized by self-awareness, understanding, acceptance and freedom from self-destructive behaviours, including substance abuse (alcohol and other mood-altering drugs), with some projects insisting upon at least six months of abstinence prior to participation;
- have freedom from distractions or interference (e.g., need for acute medical care, mental instability, communicable disease, unmanageable chronic disease, appointments or court dates);
- are prepared to be accountable for their history and the rights of other participants (e.g., sexual offenders agreeing to conditions that provide other residents or participants with information about their offending history);[60]
- have demonstrated pre- and post-treatment support (e.g., counselling opportunities, participation in self-help) beyond the life of the project; and
- have sufficient trust in others and impulse control.

Of course, there are gradations of "readiness" because not everyone is "ready" to the same degree for the same service at the same time. Great flexibility and a variety of strategies were outlined to engage those who were "not ready." In no real order of priority, communities used awareness campaigns, outreach, and relationship building with unique target-driven strategies. They developed a wide variety of actions to accommodate varying degrees of "readiness." Table 7 outlines what communities do when members are not completely "ready" for the more emotionally intensive work of healing from past trauma.

Table 7) Reaching Those Who Are Not "Ready"

Awareness Campaigns	This category of activity includes Legacy education and program promotion, including word-of-mouth communication and a variety of local media where healing is framed as an act of courage and empowerment, a rightful reclamation of culture and balance.
Outreach	Proactive and targeted efforts to engage specific individuals or groups through special invitation and personalized attention, such as home visits or individual counselling.
Relationship Building	Organizing nonthreatening, fun, positive social activities that are desired and driven by the "hard-to-reach" target, where target group members can profile their special talents (e.g., harvesting traditional foods, music, crafts, collective cooking) and be *contributors* to the event.
Providing Opportunity	Accepting referrals, waiting patiently or "just being there," offering culturally appropriate and accessible, welcoming services where opportunity for vicarious learning and contagious healing can take place. Even just one role model of successful healing can have a dramatic affect on the group and create momentum that draws those who would otherwise be reluctant.
Therapeutic Intervention	Culturally appropriate and accessible, welcoming services where individuals can maximize the intervention offered and are committed to, and serious about, making life changes.

Figure 17 provides a crude guideline for determining what intervention is appropriate at each stage of "readiness." On the left-hand side are levels of "readiness" and on the right-hand side are categories of intervention. The darkness of hue represents when key interventions are most likely to be effective, with the darker shades being the most appropriate interventions for the target group described.

Figure 17) Matching Readiness with Strategy

Awareness	Outreach	Relationship	Opportunity	Therapy

resistant, close-minded, heavy Legacy burden, many potential distractions from and interference with participation

plagued by self-destructive behaviour, unfamiliar with and uncommitted to healing but intrigued, many potential distractions from and interference with participation

open-minded and willing but unclear commitment, unstable freedom from self-destructive patterns potential distractions and interference with participation

committed, open-minded and willing but fearful, enjoys some stability from self-destructive patterns, potential but manageable distractions or interference with participation

committed, open-minded and willing, enjoys stability from self-destructive patterns, free from distractions or interference with participation

Those who are not ready occasionally slip through the referral and intake processes. When this happens, it is best to speak to the individuals privately, find out what they can commit to and review their medications; however, do not humiliate them by sending them home if they agree to live by program guidelines, be fully present to the healing process and will not disrupt others. Alternatively, they may agree to be transferred to another more appropriate service.

Beyond individual readiness, teams also spoke of a more general community readiness that is obvious when needs are well-defined, work plans are detailed, partners are engaged, and system strengths are drawn from previous experience or success in similar programs. Readiness can also be determined by expressed interest in addressing the Legacy by local service organizations or grassroots collectives, with or without leadership support, as well as through the extent to which their proposed action has been based on input from Survivors, pilot projects or *specific* research to meet Survivors' needs. When whole community systems work together and share goals, it reflects a readiness to engage—one that is easily recognized by funders outside the community. High local *demand* (not to be confused with need) for services is also a prime index of community readiness to heal. Communities are generally ready when they can demonstrate an historical, lasting commitment to wellness. When whole groups express an interest in or are attending addictions treatment, willing or engaged in addressing other social issues and reaching out to others for support, they are generally "ready." Another indicator of readiness teams watched for was the community's reaction to interventions offered. Strategies for reaching communities were similar to those for individuals and included matching strategies to level of "readiness." When the community was not "ready," teams offered these suggestions:

- engage those on the healing journey to share with others or do outreach;
- provide a special invitation to groups that are harder to reach (i.e., men);
- provide education on the Legacy and the consequences of institutional trauma on individuals and communities;
- use local radio, newsletters and word-of-mouth; and
- enlist Elders to talk with community members and take a lead role in saying that it is time to heal.

For those who do not have formal intake assessments, some guidelines or an adaptable assessment tool to evaluate "readiness" or "fit" was desired.

4.2 Team Issues, Qualities and Care

While no one who endeavoured to address the Legacy thought it would be easy, few really had any idea of the challenges that lay ahead (see Table O-3 in Appendix O).

> Although we knew from the onset how necessary this type of initiative was, it is still overwhelming to hear community members and subsequent generations speak from the heart about their experiences.[61]

For some communities (where more than 55 per cent of the participants suffer from severe addictions and histories of victimization and abuse, n=274, S1), the solid majority are living with the burden of the Legacy. Unravelling its tangled web of impacts requires focussed energy and effective strategies to reclaim identity, culture, relationships, parenting, education, economy and spirituality—all deeply rooted issues that require

a *lengthy recovery*.[62] Many teams, identified from multiple sources (i.e., document files, gathering minutes, case studies, focus group discussions and national surveys), underestimated the time and effort required to organize, reach target audiences, find the right people for the job, interview Elders and break through denial and guilt at the personal and community level.

In some scenarios, successful recruitment campaigns and community "readiness" magnified service demand and excessively strained the healing team. Pressure was created not only by the extent of the need, but also by the knowledge that supporting disclosure *requires* follow-up and aftercare. Project teams learned that healing *is a process, not an event* that calls for the support of a healthy network of professionals or healers and adequate material resources sustained by long-term commitment. Opening wounds means there can be no unethical, abrupt closure to the healing process without an enormously elevated risk of re-traumatization. In other situations, establishing trust with interested but hesitant participants required vast resources of creativity and patience.

Earning trust, guaranteeing safety, developing unique strategies for different groups, gathering and strengthening frontline teams, and integrating with other needed services—while simultaneously providing therapeutic and prevention services—overwhelmed many. Personnel managing dual roles were left in a crucial balancing act where therapeutic services consistently outweighed other functions and created delays, rescheduling or program gaps. Resource restraints meant less access to complementary resources and services; less ability to meet growing demands; insufficient outreach; inability to train referral workers; lack of pre-/post-care; and reduced public education and community information activity.

A few were overcome by the response burden created by AHF reporting requirements and changes in format, claiming that administrative reports took an enormous amount of time away from service delivery. Well-defined and detailed work plans, with sufficient administrative support to ensure that clinical teams are not hijacked by paperwork, were essential to maintaining therapeutic focus.

Still, teams struggled, often amidst crisis, to meet needs and maintain professional standards. Project teams would have enjoyed any additional support in the form of an expanded team (e.g., more support staff, therapists, healers, Elders and helpers), ideally those who could speak the language or in the form of a mentoring/training program. Projects consistently cited the need for self-care and peer support, as well as the pivotal importance of *healing the healers*. Once out in the workforce and without well-planned team care or adequate resources to meet the need, some frontline workers were at serious risk of burnout.

> I'm concerned about the level of exhaustion and real physical illness that is happening to our front line workers, the leaders, the ones that have been holding so much stress … I'm seeing the people that have been holding the fort dying of illness … I am totally concerned about the people that are vigilantly focussed on healing. They're tired.[63]

As a result, a few healers were experiencing compassion fatigue and finding it increasingly difficult to balance their lives, control their emotions, set boundaries and find the wisdom and care they needed to support their quest. In the worst-case scenarios, this resulted in high staff turnover and unstable programming.

Several projects described scenarios where they only had access to part-time or unstable direction, or a negative association with management. Skills shortages held special difficulties, with several citing conflict resolution and crisis intervention as much-needed modules for training. In some cases, although training was provided, there was insufficient time and opportunity to *really* absorb the material or for clinically supervised practice. Lack of training and experience left some unable to achieve service delivery objectives and others in unstable and ineffective working relationships. Sometimes, even though highly skilled Western practitioners were available, projects lacked someone who could comfortably combine Western and traditional approaches. In addition, finding Aboriginal people with the appropriate skill sets was always a challenge.

The success of many of the projects has been attributed to highly skilled individuals and teams, but there is a need for even greater numbers of Aboriginal healers with recognized skills and reputed practices. When community members were available to act as healers, they occasionally felt too close to clients who were relatives, neighbours, lifelong friends or even enemies. Most importantly, guidelines for determining when a healer has gained sufficient skills, experience and inner peace to lead others into healing are just beginning to take shape. Nevertheless, the need for community-based healers does require that some tolerable risks are identified for proceeding with simultaneous training and healing, and begs the development of simple and useable guidelines for graduated involvement and the development of a mentoring program.

Selecting and developing a strong project team often meant having highly skilled healers/helpers, preferably Survivors, fluent in their language who could model successful healing, were able to balance their own lives, and were free from the need to control, rescue, enable or care take. Reasons for selecting Survivors to lead the healing journey are obvious as this rationale:

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

Obviously, such individuals were difficult to find, especially ones with specific training needed to address the Legacy. Still, Survivors and healers are human and there are *no guarantees* that, in helping others, they will not be triggered to relive their own trauma. Several community informants felt that the Survivors as healers/helpers were not receiving adequate clinical support to deal effectively with their issues. Some Survivors as healers/helpers had not fully reclaimed stable, healthy, functional lives before they had embarked upon efforts to heal others. When a community is just gaining momentum on the healing journey, *there is still a serious shortage of individual Survivors who have fully healed and can function as leaders/healers without setbacks.* Becoming aware of repressed personal issues and collective problems is *part* of the healing process—emotional turbulence is to be expected. While the reasons for selecting community members to lead the healing process are clear, being thrust into the role of Survivor/healer can lead to unintended and potentially harmful consequences. To address this issue, the qualities and abilities of good healers were examined in greater depth to outline some of the preliminary criteria that communities can use to appropriately select those who will lead the journey toward wellness.

4.2.1 The Good Healer/Helper

Those who lead or facilitate the healing journey are known by several names. Most commonly, they are called healers, but they are also known as advisors, helpers, facilitators, educators, guides or, more simply, "those that know." For stylistic simplicity, those individuals who lead or facilitate a healing journey will be interchangeably called healers or helpers.

During the case study exercise, it became clear that good healers/helpers have a profound impact. As a result, their skills and qualities were the subject of several focus group discussions. What follows are the combined results identified by teams who gathered at these sessions.

Although good healers are not expected to have all the answers, teams participating in focus group discussions expected them to have a broad range of skills, operate by the highest, unwavering ethical standards, have a solid track record of contribution to the healing movement and, ideally, be recognized and respected members of the community. Though formal training and post-secondary education were valued, expertise could also be obtained *traditionally and experientially* as long as the right combination and "fit" of desired skills could be demonstrated. Where formal training is difficult to access (e.g., in the North and in remote communities), other criteria, such as language skills, experience as a Survivor and knowledge of the community, become pivotal. Ideally, healers are able to blend eclectic techniques and approaches, drawing upon those that are most effective from a variety of healing traditions or being able to work well in a blended team. In fact, stark parallels are frequently noted between traditional and Western psychotherapeutic approaches; most notably, the emphasis on self-responsibility and on improving relationships with self and others.

Both traditions also recognize that well-being is the result of multiple, synergistic factors including, but not limited to, service access. Traditional approaches appear to deviate from most Western healing practices by adding spirituality. Ultimately, those who are highly skilled, with extensive training and experience in counselling, crisis intervention, risk assessment and trauma recovery, particularly sexual abuse, were believed to be good healers. Complete competence in handling sexual abuse disclosures, counselling sexual abuse victims and perpetrators, along with a solid understanding of and ability to openly discuss healthy sexuality, were considered basic by those teams recognized as engaging in promising practices.

As a prerequisite, good healers radiate inner peace that comes from self-understanding and acceptance. In the best-case scenario, they are similar to their target group in characteristic (e.g., sexual orientation, Aboriginal identity, age, sex) and experience (e.g., parents or grandparents, community members), particularly that of the Survivor. They know the weight of the Survivor's pain because they can recognize and describe it. Living with and healing from the Legacy makes a good helper easier to relate to and respect, providing insights and skills not easily obtained in institutional settings.

Good healers are described as natural caregivers, committed, nurturing, respectful, nonjudgemental, humble, genuine, gentle, open, creative, empathetic, culturally sensitive, patient, outgoing and visible in the community. They are modest people of few words, despite great power as evidenced by their ability to accept all, bring humour and hope to the suffering, and make possible the achievement of desired results.

Good helpers are also free of a criminal history; but if they have had problems with the law, the nature of their crime and the time elapsed since the crime, as well as the extent to which the individual has taken responsibility for his or her actions and have completely resolved all issues that led to the offense, are taken into serious consideration.

Healers must be able to make Survivors feel safe, facilitate *independent* decision-making, bolster self-esteem, avoid assuming the role of rescuer, use humour effectively, as well as maintain their own balance. When a situation calls for expertise beyond their own, they gracefully recognize their limitations and make appropriate referrals. Preferably, they are fluent in the language of the community. In some settings, particularly residential treatment facilities, healers are required to abstain from mind-altering substances. A healer must be *fully present* to those in their care, able to listen with intent, hear with clarity and communicate effectively. While they have lots of charisma, they are able to share knowledge in meaningful ways while being ever mindful to do more listening than talking. Good healers have an immediate impact and are consistently eager to learn.

A few communities are in the unenviable position of engaging in simultaneous healing and training, where Survivors are being called upon as helpers. One team warned against this practice because intensive learning can interfere with counselling and, sometimes, project teams and participants were *equally impacted* by the Legacy.

> Training for frontline workers was a huge factor in them realizing that they themselves had inherited the dysfunctional behaviours of the Residential School Legacy.[64]

While few could offer any definite time for the transition of needing support to providing it, project teams were certain that several characteristics of a solid Survivor as healer would be clear.

> First and foremost, there appears to be solid consensus that the Survivor must be known as a model of healthy behaviour or successful healing. The Survivor's role as a healer is *bestowed* or created through the recognition and respect of *others* who *believe* in the Survivor's healing ability. In other words, ***exercise extreme caution when dealing with self-proclaimed "healers."***

Survivors become ready for leadership when they are free from the need to control others, and have well-established personal boundaries they are able to comfortably maintain, including the ability to handle triggers and remove themselves when exhaustion is imminent. Sufficient recovery is usually characterized as fearless and unflappable leadership and complete transition through all stages of grief (i.e., denial, anger, bargaining, depression and acceptance). Strong group facilitation skills provide healers/helpers with the tools to defuse negativity when it surfaces and allows them to regain a positive climate for healing. If Survivors are engaged in providing a traditional therapy, they must be entirely comfortable with, and completely knowledgeable of, traditions, ceremonies and spirituality, and have a respectful relationship with the land. More specifically, Survivors as healers accept the Legacy's reality, have worked through the anger associated with their loss, and do not try to bargain away their actions or the actions of others in an effort to recreate conditions before the loss. They are free from depression and recognize that life must go on.

Survivors as healers exude *absolute self-acceptance* and are also able to *demonstrate* healthy functioning by:

- being able to comfortably share their history, healing strategies, as well as develop a plan for *continued* wellness;
- being committed to breaking the cycle of abuse by initiating action and actively encouraging ownership in others;
- offering a good track record of ethical conduct (especially as it relates to maintaining confidentiality) that can be supported by references;
- living an alcohol- and drug-free lifestyle for a minimum of two years;
- exhibiting a willingness to learn from, accept and work with clinical supervision;
- understanding the boundaries of their ability and making appropriate referrals when needed; and
- regaining respect within the community.

Ultimately, Survivors can only lead others as far as they have travelled on their healing journey and, although they can still be on their own journey, they *must demonstrate sufficient resolution to protect themselves and others.* When they are not ready to assume leading or therapeutic roles, they may be engaged in the healing process as advisors, helpers or educators. Table 8 outlines the qualities of a good healer/helper.

Table 8) Qualities of a Good Healer/Helper

A Good Healer/Helper Has:	
☐ a solid track record of ethical conduct supported by references	☐ knowledge of and comfort leading or participating in ceremonies
☐ experience in and respect of the community	☐ an open mind
☐ power, humility, honesty and gentleness	☐ freedom from the need to control
☐ accepts the Legacy's reality	☐ unmistakable positive energy
☐ worked through their anger	☐ assumed responsibility for their actions
☐ completed transition through stages of grief	☐ been alcohol and drug-free (> two years)
☐ recognition *by others* as a healer	☐ a clear understanding of their limitations and makes appropriate referrals
☐ absolute self-acceptance	☐ a developed plan for continued wellness
☐ a history of triumphant recovery	☐ a commitment to breaking the cycle of abuse, initiates community action and encourages ownership
☐ able to share their history and healing strategies	☐ a spiritual grounding
☐ well-established personal boundaries that protect them from harm/burnout	☐ a respectful relationship with the land
☐ an unmistakable inner peace characterized by fearless, unflappable (not easily surprised) leadership	☐ freedom from depression, recognizes life goes on

When identified, the specific kinds of post secondary training programs that would prepare healers/helpers included social work, psychology and any other human service program.

Helpers must be able to address unresolved trauma in all of its manifestations, including, but not limited to, grief, loss and physical and sexual abuse, while safely, gently and effectively guiding recovery, particularly through remembrance and mourning, but also during flashbacks. They should be familiar with and able to dissipate the storage of trauma in the body. They must have well-honed, swift risk assessment skills and be able to distinguish between the need for crisis intervention and long-term counselling. Good healers are able to assess and understand how family dynamics may be affecting behaviour *as well as how their own family experience may influence and complicate their practice*. Working well with families affected by the Legacy requires that a good healer knows the structure, function, dynamics and effects of intergenerational patterns, including family projection (i.e., how parents transmit their emotional problems to a child). They must recognize that sibling position plays a role and children often bear symptoms of much larger, dysfunctional processes of interaction and communication in their families, and they must redirect intervention to focus on family processes rather than on the child's symptoms alone.

Healers are effective when they can help others manage their anger, offer insights about lateral violence and bullying, as well as promote and exercise self-care. Most critically, good healers can intervene in and prevent suicide. In the best-case scenario, they can offer their clients the luxury of traditional medicine, either through their own expertise or by partnering with traditional healers. Sometimes, their toolboxes also include psychodrama and alternative therapies.

Table 9) Abilities of a Good Healer/Helper

A Good Healer/Helper Can:	
☐ process intense emotion, defuse negativity ☐ swiftly determine risk and intervene in a crisis ☐ distinguish between crisis and long-term need ☐ facilitate a group ☐ combine techniques and approaches or work well in a blended team ☐ address unresolved trauma (grief, physical and sexual abuse) and guide recovery ☐ intervene in and prevent suicide ☐ share their history and healing strategies ☐ understand and dissipate lateral violence ☐ use traditional medicine or partner with traditional healers effectively ☐ plan and lead ☐ counsel sexual abuse victims and/or perpetrators ☐ handle sexual abuse disclosures	☐ openly and confidently discuss healthy sexuality ☐ engage comfortably and knowledgeably in ceremonies ☐ listen intently, hear clearly, communicate effectively ☐ encourage and facilitate taking responsibility for actions ☐ maintain good client records/charts ☐ take ownership of their actions and encourage ownership in others ☐ recognize when to remove themselves ☐ accept their limitations, learn from and work with clinical supervision and make appropriate referrals ☐ recognize where trauma is stored in the body ☐ initiate community action and encourage ownership ☐ understand and engage whole families in healing

Selecting good helpers is a combination of knowing what to look for and involving the right people in the decision-making process for selection. Informants were clear that a variety of perspectives were necessary when selecting board members, Elders, Survivors and community members. These individuals were considered the experts when it came to determining who would be best able to serve their community.

Once selected, there are a number of ways of ensuring that good practices prevail. On-the-job mentoring was cited as one strategy where key experts were seconded on a short-term basis to transfer specific skills to new team members. Experiential training (i.e., where prospective employees must engage in and complete the therapeutic process they propose to lead before using it with clients) was also felt to be a useful tool to guarantee successful implementation. Soliciting participant feedback and providing a venue for exchange between participants themselves were the most commonly cited strategies, but formal reviews, evaluations and regular meetings between managers and staff were also believed to be valuable monitoring methods. Preliminary training was deemed imperative for cultivating good healers in new programs. Ongoing training directed by team needs and interests with Elder guidance was identified as crucial to retaining and cultivating good healers in established programs.

Good healers prevail in good teams. Optimally, team members, *as a group,* have a combination of skills and experience, work *together* in a way that allows for joint decision making and enjoy the guidance of Elders. They create a climate of support and self-care with continuous learning, regular debriefing (where all players can speak freely) and wholesome, soul-feeding fun that, in turn, promotes trust and offers a comfortable and safe healing and working environment.

Finally, teams were only as good as their own ability to maintain balance. In other words, keeping team members well meant continuity and momentum were maintained, not only for individuals at a critical time of establishing safety, but also for communities who were experiencing floods of disclosure and service demand. However, they were also clear that excellent team members, program continuity and momentum were directly and negatively affected by prolonged uncertainty about funding. Others highly praised the value of group debriefing sessions as a way of diffusing the emotional intensity of the work, with peer evaluations and regular program reviews as a means for improvement. Several reported the value of tracking the performance or the achievement of desired objectives, not just as an accountability tool, but also to allow teams to establish *new* goals and directions. Team care included preparatory work to help navigate the journey *without* assuming the role of rescuer, continuous processing of the intense emotional nature of their work, and attending regular professional development opportunities. Team leaders found that they should have elevated qualification requirements and participated in more rigorous screening procedures (including more exhaustive reference checks). They discovered they needed tools or strategies to determine where prospective healers were on their own healing journey, and that supporting field workers and fostering trust between the team and participants were particularly effective practices to ensure positive public relations.

Beyond the selection, development and maintenance of healthy teams, it is clear that those addressing the Legacy have a well-stocked toolbox of therapeutic options with some favoured combinations.

4.3 Therapeutic and Program Issues

In some scenarios, interventions were chosen by actively consulting with Survivors, doing feasibility studies, participating in pilot phases or chosen out of material necessity. Frequently, teams felt ill-prepared to develop interventions without having an intimate knowledge of Survivors' needs and preferences, which led to the use of argueably irrelevant, overly academic training curricula. The experience of feeling ill-equipped was shared by those doing research within AHF-funded projects. Researchers struggled with methods to tactfully approach delicate Legacy issues.

Procedures and protocol for finding and reaching out to Survivors in order to record their needs and develop effective programming was rarely clear and certainly not documented. Furthermore, managing a number of approaches to accommodate service preferences, and the uniquely urban dilemma of meeting the needs of several different cultural communities in a sensitive way, tested several teams. Despite these challenges, teams did their best to be inclusive by using a variety of therapies,[65] not only as a way of maximizing gain, but also to respect client preferences. Because the full range of strategies is as varied as the communities themselves and healing itself convoluted, this discussion is necessarily limited to noted trends and a few select examples. While very little falls into neat categories, some general features of effective action and popular choice are clear.

Because residential school and its legacy have led to significant cost—spiritually, linguistically, socially, psychologically and economically—project teams strive to *reclaim losses* by creating opportunities for learning language, culture, communication and life skills, while supporting self-exploration, reinforcing identity and framing their approaches through a holistic worldview. Abundantly clear is the fact that *culture*, or the functional traditional and contemporary life ways and worldviews of Indigenous groups, whether they are Inuit, Métis or First Nation, *is not only a preferred but also an effective medicinal option*—a theme resonant throughout all data sources. Undoing the cultural hostility that characterized the schools was most effectively achieved by celebrating culture, speaking the language, harvesting or eating traditional foods, and using art, architecture and the natural environment to surround the participant with environmental clues that offered both explicit and expressed approval for the celebration of the Aboriginal self. Traditional activities provided "opportunity for clients to learn who they are,"[66] where Elders were the best teachers and traditional philosophy could be applied to contemporary life. Many projects affirmed the value of traditional healing and the need to increase the use of traditional healers, Elders and cultural teachings, either alone or in collaboration with other methods, while also recognizing that the approach is not for everyone. Culture and tradition also played a supportive rather than therapeutic role, especially when cultural celebrations brought people together to feast and dance, helping to overcome conflict and enhance community pride.

Teams strived to reclaim the losses associated with residential schools through the use of both individualized and more public means that allow Survivors to bond with one another. They attempted to accommodate self-direction and responsibility, and celebrated culture with both supportive and therapeutic purposes. Sometimes, individual counselling is used to prepare people for group processes or as an adjunct to group therapies as a way of providing more personalized care. Smaller groups and one-on-one counselling were preferred when greater privacy and comfort were needed.

On occasion, Elders offered one-on-one sessions where they would provide traditional teachings, followed by sweats and maybe a fast, as a way of preparing an individual for a group context. Although much healing

work takes place in a group context, teams still felt it was important to *offer clients a choice* to discuss issues one-on-one either in a community setting or in the privacy and comfort of their homes where supportive family members could be present.

For some, large group gatherings were preferred because, in part, they offered participants connection and were ideal for early sharing and Legacy education efforts. One project warned against encouraging disclosures in large group venues; although on occasion, participants can tolerate group work only if it is educational. Still, group counselling sessions and peer support settings were widely used and often popular, despite small community dynamics that might affect confidentiality. Some projects use action-oriented group processes, such as psychodrama, while many others use traditional healing, talking and sharing circles. Connecting and sharing with others was often cited as a best practice and included examples far beyond group counselling, such as gatherings, *active* outreach and whole family treatment. Connecting with others helped Survivors feel supported in a way that one-on-one sessions could not.

Light-hearted, *voluntary* gatherings with family or other Survivors where they could empower one another, laugh and have fun offered important bonding experiences that helped support the more arduous work of healing. In addition, joint child and parent activities were an effective way of enlisting the whole family. Beyond a clinical focus, healing was envisioned as a community development effort and connection at the regional level, either through coordination or training, also offered families and communities renewed strength.

Creating a Healing Environment

Healing environments were created through meticulous attention to physical detail, as well as hospitable policy and professional protocol. In particular, natural settings have a way of disarming participants, probably because they feel safe, like they belong. Men appear much more responsive to engagement and suggestion in natural settings. When on the land, individuals feel free to engage in primal screams without restriction or judgement; it is a venue to be heard, enveloped and healed by the earth, sky, wind and water. Visual cues, including Aboriginal art and symbols, generated immediate comfort and, in at least one case, returning to the residential school served as a powerful venue for remembrance, mourning, cleansing and closure. For obvious reasons, residential treatment facilities face special challenges and must be mindful that poor quality food, bunk beds and the use of flashlights on night patrol are clear triggers. Although they could lend credibility, established alcohol and drug treatment centres also prohibited some from attending AHF-funded initiatives since Survivors did not want to be stigmatized as addicts.

Hospitable policy climates appear most promising when therapies are client-driven, client-centred and integrated with a variety of treatment approaches (i.e., Western, traditional and alternative). Teams were unshakable in their belief that emphasizing personal responsibility, together with self-trust, was at the core of effective therapy. Recognizing and using the power of choice—especially in parenting, communication and anger management—were considered essential to address the Legacy and fit well with culturally appropriate treatment.

> [T]he Medicine Wheel allows Aboriginal persons to function as their own authority (priest [or] minister) whereas mainstream cultures usually place teaching and practising authority in "special" hands; this posture dis-invites self-selected and self-directed learning and growth, which most of our clients need and appreciate.[67]

In all cases, healing environments must be *free* venues for participant voice, where they are acknowledged and honoured, and where truth prevails and forgiveness is encouraged. Aside from these core features of healing environments, it is obvious that no single intervention will work for everyone.

Focussing on Unique Needs

Much evidence from the national surveys and case studies points to the high level of need among project participants juggling concurrent disorders (e.g., sexual abuse treatment with other Legacy impacts, such as substance abuse, FAS/FAE, mental illness or foster care issues); representing, perhaps, the most pervasive program challenge. Juggling the needs of the clients while remaining respectful of the limitations and availability of the therapists and healers is an ongoing test of team creativity and endurance.

Results from the first national survey illustrate how teams are addressing special participant needs. The percentage of employees trained to deal with serious issues, such as suicide, family violence and addiction, varied from project to project. Professionals were invited to provide specialized program support either weekly, monthly or yearly. This was supplemented by peer support, trained volunteers for one-on-one counselling and, occasionally, *untrained* volunteers. In some cases, referrals were made to another agency.

Sometimes, *unique* solutions were created by project teams based on individual needs. When client needs exceeded the capacity to provide effective intervention, screening participants was *essential* with some even recommending addictions treatment or life skills courses as *prerequisites* to participation. Access to appropriate outside professional support is necessary. What helped eliminate inappropriate referrals were clearly developed intake criteria and teams requesting the development of an adaptable "Survivor assessment protocol" that would enable them to develop targeted interventions. For other projects, developing whole programs or specific activities to meet the unique needs of special groups (e.g., transgender youth, teens, families, Inuit, Métis, gay/lesbian, men, women, parents, Elders, students and those with special needs) appeared to maximize program influence. However, singular guidance and support for target groups were always dependent upon program flexibility and team skill, especially when dealing with participants with FAS/FAE.

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

> [P]eople are accepting help and support at their pace. Just because we have a timetable doesn't mean the [S]urvivors are ready to move forward at our request. We must accept people where they are and support them as they need it.[68]

Teams wanted better skills and training, as well as more specialized tools, to serve the distinctive interests of sexual abuse victims and offenders. Focus group participants indicated that perpetrators of violence, incest and sexual abuse are adverse to participation because they see little or no obvious gain and a lot to lose. From a perpetrator's perspective, healing comes with shame, degradation, increased and undesirable visibility that could lead to social ostracization or retribution, and possibly jail. Recognizing the unique safety issues of incarcerated sex offenders must form part of an appropriate intervention with them. In many cases, they participate only reluctantly or under duress (e.g., mandated participation, threat of separation from family), and mandated participation was consistently ineffective. Simply stated, people cannot be forced to heal. Furthermore, there may be good reasons for resisting mandated participation since the same feelings of powerlessness and helplessness that occurred in the traumatic experience can be recreated in therapy.

> Patients who suffer from a traumatic syndrome form a characteristic type of transference in the therapy relationship. Their emotional responses to any person in a position of authority have been deformed by the experience of terror.[69]

One-on-one counselling functioned well to meet unique needs. In order to solicit this information and to facilitate self-awareness, one project developed a vision plan. Essentially, the vision plan was structured as a card game[70] where each card says, "It would make my life more complete if I had" and finishes off with something that the individual believes would make a positive change in his or her life. Details of the vision plan card game are offered in Appendix P. Mentors then provide support and nurture growth toward the vision.

In another example, fathers were given a log book with a detailed list of qualities and feelings to support their self-expression. Once sufficient material was collected in the log, the fathers were referred to a social worker who reviewed their material with them. Whereas a fuller discussion of the therapeutic needs of select groups is addressed in volume three of this report, a few target-specific lessons are offered in this volume.

Although teams continue to be challenged by their inability to engage seniors and retain youth, they suggested that focussed initiatives entice Elders by meeting their needs for connection and socialization, and that programs for young people capitalize on very structured environments with a wide variety of activity in short time spans. Uniquely tailored strategies for the Métis recommended a focus on the affirmation of identity and, on occasion, responding to the unique needs meant holding special circles during periods of time that represent higher risk (e.g., before and during Christmas).

An enduring and pervasive pattern of participation evidenced in national surveys, document files, case studies and focus group discussions points to the outstanding challenge of engaging men. While it is clear that women consistently and more readily participate in both healing and training than men, over time, it appears that this gap has narrowed slightly with respect to training.[71] On first glance, the reader could interpret this as an indication that women were somehow more "ready" than men for healing, but caution is required when reviewing gender-specific participation rates. First of all, it is widely known that men are generally less likely to consult a health practitioner even when they have symptoms. In the case of a man carrying the burden of the Legacy, this tendency might be exacerbated by fear of re-traumatization. After all, it is better to be solid than to be hurt again.[72] Some strategies used to reach out to and engage men have

included "Dad and Kids" activities and enlisting male leaders, facilitators and healers. General success is associated with gender-specific fora because there is an atmosphere of emotional safety and ease of relationship within them. Men appear to respond more to activity-oriented gatherings, such as hunting, fishing and other on-the-land activities. In one urban scenario, a men's only collective kitchen worked very well because it allowed them to resume their role as provider with a contemporary twist. In other situations, they started a "single Dads cooking" class, or gathered for hockey night or a game of darts. Men also appear to respond well to individual counselling sessions as a way of preparing them for group work.

However, before effective programming can be developed for male Survivors, more information is needed about their perspectives and preferences when healing from the Legacy. More generally, it is known that sexually abused boys, compared to sexually abused girls, are younger; more often abused forcefully and physically, resulting in injury; less often alone when the abuse takes place; less willing to tell; more often subjected to masturbatory and anal abuse; and less often subjected to noncontact abuse.[73] Male needs have not been adequately addressed in the discourse on child abuse and are thus not well served by therapies operating with a female-centred model of victimization.[74] The literature decidedly points to the need for more research, more gender-specific treatment programs, more male therapists and more understanding of the effects of therapy on men and boys.

In light of the Legacy, one of the more disturbing consequences is the potential for male Survivors of unresolved sexual trauma and abuse to commit sexual offences themselves. While the links between victimization and offending are not fully understood, male victims of child sexual abuse are at greater risk of offending than non-victims, although most child victims do not become offenders.[75] There is an estimated "150,000 Aboriginal sexual offenders in Canada,"[76] although low reporting rates mean that most offenders have never been charged. Since more offenders are not incarcerated, but are in the community, more community-based programs are needed. In addition, there is evidence that voluntary participation (among other factors) is linked more closely to successful outcomes. The primary lesson gleaned from the literature (as well as the evidence that AHF-funded healing activities attract fewer men than women) is the need for greater understanding of the therapeutic healing needs of male Survivors and intergenerationally impacted men and boys.

Combining Approaches

The combination of traditional healing and Western therapies was very popular with over 65 per cent[77] of all national survey respondents indicating they either always or most of the time combined the two approaches. Informants were certain that healing circles, ceremonies (e.g., sweat lodges, smudging, cleansing), storytelling, retreating to land-based traditional camps, together with harvesting and preparing country foods, contributed to healing—supported by Western therapies. Cultural celebration, especially those that provided opportunity for song, food and dance, offered a welcomed balance to the heavier, more emotional work done in counselling. In a few cases, choice went beyond a simple combination to a more active selection of Western techniques based upon how well they would fit *within* the culture. Once selected, the approaches were more intricately woven into the culture through the use of language and Elders.

> [We] use the modern therapeutic approaches that fit within the Inuit values and approaches. Our pair of trainers were Inuit ... and their healing approach combined imagery of the natural world of creation and the Inuit life practices to present an understanding of personal growth through life crisis. Other training facilitators from southern Canada were chosen because of their experience working with First Nations and Inuit people and their training is sensitive to and their approaches respect Inuit values and philosophy of life.[78]

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

Before discussing therapeutic choices, it is important to clarify some important distinctions among what are collectively known as Western, traditional and alternative therapies.

> ***Western*** approaches incorporate all strategies where the practitioner has been trained in Western institutions (i.e., post-secondary educational institutions) including, but not limited to, psychologists, psychiatrists, educators, medical doctors and social workers. For the most part, Western practitioners are regulated by professional bodies, have liability insurance and are state-recognized or their services are covered by provincial health care plans.
>
> ***Traditional*** approaches incorporate all culturally based healing strategies including, but not limited to, sharing, healing, talking circles, sweats, ceremonies, fasts, feasts, celebrations, vision quests, traditional medicines and any other spiritual exercises.
>
> ***Alternative*** approaches incorporate all those strategies outside of most regulated and provincially insured Western therapies and include, but are not limited to, homeopathy, naturopathy, aromatherapy, reflexology, massage therapy, neurolinguistic programming and bioenergy work, as well as ancient Eastern practices such as acupuncture, acupressure and Reiki.

The combination of tools selected by project teams depend largely upon the kind of symptoms that are obvious and what expertise is available. Western practices generally included counselling (individual, group, family and couples), psychotherapy or Christian spirituality, while traditional approaches ranged from sharing circles, sweats, ceremonies and traditional teachings. Alternative therapies varied significantly and included massage, neurolinguistic programming, Reiki, time line therapy and breath work. Examples of Western, traditional and alternative approaches used to address the Legacy are listed in Table 10.

Table 10) Western, Traditional and Alternative Approaches Used to Address the Legacy

Western	Traditional	Alternative
counselling (group, individual, family, couples)	circles	neurolinguistic programming
psychotherapy or psychology	sweats	time line therapy
life skills	ceremonies (Pipe, Naming, Honour)	massage therapy
mental health promotion	feasts	Huna therapy
art therapy	on-the-land activities (harvesting medicine/food)	breath work
Christian spirituality	fasting	bio-field (hands-on healing)
psychiatry	Métis wailers	Reiki
Rogerian therapy	cultural celebrations	acupuncture
Erikson's theory of psychosocial development	speaking the language	energy release work
Inner Child therapy	rites of passage	vibrational healing
attachment theory	cleansing	bioenergetics
Gestalt	drumming, singing	reflexology
Jung		iridology
post-traumatic stress		focussing therapy
response		
genogram charts		
social work		
social justice		
narrative therapy		

Often, traditional and Western therapies are used consecutively or offered as choices with a great deal of creativity to find and use what works, while recognizing that no one approach will work for everyone. Sometimes, the two approaches are used in a fairly balanced or simultaneous way. In other cases, there is a predominance of one over the other and the fluidity appears to be reciprocal. When traditional interventions provided the overarching framework, hints of Western practice were still obvious.

Elder involvement is the single most common traditional element of healing practice. Projects offer Elders training to enhance their competence as counsellors and provide them with the confidence they need to address the Legacy. One of an Elder's most powerful tools, storytelling, has also been used as a way of offering a "diagnosis" and explanation for the impact of the Legacy. Although stories may not directly illustrate an idea, they usually touch participants at a base level of feeling and belief, offer a form of vicarious learning, as well as a variety of nonthreatening solutions.

Also widely used and hugely popular are traditional talking or sharing circles. Historically, the floor is granted to the speaker and circle members listen intently and silently; feedback and group exchange are considered poor protocol. Yet, many teams have combined the structure of the talking circle with features of self-help groups to allow for interaction with peer members or a facilitator/counsellor.

Sweats, one of the most commonly recognized Aboriginal ceremonies of purification and prayer, are also widely used. Traditionally, they were a forum where participants were invited to speak about concerns in an *open-ended* exploration of spirit. To address the Legacy, sweats have become *theme-based* where exploration is *directed* to examine a particular issue, such as relationships with others, resolving past trauma or nurturing the inner child.

Many teams offer nutrition and health education, special counselling for diabetes, reflexology, massage therapy, as well as opportunities for fitness and recreation, because they know bodily strength supports emotional wellness. Contemporary "medicine" bundles are wrapped with modern self-care products like a candle, meditation on CDs (computer discs), bath and massage oils. Physical (e.g., fasting or dieting) and spiritual cleansing practices have been partnered as a way of achieving more comprehensive freedom from both environmental and emotional toxicity. Traditionally, it was recognized that emotions are intimately intertwined with the body; thus, some contemporary therapies that work with "body memory" are selected based upon their recognition and respect for this duality. For example, bioenergetics—a method of becoming aware of where tension and trauma are stored in the body with exercises to release them—is used in one residential treatment program.

Cleansing practices, most notably sweats, have also been used in a few projects with genogram charts or tools that resemble a family tree with specific information related to the Legacy. When family experiences of residential school are included and participants are able to see themselves in concert with family patterns, a much deeper understanding can be achieved. The use of genograms has been so commonly cited as a promising practice, not only within Legacy education efforts, but also in the development of family systems therapy, that it requires further elaboration.

Very basically, a genogram is a detailed family tree that includes genetic relationships and social dynamics between family members, usually over three or more generations. Some of the information provided in a genogram includes:

- name
- age
- date of birth
- ethnicity
- migration patterns
- mental health
- personality characteristics
- education
- occupation
- religion
- romance
- loss
- politics
- important events
- communication patterns
- toxic or "hot" issues (e.g., money, sex, parenting)
- territoriality (i.e., where important family events are held)[79]

Of course, for the purposes of addressing the Legacy, attendance at residential school is important historical information. The intent of the genogram is to allow individuals to identify both problems and solutions across generations. By examining the family *over time,* it becomes clear if family events are mere coincidences or repetitive patterns. Typical questions asked in the development of a genogram include:

- Who are you closest to in your family?
- With whom do you have the most conflicted relationship?
- Are you cut off or estranged from anyone in your family?
- When and how did this occur?
- Who went to residential school?

Once understanding is achieved, individuals who have prepared genograms are often encouraged to go "home" with the information and deal directly with those relationships that are causing current problems.[80]

Taking the value of family history and expanding it to include colonial history makes social justice and narrative therapy well-suited to addressing the Legacy. Used in combination with spirituality and nature, narrative therapy teaches people to tell a different story and develop a new view of their lives. Missing information, including colonial history and the underlying intent of residential schools, explains how Survivors have been impacted by much wider political, racial and cultural contexts. Narrative therapy encourages looking at your history *as a story outside of you* rather than *as a part of you*, so that the story is the "problem." Although social justice and narrative therapy help to erase self-blame for traumatic experiences as a victim, this does not remove responsibility for individual action.

In at least one case, traditional healing was used with Inner Child therapy, a popular approach that helps participants reconnect with their last memory of themselves as a happy, carefree child. The loved child who went "inside" or was suppressed by circumstances that led the individual to grow up too soon and stifle his or her childlike needs so that he or she could always look or be good, becomes the "inner" child. The inner

child develops when one is not loved for who one is, rather than what one does, and never has the freedom to play or act childish. This leaves much unfinished, psychological childhood experiences. Continued suppression of the inner child leads to never learning to feel normal, play, have fun, relax, manage stress or appreciate life. This can lead to guilt, workaholism, inability to enjoy family relationships, social isolation and suspicion of those who do enjoy life. Inner Child therapy seeks to *finish* the psychological experiences of childhood by reconnecting with the last memories of happiness as a child in the context of family, playmates and school, and relearning how to play, have fun or relax.[81]

The medicine wheel was often used as a self-awareness tool to examine balance in mental, emotional, spiritual and physical realms. Because so many people are focussed on survival, it becomes clear that their physical needs (e.g., housing) are acute and efforts are concentrated in that realm to achieve greater balance. The medicine wheel was also used to organize the counselling relationship and provide a visual tool for clients to assess their progress. One project uses medicine wheel teachings with the Myers-Briggs Type Indicator (MBTI) as self-awareness tools. Essentially, the MBTI is a versatile instrument that helps identify learning and coping styles, improve communication skills and provide guidance for goal-setting.[82]

The MBTI was developed using Gestalt personality theory, commonly cited as a useful model in AHF-funded projects. Gestalt therapy teaches a form of self-awareness where the emphasis is on what is being done, thought and felt at the moment, rather than on what was, might be, could be or should be. Explanations and interpretations are considered less reliable than what is directly perceived and felt.[83]

When the overarching framework for healing was grounded in Western practice, tradition was regularly part of the wellness repertoire. For example, in one Métis project, grief counselling was augmented by bringing in traditional Métis wailers. Historically, the role of the wailer was to come to a wake and cry aloud as a way of releasing grief for the family. In other cases, traditional songs, music or drumming, as well as ritual or ceremony, were used to create an atmosphere for, or as a prerequisite to, contemporary relaxation techniques and massage therapy. Opening and closing ceremonies were often used as a way to bridge Western therapies within a cultural space and some teams respected participants by singing an honour song. Teams that use sentencing circles incorporate Elders who work collaboratively with counsellors and self-help strategies, and bear an extraordinary resemblance to healing circles.

Rogerian therapy was identified as a Western approach that fit well with traditional teachings about self-responsibility. Carl Rogers, noted theorist and psychologist, developed and used a client-centred approach where individuals identify the problem, find ways to improve it and determine when therapy is done. This approach is supportive, not reconstructive, and seeks to establish freedom *while reinforcing self-responsibility* and fastidiously avoiding an unhealthy dependence upon a therapist. Such an approach allows individuals to try out their insights on their own, in real life and outside of counselling and therapy.[84]

Art therapy was hailed as a promising practice by one team because it allows for expression and healing through *nonverbal* means that are well-suited to children or adults who may use words to intellectualize and distance themselves from their emotions. Without prior art experience or talent, individuals are able to overcome barriers to self-expression with simple materials in a nonlogical and symbolic approach.

Erik Erikson's theory of psychosocial development is considered well-suited to Legacy education efforts and traditional healing practices. Essentially, Erikson proposes that each stage of life presents a basic

psychological and social conflict that, if resolved, successfully results in virtue. If not resolved, it can result in maladaptative behaviour or dysfunction.[85]

Focus group participants also identified attachment theory as a framework that resonates with Survivors because it validates the primacy of parent-child interaction and bonding (usually mother-child) for emotional development.[86] When the child and caregiver relationship is characterized by a healthy, dependable and loving bond, children are able to explore, become fully released from dependence and form mutually contributing relationships with others. When the parent-child bond is disrupted or insecure, then distrust, uncertainty and lowered expectations characterize subsequent relationships.[87] Residential schools, of course, disrupted these fundamental attachments.

> I went to residential school at 4 ½ years old, I was fluent in Dogrib and didn't speak any English … I stayed in residential school for 10 years after that. The first year I went home … Everyone was happy to meet their parents and I was afraid because I didn't know who my mom and dad were until my brother showed me. The thing that helped me to go through this is that my father could speak English and communicate for me with my mother who spoke only Dogrib. When I met my mom I didn't greet her, hug her, because ... I believed that my mother was a Nun at the school … When I saw my mom I wasn't happy at first because I didn't know who she was.[88]

Other examples of an increased sensitivity to the unique needs of Survivors and their families, as well as the clinical flexibility to draw from the best of all worldviews and tools, are reflected in simpler choices. For example, in three of the projects identified for participation in focus group discussions, intake forms and staff debriefing sessions were modified to include more holistic assessment by including information about the mental, emotional, physical and spiritual state of individuals. In other cases, teams used Western tools or technology, such as the Aboriginal Peoples Television Network (APTN), to facilitate healing. Although more specific and detailed information is required about the combination of traditional and Western approaches and how they work, what is learned suggests that a greater awareness and a sensitivity to Survivors' preferences and unique needs exist.

Challenges

Programmatic and therapeutic challenges remain, particularly as they relate to the issue of timing. Teams have created conditions conducive to healing that have drawn many into the movement toward wellness. Project participation rates suggest that thousands have disclosed their histories or engaged in remembrance and mourning. However, participants face an uncertain future of support through the most arduous healing phase of reclamation. This may represent the most compelling and pervasive challenge to community-based teams.

> Building strong families and strong communities is a long-term process. Short-term, ill-conceived responses can do more harm than good. In particular, if victims are encouraged to disclose the abuse they have suffered, adequate and appropriate services must be available … If not, many will be left even more severely damaged. A strategy that builds knowledge, trust and community capacity over time will be much more effective in the long-term.[89]

The literature is clear that the failure to provide clients with adequate time and support to heal is irresponsible.

> Programs that promote the rapid uncovering of traumatic memories without providing an adequate context for integration are therapeutically irresponsible and potentially dangerous, for they leave the patient without the resources to cope with the memories uncovered.[90]

Teams and participants urged for sessions to be longer in duration (a noted theme in case study, document review, IPQs and focus group discussions). Even though intensive or retreat formats work well, these are still *only a beginning.* There was a universal call from project teams for the development of aftercare service, especially from those teams with province-wide catchment areas. The concern was not just about formal community services, but also about the critical informal support of family and friends. The amount of time and effort the healing journey requires must be recognized so that when the AHF's mandate has expired, a simple lack of time does not become the peg on which Canadian society hangs its collective hat and says, "*sorry, we tried....*"

4.4 Partnerships and Sustainability

Perhaps the most fruitful partnerships were those established with noted "experts," namely Survivors, as a way to ensure programs would be based on their reality and not distantly developed theoretical assumptions. Depending upon the target group, this also meant that decision makers should be selected based upon their age, gender and family status. In other words, teens were best able to decide what might work for teens, men best able to develop programs for men, and so on. Certainly, Survivor and Elder involvement in governance structures, program decision-making or in less formal exchanges were *highly valued.* Continuous and formal feedback from participating partners ensured that project activities remained relevant and evolved to best suit participant needs and community aspirations with activities that were well received, powerful and workable. Where community climates were not hospitable, the establishment of a wellness committee gave projects moral independence from agency politics or apathetic local governments and turned out to be very practical partners. Networking with other communities and special outreach efforts to isolated areas produced the best results for some teams. Perhaps most importantly, *supportive leadership played a pivotal role in contributing to desired outcomes*, not only because project teams did not have to spend time challenging political resistence, but also because leaders could often find ways to supplement budgets, develop consistent policy, provide facilities and transportation or lend credibility to the endeavour.

Schools were often mentioned as powerful allies, not only in Legacy education, but also as institutions that could guard Aboriginal cultural integrity. Of course, project teams recognized that a *range* of partnerships meant service integration, more holistic care and an avenue for Survivors to continue to engage in healing, even if their needs exceeded the expertise of the project team. Having weekly clinical supervision from professional consultants (psychologist, medical doctor, dietician, nurse), as well as involving Alcoholics Anonymous sponsors and parole officers, worked very well in one context. These same alliances were important when it came to planning and ensuring adequate aftercare. Open communication and involvement with local agencies have improved trust, working relationships and access to information. Teams were convinced that their ability to secure additional support for their efforts was related to the synergy created by an interdisciplinary approach. At times, communities had to rely upon facilitators or trainers from *outside* the community to work with or develop the capacity of local caregivers. When community members

were reluctant to be viewed as an "expert" or were involved in therapeutic situations that were too close emotionally, outside expertise provided by formally established partners was considered necessary and helpful.

Still, merging with other organizations to provide seamless service was not always easy. In at least one case study, partnerships with provincial agencies was thwarted by ignorance and, quite possibly, systemic cultural oppression. Provincial services continue to refer Survivors to Western therapists despite the lack of cultural relevance, familiarity with traditional Aboriginal worldviews and knowledge necessary to address their unique needs.

> [We] are free to use the Medicine Wheel in everything we do and this is the most "threatening" feature of our operation to mainstream service providers; Aboriginal people feel at home in our shop and our programs and they do not have that same sense of belonging in other mainstream or government agencies.[91]

Other cultural tensions include the fact that provincial agencies are mandate-centred, while AHF-funded project teams are client-centred.

> Our first ethical consideration is "the good of the client," and thereafter, professional currency and public safety receive consideration as ethical priorities. The opposite is true of persons under contract to the Crown … public safety becomes the first priority, current practices, the second and the good for the individual person the lowest priority.[92]

Sensitizing Western practitioners by involving them in ceremonies was considered a particularly effective way of influencing them to consider, respect or integrate traditional practice with mainstream therapies. Some healers encouraged participants to request more culturally sensitive approaches from their non-Aboriginal therapists or actively promoted traditional approaches with Western practitioners. In one community, doctors are agreeable in permitting individuals to exercise the traditional practice of burying the placenta; a funeral director makes a hole in the casket so that the spirit can be released; and a local hospital allows "passing over" ceremonies. Raising community awareness in Canadian institutions about the Legacy, while raising Survivor awareness of the variety of healing options and healers (both in the community and with established partners), was considered a way of introducing and connecting participants to resources that could help them beyond the life of the AHF.

Finally, the uncertainty of the project's future is felt by many and affects the project teams at two levels: job uncertainty is very disconcerting for teams, and healers were concerned about uncovering traumatic memories without providing adequate follow-up. Some projects were able to address sustainability, such as reporting the implementation of fund-raising initiatives for specific objectives and needs that covered a wide range of goods and services (literature, computers, sound systems, office space, training facilities and transportation). A lucky few have secured ongoing funding, but the vast majority face an uncertain future with respect to their efforts in addressing the Legacy.

Gordon Indian Residential School
Photo: Courtesy of Janice Longboat

Performance Report

"*In order to heal, I need to speak.*"[93]

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

> ***success*** *(sckés) n. the accomplishment of what is desired or aimed at, achievement || attainment of wealth, fame, prosperity, etc.*[94]

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

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

If we consider healing as a journey and measure success as *travel* on that journey, then it is important to consider where the journey begins. In other words, at what place and time have individuals and communities started in their efforts to address the Legacy. For example, if a project is dealing with a convicted murderer whose recidivism record is high, but each infraction is less violent until finally his involvement with the criminal justice system is related to a mere probation violation, does this represent a measure of success? If recidivism is the only measure of success, then valuable information about the nature of the crime history would be missed and an opportunity for a true understanding of the distance "travelled" would be lost.

Similarly, if you begin the journey as a teen mother with FAS who is at risk of losing her baby and has a history of childhood sexual abuse and provincial wardship, does coming out of your room after three weeks of self-imposed isolation within the context of the family healing home represent success? On a statistical level, it does not. However, on a clinical level, it represents an enormous statement of trust and a foundational first step towards an improved quality of life.

Communities, like individuals, start the healing journey at a particular place in time and space. The times and the environment are landmarks in their journey and, to best understand the contribution the AHF has made, it is imperative for the reader to bear in mind both the participant and community challenges recounted in this report and previous interim evaluations.[95, 96] It is also important for the reader to consider that, although efforts have been undertaken to determine whether or not AHF-funded activity is contributing to desired short-term outcomes, it is *still very early in the life of the initiative* and each individual and community starting point is unique. Nonetheless, energy has been invested in this report to determine what early contributions, if any, AHF-funded activity has made with respect to:

1. influencing individuals and families, specifically, their achievement with respect to
    - awareness and understanding of the Legacy,
    - personal healing, and
    - their capacity as healers; and

2. influencing communities, in particular,
    - establishing partnerships and ensuring sustainability,
    - engaging, meaningfully, Survivors and the intergenerationally impacted and ensuring accountability,
    - addressing the need, and
    - managing program enhancement.

Greater detail about desired change is helpful as a pretext to a discussion of the early signs of impact. When examining project performance, it is always important to know who will change, what will change about them, when and how will it change, and how long the change will last?

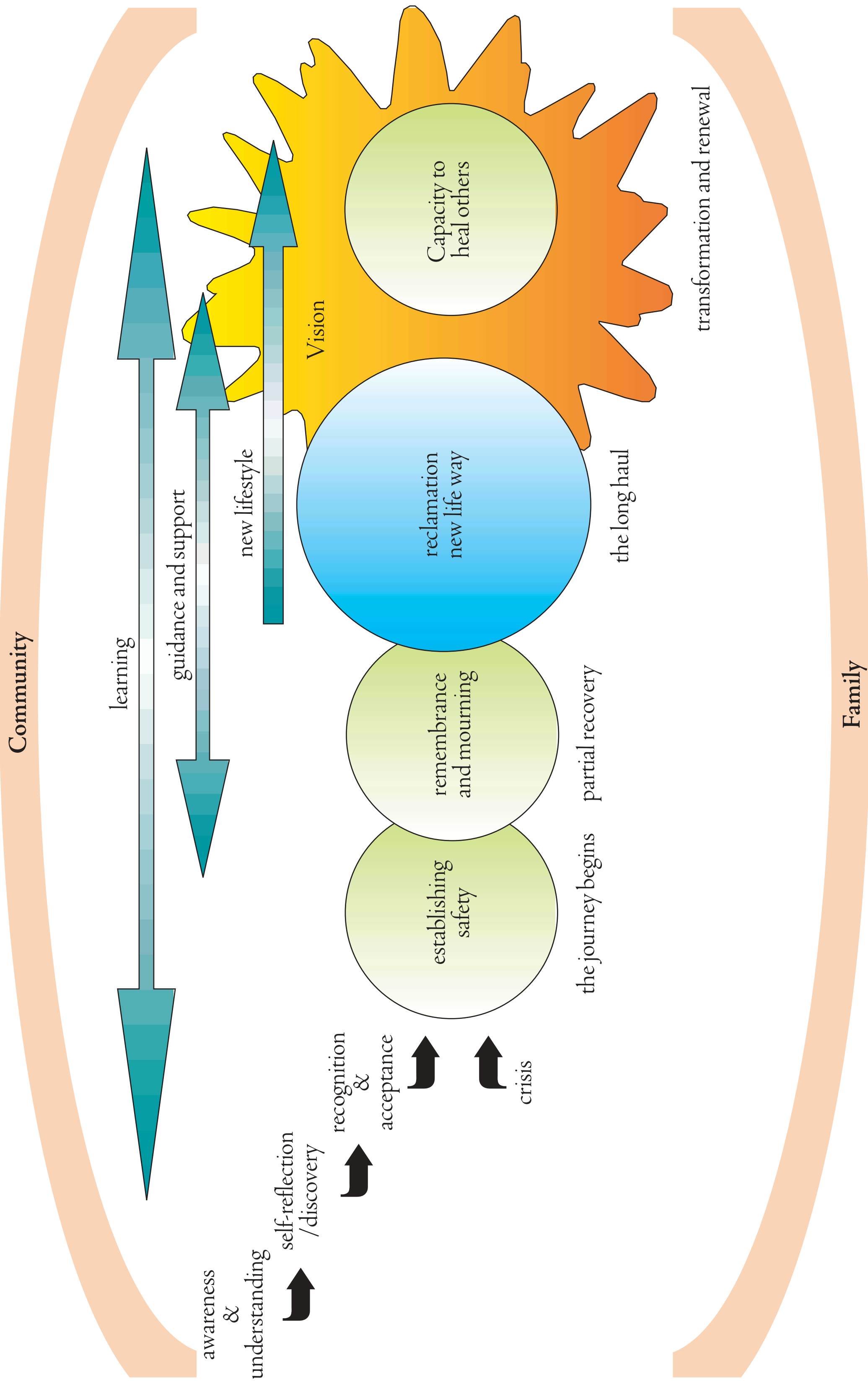
Because some information about the way individuals and communities will change is unclear, some assumptions must be made. For example, it is not entirely clear when change will happen, how much change will occur or how long it will last. It is assumed that cognitive change or change in attitudes, knowledge, motivation and intention will change immediately. In other words, all projects should be able to detect a change in participant ideas during or immediately after project implementation. Behavioural change is more difficult to predict and varies considerably, depending upon the kind of change that is desired. Some participants change their behaviours during the project and others change some time after their participation. Climates, like individuals, will vary considerably in their responsiveness to change. The following discussion looks first at individual and family change, then at community change. Information has been gathered to determine what contribution, if any, AHF-funded activity has made toward change. This chapter also advances the discussion of a more relevant performance measurement framework for addressing the legacy of physical and sexual abuse in residential schools. While it is still early in the life of this national initiative, some promising evidence is clear.

5.1 Impact on Individuals

> [I]n the course of a successful recovery, it should be possible to recognize a gradual shift from unpredictable danger to reliable safety, from dissociated trauma to acknowledged memory, and from stigmatized isolation to restored social connection.[97]

Survivors appear to live through a natural sequence on their healing journey that can begin with awareness, followed by an understanding of the Legacy's impact on self and family, which precipitates reflection, discovery and acknowledgement that can lead to healing. Of course, crisis alone can also catapult individuals into seeking help. Once in a therapeutic environment or relationship, Survivors need to *feel safe,* and this is where the hard work begins for both the Survivor and the healing team. In the next phase, past trauma is faced and resolved and the individual develops relationships with others on the journey. Finally, there is reclamation of healthy productive lives and the rightful expectation of the same outcomes as non-Aboriginal people in Canada. The reclamation phase takes *considerably more time* and requires immense discipline as well as continued support and guidance to establish stability. Reconciliation fits at end stages because healing is not complete without forgiveness. In the end, some rest comfortably in their own healing while others are called to heal family, friends or community. In any case, the latter phases are where a personal vision comes to fruition. Represented schematically and blended from the stories told to us by those addressing the Legacy, therapeutic practice, and broader Aboriginal healing experiences,[98] the Survivor's healing path might crudely be represented by Figure 18.

Figure 18) A Survivor's Journey

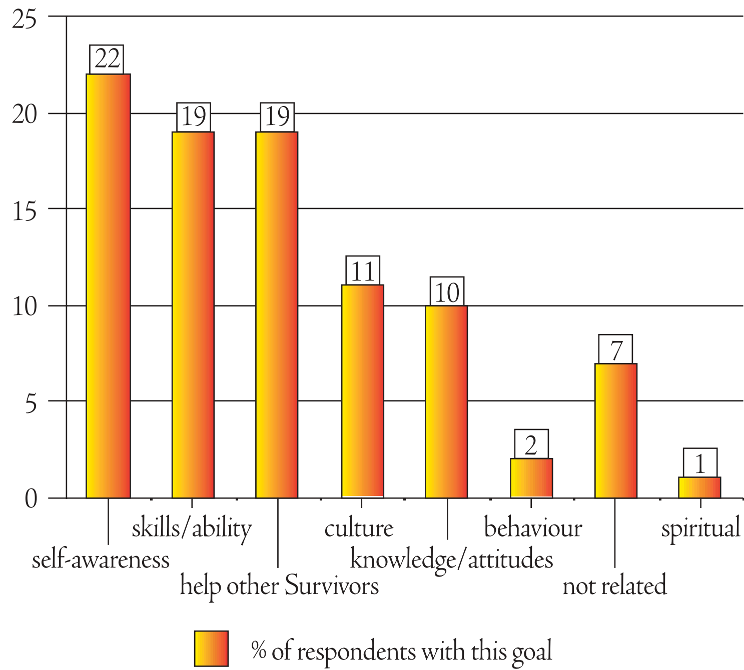


The following discussion is framed in this sequence with some phases obviously having more rich detail than others. Profiled here are the results obtained from in-depth case studies (identified in Appendix G of Chapter 2), document review (including project files as well as minutes from regional and national gatherings), focus group discussions and results obtained from individual participant questionnaires (IPQ). The IPQ was developed as a way of strengthening Survivor voice and gathering information about participant satisfaction, as well as a self-reported statement about the achievement of key AHF goals. Despite the range of activities offered, several goals for individuals are shared between projects, which include:

- ensuring a warm, welcoming climate of support and safety;
- improving connection between those in need and service providers able to facilitate healing;
- enhancing ability to move beyond or resolve past trauma, handle future trauma;
- recognizing and dealing with the Legacy;
- increasing movement toward individual healing goals;
- changes in knowledge and skills that support healing;
- better individual ability to secure support from any source (professional, familial or personal) when it is needed; and
- an overall improved ability to cope or resolve life's difficult issues.

Beyond the goals of AHF-funded activity, participants dreamed of knowing and understanding themselves in ways that helped them to feel better about who they are and what they have to offer. They craved simple solace that comes with firm identity and comforting self-love. They wanted freedom from anxiety, sadness, guilt, self-destructive behaviour and social service interventions. Some just wanted to wake up one morning *without* pain. Participants were eager to learn new skills, generate new ideas and face life with a fresh attitude so they have the mental and emotional energies required to handle problems, let go of grief, as well as seek and secure healthy relationships. Some sought after the ability to listen intently and communicate effectively so that they could relate to others, trust enough to share, as well as feel heard and understood. They wanted the ability to influence others, hold steady jobs, remain drug-free, find support and forgive those who hurt them. They yearned to be better role models, parents and students. Participants envisioned a brighter future for their communities too, where children were safe, addictions were rare and women were free from the fear of violence. They aspired to create communities where a sense of belonging prevailed, morale flourished, culture was celebrated and intergenerational abuse was someone's vague memory. Respondents' goals reflect the primacy of their individual needs and the overwhelming connection that they feel to other Survivors and/or participants. When using a deductive framework for analysis, the most commonly cited goals were self-awareness (22%, n=1,281), help other Survivors (19%), acquire new skills or abilities (19%), reclaim culture (11%), change behaviours (10%), gain knowledge or change attitudes (10%), and influence the broader community (2%). Respondents' goals by type are illustrated in Figure 19.

Figure 19) Respondents' Goals by Type (2004)



Legend: A total of 1,281 participants responded to this question.

When a more inductive analysis is done on the open-ended responses obtained regarding personal goals, the following results were obtained. A guide to the inductive analysis of participant goals is provided in Appendix Q.

Table 11) An Inductive Analysis of Participant Goals (2004)

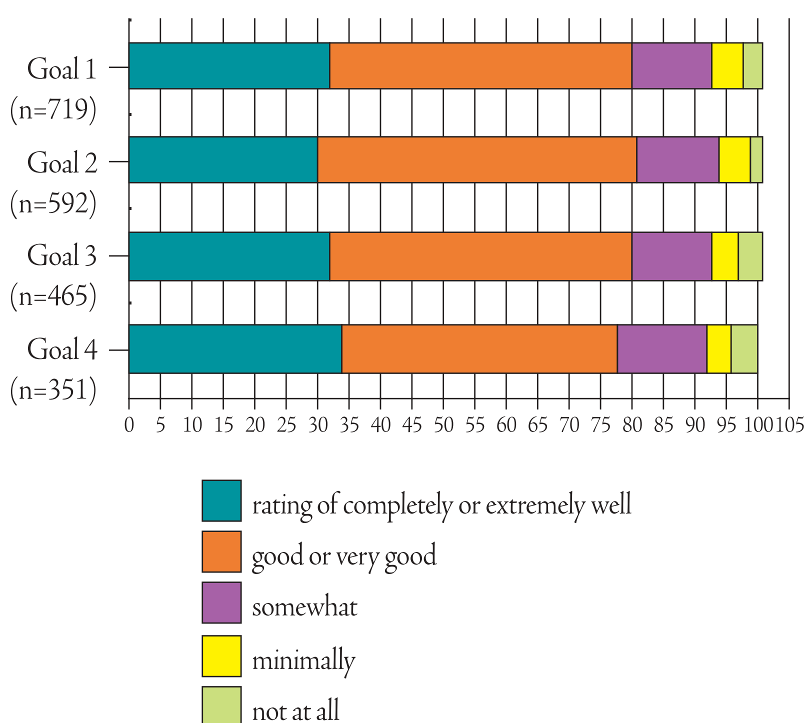
OBJECTIVE	#	% sec*	% whl*	Comments
FREEDOM from				
addiction	45	75.0%	3.7%	43 of 45 were related to drugs and alcohol
SS intervention	5	8.3%	0.4%	all were about not having child removed
incarceration	3	5.0%	0.2%	
violence	4	6.7%	0.3%	
other	3	5.0%	0.2%	2 comments about bad behaviour, one procrastination
Total Section	60	100.0%	5.0%	
PERSONAL: Achieving/increasing a positive change in behaviour/skills				
specific goal	28	7.1%	2.3%	job, home, car, financial goals, and completing program
skill or education	40	10.2%	3.3%	includes those who would like to become healers
specific information	125	31.7%	10.4%	most often about the Legacy
communication skills	25	6.3%	2.1%	
support network	17	4.3%	1.4%	
assertiveness	5	1.3%	0.4%	
cultural identity	94	23.9%	7.8%	language and traditions
other/general	60	15.2%	5.0%	
Total Section	394	100.0%	32.8%	
RELATIONSHIP:				
parent/grandparent	51	50.5%	4.2%	only 2 of the 51 referred to grandparenting skills
partner/spouse	18	17.8%	1.5%	
role model/peers	9	8.9%	0.7%	
family	23	22.8%	1.9%	"better life for children/family"
Total Section	101	100.0%	8.4%	
COMMUNITY:				
involvement	55	30.2%	4.6%	participate more in community (socialize)
sharing	55	30.2%	4.6%	actively share experience, knowledge
renewing	5	2.7%	0.4%	active part in renewal of Indian culture
creating	67	36.8%	5.6%	active part in creating safe, supportive, healed community
Total Section	182	100.0%	15.1%	

SUBJECTIVE	#	% sec*	% whl*	Comments
EMOTION: control over or ability to deal with:				
shame	5	5.9%	0.4%	
guilt	5	5.9%	0.4%	
anger	18	21.2%	1.5%	
grief/death	9	10.6%	0.7%	
pain	5	5.9%	0.4%	
sadness	6	7.1%	0.5%	
fear	6	7.1%	0.5%	
other/general	31	36.5%	2.6%	"deal with past issues"
Total Section	85	100.0%	7.1%	
An increase in self:				
identity	44	11.5%	3.7%	
respect/esteem	45	11.8%	3.7%	also worth, love
trust/honesty	17	4.5%	1.4%	also ability to share
forgiveness	20	5.2%	1.7%	
healing	73	19.2%	6.1%	self and family (4) and community (3)
awareness	70	18.4%	5.8%	understanding
empowerment	18	4.7%	1.5%	
hope	5	1.3%	0.4%	
happiness	24	6.3%	2.0%	peace, acceptance
knowledge	39	10.2%	3.2%	
general/other	26	6.8%	2.2%	feel, cope better
Total Section	381	100.0%	31.7%	
TOTAL	**1,203**		**100%**	

Legend: ss = social services sec = section whl = whole * = rounded to nearest decimal point

When asked about their ability to achieve personal goals in the context of AHF-funded projects, about a third indicated they were able to do so completely or extremely well. About half felt the project was good or very good at helping them attain personal goals; however, there remains a small group (about 10%) who are only minimally or not getting their needs met in the context of AHF-funded projects. Figure 20 illustrates how participants felt about the project's ability to help them achieve personal goals.

Figure 20) Perceptions of Achievement - Personal Goals (2004)



A total number of 1,479 IPQs from at least 143 projects were received. Respondents were as young as 10 years and as old as 93 years (average age 44, n=1,386), with the solid majority (63%) being female (n=1,389). Most respondents had completed the healing activity funded by the AHF (63%, n=1,107); those who did not complete the program (83%, n=369) claimed it was because the program was ongoing. Those who *chose to withdraw* cited psychological problems (including fear, lack of trust, denial, addiction), followed by competing responsibilities (new job, relocation, family crisis or responsibilities) and physical problems (i.e., poor health or lack of transportation). In a few cases, participants had passed away or program issues (i.e., staff turnover, inability to accommodate varying healing levels) accounted for withdrawal. For example, a few participants may not have completed the program because of poor cultural or spiritual "fit" (i.e., Christian participants looking for an approach other than traditionally spiritual practices), and only a couple of participants were terminated (i.e., noncompliance) or left due to lack of interest. Survivors (those who actually attended residential school) represented the majority of respondents (58%, n=1,283), a solid majority (78%, n=1,240) had family members (i.e., brother, sister, aunt, uncle) who attended the schools, and most respondents claimed that their parents (69%, n=1,244) and grandparents had also attended residential school (55%, n=1,045). First Nations formed the bulk of IPQ respondents (84%, n=1,433), followed by the Métis (10%), non-Aboriginal participants (2%), the Inuit (1%) and those of unknown identification (4%).

5.1.1 Awareness and Understanding of the Legacy

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

> It is very important for our people to understand that all stories are relevant and real. There is a great need for our people to find all kinds of avenues to construct their story—through ceremonies, plays, workshops—this definitely needs to happen.[99]

Surprise was expressed at how little information and understanding there is about the Legacy, especially among youth[100] and non-Aboriginal human service providers. At times, Legacy education was part of more comprehensive teachings related to the processes of colonization and decolonization that, in turn, offered more in-depth insight on individual and community dynamics and was integral to the counselling process. Secondly, awareness campaigns felt *safe* to the majority. This helped in prompting further action in addressing the Legacy, often *before* a crisis. Communities also recognized that Legacy education set a strong foundation for training and service improvement. This filled a gaping hole for those in general Canadian agencies.

> The opportunity to educate non-Aboriginal people of the long-term effects of the residential school system has been both rewarding and astounding. Shocking in the sense that the feedback that I have received from the workshops is that most people never really looked at the residual effects of such a system.[101]

Where trust still needs to be established, *information* sessions are more highly attended than *therapeutic* ones. Active efforts with local media, especially radio broadcasts in an Aboriginal language, were considered very effective, but in some situations awareness was raised passively (e.g., simply by the existence of the project).

Other strategies such as theatre, psychodrama and film facilitated understanding in an easily accessible, experiential or popular format. Psychodrama opens the door to learning new ways of acting and reacting through role-playing and other exercises. Many felt that schools were particularly important partners in this regard and that greater efforts with students should be undertaken.

Many first-time disclosures, for example, took place during debriefing sessions after *Every Warrior's Song*, a theatrical production honouring Survivors produced by the George Manuel Institute/Neskonlith Indian Band in Chase, British Columbia. Surrounded by family, community, counsellors and a skilled facilitator, Survivors felt supported and safe to process these revelations. Still, projects were open about their struggles with denial. In fact, resistance to disclosure *should be anticipated* and understood as a natural reaction to trauma.

> They [Survivors] may feel stigmatized by any psychiatric diagnosis or wish to deny their condition out of a sense of pride. Some people feel that acknowledging psychological harm grants a moral victory to the perpetrator, in a way that acknowledging physical harm does not. Admitting the need for help may also compound the survivor's sense of defeat.[102]

In Tsow-Tun Le Lum Society's Qul-Aun Program (Lantzville, British Columbia), key informants unanimously felt that an increased understanding was obvious, although restricted to about 75 per cent of the participant group. Information from the case study on the Centre for Indigenous Sovereignty's *I da wa da di* project (Ohsweken, Ontario), the vast majority of participants (91.2%, n=34[103]) felt the information presented had increased their awareness and understanding of the Legacy's impact. One *I da wa da di* participant illustrates how knowledge gave her the resolve to break the cycle.

> It helped me to further look at and understand what happened to my grandmother and why I was raised the way I was. It helped me to become even stronger and more determined to give my children, my grandchildren the things, ways and teachings about who they are, a "good life."[104]

5.1.2 Personal Healing

Once an understanding has developed, then the hard work begins: establishing safety, uncovering past trauma and reclaiming a healthy life take time, and individual goals fell everywhere along this journey. In fact, project teams and Survivors have imagined healing as a broad range of ideas and behaviours, variably represented by positive movement in any or all of the following phases of change—either simultaneously or sequentially. The outcomes they observed and sought have been organized according to an adaptation of Judith Herman's work with individuals who endure a complex post-traumatic response.

First of all, 111,170 individuals (supported by 394 organizations) have participated in healing programs [Ext - 204,564: n=725] to date. A sizeable portion of project participants (66% or 11,325 out of a possible 34,953, n=138 [Ext. – 17,890: n=218][105] may be engaged that have never before addressed the impact of the Legacy on their lives and families.[106] They spent an average of 149 hours in programmed healing activity (median[107]=80 hours, n=117, S2) and would get as little as two or as many as 1,225 hours of support and guidance. Although dramatic change was observed in some participants engaged in case study projects and responding to the individual participant questionnaire (IPQ), others showed little or no change. Furthermore, there was often disagreement about the magnitude (or depth of change within individuals) and the extent (proportion of individuals in a group) of change. Still, it was possible to gather a picture of the *nature* of change and, in only a few cases, it was clear that observed change endured beyond the life of the project.

5.1.2.1 Establishing Safety

Establishing safety was the platform upon which healing stages were based. Physical and emotional safety were provided by:

- clear guidelines and education about client rights;
- publicizing guiding principles and rules in language that prospective clients understand;
- being a client advocate first;
- providing an environment that reduces the chances of triggering traumatic memories (especially in residential facilities); and
- ensuring that the risk of punishment for disclosure is eliminated.

Teams were clear that *disclosure* was essential in stopping violent activity and reducing the risk of aggression. Warm, welcoming, predictable environments and clearly defined, well-published codes of ethics that *everyone* could understand (especially related to confidentiality) helped eliminate fear of the unknown and re-traumatization. Sharing space with an established centre of healing strengthened credibility, providing comfort to members. To further earn trust, projects created safe healing environments by:

- providing support for participants during and after workshops;
- holding smaller, more private discussion groups; and
- ensuring that healers are sufficiently healed *before* they are entrusted with healing others.

Connecting Survivors to one another and to skilled healers worked well in this regard. Large public forums and widespread publicity offered Survivors union. The project team for the play *Every Warrior's Song* (George Manuel Institute/Neskonlith Indian Band, Chase, British Columbia) remarked that disclosure was an anticipated and supported event after every performance. In Ontario, over 95 per cent of those who responded to the *I da wa da di* evaluation said they felt safe at the gathering. In La Ronge, Saskatchewan, Cree radio productions on the Legacy facilitated discussion in other venues.

In more individually-focussed therapeutic environments, establishing safety was again reinforced by offering opportunities for *connection* through group counselling sessions or by having a therapeutic team with whom Survivors and other participants could identify with. Individual participant questionnaire respondents believed that projects excelled in their ability to provide respectful, welcoming and safe environments (94%, n=1,353) for healing. Counsellors who are nonjudgemental, sincere, trustworthy, gentle, respectful, committed and culturally sensitive were clearly credited with noted progress toward comfort. Time was also a factor in establishing comfort. Survivors needed to know that their innermost selves would be safeguarded before accepting support.

> Because the tasks of the first stage of recovery are arduous and demanding ... It is often tempting to overlook the requirements of safety and to rush headlong into the later stages of therapeutic work. Though the single most common therapeutic error is premature or precipitate engagement in exploratory work, without sufficient attention to the tasks of establishing safety and securing a therapeutic alliance.[108]

One young mother spent the first two weeks in her room at the Shining Mountains Living Community Services' Tawow Healing Home in Red Deer, Alberta (a whole family parenting skills program for families at risk) with her infant child. When it became clear that coercion would not be a defining feature of intervention, she was able to receive warm, culturally appropriate guidance. In the Kikinahk Friendship Centre Inc.'s Kikinahk Parenting Program in La Ronge, Saskatchewan (for parents of teens), only women came initially. Eventually, they brought their husbands and teenagers. In fact, the level of participation surprised the team. "There are fathers who, for the first time in their lives, are having an emotional family outing with their sons." [109] Parents became increasingly comfortable to share insights and ask questions. Beyond connection and time, the physical environment was also critical. Building A Nation, Inc. (Saskatoon, Saskatchewan) seems particularly successful at creating an environment where even "hard-to-reach" groups (e.g., homeless individuals) felt welcome and safe. Complete acceptance and "drop-in" availability, together with culturally appropriate and client-centred services delivered by Aboriginal people (some of whom

speak Cree), have been credited with creating an environment where participants feel they belong. In fact, all participants return. However, residential treatment facilities with bunk beds, night security who carry flashlights and low budget cafeteria-style food may work against establishing a climate of safety. Sometimes, facilities that were too closely associated with addictions treatment also inhibited those seeking help for fear of stigmatization as an addict.

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

> My Mom is a Survivor, she attended one performance and I acknowledged her there as a Survivor for the first time … she started talking more which she never did before … like she used to have problems hugging and now she does [hug].
>
> [T]he audience opened up and wanted to talk about things at a very personal level.
>
> They [Survivors] want to do something about it and are just waiting for the right opportunity or circumstance.
>
> A lot of people attended with family members and are now doing things with them. Many wanted to see repeat performances and to bring other family members.
>
> Survivors attended rehearsals, plays and were often crying, talking, encouraging us. They expressed how glad they were that someone was telling their story. Some helped with facilitation after the plays, some taught us songs.

After five performances, 41 individuals and 14 families sought counselling and four individuals were referred elsewhere. By providing honour for those who suffered and a nonthreatening venue for the story to be told, *Every Warrior's Song* facilitated an individual's decision to seek help.

Establishing safety was often related to how participants became engaged in the first place, and most IPQ respondents were either self-initiated, referred or "mandated" to attend. For most (53%, n=1,336), this was the *first time they had ever participated in a healing program*. Of those who had participated in previous healing (n=675), 44 per cent had engaged in at least one program, 22 per cent in two programs and 33 per cent had a demonstrated investment in healing and had attended three or more different programs before participating in AHF-funded activity. When considering the types of services used and their perceived efficacy, Elders, ceremony, one-on-one counselling, healing or talking circles, traditional medicine, opportunities to gather, share and bond with other Survivors and their families, as well as Legacy education and land-based activities were considered most effective. Figures 21 and 22 show service use and preference.

Figure 21) Types of Services Used (2004)

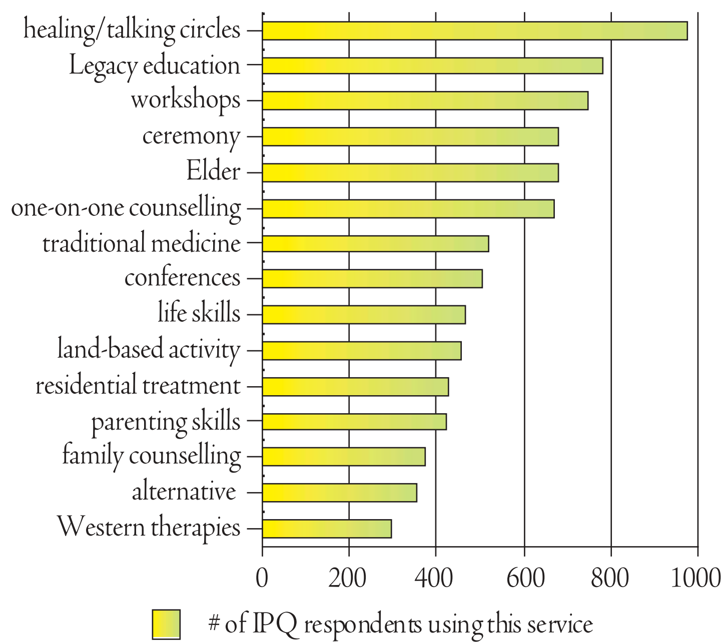
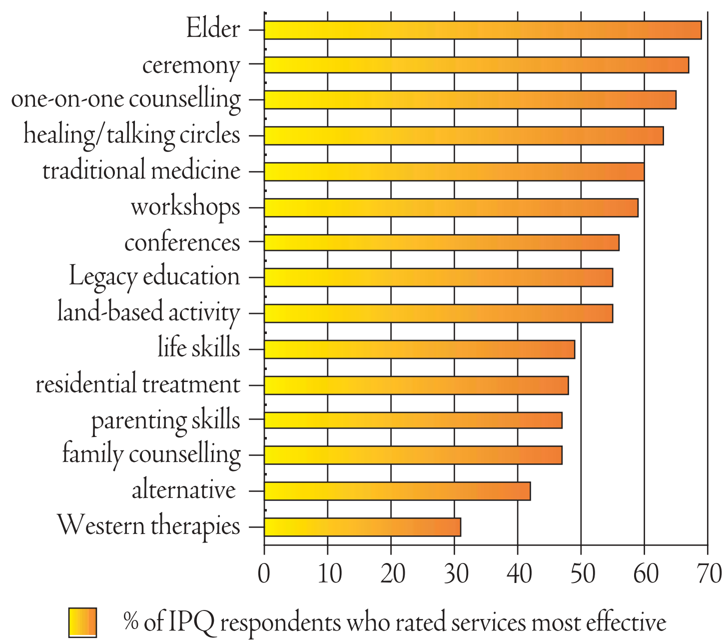


Figure 22) Rating Types of Services Used (2004)



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

type of service	n =	type of service	n =	type of service	n=
healing/talking circles	976	family counselling	374	life skills	464
land-based activity	454	one-on-one counselling	668	Elder	679
alternative	354	parenting skills	424	workshops	747
ceremony	680	Legacy education	783	conferences	503
traditional medicine	520	residential treatment	427	Western therapies	295

5.1.2.2 Remembrance and Mourning

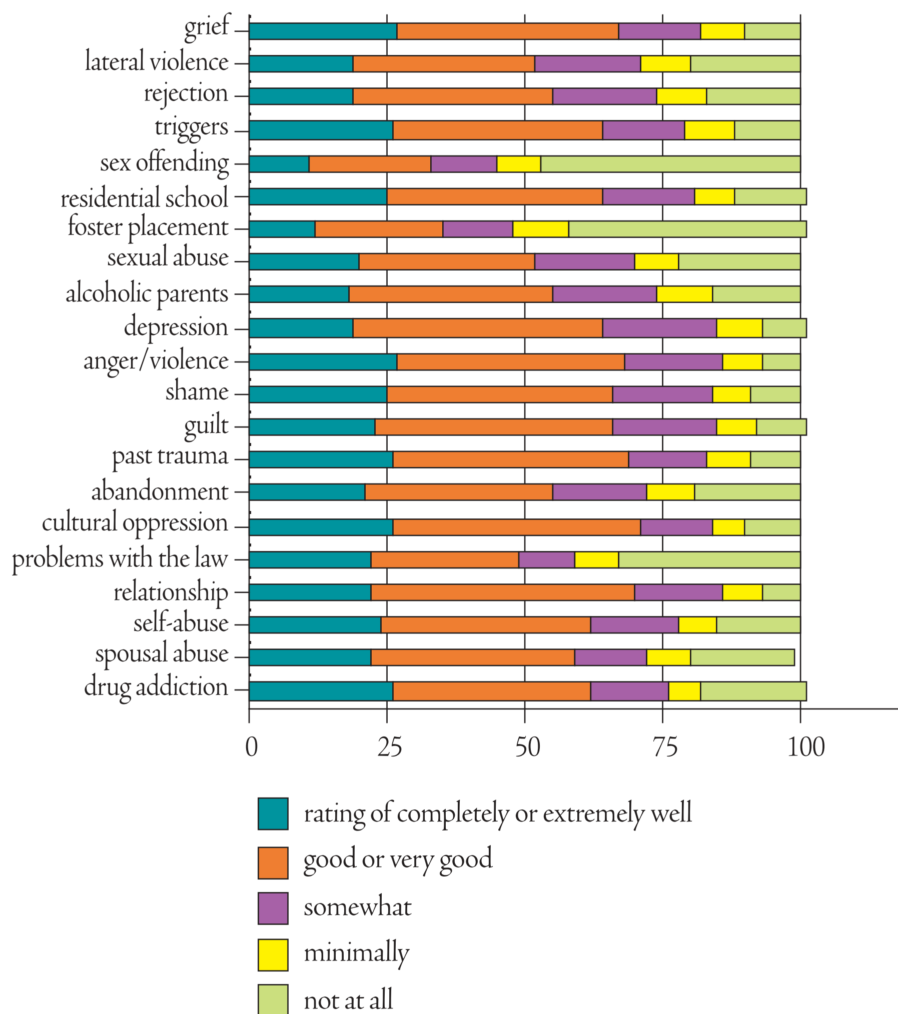
In this phase of healing, individuals share their stories. Remembrance and mourning were not featured in every case study selected, but where they were part of therapeutic processes, they were clearly handled in a variety of ways. One of the most popular ways of approaching remembrance and mourning was the use of psychodrama at the Qul-Aun Program. Many participants were completely or extremely satisfied with the group and individualized approaches to a variety of therapeutic issues. There was an even distribution of satisfaction in the Qul-Aun Program's treatment of spousal abuse, abandonment, depression, and anger and violence in group and individualized settings; however, there was a *clear preference for individualized sessions at Qul-Aun when addressing sexual offending, conflict with the law and foster care issues.*[110] In the *I da wa da di* project, 75 per cent (n=70) of those participating in the gathering agreed that remembrance and mourning helped them address past trauma.

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

> I don't know why I held on to this grief for so long … [the counsellor] was able to assist me in letting go of that pain …. Seeing the old residential school brought back some sad memories and kind of brought a closure to that bad experience.
>
> I especially enjoyed the trip to my former residential school. It has brought some closure to some sad and bad memories over there …. I will continue to seek counselling after this program.[111]

Once safety is established, remembrance and mourning usually occur in a therapeutic context of either group or individual counselling. Of those who responded to the IPQ, over 60 per cent gave *group* counselling sessions a favourable rating when the following issues were addressed: grief, identifying and handling triggers, general concerns related to residential school, depression, anger, violence, shame, guilt, past trauma, cultural oppression, addiction and relationship issues. From responses to the IPQ, there was indication that group sessions were weakest when considering issues such as sexual offending, problems with the law and foster placement. Figure 23 shows the ratings of group counselling sessions secured in AHF-funded projects.

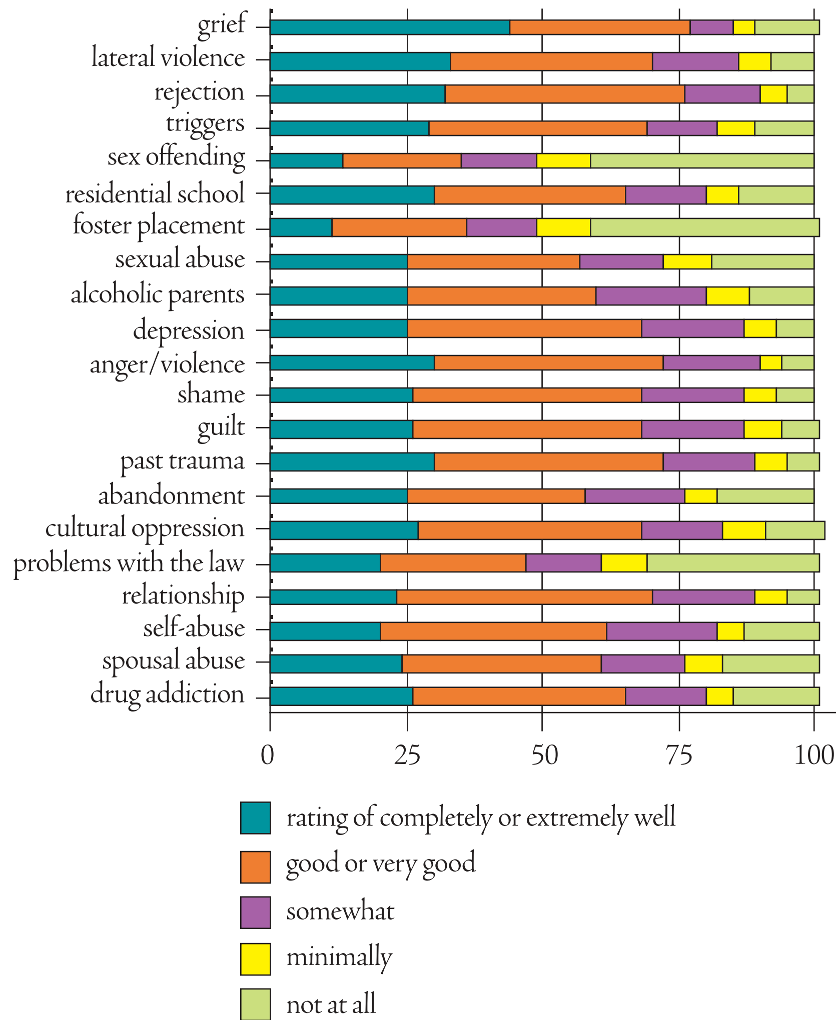
Figure 23) Rating of Group Counselling Sessions (2004)



Most IPQ respondents (57%, n=1,235) claimed that their goals changed over the course of their participation in AHF-funded activity in the direction of improved self-awareness, relationships with others, knowledge and cultural reclamation.

Over half of the IPQ respondents had the luxury of individual counselling (55%, n=1,165) and a fairly similar pattern of approval was noted for these sessions as with the group counselling sessions. Over 75 per cent gave *individual* counselling sessions a favourable rating when rejection or grief were addressed. Over 60 per cent felt positive about individual sessions when dealing with violence, triggers, depression, anger, shame, guilt, past trauma, general residential school concerns, cultural oppression, self- and spousal abuse, addiction and relationship issues. Individual sessions were also weak when considering issues such as sexual offending, problems with the law and foster placement. Figure 24 shows the ratings of individual counselling sessions secured in AHF-funded projects.

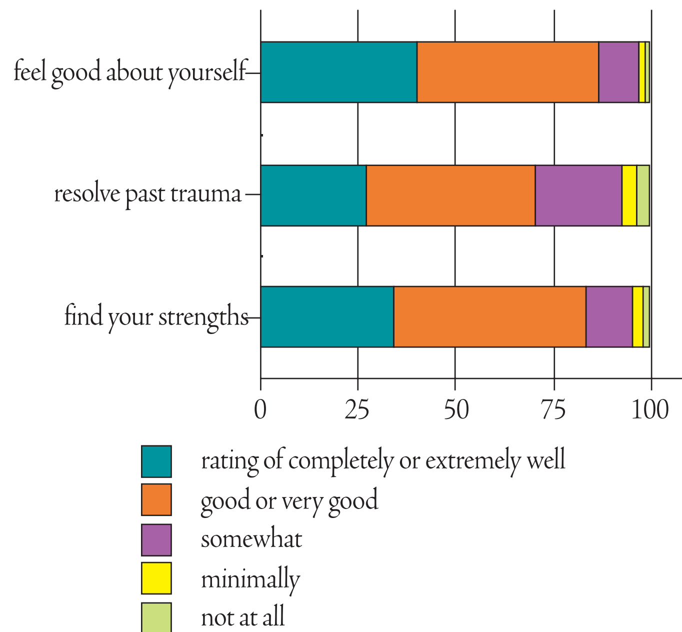
Figure 24) Rating of Individual Counselling Sessions by Specific Issue (2004)



On average, participants who responded to the IPQ received nine individual counselling sessions (median=5, n=444) and, in hierarchical order, were most likely to see trained counsellors, Elders, traditional healers, psychologists, alternative health practitioners, social workers, peer caregivers, psychiatrists or volunteers. Others involved in providing one-on-one services to participants (albeit, not all may be "counselling" sessions and in no particular order) included outreach workers, grandmothers, art therapists, chiropractors, massage therapists, medical doctors, family members, nurses, sweat lodge keepers, friends, pastors, ministers, priests, Reiki practitioners, mentors and addiction workers.

Individual sessions were also assessed with respect to their ability to help participants resolve past trauma (n=769), feel good about themselves (n=776) and find their strengths (n=794). A remarkable proportion of IPQ respondents who received individual counselling were pleased[112] with the ability of these sessions to improve their self-esteem, help them to find their strengths (87% and 83%, respectively) and work through their past (71%).

Figure 25) Rating of Individual Sessions by Select Project Goals (2004)

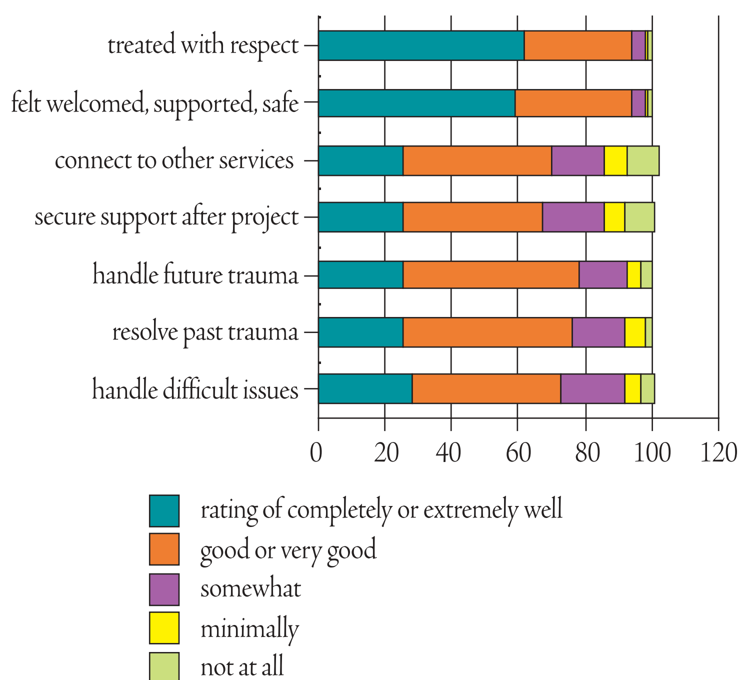


Most IPQ respondents credited *program qualities* as being very helpful on their healing journey, particularly Legacy *education* because it helped them to understand their lives and their families (43%, n=1,182). They also appreciated *opportunities to learn* about healthy, functional family life, how to process intense emotions and improve their relationships more generally. Bonding with other Survivors was also considered very powerful because it offered a venue for learning how others have reacted to and dealt with the Legacy (29%). Group settings provided feedback, support and the pivotal message that they *were not alone* in their struggles. Cultural celebration and reinforcement (16%) were attributed with giving back what was lost, supporting the reclamation of an identity and instilling pride. Spirituality, whether expressed through traditional Aboriginal or Euro-Christian means, fed participants' souls. Daily prayer, meditation, restored faith or finding their spiritual selves was credited with being most helpful (4%). Lastly, team qualities were recognized as powerful influences on the healing journey (2%). In particular, participants noted safe, respecting, nonjudgemental and validating approaches as most supportive on their journey.

5.1.2.3 Reclamation

In the last phases of the healing journey, the Survivor endeavours to reclaim his or her *rightful* place in a life of peace and balance. This is the most energy- and time-consuming of all healing phases and can involve learning a variety of skills to maintain healthy patterns of behaviour. Some projects focussed their efforts on this phase of healing *without* directly addressing past trauma. Instead, they exercised and developed skills to deal with stress, manage family life, enhance personal industry and esteem, reinforce cultural identity or cultivate leadership through a variety of interventions. Reclamation begins with the acquisition of specific skills to address the Legacy. The majority of IPQ respondents felt their experience in the project helped them with such skills, including handling difficult issues (72%, n=1,264), resolving past trauma (76%, n=1,284), preparing for and handling future trauma (79%, n=1,242) and securing support (69%, n=1,233), if needed, once the project was completed.

Figure 26) Perceptions of Achievement - Project Goals (2004)



Other skills that are acquired when reclaiming a rightful place of peace and balance are more general. IPQ respondents were most likely to acquire *relationship skills* while participating (50%, n=908), including communication and parenting skills. They felt better able to listen, forgive, respect and understand others. Participants believed they were better spouses and/or friends because they had increased their patience and sensitivity, and they were relieved by their new-found abilities to offer and enjoy intimacy. Many (21%) learned new and improved ways of relating to *self* by being more confident, taking time for self-care, revelling in enlightenment and trusting their instincts. A solid group (14%) left with improved coping and life skills, such as remaining alcohol- and drug-free and seeking help when it was needed. Some (8%) gained important cultural knowledge and skills including, but not limited to, drum making, singing, relating to the natural world, respecting Elders and recounting legends. A few were more skilled counsellors (1%), could better engage in spiritual practices (1%) or share the Legacy's impact with others (5%).

In Big Cove First Nation's "Our Youth, the Voice of the Future" project (New Brunswick), change was most dramatic in cultural awareness, but weak in parental involvement. Youth did not seem as angry as before, they felt *heard* and supported, and their group has shown healthy, steady attendance. They started showing up on time, trusting and confiding in, as well as bonding with others. One teacher noted increased youth voluntarism and willingness to help with younger children. Of particular note is the extent of initiative, leadership and assertiveness demonstrated by the youth team involved. For example, in Mi'kmaq communities, wakes are almost always held in family homes. Youth team members challenged this tradition, held the wake of a young suicide victim at the drop-in centre, and monitored the facility on a 24-hour basis, assuming responsibility for the direction taken. Moderate change was noted in the development of social and leadership skills, goal orientation, self-esteem, mother-daughter communication, family relations and peer support.[113]

Gay and lesbian youth in the Urban Native Youth Association's Two-Spirited Youth Program (Vancouver, British Columbia) felt that their ability to face homophobia and deal with their sexuality and depression had improved. They better understood the impact of the Legacy and felt motivated to face their alcohol or drug use head on. In fact, four gay/lesbian youth reunited with their families and communities.

After the Centre for Indigenous Sovereignty's *I da wa da di* project in Ohsweken, Ontario, some women went on to facilitate workshops, others began drumming and singing, and most left with a stronger sense of self. Some became more attentive to their families, committed to passing on cultural teachings, spending time with Elders and personal wellness. One woman gained enough self-confidence and love to leave an emotionally abusive relationship of 20 years. Others felt less alone, more forgiving, returned to school or made career moves.

In the Hamlet of Cape Dorset's Healing and Harmony in Our Families project (Nunavut), people spoke about "growing up" emotionally and finding other ways to deal with personal strife other than just crying. Some were happier and better able to cope, as well as more confident and stable. Lower levels of improvement were noted for those simultaneously participating in addictions treatment and among known violent perpetrators.

For participants at the Nelson House Medicine Lodge Inc.'s Pisimweyapiy Counselling Centre in Nelson House, Manitoba, evidence of change included some appearing better able to maintain sobriety, seek and secure employment, disclose past trauma, display physical affection, be outgoing, seek spiritual fulfilment and recruit others to participate. While the majority were clearly excited about cultural teachings and eager to learn more, some with strong Euro-Christian ideals were resistant.

Reinforcement of culture and identity is also characteristic of the healing journey. For the Métis of Willow Bunch, Saskatchewan, Local #17 membership increased from 150 to 250 four years later (from Willow Bunch, Coronach, Rockglen and Bengough). "I see kids in my classes that talk about being Métis now and I don't know if that would have happened ten years ago or five years ago, for that matter." Increased attendance at Local meetings, discussion about Métis identity and knowledge of *accurate* Métis history, as well as involvement and pride in Métis culture, were all noted.

Change was also noted for those projects that addressed individuals in the context of their families. One project offered whole family therapy in a country home setting with a large yard for play, other families on the same journey, and an air of comfort and warmth provided by a Cree grandmother who could model traditional parenting skills. Parent-child interactions were characterized as more patient, confident and nurturing—evidenced by investments in cooking, laundry, play and quality time spent with children. Before attending Shining Mountains Living Community Services' Tawow Healing Home in Red Deer, Alberta, one parent was ready to give up on her oldest child but now wants to keep the family together. Two families became sufficiently stable to live on their own, one of which was previously homeless. While there were changes in emotional independence, economic self-sufficiency may be a long-term goal as all still rely partially or wholly on social assistance.

In the Kikinahk Friendship Centre's Kikinahk Parenting Program for parents of teens in La Ronge, Saskatchewan, some became more relaxed, patient and skilled communicators over time. They were less likely to "push their teenagers away" by more carefully selecting their words and tone, while others seemed

better able to allow their teens to have fun or to do things *with* their teens. Mothers who participated were not accessing services as often as those who did not attend the Kikinahk Parenting Program.

Other examples, taken from the Kikinahk Friendship Centre Inc.'s AHF-funded project files, show the variety of changes noted in project participants:

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

Of course, these reports are based upon the *immediate* assessment of desired outcomes. In only one case the assessment of the *endurance* of project goals was secured.

At three months follow-up, the majority who attended the Tsow-Tun Le Lum Society's Qul-Aun Program in Lantzville, British Columbia, (70%, n=23) reported that it helped them to act upon their strengths, made a difference in their lives (78%, n=23), helped them move beyond the trauma of their past (76%, n=49), and prepared them to handle future trauma (78%, n=23) completely or extremely well. The majority also indicated that the Qul-Aun Program helped them to achieve their personal goals extremely well or completely (n=59, from five different Qul-Aun Program sessions).

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

> The core experiences of psychological trauma are disempowerment and disconnection from others. Recovery, therefore, is based upon the empowerment of the Survivor and the creation of new connections. Recovery can take place only within the context of relationships; it cannot occur in isolation.[114]

In Building A Nation, Inc.'s Healing the Multi-generational Effects of Residential School Placement - Urban Access Program (Saskatoon, Saskatchewan), a variety of therapeutic and post-therapeutic supports were available. The project rightfully assumed that beyond psychological help, other adjunctive services would be required, including life skills development, advocacy services, even help finding lost parents. Such a continuum of service, support and guidance creates opportunity for individuals to achieve real transformation in their lives.

5.1.3 Capacity to Heal

For Survivors, the capacity to heal comes at the end of a long, arduous journey and, while supporting and guiding others on their healing path is not a Survivor's responsibility alone, we regularly heard that healers with whom Survivors could identify appeared to work best. Projects primarily employed Aboriginal people, including residential school Survivors and their descendants who, along with volunteers, had access to a wide range of training[115] opportunities. In fact, training was provided to at least 28,133 participants (n=246; median=31.5 participants per project; average=114 [Ext - 49,095: n=429[116]]) and trainees spent an average of 193 hours in training (median=74 hours, n=92, S1). Over half of the AHF-funded project files (n=36) reviewed found that they would have benefitted from greater capacity. Although most projects could make referrals when the special needs of their groups exceeded capacity (e.g., FAS/FAE or life-threatening addiction), others had no choice but to try to address special needs with whatever resources they had. They also made the case for counsellors *specifically trained in residential school abuse,* but warned *against* simultaneous program delivery and training. On occasion, teams and participants were *equally impacted* by the Legacy. One project noted:

> Training for frontline workers was a huge factor in them realizing that they themselves had inherited the dysfunctional behaviours of the Residential School Legacy. It gave the participating frontline workers an opportunity to dig deeper within themselves recognizing that each of them need to work.… so that they can enhance their helping skills and abilities.
>
> We continue to recognize our own need for personal growth as part of our need as caregivers working towards supporting our families and communities in their healing.
>
> Some trainees took leave from their training to work on their own issues.[117]

Because teams had the unenviable and *unprecedented* task of *simultaneously* building capacity and struggling with denial while designing and implementing programs to address the Legacy, a longer time frame was needed to strengthen healing capacity. Nevertheless, many Survivors *do* leave projects with a vision to heal others. Some enter the field of social work and give back to the community as volunteers or serve on governing boards. There is also evidence that Survivors leave projects with new or enhanced skills. In the Pisimweyapiy Counselling Centre, Qul-Aun Program and *I da wa da di* project case studies, *strong, positive* participant satisfaction led to the conclusion that the training and experience of the team was well suited to facilitate healing, and that the training programs used for these teams may be appropriate for others. In the *I da wa da di* project, participants felt they would be more empathetic, supportive, compassionate, and nonjudgemental in their work with participants. In addition, both Tawow Healing Home's team and *I da wa da di's* participants felt better equipped to use traditional approaches to support others on a healing journey. On the other hand, the Odawa Native Friendship Centre's (Ottawa, Ontario) *When Justice Heals'* project volunteer members of the Aboriginal Peoples' Justice Circle came to the committee with "a vast amount of experience in their respective fields," but they also recognized the need for training specific to sentencing circles. Skills learned at the training workshops in Cape Dorset included active listening and recognizing pain. Trainees also felt more committed to their role as models, better able to empathize with the sexual abuse victim, intervene in a crisis and share their learning.

> Caregivers have a big job, they are available at deaths, crisis [sic]. They now have the tools to deal effectively in these situations.[118]

Overall, 74 per cent believed that training provided was adequate (n=226, S1). Most often, trauma awareness and Legacy education were reported as adequate (81% for both, S1). The four most commonly cited areas of continued training needs included crisis intervention, trauma awareness, counselling skills and dealing with family violence (S1). A strong majority of the document files reviewed revealed that projects provided training of some kind to a variety of targets, including leadership, project personnel and community members, in general as a way of developing healthy and culturally respectful programs. Some offered instruction as a way of developing community-based trainers; however, there was some noted resistance to becoming "an expert" because of the daunting task ahead. The files suggested training may need to change in order to better recognize a more step-by-step approach to healing. For example, it may be more effective to teach basic adult-child interaction skills before setting out to teach parenting. Also suggested was that training be focussed upon community 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.[119]

When participants were questioned about who they would look to for future support, they were most likely to consult a counsellor or therapist (29%, n=1,306, IPQ results), Elder or traditional healer (27%) or an AHF-funded project team member (21%). A few were planning to rely upon themselves, their families and friends (8%), spiritual leaders (3%), other nondescript helpers (9%) or addictions workers (1%). The capacity of healers/helpers would also be supported by programmatic change. For example, most IPQ respondents advocated for *more time,* either through program continuity or increased frequency of healing and training sessions (29%, n=984). A surprising proportion felt that better equipment and facilities would improve project functioning (10%), and some referred to changing program qualities (29%), most particularly, having more intimate, smaller group sessions or one-on-one counselling. Others believed that projects could be improved if they focussed more on better communication (11%). In particular, they cited translation and suggested popular or common language be used to help draw the community into activities. Legacy education was a key focus in their recommendations for improved communication, awareness and participation. Participants urged for greater integration of culture, Elder involvement, land-based activity and spirituality (9%). They wanted more Survivors and Aboriginal people as healers, greater access to professional resources and an overall increase in the size of the project team (13%).

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

> More people are like that now in our community, not in denial about problems. We can face reality, see what it is. Have better problem solving skills. More awareness of sexual abuse, spousal abuse and now can say that's not okay. In the long run it will be less and less okay, people won't just hide their heads. Even if my kid was the abuser, I'd deal with that.[120]

5.2 Influencing Communities

The long-term vision of the AHF is that those affected by the Legacy will have addressed unresolved trauma, broken the cycle of abuse and enhanced their capacity to sustain well-being. Reconciliation, another desired long-term outcome, is expected to become more evident once a critical mass of individuals, families and communities have progressed further along the healing path.

Early in the life of the initiative, AHF board-selected measures of long-term impact included reduced rates of physical and sexual abuse, children in care, suicide and incarceration. In the hopes that some discernible change might be noted in these social indicators, case studies attempted—naively but in earnest—to capture these rates and, to the extent that these data were available, they have been reported.[121, 122] Although some key informants in case study communities expressed the view that rates of physical and sexual abuse, suicide and children in care had declined, there was by no means consensus. Many said they just did not know, while others had observed no change. For the most part, social indicator data suggest that the incidence of suicide, suicide attempts, physical and sexual abuse, incarceration and children in care remain high, and it is amply clear that they are insufficiently sensitive measures of early progression on the healing journey for Survivors and their families.

As a result, it became clear to the external evaluation team that outcome measurement had to be reoriented in order to focus upon those changes that would be immediately apparent, sufficiently sensitive and maximally relevant to the goals of the AHF. At the community level, these included:

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

In addition, several other indices of community readiness to heal and progression on the healing journey have been identified here that are specifically relevant to Survivors, their families and communities. These proposed indicators represent the collected wisdom of those on the front lines addressing the Legacy and what they have told us about how change becomes evident. Not only can these indicators be adapted and refined as a way of measuring performance in the future, but they could also be used to target communities in greatest need.

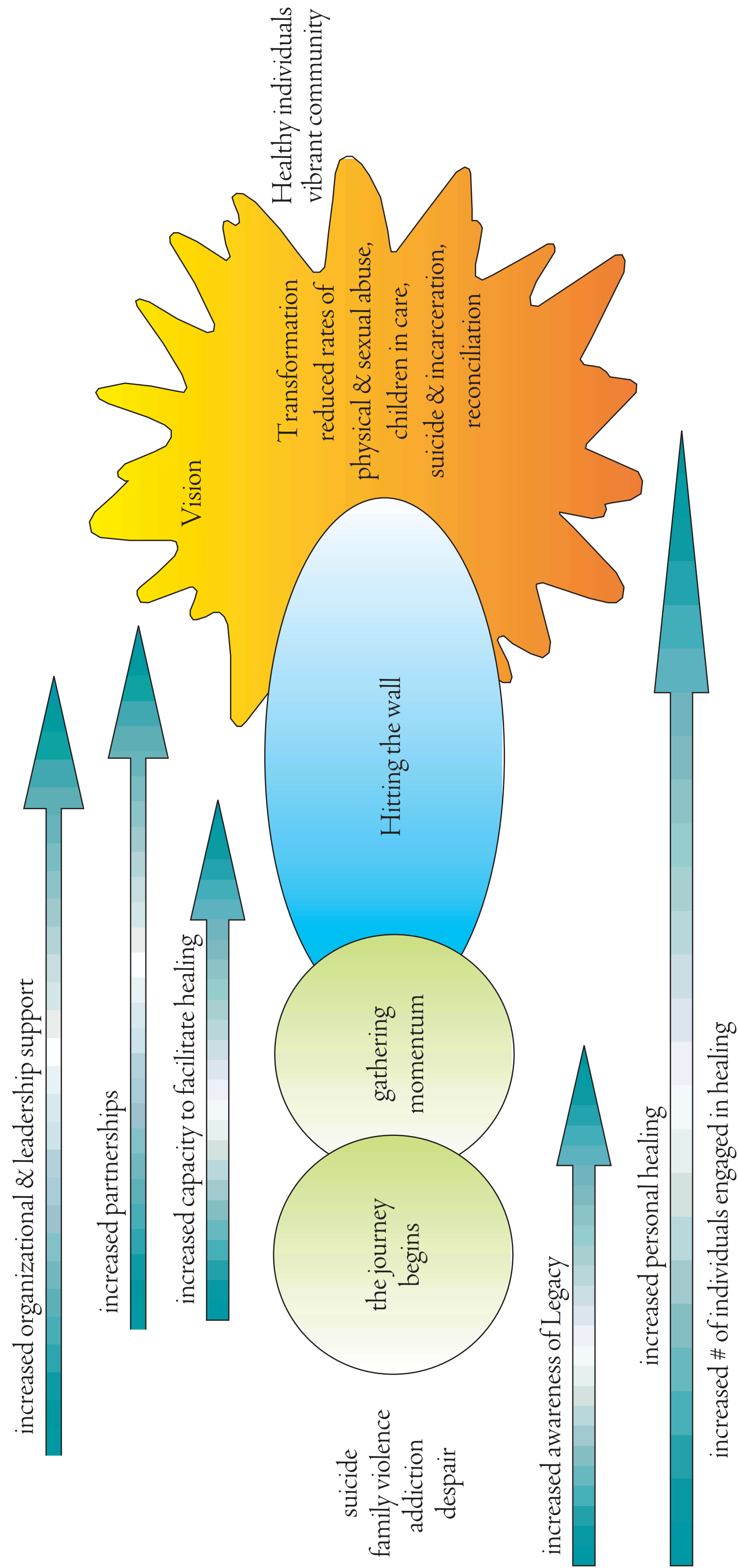
Early in the evaluation effort, classical, linear models of outcome measurement were used, and while there is merit to examining change this way, a more *relevant* and circular framework for performance measurement and risk management has been selected based upon how healing generally unfolds in Aboriginal communities. *Mapping the Healing Journey*,[123] a paper prepared for the AHF and Aboriginal Corrections Policy Unit (Solicitor General of Canada now Public Safety and Emergency Preparedness Canada), suggests that the community healing process goes through distinct stages or cycles. Each stage has specific "drivers" or conditions that propel the community to begin healing and move from one stage to the next, as well as success indicators and restraining forces or challenges. The four stages of community healing are described and the early evidence of the achievement of desired outcomes outlined *within* this model. While the "map"

provides a useful lens for the reporting of community-based results, in reality, social groups are always more complex than models can portray—events that lead to transformation tend *not* to unfold in completely predictable ways. It is also recognized that communities enter the AHF's constellation of funded projects at various stages of development and that progress is not uniform. Therefore, excerpts from case studies are offered as a way of merely illustrating progression.[124] In fact, the authors of *Mapping the Healing Journey* acknowledge the benefits and limitations of their proposed model:

> Taken together, these stages form one type of "map" of the healing process, which can be useful both for understanding the current dynamics of the community [healing] process and determining future actions and priorities. It must be stressed at the outset that these stages are only approximate models of complex real-life events.… They also do not take place in a linear way. They are more like ripples unfolding in a pool, where each new circle contains the previous one.[125]

The model also serves as a skeleton for the body of change, evident from a variety of other data sources (e.g., document review and national surveys), as well as indices identified by participants and AHF-funded project teams in case studies, selected promising projects (including several evaluations completed by these projects),[126] and the national gathering held in July 2004. Therefore, the model adapts and advances the "logical" framework for performance measurement and aids in the refinement of strategies used to *sensitively and appropriately* measure progress on the journey. The reader is reminded that although some indices seem well suited to one phase over another, they are usually apparent in other phases as well. Even though this discussion attempts to organize these indices sequentially, they are far more circular and many apply at several phases along the way. Still, as an ever-evolving tool, this model can help to explain and perhaps legitimize the community's experience of healing with a more socioecological, organic and fluid view. An understanding of the challenges and successes of each stage can reduce frustration when setbacks occur and concrete results seem out of reach. To begin, Figure 27 offers a visual representation of the community healing journey.

Figure 27) Community Healing Journey



5.2.1 Stage One: The Journey Begins

It is fair to say that those communities and organizations, which apply for AHF funding, have recognized the need to take action and have identified an approach. Potential grantees must show how they intend to address the Legacy with detailed work and evaluation plans, planned partnerships (including letters of support), and accountability strategies.[127] The journey has begun when needs are well-defined and high local *demand* (not to be confused with need) for services catapults communities to act. In fact, 86 per cent (n=209, S3) have noted an increase in service demand from those in need of healing.[128] Furthermore, the extent to which proposed action has been informed by Survivors and their families—based on pilot projects or *specific* research to meet the needs of those impacted by the Legacy—is a prime index of readiness to heal. The amount of work required to complete an application, and the clarity with which they must identify problems and interventions, place communities funded by the AHF firmly within the first stage of healing. At least 3,241 proposals were received with 1,346 (or 42%) resulting in a contribution agreement. As a result, 58 per cent (n=209, S3) feel there is a noted increase in the availability of local services that are appropriate for Survivors and their families.[129] The solid majority (63%, n=209, S3) of those communities responding to the most recent national survey have indicated that this is the *first time* they have formally addressed the legacy of physical and sexual abuse resulting from residential school in their community.

Individual engagement in healing is an essential component of the community healing journey. As reported earlier, many people (67%, n=209, S3) are engaged in healing *for the first time*. In the most recent national survey, 90 per cent of respondents reported increases in healing participation,[130] 74 per cent noted an increased rate of physical abuse disclosures,[131] and 68 per cent reported increases in sexual abuse disclosures.[132] Informants in two of the case study projects (Big Cove First Nation's project "Our Youth, the Voice of the Future," New Brunswick, and the Urban Native Youth Association's Two-Spirited Youth Project, Vancouver, British Columbia) specifically referred to their project as filling a service gap—allowing for increased participation by historically underserviced groups, namely youth and gay/lesbian populations. Also, it is clear that a greater proportion of participants across most case studies were women. While the problems associated with lower levels of male involvement are addressed elsewhere in this volume, it is reassuring to find that the first stage of community healing is often driven by a core group within the community, frequently comprised of women. This was certainly the case for Healing and Harmony in Our Families (Cape Dorset, Nunavut), the Tawow Healing Home (Red Deer, Alberta), *I da wa da di* (operating at Ohsweken, Ontario), the Kikinahk Parenting Program (La Ronge, Saskatchewan) and Koskikiwetan (operating in the Atikamekw communities of Quebec).

In Willow Bunch, Saskatchewan, Métis Local #17 undertook a project aimed at providing a positive awareness of the history of the Willow Bunch Métis to the community and increasing pride in being Métis. This may not at first appear to be related to community healing, but racism has been a common feature of the social climate in Willow Bunch and Métis were shunned from institutions, such as the credit union, community councils and organizations. Not everyone in the community was positive about the project (some felt that less than 10% and others felt as much as 50% of the community had negative attitudes toward the project), but a core group of people worked to build momentum. Those who were positive included Métis involved with the Local, students, people with an appreciation for history, many of the Elders, those with a broad worldview, and those who had left Willow Bunch and experienced other environments and different cultures. Resistance and denial (obstacles common in the first stage of healing)

were more common among older residents and those who felt threatened by an accurate history, changes in school language laws and economic development funding for the Métis.

> The people who never left Willow Bunch who have taken one interpretation of history for granted for so long and because a project like this is going to challenge some of those assumptions, they're perhaps a little defensive about it.[133]

The Willow Bunch project led to numerous activities that had never taken place before: workshops, Métis cultural activities, work within the school, visits from other Métis organizations, newspaper articles and interviews about Métis history. Overall, respondents believe that increased awareness of and respect for Métis culture and history have evolved as a result of project activities.

> The more I can see, it's even broadening my own perspective to know that some of the most highly decorated veterans from this community were Métis.… I think most of the history of this area has come from a Euro-centric perspective up until the healing project.[134]

In carrying out these activities and meeting its service delivery objectives, this project has changed the social environment in a small but important way: the conditions now exist for a community healing process to begin.

In the first phase, the ability of AHF-funded projects to meet service delivery objectives or achieve the kind of immediate outputs desired (e.g., products, reactions and participation), was exemplified by the various responses to the first national survey:

- increased participation in healing circles;
- expanded participation of Survivors or intergenerational community members;
- increased number of participants in the residential support group; and
- increased requests to have the healing project taken to the communities/reserves.

Other immediate cognitive changes (i.e., changes in knowledge, thoughts, attitudes and skills) characteristic of this phase are illustrated by the following examples:

- understanding and awareness of issues around and the effects of the impact of residential school;
- learning/remembering the more positive aspects of the First Nations' culture and traditions;
- increased respect, confidence or feelings of empowerment;
- letting go of negative attitudes, e.g., self or family blame; and
- decreased resistance from the second generation and youth.

Data from the first 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 (63%, n=223, S1), although some did reserve enthusiasm. Of those questioned about change, 36 per cent (n=223, S1) felt it was too early to tell, and one project reported there was no change. Overall, teams responding to the first national survey primarily reported short-term outcomes, which was normal given the longevity of the initiative.[135] Their open-ended responses about observed change were categorized according to classical models of performance measurement as follows (n=139):[136]

- outputs or service delivery objectives (e.g., participation) (38%);
- knowledge or awareness (53%);
- attitudes (35%); and
- behaviours (22%), including the establishment of networks (3%).

With respect to the data that could be gleaned from the review of project files (done in 2000), teams measured success primarily by the extent to which immediate service implementation objectives were met and suggested that many exciting, positive immediate- and short-term outcomes were realized.[45] For example, the increased demand for counselling services that numerous projects reported, suggests that denial and resistance may be decreasing. The following information, taken from the project files, show other examples that fit into this early phase of healing:

- "both secondary schools, where workshops were held, have been in contact with the program to do further workshops;"
- "trust is building up and gradual increase of clients;"
- "reputation for being a confidential, safe place;"
- "new clients approaching the healer on a regular basis;"
- "healing circle for women is progressing well;"
- "many clients previously unable to move from their abuse have developed treatment plans;"
- "some participants are reported to have stronger self-esteem and are requesting more training or teachings;"
- "student attendance has increased;" and
- "women attending the women's circle are gaining support from other women in the community. Women are not as isolated and quiet about what women's issues are. The silence around sexual abuse and family violence has been broken. Women healing from their own sexual abuse can better provide their children with safety and prevention from sexual abuse. As women heal and recover from sexual abuse or family violence, the men are beginning to see a need to change also. As one person in the family changes, the whole dynamics of the family are affected."

Where project files included feedback or evaluation forms from workshops, retreats or conferences, the results were overwhelmingly positive:

- "I'm grateful that I had opportunity to come to this workshop. I have been lost and now I'm found and I thank you's to have assist me to find myself."
- "I felt this training gives to us what was once taken away from our people."
- "I have learned to be more respectful to others. I have learned to pray more and listen to others. I am an elder and I'm trying to be more understanding to young people."

One project included a follow-up survey some time after the intervention with the following feedback:

- "It changed my life—brought my family closer together. We received more direction and purpose in life."
- "My family has come a long way since a year ago. My grandchildren have become pipe carriers. My sister and my daughter have become pipe carriers. My son and his family have started coming to the weekly ceremonies."

- "Yes. It helps—not too much suicides now. More young people in ceremony compared to last year—from a few to 40–50 people."

While it was understood in 2001 that it may be premature to expect radical social change, national respondents who were consulted in that year also noted an increased sense of hope as walls of silence and denial were dismantled: respondents watched Survivors reach out to *other* Survivors to encourage them to heal; and Elder/youth dynamics seemed particularly successful in this regard. Many Survivors expressed thanks to AHF board members and many more were connected to healers that could help them achieve their personal goals. The established partnerships or linkages were clear to national key informants, as well as the resounding success of teaching youth about the Legacy. Informants witnessed a variety of healing strategies that *engage* Survivors and believe that AHF-funded activity is having a positive impact since participants share their satisfaction.

Proposed Performance Indicators for Stage One: The Journey Begins

As the journey begins, key people—often women—are the driving forces behind community healing. They identify substance abuse, addictions and suicide as problems, and work to address crisis situations, denial, fear and opposition to create climates that are conducive to healing. This key group is engaged in personal healing and in forming support networks as they seek help for problems, such as addictions.

As Survivors and their family members learn about their family histories, they begin to understand how residential school experiences have affected them. Community members and organizations may then begin to educate others (e.g., local Aboriginal groups, organizations, students and human service professionals) about the legacy of physical and sexual abuse in residential schools, which then leads to a growing awareness and understanding in the community at large. There are more open discussions about residential school and increased disclosures of physical and sexual abuse. Honouring ceremonies for Survivors begin to take place, as do other commemorative events. Reclamation and celebration of culture can be focal points and become manifest in the traditional values of sharing and respect. A core group of Survivors *want* services, and as demand for programs increases, so too does the connection between healers and Survivors. For those communities who have taken steps to secure support, greater service options become available, including both traditional and Western approaches. Together, these indicators reflect that the community sees the possibility for a different tomorrow.

Table 12) Stage One: The Journey Begins—Indicators of Community Healing

	The Journey Begins
Driving Forces	Problems identified (addictions, suicide); key individuals (often women) engaged in healing; key organizations work to address the "crisis;" leaders create enabling climate.
Indicators	People engaged in personal healing; informal support networks forming; growing number of people seeking help for a particular problem (e.g., drinking); success and failure are measured in stark terms (e.g., sobriety versus drinking).
Outcomes/Indicators relevant to healing from the abuse in residential school	*Survivor Action and Involvement* • Survivors want healing services there is more opportunity for Survivors to meet (either to celebrate or cry), connect, support each other or encourage *other* Survivors to heal, the group keeps expanding • a Survivors' group can be established *informally* (i.e., gathers without support or recognition from local or other institutions) or formally *Team and Community Capacity to Address the Impact of Residential Schools* • local access to learning and training opportunities by target (healer/helper teams: Survivors and their descendants, volunteers) • increased ties between healers and Survivors; increase in service options available (traditional and Western approaches) *Awareness and Understanding of the Impact of Residential Schools* • people are taking the time to examine and learn their family history; Survivors and their families *understand* how the history of residential schools has affected them, their parents, grandparents, etc. • The community provides education about residential school to: • Aboriginal groups, organizations, students/schools, human service workers/professionals *Healing* • extent of open discussion about residential schools • disclosure of physical abuse/sexual abuse • long-term commemoration, restoration and development in the spirit of healing, honouring ceremonies for Survivors • culture is celebrated and manifest in behavioural codes that reflect the traditional values of sharing and respect *Plan or Vision to Continue Healing* • the community sees the possibility of a different tomorrow
Restraints	Denial; fear; opposition.
Link with Desired Outcomes for AHF-Funded Projects	Funding application submitted (e.g., recognition of a problem and desire to address it). Funded projects fulfill service delivery objectives.

5.2.2 Stage Two: Gathering Momentum

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

The healing project in Cape Dorset, Nunavut, exhibits many of these characteristics. The project was designed to provide healing and training to individuals who are committed to personal healing and who will support healing within the family and the community at large.[138] A 19-member community healing team (CHT) planned and coordinated healing and training activities, as well as participated in them. The CHT was composed almost entirely of Inuit women (one non-Inuk, two men). Key informants were asked to give an example of how the community has benefitted from the project. Several described an increased skill level among community caregivers and an increased capacity to deal with crisis. One person spoke about how her personal growth has led others to approach her to discuss their problems. The collective impact of having a number of individuals involved in healing who live and work in the community is evident in the following response:

> [There's] more hope. We have more capable people to make it a healthier place. This may happen just in their family but also at the community level. My family is better because of my participation. It has a domino affect. Kids will learn this stuff too.[139]

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

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

Looking to the future, one person commented: "One goal is to have all community organizations and agencies come together as one, with no barriers."[140]

The experiences of the Koskikiwetan project in the Atikamekw communities (Quebec) of Opitciwan, Wemotaci and Manawan also fit well here. Many more recognize the connection between their experiences at residential school and current rates of social distress. This has resulted in more individuals seeking help, much less tolerance for violent behaviour and increased reporting of sexual and physical abuse. Although there was stark disagreement about rates of children in care, respondents did note enhanced collective and parental responsibility for children. The challenges faced by the Koskikiwetan project included securing

sufficiently skilled human resources, enlisting Survivors who have healed enough to lead others into healing, uncertainty about future support for the healing process initiated, and revitalization of Atikamekw solidarity.

From document review, several unexpected benefits were noted that would characterize the *Gathering Momentum* phase of healing. Spinoff activities are indications of increased community spirit and included talent shows, potluck dinners, private healing circles, pizza day for children, burning ceremonies, sweats, and full moon ceremonies—all held as a result of the spark ignited by AHF-funded activity. A deepening interest in culture and traditions was noted and evidenced by cultural changes in the daycare centre, and more community feasts, sweats, and people seeking information on cultural activities. The establishment of a food bank was reported as a spin-off activity by one project, as well as a breakthrough in getting the school to provide more culturally appropriate programming. Another was credited with being the impetus for several new actions for holistic healing, including the rejuvenation of the Mi'Kmaw language. The document review (of 36 AHF-funded project files) done early in the evaluation effort offered these examples of movement at this phase:

- "increased networking activities with a large variety of other agencies and communities;"
- "healing circle attendance is growing;"
- "the number of referrals has almost tripled;"
- "more northern communities are providing transportation and lodging for clientele to attend the healing services;"
- "workshops have picked up momentum as various members from different communities joined in;"
- "awareness is growing in areas of safety issues, substance abuse prevention, the need for action on violence, and the impact of residential school on present generations;"
- "the health board has increased the hours of therapeutic visits;"
- "friends bring friends to the program; and"
- "more requests for counselling, support and skill-building for support staff; receiving calls from all over the province and other provinces from those who have heard about the program."

The most recent national survey shows most AHF-funded project teams believe there has been an increase in Survivor action and involvement, their use of and direction over local services, the extent to which the community is working together for change, and the family-focussed nature of the services offered. More specifically, teams (n=209) believe that:

- Survivors are more likely to meet to support each other and encourage other Survivors to heal (73%);[141]
- Survivors are more involved in decision-making about the project (65%);[142]
- there are more local services for Survivors who are willing to use them (57%);[143]
- Survivors are using a greater range of service supports (67%);[144]
- there is more collaboration at the community level to support healing (74%);[145] and
- a greater number of healing activities are targeted at *both* Survivors and their families (86%).[146]

5.2.2.1 Awareness and Understanding of the Legacy

The second phase of community healing is where the focus shifts to recognizing the root causes of addictions and abuse. As noted earlier, a personal understanding of the Legacy can be a pivotal first step towards the

success of the healing endeavour. When history is shared, a social context is created for what was previously viewed as an individual problem. A similar process occurs at the community level. On a national scale, almost all (90%) survey respondents (n=209, S3) believe that Survivors and their families better understand how the Legacy has affected them.[147] The solid majority (68%, n=209) are convinced that there has been increased community use of learning tools (e.g., archives, audiovisual materials, curriculum packages, visitor's centres, commemorative sites) to teach about residential school, as well as an increased awareness and understanding of the impact of the Legacy within broader Canadian agencies.[148] In terms of documenting the history and disseminating information about the Legacy, the AHF has:

- funded the development of 32 historical documents or records;
- produced, published and distributed 15 research studies to a database of 2,174 addresses (12 research studies are in progress);
- organized 27 regional gatherings with a total of 2,537 participants and one national conference with over 2,000 participants (690 of whom attended residential school); funded projects have hosted 17 additional conferences (participation rates unknown);
- funded 97 education and training workshops and the development of 16 curriculum packages;
- funded the organization of 116 knowledge-building and 207 prevention and awareness workshops; and
- funded the development and the production of 114 resource materials.

Over the past four years in La Ronge, Saskatchewan (through the Kikinahk Parenting Program), there have been at least three community-wide awareness workshops and a radio talk show in Cree on the Legacy. These media represent a distinct environmental difference from even five years ago. Hearing the radio talk show *in Cree* made it okay for individuals to talk in other venues—with those in the 40 to 50 year-old category appearing much more willing to talk than those who were older. For the Nisichawayasihk Cree Nation in Manitoba (Pisimweyapiy Counselling Centre), more open discussion about and different attitudes toward the Legacy, together with public denouncement of high-profile perpetrators, suggest that the climate has changed. Recommended program improvements included building on this initial success by enlisting partners in Legacy education.

While the *I da wa da di* project served Aboriginal women from across Ontario, its training sessions for frontline workers were held in partnership with other community agencies. These workshops were especially successful in increasing participants' knowledge of the Legacy, and this new understanding was used in their healing work with clients.

Tsow-Tun Le Lum Society's Qul-Aun also has a province-wide catchment area in British Columbia, but there is some evidence that the program also influenced the community surrounding the centre. Case study key informants were asked about their attitude regarding the local community's understanding of the Legacy. They unanimously noted that change was obvious (n=13); however, they did not believe that the entire community had been affected. Many (11) felt that at least half of the community, if not more, now has a better understanding of the impact of the Legacy. Two people felt that the change in knowledge and understanding of the Legacy was restricted to a small group (<20% and <10%). The impact of Qul-Aun on all communities of origin (e.g., where participants reside) was not measurable within the resources allocated. However, the outreach component played a major role in getting information to regional communities. Word-of-mouth also functioned as a communication vehicle; in fact, many participants

> have been empowered to advocate for community healing and have lobbied their local councils to support and encourage healing activities. We have indications that a number of clients have taken on a support role in going to different communities to speak on the issues of the effects of residential schools.[149]

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

- "The conversation has been opened up with a lot of family members. They were all there [together], all crying, all supporting, all spoke. The healing was transpiring right before our eyes."
- "I saw an impact on frontline workers, development and education, even for the leadership."
- "Survivors did an honouring at each performance. The community now sees their strength and how Survivors can make contributions to the community."
- "I know that Survivor support groups were started, even a theatre group in Merritt was started."
- "I know one Friendship Centre is now running training for counsellors."
- "Frontline workers at each performance got more understanding of trauma. We recognize basic alcohol and drug counselling isn't enough."

Although some respondents felt that sexual abuse issues were adequately addressed by the Kikinahk Parenting Program's awareness campaign in La Ronge, Saskatchewan, they were not convinced that such abuse was adequately linked to residential schools.

How well the youth project in Big Cove First Nation (New Brunswick) is addressing the Legacy still remains unclear. The residential school in Shubenacadie, Nova Scotia, where First Nation children in the Atlantic region were sent, has been closed for almost 40 years; yet many of the community's youth are intergenerationally impacted. The project's goals include developing personal, social, mental and physical well-being to combat the effects of unresolved trauma originating from the Legacy. This community exhibits many of the characteristics of a community well along the healing path, but it appears not to have explicitly addressed this issue, at least not as part of this youth initiative. Big Cove is discussed in greater detail under the third stage of community healing.

Proposed Performance Indicators for Stage Two: Gathering Momentum

As momentum is gathered, people increasingly realize that underlying trauma (e.g., residential school, sexual abuse) is the root cause of many problems, such as substance abuse and violence. More community members are becoming sober and walking on paths to wellness, fostering hope and transforming visions of life in Aboriginal communities—people starting to really believe community healing is possible. Survivors continue to support and encourage one another to heal. Informally established groups grow and may become more formalized and enjoy the support of local leadership. Survivors may become more involved in decision-making with respect to project administration, hiring and program design or become a more established presence in multidisciplinary committees.

As the movement grows, so does the community's capacity to address the Legacy. Locally, healing services have become more suited to the unique needs of Survivors and their families. Healing teams are *effectively* dealing with physical and sexual abuse issues with an expanded range of interventions (i.e., traditional and Western), and people are now able to seek help *inside* the community where the help did not exist before. The focus may shift from Survivors as a priority group to include their children and grandchildren. Learning and training opportunities may be more frequently offered locally. The network of support services expands with increased interagency cooperation, linkages and co-sponsorship of community events. In addition, these partners may extend to include churches (e.g., United, Anglican and Catholic), universities and colleges who also advance healing efforts. Core groups of volunteers have been formed, as have spin-off programs. Broader Canadian institutions may become more respectful of Aboriginal culture and history, and more sensitive and able to address the unique needs of Survivors; hence, these institutions will become more widely used by Survivors and their families.

As mentioned in *3.1.1.3 Participant Challenges*, projects reported that *some* employees are trained to deal with serious issues such as suicide, family violence and addiction (61%, n=242, S1). 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. Other commonly cited strategies to deal with special needs include 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 specialized approach.

Community members or organizations might engage in research about residential schools. Their findings are archived, produced for audiovisual presentations and used to develop curricula, visitor's centres and commemorative sites. Legacy education efforts start to extend beyond Survivors and their families to other Aboriginal and non-Aboriginal students, human services, professionals, groups and organizations. Enhanced openness about the Legacy, established in stage one, starts to solidify and disclosures continue. "Sober dances" and feasts may become more common events, with more people being drawn out from their homes to engage, signifying a renewed sense of community ownership and the desire to belong. Participation in healing starts to expand and it becomes obvious in a broader range of target groups (e.g., women, men, youth, Elders, gay and lesbian people). Referral rates from mainstream services to community-based healing initiatives escalate and the healing efforts begin to create the foundation for reduced risk for children. Less outreach may be required as friends bring friends to the program, young people reach out to Elders, and isolated communities find whatever resources they can to provide transportation and lodging to the nearest healing action. Teams may become inundated with inquiries from others addressing the Legacy who are looking to share promising practices. Honouring ceremonies and commemorative events continue to take place and, in urban communities, second and third generations of Aboriginal people are showing signs of an emerging political agency and are seeking to retain their cultural heritage. Planning for long-term healing and efforts to secure resources reflect the community's commitment to healing. What began as an individual journey for redress and healing have transformed into a social movement.

Table 13) Stage Two: Gathering Momentum—Indicators of Community Healing

	Gathering Momentum
Driving Forces	Growing awareness of the scope of the problem; recognize underlying trauma as root causes (e.g., residential school trauma, sexual abuse).
Indicators	More sobriety; increased number of people on a wellness path; a growing sense of hope, momentum, transformed vision—people believe community healing is possible.

Outcomes/Indicators relevant to healing from the abuse in residential school	*Survivor Action and Involvement*
	• Survivors continue to meet to support each other or encourage *other* Survivors to heal, the group expands and they may now establish more formally
	• There is increased recognition of Survivors as a group evidenced by
	  • their extent of decision-making in the project
	  • support of local leadership
	  • Survivors designing programs to suit their healing needs
	  • Survivors and healing teams are part of multidisciplinary committees in the community
	  • Survivors involved in hiring decisions for healing teams
	
	Team and Community Capacity to Address the Impact of Residential Schools
	• local healing services exist that are *unique* to Survivors and their families (e.g., information, communication, service options) that *are used* by Survivors and their families, in other words people look *inside* the community for help
	• leadership trusts the healing team and is satisfied with the work
	• healers/helpers have adequate knowledge and skills to effectively deal with physical and sexual abuse issues, they solidify as a group and demonstrate increased ability in both traditional and Western disciplines, there is an overall increase in the number of skilled healers/helpers to address the Legacy (Aboriginal and non-Aboriginal)
	• local access to learning and training opportunities by target (healer/helper teams: Survivors and their descendants, volunteers)
	• core group of volunteers formed, spin-off programs, support groups and activities have developed
	• network of supports for Survivors, more interagency cooperation, partnerships and linkages, co-sponsorship of community events and healing activity and these community services are more respectful, sensitive and able to address the unique needs of Survivors—as a result, this broader range of support is more widely used by Survivors and their families
	• increased ties between healers and Survivors; increase in service options available (traditional and Western approaches)
	• extent and range of partnerships expand beyond services to include other local institutions, such as the Anglican, United and Catholic churches or universities and colleges with the intent to advance healing for Survivors
	
	Awareness and Understanding of the Impact of Residential Schools
	• community is using tools (e.g., archives, audiovisual materials, curriculum development or use of a curriculum package, visitor's centre, commemorative site, research) to learn or teach about residential schools

	• community is involved in research on residential school • to Aboriginal groups, organizations, Aboriginal and non-Aboriginal students/schools, human service workers/ professionals *Healing* • extent of open discussion about residential schools • disclosures of physical abuse/sexual abuse • the existence of and participation in sober dances and feasts • community is working together to support healing • more people are out of their homes, socializing with others, visiting Elders and in the community actively contributing to community events because there is a renewed sense of ownership and a desire for belonging • increased program demand evidenced by—participation rates by target (e.g., women, men, youth, Elders and the gay/ lesbian community); referral rates from mainstream services to community-based healing initiatives; need for outreach/ solicitation is reduced because demand has escalated; inquiries about promising practices; rates of first-time participation; friends bring friends; Survivors reaching out to *other* Survivors; and the young reach out to Elders to encourage them to heal • barriers to participation are being eliminated—isolated communities providing transportation and lodging for Survivors to attend healing in other communities • long-term commemoration, restoration and development in the spirit of healing, honouring ceremonies for Survivors • culture is celebrated and manifested in behavioural codes that reflect the traditional values of sharing and respect • a truly urban native "community" is taking root with people who are second and third generation city dwellers who are increasingly seeking to retain their heritage and showing signs of an emerging political agency • number of children who are at risk in the community • healing activities are targeted at both Survivors and their families or the healing focus has moved from Survivors to the children of Survivors *Plan or Vision to Continue Healing* • the community sees the possibility of a *different* tomorrow and is motivated to create change evidenced by their actions to plan for long-term healing and seek resources for their quest • organizations and service agencies (inside and outside the community) are trying to secure support for long-term healing for Survivors and their families • healing has become political, the individual journey has transformed into a social movement, more seek redress
Restraints	Lack of service capacity and trained employees; lack of resources; inability of service providers to work together; political support absent or token; resistance to healing by some groups within the community.
Link with Desired Outcomes for AHF-Funded Projects	Increased awareness and understanding of the Legacy; increased documentation of history; evidence of individual healing and increased number of people engaged in healing; increased hope; capacity-building is underway; increased ties between Survivors and healers.

5.2.3 Stage Three: Hitting the Wall

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

> What appears to have been a wall may in fact be a long plateau. One of the characteristics of a plateau is that not much seems to be happening and you don't seem to be going anywhere, but it is actually where the foundation for all future advances are being laid.[150]

Some aspects of the Big Cove First Nation's youth initiative project in New Brunswick may be seen as reflective of the activity that takes place in stage three of community healing. The project targets youth between the ages of 10 and 29 and offers a wide range of sports and other nonalcoholic activities, support groups, and cultural and spiritual events. The project team includes young people who work with representatives of other community agencies (e.g., social services, psychological services, alcohol and drug prevention and treatment) on a youth advisory board. The board is connected to the Big Cove First Nation Wellness Committee, which is a good example of interagency partnering that brings together social and health services with economic development, police, community leadership and Elders. Case study informants felt support from leadership was strong.

The youth initiative project was one way the community responded to the high incidence of youth suicide. The crisis peaked in 1992 and, for the following eight years, Big Cove First Nation's annual suicide rate was 116 per 100,000 with a total of 21 deaths. By comparison, the Canadian suicide rate during this period was 13 per 100,000.[151] The project coordinator confirmed that, in the years surrounding 1992, all community service agencies were essentially doing crisis management. This resulted in burnout and an inability to effectively manage long-term treatment plans for many in need. Over time, with some additional resources and increased coordination within the community, they have been able to shift from crisis mode to a more proactive approach.

Social indicator analysis suggests that suicide and attempted suicide, physical and sexual abuse, and alcohol and drug use remain high in Big Cove First Nation. Vandalism and break-and-enters were identified as common crimes committed by youth. According to a youth survey[152] conducted early in the project, 91 per cent of respondents felt alcohol and drug use was the greatest problem facing youth today, followed by peer pressure (45%) and unwanted pregnancy (35%). Figures cited in a study of special educational needs[153] showed that, of the 157 students at Big Cove School, one-fifth had been exposed and affected by alcohol and drugs prenatally. Interestingly, when this case study was completed, a copy of the report was sent to the project team and they contacted the author because they felt the data underrepresented the problem of sexual abuse. Additional material was provided, including a study on family violence completed in 1992, which indicated *between 60 and 90 per cent of the Big Cove population as being directly or indirectly affected by sexual abuse.* This was an important development in that the case study report led to a decision to publicly disclose

additional information about the seriousness of sexual abuse based on the contention that the problem could not be addressed unless it was acknowledged.

These figures suggest the community is still in crisis, yet the case study also shows that significant progress has been made. For example, the youth initiative project appears to be playing a major part in closing the service gap. One case study informant stated: "there had been no suicide training for youth before this project, it had all been given to adults and staff." Another referred to the crisis management approach before the project. Half of the responses spoke about a greater awareness of suicide, a new openness to talking about it, and the fact that there is now more support available, including the capability for immediate response in a crisis. There were direct references to the youth initiative project, as well as the fact that a more cooperative, proactive, multiagency approach is now in place.

Key informants in the case study described a number of other benefits of the project:

- provided youth with a safe place with positive diversions from alcohol, drugs and trouble that directly involved them and offered support;
- project staff worked well as a team and were able to facilitate cooperation among community service providers;
- developed self-esteem and new skills; and
- provided hope.

The investment in the youth initiative project's team, as evidenced in the large number of training opportunities provided, was a logical and ultimately effective place to begin. As one person said, "the key to the youth will come from the youth themselves." As the project begins to slowly raise self-esteem, confidence and skill levels, perhaps new leaders will emerge from this group. The project is having a positive influence in other ways as well. For instance, it has provided other community services with an opportunity to shift from crisis management to more effective long-term wellness planning and community development. Structured activities, bonding between staff and participants, and the guidance of adults involved in community agencies should support continued short-term changes and help build the foundation for long-term results. The approach to community issues taken by this project is also part of the capacity-building among youth. Having a seat on the wellness committee and liaising with other initiatives can broaden the perspective of the young project team, and allow them to be guided and nurtured by people who have a wealth of experience and expertise to offer.

The document review of 36 AHF-funded projects done early in the evaluation effort offered these examples of movement at this phase. One project reported that a number of community members who first came to them for services are now giving back to the community as volunteers and board members. There were also reports from other projects of clients moving into leadership roles, returning to school and going back to work. Other noted impacts characteristic of this phase included:

- fourteen children returned to parents from foster care;
- two of the youth that were accessing the program have moved back home to their birth families;
- calls received from all over the province and other provinces that have heard about the program;
- ten frontline workers trained, more than 200 clients counselled, education to government workers, legal forums and a conference (approximately 150 persons);

- good cooperation from the school, counselling sessions for children are held in the school;
- increased parental involvement in school;
- reading tests have shown that the students have increased by 37.2 per cent (high school students);
- clients entering the field of social work and facilitation;
- team members attending the training have observed that the changes they make in their own healing and personal growth impacts directly on other family members;
- some trainees took leave from their training to work on their own issues;
- only one student out of the 11 students who have gone through the program has had further difficulties—parents are requesting their children go through the program as a means of support and help;
- a number of Survivors and their descendants have made long-term commitments to counselling and their progress is "visible;"
- some parents have proven dedicated and eager to examine past and current patterns that impact on their parenting role.

5.2.3.1 Increasing Capacity to Facilitate Healing

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

Big Cove First Nation (New Brunswick) focussed its efforts on building capacity and skills among youth, and key informants in that case study believed that youth self-esteem and leadership skills showed dramatic increases. Centre for Indigenous Sovereignty's *I da wa da di* project in Ohsweken, Ontario, provided training to women. One of the most notable changes recorded by *I da wa da di*, in both the interviews and the participant evaluation reports, is the fact that women are feeling less isolated and more involved in community life. What has been observed by key informants of the case study is that women are taking small steps toward leadership roles and forming more solid networks in the community.

Case study respondents from the Kikinahk Friendship Centre Inc.'s Kikinahk Parenting Program in La Ronge, Saskatchewan, reported strong administration, a few dedicated team members, adequate training and education, and a clear long-term vision as contributing to the project's success. However, the need for ongoing education and skill development is probably reflected in the fact that not everyone was completely satisfied that Kikinahk Parenting Program was able to deal with sexual abuse issues in a *clinical* capacity. Tsow-Tun Le Lum Society's Qul-Aun Program in Lantzville, British Columbia, on the other hand, provided all team members with *12 weeks of core training*, as well as internships for trauma counsellors and other professional development workshops. The purpose of training all staff was to ensure a fully qualified team to work with Survivors. In particular, the 12-week core training prepared the Qul-Aun team for the implementation of the five-week treatment program.

The national surveys found that only a few (4%, n=467) projects have a training-only focus, but almost half (49%) provide both healing and training. Training projects provided services to 28,133 participants (n=246; median=31.5 participants per project; average=114 [Ext - 49,095: n=429[154]]). Trainees spend an average of 193 hours in training (median=74 hours, n=92, S1)[155] In addition to building skills through training, AHF-funded projects are employing Aboriginal people. The national surveys found a total of 4,833 paid employees (n=330 [Ext - 10,618: n=725]), 2,004 of which are full-time positions (i.e., working more than 30 hours per week on a regular basis) and 2,829 are part-time [Ext - 4,403 full-time; 6,215 part-time: n=725]. Aboriginal people occupy 91 per cent of all full-time positions and 85 per cent of all part-time positions (n=160, S2). Clearly, AHF-funded projects provided community-level employment and training opportunities not previously available. Large numbers of Aboriginal people have been hired and trained and are now participating actively in community healing initiatives. This represents a significant contribution to building a healing capacity within participating communities. In the most recent national survey, 61 per cent (n=209) of respondents believe that local access to training opportunities for healers/helpers has increased,[156] while 73 per cent believed that the skills and knowledge of healing or helping teams had increased with respect to their ability to address physical and sexual abuse.[157]

5.2.3.2 Strategic Planning

AHF-funded projects invested varying efforts in strategic planning. Some included this as a project objective (Cape Dorset, Nunavut—Healing and Harmony in Our Families), while others were initiated following a lengthy planning cycle (Lantzville, British Columbia—Qul-Aun Program). Others could have benefitted from an increased focus on planning (Vancouver, British Columbia—Two-Spirited Youth Program). *Mapping the Healing Journey* recommends that every community in recovery develop a comprehensive (5- to 10-year) plan that weaves together community healing and development.[158] This approach refers to strategic planning at the community rather than project level. Over the long-term, the involvement of AHF-funded projects in community-level strategic planning may contribute to the sustainability of healing initiatives, as well as their integration into community plans.

Most (70%, n=209, S3) have identified an increase in community planning for long-term healing,[159] with more leaders seeking resources to support the journey (61%),[160] along with organizations and service agencies located within and outside of the community (61%).[161] When the AHF ends, projects (n=209, S3) have:

- plans to continue with self-help groups and volunteer efforts (55%);
- secured short-term funding from other sources (10%);
- secured long-term funding commitments from other sources (1%);
- plans to prepare proposals to secure other funding (76%); or
- plans to discontinue their efforts (12%).[162]

Proposed Performance Indicators for Stage Three: Hitting the Wall

At the third stage of the healing process, much progress has been achieved at this point. However, teams are beginning to get tired. Describing the nature of team burnout and how it is being dealt with reveals how community systems are weakened and then strengthened to address the emerging challenges (e.g., gambling or youth gang activity). Movement is not as obvious or swift, but institutional stability, as well as the groundwork for future advances in healing, are being solidified as communities work through this long and lackluster phase. The existence and stabilization of many of the same community features in stage two are still evident in stage three and are repeated here in Table 14. While progress may be stalled, subtle changes may still be evident. For example, the local Survivors' group may become active on a regional or national level. With some experience behind them, teams may be increasingly able to deal with a range of special needs (e.g., people with HIV/AIDS, the homeless, those with multiple issues), and programs are developed that better reflect and include family systems. As in stage two, community planning and vision are indicated by their continued efforts to secure sustainable wellness with a range of supportive partners.

Table 14) Stage Three: Hitting the Wall—Indicators of Community Healing

	Hitting the Wall
Driving Forces	Progress has been dramatic but maintaining momentum presents challenges; professional capacity grows but healing becomes more institutionalized.
Indicators	Increased participation, support for healthy activities; negative behaviours (violence, abuse) not publicly tolerated; new programs support individual and family healing; more people seeking education; increase in cultural awareness, practices.
Outcomes/Indicators relevant to healing from the abuse in residential school	*Survivor Action and Involvement* • Survivors continue to meet to support each other or encourage *other* Survivors to heal • a Survivors' group may be *formally* established with the support of local leadership • local Survivors are involved in lobbying efforts (e.g., for national Survivor organization or justice, or increased healing resources) • There is a stabilized recognition of Survivors as a group evidenced by • Survivors designing programs to suit their healing needs, are involved in hiring decisions for healing teams, have decision-making authority in the project as well as in other service networks (sit on boards as representatives), and multidisciplinary committees in the community *Team and Community Capacity to Address the Impact of Residential Schools* • local healing services exist that are *unique* to Survivors' needs (e.g., information, communication, services) *and are used* by Survivors and their families • Survivors are using a range of social support services • leadership trusts the healing team and is satisfied with the work • local access to learning and training opportunities by target (healer/helper teams: Survivors and their descendants, volunteers) • healers/helpers are skilled to deal with physical and sexual abuse issues (and greater capacity to deal with special needs), with either traditional or Western approaches, and there is an established core group of skilled healers/helpers (Aboriginal and non-Aboriginal); however, they become tired and either burn out, find other work or develop team care strategies and supports that sustain them • network of support services for Survivors, increased interagency cooperation, partnerships and linkages, co-sponsorship of community events and healing activity. Broader Canadian systems are more respectful of Aboriginal people/culture, as well as sensitive and able to address the unique needs of Survivors—as a result, they are more widely used by Survivors and their families

	Awareness and Understanding of the Impact of Residential Schools
	• community is using tools (e.g., archives, audiovisual materials, curriculum development or use of a curriculum package, visitor's centre, commemorative site, research) to learn or teach about the Legacy
	• community is involved in research on the Legacy
	• agencies *outside* of the community are aware of and understand the impact of the Legacy
	• community provides education about residential school to:
	   • Aboriginal and non-Aboriginal students/schools
	   • Aboriginal and non-Aboriginal human service workers/professionals
	
	Healing
	• disclosures of physical abuse/sexual abuse
	• the existence of and participation in sober dances and feasts
	• community is working together to support healing
	• long-term commemoration, restoration and development in the spirit of healing, honouring ceremonies for Survivors
	• healing focus is firmly upon Survivors *and* their families
	• greater acceptance of and ability to deal with people with special needs (e.g., HIV/AIDS, homelessness, etc.)
	
	Plan or Vision to Continue Healing
	• organizations and service agencies (inside and outside the community) continue their efforts to secure support for long-term healing
	• experience addressing the Legacy
	• healing has become political, the individual journey has transformed into a social movement, more seek redress

Restraints	Lack of holism: interagency conflicts, isolated funding pockets, difficulties linking funding sources to community agenda; pressure to produce "results;" burnout; vested interests oppose healing; and new problems emerge, especially among youth.
Link with Desired Outcomes for AHF- Funded Projects	Increased partnerships; increased capacity to facilitate healing (access to services and healers); development of strategic plans with a focus on healing (multiagency, community-level planning with support of community members and leaders).

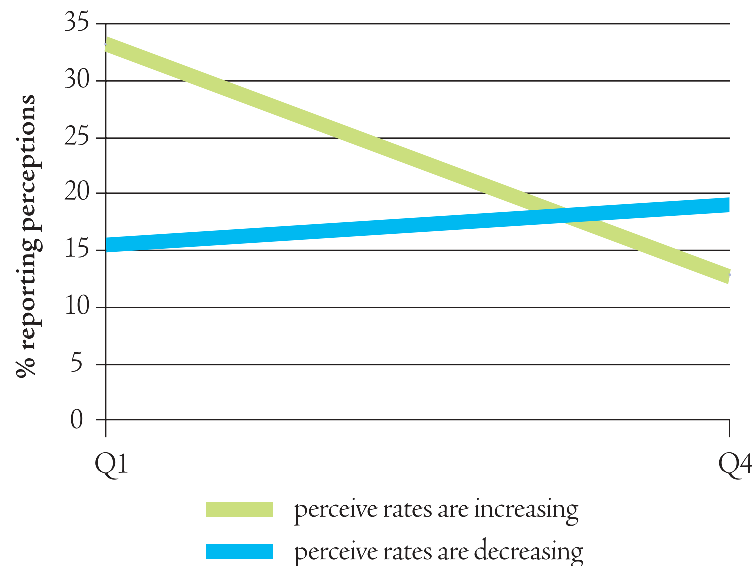
5.2.4 Stage Four: Transformation

Stage four of the community journey is where healing becomes more integrated with other community development initiatives and the focus shifts from fixing problems to transforming systems. For example, the debilitating effects of poverty and unemployment on individual and community health become structural focal points, since healing from the legacy of physical and sexual abuse by itself does not sustain well-being.

> It doesn't make sense to get people well without sustaining that wellness. The long-term vision must address the unemployment in our community. It's an essential part of holistic healing.… Treatment and employment go hand in hand.… With our next generation of kids, economic development must be factored in. Opportunities for our children will help them. Otherwise, there is a chance of them getting into trouble.[163]

During the fourth stage of community healing is when significant reductions in rates of physical and sexual abuse, children in care, incarceration and suicide are most likely to occur. As noted at the beginning of this chapter, it is still too early to assess the contribution of AHF-funded projects by measuring improvements in the environment based on these social indicators; however, it is never too early to gather baseline data on key indicators and all AHF-funded project teams are encouraged to do so. Even though there was little in the case studies or document review that would suggest transformative change is occurring, hints of fundamental change were clear in the most recent national survey. Over a third of national survey respondents (39.4%, n=209, S3) have noted a decided increase in the extent to which Survivors have decision-making authority *in other service networks* (i.e., not AHF-funded projects),[164] and a few (23%, n=209, S3) believe that the number of children at risk may be decreasing. Still, almost as many believe it is increasing (20.6%) or believe there has been no noted change (20.1%).[165] Perceptions about the number of children at risk also appear to depend upon the longevity of the initiative in the community. Figure 28 illustrates this relationship.

Figure 28) Team Perceptions about Children at Risk by Duration of Project Operations



Legend:
Q1 - indicates that the project has been operational for 2-15 months.
Q4 - indicates that the project has been operational for 42-62 months.

In the end, it is important to remember that while the healing journey is long and often arduous, progress has been realized. Collectively, AHF-funded project teams and key informants from the case studies claimed to have increased awareness of the Legacy; broken through some of the barriers of silence; built support systems, networks and partnerships; held workshops, retreats and cultural camps; provided individual and group counselling; and enhanced local caregiving capacity. Projects employed Aboriginal people, including residential school Survivors and their descendants who, along with volunteers, had access to a wide range of training opportunities. Protocols were developed, research conducted and newsletters printed. A respondent in one of the case studies spoke about changes in the way some people are speaking about "community:"

> We are hearing a different language; before people would not even say "my community", they would say, "the community." Now they are saying **my community**. This shows that people are taking ownership of who they are. Once we do this we can overcome ownership versus denial. This will help us to challenge more and more and in this we can move ahead [emphasis added].[166]

When questioned to what extent the AHF has contributed to noted change, respondents from the most recent survey were divided. A few (6%) felt that the AHF had little or no influence, 43 per cent credited the AHF with a moderate influence, 50 per cent felt it had more than a moderate influence and 17 per cent gave the AHF complete credit for the changes noted in their community (n=209, S3).

When transformation is complete, teams told us that it will become obvious because children will be safe, addictions will be rare, women will be free from fear of violence, and a sense of belonging and ownership will prevail. A climate of cultural renaissance, hope and optimism will be apparent, Aboriginal languages will flourish, and Survivors and their families will have the power to influence their communities. There will be movement away from the management of service industries designed to address the impacts of residential school (e.g., child welfare, crisis intervention, suicide prevention, etc.) to the creation of culturally-grounded, adequately resourced and self-sustaining institutions that function to maximize social strength. There will be increased visibility, awareness, respect and recognition of Survivors and their families in Canadian institutions and governments. This, in turn, will lead to sufficient and effective partnerships that are responsive to Survivors, their families and communities. Ultimately, the goal is to achieve a quality of life for Survivors and their families second to none in Canada where intergenerational abuse becomes someone's vague memory and sustainable well-being, self-sufficiency and reconciliation characterize the community.

Proposed Performance Indicators for Stage Four: Transformation

During stage four of the community journey, healing becomes more integrated with other community development initiatives and the focus shifts from fixing problems to transforming systems. Sufficient and well-trained healing teams may exist that offer whole family treatment, but there is an increasingly evident desire and movement toward the establishment of institutions and systems that maximize social strength. In this phase, Survivor groups have moved from wanting help to giving help, and their formally established associations have become enduring institutions with developed governance structures, long-term financial strategies and secured financial/land trusts allowing for sustainability. The Survivor group may support Aboriginal education or continued healing. Team and community capacity is measured, not only by their ability to address the Legacy, but also by their ability to provide a solid foundation for future wellness through active, holistic strategies beyond remedial action. Ultimately, healing will be measured by indicators selected by the AHF board; namely, rates of physical and sexual abuse, suicide, incarceration, reconciliation and children in care.

Table 15) Stage Four: Transformation—Indicators of Community Healing

	Transformation
Driving Forces	Limitations of current approaches recognized; a shift from healing as "fixing" to healing as "*building*," growing participation by community members in the wider economy.
Success Indicators	Increased community control of services; links between community economic development, community development and health; networks and alliances with outside groups.
Outcomes/Indicators relevant to healing from the abuse in residential school	*Survivor Action and Involvement* • Survivors move from wanting help to giving it • formally established Survivors' group becomes registered as an enduring institution or a non-profit, charitable organization with a developed governance structure that is able to hold property and other resources in trust and has a long-term fiscal strategy • the group (with resources held in trust) supports Aboriginal education and continued healing • local Survivors are involved in lobbying efforts (e.g., for national Survivor organization or justice, or increased healing resources) • Survivors and healing teams have decision-making authority in other service networks (sit on boards as representatives) *Team and Community Capacity* • service industries designed to address the impacts of the Legacy (e.g., child welfare, crisis intervention, suicide prevention, etc.) will exist, but there will be an increasing movement away from them to the creation of culturally grounded, adequately resourced and self-sustaining institutions that function to maximize social strength *Awareness and Understanding of the Impact of Residential Schools* • the majority of Aboriginal and non-Aboriginal Canadians are aware of and understand the impact of the Legacy on Aboriginal life *Healing* • healing activities are targeted at **both** Survivors ***and their families*** or the healing focus has moved from Survivors to the children of Survivors • rates of incarceration, family violence (and violence more generally), children in care, suicide, addiction (mortality and morbidity) *Plan or Vision* • the key goal is to sustain the social strength of the community with a variety of systems
Restraints	Ongoing effects of trauma; competent leaders drawn to employment outside community; community governance may maintain divisions and disunity; outside government policies geared to maintain dependency and external decision making.
Link with Desired Outcomes for AHF-Funded Projects	Reduced rates of physical and sexual abuse, suicide, children in care and incarceration; reconciliation.

A discussion about the ability of AHF-funded activity to influence communities would be incomplete without some consideration of the role of time. In other words, does the duration of activity appear to influence results? Although based upon the perception of change noted by national survey respondents, a possible trend is emerging. When looking at the most recently funded project teams (i.e., operational for less than 15 months or Q1) and comparing them to those who were the earliest funded project teams (i.e., those operational for 42 months or more or Q4), there is a notable trend related to the duration of project activity. In other words, more of the earliest funded teams identified increases in the following than did their recently funded counterparts:

- the extent to which Survivors want healing services;
- Survivors meeting to support each other or encourage *other* Survivors to heal;
- the existence of local healing services that are unique to the needs of Survivors and their families;
- the range of services used by Survivors and the intergenerationally impacted;
- the extent of the community's use of learning tools (e.g., archives, audiovisual materials, a curriculum package, visitor's centre, commemorative site) to teach about residential schools;
- the number of agencies *outside* of the community that are aware of and understand the impact of residential schools on Aboriginal families and communities;
- the degree that Survivors and their families understand how the history of residential schools has affected them/their parents/their grandparents;
- local access to training opportunities for healers/helpers;
- the level of healer/helper knowledge and skills required to effectively deal with physical and sexual abuse issues;
- participation in healing;
- disclosures of physical and sexual abuse; and
- the level of community collaboration and leadership initiative to support healing.

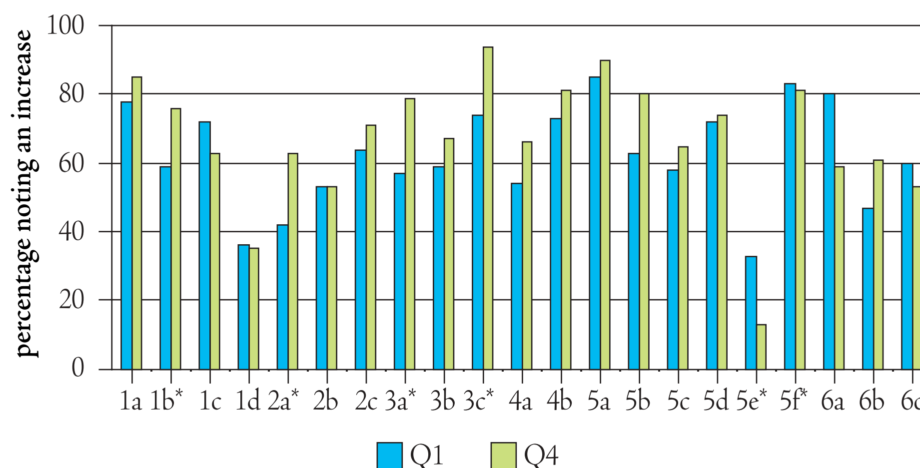
Equally interesting to note is that the recently funded projects were more likely to observe increases in the extent of the following than did their earliest funded counterparts:

- Survivor involved in decision-making about the project;
- Survivor involvement in decision-making authority in other service networks;
- healing activities are targeted at both Survivors *and their families*;
- community planning for long-term healing; and
- organizations and service agencies (inside and outside the community) trying to secure support for long-term healing for Survivors and their families.

These results might suggest that Survivor involvement in decision-making, community planning for long-term healing, focussing efforts on Survivors and their families (versus whole community development for example) and efforts to secure support are pivotal in program design and setup phases, but become less so over time. In any case, these results *must be interpreted cautiously* as they may also be artifacts related to other variables that have not been controlled. In other words, these differences may also have something to do with the potential and natural variation between those communities who are "new" to AHF's constellation of projects and those that have endured over the past three to five years. In fact, the "newer," "younger" teams are more likely to be in remote communities (77.8% of those who have been funded for 15 months or less [Q1] are in remote communities versus 22.2% of those who have been funded for 42 months or more

[Q4]), and the older teams more likely to be located in urban centres (62.1% in Q4 and 37.9% in Q1). In any case, further exploratory work is required to determine the influence of time and how much time is enough.

Figure 29) Trends over Time on the Perception of Select Impact Variables



Legend:
* indicates those variables where the differences indicate or may be approaching statistical significance, however, in all but one case (1b), the minimal n or expected frequencies for each cell *were not* achieved. For those results that are statistically significant, see endnote for fuller details of analysis results.[167]

Q1 = refers to the first quartile of projects on the dimension of time—those who responded to the third survey who have received between 2 and 15 months of AHF support (average 7.1 months, median 5 months).

Q4 = refers to the fourth quartile of projects on the dimension of time—those who responded to the third survey who have enjoyed between 42 and 62 months of AHF support (average 51 months, median 51 months).

In the following list, bolded type indicates those variables where the differences may be approaching statistical significance.

1a - Survivors want healing services
1b - Survivors meet to support each other or encourage *other* Survivors to heal
1c - Survivors are involved in decision-making about the project
1d - Survivors have decision-making authority in other service networks
2a - There are local healing services unique to the needs of Survivors and their families
2b - Local services for Survivors are used by Survivors and their families
2c - Survivors are using a range of social support services
3a - Community is using learning tools (e.g., archives, audiovisual materials, a curriculum package, visitor's centre, commemorative site) to teach about residential schools
3b - Agencies *outside* of the community are aware of and understand the impact of residential schools on Aboriginal families and communities

3c - **Survivors and their families understand how the history of residential schools has affected them /their parents/their grandparents, etc.**
4a - Local access to training opportunities for healers/helpers
4b - Healing team or helpers have adequate knowledge and skills to effectively deal with physical and sexual abuse issues
5a - Participation in healing
5b - Disclosures of physical abuse
5c - Disclosures of sexual abuse
5d - Community is working together to support healing
5e - **Number of children who are at risk in the community**
5f - Healing activities are targeted at both Survivors *and their families*
6a - **Community planning for long-term healing**
6b - Community leaders are seeking resources to support long-term healing
6c - Organizations and service agencies (inside and outside the community) are trying to secure support for long-term healing for Survivors and their families

(a) the minimal n or expected frequency in each cell was not met in these cases.

5.2.5 Engage Survivors and Ensure Accountability

Three of the four urban case study projects—Two-Spirited Youth Initiative (Vancouver, British Columbia), *When Justice Heals* (Ottawa, Ontario) and Tawow Healing Home (Red Deer, Alberta)—struggled with issues of community participation and Survivor involvement. The fourth project, Healing the Multi-generational Effects of Residential School Placement—Urban Access Program (Saskatoon, Saskatchewan), reported a large majority of Survivors among project participants, Survivor involvement on an advisory committee and creative strategies to engage the community, such as monthly feasts. This may be that extraordinary efforts are required to engage Survivors and community members in urban areas where the community is geographically dispersed among a larger non-Aboriginal population. Moreover, the definition of "community" may itself be a challenge in the urban context. In Ottawa, for example, the Inuit community does not necessarily identify with a generic "Aboriginal" community. At the very least, the meaning and definition of "community" is more diffuse in cities than in smaller geographic communities.

Four of the thirteen case study projects appear to have achieved high levels of Survivor and community engagement, while the others had mixed results. Koskikiwetan (La Tuque, Quebec) is a stellar example of a Survivor-driven project—over half of the 14-member multidisciplinary team that developed the project proposal were Survivors. Survivors directed the project and delivered the therapy. This had a cathartic effect on local workers as participants since Survivors can share experience, model healthy behaviour, truly understand and empathize, and appear to be more effective at shattering the silence that surrounds abuse. The project ensured collaboration between various partners by either directly involving them or by informing them regularly on the progress of ongoing activities. Team members also took advantage of meetings organized by health and social services, education and police services to provide reports on activities. As well, the project was promoted during an Elders' conference and reports were presented to the Atikamekw Nation Council.

The Qul-Aun Program (Lantzville, British Columbia) was also an outstanding example of Survivor involvement. Survivors were enlisted as peer partners with psychologists and other counsellors during the long program development period. In addition, Qul-Aun's formalized system of participant feedback ensured that information was regularly gathered and used as a basis for program evolution. In contrast, the national surveys found that Survivors were least likely to be involved in the development of program content or materials while they were most commonly enlisted as advisory committee members.[168] *Every Warrior's Song* (Chase, British Columbia) also involved Survivors early in the project. In fact, the play was based on the experiences of Survivors interviewed during the research phase. Survivors and Elders participated throughout, and their involvement was credited to sustaining the project's momentum.

The Pisimweyapiy Counselling Centre (Nelson House, Manitoba) involved Survivors and Elders on the project team and board of directors, and the residential school advisory group provided support to the project team. Accountability to the community was highly rated and a solid majority of case study respondents felt the project needed little or no improvement in this regard. Accountability was fulfilled through local radio, community presentations, monthly newsletters and residential school advisory committee meetings, as well as posted program activity schedules. Table 16 provides a summary of the various ways that case study projects attempted to achieve accountability and engage Survivors.

Table 16) Overview of Accountability and Survivor Engagement in Case Study Projects

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

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

Half of the national survey respondents (51%, n=154, S2) had no difficulty getting Survivors involved. Some (49%) are still struggling for a variety of reasons; Survivors in their communities are elderly with pressing health issues who generally do not want to recount or address their experiences in residential school.

> Elders have been reluctant to get involved due to beliefs that healing is not possible and to a fear of facing and integrating the past into present day life.[169]

> At times, it is difficult because the Survivors are elderly, sick and are not interested with dealing with their pain, not all of them but there are those that we will never be able to help because they don't want to hear, see or talk about their experiences of Residential school.[170]

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

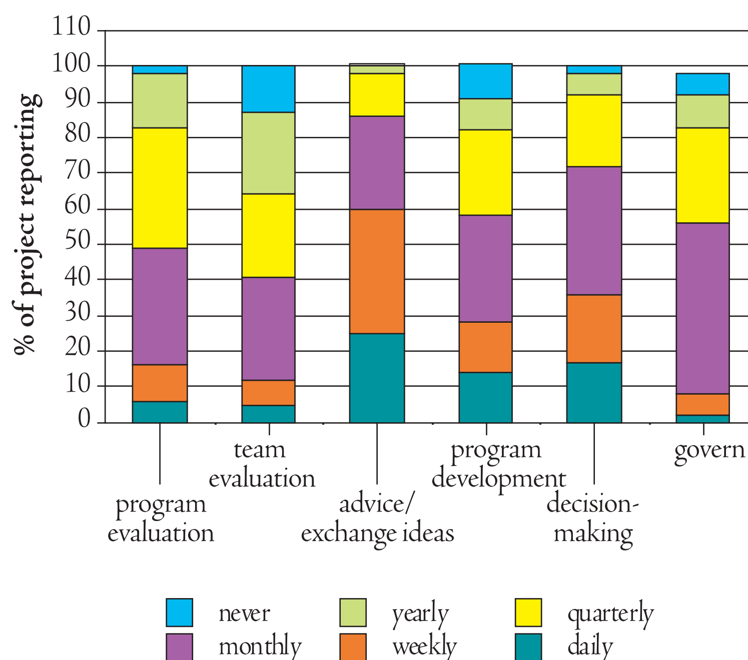
> Many [S]urvivors have trust issues, some have difficulty with people in authority figures, and others are too involved in destructive patterns to become involved in healing projects in any supportive way. Some simply refuse to become involved or even speak of their experiences for any number of reasons. [171]

> Survivors are leery of projects because they think that their involvement will jeopardize their financial claim currently in the courts. Survivors feel that they are being used because of their past.[172]

> What I found is that people did not connect their behaviour or lifestyle to the past. They did not always understand that it is because they lost their identity that they are lost.[173]

Some were thwarted by shame, fear, grief, denial or reticence to be viewed as critical of the churches, and others have lost hope altogether: "some have suffered so atrociously that it seems to them no one could ever understand."[174] Physical and financial barriers include lack of transportation and child care, poor weather, unemployment and insufficient support to engage in healing. In other words, more pressing needs, such as feeding a family, came first when determining where to invest energy.

When they were involved, Survivors were most frequently providing advice, exchanging ideas (60%) and making decisions with project teams at least daily or weekly (n=164, S2). Over half of the project teams (n=161, S2) enlisted Survivors in program development activities or within a governing board or advisory committee structure at least once a month. Survivors were also involved in program and team evaluations; however, these activities were more likely to occur on a monthly, quarterly or yearly basis. Figure 30 shows the frequency of Survivor involvement in project management activity based on results from survey 2002.

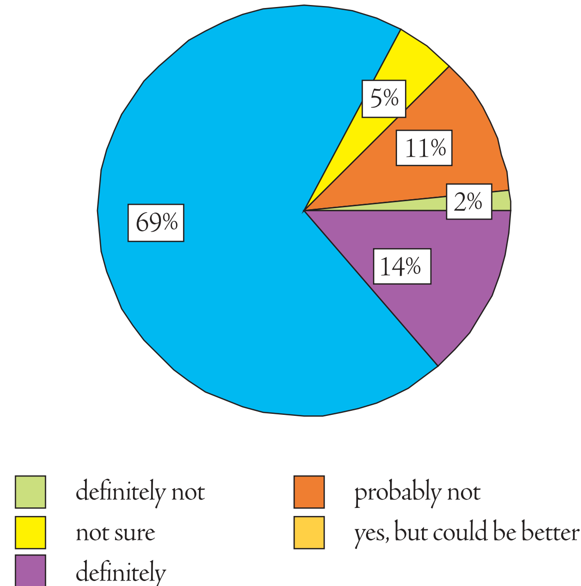


Survivors represent 32 per cent of project teams (n=116, S3), 43 per cent of all volunteers (n=104, S3), 47 per cent of contract workers and those receiving honoraria (n=137, S3), and 51 per cent of all governing or advisory boards (n=164, S3). The intergenerationally impacted were also well-represented and formed 60 per cent of project teams (n=128, S3), 57 per cent of all volunteers (n=108, S3), 44 per cent of those on contract or receiving honoraria (n=120, S3), and 43 per cent of board and advisory committee members (n=145, S3).

5.2.6 Addressing the Need

While there is much evidence to suggest that projects are addressing the needs of Survivors, teams face challenges associated with needs that exceed resources and abilities. In addition, some target groups remain difficult to engage and information about barriers to participation was not always clear. Almost half (44%, n=164, S2) claim that they are able to provide healing and training to all those in need. A full 56 per cent claimed that they *could not* meet the need and 36 per cent (n=166, S2) maintain a waiting list for participation. Only a small group (13.5%)[175] were certain that their efforts were reaching those in *greatest* need. Most (69%) acknowledged that, although they were probably reaching those in greatest need, their efforts could be better. Some (5%) were unsure, while others (12.5%) were clear that they were probably or definitely not reaching those most affected by the Legacy. From other sources, it is clear that widespread fear and denial or under-resourcing may be inhibiting progress in this regard. National respondents were unanimous in their estimation that the AHF was able to meet relatively few needs and that the task at hand was far greater than the resources (time or money) allocated to the effort. Figure 31 illustrates the projects' perceptions regarding their ability to reach those in greatest need.[176]

Figure 31) Ability to Reach Those in Greatest Need (2004)



When asked how many more people could be serviced if the project had adequate time and resources, project responses added up to a total of 138,130 people that they could service (n=183) [Ext - 306,452: n=406, i.e., 56% of n=725 or the total number of discrete organizations funded by the AHF at 1 September 2004].[177]

Although national survey respondents feel that the AHF 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 3,241 proposals received, 1,346 (or 42%) have resulted in a contribution agreement. Unsuccessful applicants may not directly address the Legacy (i.e., physical and sexual abuse), have sufficient accountability strategies to Survivors and community or lack information for the program and finance requirements. As well, the enduring misunderstanding that AHF resources equaled compensation for Survivors has meant that some in great need are confused by the purpose of the AHF. For those communities who write well, prepare complete proposals and meet minimum reporting criteria, the AHF appears to work very well; however, those in greatest need do not always have local capacity to engage. The AHF has responded with a more straightforward, interactive and supportive proposal approval and project monitoring process in an attempt to reach these communities. Still, simultaneous court proceedings, sensational and often misguided media coverage, together with the overall sensitivity of the issue, has led to misconceptions about the AHF's essence and purpose. The AHF uses public education to quell misunderstandings so that Survivors will engage in healing, not as a substitute for redress, but *in addition* to their quests for justice.

When examining the ability of case study teams to address the need, a variety of capabilities were noted. For Big Cove First Nation's project "Our Youth, the Voice of the Future" in Big Cove, New Brunswick, it was estimated that roughly 17 per cent of the target group of 900 youth participated. With adequate resources and more active outreach, informants claimed they *could have served as many as 500 youth.* In Cape Dorset, Nunavut, womens' and teen girls' healing groups appear well-established and Elders participate,

yet men continue to be underrepresented. For well-developed healing and training projects with regional target populations, the costs of travel and child care enabling participation are unclear. Still, regional programs do have representation from a wide range of communities, suggesting solid communication strategies and the ability of some participants either to overcome or to be supported in their travel and child care needs.

Sometimes, it became clear that Survivors' needs were *beyond* team capabilities and *professional* counselling was recommended. In other words, while teams may have been well-equipped to strengthen parenting skills, they felt ill-prepared to address FAS/FAE, serious chronic addiction, dissociative disorders and other psychosocial symptoms associated with post traumatic stress. Generally, healing projects identified 27,855 (n=267) 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, 37 per cent (median=25%, n=163, S1) of participants require greater than normal attention to deal with their special needs.[178] As a result, some Survivors had to be referred elsewhere.

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

Some Survivors start their healing journey and then slip through the cracks because they are not prepared to face their issues or their needs do not "fit" with the approach. Accommodating these Survivors has been difficult because little is known about this group, other than many of them may have been mandated to attend. More information about those who start but do not finish is necessary before their needs can reasonably or adequately be addressed. Similarly, although community-wide education on the Legacy was met with enthusiasm, there is evidence that denial *persists.* Most respondents felt there was room for improvement in reaching those in greatest need through more active, creative and enduring outreach efforts. Legacy education was consistently cited as one strategy to engage Survivors in healing. Influencing women was considered one avenue to the eventual participation of men.

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

5.2.7 Establishing Partnerships and Ensuring Sustainability

The Aboriginal Healing Foundation was established to serve as a catalyst for community action to address the Legacy. With fixed resources and a definitive 10-year time frame, an end to AHF activity was always clear. Therefore, projects were encouraged to engage long-term sustainable funding from other partners or

otherwise develop viable healing strategies. There is also a well-established body of literature that supports a coordinated, holistic approach to health and healing through community development.[179] One of the consistent lessons learned from experiences with healing initiatives in Aboriginal communities is that: "Community healing requires personal, cultural, economic, political, and social development initiatives woven together into a coherent, long-term coordinated strategy."[180] Several indices were chosen to reflect the value added by cooperative relationships, including their range, frequency, quality, financial resources associated with them and their perceived efficacy. Document review, national surveys and case studies all provided insight into how relationships influenced projects.

From the review of documents, all but one of the 36 AHF-funded project files reviewed reported established partnerships, and survey results show that the majority (72%, n=247, S1) of funded organizations were linked with other healing or training efforts.[181] Relationships are concentrated at the local level and community services are the most likely partners. Overall, AHF-funded projects developed significant working relationships with a variety of service providers and agencies in their communities and regions, primarily as a way of expanding the range of services. Table 17 lists a variety of organizations and services mentioned in project files, along with the number and percentage of projects where linkages were established.

Table 17) Partnerships Established

Organizations and Services	# of projects	Percentage
Health, including medical and mental health services, boards and committees	21	58.3
Education: schools and education committees/ councils[182]	16	44.4
Local Aboriginal government/council/hamlet, band or community	15	41.7
Social service agencies/social workers	14	38.9
Child and family services	13	36.1
Alcohol and drug/addictions services	12	33.3
Police/RCMP	10	27.8
Youth groups/councils/services	10	27.8
Provincial/federal department or program	7	19.4
Shelter, sexual assault/women's centres	6	16.7
Elders' groups	4	11.1

From case studies, it is clear that active coordination and interagency work appear to have *created* conditions conducive to initiating an AHF-funded project. For example, key informants for the Tawow Healing Home case study indicated that some landlords are reluctant to rent to Aboriginal people and employers are reluctant to hire them as well. In the past 15 years, Aboriginal organizations and services in Red Deer have grown and formed an interdisciplinary team of integrated services. New initiatives include funding for the homeless, community-supported housing, opening of the Red Deer Aboriginal Employment Centre and a new Aboriginal council that oversees all programs affecting the community. In addition, cultural awareness

education for all agencies dealing with Aboriginal people is required. The Tawow Healing Home entered this animated environment and filled a gap by providing the only culturally based, non-mandated therapeutic program for Aboriginal children, adolescents and their families at risk of intervention by social services.

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

The Aboriginal Peoples' Justice Circle in Ottawa, Ontario, encouraged membership from the Aboriginal community, as well as from the mainstream justice system, including representatives of the Crown Attorney, police and the judiciary. While interview respondents did not agree on the level of support community partners gave to the project, there was some evidence of progress with respect to increased awareness and acceptance of Aboriginal values and practices. The project's third quarterly report stated that the assistant crown attorney, as a member of the circle, had been "instrumental in having Aboriginal persons diverted away from the mainstream justice system." One respondent communicated that justice officials "have begun to listen and learn and to accept our teachings … this type of networking allows us to gain credibility and more respect and there is more willingness to learn our ways." In fact, it was reported that smudging is now allowed and respected in court.

Two of the projects travelled to communities: one to present a play (*Every Warrior's Song,* British Columbia) and the other to deliver training workshops (*I da wa da di,* Ontario). In both cases, host communities and organizations took on organizational responsibilities. The funding application for the theatrical production listed six initial partnerships with bands, treatment centres and residential school committees. The play was presented at 12 sites across the province and, in the project's final report, 13 additional partnerships were named. Host communities provided facilities with a stage and an area large enough to house their anticipated audience, plus marketing, transportation for the audience, a feast, a counsellor, pre- and post-action plans for participant support, and roving counsellors during the performance. *I da wa da di* training workshops were sponsored by three different agencies who provided local promotion and outreach, as well as meals and refreshment breaks. Included in these partnerships are the traditional healers and Elders who came from different regions to the training workshops and the annual gathering to share their teachings and wisdom on healing.

The case studies addressed the issue of sustainability primarily by asking key informants about the project's potential for continuing after AHF funding had lapsed. Two of the British Columbia projects are no

longer operating—the theatrical production *Every Warrior's Song* and the Two-Spirited Youth Project. Two others felt they could not sustain project activity beyond the life of the AHF, at least not without the support of a strong partner. In one case, this was due to the unique service provided: Tawow Healing Home (Red Deer, Alberta) is the only whole family, *non-mandated* family service option in the region. If the organization accepts funding from social services, the program will have to change to adhere to their guidelines and may lose its unique approach. The difficulties in establishing partnerships, caused primarily by differing philosophies and practices with child welfare agencies, decreases Tawow Healing Home's chances of sustainability. At the time of the case study, *When Justice Heals* (Ottawa, Ontario) operated without funds both before and after the end of AHF funding.

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

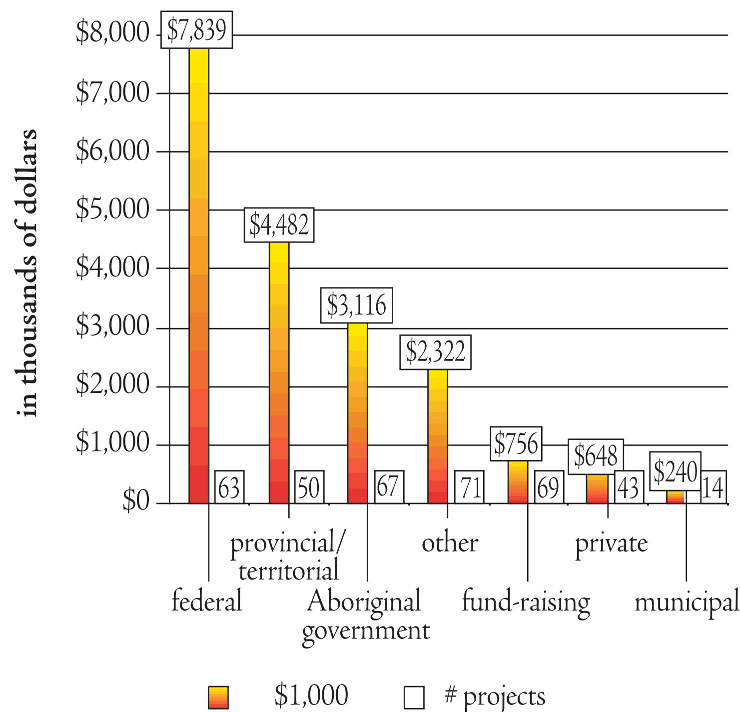
The index chosen to reflect sustainability is the amount of long-term funding secured to date. Partnerships, on the other hand, are represented by all contributions, short- and long-term (monetary or not), as well as working relationships with complementary service agencies. In the presentation of financial information, totals are used because they more fairly represent what is being contributed *nationally*.

Eighty-five per cent (n=199) are addressing the legacy of physical and sexual abuse with other agencies or organizations. National survey results show that less than half of all respondents (44%, n=467) reported receiving funding from other sources during the operation of their project, down from about two-thirds of all respondents in the first national survey (n=234, S1).

> **A total of $19,401,480 was received from partners *during* the operation of the 205 projects that reported receiving funds from sources other than the AHF.**

The greatest amount that came during the projects' operation was from the federal government ($7,838,611), followed closely by provincial and territorial governments ($4,481,659). Aboriginal governments donated $3,115,653, while those gathered in the catch-all "other" category contributed over two million dollars ($2,321,512). "Others," by name, included supporters from local health and social service agencies, the United, Anglican and Catholic churches, tribal councils and Aboriginal service agencies, noninsured health benefits, the Métis Nation, local training and employment boards, industry, individual pledges, the United Way, Aboriginal women's associations and the Canadian Conference of Catholic Bishops. Community fund-raising generated over three-quarters of a million dollars ($756,018), private granting foundations offered $648,370 and municipal governments pitched in $239,657. The distribution of total funds by source is highlighted in Figure 32. As a way of ensuring each donation appears in perspective, the reader will note the number of projects that claimed to receive these contributions is displayed close to the x-axis (bottom horizontal line and on the right side of the graphic bar).

Figure 32) Total Funds Contributed by Source (2004)

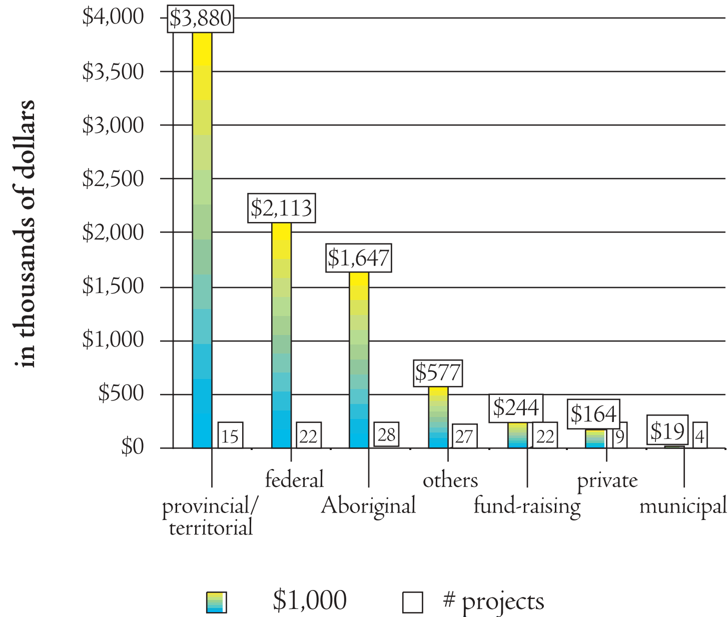


A small group reported receiving *ongoing funding* from federal departments, provincial, municipal, hamlet and/or Aboriginal governments, as well as private granting foundations and community fund-raising efforts. In fact,

a total of $8,643,573 of *ongoing* funding was reported by 81 organizations.

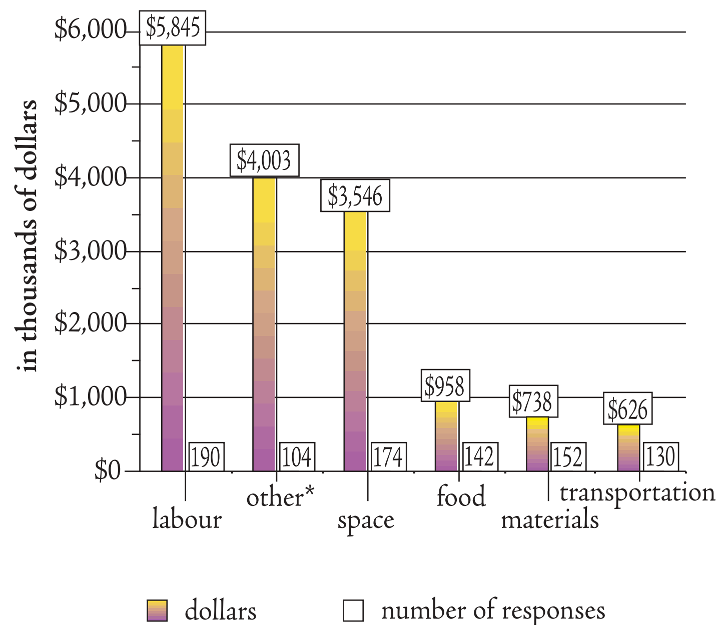
Almost one-quarter (24%, n=199, S3) of the respondents believe they *will be able* to continue addressing the Legacy beyond the life of the AHF. About as many (23%) were sure they would be *unable* to continue their healing work and the majority (53%) were unsure. Provincial partners have committed the largest amount to *ongoing* healing after AHF funding ($3,879,889), followed by the federal government ($2,113,197) and Aboriginal governments ($1,647,245). The generic "other" category, again, has an impressive long-term commitment of $576,953 and includes supporters from local health and social service agencies, the United, Anglican and Catholic churches, Aboriginal governments and service agencies, noninsured health benefits and fund-raising efforts. Again, the reader will note the number of respondents to the survey who claimed to receive these contributions is displayed close to the x-axis (bottom horizontal line and on the right side of the graphic bar).

Figure 33) Total Ongoing Funds Contributed by Source (2004)



More than half (60%, n=467) of the respondents to the national surveys reported receiving donations of goods or services at an *estimated value of $15,715,169.* Donations of labour were clearly in the lead and valued at $5,844,635, followed by miscellaneous[183] donations totalling $4,002,641. Donations of space ($3,546,431), project materials ($737,621), food ($957,653) and transportation ($626,188) were also common. The pattern of donations received is depicted in Figure 34. Once more, the reader will note the number of respondents to the surveys who claimed to receive these donations is displayed close to the x-axis (bottom line and on the right side of the graphic bar).

Figure 34) Total Value of Donations by Type (2004)

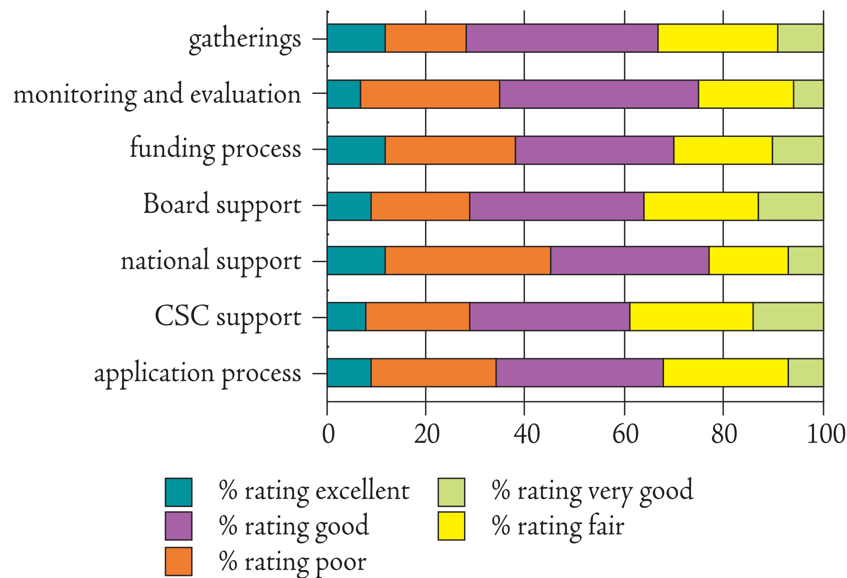


* "other" includes promotional media, medicine and other miscellaneous items.

When teams were questioned about how effective their working relationships with partners were, almost half (49%, n=247, S1) reported very effective; however, about one-fifth of all projects (20%) rated their partners as only somewhat effective or ineffective. Appendix R illustrates team opinions about their established partnerships.

Lastly, teams had the opportunity to comment upon their partnership with the AHF. Much of the AHF's activity was rated favourably. In particular, they felt very positive about the support they received from the AHF national team, especially with respect to the monitoring and evaluation process. Figure 35 shows the distribution of opinions about AHF processes.

Figure 35) Rating of AHF Activities



Note: CSC = community support coordinator

5.3 Manage Program Enhancement

Early in the AHF's mandate, it was clear that roughly three-quarters (74%, n=230, S1) of all survey respondents were measuring change in some way. Healing projects (n=203, S1) most regularly used informal observations (76%), solicited feedback (64%), evaluations (60%) and formal observations (54%). Some reported using unsolicited feedback (32%) and only a few (23%) were using a formal assessment. Rarely (2%) do projects use aftercare or follow-up practices as a way of measuring change on the healing journey. With respect to training projects, 22 per cent were not measuring change in any way (n=137, S1). When changes in trainees were measured (n=197, S1), the most common methods were solicited feedback (40%), informal observations (37%), formal observations (25%), unsolicited feedback (20%) or formal testing (12%). A small number (5%) used evaluations or follow-up strategies to determine if knowledge or skills acquired during training have been applied.

For the purposes of the document review, indicators were categorized under the following headings: awareness, knowledge, attitudes and behaviours. The overwhelming majority of indicators suggest that projects intend to impact participant *behaviour* (e.g., reduced rates of family violence, improved school attendance, increased rates of parental involvement in schools). In fact, their proposed evaluation strategies indicated that, while projects planned to measure changes in behaviour, reports were almost exclusively focussed on the attainment of immediate service delivery objectives. In other words, the document files revealed an overwhelming focus on reporting activity, but very little on the achievement of desired results for individuals, families or the community. In fairness, the evaluation of *behavioural* indicators was premature in 2001, when initiatives were only a few years old and community-based teams found themselves in the unenviable and *unprecedented* task of *simultaneously* determining needs, building capacity and struggling with denial while designing and implementing programs to address the Legacy. More rigorous effort is required to report changes in *realistic* short-term indicators (e.g., changes in awareness and attitude) in a *way that is clear and measurable*.

Evaluation reports were completed for some (17%, n=36) of the project files reviewed; however, team impressions regarding project implementation and impact were included in the solid majority of files (72%). Qualitative information in project files reveals that AHF investment is valued and needed. Sometimes, reports indicate positive participant feedback without any submission of the participant evaluation forms (i.e., raw data). Similarly, there were claims of high participation rates without corresponding details regarding the proportion of Survivors within the community who are engaged in healing. Many noted increases in service demand without illustrating, even anecdotally, how they knew there had been an increase. In some cases, raw data were included in progress reports (e.g., participant satisfaction forms), but no analysis or synthesis of participant voice was included. This was probably the result of the therapeutic demands on project teams, as well as community capacity.

Still, there were some stellar examples of community-based self-evaluation that are worthy of note here. One project questioned participants directly in an open-ended fashion about their expectations and whether or not the project was able to meet these expectations (e.g., usefulness of information provided, effectiveness of facilitators and staff, quality of the gathering). This information provided rich qualitative data from which a clear picture of project activities and impacts could be gleaned and analyzed. Another project proposed using "key features" to determine project performance. Such "key" features would be determined by consensus among the stakeholders (i.e., participants and project deliverers), and could include participant life satisfaction, observable changes in self-sufficiency, effectiveness of project management and the degree to which the project was able to become financially self-sustaining. Finally, another project undertook an impact evaluation using a within-groups repeated measures approach for a 12-week program. While the final report "notes very little change," it also cautions that the length of the program was only 12 weeks, and thus no significant changes were expected.

From document review, it was clear that data collection methods varied and included participant evaluation, community questionnaires, focus groups and key informant interviews. Some projects indicated that they were using standardized, rigorously evaluated instruments, such as the Substance Abuse Subtle Screening Inventory (SASSI), the Myers-Briggs Type Indicator, the Achenback Child Behavior Checklist and the Gates MacGinite Test for reading. *The results of these instruments will hold significant weight in assessing the impact of AHF-funded project activity in the future.*

Project teams encountered difficulties when assessing the contributions their efforts made toward desired goals, which indicate both the sensitive nature of AHF-funded program activities and a need for community-based evaluation training.

> Field workers found out that the majority of people were afraid to do the questionnaires. We as a team concluded the fear came from the unknown and un-dealt issues within each individual's life.
>
> Incomplete data collection — frustrating outcome given the time and energy invested.[184]

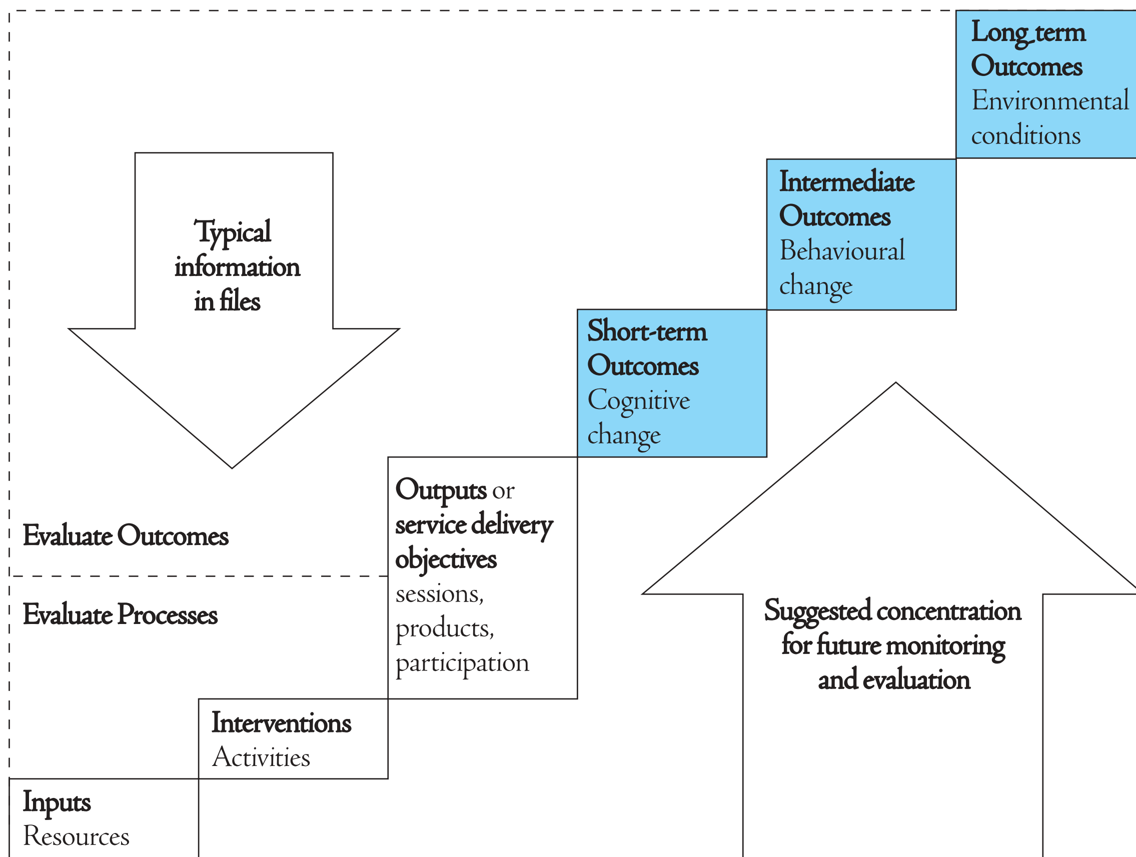
In addition to evaluation, a full series of accountability activities ranging from formal written reports and meetings to less formal community feedback sessions and media coverage were noted including: quarterly evaluation and monthly reports; call-in radio shows to elicit community feedback; scheduled monthly dinners; community feedback sessions; newsletters, local health fairs and conferences; internal monitoring bodies (e.g., volunteer community Survivors committees); and monthly interagency meetings.

Case study project files were *rich* in detail regarding the achievement of service delivery objectives, and some *formally* collected feedback from participants that were invaluable to adding participant voice to this report. Informal feedback was a common strategy used to assess participant satisfaction. Although all projects submitted evaluation plans, many selected for case study analysis did not have the expertise, time nor the appropriate tools to carry out their evaluation. Also, it is possible that project teams may have confused their investment in completing project monitoring and evaluation forms requested by the AHF as sufficient to meet the requirements of AHF evaluation. In the following section, recommendations are noted for improving program enhancement efforts that address the distinction between outputs and outcomes, an appropriate and sufficiently sensitive target for analysis, useful measurement tools and suggested evaluation designs.

5.3.1 Outputs Versus Outcomes

In general, more clarity on the difference between the ability to measure *implementation objectives* (e.g., what we did or *output*) and *real change* (e.g., what we wanted or *outcome*) is needed. In other words, while it is important to report the achievement of service delivery objectives or immediate outputs (e.g., documents, participation, meetings and conferences), a more powerful statement can be made if the effort focusses upon whether or not any *changes* have occurred in ideas, intentions, behaviours or conditions (e.g., the outcomes). The suggested focus of future project monitoring and evaluation efforts are shaded in Figure 36.

Figure 36) Focussing Efforts on Change



In addition, it would be helpful if projects were encouraged to strive for more *realistically attainable* goals that can be articulated *in finer detail* so that the theory underlining each effort is clear. To a large extent, such finely detailed and realistically attainable outcomes are profiled in sections *5.1 Impact on Individuals* and *5.2 Influencing Communities*. Table 18 is offered as a means of ensuring that AHF-funded programs are designed in a way that facilitates effective evaluation.

Table 18) Key Questions for Measuring Performance[185]

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

For example, Legacy education campaigns would be more effectively assessed if a clearly articulated set of learning outcomes were identified. A sample of specific learning outcomes designed for Legacy education has been provided in Appendix S. Furthermore, Legacy education campaigns would also be well served by collecting information on indicators traditionally used to evaluate similar efforts[186] in order to estimate the amount of perceived change in community awareness, attitudes toward healing, behavioural intentions to heal, interpersonal communications (e.g., talking with others about the Legacy), and current service access and use trends. The collection of program participation statistics would be well served by unique identifiers so that no individual is counted twice. Project monitoring and evaluation should also consider using qualitative data processing software and coding key segments of submitted reports for quick retrieval of information. Another essential dilemma in evaluating funded activities is selecting an appropriate target for study.

5.3.2 Individuals Versus Communities

Social indicators give reasonably objective, "big picture," bottom-line evidence; a more comprehensive view of the social environment is always valuable.[187] Key indicators were selected based upon their relevance to healing, and included community or provincial rates of children in care, incarceration, suicide and physical

and sexual abuse. Only during data collection did it become clear the extent to which they would be available, *sufficiently sensitive*, accurate and possible to collect. In other words, while focussing on changes in community conditions is honourable and ambitious, it may not be well-suited for early evaluation efforts. Therefore, creative strategies that are *adequately discriminating* must be developed to ensure *direct* measurement of change in individuals, since the appropriate target for study is not always communities and is most certainly not provinces. When individuals are the appropriate unit of analysis, they should be followed over the long-term, especially when the sponsoring organization is not entirely dependent upon the AHF for funding (e.g., community councils, treatment centres, friendship centres and so on). Furthermore, *some effort should be made to determine how successful participants differ in response to healing activities from those who are not successful in the short- and long-term*. Once follow-up data are secured, these can be analyzed and reported by an external evaluator. The report should contain broad-based follow-up efforts only with respect to those scenarios in which the community is the appropriate unit of analysis and in which community information was secured on key social indicators (e.g., physical and sexual abuse), like Big Cove, New Brunswick and Red Deer, Alberta.

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

Recognizing the liabilities associated with direct assessment of individuals, it is recommended that additional support (beyond the AHF's *Community Guide to Evaluating Aboriginal Healing Foundation Activity*, which was distributed to AHF-funded projects) be provided to project teams in the form of a measurement directory that would identify either an ideal tool, or a series of tools that could be used to measure healing from sexual abuse, self-esteem enhancement, employability, life skills and other desired outcomes. Because direct assessment or direct observation of participants is ideal, a sample consent form is presented in Appendix T and *must be used to gain informed consent prior to observation or administration of any assessments.* Supporting materials must be made available to participants to explain what, when, why and how they would be assessed and why AHF-funded projects need to be evaluated as a matter of ethics in research and evaluation. Participation in the assessment would be quite important for validity; however, it would be voluntary.

5.3.3 Suggested Measurement Frameworks, Strategies and Tools

Long-term follow-up of those participating in healing programs should include personal, educational, vocational, criminal and treatment histories, as well as level of functioning in the home, and as a partner in a romantic relationship, in the workplace, with their own children, friends and parents. These data could

be collected during intake, as a baseline measure, then again at the end of the program, at six months and at one year of aftercare. More specifically, these data might include the following items listed in Table 19.

Table 19) Suggested Intake and Follow-up Information on Individuals

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

Furthermore, answers to the following questions (with suggested indicators) in Table 20, adapted from the evaluation plan submitted by Tsow-Tun Le Lum Society's Qul-Aun Program (British Columbia), should be considered in any long-term follow-up of healing project participants.

Table 20) Evaluation Questions and Possible Indicators in Assessing Individual Progress

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

For youth development programs, the AHF may want to support projects in *adapting* tools developed by others. For example, the growing popularity of the concept of resiliency in youth development programs has led to a comprehensive measure of positive youth development. This measure addresses caring relationships, high expectations, opportunities to participate in meaningful activities, social competence, autonomy and a sense of meaning and purpose. Items assess attitudes toward school, family background, communication, community conditions and involvement in positive activities (a copy of the *California Healthy Kids Survey* for resilience assessment is included in Appendix U). For offenders, special consideration should be given to the dynamic factors already assessed as part of Correctional Service Canada's protocol for

rehabilitation programs, particularly changes in mandatory and discretionary referral criteria and the adaptation or adoption of observation guidelines developed by the Waseskun Healing Lodge for Aboriginal Men (see Appendix V). Of course, others have creatively addressed their needs for assessment by creating their own tools. For example, in the Child and Family Art Therapy Project operating out of the Wabano Centre for Aboriginal Health (Ottawa, Ontario), evaluators gathered with parents to ask them about the day-to-day challenges they faced and what results they hoped to gain from their participation in the program. These desires were then combined with a simple Likert scale[188] to form a pre- and post-test questionnaire to fit the unique goals of families participating. A sample of their tool is included in Appendix W.

Other instruments in use by project teams include the *Beck Depression Inventory*,[189] *Beck Anxiety Scale*[190] and *Dissociative Experiences Scale*.[191] Tools that were recommended for use include the *Posttraumatic Stress Diagnostic Scale*[192] and the formal observation guidelines contained in the YWCA of Greater Toronto's *Life Skills Coaches* training program[193] for those also hoping for improvements in life skills. In addition, Mary Jane Alexander[194] is developing a reliable and valid instrument to assess healing from sexual abuse trauma that is expected to be piloted in 2005. More general healing programs that attempt to strengthen life skills in adults may want to consider using Antonovsky's *sense of coherence scale*[195] (see Appendix X) or tools that were developed based upon the learning outcomes of Teresa LaFromboise's *American Indian Life Skills Development Curriculum*.[196] More community-wide endeavours would be well-advised to use the proposed performance measurement framework described in section *5.2 Influencing Communities* or an adaptation of the *Community Wellness Report Card* suggested by Four Worlds[197] (included in Appendix Y).

Of particular interest to most teams addressing the Legacy would be the work of Judith Herman[198] whose theoretical framework is used in section *5.1 Impact on Individuals* as an organizing structure for performance measurement. Her framework may also prove useful for most clinical approaches to addressing the legacy of trauma experienced in residential school. While increased awareness, understanding and acknowledgement of the Legacy are common and powerful starting points on the healing journey, where progress can be easily measured by the attainment of specific learning outcomes and their application (see Appendix S),[199] gaining freedom from the impact of trauma is far more complicated to achieve and measure. Herman offers a useful way of looking at movement away from a complex post traumatic response, by profiling what symptoms are commonly associated with the experience of trauma[200] that, when framed positively, bear remarkable resemblance to the desired outcomes and indicators cited by project teams in focus group discussions, case studies, document review and one-on-one interviews. This symptom profile includes changes in:

a) the ability to regulate emotion (characterized by such conditions as persistent depression, chronic rage or fear, self-injury, suicidal preoccupation, and compulsive or inhibited sexuality);

b) consciousness (which may include an inability to remember a traumatic event or excessive preoccupation with a traumatic event, dissociative episodes where the mind is able to "divorce" itself from reality, and depersonalization);

c) how the individual views himself or herself (including feelings of helplessness, shame, guilt, self-blame or a sense of complete difference from others);

d) how the individual views the perpetrator (characterized by granting the perpetrator greater power than he or she actually has, preoccupation with revenge, and a sense of a special or supernatural relationship with the perpetrator);

e) relationships with others (including persistent distrust, isolation and withdrawal, and a disruption or an inability to engage in intimate relationships); and

f) changes in systems of meaning (loss of faith and a sense of hopelessness and despair).

When this symptom profile is considered within an Aboriginal view in which all healing is based upon relationship, there are essentially two categories of relationship that are being addressed by project teams: relationship with self and relationship with others. When positively framed, the changes described above offer guidelines for the formal observation of movement away from a complex post-traumatic response. The indicators selected and represented in Tables 21 and 22 illustrate the parallels between the theory and the practice. In other words, it has become clear that project teams, to a large degree, are observing movement away from a complex post-traumatic stress response. The noted divergence between theory and practice appears to be related to addressing changes in consciousness (i.e., amnesia and dissociative disorders) and to the strong emphasis of project teams upon reconnection with family.

Before reviewing the illustrated observations and indices, it is important to emphasize that any single indicator or "sign" of change can be used to measure progress with respect to a variety of desired outcomes. In other words, when previously isolated individuals start to welcome more social interaction, this is a sign of increased trust, greater happiness, improved self-esteem and enhanced ability to positively effect change. Therefore, indicators or "signs" or "thermometers" of change are not always easily classified by outcome. Similarly, indicators are not neatly grouped by target. In other words, while greater participation in and completion of healing programs could be an indicator of individual and family strength, it could also reflect social changes more broadly at the community level. For example, when previously oppressed or painfully shy individuals start to speak up and challenge authority or make their needs known, it may be a sign of increased *self*-confidence or improved *community* security. For that reason, some "signs" or "thermometers" of change are listed here for individuals whose progress may also be applied to other areas of a results-based performance measurement framework. The following list of indicators should be viewed with an open mind, as well as a critical eye, because they are offered here for further consideration and elaboration of invested stakeholders. Some of the most frequently cited "signs" of change in participants included those listed in Tables 21 and 22.

Table 21) Indicators of Change in Relationship with Self

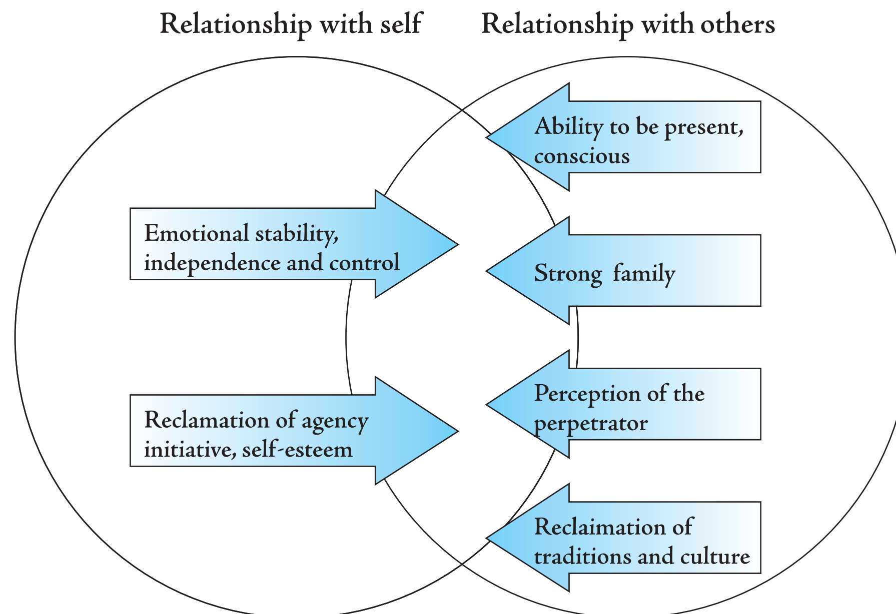
Pathological Frame	Positive Reframe	Signs or Indicators
Alterations in affect regulation	Emotional stability, independence and control	reduced fear of being judged, impulse control, knowledge and use of grounding techniques, ability to express and show emotion in socially acceptable ways, ability to accurately assess risk, freedom from hyper-vigilance, excitability, appropriate response to perceived threat
Alterations in self-perception	Reclamation of agency, initiative, self-esteem and identity	**agency** - confidence, leadership skills, sense of self-responsibility, identify and use their own personal resources, employability, greater financial independence, recognition of strengths and abilities in ways that inspire and motivate, and reduced dependence upon the program **initiative or goal orientation** - going back to school, seeking a job, planning a future, daring to and developing a dream; undertaking action for change, physical appearance, and more active participation in processes and programs **self-esteem** - greater knowledge and use of self-care strategies, such as relaxation techniques, stress management, exercise, seeking and accepting support that includes peer, professional and social; completing treatment programs; better dietary choices; engage in, seek or continue treatment and secure support; behavioural evidence of empowerment or assertiveness; and freedom from self-abuse (including addiction) and suicidal ideation, and behavioural evidence of healthy coping strategies **identity** - begin to accept and celebrate an Aboriginal identity by embracing their heritage and culture shedding notions of internalized colonialism

Table 22) Indicators of Change in Relationship with Others

Pathological Frame	Positive Reframe	Signs or Indicators
Relationships with others	Relationships with others	degree of isolation, withdrawal, nature of intimate relationships (e.g., nonviolent, caring and healthy sexuality); ability to share and express emotion; ability to recognize, disclose and leave or change an abusive situation; able to distinguish between healthy and unhealthy relationships; trust of other people; conflict resolution and communication skills (e.g., ability to communicate in a way that makes them feel heard and understood); accept and give support; and changed nature of personal narrative
	Strong family	improved parenting skills, bond or attachment to family members; ability to forgive, share fun with and touch lovingly; and increased contact with their apprehended children, either through visitation or custody
Alterations in consciousness	Being present	freedom from intrusive memories or ability to remember, process, mourn and resolve past trauma; and ability to remain with reality
Perception of the perpetrator	Reclamation of power from the perpetrator	freedom from the need for revenge; reclaimed personal power from the perpetrator; freedom from a sense of special or supernatural relationship with the perpetrator; and ability to recognize flaws in the perpetrator's belief system or rationalization for the abuse
Systems of meaning	Reclamation of traditions and culture	reclamation of faith in spiritual foundations or the love and support of family, friends and community; a sense of hope; volunteer efforts, interest and action to reclaim language, heritage, identity and traditional medicine; engagement in ceremonies; and renewed commitment to spirituality and culture

Of course, desired change in relationship with self can have impacts upon relationships with others, and the reciprocal relationship between these connections is illustrated in Figure 37.

Figure 37) The Reciprocal Influence of Changing Relationships



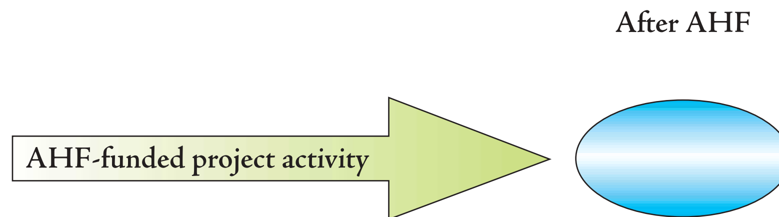
Perhaps the most significant challenges faced by those who have engaged in project level evaluations include keeping track of highly transient populations and engaging in testing that was valid, reliable and reasonable, while retaining interest. Although some project teams have much data that are useful for evaluation, they do not have the resources to compile and synthesize the information. Of those teams identified for one-on-one interviews on evaluation, most are using pre- and post-test instruments; however, at least one project team stated that the use of a specific pre- and post-measurement tool or strategy may be problematic for highly fluid program activities (e.g., planning to measure self-esteem when the healing circle moves in a way that influences *other* cognitive change, such as knowledge of family systems or the impact of the Legacy).

A results-based management framework for teams addressing the Legacy should consider the use of the theoretical frameworks offered here as a way of capturing details about the achievement of desired outcomes, particularly at a clinical level. A variety of instruments already exist that are reliable, valid, rigorously tested, standardized and widely accepted measurement tools. However, for some situations, tools may have to be adapted or developed to be most relevant and sensitive to participant needs. The use of recognized or piloted tools, together with a strong evaluation design, would lend strength to statements about the plausible association between AHF-funded project activity and outcomes.

5.3.4 Suggested Evaluation Designs

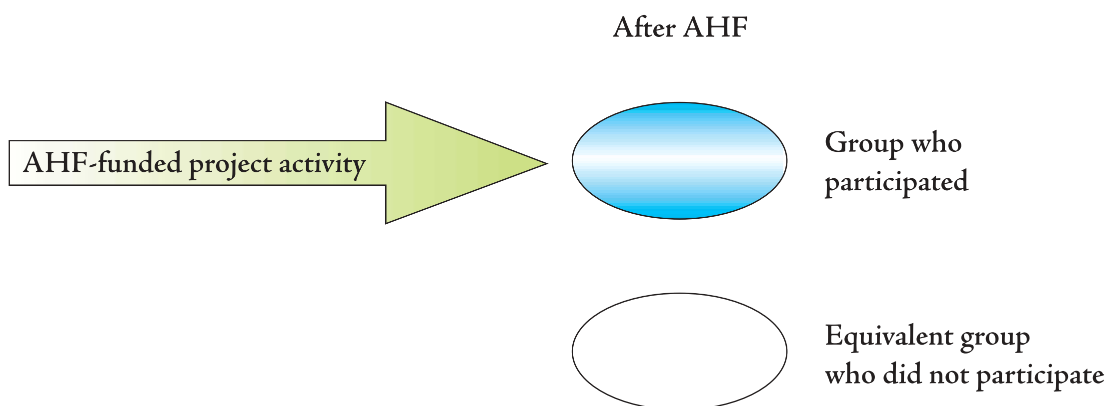
Over time, it became clear that the original "within-groups repeated measure" design planned for case studies was not feasible; however, there are select case studies where a repeated measures design should continue if *other* research or evaluation resources can be secured (e.g., Tsow-Tun Le Lum Society's Qul-Aun Program, British Columbia; Nelson House Medicine Lodge's Pisimweyapiy Counselling Centre, Manitoba; Big Cove First Nation's Our Youth, the Voice of the Future project, New Brunswick; Hamlet of Cape Dorset's Healing and Harmony in Our Families project, Nunavut; and Shining Mountains Living Community Services' Tawow Healing Home, Alberta). The design used for case studies is graphically represented in Figure 38. The arrow represents AHF-funded activity over time and the shaded oval represents the group (community or individuals) who participated.

Figure 38) Post-Project Only Design



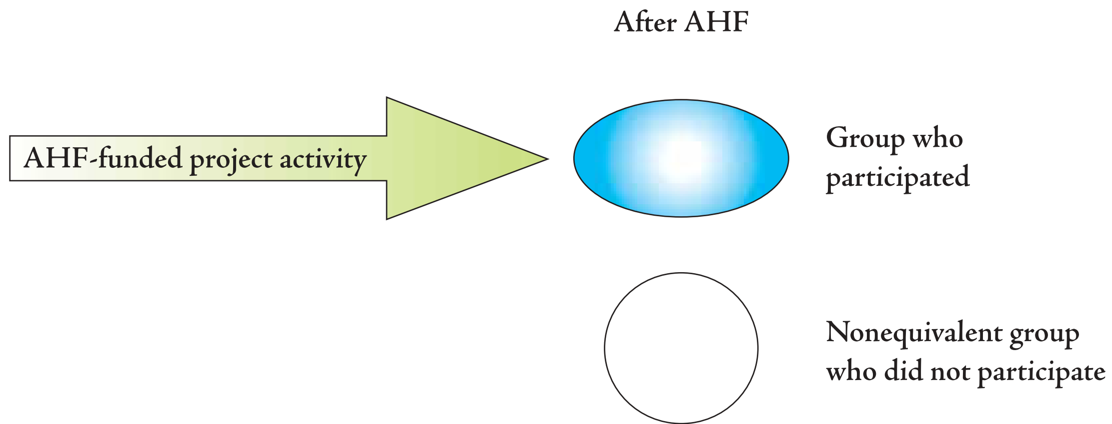
In an ideal world, the AHF evaluation team would be able to compare two groups selected at random (either communities or groups of individuals) that were identical on important characteristics (e.g., age, sex, socioeconomic status) and *differed only in their participation in AHF-funded project activity*. In such a case, it would be safer to assume that the differences between these two groups could be "attributed" to project activities. One possible design that would offer such strength might look something like Figure 39.

Figure 39) Post-Project Only Equivalent Comparison Design



Because finding an *equivalent* comparison group can be difficult or costly, nonequivalent comparisons are often used. An evaluation design where nonequivalent groups are compared is depicted in Figure 40.

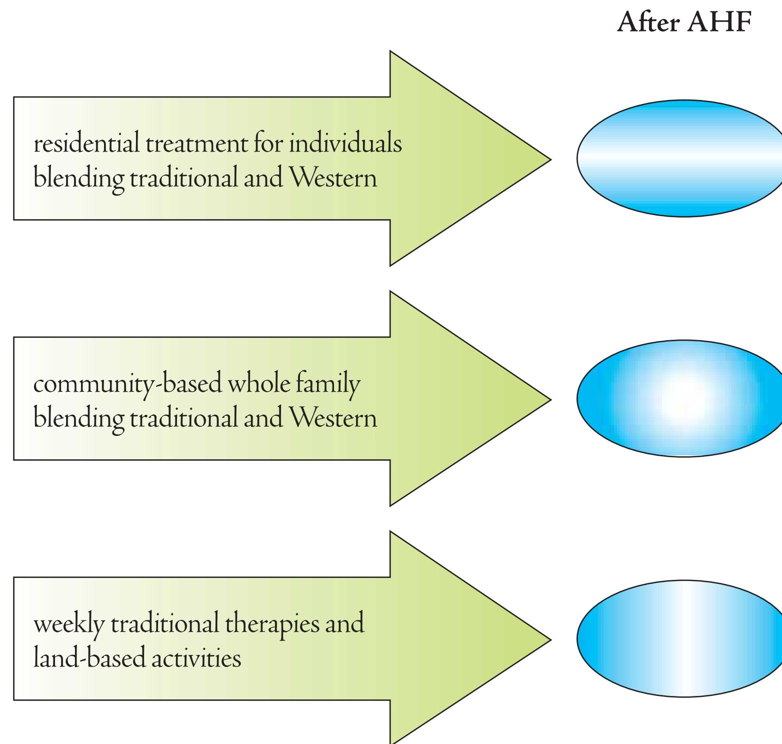
Figure 40) Post-Project Only Nonequivalent Comparison Design



Of course, there are *ethical issues to consider in the use of comparison groups*, which have already been addressed in Chapter 2. Therefore, *before the use of comparison groups is seriously considered, the funding policy would have to be changed to ensure that any group enlisted as an equivalent or nonequivalent comparison would eventually be funded to address the Legacy at some later point in time.* To assure that if a community or individual is in a comparison group, they will not be excluded from a needed intervention.

To compare interventions to one another, the AHF may also want to consider a post-program only design, using a variety of different approaches to healing or training. This design is schematically represented in Figure 41.

Figure 41) Post-Program Only Comparing Different Healing Approaches



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

Photo: Kawennaié:ri

Concluding Remarks

Ultimately, efforts to address the legacy of physical and sexual abuse in residential schools cannot be separated from the totality of colonization and the Canadian context. The link between health and social stratification is strong.[201, 202, 203, 204] Health, after all, is the by-product of strong social organization and not an end to a complicated array of services. The AHF, like any other service, is extremely limited in its ability to change the rank of Aboriginal people in the Canadian social hierarchy, and it may be *this factor* that affects wellness more powerfully than any other.

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

Awareness and Understanding of the Legacy

Perhaps the most obvious contribution that AHF-funded project activity has made is related to Legacy education. By providing a social context for what has historically been viewed as individuals' problems, Legacy education created a climate that facilitated movement toward healing *without* first facing crisis. Legacy education also provided a constructive framework for addressing Survivors' needs. In fact, open discussion about and different attitudes toward the Legacy have led to public denouncement of powerful, high-profile perpetrators. Survivor action and involvement are also key indices of awareness and understanding, and it is clear by their representation on project teams and governance structures that they are intimately involved in leading the journey in many communities. While AHF-funded project activity did raise awareness and understanding of the Legacy, informants were *clear* that their work was not complete, since ignorance, denial and silence persist.

Capacity of Aboriginal People to Heal Others

Many team members and trainees felt more intimately familiar with and capable of responding to Survivors' needs borne of the Legacy. They believe they had acquired skills to support healing within their family and community, and to effectively manage crisis. Still, many are not able to address serious special needs. As a result, embracing hard-to-reach groups will be an ongoing challenge. For others more resistant to change or suffering from severe conditions, more training or a different approach may be required. Although training

was a logical and ultimately effective place to begin because it helped others understand and become more successful healers, there is a continued need to upgrade skills to allow community counsellors to work more effectively with Survivors. Conditions defining when simultaneous training and healing are feasible need to be defined. The most pressing outstanding training needs are related to crisis intervention, trauma awareness, counselling skills and family functioning. Teams also felt they would be better equipped to address the Legacy with unique tools and training for victims and offenders. Volunteer contributions represent capacity from a community development perspective and add to the healing capacity that has been developed in more formal training initiatives. Almost three million dollars of volunteer effort has been invested annually in organizations that have received AHF funding. The initial healing teams cultivated in this early phase will lead the way on this journey, not only through the development of strong selves, but also by changing the nature of "healing from the Legacy" that never seemed to feel right or work well. These individuals will feed the fuel needed to address the Legacy's impact because those that come after them will learn that they *too* can be part of ensuring that tomorrow is better than today.[205]

Connections Between Survivors and Healers

The vast majority of project teams were able to overcome or reduce denial sufficiently to have the program operate to capacity; many could not meet the demand. Success in this regard may be partly due to the fact that Survivors finally felt there was an adequate "fit" between their unique needs and *appropriate* services designed by them for them. What is clear and consistent is that Survivors, their families and communities are engaged as never before, with the majority of participants (66 per cent of individual participants) having never participated in a similar healing program. In fact, 63 per cent (n=209) of participating communities had never formally addressed the legacy of physical and sexual abuse. Other evidence suggesting AHF work remains highly relevant includes the fact that *teams have identified as many as* 27,855 individuals with special needs (n=267: e.g., suffered severe trauma, inability to engage in a group, history of suicide attempt or life-threatening addiction). This index has changed substantially over time,[206] which suggests:

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

In any case, the index serves to support the contribution the AHF has made to increase the connection between Survivors and healers, and the increased capacity of Aboriginal people to provide healing services. Evidence of an expanded network of Survivors on the healing journey includes healthy participation rates, service demand and increased spin-off healing activity (e.g., conferences and gatherings of Survivors not funded by the AHF). Funded activity has also contributed to enhanced trust and pride in traditional healing methods. Still, the connection between those in need and potential healers was not always the best fit since participant needs often exceeded team capacity (e.g., FAS/FAE or serious chronic addiction). The most consistently cited priority need was increasing the number of team members. In other words, even more people (approximately 138,130 more) could be serviced with adequate resources.

Strategic Planning with a Focus on Healing

There are examples among the case studies selected that indicate *years* of development and careful attention to Survivors' interests and needs were undertaken in order to develop a strategic therapeutic plan. In another case, funded activity was credited with contributing to a shift from crisis management to more effective long-term wellness planning and community development. A proactive and coordinated approach to Legacy issues often functioned to reduce gaps in services with some commanding widespread respect for their service delivery standards and success rates. In fact, one health service agency will be modelling its efforts on the practices and protocols of an AHF-funded project. Still, a strategic therapeutic plan is dependent upon a long-term commitment to its support, and most projects are *at risk* because they have been unable to secure long-term financial commitments. Of the 725 funded organizations, only 81 have secured long-term funding commitments from partners for a total of $8,643,573. Sometimes, difficulty establishing partnerships was caused by philosophical differences; where some projects have enjoyed moral independence and self-directing freedom under the support of the AHF, and other projects identified in case studies and focus group discussions noted that partnering agencies expect adherence to regulations, which may thwart bold, creative, culturally appropriate approaches.

Participation in the Healing Journey

Indicator data show that suicide, physical abuse, sexual abuse, children in care and incarceration rates remain high, and there is no consensus among key informants that these problems are decreasing. However, a ripple effect is being witnessed as many informants spoke about how participants' families and partners have benefitted. Within projects, there appear to be large differences between individuals. While some move quickly toward desired outcomes, others apparently do not. What the differences are between these groups is still unclear. Therefore, while some statements can be made about what approach seems to work well, little can be said about whom it works for and who requires something different. The only real "lead" in this direction is that current approaches may work well for women and the intergenerationally impacted (as they represent the majority of participants), but other approaches may be required for older Survivors, children and men.

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

In some communities, progress is slow because projects are reaching only a small number of their target group. There is also a clear difference between those who are ready to face and heal from the Legacy and those who are not. While initial efforts should focus on those who are ready, some guidelines should be

offered on how to creatively dismantle denial where it exists, not just in a community context, but also for individuals. It has been repeatedly demonstrated that inviting and attracting women to participate can act as a catalyst within the family, but *other* unique, *proactive*, appealing and nonthreatening strategies are needed for men who are consistently underrepresented in healing programs.

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

- over time, proportionately fewer women and more men received training;
- Survivors and the intergenerationally impacted are well-represented at all levels of project operation;
- over time, projects became less able to accommodate all;
- later samples did not experience the same degree of resistance or lack of support within the community;
- over time, fewer teams identified more individuals whom they could have serviced if they had the resources;
- community members continue to be rated the most generous donors of goods and services; and
- most projects had no difficulty getting Survivors involved.

Documentation, History and Honour for Survivors

Drama worked well, in both a community and a therapeutic context in recounting history and honour to Survivors. Accuracte historical accounts of Métis contributions to society contributed to increased Métis identification, attendance at Local meetings and broader community celebration of Métis history and culture. Honouring Survivors facilitated understanding of the Legacy, disclosure and, ultimately, counselling. For others, reviewing history was a method of engaging in remembrance and mourning, an essential stage of healing from trauma. In addition, the AHF has produced and published 15 research studies, which was distributed to a database of 2,174 addresses (12 research studies are in progress); and organized 27 regional gatherings (with a total of 2,537 participants) and one national conference with over 2,000 participants (690 of whom attended residential school). The AHF has also funded projects to: develop 32 historical documents or records; host 17 additional conferences (participation rates unknown); deliver 97 education and training workshops and prepare 16 curriculum packages; organize 116 knowledge-building and 207 prevention and awareness workshops; and complete the production of 114 resource materials.

The information available suggests *there is greater awareness with respect to awareness of the Legacy and the initiation of a long and complicated healing journey.* While the data strongly suggest that AHF has played a role, it cannot be stated with certainty how powerful that role has been. A variety of reasons have been offered or discovered to account for the changes observed. Individual change was often credited to personal motivation that was sometimes characterized as simply wanting their children's lives to be better than their own. Consistently, those who *chose* to participate with hopes for a better life left with more than those who were *mandated* to participate. An approach that granted freedom to exercise decision-making skills with supportive, nonjudgemental guidance in a culturally sensitive environment of *acceptance* where Aboriginal people could empower one another worked very well.

> Therapy requires a collaborative working relationship in which both partners act on the basis of their implicit confidence in the value and efficacy of persuasion rather than coercion, ideas rather force, mutuality rather than authoritarian control. These are precisely the beliefs that have been shattered by the traumatic experience.[207]

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

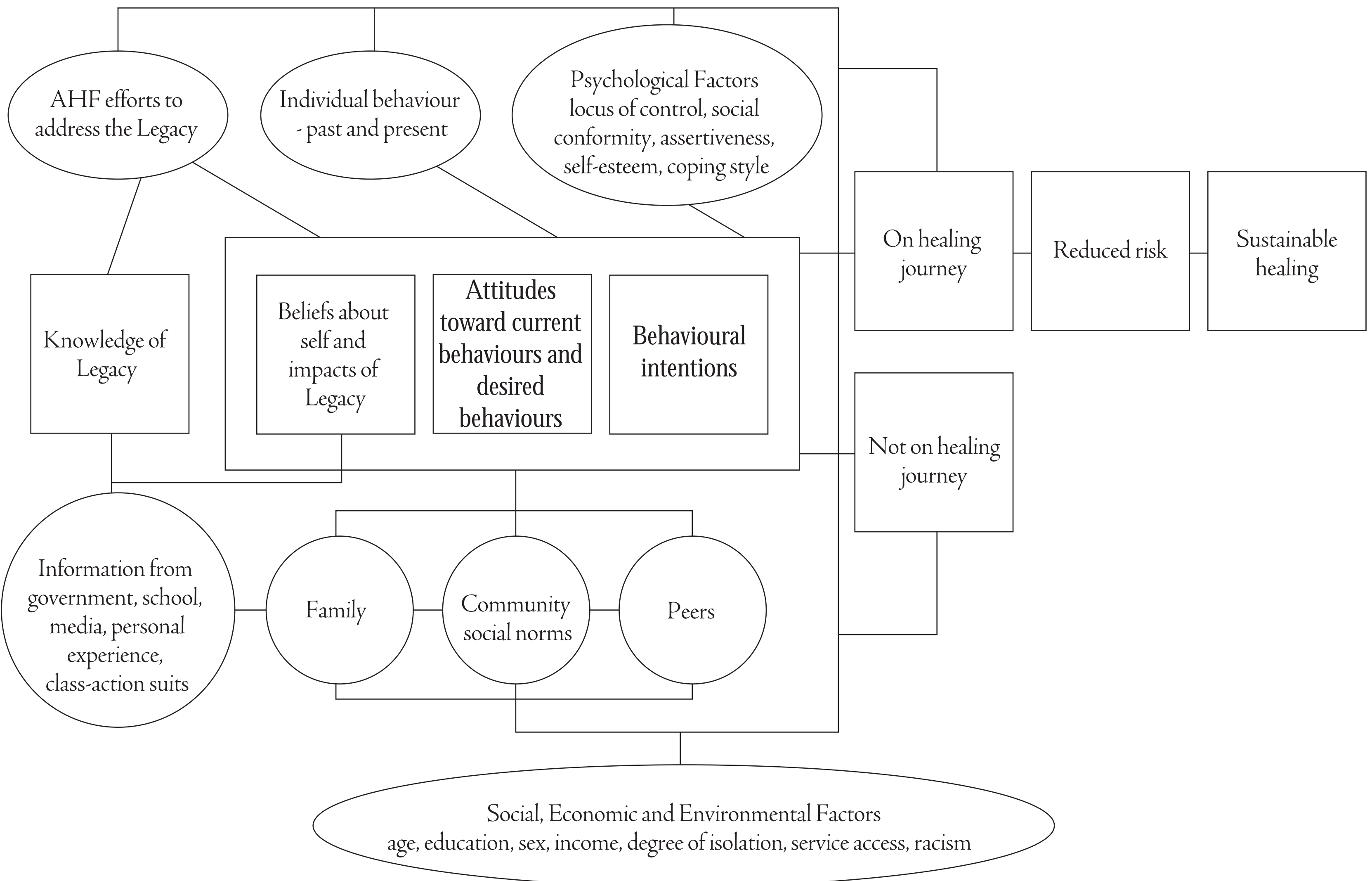
- protocols and procedures that support Survivors and the intergenerationally impacted on their journey;
- creative strategies for dismantling denial and fear;
- screening criteria for potential healers (with a special focus on the Survivor as healer); and
- effective blends of Western and traditional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

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

Project teams reported that the influence of community dynamics on project performance is *very strong.* The structural differences between communities that facilitate and those that hinder illustrate that community systems are inextricable from the healing equation. They suggested that simultaneous efforts *to change the environment* (e.g., by changing practice and policy) were needed to support efforts that focus on *changing individual behaviour*. After all, healing is *nonlinear*. In other words, human service agencies and individuals do not undertake one activity at a time. Instead, many interrelated activities occur at the same time and success in one area usually breeds success elsewhere. Informants were convinced that creating supportive climates had important implications, not only for the maintenance of aftercare, but for sustaining momentum.

Community climates that thwarted individual journeys were usually characterized by widespread poverty, addiction, family dysfunction, occasional clashes between Aboriginal spirituality and Christianity, as well as community members or groups who are resistant, either because they benefit from the status quo or they are paralyzed by fear. In fact, there are a variety of individual factors and community dynamics that not only play a role in the decision to heal, but also in how well healing progresses and is maintained. Those factors are represented in Figure 42, which offers a conceptual model of the myriad of influences affecting the decision to engage in the healing journey.

Figure 42) Factors Influencing the Decision to Engage in the Healing Journey



There is also substantial evidence to indicate that *something beyond the life of the AHF is definitely happening*, as evidenced by: steadily increasing enrollment of Aboriginal students in postsecondary education; a virtual explosion of Aboriginal entrepreneurship; strengthened focus on Aboriginal issues after the Oka crisis; and policy change following the report of the Royal Commission on Aboriginal Peoples. While colonialism still thrives in many circles, no longer are Aboriginal people merely a backdrop to colonial history, they are now featured in prime-time media as thriving, contemporary members of Canadian society. Increased local control over a variety of services, shared resource management agreements, the resurgence of culture and language, restorative justice initiatives, federal early childhood development programs, and provincial investment in Aboriginal health all contribute. Media attention to Mount Cashel orphanage/school in St. John's, Newfoundland and, more recently, pedophilia within the Catholic Church cannot be discounted. In fact, the Aboriginal Healing Foundation represents a small segment of time in what has been described as an Aboriginal healing movement.

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

The greatest challenge that remains is to reach, through creative means, those who are in denial of the problem or fear the healing journey. This challenge must be undertaken through the collaborative efforts of those who have successfully dismantled individual and community resistance. The influence of the AHF, at least for the shorter term, may be strongest in opening up Survivors and their families to the possibility of a different way of life. However, beyond the facilitation of disclosure and acknowledgment of the impact of the Legacy, there is a long and complicated road to well-being. When Survivors do embark on this journey, there must be respect and recognition for the challenges they will face. What is *essential* to understand, with respect to this analysis, is that there is still a *great disparity between Aboriginal communities* on the healing journey. For the future, the AHF must continue its work in supporting those who have been weakened by the Legacy, it must continue to monitor its investment in healing the Legacy to ensure that funds equitably address all those in the circle with clearly defined (measurable, specific and time limited) service delivery objectives, as well as distinct targets and desired outcomes.

Measuring change along this journey is complicated by the fact that communities and individuals start their healing at different points in space and time, and the progression is a complex interplay between *environment* and *person*. Some begin in *very difficult* circumstances, and individual or familial progress may be thwarted in hostile community contexts. Such landmarks are *fundamental clinical indices* for understanding the contribution the AHF has made. Although many signs of hope are clear, it is still very early in the life of the initiative, and the real contribution of the Aboriginal Healing Foundation is yet to unfold. If goals are best achieved by beginning with the end in mind, then a more detailed vision is still required that takes into account the Legacy's complexity and the mandatory time to erase it from Aboriginal life in Canada. Unravelling the Legacy's tangled web requires focussed energy and effective strategies to deal with identity, culture, relationships, parenting, education, economy and spirituality; all issues that are *deeply rooted* and require a *lengthy recovery*. Clearly, approaches for addressing the Legacy must be tailored to reflect community

and individual "*readiness*" to heal. These approaches must also be framed positively and involve contributions from a broad range of Canadian institutions. Lastly, still inconclusive and vital are the fuller details about *long-term* consequences of participation in AHF-funded activity and the unique perspective of the Métis and Inuit groups.

Aklavik Indian Residential School (Anglican)
Photo: Courtesy of Janice Longboat

List of Document Review Files

Region	Contract #	Organization Name
Atlantic	CT-391-NS	Membertou Band Council (now Membertou Wellness Committee)
Atlantic	CT-53-NS	Eskasoni Mental Health and Social Work Service
Atlantic	CT-78-NB	Metepenagiag First Nation
Quebec	DV-310-QC	Conseil de la Nation Atikamekw inc.
Quebec	DV-375-QC	Council of the Cree Nation of Mistissini
Quebec	CT-917-QC	The Nemaska First Nation of James Bay (now Nemaska First Nation of James Bay, Quebec)
Ontario	DV-232-ON	Algonquins of Pikwàkanagàn First Nation
Ontario	DV-266-ON	Chapleau Cree First Nation
Ontario	DV-307-ON	Algoma University College (now Children of Shingwauk Alumni Association)
Ontario	CT-377-ON	Minwaashin Lodge: Aboriginal Women's Support Centre
Ontario	CT-324-ON	Mnjikaning First Nation
Ontario	DV-581-ON	Ojibways of the Pic River First Nation
Ontario	CT-267-ON	UCCM Mnaamodzawin Health Services (now Mnaamodzawin Health Services Inc.)
Ontario	DV-592-ON	Walpole Island and First Nation Council
Manitoba	DV-597-MB	Ma Mawi Wi Chi Itata Centre (now Ma Mawi Wi Chi Itata Centre, Inc.)
Saskatchewan	DV-369-SK	Agency Chiefs Tribal Council
Saskatchewan	CT-2429-SK	Building a Nation Life Skills Training Inc. (now Building A Nation, Inc.)
Saskatchewan	DV-181-SK	Cote First Nation (now Cote First Nation #366)
Saskatchewan	CT-180-SK	Ile-à-la-Crosse Friendship Centre (now Ile-à-la Crosse Friendship Centre Incorporated)
Saskatchewan	CT-167-SK	Kanaweyimik Child and Family Services Inc.
Saskatchewan	DV-165-SK	Prince Albert Associated Counselling and Mediation Services (now Deer Creek Training and Therapy, Inc.)

Region	Contract #	Organization Name
Saskatchewan	CT-229-SK	Prince Albert Associated Counselling and Mediation Services (now Deer Creek Training and Therapy, Inc.)
Saskatchewan	HH-42-SK	The Stardale Women's Group Inc.
Saskatchewan	CT-190-SK	Yorkton Tribal Administration Inc.
Alberta	CT-316-AB	Alexis Health Department
Alberta	DV-343-AB	Kainaiwa Education Society
Alberta	DV-101-AB	Loon River First Nation #476
British Columbia	CT-65-BC	Gitsan & Wet'suwet'en Residential School Committee (now Ano'oyam Gan Moot'xw Society ('Tools of Healing))
British Columbia	DV-1369-BC	Chawathil First Nations
British Columbia	CT-350-BC	Healing Our Spirit BC First Nations AIDS Society (now Healing Our Spirit B.C. Aboriginal HIV/AIDS Society)
British Columbia	DV-491-BC	Tsawataineuk Band Council
British Columbia	CT-161-BC	Tsleil-Waututh Nation
British Columbia	CT-302-BC	Urban Native Youth Association
North	DV-160-NT	Dene Cultural Institute
North	CT-411-NT	Hamlet of Cape Dorset (now Municipality of Cape Dorset)
North	RB-235-NT	Mianiqsijit

Document Review Template

Project Number:

Project Title:

Grantee:

Region:

Start Date:

End Date:

Contribution Amount:

Documents included in file: (check)
____ Final Project Monitoring Transfer Sheet
____ Project Performance Review Format: 4th Quarter
____ 3rd Quarter Project Monitoring Transfer Sheet
____ Project Performance Review Format: 3rd Quarter
____ 2nd Quarter Project Monitoring Transfer Sheet
____ Project Performance Review Format: 2nd Quarter
____ 1st Quarter Project Monitoring Transfer Sheet
____ Project Performance Review Format: 1st Quarter
____ Application for Project Funding
____ Review Criteria

Supporting Documents (e.g., final reports, evaluation reports): List titles

Project Description: (summary)

Target Groups:
____ First Nations on-reserve
____ Inuit
____ Métis
____ Women
____ Youth
____ Elders
____ Incarcerated
____ Gay or lesbian
____ First Nations off-reserve
____ Other (specify)

Challenges:
References to challenges, obstacles and barriers mentioned in the project reports, including responses to the question: *Was there anything that you would not do the next time?* Also refer to sections of quarterly reports asking for explanations where objectives were not achieved.

Lessons Learned:
Specific references to lessons learned or problems, obstacles or challenges that were overcome in the course of the project and how they were overcome. Also refer to responses to the question: *Are there any changes that you would make in the development or implementation of the project?* And relevant responses to: *Are there any activities or approaches that you think other projects or AHF would find useful?*

Successes:
References to successful activities including responses to reporting question: *What activities would you continue …?* And relevant responses to: *Are there any activities or approaches that you think other projects or AHF would find useful …?* Also, references to unanticipated benefits of the project and responses to other results, observations, spinoffs and comments sections of reports.

Evaluation:

i) **If the project has been completed, does the final report include an evaluation or has a separate evaluation report been submitted? Yes ___ No ___**

If yes, include details (e.g., name of report, author, whether it was done internally or externally).

ii) **Evaluation Methods:**
References to the methods used to evaluate the project. If project is in process, refer to the evaluation methods outlined in the project proposal.

iii) **Evaluation Results:**
Reported results of evaluations, including participant feedback.

Comments and Quotations: Any additional, miscellaneous or supplementary information that is noteworthy or unique, including particularly powerful or insightful quotations.

TO BE CONSIDERED: (**The question is:** ***Would these categories provide any useful information that will not otherwise be captured?***)

Capacity Building:
___ Training (including details such as who was trained and the nature or content of the training)
___ Hiring community members
___ Use of resources/expertise from outside the community (provide details regarding how this supports capacity building)

Linkages/partnerships with other organizations, agencies, programs, services, etc. (Is there a need to address linkages since all projects seem to have developed them?)

Site Visit:
Note any references to a recommended site visit or reports on a site visit by AHF staff. (NOTE: Visits by community support workers are not referred to as site visits, so the wording should be changed to include these visits as well.)
Recommendations made by AHF staff and reviewers:
Recommendations made by project grantees:

National Surveys

Mail Out Process Evaluation Survey 2001

DESIGNED TO BE FILLED OUT WITH YOUR GUIDE

Project Name: ______________________ Project Code: ______________

Location (City/town/hamlet or village): ______________________________

Region: ______________________ Project Start Date: ______________

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

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

If you have any questions about how a particular question should be answered, please consult your survey guide. If time does not allow the gathering of a group to complete this survey, please have a community member who is most familiar with the program fill out the questionnaire.

A. WHO
Participants

A.1 Is your project …
- ☐ a healing project? If your project has a healing component, answer questions A.2 through A.5, otherwise proceed to A.6.
- ☐ a training project? If your project has a training component, answer questions A.6 to A.9.

A.2 How many *individuals* have participated in healing activity as a client (includes centre-based therapeutic healing, sharing circles, camps and retreats, etc.)? Each client should only be counted once.
- ____ total # of people who have participated in healing activity.
- ☐ not sure
- ☐ not applicable (e.g., video production, research or documentation projects)

A.3 How many individuals participated in a *group event* associated with the *healing* activity (includes a feast, social, pow wow, etc.)? Consult your survey guide for this question.
- ____ total # of people who have participated in healing activity.
- ☐ not sure
- ☐ not applicable

A.4 How many individuals who participated/are participating in AHF-funded *healing activity* are in the following categories? (Provide the best estimate.)
- ____ First Nations on-reserve
- ____ First Nations off-reserve
- ____ Métis
- ____ Inuit

A.5 How many individuals who participated/are participating in AHF-funded *healing activity* are in the following categories? (Provide the best estimate.)

____ youth
____ women
____ gay or lesbian
____ incarcerated
____ men
____ Elders
____ intergenerationally impacted
____ homeless
____ Survivors

If your project has a TRAINING component, answer questions A.6 to A.9.

A.6 How many *individuals* have participated in *training as trainees* (includes workshop participation, formal classroom training, etc.)?

____ total # of people who have participated in training.
☐ not sure
☐ not applicable (e.g., video production, research or documentation projects)

A.7 How many individuals participated in a *group event* or group events (includes a feast, social, pow wow, etc.) associated with the *training* activity?

____ total # of people who have participated in group event associated with training activity.
☐ not sure
☐ not applicable

A.8 How many individuals who have participated in AHF-funded *training* are in the following categories? (Provide the best estimate.)

____ First Nations on-reserve
____ First Nations off-reserve
____ Métis
____ Inuit

A.9 How many individuals who have participated in AHF-funded *training* are in the following categories? (Provide the best estimate.)

____ youth
____ women
____ gay or lesbian
____ incarcerated
____ men
____ Elders
____ intergenerational
____ families
____ homeless
____ Survivors

A.10 To what extent do the following participant characteristics present challenges/difficulties you must deal with in *operating* your AHF project? (Indicate the extent of the challenge by checking the appropriate box.)

		Severe (>80%)	Moderate (40-80%)	Slight (1-40%)	No Problem
(a)	lack of Survivor involvement in the project	☐	☐	☐	☐
(b)	history of incarceration	☐	☐	☐	☐
(c)	denial, fear, grief	☐	☐	☐	☐
(d)	lack of parenting skills	☐	☐	☐	☐
(e)	history of suicide attempts	☐	☐	☐	☐
(f)	history of abuse as a victim	☐	☐	☐	☐
(g)	history of abuse as an abuser	☐	☐	☐	☐
(h)	history of adoption	☐	☐	☐	☐
(i)	history of foster care	☐	☐	☐	☐
(j)	family drug or alcohol addictions	☐	☐	☐	☐
(k)	poverty	☐	☐	☐	☐
(l)	lack of literacy skills	☐	☐	☐	☐
(m)	lack of communication skills	☐	☐	☐	☐
(n)	other, please specify ______________________	☐	☐	☐	☐

Notes or comments: ____

A.11 How many of the people participating in your *healing project* require *greater attention* because of special needs (e.g., severe trauma suffered, inability to open up in a group, history of suicide attempt or life-threatening addiction, etc.)? ____________

A.12 How are special situations addressed in your project?

CHECK ONE, IF IT APPLIES:

- ☐ we do the best we can *without* special training, community services or volunteer support
- ☐ *all* employees are trained to deal with serious issues (e.g., suicide, family violence, addiction)
- ☐ *some* employees are trained to deal with serious issues (e.g., suicide, family violence, addiction)

CHECK ONE, IF IT APPLIES:

- ☐ visiting professionals (specifically trained to deal with special needs) provide support weekly
- ☐ visiting professionals provide support *monthly* or *yearly*
- ☐ we believe that there is no one in our project with a condition that is serious enough to require a different approach

CHECK ONE, IF IT APPLIES:

- ☐ volunteers (*with* special training) work one-on-one with these individuals/families
- ☐ volunteers (*without* special training) work one-on-one with these individuals/families
- ☐ we rely on peer support

CHECK IF IT APPLIES:

- ☐ other, please specify ______________________________________

A.13 Is your project able to accommodate all the people who need therapeutic healing or who desire training?

- ☐ yes If yes, proceed to question A.15
- ☐ no If no, proceed to question A.14

A.14 If your project found it *could not/cannot* enroll all who want to participate, how would you/do you choose participants? In other words, who is given first priority?

____

A.15 In the opinion of the group gathered to answer this survey, is the project reaching those who need the service the most? Please check only one response.

5	4	3	2	1
____	____	____	____	____
yes definitely	yes but could be better	not sure	probably not	definitely not

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

____

A.16 How many more people in need of therapeutic healing/training could you serve if you had more space/qualified human resources/money?

___ (# of people seeking healing services/training)

___ unsure

A.17 How many people currently participating in therapeutic healing/training have participated in another *similar* healing/training project (not funded by AHF) *before* they came to your project? (Please consult your survey guide.)

☐ none

☐ unsure

# of people who have participated in previous healing projects ________

Personnel and Volunteers

A.18 Please think about the total duration of your project. Over that time period, how many *full-time* (who work 30 hours per week or more) paid employees did/do you have in total?

____

A.19 Please think about the total duration of your project. Over that time period, how many *part-time* (who work less than 30 hours per week) paid employees did/do you have in total?

____

A.20 What kind of training did employees take during the project? Check all that apply. Please also tell if the training was adequate or inadequate to meet project needs by checking the appropriate box. Use your survey guide to help answer this question if needed.

		Basic training	Advanced training	Training is/was ADEQUATE for project needs	Training is/was NOT ADEQUATE for project needs
(a)	crisis intervention	☐	☐	☐	☐
(b)	trauma awareness	☐	☐	☐	☐
(c)	counselling skills	☐	☐	☐	☐
(d)	original language/culture	☐	☐	☐	☐
(e)	computer/internet training	☐	☐	☐	☐
(f)	learning about the history and impact of Residential Schools	☐	☐	☐	☐
(g)	learning about the application of the Charter of Rights and Freedoms in the project	☐	☐	☐	☐
(h)	dealing with family violence	☐	☐	☐	☐
(i)	professional development training	☐	☐	☐	☐
(j)	CPR/first aid	☐	☐	☐	☐
(k)	programs related to family functioning (e.g., child development and parenting skills)	☐	☐	☐	☐
(l)	other, please specify ___________	☐	☐	☐	☐

A.21 What additional training was/is needed for the same employees?

		Basic training	Advanced training
(a)	crisis intervention	☐	☐
(b)	trauma awareness	☐	☐
(c)	counselling skills	☐	☐
(d)	Aboriginal language/culture	☐	☐
(e)	computer/internet training	☐	☐
(f)	learning about the history and impact of Residential Schools	☐	☐
(g)	learning about the application of the Charter of Rights and Freedoms in the project	☐	☐
(h)	dealing with family violence	☐	☐
(i)	professional development training	☐	☐
(j)	CPR/first aid	☐	☐
(k)	programs related to family functioning (e.g., child development and parenting skills)	☐	☐
(l)	other, please specify ___________________________	☐	☐

A.22 In a typical month, estimate the number of hours of volunteer service contributed to the project.

____

A.23 Where were volunteers (not paid employees) most likely to contribute their time. Please check *only the most common* activities.

- ☐ administration (planning, management)
- ☐ food preparation
- ☐ operations (maintenance)
- ☐ workshops
- ☐ fund-raising
- ☐ healing circles
- ☐ recruitment
- ☐ transportation (e.g., providing or bus monitoring)
- ☐ other, please specify ____________________

B. WHAT

B.1 Where are *most* (i.e., more than 50 per cent) of your project resources spent? (Choose only two.) Please refer to the survey guide for definitions of these answer categories.

- ☐ communications or public awareness
- ☐ research or history documentation (honour)
- ☐ healing
- ☐ training
- ☐ curriculum development
- ☐ community service
- ☐ reconciliation
- ☐ strategic planning
- ☐ needs assessment
- ☐ other, please specify____________________

If your project has a healing component, answer questions B.2 through B.6, otherwise proceed to B.7.

B.2 If your project has a *healing* (centre-based, healing circles, counselling, etc.) component, estimate how many hours an INDIVIDUAL participates in healing activity from the beginning of the healing program to the end? Please consult your survey guide to answer this question. __________

B.3 What is the total number of people who have participated in AHF-funded *healing* activities? Do *not* count the same person twice and consider all healing activities offered during your contract with AHF. Please consult your survey guide to answer this question.

___ total # of participants

B.4 How many individuals completed the *healing* project? ___

B.5 How many individuals did NOT complete the *healing* project? ___

B.6 Why did they not complete the *healing* project? Please explain.

____

If your project has a training component, answer questions B.7 through B.12, otherwise proceed to the next section.

B.7 Please estimate how many hours INDIVIDUAL participants have attended *training* sessions. You may wish to consult your survey guide to answer this question. ____

B.8 What is the maximum number of trainees you can enroll in your *training* project in a given year? ____ (# of trainees)

B.9 How many completed the *training* project? ____

B.10 How many did not complete the *training* project? Provide your best estimate. ____

B.11 Why did they not complete the *training*? Explain.
____

B.12 How do employees promote your project? (Please check all that apply.)
- ☐ participated in public speaking and other public forums
- ☐ attended/hosted workshops
- ☐ distributed literature
- ☐ put articles to local newspapers/journals/newsletters
- ☐ put articles to other newspapers/journals/newsletters
- ☐ invited, spoke to or met with local politicians
- ☐ met with local service agencies
- ☐ invited other projects to visit
- ☐ meetings
- ☐ outreach
- ☐ use of local radio station
- ☐ public relations or media relations events
- ☐ sent out a petition and letters for more money
- ☐ shared printed materials with other AHF projects
- ☐ visited other AHF sites
- ☐ other, please specify ______________________________

B.13 What is main method of promotion? ______________________________

C. WHERE

C.1 How many communities does this project serve? ____

C.2 Describe your community or most of the communities that you serve.
(Please check only one.)
- ☐ Remote—a community that cannot be reached by road or ferry service
- ☐ Isolated—a community that can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people
- ☐ Rural—a community that can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people
- ☐ Urban—a community that can be reached by road or ferry service AND is located within 50 kilometres of a town/city with more than 25,000 people

C.3 How many people live in your community? If your project serves more than one community, what is the *average* population of those communities? If you are unsure, ask your local government. Please consult your survey guide to complete this question.

_______________ # of people in the community OR the *average* # of people in the communities

C.4 Where was the project delivered?

- ☐ at the friendship centre
- ☐ at the local health centre
- ☐ at the local school
- ☐ at a bush camp
- ☐ in home settings
- ☐ other, please specify____

C.5 Is the agency or organization delivering AHF-funded activity linked with other healing or training efforts?

- ☐ no
- ☐ yes, please explain ____

C.6 To what extent do the following issues affect your community? (Please indicate the extent of the challenge by checking the appropriate box.)

		Severe Challenge	**Moderate Challenge**	**Slight Challenge**	**No Problem**
(a)	adult illiteracy (*inability* or *difficulty* reading MOST printed material in any language including Inuktitut syllabics)	☐	☐	☐	☐
(b)	lack of acceptance of Aboriginal language and culture by local institutions (e.g., schools, hospitals)	☐	☐	☐	☐
(c)	apathy or lack of active Aboriginal community support	☐	☐	☐	☐
(d)	local community opposition (fear, denial)	☐	☐	☐	☐
(e)	poor local economic conditions (e.g., high unemployment, poor housing conditions)	☐	☐	☐	☐
(f)	substance abuse	☐	☐	☐	☐
(g)	family violence	☐	☐	☐	☐
(h)	sexual abuse	☐	☐	☐	☐
(i)	lack of transportation (local bus, vehicles, etc.)	☐	☐	☐	☐
(j)	lack of community resources, facilities, services, etc.	☐	☐	☐	☐
(k)	suicide or attempted suicides	☐	☐	☐	☐
(l)	fetal alcohol syndrome (FAS)/fetal alcohol effects (FAE)	☐	☐	☐	☐

D. WHEN

D.1 What other community/family events or healing efforts happened/are happening which may have an impact on your results? Consider all aspects of community life (e.g., rash of suicides, reawakening of culture, widespread early intervention projects, political upheaval, court cases, increased provincial funding for health services, new treatment centre, new road access, relocation). Please consult your survey guide for the definition of impact. (Please explain.)

____

E. HOW

Project Features

E.1 How do you encourage Survivors to participate? (Please check all that apply.)

- ☐ meet with individuals or families (in our facility)
- ☐ invite individuals/families to visit the project
- ☐ advertise
- ☐ circulate pamphlets and brochures in the community
- ☐ “beat” the street (seek participants by having a presence in the street)
- ☐ consult with other social service and health care providers
- ☐ use of community bulletin boards
- ☐ join interagency groups (e.g., health, social service, teachers, and police)
- ☐ by word-of-mouth
- ☐ interviews
- ☐ telephone campaigns
- ☐ newsletters
- ☐ home visits
- ☐ annual open house
- ☐ involvement in all aspects of human services in the community
- ☐ other ____________________

E.2 Which method is used the most?

____

E.3 How do you ensure participant safety? (Please check all that apply.)

- ☐ Child Abuse Register check
- ☐ thorough criminal record checks by the CPIC (Canadian Police Information Centre)
- ☐ by word-of-mouth
- ☐ interviews
- ☐ periodically check with participant group to ensure their safety
- ☐ consult with others who have used their services
- ☐ consult with their professional associations regarding their history of professional conduct
- ☐ all healers (practitioners) must sign a code of ethics
- ☐ character references
- ☐ other, please specify ____________________
- ☐ other, please specify ____________________

E.4 Do you have a waiting list (formal or informal) for those who want to enrol in therapeutic healing/ training?
- ☐ yes   If yes, proceed to Question E.5
- ☐ no   If no, proceed to Question E.6

E.5 If a waiting list is maintained (formal or informal), what is/was the maximum number of people on that waiting list at any given time? __________

E.6 In the opinion of the group gathered to answer this survey, has the project operated in a manner consistent with the Charter of Rights and Freedoms? Please check only one response that best describes how the group feels.

5	4	3	2	1
______	______	______	______	______
yes definitely	yes but could be better	not sure	probably not	definitely not

Explain why your group feels this way. ______________________________

E.7 How effective was your project at empowering INDIVIDUAL WOMEN participants? Please circle only one response.

2	3	4	1	0
______	______	______	______	______
little or no influence	some influence	dramatic influence	not sure	not applicable

Explain why your group feels this way.

____

E.8 How effective was your project at empowering WOMEN AS A GROUP who have participated? Please check only one response.

2	3	4	1	0
______	______	______	______	______
little or no influence	some influence	dramatic influence	not sure	not applicable

Explain why your group feels this way.

____

E.9 How effective was your project at changing the STATUS AND DECISION MAKING POWER OF WOMEN IN THE COMMUNITY who participated? Please check only one response.

2	3	4	1	0
______	______	______	______	______
little or no influence	some influence	dramatic influence	not sure	not applicable

Explain why your group feels this way.

____

E.10 What are the key features of your healing (centre-based, sharing circles, retreats, one-on-one or family counselling or any other type of healing) project? (Check one box for each item indicating how often each approach is used.)

		Always	Most of the time	Sometimes	Rarely	Never
(a)	use of *traditional approaches only* (e.g., healing/sharing circles, consultations or free time with Elders, cultural teachers, traditional people, spiritual guides, Aboriginal celebrations, ceremonies, dances, songs, storytelling, fasting, sweats, land-, bush- or camp-based activity)	☐	☐	☐	☐	☐
(b)	use of a *Western therapeutic approach only*, visiting professionals (e.g., those trained in Western institutions such as psychologists, psychiatrists, educators, trainers)	☐	☐	☐	☐	☐
(c)	use of a *combined approach including both traditional and Western therapeutic methods*	☐	☐	☐	☐	☐
(d)	gender-specific treatments (i.e., separate groups for men and women)	☐	☐	☐	☐	☐
(e)	age-specific treatments (i.e., separate groups for children, youth, Elders, etc.)	☐	☐	☐	☐	☐
(f)	any other grouping based upon ____________ (please specify what type of group)	☐	☐	☐	☐	☐
(g)	sport, recreational activities (e.g., music, drama)	☐	☐	☐	☐	☐
(h)	alternative therapies (e.g., homeopathy, naturopathy, aromatherapy, reflexology, massage therapy, Reiki, etc.)	☐	☐	☐	☐	☐
(i)	other, please specify ____________	☐	☐	☐	☐	☐
(j)	other, please specify ____________	☐	☐	☐	☐	☐

F. MEASURING CHANGE

F.1 Are you measuring changes in AHF project participants (e.g., participant knowledge, attitudes or behaviour)?

☐ yes If you are measuring changes, proceed to question F.2
☐ no If you are not measuring changes, proceed to question F.5

F.2 For projects with a *healing* component, please tell us how you measure change in project participants (e.g., participant knowledge, attitudes or behaviour) with respect to their healing journey? For complete definitions of each answer, see the survey guide. Check all that apply below.

- ☐ informal observations (not written or recorded)
- ☐ formal observations (written and recorded)
- ☐ evaluations (specific effort to measure project performance)
- ☐ solicited feedback (ask for the opinion of others and record)
- ☐ unsolicited feedback (do not ask for the opinion of others)
- ☐ formal assessments (tests or surveys) of substance use
- ☐ other, please specify ______________________

F.3 For projects with a *training* component, please tell us how you measure change in knowledge, ability or skill in trainees? For complete definitions of each answer, see the survey guide. Check all that apply below.

- ☐ no testing is done, we assume that if they have participated in the training project that their knowledge, skills and ability have changed

If you are measuring, check all that apply below.

- ☐ informal observations (not written or recorded)
- ☐ formal observations (written and recorded)
- ☐ formal testing (specific effort to measure changes in knowledge, skills or behaviour)
- ☐ solicited feedback (ask for the opinion of trainee about what they believe they have learned or can do now that they did not know or could do before)
- ☐ unsolicited feedback (do not ask for their opinion about how they have changed, but they provide it anyway)
- ☐ other, please specify ______________________

F.4 What is done with the information that is collected regarding change in individual project participants? If nothing is done state that in the space provided.

____

F.5 How often does your AHF project engage Survivors in the following project management activities?

		Daily	Weekly	Monthly	Yearly	Never
(a)	developing project materials or content	☐	☐	☐	☐	☐
(b)	decision making	☐	☐	☐	☐	☐
(c)	informal communications to seek advice/exchange ideas	☐	☐	☐	☐	☐
(d)	evaluating progress or performance of project	☐	☐	☐	☐	☐
(e)	evaluating progress or performance of AHF team members	☐	☐	☐	☐	☐
(f)	as part of an advisory or governing committee	☐	☐	☐	☐	☐

F.6 Does your project have an advisory council or a board of directors which involves Survivors enrolled in the project?
- ☐ no
- ☐ yes

How many Survivors or intergenerationally impacted participate on a regular basis? ____ #
How many are incarcerated? ____ #
How many are gay or lesbian? ____ #
How many are women? ____ #
How many are youth? ____ #
How many are homeless? ____ #
How many are Elders? ____ #
How many times per year does it meet? ____ #

F.7 Do Survivors participate in staff hiring/evaluation decisions?
- ☐ yes
- ☐ no Why not ______________________________

F.8 Has it been difficult to get Survivors involved?
- ☐ no
- ☐ yes If so, what are the barriers to Survivors being more involved? In other words, why has it been difficult to involve Survivors?
____

G. PROJECT FINANCES

G.1 Take some time to think about a wish list for your project. In the left-hand column, rank order your most important project needs by putting a 1 by the most important need, a 2 by the second most important and so on. In the right-hand column, estimate how much money would be required to address this need.

Rank	Need	$
____	increase employee numbers and benefits	____________
____	improve the project and expand it locally	____________
____	provide training for employees and potential healers	____________
____	offer, increase or improve transportation	____________
____	improve and expand our building	____________
____	develop/distribute information on the history and impact of residential school	____________
____	purchase equipment or supplies	____________
____	special needs (resources, professionals)	____________
____	solicit and establish partnerships/networks	____________
____	improve communication (with community, AHF, Canadians generally)	____________
____	project monitoring and evaluation	____________
____	obtain professional assessments of skill development and healing	____________
____	improve Survivor involvement	____________
____	improve family support and parenting skills	____________
____	encourage community involvement	____________
	Grand Total	____________

G.2 Do you think part of the project budget should be set aside for evaluation?

- ☐ yes
- ☐ no

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

Funder	**Contributions made during project operation**	**Amount of ongoing commitment to funding**
other federal departments, branches or divisions	$________.00	$________.00
provincial or territorial governments	$________.00	$________.00
municipal or hamlet governments	$________.00	$________.00
Aboriginal governments	$________.00	$________.00
private granting foundations	$________.00	$________.00
community fund-raising efforts	$________.00	$________.00
other, please specify:		
____________________	$________.00	$________.00
____________________	$________.00	$________.00
____________________	$________.00	$________.00

G.4 What is the estimated value of donated goods or services (in-kind contributions) you have received (i.e., from the date you first received funding from AHF until you stopped receiving funding OR if you are still receiving funding, to the present date) for the following? (Please estimate APPROXIMATE VALUE.)

		Cannot Estimate
transportation	$________.00	☐
food	$________.00	☐
project materials	$________.00	☐
labour (including volunteers)	$________.00	☐
space for project	$________.00	☐
other, please specify		
____________________	$________.00	☐
____________________	$________.00	☐
____________________	$________.00	☐

☐ none

G.5 Who *donates* the largest amounts of *goods and services* to your project? Identify the three most generous partners by putting a 1 by the most generous, 2 by the next most generous partner and so on.

- ____ school
- ____ health services
- ____ social services
- ____ police
- ____ local government
- ____ local businesses
- ____ community members
- ____ local church
- ____ other, please specify ________________________
- ____ other, please specify ________________________

H. FIRST IMPRESSIONS ABOUT AHF-FUNDED ACTIVITY

H.1 How *effective* were working relationships between partners?

0	1	2	3	4
____	____	____	____	____
not applicable	ineffective	somewhat effective	moderately effective	very effective

If the group answered "ineffective," explain why the group feels this way?

____

H.2 What are the most important lessons that you learned while developing, implementing and completing this project?
Please specify ________________________

H.3 What are your best practices?
Please specify ________________________

H.4 What were your greatest challenges?
Please specify ________________________

H.5 What will *improve* the success of future projects from a:
Survivor's perspective?
Elder's perspective?
project team members/leaders/trainers/healers?
project sponsor's perspective?
youth perspective?
women's perspective?
gay and lesbian perspective?
homeless people's perspective?

H.6 Has anything changed as a result of your AHF-funded activity so far?

- ☐ no Explain why you feel nothing has changed.
- ☐ may be too early to tell.
- ☐ yes Explain why you feel things have changed.

____

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

		poor	fair	good	very good	excellent
(a)	application for funding process (principles, guidelines, support in completing application)	1	2	3	4	5
(b)	support and assistance from the Community Support Coordinators	1	2	3	4	5
(c)	support and assistance from the national team (head office staff)	1	2	3	4	5
(d)	support and representation provided by the national board	1	2	3	4	5
(e)	funding processes (e.g., quarterly monitoring reports, cash flow and renewal)	1	2	3	4	5
(f)	monitoring and evaluation process	1	2	3	4	5
(g)	gatherings	1	2	3	4	5

Survey Contacts: Indicate below, the name of the person who has coordinated the completion of this survey. The survey contact information will not be placed in the data base, and will be used only in the event that we need to ask you what a certain answer means. PRINT OR TYPE. Please also secure a sponsor's signature who has reviewed the answers presented in this survey.

The project deliverer participating in the completion of this survey: ________________
The Survivor participating in the completion of this survey: ________________
The Community Service provider participating in the completion of this survey: ________________
Other interest parties participating in the completion of this survey: ________________

Question J.1

This question is to be completed in confidence by the project director. Please complete this table for all full-time and part-time positions. Make extra copies of this page if necessary. To complete this question, please refer to your survey guide.

Position or Role	Aboriginal (yes or no)	Healed Survivor (yes or no)	Type of diploma/ degree or certificate	# of years relevant experience

AHF National Process and Impact Evaluation Survey 2002

DESIGNED TO BE FILLED OUT WITH YOUR GUIDE

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

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

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

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

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

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

1. How many communities does this PROJECT serve? ______________

2. Describe your community or most of the communities that you serve. (Please check only one.)
   - ☐ Remote—a community that cannot be reached by road or ferry service
   - ☐ Isolated—a community that can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people
   - ☐ Rural—a community that can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people
   - ☐ Urban—a community that can be reached by road or ferry service and is located within 50 kilometres of a town/city with more than 25,000 people

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

A. WHO
Participants

A.1 Is your PROJECT …

- ☐ a healing PROJECT? If your PROJECT has healing activities, answer questions A.2 through A.5, otherwise proceed to A.6.
- ☐ a training PROJECT? If your PROJECT has training activities, answer questions A.6 to A.9.
- ☐ both healing and training? If your project has both healing and training activities, answer questions A.2 through to A.7.
- ☐ other—neither healing or training (e.g., video production, history documentation)

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

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

____ total # of people who have participated who want and need healing
☐ not sure
☐ not applicable (e.g., video production, research or documentation)

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

____ First Nations on-reserve
____ First Nations off-reserve
____ Métis
____ Inuit
____ Other

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

____ Survivors
____ intergenerationally impacted
____ those who do not identify as Survivors or intergenerationally impacted

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

____ youth
____ women
____ men

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

____ gay or lesbian
____ incarcerated
____ Elders
____ homeless (see guide for definition)

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

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

____ total # of people who have participated in training.
☐ not sure
☐ not applicable (e.g., video production, research or documentation PROJECTs)

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

____ First Nations on-reserve
____ First Nations off-reserve
____ Métis
____ Inuit
____ Other

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

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

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

____ youth
____ women
____ men

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

____ gay or lesbian
____ incarcerated
____ Elders
____ homeless (see guide for definition)

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

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

notes or comments:

____

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

requiring greater than normal attention ________

A.10 What do you think should be done to address the special needs of participants counted in question A.11? We understand that more resources are needed, what we want to know is HOW should those resources be used. (Check all that apply.)

- ☐ training
- ☐ increase the project team
- ☐ improved facilities
- ☐ improved networking
- ☐ better access to services locally
- ☐ visiting professionals
- ☐ other, please specify ______________________________________

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

- ☐ yes If yes, proceed to question A.13
- ☐ no If no, proceed to question A.12

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

____

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

5	4	3	2	1
____	____	____	____	____
yes definitely	yes but could be better	not sure	probably not	definitely not

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

____

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

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

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

A.17 How many people currently participating in therapeutic healing/training have participated in another similar healing/training PROJECT (not funded by AHF) before they came to your PROJECT? (*Please consult your survey guide to be clear about what is meant by another similar healing project or program.*)
☐ none
☐ unsure
# of people who have participated in previous healing PROJECTs ____________

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

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

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

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

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

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

		Daily	Weekly	Monthly	Quarterly	Yearly	Never
(a)	developing PROJECT materials or content	☐	☐	☐	☐	☐	☐
(b)	decision making	☐	☐	☐	☐	☐	☐
(c)	informal communications to seek advice/exchange ideas	☐	☐	☐	☐	☐	☐
(d)	evaluating progress or performance of PROJECT	☐	☐	☐	☐	☐	☐
(e)	evaluating progress or performance of AHF team members	☐	☐	☐	☐	☐	☐
(f)	as part of an advisory or governing committee	☐	☐	☐	☐	☐	☐

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

☐ yes

☐ no Why not ____________________

Question A.23

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

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

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

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

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

B. WHAT

If your PROJECT has healing activities, answer questions B.1 through B.5, otherwise proceed to B.6.

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

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

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

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

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

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

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

B.7 How many completed the training PROJECT? ____

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

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

____

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

		Severe Challenge	Moderate Challenge	Slight Challenge	Don't know	Slight Benefit	Moderate Benefit	Outstanding Benefit
(a)	supportive leadership	☐	☐	☐	☐	☐	☐	☐
(b)	Aboriginal language and culture supported by local institutions (e.g., schools, hospitals)	☐	☐	☐	☐	☐	☐	☐
(c)	active community support	☐	☐	☐	☐	☐	☐	☐
(d)	those in need *want* to participate	☐	☐	☐	☐	☐	☐	☐
(e)	employment	☐	☐	☐	☐	☐	☐	☐
(f)	access to health and social services	☐	☐	☐	☐	☐	☐	☐
(g)	ability to harvest and eat traditional foods	☐	☐	☐	☐	☐	☐	☐
(h)	community members speak the language, know the culture	☐	☐	☐	☐	☐	☐	☐
(i)	transportation (local bus, vehicles, etc.)	☐	☐	☐	☐	☐	☐	☐
(j)	housing	☐	☐	☐	☐	☐	☐	☐
(k)	other, please specify______	☐	☐	☐	☐	☐	☐	☐
(l)	other, please specify______	☐	☐	☐	☐	☐	☐	☐
(m)	other, please specify______	☐	☐	☐	☐	☐	☐	☐
(n)	other, please specify ______	☐	☐	☐	☐	☐	☐	☐
(o)	other, please specify ______	☐	☐	☐	☐	☐	☐	☐
(p)	other, please specify _____	☐	☐	☐	☐	☐	☐	☐

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

____

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

		Always	Most of the time	Sometimes	Rarely	Never
(a)	use of *traditional approaches only* (e.g., healing/sharing circles, consultations or free time with Elders, cultural teachers, traditional people, spiritual guides, Aboriginal celebrations, ceremonies, dances, songs, storytelling, fasting, sweats, land-, bush- or camp-based activity)	☐	☐	☐	☐	☐
(b)	use of a *Western therapeutic approach only*, visiting professionals (e.g., those trained in Western in stitutions such as psychologists, psychiatrists, educators, trainers)	☐	☐	☐	☐	☐
(c)	use of a *combined approach including both traditional and Western therapeutic methods*	☐	☐	☐	☐	☐
(d)	gender-specific treatments (i.e., separate groups for men and women)	☐	☐	☐	☐	☐
(e)	age-specific treatments (i.e., separate groups for children, youth, Elders, etc.)	☐	☐	☐	☐	☐
(f)	any other grouping based upon ______________ (i.e., gay/lesbian, incarcerated)	☐	☐	☐	☐	☐
(g)	sport, recreational activities (i.e., music, drama)	☐	☐	☐	☐	☐
(h)	alternative therapies (i.e., homeopathy, naturopathy, aromatherapy, reflexology, massage therapy, Reiki, etc.)	☐	☐	☐	☐	☐
(i)	other, please specify ______________	☐	☐	☐	☐	☐
(j)	other, please specify ______________	☐	☐	☐	☐	☐

C. PROJECT FINANCES

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

	Rank	Need	$
(a)	____	increase employee numbers and benefits	________
(b)	____	improve the PROJECT and expand it locally	________
(c)	____	provide training for employees and potential healers	________
(d)	____	offer, increase or improve transportation	________
(e)	____	improve and expand our building	________
(f)	____	develop/distribute information on the history and impact of residential schools	________
(g)	____	purchase equipment or supplies	________
(h)	____	special needs (resources, professionals)	________
(i)	____	solicit and establish partnerships/networks	________
(j)	____	improve communication (with community, AHF, Canadians generally)	________
(k)	____	PROJECT monitoring and evaluation	________
(l)	____	obtain professional assessments of skill development and healing	________
(m)	____	improve Survivor involvement	________
(n)	____	improve family support and parenting skills	________
(o)	____	encourage community involvement	________
(p)	____	other, please specify ________________	________
		Grand Total	________

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

- ☐ no
- ☐ yes, please explain ______________________________

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

Funder	**Contributions made during PROJECT operation**	**Amount of *ongoing* commitment to funding**
(a) other federal departments, branches or divisions	$________.00	$________.00
(b) provincial or territorial governments	$________.00	$________.00
(c) municipal or hamlet governments	$________.00	$________.00
(d) Aboriginal governments	$________.00	$________.00
(e) private granting foundations	$________.00	$________.00
(f) community fund-raising efforts	$________.00	$________.00
(g) other, please specify ________	$________.00	$________.00
(h) other, please specify ________	$________.00	$________.00
(i) other, please specify ________	$________.00	$________.00
(j) other, please specify ________	$________.00	$________.00

C.4 Will you be able to continue with your activities when the AHF is gone?
- ☐ no
- ☐ yes
- ____not sure

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

			Cannot Estimate
(a)	transportation	$________.00	☐
(b)	food	$________.00	☐
(c)	PROJECT materials	$________.00	☐
(d)	labour (including volunteers)	$________.00	☐
(e)	space for PROJECT	$________.00	☐
(f)	other, please specify	$________.00	☐
(g)	____________	$________.00	☐
(h)	____________	$________.00	☐
(i)	____________	$________.00	☐
(j)	☐ none		

C.6 Who donates the largest amounts *of goods and services* to your PROJECT? Identify the most generous partners by putting a 1 by the most generous, 2 by the next most generous partner and so on.
- a) ____ school
- b) ____ health services
- c) ____ social services
- d) ____ police
- e) ____ local government
- f) ____ local businesses
- g) ____ community members
- h) ____ local church
- i) ____ other, please specify____________________
- j) ____ other, please specify____________________

D. LEARNING

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

____

D.2 What were your best practices? Please specify

____

D.3 What were your greatest challenges? Please specify

____

D.4 Has it been difficult to get Survivors involved?

☐ no

☐ yes If so, what are the barriers to Survivors being more involved? In other words, why has it been difficult to involve Survivors?

D.5 Has it been difficult to get men involved?

☐ no

☐ yes If so, what are the barriers to men being more involved? In other words, why has it been difficult to involve men?

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

Characteristics of Healing	**Before project began**	**After project was complete**	**Does not apply**	**Do not know**	**Comments**
% of the Aboriginal participants who are trying to address the Legacy of Physical and Sexual Abuse					
% of community households with persistent violence					
% of youth/children at risk and *without* adequate support					
% of Aboriginal community are aware of and understand the impact of the Legacy of Physical and Sexual Abuse					
% of local non-Aboriginal service providers (i.e., health, justice, etc.) who are aware of and understand the impact of the Legacy of Physical and Sexual Abuse					
% of Aboriginal community members with a positive attitude toward healing					

Characteristics of Healing	Before project began	After project was complete	Does not apply	Do not know	Comments
# of sexual abuse disclosures					
# of reported sexual assaults					
# of attempted suicides					
# of reported cases of spousal abuse					
# of physical assault charges					
% of Survivors and the intergenerationally impacted who are involved or committed on a personal healing journey					
# of Aboriginal people *able to lead others in healing*					
# of documents or productions (i.e., educational videos) on the history of residential schools					
# of strategic plans with a focus on healing					
% of those in need who are connected to those who can facilitate healing					

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

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

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

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

The PROJECT deliverer participating in the completion of this survey:
(Name) ____
(Telephone) ____
(Signature) ____

The Survivor participating in the completion of this survey:
(Name) ____
(Telephone) ____
(Signature) ____

The Community Service provider participating in the completion of this survey:
(Name) ____
(Telephone) ____
(Signature) ____

Other interest parties participating in the completion of this survey:
(Name) ____
(Telephone) ____
(Signature) ____

AHF National Evaluation Survey (3)

DESIGNED TO BE FILLED OUT WITH YOUR GUIDE

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

Organization ID:		Request ID:	
Organization Name:			
Location:			
Region:			
Total # of **Months** of Receiving AHF Funds:			

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

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

If you have any questions about how a particular question should be answered, please consult your survey guide. If time does not allow the gathering of a group to complete this survey, please have a community member who is most familiar with the project fill out the questionnaire.

Community Type

Describe your community or most of the communities that you serve.

(Please check only one.)

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

Project Type

Is your project …

____ a healing project? If your project has healing activities, answer questions A.1 through A.3, otherwise proceed to A.4.
____ a training project? If your project has training activities, answer questions A.4 through A.6.
____ both healing and training? If your project has both healing and training activities, answer questions A.1 through A.6.
____ other - neither healing or training (e.g., video production, history documentation, prevention/ awareness), go to B.1.

Participants
If your project has healing activities, answer questions A.1 to A.3.

A.1 How many ***individuals*** **have participated in healing activity who want and need healing services** (includes centre-based therapeutic healing, sharing circles, camps and retreats, etc.)? ***Each participant should only be counted once***. This total ***does not include*** community members who may have attended large-scale community healing or social events such as feasts, conferences and pow wows, but *who are **not** seeking healing services.*
____ total # of people who have participated *who want and need healing*
☐ not sure
☐ not applicable (e.g., video production, research or documentation)

A.2 How many individuals who participated/are participating in AHF-funded **healing activity who want and need healing services** are in the following categories? (Provide the best estimated count.)
____ First Nations on-reserve
____ First Nations off-reserve
____ Métis
____ Inuit
____ Other

A.3 How many individuals who participated/are participating in AHF-funded **healing activity who want and need healing services** are in the following categories? (Provide the best estimated count.)
____ SURVIVORS (actually attended residential school)
____ intergenerationally impacted (i.e., children and grandchildren of Survivors)
____ those who do not identify as Survivors or intergenerationally impacted

From the above total estimate, please indicate how many are in the following categories.
____ youth
____ women
____ men

Also from the above total estimate, please indicate how many are in the following categories. (If applicable)
____ gay or lesbian
____ incarcerated
____ Elders
____ homeless (see guide for definition)

If your project has training activities, answer questions A.4 to A.6.

A.4 How many ***individuals*** have participated in **training as trainees** (i.e., trauma workshop participation, sexual abuse training, etc.)? (Provide the best estimated count.)
____ total # of people who have participated in training
☐ not sure
☐ not applicable (e.g., video production, research or documentation projects)

A.5 How many individuals who have participated in AHF-funded **training** are in the following categories? (Provide the best estimated count.)
____ First Nations on-reserve
____ First Nations off-reserve
____ Métis
____ Inuit
____ Other

A.6 How many individuals who have participated in AHF-funded **training** are in the following categories? (Provide the best estimated count.)
____ Survivors (actually attended residential school)
____ intergenerationally impacted (i.e., children and grandchildren of Survivors)
____ those who do not identify as Survivors or intergenerationally impacted

From the above total estimate, please indicate how many are in the following categories.
______ youth
______ women
______ men

Also from the above total estimate, please indicate how many are in the following categories. (If applicable)
____ gay or lesbian
____ incarcerated
____ Elders
____ homeless (see guide for definition)

A.7 How many of the people participating in your **healing** project require **greater attention** because of special needs (e.g., severe trauma suffered, inability to open up in a group, history of suicide attempt or life-threatening addiction, etc.)?
____ # requiring greater than normal attention

A.8 How many more people in need of therapeutic healing or training could you serve if you had more space/qualified human resources/money?
____ # of people seeking healing services or training
____ unsure
____ we are able to service all of those interested and motivated to engage in healing or training

A.9 How many people currently participating in therapeutic healing or training have participated in **another similar** healing or training project (**not funded by AHF**) ***before*** they came to your project? (*Please consult your survey guide to be clear about what is meant by another similar healing project or program.*)

- ☐ none
- ☐ unsure
- ___ # of people who have participated in previous healing or training projects

Personnel and Volunteers
(Please see your Guide to answer questions B1 to B4.)

B.1 Please think about the *total duration* of your Project **(i.e., from the first time you received AHF funding until now)**. Over that time period, how many **full-time** (who work **30 hours per week *or more***) paid ***positions*** (not individuals) did/do you have in total? Note: this includes employees, contractors and those who receive honoraria from AHF-funding.

B.2 Again, please think about the *total time you have been operating an AHF project* (**i.e., from the first time you received funding until now**) and *all the people involved*. Please indicate how many of the people involved have been Survivors (i.e., attended residential school) or intergenerationally impacted (i.e., children and grandchildren of those who went to residential school).

Roles	**Total #**	**# of Survivors** (went to residential schools)	**# of intergenerationally impacted** (did not go to residential school but impacted just the same)
employees			
volunteers			
contractors or those who receive honoraria			
board or advisory committee members			

B.3 Do Survivors (i.e., those who attended residential school) participate in staff hiring/evaluation decisions?

- ☐ yes
- ☐ no why not____

B.4 In a typical month, estimate the number of hours of volunteer service contributed to the project.
__________ # of hours contributed by volunteers in a typical month

PARTNERSHIPS

C. 1 Are you addressing the Legacy of Physical and Sexual Abuse with other agencies or organizations?

- ☐ no
- ☐ yes, please explain ____

C.2 How much funding did you receive from other sources while operating the Project (i.e., from the date you first received funding from AHF until you stopped receiving funding or if you are still receiving funding, to the present date)? How much have these same partners committed to ***ongoing*** funding of healing, training, service or research Projects or any other AHF-related activity?

	Funder	Cash Contributions made during Project operation	Amount of *ongoing* commitment to funding
(a)	federal government	$__________.00	$__________.00
(b)	provincial or territorial governments	$__________.00	$__________.00
(c)	municipal or hamlet governments	$__________.00	$__________.00
(d)	Aboriginal governments	$__________.00	$__________.00
(e)	private granting foundations	$__________.00	$__________.00
(f)	community fund-raising efforts	$__________.00	$__________.00
(g)	other, please specify __________	$__________.00	$__________.00
(h)	other, please specify __________	$__________.00	$__________.00

C.3 What is the estimated value of donated goods or services (in-kind contributions) you have received (i.e., from the date you first received funding from AHF until you stopped receiving funding OR if you are still receiving funding, to the present date) for the following? (Please estimate APPROXIMATE VALUE.)

			Cannot Estimate
(a)	transportation	$__________.00	☐
(b)	food	$__________.00	☐
(c)	project materials	$__________.00	☐
(d)	labour (including volunteers)	$__________.00	☐
(e)	space for project	$__________.00	☐
(f)	other, please specify	$__________.00	☐
(g)	__________	$__________.00	☐
(h)	☐ none		

Community Impact

The next section asks about the kind of changes you have noticed in your community ***since you began your AHF -funded project***. Don't worry if you are struggling or have just begun your healing work. It is understood that healing takes a long time and that programs do not always run according to plan. There are no right or wrong answers—only answers that *are true* for your community. In this question, community is defined as any collection of people gathered to achieve the same goals whether they are in a remote hamlet or a large urban centre. It is based upon what we have heard from project teams about the kind of change that is ***immediately obvious*** in the community. To answer the question, put a check mark (√) in the check box that best describes your opinion. Of course, if you do not know if the issue exists, has increased, decreased or stayed the same, then you may place a check mark in the last column to the right labelled "Don't Know."

		Since we started running our AHF project, this has			
		Increased	**Decreased**	**No change**	**Don't Know**
D.1	**Survivor action and involvement**				
a)	Survivors want healing services	☐	☐	☐	☐
b)	Survivors meet to support each other or encourage *other* Survivors to heal	☐	☐	☐	☐
c)	Survivors are involved in decision making about the project	☐	☐	☐	☐
d)	Survivors have decision-making authority in other service networks	☐	☐	☐	☐

Comments:

____

D.2	**Appropriate services for Survivors and their connection to them**				
a)	there are local healing services that are appropriate for Survivors and their families (i.e., *unique* to their needs as Survivors)	☐	☐	☐	☐
b)	local services specifically for Survivors are used by Survivors and their families	☐	☐	☐	☐
c)	Survivors are using a range of social support services	☐	☐	☐	☐

Comments:

____

	Since we started running our AHF project, this has			
	Increased	Decreased	No change	Don't Know
D.3 Understanding and awareness of the impact of residential schools				
a) community is using learning tools (e.g., archives, audiovisual materials, a curriculum package, visitor's centre, commemorative site) to teach about residential schools	☐	☐	☐	☐
b) agencies *outside* of the community are aware of and understand the impact of residential schools on Aboriginal families and communities	☐	☐	☐	☐
c) Survivors and their families understand how the history of residential schools has affected them/their parents/ grandparents, etc.	☐	☐	☐	☐

Comments:

____

	Increased	Decreased	No change	Don't Know
D.4 Team capacity to address the impact of residential schools				
a) local access to training opportunities for healers/helpers	☐	☐	☐	☐
b) healing team or helpers have adequate knowledge and skills to effectively deal with physical and sexual abuse issues	☐	☐	☐	☐

Comments:

____

		Since we started running our AHF project, this has			
		Increased	Decreased	No change	Don't Know
D.5	**Healing**				
a)	participation in healing	☐	☐	☐	☐
b)	disclosures of physical abuse	☐	☐	☐	☐
c)	disclosures of sexual abuse	☐	☐	☐	☐
d)	community is working together to support healing	☐	☐	☐	☐
e)	number of children who are at risk in the community	☐	☐	☐	☐
f)	healing activities are targeted at *both* Survivors and their families	☐	☐	☐	☐

Comments:

____

		Increased	Decreased	No change	Don't Know
D.6	**A plan or a vision to continue healing**				
a)	community planning for long-term healing	☐	☐	☐	☐
b)	community leaders are seeking resources to support long-term healing	☐	☐	☐	☐
c)	organizations and service agencies (inside and outside the community) are trying to secure support for long-term healing for Survivors and their families	☐	☐	☐	☐

Comments:

____

D.7 To what extent has your AHF project contributed to the changes that you have identified? Please check only one box below to indicate the contribution your AHF project has made to community change. A score of 1 would reflect a belief that the AHF project had *no influence* on community change and that many other events, activities or programs contributed to the observed change, a score of 3 would reflect a belief that AHF activity had *some influence in combination with other community efforts* and a score of 5 would reflect a belief that your AHF project was *completely responsible for the changes* you have noted in your community.

1	2	3	4	5
☐	☐	☐	☐	☐
the AHF contribution has had **no** influence on community change		the AHF contribution has had a moderate amount of influence on community change		the AHF contribution was completely responsible for community change

D.8 Was your AHF project the first time that the legacy of physical and sexual abuse in residential schools was formally addressed in your community?

☐ Yes

☐ No

D.9 It is clear that some communities have been addressing the legacy of physical and sexual abuse in residential schools for a long time and others are just beginning. To help us understand the contribution that the AHF may have made to your community's healing journey, please tell us where you believe your community is on that journey.

1	2	3	4
☐	☐	☐	☐
we are only just beginning to address physical and sexual abuse	we have **accomplished a few goals** in our effort to address physical and sexual abuse but **much work remains**	we have **accomplished many goals** in our effort to address physical and sexual abuse **but some work remains**	our community is as strong and healthy as we would like it to be

D.10 What does your community intend to do after AHF funding ends? Please check all that apply.

☐ We will continue with self-help groups and volunteer efforts

☐ We have secured **short-term** funding from other sources

☐ We have secured **long-term** funding commitments from other sources

☐ We plan to prepare proposals to secure other funding

☐ We will have to discontinue our healing efforts

Other, please explain

____

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

The project deliverer participating in the completion of this survey:
(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

The Survivor participating in the completion of this survey:
(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

The Community Service Provider participating in the completion of this survey:
(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

Other interest parties participating in the completion of this survey:
(Name) ______________________________
(Telephone) ______________________________
(Signature) ______________________________

National Interview

This interview is intended to gather a national perspective about AHF-funded activity at the community level. Therefore, in responding to these questions, please focus upon the program activity funded by the AHF and not on the organizational activity at the national office. An organizational review is being conducted but does not form part of this effort. You have been selected as a national representative with the greatest insights regarding project activity.

1) Is there anything that you would like to share about the evolution (e.g., eligibility criteria, funding policy, focus, administration as they relate to community-level activity) of the AHF from its inception to now?

2) Please share your impressions about whether or not each of the following groups or community types have received their *equitable* share of AHF resources.

		Definitely not	I don't think so	I think so	Yes Definitely	Not sure
(a)	First Nations on-reserve	Q	Q	Q	Q	Q
(b)	First Nations off-reserve	Q	Q	Q	Q	Q
(c)	Inuit	Q	Q	Q	Q	Q
(d)	Métis	Q	Q	Q	Q	Q
(e)	youth	Q	Q	Q	Q	Q
(f)	women	Q	Q	Q	Q	Q
(g)	incarcerated	Q	Q	Q	Q	Q
(h)	homeless	Q	Q	Q	Q	Q
(i)	gay or lesbian	Q	Q	Q	Q	Q
(j)	men	Q	Q	Q	Q	Q
(k)	Elders	Q	Q	Q	Q	Q
(l)	intergenerationally impacted	Q	Q	Q	Q	Q
(n)	Survivors	Q	Q	Q	Q	Q
(n)	remote—cannot be reached by road or ferry service	Q	Q	Q	Q	Q
(o)	isolated—can be reached by road or ferry service and is more than 350 kilometres from a town with more than 1,000 people	Q	Q	Q	Q	Q
(p)	rural—can be reached by road or ferry service and is more than 50 kilometres from a town with more than 1,000 people	Q	Q	Q	Q	Q
(q)	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	Q	Q	Q	Q	Q

3) From your perspective, to what extent do you believe the following participant characteristics present challenges/difficulties in operating AHF projects? (Indicate the extent of the challenge by checking the appropriate box.)

		Severe (>80%)	**Moderate** (40-80%)	**Slight** (1-40%)	**No Problem**
(a)	lack of survivor involvement in the project	Q	Q	Q	Q
(b)	history of incarceration	Q	Q	Q	Q
(c)	denial, fear, grief	Q	Q	Q	Q
(d)	lack of parenting skills	Q	Q	Q	Q
(e)	history of suicide attempts	Q	Q	Q	Q
(f)	history of abuse as a victim	Q	Q	Q	Q
(g)	history of abuse as an abuser	Q	Q	Q	Q
(h)	history of adoption	Q	Q	Q	Q
(i)	history of foster care	Q	Q	Q	Q
(j)	family drug or alcohol addictions	Q	Q	Q	Q
(k)	poverty	Q	Q	Q	Q
(l)	lack of literacy skills	Q	Q	Q	Q
(m)	lack of communication skills	Q	Q	Q	Q
(n)	other, please specify ____________	Q	Q	Q	Q

notes or comments

____

4) In your opinion, is the AHF reaching those who need it the most? Please check only one response.

5	4	3	2	1
______	______	______	______	______
yes definitely	yes but could be better	not sure	probably not	definitely not

Explain why your group feels this way.

____

5) Where should MOST (i.e., more than 50 per cent) of AHF resources be spent? Choose only two. Please refer to the survey guide for definitions of these answer categories.

Q communications or public awareness
Q research or history documentation (honour)
Q healing
Q training
Q curriculum development
Q community service
Q reconciliation
Q strategic planning
Q needs assessment
Q other, please specify______________________

6) From your knowledge of the communities being serviced, to what extent do the following issues affect them? (Please indicate the extent of the challenge by checking the appropriate box.)

		Severe Challenge	Moderate Challenge	Slight Challenge	No Problem
(a)	adult illiteracy (*inability* or *difficulty* reading MOST printed material in any language including Inuktitut syllabics)	Q	Q	Q	Q
b)	lack of acceptance of Aboriginal language and culture by local institutions (e.g., schools, hospitals)	Q	Q	Q	Q
(c)	apathy or lack of active Aboriginal community support	Q	Q	Q	Q
(d)	local community opposition (fear, denial)	Q	Q	Q	Q
(e)	poor local economic conditions (e.g., high unemployment, poor housing conditions)	Q	Q	Q	Q
(f)	substance abuse	Q	Q	Q	Q
(g)	family violence	Q	Q	Q	Q
(h)	sexual Abuse	Q	Q	Q	Q
(i)	lack of transportation (local bus, vehicles, etc.)	Q	Q	Q	Q
(j)	lack of community resources, facilities, services, etc.	Q	Q	Q	Q
(k)	suicide or attempted suicides	Q	Q	Q	Q
(l)	fetal alcohol syndrome (FAS)/fetal alcohol effects (FAE)	Q	Q	Q	Q

7) What other national programs or healing efforts do you believe will have an *impact* on AHF results? Explain ____

____

8) What percentage of the total number of proposals submitted actually receive funding?

9) What are the core problems with proposals that are rejected? How does the AHF address these issues?

10) How effective were AHF projects at empowering WOMEN? Please check only one response.

2	3	4	1	0
______	______	______	______	______
little or no influence	some influence	dramatic influence	not sure	not applicable

Explain why your group feels this way.

____

11) Did you believe that Survivors (including intergenerationally impacted) are getting the kind of service they want?

1	2	3	4
________	________	________	________
no, definitely not	no, not really	yes, generally	yes, definitely

12) To what extent has AHF-funded activity met Survivors (including intergenerationally impacted) needs?

4	3	2	1
________	________	________	________
almost all needs have been met	most needs have been met	only a few needs have been met	none of the needs have been met

13) Take some time to think about a wish list for the AHF and its ability to support communities in their quest for sustainable healing. In the left-hand column, rank order your most important needs by putting a 1 by the most important need, a 2 by the second most important and so on. In the right-hand column, estimate how much money would be required to address this need.

Rank	Need	$
____	increase project employee numbers and benefits	________
____	improve projects and expand them locally	________
____	provide training for project employees and potential healers	________
____	offer, increase or improve transportation	________
____	improve or expand facilities	________
____	develop/distribute information on the history and impact of residential schools	________
____	purchase equipment or supplies	________
____	special needs (resources, professionals)	________
____	solicit and establish partnerships/networks	________
____	improve communication (with community, Canadians generally, private sector)	________
____	project monitoring and evaluation	________
____	obtain professional assessments of skill development and healing	________
____	improve Survivor involvement	________
____	improve family support and parenting skills	________
____	encourage community involvement	________
	Grand Total	________

14) What are the most important lessons that you learned while developing, implementing and administering AHF activity?
Please specify ____________________

15) With respect to supporting communities, what do you believe are the AHF's best practices?
Please specify ____________________

16) With respect to supporting communities, what are the AHF's greatest challenges?
Please specify ______________________________

17) How can the AHF facilitate the success of future projects from your perspective?
Please specify ______________________________

18) The interim evaluation report due in June is focussing upon the process of implementing AHF-funded activity at the community level, is there anything more that you would like to add regarding these processes so far?
____

19) It is understood that expecting major change at this stage of the AHF's life may be premature; however, given your national view of AHF activity at the community level, do you believe anything has changed (at the community level) as a result of AHF-funded activity so far?
Q No. Explain why you feel nothing has changed.
Q It may be too early to tell.
Q Yes. Explain why you feel things have changed.
____

Focus Group Questions

Aboriginal Healing Foundation
Healing Project Voices: Focus Group Discussions

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

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

Table 1) Dismantling Fear and Denial

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

Table 2) *Blending* Traditional and Western Therapies

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

Table 3) Identifying a Good Healer

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

Criteria Used to Select Case Studies and Case Study Summaries

ORGANIZATION	Métis	Inuit	FN	Non-Status	Youth	Men	Women	Gay/ Lesbian	Incarcer -ated	Elders	Urban	Rural/ Remote	North	French	East	West
NORTH																
Hamlet of Cape Dorset (now Municipality of Cape Dorset)		•											•			
BC																
Urban Native Youth Association					•			•			•					•
George Manuel Institute/ Neskonlith Indian Band			•									•				•
Tsow-Tun Le Lum Society						•					•					•
ALBERTA																
Shining Mountains Living Community Services					•	•	•				•					•
SASKATCHEWAN																
Building a Nation, Life Skills Training Inc. (now Building A Nation, Inc.)					•	•	•		•	•	•					•
Willow Bunch Métis Local #17	•											•				•
Kikinahk Friendship Centre Inc.					•		•					•				•
MANITOBA																
Nelson House Medicine Lodge Inc.			•		•	•	•					•				•
ONTARIO																
Centre for Indigenous Sovereignty			•				•				•				•	
Odawa Native Friendship Centre	•	•	•	•					•		•				•	
QUEBEC																
Conseil de la Nation Atikamekw Inc.			•											•	•	
NEW BRUNSWICK																
Big Cove First Nation			•		•							•			•	

ORGANIZATION	Community services	Conference/ gatherings	Performing arts	Health centre (residential care)	Camp/ retreat (away from community)	Day program in community	Healing circles	Materials development	Research knowledge planning	Traditional Activities	Parent Skills	Professional Training	$	N	
NORTH															
Hamlet of Cape Dorset (now Municipality of Cape Dorset)		•			•	•	•			•			121,080	CT-411-NT 32-NT	
BC															
Urban Native Youth Association	•					•							81,420	CT-302-BC 237-BC	
George Manuel Institute/ Neskonlith Indian Band			•										147,366	180-BC	write and produce a play
Tsow-Tun Le Lum Society				•			•			•			459,560	HC-36-BC 67-BC	
ALBERTA															
Shining Mountains Living Community Services					•		•			•	•		150,000	1397-AB	
SASKATCHEWAN															
Building a Nation, Life Skills Training Inc. (now Building A Nation, Inc.)	•				•	•	•			•	•	•	222,800	1256-SK	
Willow Bunch Métis Local #17								•					109,200	1176-SK	book
Kikinahk Friendship Centre Inc.					•					•	•		186,190	RB-67-SK 364-SK	
MANITOBA															
Nelson House Medicine Lodge Inc.							•			•		•	464,526	52.01-MB	
ONTARIO															
Centre for Indigenous Sovereignty		•				•	•			•		•	191,532	RB-268-ON 455-ON	
Odawa Native Friendship Centre							•					•	77,165	1291-ON	
QUEBEC															
Conseil de la Nation Atikamekw Inc.		•							•				517,317	DV-310-QC 28-QC	
NEW BRUNSWICK															
Big Cove First Nation	•					•	•			•			189,300	RB-175-NB 412-NB	outreach aftercare program youth at risk

Summary of Case Studies

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

Project Description

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

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

The Hamlet of Cape Dorset sponsored the project.

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

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

Project Team

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

Participant Characteristics

All 46 participants in healing activities were Inuit, as were 21 of 22 training participants. Over one-third of healing participants and two-thirds of training participants were Elders. Most (89.1%) of the participants in healing were women and almost one-third were youth. In this project, the term "Survivor" refers to survivors of sexual abuse (rather than residential school Survivors), and 87 per cent identified as Survivors. With respect to training, 86.4 per cent of participants were women, while 13.6 per cent were men; none of the training participants were youth. A community awareness session attracted over 60 individuals, all Inuit.

Context

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

Cape Dorset is well known in the art world for its printmaking and carvings, with estimated earnings in the range of a few million dollars. However, unemployment rates remain high – between 22.8 per cent and 42.6 per cent depending on the criteria used. The serious impact that physical and sexual abuse had on some female community members who attended southern institutions was mentioned in the project proposal, as well as the impact of a male teacher who sexually abused male students in the 1980s. The social indicators point to a community grappling with significant issues of physical and sexual abuse, suicide and incarceration. The number of children in care, while below the territorial average, is still noteworthy.

Outcomes and Measures

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

Cape Dorset Healing and Harmony in Our Families Performance Map

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

HOW?	WHO?	WHAT do we want?	WHY?
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Provide healing and support through weekly healing circles; provide on-the-land camps; and provide training and support through various workshops and a healing strategy.	Women, youth, Elders, caregivers and men.	Increased skill and capacity among caregivers; increased capacity to deal with crisis; increased capacity to serve hard-to-reach groups, especially men; community healing in areas of lateral abuse, violence, sexual abuse and suicide; overcoming powerlessness and helplessness; and increased sense of pride in culture and spirituality as it relates to healing.	Restored balance and harmony in families and community.

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

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

Influencing Individuals and Communities

Service delivery objectives were met and there was evidence of progress towards achieving the following short-term outcomes: increased skill and capacity of caregivers to support healing within their family and community; increased capacity to effectively manage individual and family crisis; a strong, effective CHT; overcoming powerlessness and hopelessness; and an increased sense of pride in culture and spirituality as it relates to healing. However, the healing and training participants were primarily Inuit women, and the objective of reaching men was not achieved. The project was designed to *heal the healers first*, an approach that only benefited those the core group came in contact with – family members, community members, clients in professional roles. While the project only received AHF funding for the last two years, there were prior efforts on a smaller scale since 1995, allowing greater time for an impact on individuals and the community.

Impact on Individuals

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

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

One hundred per cent of respondents observed the following changes in participants who attended **healing** activities: healthier coping patterns; better self-esteem; understanding sexual abuse; and dealing better with depression. Ninety per cent (90%) observed changes in youth self-esteem, talking about suicide, community support for Elders and a stronger CHT; and eighty per cent (80%) reported changes in participants not attempting suicide, victims getting help for violence and abuse, and getting support from Elders. In general, these are issues that can be dealt with through positive, supportive measures and through the provision of information (education and training). Lower levels of improvement were observed for men getting treatment[208] (30%), women getting treatment (60%), abusers getting help to stop physical abuse and violence (40%), and men dealing with violent behaviour (50%).

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

- listening skills were most often mentioned: "learned to listen to a person in need of help, who is needing someone to talk to. Understanding and dealing with a suicidal person. Understanding grief helped me a lot and the affect [of grief] on a person;"
- being able to recognize when another is in pain;
- breathing exercises and massage;
- making healthier choices, such as not committing suicide;
- learning about what their children may be going through as sexual abuse victims;
- being more confident because of the training;
- becoming more aware of being a role model for younger people;

- increased self-awareness to making better life choices;
- being able to share what they learned with others; and
- "I'm worth something. I'm a better parent."

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

Impact on Community

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

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

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

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

Establishing Partnerships and Ensuring Sustainability

Nineteen people were listed as being members of the Community Healing Team with the following agencies represented: Uquajjigiaqtiit Justice Committee (six members, including the chairperson and

justice specialist); social services; Tukkuvik Women's Shelter; school counsellors; Anglican Women's Auxiliary (layperson caregivers); two land guides; and two people were listed without any affiliation. A number of these organizations, as well as the RCMP, the hamlet (municipality) and the health centre, provided letters of support for the initial funding proposal. Community members were the largest donators of goods and services along with the hamlet and the justice committee. The estimated value of donated goods and services is $2,000 in food and $24,000 in office space for the project.

Five of eight respondents either agreed the project was sustainable or said it would continue, "if there is a strong desire to continue with it on a voluntary basis, and/or to seek funding elsewhere." Some speculated as to how they might continue without AHF funding and all seemed to indicate a desire to have the project continue in some form, such as a scaled back version or operating with volunteers.

Meaningfully Engaging Survivors (including the intergenerationally impacted)

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

Managing Program Enhancement

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

Best Practices

Key informants cited the project as having a positive impact on individual participants with respect to their personal healing and by providing knowledge and skills to improve their capacity to help others. Practices identified as successful include the following:

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

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

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

Challenges

Reaching men was consistently raised in the interviews as a challenge, as well as project documentation. Some responses suggested the men's group had started, but not without a struggle. What was not clear is whether this was a recruiting problem (e.g., if participant recruitment was done differently, would more men come?) or a programming issue (do the kinds of healing and training programs offered appeal to men? Is there a difference between male participation in group events and in individual counselling?).

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

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

Ensuring Accountability

The project received an average score of only 2.8 out of 6 on how well it had been accountable to the community. Reasons tended to focus on the need for more outreach to, and feedback from, the community.

Reaching Those in Greatest Need

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

While most respondents felt the project's methods, activities and processes worked reasonably well, there was a recognized gap in relation to men: "Not enough participation from men, especially sexual abuse victims." "Men's healing is struggling." "It's happening, I know there are men out there but not sure what will reach them."

Lessons Learned

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

- bring in more male-female training teams;
- heal the healers first - the project recognized they had to deal with personal issues first (personal growth);
- hesitant to start a men's group unless men can get healing and training to support the group;
- the men wanted experienced group facilitators;
- one person cannot heal the community, it takes a team approach;
- "we all need to recognize that it took two generations for our community to get to a state with the highest rate of suicide in the eastern arctic, high rates of incarceration, and all the other issues we face;"[209]
- the word *"healing"* creates some division. Whether the term is misunderstood may be partly at issue, as three informants observed there was public resistance to radio announcements about healing. The announcements were amended and fewer people seem to be resisting the concept.

Conclusions

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

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

The indicator data show that suicide, physical abuse, sexual abuse and incarceration rates remain high and there is no consensus among key informants that these problems are decreasing. However, a ripple effect is being witnessed as many informants spoke to how their families and partners have benefited. The spirit behind this project is strong and often was reflected through the personal testimony that came from key informant interviews. Although many expressed personal trauma, all gave examples of how their own journey has been made easier by the project and the CHT. Some spoke of healing from sexual abuse, others said they had stopped drinking alcohol, while others talked of new jobs that they directly attributed to their healing journey. The Elder who inspired the title of this study said:

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

Programming Recommendations

- Greater efforts should take place to partner with probation services to: a) gain wider access to men in a captive audience; and b) identify and support men in their healing on a personal level first. A secondary focus should be the eventual facilitator role that is being sought for the men's group, to avoid undue pressure on men who may be solely interested (at this stage) in healing;
- until such time that enough interest is generated to begin a men's group, more male facilitators should be brought into the community;
- men in the community should be asked directly about their healing needs and preferences;
- there was some community and church resistance to using the word "healing" ("mumisuq"), and the project responded by amending their radio announcements. Opportunities should be pursued to engage in broader discussions on the most appropriate Inuktitut word for healing and culturally appropriate ways of promoting the concept of healing;
- improved reporting is recommended, which captures and reflects age and gender breakdowns; and
- a healing strategy should be formalized into a document; it is further recommended that a needs assessment be designed and implemented to better determine the issues facing specific target groups and the community as a whole.

Evaluation Recommendations

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

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

Project Description

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

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

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

Project Team

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

Participant Characteristics

The National Process Evaluation Survey (NPES) showed a total of seventy people were reached in individual and group healing activities: 85.7 per cent were First Nations, 14.3 per cent were Métis, and all were youth. The majority were male (71.4%), followed by women (21.4%) and transgendered (7.1%). Over three-quarters (78.6%) identified as gay, lesbian or questioning their sexual identity. Project files suggested lower participation rates: 5 to 29 youth in drop-in groups, and between 6 and 15 participating in individual counselling. Community awareness and educational activities reached over 200 people.[210]

Context

Based on the 1996 Census, Metropolitan Vancouver has a population of 1,831,665 of which there are an estimated 31,140 Aboriginal people. The number of street-involved people is difficult to estimate as this is an especially migratory population. In its year-end report on the program (1999-2000), UNYA stated: "40% of the street youth population in Vancouver self-identified as gay, lesbian, bisexual, transgendered or questioning youth … 40% of the total street population were Aboriginal."[211] The downtown east side,

where many of the target population live, is known for high rates of injection drug use, poverty, unemployment, homelessness, sexual exploitation and incidence of diseases such as HIV/AIDS and Hepatitis C. One local study found suicide rates among First Nations to be twice that of the rest of the population.[212] Another noted that incarceration rates for Aboriginal youth were eleven times the provincial rate and five times the national rate.[213] A review of a safe house program for Aboriginal youth found that 26 of the 53 youth who accessed the safe house were known to have been sexually exploited.[214] The project recognized their target group as a high needs and hard-to-reach population.

The project's response to the NPES supports the view that the target population faces a number of severe challenges, including: lack of acceptance of Aboriginal language and culture by local institutions (e.g., schools, hospitals); apathy or lack of active Aboriginal community support; local community opposition (fear, denial); poor local economic conditions (e.g., high unemployment, poor housing conditions); substance abuse; family violence; sexual abuse; and lack of transportation (e.g., local bus, vehicles).

Outcomes and Measures

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

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

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

Urban Native Youth Association Performance Map

MISSION: Gay, lesbian, bisexual and transgendered Aboriginal youth are free of the abuses that have been damaging their lives - they are travelling down the long road to recovery and gaining realistic hope for a healthier lifestyle for the future.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Provide peer support/healing through regular group meetings and healing through individual counselling; establish contact with youth agencies, other social service providers, the media, youth on the streets and the community-at-large regarding issues of intergenerational impacts and gay/lesbian youth (including the availability of programs to serve them).	Gay/lesbian youth; agencies, community, etc.	Increased healing (reduced incidence of suicide, depression, substance abuse, sexual exploitation and youth living on the street); enhanced self-esteem and ability to cope with sexuality and homophobia; increased peer support to enhance healing; increased awareness of the intergenerational impacts of residential school abuse and gay/lesbian youth issues (reduction in homophobia and increase in community understanding and support).	Gay/lesbian youth are off the streets and engaged in healthier lifestyles free of abuse, depression, suicide and sexual exploitation.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	**Reach**	**Short-term Measures**	**Long-term Measures**
$81,420	# of participants from gay/lesbian youth community; community-at-large.	Level of participation in individual and group counselling/healing; evidence of peer support and healing (individual and group feedback, perceptions of key informants); social indicator analysis (rates of suicide, indicator analysis (rates of suicide, attempted suicide, sexual abuse, substance abuse); numbers of gay/lesbian youth living on street; evidence that media and other agencies understand the intergenerational impacts of the residential school system and the extent to which the Legacy is acknowledged and openly discussed in counselling and group work; and level of homophobia in schools and agencies.	Reduced rates of suicide and attempted suicide; and reduced numbers of gay/lesbian youth living on the streets and engaged in abusive behaviours (alcohol and drug abuse, sexual exploitation).

Impact on Individuals

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

Impact on Community

Using a scale of one to five (1 low, 5 high), a clear majority of key informants felt the program was filling a gap and enhancing services. Average scores were 4.5 and 4.8, respectfully. Four respondents said that agencies who had partnered with the program are more aware of the Legacy.

There were numerous references to homophobia in the project files and in the interviews. In fact, this was the reason the program pulled out of networking with other AHF-funded projects in the city. The counsellor/facilitator's response to how he saw other AHF projects relate to the gay/lesbian youth program was:

> I don't. This is a totally unique program. I have no support from the other ones. At the AHF Networking meeting last November, I pulled out. Even healers don't want to talk about it (two-Spirit issues). I found this meeting to be very patronizing. I confronted the whole room and said 'until I get support, I won't come back.' I feel all alone out there.

While homophobia is clearly a very real barrier, the claim that there was no support from other AHF-funded projects remains unanswered at this stage since the interviewer did not approach other projects. In searching relevant Aboriginal data for the greater Vancouver area, it was found that a number of AHF-funded projects exist in the same area, but none appear to be duplicating the services of the program. Thus, it appears the project was filling a service gap by specifically targeting gay/lesbian Aboriginal youth and publicly advocating their issues. However, given the extent of homophobia, much more time would probably be required to achieve a sustainable impact. Based on the large number of partnerships and linkages established by the project and its education and awareness activities, there may have been an impact over the short-term; but in the absence of evaluation material, this is merely speculation.

Without interviewing a wider audience, it is difficult to measure what impact or response was being felt among the target groups for education and awareness activities. Data are sparse from participant feedback and only three social service agencies were part of this case study. When asked what level of support community agencies have provided, Aboriginal respondents rated support much lower than non-Aboriginal respondents. The three Aboriginal informants identified resistance from the Aboriginal community around *hearing about* gay/lesbian issues as the biggest challenge. Three respondents said things had improved when questioned how partnering agencies dealt with residential school issues differently as a result of the project. However, when asked what changes were made in the way they do their work, two of three partnering

agency representatives said they made no changes. There was a sense that an education and awareness process was taking place among the key informants themselves, but further support and awareness were required. One person stated: "I talk more openly about two-spirit issues." This individual, including two others who spoke of becoming more vocal, were the Aboriginal informants.

Establishing Partnerships and Ensuring Sustainability

The final project monitoring sheet listed linkages with 31 agencies in addition to the partnering programs and four media outlets (radio, television, newspapers). Workshops were presented to bands, schools, youth groups, parole officers, and gay and lesbian groups. However, it is difficult to determine the effectiveness as there were few participant evaluations to rely on. Direct linkages were established with 16 Aboriginal and mainstream service agencies. Three external agencies and one program by UNYA were directly involved with the gay/lesbian youth program. This involvement included providing space for drop-ins or group activities. Four of six respondents said that agencies who had partnered with the program became more aware of the Legacy.

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

The estimated value of donated goods and services (food, labour, space for group meetings) over a period of 18 months was $14,400. Donations came from social services, health services, a local youth resource centre and community members.

Meaningfully Engaging Survivors (including the intergenerationally impacted)

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

Managing Program Enhancement

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

Implementing the evaluation plan outlined in the proposal may have allowed for revising the work plan to place emphasis where it was needed most and/or where it would have been most effective.

Best Practices

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

- the counsellor/facilitator was an Aboriginal gay/lesbian person, increasing the likelihood that clients would identify with him;

- the program linked with key agencies serving the Aboriginal community and maintained a presence at drop-in groups. This provided gay/lesbian youth with opportunities to become familiar and comfortable with the counsellor/facilitator at their own pace; and
- the program included services to transgendered youth, who oftentimes find themselves with many barriers and stigmas that inhibit or prevent participation in more generalized programs.

In addition, several of the respondents mentioned the quality and dedication of the counsellor/facilitator.

Challenges

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

Other identified challenges include:

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

Ensuring Accountability

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

The absence of a systematic participant evaluation process combined with no needs assessment provides little concrete information to help support or guide the direction of the program.

Not working with the Aboriginal gay/lesbian community seemed a weakness. There was an assertion of not enough positive role models for this group, and that it was difficult to find gay/lesbian Elders. The need for gay/lesbian Elders is not a necessity provided the Elder could demonstrate compassion and empathy. Likewise, there are positive role models among the gay/lesbian population, some who are on the *red road* (in recovery or following traditional teachings) and they may have been a valuable resource and support to both clients and staff.

Reaching Those in Greatest Need

This is a high-needs target group and the issues being addressed range from overcoming substance abuse to healing from sexual abuse to coping with one's own sexuality in a homophobic society. The project reported in the NPES that: "five clients have been actually referred elsewhere, due to dual diagnosis, treatment programs, etc. But, in reality, I would say all clients suffer from some form of inability to open up in group and deal with severe trauma, e.g., sexual abuse, racism, sexism, etc." While it was unclear if the project

actually reached those in greatest need (Aboriginal gay/lesbian youth), it clearly attempted to fill a service gap. However, one key informant mentioned the lack of clients: "we need to ask, what is it they [the youth] aren't able to connect with the program on?"

Lessons Learned

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

- most informants interviewed suggested a second staff person might improve the project, and was also suggested that a female staff member would provide for gender balance;
- the counsellor/facilitator felt he was doing a half-service to each area (counselling and awareness/ education), and awareness efforts could have been more strategically delivered by reducing the number of education and awareness activities;
- the counsellor/facilitator indicated a personal lesson learned, by speaking of how he operated at the beginning of his project and towards the end. "I've become more flexible. I never really worked with youth before, strictly speaking, and I was so available at the start. Now I have limits. I turn my cell off from 11 pm to 7 am and the youth know that. I really live my job;"
- two respondents mentioned how they speak more openly and frequently about gay/lesbian issues; and
- some non-Aboriginal agencies that linked with the program indicated no substantial change in how they did their work. However, they did indicate a benefit to their agency and one informant said he learned more about gay/lesbian issues.

Conclusions

There is some indication that the program had an impact on increasing knowledge and awareness on both residential schools and gay/lesbian issues through numerous workshops and presentations. Without participant evaluations, it is difficult to know what was learned from these workshops. Further benefits of the program can be seen in examples provided where four gay/lesbian youth reunited with their families and communities. As one person put it: "in a good way and not just to fight." No dollar figure can be placed on the value for even one youth who reconciled with his/her family; moreover, the program was just beginning. Since "street-involved youth have experienced a series of losses: family, housing, innocence,"[215] it seemed another loss was dealt them when the gay/lesbian youth program ended.

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

Recommendations

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

- Given the nature of this work and the size of the population, efforts to secure two staff for this project would have minimized the isolation and frustration felt by the counsellor/facilitator; it was felt the

budget was sufficient to hire at least one full-time position and one part-time. At the very least, other sources of funding could have been pursued to ensure meeting this requirement. A second aspect to this would have been the benefit of having gender balance to increase opportunity for clients to bond with at least one staff member, especially if they had gender issues.

- An advisory committee should have been organized to help formally guide the counsellor/facilitator and the program.
- Greater efforts to find healthy, positive role models from the older Aboriginal gay/lesbian community would have been a logical place to start, especially since the program felt the Aboriginal community was the most resistant. Drawing on the knowledge of Aboriginal gay/lesbian people, who may have experienced many of the same issues as Aboriginal gay/lesbian youth, would have allowed for greater opportunities to create a support base for the youth.
- The program had difficulties finding gay/lesbian Elders. Involving healthy Elders who are compassionate to the needs of youth and who were not homophobic was felt to be all that was necessary.
- Partnering with appropriate Aboriginal agencies could have provided links into the Aboriginal community. For example, the local Aboriginal AIDS organization based in North Vancouver has done a lot of work to gain support from leaders and health care workers in dealing with both HIV/AIDS and gay/lesbian people who are living with this disease.
- Implementing the evaluation plan outlined in the proposal may have allowed for revising the workplan to place emphasis where it was needed most and/or where it would have been most effective.

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

Project Description

The project involved researching, writing, producing and delivering a play that addressed the legacy of physical and sexual abuse, including intergenerational impacts. The writing is based on the experiences of Survivors interviewed during the research phase; Survivors were also involved as advisors throughout the project. The funding application reported the project was expected "to provide a creative process of healing for residential school Survivors and their families by putting words to their experiences of physical and sexual abuse and providing them with an opportunity to share their experiences in a safe environment." The project was sponsored by the Neskonlith Indian Band and the George Manuel Institute, located near Chase in the interior of British Columbia.

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

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

Project Team

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

A key factor was hiring actors who were on a healing path. In addition to the staff and actors, there were 40 roving counsellors and 30 volunteers who supported the development and delivery of the theatrical production. The roving counsellors were provided by the host community to gauge how the audience was responding, and to intervene and provide counselling if someone expressed or showed a need. The playwright/director facilitated debriefing sessions at the end of each performance, which required a lot of skill and experience. The debriefing sessions were also utilized to work with actors and staff to prepare for and process the intensely emotional subject matter. Several actors stated that the person who provided this guidance was exceptional and that, without her, they would never have tackled this type of theatre job.

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

Participant Characteristics

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

The project's first quarterly report showed 40 individuals directly involved in the project: 5 per cent were under the age of twenty-five, 35 per cent over the age of fifty and the remaining 60 per cent falling in between. Most (80%) were status on-reserve, 17.5 per cent were status off-reserve and 2.5 per cent were Métis. All were Survivors or later generations (82.5% Survivors and 17.5% later generations). Males and females were equally represented. The number of participants dropped in the third quarter to 19, likely because interviews with Survivors had been completed. The statistical profile showed fewer Elders (21% over the age of 50) and an almost equal balance of Survivors and later generations.

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

The theatrical production held 12 performances throughout the province of British Columbia, including two performances for clients only at treatment centres. The project files reported reaching an estimated 4,000 people. Many interviewees reported standing room only at the facilities where the performances were held.

Context

According to Statistics Canada, the Aboriginal population in British Columbia in 1996 was 139,655. Persons registered under the *Indian Act* living both on- and off-reserve were listed as being 93,835. In keeping with similar Aboriginal demographics across the country, almost half of British Columbia's Aboriginal population (57,645) were under the age of 19. Adding the next age group (20-24), this figure rises to 69,595. Combined with the next age group (25 to 34), the figure rises to 93,845, which means a significantly young Aboriginal population in British Columbia. These figures (1996 Census) are important, since the play was partially about teaching history, and the above-mentioned population would not have been old enough to attend residential schools that closed (last one to close in British Columbia was St. Mary's Mission in 1985). The 1996 Census also cited 26,000 Métis persons living in British Columbia.

Populations of Centres that Held Performances

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

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

Outcomes and Measures

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

Neskonlith Indian Band/George Manuel Institute Performance Map

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

HOW?	WHO?	WHAT do we want?	WHY?
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Research and write a play in consultation with Survivors; recruit staff; hold auditions to recruit actors based on skills and familiarity with residential school issues; produce and deliver performances locally, provincially and possibly elsewhere in Canada; engage, debrief and interact after each performance with the audience; and provide closure to staff and actors.	Residential school Survivors, family and community members, actors, staff and volunteers, community staff and leaders.	Increased knowledge and awareness of residential school issues; involvement and input from Survivors; accurate, true portrayals of the original experiences of Survivors; honouring the resilience of Survivors at the family and community levels; appropriate guided dialogue after each performance; and appropriate wellness/safety plans for all involved or working on the project.	Restored balance and honour of Survivors with their families and communities.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	**Reach**	**Short-term Measures**	**Long-term Measures**
$147,366 one year only	12 locations: 4,000 people, 6 actors, 6 project staff, 12 support staff, 40 roving counsellors and 30 volunteers.	Through dialogue after each performance: to gauge # of audience members staying for discussion, reports of audience reaction, length of time people would stay, discuss and listen to issues; perceptions by actors, staff, volunteers on what changes have been seen in Survivors, their families and communities; self-reported and key informant views on how the performance has impacted those directly involved with the project; and evidence of increased awareness of residential school issues within communities.	Increase in Survivor healing, as seen through a sense of belonging, validation, utilization as a resource, family and community reconciliations; decreased rates of physical and sexual abuse due to education, awareness and willingness to acknowledge and intervene in these areas; and decreased rates of suicide, children in care and incarceration.

Influencing Individuals and Communities

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

Impact on Individuals

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

> I felt like I was reliving a part of my past when I was drinking and drugging and on the skids. Before the play, I stopped drinking. Going through the play and understanding the process helped me stay off of booze. I previously had problems stuffing emotions, but the play allowed me to open up. I want to go back into the field of theatre. I now have more compassion. I understand and see the real reasons behind certain behaviour.

> My Dad is a Survivor. A lot of personal issues came up [informant becomes emotional and interview is paused]. Issues came up for me about alcoholism, suicide, feelings of self-worth all surfaced.

> My Mom is a Survivor and started talking more, which she never did before. I saw changes emotionally with my family, like she used to have problems hugging [before] and now she does.

> Healing is an ongoing thing and I'm still working on my issues. Writing is like therapy, many times I was moved to tears. I needed a strong support system and I totally related to residential school Survivors.

> It is very important for our people to understand that all stories are relevant and real. There is a great need for our people to find all kinds of avenues to construct their story - through ceremonies, plays, workshops. This definitely needs to happen.

> It's only the tip of the iceberg. The AHF process is good, an alternative to what non-Native people are offering us, as solutions to our problems.

> Felt good knowing the project was a little about prevention, little about treatment, some education, even for non-Native people.

Other examples of positive action actors were taking include making decisions to go back to school, and several stated they were going into counselling or therapy. Also, two mentioned not using alcohol and drugs and how this seemed to be a part of character-building for them. One person said: "I feel so much better about me. I'm approachable, trustworthy, never been as involved in the Aboriginal community as I didn't grow up on the reserve. I'm more spiritual than before."

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

> My Mom is a Survivor, she attended one performance and I acknowledged her there as a Survivor for the first time.
>
> I'm closer to my Dad who went to residential school, kind of ironic that something that separated us also brought us closer [together].
>
> I learned about their resiliency, compassion, the audience opened up and wanted to talk about things at a very personal level.
>
> They [Survivors] want to do something about it and are just waiting for the right opportunity or circumstance.
>
> A lot of people attended with family members and are now doing things with them. Many wanted to see repeat performances and to bring other family members.

In follow-up telephone calls, communities were asked about the number of clients and families who sought counselling following the performance. After five performances, 41 individuals and 14 families sought counselling and four individuals were referred elsewhere.

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

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

Impact on Community

A majority of the key informants from the project team and sponsoring community organizations believed there will be an impact on the long-term social indicators the AHF hopes to positively influence. In fact,

95 per cent of respondents stated the project will have "a lot" or "some" impact on sexual abuse and 90 per cent believed the same about physical abuse. The following comments were made by key informants on how communities dealt with residential school issues differently or whether services had improved:

> I feel they can now deal with things differently because the conversation has been opened up with a lot of family members. They were all there [together], all crying, all supporting, all spoke. The healing was transpiring right before our eyes.
>
> I saw an impact on frontline workers, development and education, even for the leadership. People feel they must now start organizing, find all avenues for our people to feel safe.
>
> I feel the play can be used as a reference. It made some people want to apply for funding and those already with funding incorporated the play into their work.
>
> One community, Lillooet, said they were talking about starting group meetings for Survivors. People also discussed the play and the impact on them.
>
> I know many people, bands and places we didn't go heard about it [the play]. More people started showing up at healing places on the reserves, one being my stepfather. I've also heard they want more healing.
>
> I feel they are now more informed. Talking equals solutions. Survivors did an honouring at each performance. The community now sees their strength and how Survivors can make contributions to the community.
>
> I know that Survivor support groups were started, even a theatre group in Merritt was started.
>
> After each performance, groups were held, healing circles for Survivors.
>
> I know one Friendship Centre is now running training for counsellors.
>
> Frontline workers at each performance got more understanding of trauma. We recognize basic alcohol and drug counselling isn't enough.

Establishing Partnerships and Ensuring Sustainability

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

Host communities were expected to provide: facilities with a stage and area large enough to house their anticipated audience; marketing; transportation for the audience; a feast; a counsellor; pre- and post-action plans for participant support; and roving counsellors during the performance.[216]

Meaningfully Engaging Survivors (including the intergenerationally impacted)

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

Best Practices

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

More specifically, best practices include the following:

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

Challenges

A number of key informants stated "getting people to come out" was a challenge, especially since the production dealt with such an emotional subject. (In spite of this, performances were reportedly well-attended.) Two informants mentioned "dealing with our own emotions" or "getting over or looking at our own issues and experiences." Even months later, during the interview process, at least two informants became emotional, requiring the interviewer to pause.

Budgetary problems were mentioned. For example, the application under-estimated certain costs. Because project funds were limited, this prohibited the ability to travel to more communities. In addition, four people cited various problems with the project sponsor, including: "the financial management from our host organization, we didn't know if we would get paid at times or working with administrative bodies who aren't all in healing themselves or are unaware of theatre work." Also, a vacuum was created when the original contact person from the host organization departed early.

The recruitment process for the cast posed some challenges. A key requirement became, not so much their acting experience, but their commitment to personal wellness. One informant mentioned the challenge of

"finding actors with a grassroots understanding of culture, spirituality and tradition, then develop that the play." Lastly, reference was made to the subject matter itself and how certain individuals may have found it difficult to hear or talk about these issues.

Ensuring Accountability

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

Lessons Learned

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

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

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

Conclusions

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

One informant, a Survivor, rightly observed: "the spirit of the play will move in the direction it wants to. [We] must move forward, start the real forgiveness, forgetting the memory, move on to bigger and better things, and we are contributors to society." Another Survivor wrote a support letter after witnessing the performance held at the Kelowna Friendship Centre:

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

Recommendations

There were no recommendations as the project was completed.

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

Program Description

This case study reported on the progress of the Qul-Aun Program (HC-36-BC) sponsored by the Tsow-Tun Le Lum Society. The program was selected as an inpatient treatment centre model based on a blend of traditional healing activities and centralized residential care. The Qul-Aun Program is the extension of the two-year pilot for residential school Survivors originally funded by Health Canada and includes: individual daily activity (reading assignments, exercise journal work), men's and women's groups focussing on abuse and abandonment, anger management, inner child work, psychodrama, healing circles, team sports and traditional ceremonies with support of resident Elders. The implementation objective was to develop an inpatient program. This would provide a healing opportunity for those who have issues caused by abuse trauma that contributed to substance abuse relapse and an inability to deal with life stresses in the areas of self-care, parenting and relationships. The main goals were lasting healing and well-being, cultural pride and capacity to address the Legacy. Because the focus of this evaluative effort was on individual treatment, the specific phases of activity are highlighted below:

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

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

Funding: The Aboriginal Healing Foundation (AHF) continued to fund the project as a pilot for one year in the amount of $459,560. The project received an extension, which increased the contribution agreement to $689,340 for a 17-month program. Plus, an in-kind contribution from the substance abuse program in the amount of $235,000 raised the actual total to $924,340. The majority of funding was invested in healing.

Context

Qul-Aun is administered by the Tsow-Tun Le Lum Society in the central Vancouver Island region, although clients arrive from all over British Columbia. The society has operated programs for those suffering from addiction, sex offenders and sexual abuse survivors, and "believes that healing begins with the individual, extends to the family and moves out into the entire community." The society's main funding source is the First Nations Inuit Health Branch of Health Canada; however, some resources do come from Correctional Service of Canada for treatment beds assigned to inmates that participate in Qul-Aun. The centre prides itself in the traditional décor; the building is complemented by a sweat lodge area and a traditional healing pond located in the natural forest that surrounds the centre. The centre has accumulated over fifty partners who continue to contribute to referrals and aftercare.

Outcomes and Measures

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

Tsow-Tun Le Lum Society "Qul-Aun Program" Performance Map

MISSION: The primary mission of the Healing Initiative will be to strengthen the ability of Aboriginal People to live healthy, happy lives and the affirmation of pride in the Aboriginal identity.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Counselling services (e.g., psychodrama, post-traumatic stress therapy, healing/talking circles, traditional ceremonies), solicit feedback, monitor outreach and review aftercare.	Aboriginal adults (> 19 years, status blind, on- or off-reserve) residing near vicinity of TTLL, Vancouver, Yukon and inmates from Correctional Service of Canada.	Increase in pride in Aboriginal identity, confidence, feelings of empowerment, community knowledge of Legacy and personal capacity to address Legacy; and reductions in abuse and feelings of victimization.	Restoration of the emotional, mental, physical and spiritual health and well-being for participants, families and communities; broken cycle of abuse; and lasting healing.
Hire team; review other treatment material for relevance; establish community contacts; held open house; mass mail-outs; news ads; and ongoing staff meetings to review programming.	Not applicable		
Core training for all staff; internships for trauma counsellors; workshops; promote awareness of program; implement special session for frontline workers; and evaluation.	Team delivering trauma treatment.	Increase knowledge and skill to address Legacy.	
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	**Reach**	**Short-term Measures**	**Long-term Measures**
$459,560 (12 months) $680,157 (17 months) plus $235,000 (in-kind)	123 utilized the program	Observed and indirectly (self-) reported changes in substance abuse, violence, use of healthy parenting skills, cultural pride, feelings of empowerment and victimization, understanding of self, knowledge and understanding of Legacy, awareness of needs and issues of Survivors by leadership and referral network, # of community organizations seeking education on the Qul-Aun Program, service demand for residential trauma treatment and measures of skill or capacity to address Legacy.	Need and rate of participation in treatment programs; observed and self-reported changes in parenting skills; and reduced rates of children in care; family violence and suicide (including attempts).
budget for development $18,000	Not applicable	Awareness of the residential school impacts; # of partnerships established (either by formal protocol or informal networking opportunities) between frontline workers addressing impact of the Legacy; documents on issues and needs of residential school Survivors; Survivor feedback on quality of trauma treatment program.	
budget for training $16,000	12 staff trained	Self-report and observed changes in skills, knowledge, treatment application, awareness of needs and issues of Survivors in trainees; solicited feedback from participants about quality of trainees' ability to facilitate healing.	

Participant Characteristics

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

- substance-free for six months inclusive of any active/mood-altering drugs;
- demonstrated pre-/post-treatment support;
- mentally stable, able to participate in intense individual and group counselling;
- prepared to address past trauma in both group and individual experiences;
- committed to review his/her present lifestyle, behaviours and feelings;
- free of any acute care hospital requirements;
- in control of all disease and free from any communicable disease; and
- free of any appointments or court dates that would occur during the program, such as physician or court appearances.

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

At least 90 per cent of all participants (n=123) before or up to July 2001 have a history of physical, sexual and substance abuse, as well as family violence. Almost three-quarters have abused drugs (74%) or have a history of foster care (77%) and over half (65%) lack basic life skills. Forty-six per cent have attempted suicide and 20 per cent have suffered from incest or have a criminal record. The vast majority are First Nations (94%) and some are Métis (3%). There are no Inuit participants at Qul-Aun. An overwhelming majority are residential school Survivors (19%) and, congruent with most other AHF-funded programs nationally, women outnumber men by almost two to one. A small number of Elders (16) and incarcerated individuals (12) have also participated in treatment. Worthy of note is that some of the participant group are also service providers (10).

Project Team

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

Impact

Because the service delivery area is very broad geographically, it is unfair and difficult to focus on one community for changes in rates of suicide, sexual abuse, physical abuse, incarceration or children in care. Therefore, what follows are the sentiments of Qul-Aun's participants regarding the efficacy of the treatment approach when addressing these issues.[217]

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

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

Almost all (>95%) Qul-Aun participants had a history of **physical abuse** or family violence. Physical abuse, anger, violence and spousal abuse were addressed in treatment. There appeared to be an even distribution of the level of satisfaction in the treatment of these issues in both group[218] and individualized settings.[219]

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

Almost half (46%) of Qul-Aun participants have a history of **suicide** *attempt*. While suicide was not specifically addressed in Qul-Aun, self-abuse and depression, both closely related to suicide, were topics of discussion. These topics appeared to create the greatest satisfaction when addressed in the individualized treatment context (n=28: self-abuse; n=29: depression), but were also satisfactorily addressed in the group context by the majority (n=49: self abuse; n=46: depression).

Accountability to the Community

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

Impact on Individuals

There was recognition that a substance-free lifestyle allowed participants to stay focussed and complete treatment sessions. Clients who had prior counselling and understand healing techniques achieved the most (based on referral workers statement), and often required minimal aftercare. The clients who come in with minimal understanding of healing techniques often require longer aftercare/counselling and, most of

the time, need a refresher course or second session. Therefore, it is safe to assume that the five-week session works best if participants have demonstrated a solid commitment to heal, as well as have a support system.

The following were the summarized responses of one-on-one interviews with Qul-Aun team members (4), community referral workers (7) and administration (2), making a total of 13 people. Discussion highlighted the opinions of these key informants regarding change in the Qul-Aun participants and in the community. While the Qul-Aun team was unanimous that an increase in **cultural pride** had occurred (n=4), referral workers (n=6) did not all uniformly share that optimism; however, 80 per cent agreed that a change was noticeable. Respondents most often indicated they observed changes in individual attitudes toward spiritual beliefs and cultural practices evidenced by individuals taking up crafts where there was no interest before; however, they did not believe that all participants had been affected. When asked to estimate how many participants changed, most felt that 50 per cent or more of the participant groups had enhanced feelings of cultural pride. One felt that such change was restricted to less than 10 per cent of the group. Respondents most often attributed changes in individuals to program content. They recognized that the integration of traditional practices honoured at the treatment centre probably accounted for increases in cultural pride. Those who saw little change believed that participants may already have a strong cultural base before arriving at treatment.

When respondents were asked about noted positive changes in **coping patterns**, **self-worth and life skills**, they unanimously agreed that changes were visible (n=13). When asked what evidence of change was observed, respondents equally noted behavioural and cognitive change (e.g., going back to school and higher self-esteem). When asked to estimate the magnitude of change, there was very little discrepancy; it was unanimously felt that 80 per cent of the participants had more confidence, feelings of empowerment, personal capacity to address the Legacy and reduced feelings of victimization. At least two respondents felt positive changes in improved life skills were restricted to a small group (<10% and <20% of the total number of participants). Respondents most often attributed changes to the combined influences of program content, team quality, the cultural component, group dynamics and forms of therapy such as psychodrama. Those who saw little change believed that participants may already have a strong support system or developed life skills and healthy coping patterns from participation in substance abuse treatment programs prior to arriving at Qul-Aun.

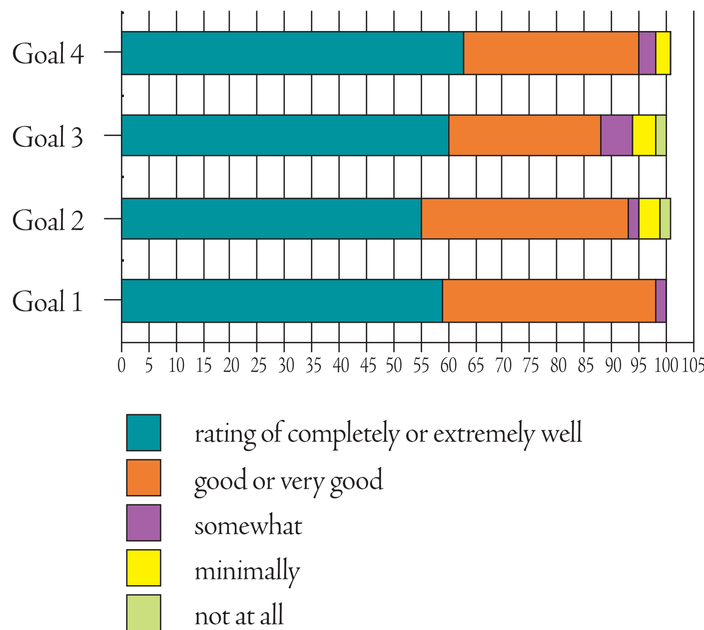
Referral workers noted that many clients **continue with external counselling and self-support groups**; however, staff did not share this analysis. Some believed that participants, who go back to the correctional facility or to remote regions, did not get the support they required. Although most felt that 50 per cent or more of the participant groups had maintained aftercare, one felt that such change was restricted to less than 10 per cent of the group. Respondents most often attributed client maintenance of aftercare to planning, although community isolation or incarceration presented challenges to aftercare.

When respondents were asked about participant **understanding of the Legacy**, they unanimously felt that change was obvious (n=11), although most felt that increased understanding was restricted to about 75 per cent of the participant group. Respondents unanimously credited program content, including psychodrama and history, with participants being able to come to a place of acceptance and understanding of the impact of the Legacy.

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

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

Achievement of participants' personal goals



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

Impact on Community

Respondents were asked about their attitude regarding the **community's understanding of the Legacy** and they unanimously noted that change was obvious (n=13); however, they did not believe that the entire community had been affected. Many (11) felt that at least half of the community or more now has a better understanding of the impact of the Legacy, and two people felt that the change in knowledge and understanding of the Legacy was restricted to a small group (<20% and <10%).

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

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

> Have been empowered to advocate for community healing and have lobbied their local councils to support and encourage healing activities. We have indications that a number of clients have taken on a support role in going to different communities to speak on the issues of the effects of residential schools.[220]

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

Partnerships and Sustainability

Qul-Aun had established credibility with Correctional Service of Canada in serving inmates who were ready for parole and the program was funded per diem for each bed inmates occupied; however, this would not be substantial to run a full program. The centre was reviewing other methods of funding to ensure they continued to meet the needs of the community. Qul-Aun is overseen by the substance abuse treatment program administration and is supported by in-kind contributions from Tsow-Tun Le Lum. The only volunteer element of Qul-Aun is the board of directors who give generously of their time and knowledge. The ability to sustain Qul-Aun activity beyond the life of the AHF is in question.

Addressing the Need

Respondents were asked specifically about Qul-Aun's ability to address physical and sexual abuse and, more generally, about its ability to meet community needs. Almost all informants felt Qul-Aun addressed physical and sexual abuse issues reasonably or very well and that only some improvement may be needed; however, there are still some clients slipping through the system who are not prepared to address these issues.

Best Practices

Among Qul-Aun's best practices are:

- engaging Elders as teachers and peer support counsellors;
- having team members who are Survivors and can model healing;
- using a blend of traditional approaches and Western approaches (most particularly psychodrama);

- ensuring team is well trained, thoroughly healed, professional, compassionate and able to create a safe environment;
- treating participants equally and consistently;
- educating about the Legacy and client rights;
- ensuring participants are well screened with adequate aftercare;
- using an already established centre of healing;
- ensuring participants are selected based upon their commitment to heal, a healthy support system (counselling) and sometimes attendance in the substance abuse treatment program prior to Qul-Aun;
- doing genograms with each individual, which allows them to walk through their own history to clarify what patterns they learned and emphasize they have a choice to NOT repeat this pattern; and
- having weekly clinical supervision from professional consultants (psychologist, medical doctor, dietician, nurse, Alcoholics Anonymous sponsors and parole officer).

Challenges

Regular difficulties associated with programming include:

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

Lessons Learned

Bunk beds and the use of flashlights on night patrol are clear triggers for some clients. One employee felt these features of a residential inpatient facility can sometime keep participants from coming. Other triggers of inpatient treatment are related to food quality, which is not always optimal in institutional environments. Qul-Aun has also learned that:

- family-of-origin discussions are essential to breaking through self-blame;
- participants require solid preparation for residential trauma treatment;
- referral workers require more information about Qul-Aun; and
- there is a clear need for behavioural boundaries in treatment.

Conclusions

Although it is premature to conclude that Qul-Aun has developed lasting healing from the Legacy, it would be safe to say there is tremendous instant gratification for up to six months after completing the program. Participants credit Qul-Aun in helping them to achieve their personal goals, deal with historical trauma and face the ever-present stressors of life. The overall message from the community is that the program is very well respected and accepted for its admirable standard of service delivery and success rates.

Recommendations

Clearly, Qul-Aun cannot, on its own, significantly influence any change in the entire province. To that end, it is clear that a 12- to 24-month follow-up of Qul-Aun *participants* should include some answers to the following questions adapted from the evaluation plan submitted with Qul-Aun's proposal. These identify the key evaluation questions to be answered, as well as the possible indicators that could be used to identify the long-term impact of Qul-Aun:

- Do clients achieve an enduring sense of peace and resolution of specific traumas and issues?
  Possible indicator: client mental and physical health status.
- Do clients acquire specific life skills, routines and techniques to help them maintain harmony and stability in their daily lives (e.g., structure and rules, constructive management of family, work and leisure time, stress management)?
  Possible Indicators: stability and place of client living situation (e.g., marital home, with friends, boarding, transient on the street) and use of routine in day-to-day life (e.g., gets up in the morning at a regular time, has meals at a regular time, goes to work at a certain time).
- Are community aftercare support systems developed to help maintain client abstinence from alcohol/ drugs for an extended period (e.g., one year)?
- Do clients develop and implement life plan goals and objectives (e.g., to get a job, continue school, improve family relations, develop and use other methods in dealing with people and their environment that reflect quality existence rather than immediate gratification)?
  Possible Indicators: client employment or attendance at school, degree of client commitment and achievement of life plan and goals, degree to which client copes with stressful situations without utilizing alcohol/drugs.
- Do clients develop a social and therapeutic network of friends and counselling support such that they are not alone and can get help when needed?
  Possible Indicators: existence of family/social support network, involvement in other counselling and attendance at self-help groups.
- Do clients develop an improved sense of self-worth and a more realistic perception of who they are and what they can contribute to their community?
  Possible Indicators: degree to which client is able to see self clearly and realistically, degree to which client wants higher quality of life and extent to which client participates in community.

- What other benefits do clients achieve in terms of improved functioning in areas of work, family life, educational upgrading and health?

At the time of data collection, this information was not available for graduates of the Qul-Aun program, but would be the most valuable information to secure to determine the long-term impacts of Qul-Aun.

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

Project Description

The project addressed here is the Tawow Healing Home delivered by the Shining Mountains Living Community Services (SMLCS) of Red Deer, Alberta. The primary purpose of the project is to provide a culturally-based, non-mandated therapeutic home environment for Aboriginal children/adolescents and their families at risk for involvement with protective services. The project was selected for a case study because it covered services in an *urban* context that strengthens *parenting skills* using *traditional* approaches and *land-based activities*. Key components of the project were to ensure:

- service delivery by Aboriginal providers;
- independence in parenting through modelling, positive encouragement and partnership between the parent(s) and healing helper(s) (co-parenting);
- the use of traditional teaching, recreation, values and parenting methods;
- a safe, comprehensive cooperative approach working with community resources;
- service specific to the unique needs and beliefs of the Aboriginal person;
- and aftercare.

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

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

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

Funding: Co-funding for this project was provided by the Métis Local #84, SMLCS and through private donation. The program makes use of services available from other agencies, such as the Family Life Improvement Program (FLIP) newly offered by the Native Counselling Services of Alberta. The Tawow Healing Home, located 20 minutes north from downtown Red Deer, has an ideal country home setting that gives a feeling of comfort and warmth, and is an isolated five-bedroom house with a large lot for play. The house mother lives in the home to provide full-time care. The home can provide care to approximately three to four families at one time.

The Project Team – Personnel, Training and Volunteers

SMLCS, established in 1995, has experience administering and delivering a variety of programs[221] and shares facilities with four other Aboriginal agencies. The Tawow Healing Home has three team members. A large portion of program responsibilities are shared by the executive director and the bookkeeper. The director has extensive experience in addiction, rehabilitation, crisis, family and life counselling. The third team member, a live-in house mother, had the most contact with participants by providing motherly care in a holistic, traditional Cree way. Four Elders visited the project and provided consultation and traditional

wisdom, and received honoraria for this service. Volunteers consist of three Survivors who gave support and circle guidance to SMLCS team members and participants; two youth who attended yard care and provided support to the younger children in recreational pursuits; and one parent/grandparent who offered transportation, social interaction and yard care. The number of board members seemed to fluctuate from four to six and included both Aboriginal and non-Aboriginal community members. Political posturing had caused some complications for the board.

Participant Characteristics

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

Community Context

Red Deer, Alberta is an urban community located halfway between Calgary and Edmonton with a population of 68,308.[222] The city is known for its growing agriculture, oil and gas industries, which feed increases in employment and population growth, but also creates a zero per cent vacancy rate. Red Deer has a reputation as a hostile environment: landlords are reluctant to rent to Aboriginal people and employers are reluctant to hire them as well. A highly transient population means many homeless youth fall victim to prostitution and substance abuse. On a more positive note, in the past fifteen years, Aboriginal organizations and services in Red Deer have grown and formed an interdisciplinary team of integrated services where SMLCS is the only *non-mandated* family service option. While there is an unknown number of Survivors in the area, there were three residential schools around Red Deer: Ermineskin Indian Residential School in Hobbema run by the Roman Catholic Church from 1916 to 1973; Blue Quills Indian Residential School aka St. Paul's Residential School in St. Paul run by the Roman Catholic Church from 1931 to 1970; and Red Deer Industrial School aka Red Deer Boarding School in Red Deer run by the Methodist Church from 1889 to 1944.[223]

Outcomes and Measures

Tawow provided a structured home environment for the family as a *unit* that was *nonthreatening* and *voluntary*. During the participants' stay, they were encouraged to: learn parenting and life skills through role-modelling and participation in parenting classes; increase their knowledge of culture and language through participation of traditional activities; seek employment/training or education; as well as dialogue with their family,

SMLCS team members and other participants through the use of healing/talking circles and day-to-day activities. Through these activities, it is the project's long-term hope that families will be healed and reunited, the cycle of abuse will be broken and a self-supporting community on its healing journey will exist. The relationship between project activities and short- and long-term benefits is set out in the following performance map.

Shining Mountains Living Community Services Performance Map

MISSION: Tawow Healing Home project seeks to restore, rebuild and reunify our children, families and communities in physical, emotional, intellectual and spiritual health.			
HOW?	WHO?	WHAT do we want?	WHY?
Resources	Reach	Results	
activities/outputs		short-term outcomes	long-term outcomes
Provide a cohesive, adaptable and welcoming program of family care; provide opportunities for family growth and parenting skills development during residence through modelling, positive encouragement and genuine partnership between the parent(s) and healing helper(s); utilize traditional teaching, recreation, values and parenting methods; provide a comprehensive cooperative approach for families to access community resources based on the principles of healing and family empowerment to promote the growth of the family; provide healing environment services specific to the unique needs and beliefs of the Aboriginal person; maintain safety and security of the family; and build independence in parenting and self-sufficiency based on significance, power, competence and virtue (the 4 bases of self-esteem and traditional educational practices).	Aboriginal children/adolescents and their families at risk for involvement with protective services.	Reduce occurrences of family violence within participant families; increase involvement of participant families in community activities, traditional activities, counselling sessions and education or employment; reduce the contributory factors that lead to family breakdown with our target population; increase awareness of services available to assist family function in the community; and increase in dependence in parenting and self-sufficiency.	Create a self-supporting healing community.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Budget	Reach	Short-term Measures	Long-term Measures
$150,000	14 Aboriginal children and their families (9 adults) at risk with protective services in Red Deer, Hobbema and Rocky Mountain House.	Participation in co-parenting, traditional activities, community activities, counselling sessions, employment and education; reduced occurrences of family violence; observed changes in awareness of available services; and observed changes in parenting behaviour and self-sufficiency.	Reduced rates in family violence, children in care and incarceration; and change in number of families involved in community.

Impact on Individuals

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

Parent-child interactions were characterized as more patient, confident and nurturing, as evidenced by parental investments in cooking, laundry, play and quality time spent with their children. Before attending the program, one parent was ready to give up on her oldest child, but now wants to keep the family together. For most respondents (7 of 8), this change was obvious in all participants to some degree. Many respondents believed that **parenting skills** had improved because most participants were making decisions independent of social services. Many parents, who entered the program with a lot of aggression, left better able to discuss issues with respect and not just "fly off the handle." Most informants (6 of 9) felt that changes in parenting skill were obvious in all participants. Direct feedback forms and interviews (collected by the project team from Tawow participants) revealed that participants came away with a more positive approach to caring for their families and a more positive approach to life in general.

With respect to **self-sufficiency**, some participants (who were not doing so before their participation in Tawow) decided to seek or secure employment, training or educational opportunities. Informants observed that participants started to do things more on their own without asking for help and that two of the participant families had become stable and were living on their own. *(It should be noted that one of these families came from a homeless situation.)* What was noted is that participants were increasingly able to resist the confining regulations imposed by social services and had become more assertive by asking for what they needed. One respondent felt there was a change in independence, but not in self-sufficiency because of the reliance on the welfare system (all participants, even the ones who have already gone through the program, rely partially or wholly on social assistance). One problem noted was that participants relied heavily on SMLCS team members to get them to their appointments and classes due to the home being outside the city. All respondents felt that at least half of participating families increased their level of independence and self-sufficiency.

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

Changes in individual participants were credited to:

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

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

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

Impact on Community

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

The project estimates that there are 1,240 (11.3%)[224] Aboriginal community members in Red Deer suffering from **physical abuse**.[225] Out of 13 respondents, 53.8 per cent felt there was a decrease in the rate for physical abuse and 46.2 per cent were unsure. This perception was supported by data on *reported* assaults obtained from the RCMP detachment in Red Deer. Clearly, there was an overall decrease in assault cases in 2001, which may have been affected by the increase in employment opportunities, new programs or a highly migratory population. The following table reveals indicator data on physical abuse.

Reported Complaints of Physical Abuse[226]

Crime Code	January 1-August 31, 2000	January 1-August 31, 2001
Assault (level 1)	590	481
Assault weapon/bodily harm	60	32
Aggravated assault	5	3
Assault causing bodily harm	2	3
Total	657	519

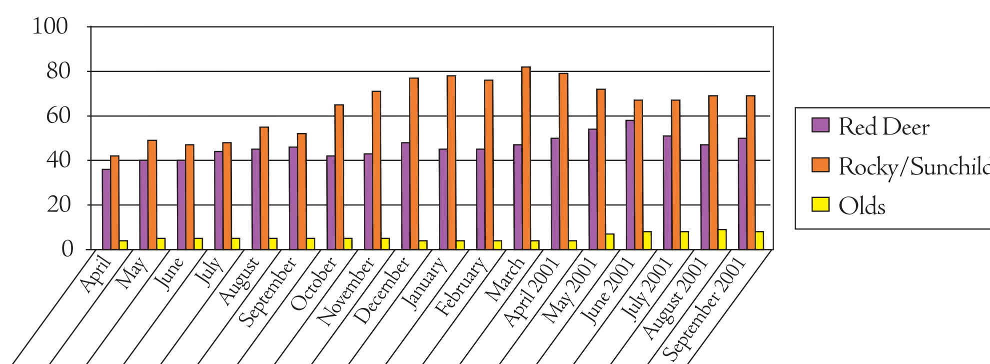
The project estimates there are 360 (3.3%)[227] Aboriginal community members in Red Deer suffering from **sexual abuse**.[228] Only 4 of 13 (30.8%) respondents felt the rate for sexual abuse had decreased and the rest (69.2%) were unsure if there was any change. The table below indicates the number of *reported* sexual assaults and may or may not include Aboriginal people. Although the numbers indicate very few attacks, it is *very likely* that a much greater number is undisclosed. These data are clearly in contrast to the opinions of respondents to the AHF Supplementary Survey.

Reported Complaints of Sexual Abuse[229]

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

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

Total Number of Aboriginal Children in Care (Red Deer, Rocky/Sunchild, Olds)[230] for 2000/2001



The current total population for Red Deer is 68,308. If we assume that roughly 3.45 per cent[231] of the population is Aboriginal, then it is estimated there were 825 Aboriginal children[232] under the age of 15 living in Red Deer in 2001. The project estimated there were 454 children in care[233] in the Red Deer area, which probably included rates from Hobbema and Rocky Mountain. Looking at children from Red Deer alone, a total of 286 Aboriginal children were placed in care (temporary and long-term care between 1 January 2001 to 4 October 2001) through the intervention of the Red Deer Native Friendship Society (RDNFS).[234] Caution is required in interpreting this information because no information could be obtained on the exact number of children who were in and out through a 'revolving door' child care system. In other words, one child could be counted more than once in the total number of children placed in care. When questioned about whether or not rates of children in care had changed, opinions from respondents differed slightly. About half the respondents (46.2%) felt there was a decrease in the rates for children in care, 15.4 per cent felt there was an increase, 7.7 per cent felt there was no change and 30.8 per cent were unsure.

The project estimated that 125 (1.1%)[235] Aboriginal community members have been **incarcerated**. Out of 13 respondents, one felt there was an increase and one felt there was a decrease in the rates for incarceration. The rest of the respondents were not sure.

The project estimated there were 42 (0.4%)[236] Aboriginal people who either attempted or committed **suicide** within the past year. Although it was already mentioned there was an increase in suicides in Hobbema during the past summer (one respondent said there were a total of four suicides), 46.2 per cent

still felt that, overall, there was a decrease in the rates for suicide. These respondents, who are leaders of the Aboriginal community in Red Deer, perceive that suicide is on a decline and that the rash of suicides in Hobbema was not indicative of a trend. However, the majority (53.8%) could not decide whether rates had changed. The table below shows a slight decrease in the number of Aboriginal suicides for the province of Alberta. The following tables were prepared with statistics provided by the Office of the Chief Medical Examiner of Alberta.

Number of Deaths by Suicide by Aboriginal Identity in Alberta

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

The next table shows that 11.6 per cent of Aboriginal suicides in Alberta for 2000 took place in Hobbema and Rocky Mountain House, while there were no suicides in the city of Red Deer for that year. Also, it shows that 31.4 per cent of Aboriginal suicides in Alberta for 2001 took place in Red Deer and Hobbema. This percentage indicates a severe increase in the number of suicides for this region within the past year and negates the opinions of some respondents.

Number of Aboriginal Suicides by Age for 2000

	Red Deer				Hobbema				Rocky Mountain House				
	2002		2001		2002		2001		2000			2001	
Age	M	F	M	F	M	F	M	F	M	F	Un-known	M	F
Under 15						1		2					
15-19								3					
20-24					1		2	2					
25-44			1				1						
Unknown											3		
Total	0	0	1	0	1	1	3	7	0	0	3	0	0

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

Partnerships and Sustainability

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

Successes and Best Practices

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

Challenges

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

Addressing the Need

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

Lessons Learned

The importance of whole family therapy and traditional ways has been key to *keeping* families together. What was recommended is that hands-on bush experience was needed. The project team felt the need to

modify intake forms and referral processes to better detect FAS/FAE, as well as to clarify whether or not to accept FAE participants. Also clear is that one alternative care home is not enough. Increasing service and team capacity are felt to be urgent matters to adequately meet needs. Facility restrictions (e.g., having one bathroom) also caused some challenges.

Conclusions

As a ***whole family, non-mandated***, culturally sensitive therapy facilitated by cultural insiders in a home setting, Tawow appeared to be having a positive influence on most who participated (although not all responded to the same degree). Also, this service was well received by the community. SMLCS Tawow Healing Home appears to be having an impact on the majority of participants. Clearly, the program is not able to address serious special needs alone, and it is not clear how enduring the changes noted thus far will be nor to what extent they are life-altering. Also unclear is what extent is the role of referring agencies, broader community development and established partnerships contribute to these changes (e.g., FLIP). The house mother, who is credited with much of Tawow's success, may be one of the more powerful influencing elements of Tawow. Unfortunately, the project is reaching only a small number of its target group; therefore, community impact is limited. If resources are not forthcoming, both personnel and financial, the Tawow Healing Home will no longer exist or expand its reach. The difficulties in establishing partnerships caused by differing philosophies and practices with child welfare agencies decreases Tawow's chances of sustainability.

Recommendations

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

- make time to summarize oral reports into a written format for evaluative purposes to give proof of positive impact on participants;
- give more detail in AHF activity reports to show AHF that the project is addressing the Legacy and needs that were set out in the proposal;
- increase efforts to pursue other resources outside the child welfare system in order to sustain and expand the project to reach more of its target group and to maintain project integrity; and
- amend intake forms regarding mental health as the project has no in-house counsellor to deal with critical mental health issues (e.g., FAE).

With respect to the continued evaluation of Tawow, it is recommended that the intake form be used as a baseline measure. Also recommended is that the project team should summarize **all** participants' information regarding personal, educational, vocational, criminal and treatment histories, as well as level of functioning in the home, as a relationship with husband/wife/partner, in the workplace, with their own children, friends and parents. The intake form could be used as a follow-up at the end of the program, six months and one year later during aftercare. This is valuable information that can be used to evaluate the project's effectiveness and is a powerful tool that can be used when securing resources for the program. In addition, it would also be useful to examine social indicators discussed here (e.g., children in care, sexual and physical abuse, suicide, incarceration) in 2007 to determine trends over time.

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

Project Description

This case study was selected to reveal the unique challenges facing urban-based projects with First Nations, Métis, homeless and incarcerated beneficiaries from a western geographical perspective. The project that forms the basis for this case study is titled "Healing the Multi-generational Effects of Residential School Placement – Urban Access Program" (AHF Project # CT-2429-SK/1256). The program, more commonly known as Building A Nation or BAN, provided healing activities and continuing support. A review of quarterly reports show that two key training programs were offered (Aboriginal Parenting Skills and Counselling First Responders). The latter became known as A.C.C.E.S.S., which stands for Aboriginal Counselling and Cultural Education Strategies and Systems and offered four levels of certification. In addition to the individual and group counselling, healing activities included traditional celebrations and ceremonies, continuing support (e.g., drop-in centre, client advocacy for those involved with the justice system, child custody) and social gatherings. Training was considered part of the continuing support to help individuals manage personal and familial crisis independently.

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

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

Project Team

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

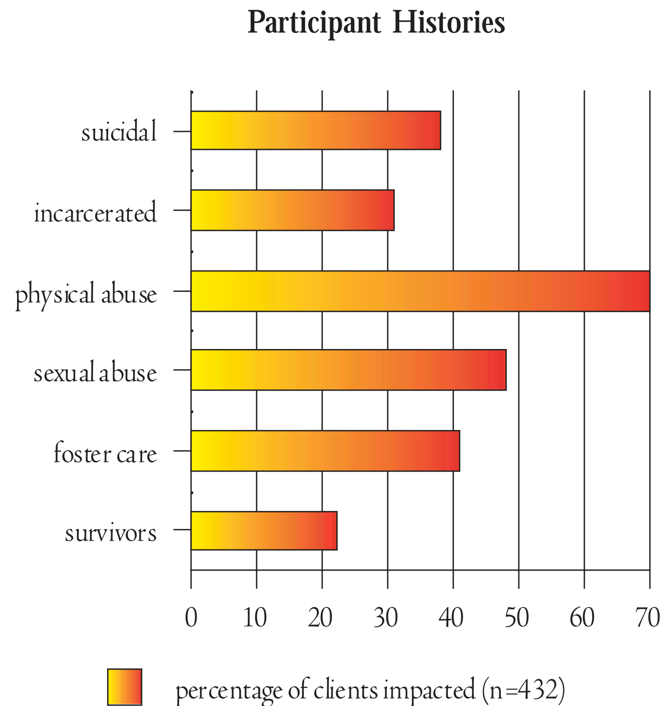
BAN Project Team

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

In addition to the project team, an advisory board was established with designated Survivors. The "Advisory Board will have direct input to the design of data gathering instruments, analysis of data, and both formative and summative evaluation phases of project management and reporting."[237]

Participant Characteristics

Participants were described as "likely multi-addicted, prone to a lifestyle of dependency and living from crisis to crisis, involvement with the criminal justice system, minimal, if any, understanding of Aboriginal culture, past and current family violence and low self-esteem." The vast majority (70%) have experienced physical abuse and many (slightly less than 50%) are sexual abuse victims with a history of suicide attempts and ideation. Just over 40 per cent have been wards of the province.



The percentage of *direct* Survivors (e.g., those who attended residential school) remained at or near the 80 per cent mark; it should be noted that virtually all were dependent upon social assistance and *men appeared to have higher participation rates in healing activity than women.*[238] Severe participant challenges (more than 80%) were identified as: lack of Survivor involvement; incarceration; denial, fear, grief; lack of parenting skills; history of suicide attempts; history of abuse as a victim; history of abuse as an abuser; history of foster care; family drug or alcohol addictions; poverty; and lack of communication skills.[239]

Context

Very little information was found on the indicators selected (e.g., suicide, children in care, physical abuse, sexual abuse and incarceration) for the Aboriginal population in *Saskatoon*. Figures for the province and for the non-Aboriginal population are intended *only* to provide a general context. Saskatoon has a population of between 193,647 and 219,056, of which 16,160 are Aboriginal.[240]

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

> The Saskatoon area has the full range of services expected in a major city, but access to these is severely limited compared to the need in Aboriginal families; none of these [services] has adequate Aboriginal content or cultural sensitivity to Aboriginal values; even though Aboriginal persons are hired by these service organizations and institutions, they are obligated to honor the mainstream policy environments into which they are hired; mainstream denial and de-culturation mechanisms dominate what address is given to Aboriginal issues.[241]

The following unemployment figures showed Saskatoon had a 7.5 per cent rate, slightly higher for males at 7.7 per cent than females at 7.4 per cent.[242] In Saskatchewan, as of 31 March 1999, there were 3,392 families receiving child protection services with 2,710 children in care, and 65 per cent were First Nation and Métis. According to the Saskatchewan Social Services annual report for 2000-2001, the two main causes for child protection involvement were "physical neglect and lack of parenting ability."[243] Sexual assault figures for all of Saskatchewan were 1,525 in the year 2000.[244] For Saskatoon, there were 347 sex offences in 1991 and 274 in 1996.[245] Saskatoon had 722 major assaults and 1,523 common assaults[246] in 1996, an increase of about 37 per cent over previous years.[247] In 1999, Saskatchewan had "1,144 inmates in provincial custody"[248] with a clear overrepresentation of Aboriginal offenders. In Canada as a whole, Aboriginal over-representation is greatest in the Prairie provinces.[249] Further information showed that "Aboriginal peoples represent 2.8% of the Canadian population, but account for 18% of the federally incarcerated population."[250]

In addition, the number of young offenders in Saskatchewan, regardless of ethnicity, have been steadily increasing annually since 1992 by about 6 per cent.[251] In 1992-1993, there were 291 young offenders in custody in Saskatchewan and, in 1998-1999, the figure was 398.[252] The three-year national average rate of suicide for First Nations people was 38 per 100,000, about three times higher than the national average.[253] Over a four-year period, suicide accounted for 23 per cent[254] of injury and poisoning deaths in Saskatchewan for First Nations people.

Outcomes and Measures

The logical link between BAN's activities, what they hope to achieve in the short-term, and the desired long-term outcomes, as well as performance measures, have been summarized and presented in the table on the following page.

Building A Nation Logic Model

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

Impact on Individuals

While the more detailed impact of BAN intervention on individual lives (see logic model for list of indicators) remained unclear, the project did offer opportunity for individuals to move toward reclamation of a healthy, stable, functional life *without* any service interruption commonly associated with other short-lived interventions (e.g., counselling offered under the Non-Insured Health Benefits Program). In addition, some evidence was secured to suggest that BAN had an impact upon some participants that led to an enduring commitment to engage in addictions treatment, greater cultural identity/pride and community spirit, increased understanding and use of traditional healing and increased access to culturally appropriate human services. BAN's inclusive, family orientation has led to a reduced risk of child apprehension, which they attributed to their ability to provide *skilled* support during crisis and more general support for lone-parent households. Some participants have developed sufficient leadership skills, such that they now manage the administrative details associated with group events (e.g., advertising, scheduling). Overall, respondents felt that BAN was able to achieve desired results reasonably well. This belief was based on the fact that the project receives unsolicited calls from referral agents and clients who say so. They also felt that the comprehensive and ***voluntary*** nature of their services (e.g., culturally appropriate healing, advocacy and support as well as life skills reinforcement that emphasizes self-responsibility) helped. Ideally, the evaluation plan to measure individual and family impact should be implemented.

Some young offenders represent a third or fourth generation dependent upon social assistance. When they become teen parents, as many of them do, the cycle continues; but, like other teens: "All they want is love, they need a comfort zone ... We have positive activities, they take it all in, absorb all of it." Informants believe that a bond based on trust has developed between young people and the BAN team. Evidence of this relationship is best illustrated by the fact "they [the young offenders] always come back, if not this month, next month." Furthermore, a sense of belonging was created and self-discipline cultivated, which the team credited to the cultural components of the program (e.g., impulse control taught in sweats). At last, BAN represents a new system with various layers of support not offered elsewhere (e.g., help looking for parents or apartment hunting).

Part of BAN activity included a ten-week theatre program (Circle of Voices) to help all youth (ages 12 to 26) feel safe to creatively express themselves, build self-esteem, as well as learn about theatrical production. Over time, it became clear that this young group became dependent upon each other for support and encouragement, felt a sense of responsibility to the group and grew determined to create a solid production. They eagerly anticipated the talking circles and showed respect and kindness to the volunteer and Elder support that made *Circle of Voices* possible. The youth became increasingly confident and more willing to take risks. In fact, one participant went to an audition for a film project and landed the part; another was approached by a production company for a job. Family members were also influenced as evidenced by their voluntary attendance at daily workshops, involvement in talking circles and support for the theatrical production. Some parents even motivated their children to continue in the performing arts industry.

One hundred and fifty-three people completed the Counselling First Responders training from the start of the project until March 2002. However, it was not clear to what extent participants acquired the necessary knowledge or skill to effectively manage crisis in their lives. However, the BAN team felt that training provided them with a greater sense of self-responsibility, understanding of the power of forgiveness in healing, knowledge of traditional values, as well as a dream about how Canada could be a place where

Aboriginal people would be recognized, respected and accepted. Also, the need for Legacy education was consistently reinforced, not just for participants, but for a variety of human service agencies.

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

Impact on Families

While it was unclear to what extent family therapy ultimately led to desirable outcomes, respondents *were* clear that the challenges facing families were many (e.g., poverty and addiction). It should be noted that virtually all participants were dependent upon social assistance. If family members were not victimized directly, they witnessed horrific acts of violence and *client needs often exceeded program capacity*. Still, whole family treatment served as a "reality check" by helping families recognize and accept the need for change. Family sessions also helped strengthen healthy communication skills. The philosophical approach at BAN was that healing came first and justice issues came later. In part, this philosophy helped establish trust that was critical to engaging families in a way that would facilitate results. Such trust was also credited to BAN being Aboriginally-owned, with a team majority of First Nations and Métis, as well as a sensitivity to Legacy issues and cultural understanding.

Impact on Community

BAN's team has a *good* reputation. They are perceived as friendly, understanding, prompt, conscientious, respectful and easy to work with. There were *always* people in the sitting area. External agencies further noted that BAN training was excellent, but recommended a more balanced approach to the relationship between Aboriginal and non-Aboriginal people. The informant acknowledged that the history was not always pleasant, but felt that enlisting allies might require a less threatening approach.

Referral agents have noted that some of the clients shared with BAN became involved (in BAN) as a result of their own initiative, resulting in increased access to advocacy services. Sometimes, referral agents were frustrated by the lack of progress in *their own* approach. Even with the support of various provincial departments, agents have referred several clients to BAN and believe they need to refer *more.*

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

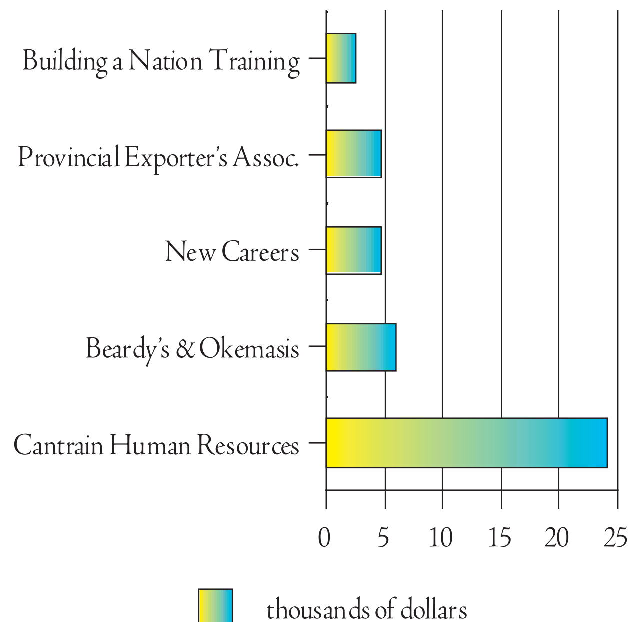
> Building A Nation's board is comprised of First Nations, French speaking people, Métis and white. We had to learn to work out our differences and how to bridge the gap. When we formed our board, we did not see eye-to-eye, but it worked. We learned about each other. We learned about each other's culture.[255]

Finally, there was a noted increase in demand for the Counselling First Responders (CFR) course that led BAN to seek registration as a private vocational school (BANTI) with the province so that trainees can receive certification. Also, court referrals for community release programs managed by BAN have increased over time. Saskatoon courts recognize BAN as an "alternative sentencing" program, possibly the result of more culturally sensitive staff in these agencies.

Partnerships and Sustainability

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

Funds Donated by Partners



The *Circle of Voices* youth theatre production was supported by the Westmount Community School, Dark Horse Studio, Blue Hills Productions and the Saskatoon Fringe. Some external informants, although not all, felt their organization benefited from the work done by BAN. BAN had many formal referral systems with other organizations. Many have taken BAN training, including the Saskatoon Police's Aboriginal cultural coordinator. Each school year, roughly fifty children come for an information session on the Legacy, including social services and the program coordinator at a local youth group home. Some referral agents felt that BAN facilitated 'bridge-building' between agencies with different worldviews, and that the cultural orientation and Legacy education was definitely needed.

Accountability

Although informants felt BAN was engaging in clear and realistic communication with the community, they acknowledged communication was a challenge with their target group (e.g., homeless or incarcerated individuals who could be highly transient). Their most successful strategy is to use monthly feasts for sharing information and soliciting feedback. Informants were mindful that a balance was required between active outreach, extensive public relations campaigns and delivering services to clients who find themselves in a constant state of crisis. When priorities have to be set, client needs came first. Although they believe some improvements could be made, none were offered. There was also no indication that community meetings occurred or whether board meetings were open to the public.

Addressing the Need

All felt the program was addressing the needs of participants very or reasonably well, although some felt there was room for improvement. Remarkably, all who attended (and this included five to seven new people each week) continued coming, even if only sporadically. In other words, no clients were 'lost.' Informants believe their efforts to cultivate trust and offer client-centered support with counsellors sensitive to Legacy issues are the reasons for program popularity. When improvements were suggested, they were related to the time and support required to move through all healing phases.

Best Practices

- Medicine wheel-based counselling encourages self-directed learning and growth;
- role modelling was an effective strategy for creating healthy lives for beneficiaries;
- being a client *advocate*, first and foremost, without feeling the obligation to adhere to governmental agency-based policy was a highly-regarded philosophical foundation;
- an Aboriginal team, some of who speak an Aboriginal language, was believed to contribute to desired outcomes;
- Aboriginal control of Aboriginal programming in an urban area where few other similar services exist; and
- BAN attempts to offer clarity in the therapeutic process by helping individuals to identify their strengths and weaknesses. They do this by blending Western tools (e.g., Myers-Briggs) within a culturally appropriate framework for analysis (e.g., the medicine wheel). This exercise was done solely for the expressed purpose of offering clients insight, which apparently worked very well to create self-awareness, establish trust and integrate Western and traditional approaches.

Challenges

Merging with provincial agencies to provide seamless service was a challenge due to a lack of understanding about the Legacy, the dis-empowering nature of mainstream services and cultural domination. Some external agencies were resistant to the restorative nature of BAN's clinical and adjunctive programming.

Many participants came from harsh circumstances, often experiencing *several* layers of difficulties. Service demand, burnout, over-scheduling, and double-duty (e.g., management and service delivery) also stressed the team. Managing caseloads became problematic as the client base grew and the amount of time involved

in meeting requests for counselling was overwhelming. Furthermore, community release plans increased pressure for more adjunctive activities *(e.g., support related to housing, employment, life skills development).* Being unfamiliar with the justice system posed a barrier early in the project's mandate. Also, administrative costs, such as accountant's and lawyer's fees, became burdensome.

Programming issues listed as barriers include: transportation during daytime hours as "some clients cannot afford it [transportation] or daycare;" tuition fees for training provided by BAN; and the unique challenges that come with servicing a homeless population. Informants reinforced the importance of having a devoted Aboriginal team motivated by their desire to inspire others toward healing, most particularly Elders, together with an immediate need for more Aboriginal people trained in both standard-recognized and traditional therapies. The project also struggled with evaluation skills and requirements. The planned evaluation appeared to have been only used for the theatre production.

Lessons Learned

What became clear to team members was the extent to which Cree and Euro-Christian worldviews were fundamentally different. They gained clarity about their identity, as well as the extent to which systemic racism and forced cultural assimilation had affected not only their lives, but the undercurrent of rage in their communities. Some had no idea of the extent of the abuse, family breakdown or level of hurt. BAN *finally offered a social explanation* for the impact of the Legacy that other individual and symptom-focussed treatment programs had not.

There was insufficient attention to establish ongoing funding commitments. Some felt that the strength of partnerships needed to extend beyond financial support to include an integrated service network. The team also warned against simultaneous training and program delivery. Training cannot occur when you need a team that must deliver services immediately; but, the combination of having skilled traditional and clinical therapists working together meant prompt movement from assessment and planning to healing.

Conclusions

BAN is proving to be a resource for a significant amount of Aboriginal people living in Saskatoon. Referrals and client numbers have increased steadily and most return for ongoing counselling and support. The project has created an environment where participants feel they belong and are respected. Positive results were most often attributed to the *culturally appropriate* services offered. When change was not immediately apparent, the team acknowledged that the stresses of undergoing healing and training, while maintaining economic self-sufficiency, was a harsh reality and was a struggle for some participants. Referral agents also acknowledged that the target group (especially incarcerated and homeless individuals) were a challenging group to maintain. The project has created a better understanding of Aboriginal culture within mainstream service agencies in Saskatoon. Finally, it can be stated that BAN is clearly filling a need by offering a continuum of services where previous gaps existed.

Recommendations

- *Focus* the effort either by reducing the target or identifying *more realistically attainable* outcomes for such a broadly based and multi-challenged beneficiary group;
- provide more clarity about how Western and traditional healing methods complement each other or blend together;
- following through with the plan to develop a 'Survivor's assessment protocol' adapted or blended from widely recognized tools and well suited to the cultural context;
- partnerships should continue to be nurtured to provide needed support for adjunctive services. Also, partnerships should be strategically selected so that efforts to raise awareness in and train external agents to address the Legacy are sufficiently resourced with detailed curricula and time;
- merge program databases to provide one record; and
- revisit the evaluation plan to gauge the effectiveness of key program components,[256] which include collecting information on:
  - measurable change in participant life satisfaction;
  - measurable degree of satisfaction of participant family members;
  - observable change in self-sufficiency;
  - effectiveness of project management; and
  - degree to which the project builds longevity past AHF funding.

Willow Bunch Métis Local #17: Willow Bunch Healing Project
(AHF Project # 1176-SK)

Project Description

The Willow Bunch Healing Project delivered by the Willow Bunch Métis Local #17 of Willow Bunch, Saskatchewan, (AHF Project # 1176-SK) intends to "give a positive awareness of history of the Willow Bunch Métis to the community ... [and] increase pride in being Métis."[257] This case study covers the following project types and targets: Métis, rural, West, materials development.

Target Groups: The target group includes Métis and others living in Willow Bunch, Saskatchewan.

Funding: The project commencement date was 1 October 2000 and was funded as a one-year project that ended 30 September 2001 with a contribution in the amount of $109,200.

The Project Team

The Métis Local (referred to as "the Local") was established in the 1940s, but has never received core funding nor delivered services from an established location until it was supported by the AHF; it existed solely through membership fees and the elected board participated on a voluntary basis. Although the process evaluation survey stated the project had four full-time employees, two part-time employees and a number of volunteers who contributed approximately forty hours per month, it became clear that the project coordinator was the only full-time team member. The consultant and researcher visit the project three to four days per month. There was another researcher/interviewer for the first six months, but is no longer with the project.

The project coordinator is Métis, born in Willow Bunch, but left when he was ten years old and returned years later to settle in the community. He was president of the Willow Bunch Métis Local #17 from 1996 to 2000. He stepped down as president in order to become the project coordinator. Since 1996, he has been involved in various Métis and community issues. The project consultant (co-coordinator for current AHF-funded year) is also Métis, with familial ties to Willow Bunch, who has offered consulting services on many projects for a number of Aboriginal organizations and governments. The researcher/writer holds a Ph.D., M.Ed. and a B.A. She has completed an extensive list of reports for a number of Aboriginal organizations, both national and provincial. According to the project coordinator, 30-35 volunteers contributed to the Local office set-up. One Elder, whose family members are prominent ranchers, is involved. Involvement of youth seems limited as there is only one youth volunteer at present. The advisory committee for the AHF-sponsored project is also the board of directors for the Local.

Participant Characteristics

Activities where participation was estimated include:

- the Métis fiddle dine and dance (150-300 people attended);
- a workshop on Métis identity (50 people attended and all were Métis from Assiniboia, Wood Mountain, Rock Glen and Willow Bunch); and
- a cultural day event at school (120 participants of whom 110 were students).

All other activities that occurred did not indicate participant estimates or gave further details on participant characteristics.

Context

The town of Willow Bunch, Saskatchewan, is located at the southern end of the province. Many homes and buildings are empty with long-standing "for sale" signs out front, giving the town an almost abandoned look. Services include a garage, motel/restaurant, tavern, gas station, town hall/fire hall, rural municipality building, co-op store, post office, library, school, retirement home, museum/community centre/day care centre and the Métis Local.

Agriculture and mining of non-mineral resources are the major industries, and the farming community is struggling with a three-year drought. Economic growth dollars trickle into the community and are limited to small grants, such as the one from Quebec to improve tourism and from the Saskatchewan government for its commitment to Métis education and other Métis initiatives. In 1998, Métis Local #17 received a grant from the Clarence Campeau Development Fund, which is a Métis-controlled economic development funding agency.

The population of the town is 400 with 50 per cent Métis.[258] The project team believes that approximately 90 per cent are Métis, but do not identify or do not know. In July 2001, there were 395[259] people living in Willow Bunch compared to 431[260] in 1996, which is indicative of the economic turmoil this small rural town faces. Many high school graduates leave the community for opportunity or education and never return. Racism has also been a common feature of the social climate in Willow Bunch: Métis were shunned from institutions such as the credit union, parish councils and other organizations.

> They could be part of the parish ... not any of them that sat on parish council or school boards ... I remember playing with a French boy and we were getting along fine and the nun come over ... I couldn't speak French that good but I could understand some of it to get by and I remember her saying, 'you don't play with Michif, you play with your own kind.' She took him away from me, you know ... the dirty half-breed.

Métis were considered intellectually inferior. To gain opportunity, a Métis would have to forego his or her identity. The following excerpt is from a history book that is still held in the Willow Bunch school library and was used as reading material for history class. In it, the Métis were defined as:

> Irascible, inconsistent, wasteful and love alcoholic beverages. They cannot work consistently nor can they adapt as [sic] farming or business. They become easy prey to the european settlers that unscrupulously buy their land for a piece of bread or a bottle of whiskey.[261]

Finally, social indicator analysis revealed there were no cases of physical or sexual abuse, children in care or attempted or completed suicides in Willow Bunch for the year 2001. Although the data suggest that Willow Bunch is a healthy community, some respondents feel this may not be the case.

Outcomes and Measures

The main program activities expected to produce change in the contributing conditions were:

- collect and analyze stories, interviews, research material;
- examine the loss of Métis identity;
- identify what it means to be Métis;
- identify Métis families and their contributions;
- involve Métis Elders and youth;
- develop a communication plan;
- revive and appreciate traditional Métis activities (e.g., Aboriginal Day, Riel Day, fly the Métis Nation flag);
- maintain regular public meetings, newsletters, use all media to inform and promote a positive image;
- reeducate the Métis and non-Métis community about true history;
- work with schools, museum, provincial Métis agencies and organizations to promote positive Métis history;
- co-sponsor workshops and cross-cultural awareness in Willow Bunch and elsewhere with other Métis organizations, agencies and services; and
- work with community leaders on promoting Willow Bunch in a new positive image.

These activities would then lead to the production of:

- booklets, brochures, posters on Métis contributions to the area;
- book or publication of healing process; and
- book or publication on the Willow Bunch Métis.

Which then would ultimately create conditions where there would be:

- an increased pride in being Métis;
- a positive awareness of the history of the Willow Bunch Métis;
- a better relationship with the non-Métis community; and
- an improved Métis image would develop.

The relationship between activities and selected outcomes is set out in the following performance map, which shows what measures will be used to note change. This "map" was used to determine what information should be gathered.

Willow Bunch Healing Project Performance Map

MISSION: Give a positive awareness of history of the Willow Bunch Métis to the community; increase pride in being Métis; and community to begin the healing process.			
HOW?	WHO?	WHAT do we want?	WHY?
Resources	Reach	Results	
activities/outputs		short-term outcomes	long-term outcomes
Communicate/educate: develop communication plan; reeducate community; regular public meetings, use all media to inform and promote; revive and appreciate traditional Métis activities (e.g., Aboriginal Day, Riel Day, fly Métis Nation flag); work with schools, museum, provincial Métis agencies and organizations to promote positive Métis history; and work with community leaders to promote a new image.	The whole community of Willow Bunch.	Increase # of Métis participation in cultural activities, interviews, meetings, increase awareness of true Métis history.	Ensure a positive portrayal of the history of the Willow Bunch Métis and increase pride in being Métis.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	Reach	Short-term Measures	Long-term Measures
$109,200	# of Métis who participated in cultural activities and # of participants who attended meetings.	# participating in cultural activities, # who shared stories and # aware of true Métis history.	# who are proud to be Métis and # of people who are aware of the true history of Métis in the community.

Results

The desired outcomes that were examined focussed on: impact on the individual including project awareness, Métis involvement and identification; impact on the community including response to the project; access to information on the Métis; community knowledge of Métis; and community relations. Results are almost exclusively based on the opinions of key informants; it should be noted that some planned outputs were not realized. No book was produced or distributed due to the difficulty obtaining a sufficient number of stories and interviews and no *formal* communication plan was developed. Furthermore, there was no evidence of any brochures, pamphlets or posters produced by the project.

Impact on Individuals

The majority of respondents were aware of the project, although most saw it as a Local activity rather than an AHF-funded project activity. While most were clear about the central message, some thought the project's intent was job creation or to start another museum. Local membership stands at 250 (from Willow Bunch, Coronach, Rockglen and Bengough), up 150 from four years ago. "I see kids in my classes that talk about being Métis now and I don't know if that would have happened ten years ago or five years ago, for that matter." Respondents have observed increased attendance at Local meetings, increased discussion about Métis identity, a dramatic increase (over 80%) in participant knowledge of accurate Métis history, as well as involvement and pride in the Métis culture. The Métis flag is flown on all occasions and more community members wear the Métis sash with pride. Respondents also felt there was a moderate to dramatic increase (40% plus) in participant knowledge of Métis culture and Métis identification. In fact, it became clear that some in the broader community "didn't even know that there were Métis. They didn't even know that there was an organization or a nation. No, it is there, as in there were Métis people or a Métis Nation that there could be a membership." However, they know now.

Impact on the Community

Not everyone was *positive* about the project (anywhere from less than 10% to 50%). Those that were positive were Métis involved with the Local, students, people who have an appreciation for history, many of the Métis Elders, those with a broad worldview and those who have left Willow Bunch and experienced other environments and cultures.

> The ones that did live in a Métis way or recognized as Métis people here, they really are reluctant ... because they were always put down ... the people that are enthusiastic are the ones that were never treated any differently ... they never really went out to say they were [Métis]. They were a little more light-skinned ... and given opportunities to better themselves economically.

Others who showed *enthusiasm* included the mayor, librarian, nuns at the rectory, kinsmen club and the local principal. The Local is also gaining ground with the museum board who have resisted changes to the existing displays. The less enthusiastic (estimated at 10 to 50%) were older, more closed-minded, felt threatened by an accurate history, changing of school language laws and resented economic development funding for the Métis.

> The people who never left Willow Bunch who have taken one interpretation of history for granted for so long and because a project like this is going to challenge some of those assumptions, they're perhaps a little defensive about it.

Many activities were possible over the past year that have never been done before: 10 to 12 workshops were open to the general public; 8 to 10 Métis cultural activities were sponsored; the Local worked within the school; other Métis organizations visit the community; newspaper articles and reports on Métis were published; and interviews regarding history were held. Most communication has occurred mainly through open discussion with animated displays of Métis culture. These seemed to work well, albeit limited to a smaller audience. The team believes that Métis history and culture, rich with life and colour, is better related through demonstration. All informants concur that the broader community has greater knowledge

of Métis history and traditions as evidenced by the increase in youth identification, as well as invitations to participate in non-Métis events and committees. They believe that a number of factors have created conditions where change was possible, such as:

- Local workshops and activities associated with Métis history and culture, especially those enabled by AHF support where experts came (e.g., Gabriel Dumont Institute and the Métis Employment and Training Services Inc.);
- the importance of having someone validate your identity;
- recognizing Métis contributions in a positive, nonthreatening way;
- having a physical presence in the community (e.g., the building);
- having articles about the Métis for distribution; and
- the Saskatchewan government's education policy that encourages Aboriginal history to be incorporated into school curriculum.

Increased community involvement and curiosity in Métis culture (especially among youth), an informal agreement made between the historic village committee and the project,[262] and increased hiring of Métis all suggest that something is happening. Although minor, respondents credited the improved image to Métis displays, the physical presence of the Local, other Métis organizations in the province, Métis in the media, provincial education policy, open discussion about Métis issues and the steadfast enthusiasm, congenial approach and firm vision of the project team.

To determine how much knowledge the community has on the Métis, respondents were asked what it means to be Métis. Responses included:

- Aboriginal blood mixed with non-Aboriginal blood;
- trace roots back to a particular people and culture;
- descendants from seven Métis families from the Red River settlement near Winnipeg who were the first settlers of the prairies and have a separate culture;
- musical history and sash; and
- I don't really know. As far as I'm concerned I'm a Canadian, Canadian-Métis … In the early years you see you didn't go around bragging that you were a Métis. But now it seems everybody wants to be a Métis ... it hasn't changed me at all but I'm glad to see the way things are going.

Although there was some disagreement about the extent of change, respondents did believe that some non-Métis people have better knowledge of *accurate* Métis history. Respondents credited a variety of actions and conditions for this noted change, including:

- individual desire to learn;
- the influence of the school librarian and principal;
- the commitment of the project team and project activities (no accurate information on Métis history existed before);
- open and inviting cultural events during holidays and school time, which are focussed upon reconciliation (not blame), most particularly, a Métis dine and dance where about 150 to 300 people attended;
- the existence of the Métis Local facility, as well as their increased participation with Métis Nation Saskatchewan affiliates.

Overall, respondents believe increased awareness of, and respect for, Métis culture and history has evolved as a result of project activities.

> The more I can see, it's even broadening my own perspective to know that some of the most highly decorated veterans from this community were Métis ... I think most of the history of this area has come from a euro-centric perspective up until the healing project.

Establishing Partnerships and Sustainability

No *formal* partnerships have been established and sustainability is at risk. Still, *informal* partners are plenty and include the local leadership, school staff, kinsmen club, parks and recreation department, postmaster, town council and rural municipality whose support was considered helpful and earnest. However, trust issues are still an undercurrent in the relationship between the Métis and others in the community. Some suspect that other overly-enthusiastic "partners" may be clamouring for Métis-specific funding without any intent of sharing power with the Métis. External linkages have also been established with the Métis Addictions Council of Saskatchewan Inc. (MACSI), the Gabriel Dumont Institute (GDI) of Native Studies and Applied Research and the Métis Nation of Saskatchewan (MNS). AHF is the Local's only funding source: they will be looking at Heritage Canada, Gabriel Dumont Institute and the Clarence Campeau Development Fund for future funding.

Accountability

One team member believed that the Métis leadership is constantly monitoring and evaluating activities. Even though the project stated they were using feedback forms to evaluate and monitor,[263] none were submitted with project monitoring reports. The project may have felt that completing the project monitoring reports was the only evaluation exercise required. Communication with the community included sharing the work plan for year two of the project, constant informal communication with the school, museum, historical committee and other Métis institutions, as well as press releases, public announcements and live interviews.

Addressing the Need

By examining the loss, reclaiming Métis identity, documenting an accurate history and using this information to reeducate the community, the project has set a foundation for an improved relationship, not only with others, but also within the Métis community.

Successes and Best Practices

Open communication and cultural celebrations that provide opportunity to taste, see and hear Métis food, song and dance have been very well received. Involvement of local agencies in project activities has improved trust and relationships. Linking with other Métis organizations has increased access to information. Having a constant physical presence (flying the Métis flag and showcasing the Red River cart), a voice in the community and cultural activities at the school were all considered best practices.

Challenges

The project identified difficulty dealing with some Métis Elders who were reluctant to relate their experiences. Some relations in the community are strained, especially with the older set who continue to show dominance and hostility, but with a sense of complete normality. Changing such attitudes will take more than two years. The project also had difficulty convincing people that it is trying to *improve* community relations.[264]

Lessons Learned

More time is needed to interview older Métis. The guilt and denial they feel about their heritage required that they first develop trust and comfort. New resources for Métis initiatives are causing some resentment by those feeling left out of the resource loop. Creative ways of working together in shared celebration of the community history and culture may overcome these sentiments. Targeting efforts at youth who are more open may be the best use of resources. The tenacity of those who are threatened by a new social order where Métis value is recognized was unanticipated and underestimated; changing their minds will be a long-standing endeavour.

Conclusions

Although the project's first year plan was to complete an accurate historical account of the Métis of Willow Bunch, only one-quarter of the book was complete. However, work with the museum committee to improve the Métis displays is well underway. While the extent and magnitude of change is not entirely clear, "something" beyond physical changes is apparent in Willow Bunch. Métis identification is on the rise; more Métis people attend Local meetings and the broader community is more involved in the celebration of Métis history and culture, *especially* the school.

Contributing factors include:

- community desire to learn;
- influence of provincial education policy and enthusiastic partnership with school leadership;
- legislative changes that benefit the Métis (e.g., economic development and education funding);
- open and friendly cultural events;
- physical presence (e.g., Métis flag, Red River cart display, cultural events, Métis Local facility is evident, all *for the first time*);
- participation from, and support of, other Métis organizations;
- workshops, use of media; and
- the project team's nonthreatening approach.

Nonetheless, there is a community element who are resistant (estimated at 10 to 50%) this element is composed of those who benefited from the historical social hierarchy, have never left the community and are threatened by changes to school language laws (English rather than French is the primary language of instruction in Saskatchewan schools). Also, some older Métis are still reluctant to share their stories.

Recommendations

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

- increase information on Métis (open discussion and *written materials*); continue celebration of Métis song, dance and food;
- include *project-produced* documentation to hand out during cultural demonstrations and information sessions; and
- *project-produced* documentation and advertising of events to be included in local paper and distributed to the whole community to ensure information dissemination to everyone in Willow Bunch.

Evaluation recommendations include:

- develop a participant feedback form to guide improvements; and
- develop and conduct a community survey to determine extent of Métis knowledge and rate of racial discrimination.

Kikinahk Friendship Centre: Kikinahk Parenting Program (AHF Project # RB-67-SK)

Project Description

This case study examines the Kikinahk Parenting Program (KPP) in a rural community, which combines Western and traditional approaches. The primary purpose of the project is to ensure that families will develop traditional and modern parenting skills and ways of relating that will allow them to be functional and healthy. KPP hopes to accomplish this goal via a parenting skills program where a blend of traditional parenting models, together with opportunities to learn modern expectations of parents, are offered. KPP combined an informal, voluntary, "drop-in" approach with more active recruitment; it seemed that encouraging people via word-of-mouth was the most effective way of enlisting participation. One-on-one counselling, weekly scheduled support groups, conferences, family evenings and special events with Elders (camping, harvesting traditional foods, sharing traditional knowledge) were some of the activities undertaken by KPP.

KPP is being delivered by the Kikinahk Friendship Centre (KFC) in La Ronge, Saskatchewan, a rural area with a population of about 7,000. KPP is closely linked to a variety of other programs within the Friendship Centre and the community, such as the Lac La Ronge Indian Band, local women's shelter, social services, mediation and diversion program, young parent program, head start, outreach, child care co-op, youth service, recreation and prenatal nutrition. Perhaps the closest working relationship is with the Piwapan Women's Shelter that has a similar program for parents.

Target Groups: The project targets Survivors, whether they are First Nation, Métis, gay/lesbian, disabled, men, women, youth or Elders, who are living in La Ronge, Saskatchewan, and surrounding area.

Funding: KPP's budget for the year was $186,190.

Outcomes and Measures

The following performance map identifies activities, desired outcomes and performance measures used in this case study.

Kikinahk Parenting Program Performance Map

MISSION: To strengthen the family bonds of Survivors and those intergenerationally impacted by residential schools, so that First Nations/Métis families in La Ronge and surrounding area can enjoy a happy and functional family life.

HOW?	WHO?	WHAT do we want?	WHY?
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Address parenting issues (e.g., violence, sexual and mental abuse), provide training for individual family members to change their individual and group behaviours, one-on-one counselling, support group meetings, evening activities (e.g., supper, dance), traditional activities (e.g., camping, harvesting traditional foods), conferences, culture week activities, group activities, parenting weekend in the bush, and neck bone and bannock supper with the Elders.	Residential school Survivors and those who have been affected intergenerationally whether they are First Nation, Métis, gay/lesbian, disabled, men, women, youth or Elders living in La Ronge and surrounding area.	Increase involvement of parents and teens in community activities, improved communication and attachment between Survivors and their offspring, reduce abuse, increase awareness of family issues, and increase awareness of issues for community to better support and understand the legacy of residential school resulting in reduced denial of the problem.	Confident and responsible parents raising children in nonviolent homes and protecting their children from abuse, ongoing healing process, and increased awareness of issues related to the Legacy.

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

Resources	Reach	Short-term Measures	Long-term Measures
$186,190	# of families who participated in community-based program.	Observed changes in awareness and understanding of the Legacy, communication skills and attachment of parents and teens, participation in education and healing sessions, individual service demand for healing, and community demand for education on the Legacy.	Reduced rates of abuse, family violence, children in care, child/teen suicide, and evidence of change in community support systems for Survivors and their families.

Project Team and Participants

The KPP team consisted of a finance officer, project coordinator, Elder grandparent team and part-time bus driver. While it is not clear what qualifications or training any of the team members had, it was obvious that the grandparents selected as Elder models of traditional parenting were highly regarded, well skilled and tirelessly motivated.

Most participants were First Nations (both on- and off-reserve) and intergenerationally impacted young, single parents. These were mainly women from ages 20 to 40 years, who accessed the program by dropping in or were referred by Mental Health Services or the Piwapan Women's Shelter. Forty individuals participated on a regular basis in all or most of the events sponsored by KPP, but more than 100 individuals have participated in at least one group event associated with healing (e.g., family evenings, conferences, feasts, sharing with Elders). A total of 150 people participated in broader community events intended to educate the community about the Legacy. Again, most were First Nations, intergenerationally impacted. Women had outnumbered men at this event with a ratio of four to one.

Context

KPP operates mainly in the gym at the Friendship Centre, but the Elder grandparents have their own office where they meet with participants one-on-one or where they teach traditional activities. Boardrooms are used for day or evening activities and a family room is used where parents can bring their children and still be involved with the program (babysitters are provided so that parents could actively attend). Sometimes, traditional activities are organized off site at an island cabin.

The town of La Ronge sits on the western shore of Lac La Ronge in northern Saskatchewan and is really a combination of three communities: the town, Air Ronge and the Lac La Ronge Indian Band. Acculturation has been swift, pervasive and accompanied by some stressful social dynamics that include racism and a class structure based upon a cash economy. There is also a pronounced tension between Euro-Christian followers and those who practice traditional Aboriginal spirituality. According to responses to the National Process Evaluation Survey (NPES), KPP team members recognize the following community challenges to be severe (e.g., affecting 80% or more of the population): poor local economic conditions, substance abuse, fetal alcohol syndrome (FAS) and fetal alcohol effects (FAE), as well as family violence. La Ronge and surrounding Aboriginal communities are also plagued by housing shortages. In some cases, they are so acute that as many as two or three families are living in one house. There is a high rate of homelessness among young people (< 25 years) who may have been thrown out or who have left due to violence in the home. It was clear that the solid majority (71%) of mental health clients were First Nation and many (41%) were youth (13 to 18 years old). The most common problems, in order of frequency, were related to: relationships, suicidal ideation, depression, anxiety and behavioural problems. Finally, of all assault charges laid, many were of a sexual nature and *an alarming proportion of sexual assault charges involve youth and children as victims!*

This case study will evaluate changes in the individual participant and in the community. More specifically, the evaluation questions were:

- Was the KPP effective at teaching traditional and current parenting skills?
- Did the community's awareness and understanding of the Legacy change?

Interviews were prepared to secure perceptions regarding change on a variety of short-term indicators. Actual interviews were conducted by one AHF team member, and most of the agencies in La Ronge that serviced Aboriginal people were interviewed or contacted.

Impact on Individuals

From the KPP team's perspective, participant characteristics certainly changed over time. Initially, only women were coming to the program. Eventually, they brought their husbands and teenagers. In fact, the level of participation surprised the KPP team. "There are fathers who, for the first time in their lives, are having an emotional family outing with their sons."[265] Parents became increasingly comfortable to share insights and ask questions. Some even appeared to become more relaxed, patient and skilled communicators over time. Parents were less likely to "push their teenagers away" by more carefully selecting their tone and words, while others seemed better able to allow their teens to have fun or to do things *with* their teens when before they could not. One respondent noted that mothers who have participated in KPP are not accessing services as often as those who have not been to the program. Respondents saw greater enthusiasm and motivation was evidenced by increased teen participation in activities and knowledge of traditional practices. A few were thinking about going back to school and some have decided to stay in school.

From the periphery, success was not always clear. While some did note that at least a few have "straightened out" their lives by getting jobs, going back to school and improving their relationships, not everyone heard evidence about parents sobering up, upgrading skills or getting their children back. In short, a respondent was quick to clarify that, while dramatic change was observed in some participants, there were "absolutely no changes" in others. Also, it was not clear to what extent any changes endured beyond the life of the project.

Impact on Community

There was a clear difference in opinion about whether or not KPP was able to facilitate an increased understanding of the Legacy. While some argue that many are still in denial, others notice an increased willingness to discuss the Legacy, albeit superficially. Over the past four years, there have been at least three community-wide awareness workshops and a radio talk show in Cree on the Legacy: these media represented a *distinct environmental difference from even just five years* ago. Also, age appeared to play a role with those in the 40 to 50 years old age category who appear much more willing to talk about the Legacy than those who were older.

There was some disagreement about the community's interest and willingness to participate in the program. At least one respondent indicated that, although the community is aware of KPP, there was a serious lack of participation. However, other respondents indicated that the number of drop-in visitors and telephone inquiries about KPP activities increased over time. In fact, one team member recounted that community members *would not wait* to receive information about scheduled traditional activities sponsored by KPP, but *actively sought* information. Engaging in harvesting and preparing traditional foods, especially caribou hunting and smoking fish, brought participants back to a *fond* time in their childhood. This created an obvious and eager anticipation in the community.

With respect to any changes over time in board-selected social indicators, one key informant noted that rates of domestic violence remain high and victims, including children, have been threatened after their disclosure. Key informants were also clear that primary (directly abused) and secondary (witness to the abuse) sexual abuse victims were getting younger. Rates continue to be high and silence ensures maintenance of the status quo. While some respondents felt that sexual abuse issues were adequately addressed by KPP's awareness campaign, they were not convinced that such abuse was adequately linked to residential school, nor were they completely satisfied that KPP was able to deal with sexual abuse issues in a *clinical* capacity. Again, there was a noted inconsistency in opinions regarding whether or not rates of children in care have changed. Some feel the rates have increased and have observed that the community's ability to accommodate these children has been saturated. At last, while respondents believe that the community is in a better position to intervene earlier, most did not believe that suicide rates have changed from what is an unacceptably high rate. "In Stanley Mission, there were 125 attempts in one year out of 1,200 population."

About half of all respondents felt that KPP was addressing the Legacy reasonably well, although many were not sure and a few felt that the project was struggling in this regard. Those who felt the Legacy was addressed well did so because they saw an increase in willingness to seek information and, ultimately, help. Other respondents felt there was a misunderstanding about what KPP had to offer. In other words, not everyone in the community was entirely clear that KPP was a *healing* program and not a child and family service organization or a class action suit.

Accountability to the Community

Although the majority (80%) felt that KPP was accountable to the community, they also felt there was room for improvement. At least one respondent felt there should be a variety of ways of communicating with the community that included efforts beyond radio, brochure and newsletter distribution. School officials felt they should have had a formal opportunity to provide feedback. KPP's steering committee did not meet due to the fact that most members were professional people whose schedules conflicted with their involvement.

Outside of project files, records of participation and AHF reports, it was not clear how KPP was evaluated, if at all. There was no evidence that KPP was able to follow through with its evaluation plan. In fact, in many of the reports submitted to the AHF, it was clear that KPP administrators confused means with ends. In other words, most responses to questions about expected outcomes (e.g., changes in participants) focussed almost exclusively on the attainment of implementation objectives (e.g., project participation).

Explaining Results

Clearly, parenting education and traditional activities, facilitated by skilled Elders who have long-thirsted after the opportunity to right the wrongs of residential schools, set a solid footing for those who are eager to end the Legacy's impact on their lives. While KPP could not reach everyone in need or have an impact on all those who participated, the information suggests that at least an immediate, if even short-lived, difference was achieved for some families. In addition, albeit not comprehensive or perfect, it appears that the shackles of denial have been loosened in La Ronge. What is not clear is whether or not the desired change has had a *lasting* impact on KPP participants or if any ripple effect is happening in a more general way in the community. To address gaps in understanding, more information is needed on:

- participant characteristics, particularly, what is it about those for whom the program works and does not work?
- do any differences endure six months, a year or two years later? and
- what are the current rates of physical and sexual abuse, children in care, suicide and incarceration for the target group?

The Elder grandparents who facilitated KPP during its first year of operation won widespread allegiance, as evidenced by some participants who dropped out of the program when the grandparents left. Their nonjudgemental, comforting and culturally relevant approach to strengthening parenting skills, together with their tireless motivation, was consistently cited as the reason KPP had an impact. Group dynamics and Legacy education also won credit as powerful change makers. As part of a *group*, participants were not alone in their struggle and, over time, came to understand that their struggles were not unique. Participants no longer thought of themselves as "bad" parents, but just parents lacking skill and support.

Change was also commonly attributed to participant motivation or a "readiness" for change. KPP teaches relationship skills, which provide an alternative to emotionally charged and generally futile interactions. Participants clearly thirst for these alternatives and the opportunity to break the cycle of abuse "to learn something different than how they were brought up." Focussing on communication skills, "quality" time with loved ones, home visits and the power of effective role models were important program elements contributing to change. Finally, but perhaps most importantly, participants felt respect from the team, which facilitated a climate of trust. For young people, feeling heard and understood, as well as establishing friendships among their peers, made KPP a pleasant place to be.

There were a myriad of explanations for those families and individuals who did not experience life-altering changes as a result of their participation in KPP. Community socioeconomic conditions and the endurance of denial are perhaps the most notable environmental barriers. However, lack of appropriate and sustained access to parenting education, support programs, personal challenges related to addictions, literacy and poverty, as well as racism and classism, may also play a role.

Partnerships and Sustainability

KPP worked closely with other programs of the Friendship Centre, as well as local institutions and resource people. However, respondents were almost unanimous in their opinion that KPP could not sustain activity beyond the life of the AHF.

Addressing the Need

The majority of participants at KPP were young, single mothers and community-wide education on the Legacy was met with sparked enthusiasm. As a non-mandated, culturally relevant program, with access to Cree Elders and traditional parenting skills education, KPP was also filling a service gap. Still, respondents felt that the need exceeded KPP resources and that partnerships might have worked well to achieve greater results. Furthermore, there is evidence that denial *persists* in La Ronge. Eighty per cent of all respondents felt there was room for improvement in KPP's ability to target those in greatest need.

Successes and Best Practices

The presence, experience and character of the Cree grandparents were consistently credited with any positive changes noted in program participants. Feasting, conferencing, lessons in parenting and communication, scheduled family outings, traditional activities and Legacy education were also well received by participants and considered successful program elements by most respondents. In particular, a community conference entitled "Journey to Awareness" was credited with opening dialogue about painful social issues. Establishing working relationships with complementary services and keeping team members well were also considered best practices. The project's location, leadership and community support also helped to create conditions where change was possible. Strong administration, a few dedicated team members, adequate training and education, as well as a *vision* for the long haul was clear.

Challenges

Kikinahk faces the following day-to-day challenges:

- inadequate services to meet demand;
- lack of community involvement and soliciting program participation, particularly for youth;
- "drop-in" nature may have been viewed as a babysitting service;
- limited resources spelled limited results;
- the board was opposed to the use of traditional spiritual practices;
- high staff turnover;
- lack of expertise and support for evaluation;
- lack of transportation to off-site events; and
- lack of paternal commitment.

Poverty and lack of parenting skills were severe challenges (affecting 80% or more of participants). Lack of Survivor involvement, denial, fear, grief, history of abuse as a victim or in foster care, family drug or alcohol addictions, lack of literacy and communication skills were considered moderate challenges (affecting 40 to 80% of participants).

Denial was also a barrier to progress, which respondents believed could be resolved by increased Survivor involvement in program planning. More involvement from parents of youth would also facilitate KPP's ability to give support and guidance to other parents of teens. To encourage participants to *be with* their families and *attend activities* ***with*** their children was a constant challenge for the Elders. Greater partnership with the schools could have supported youth involvement in KPP, which was also considered very low.

Lessons Learned

In point form, some of the lessons learned by the KPP team include the following:

- find the *right* people for the job;
- exhaustive criminal record checks are ***absolutely essential***;
- avoid creating service dependency;
- you cannot tell Elders what to do;

- guard against team burnout;
- traditional feasts and teen dances are popular social gatherings;
- more rigorous screening of professional credentials and abilities;
- bringing tough issues out in the open could lead to partnerships and initiatives to face problems head-on (e.g., FAS/FAE);
- schools are very interested in finding Elders that are knowledgeable in traditional ways;
- a combination of Western and traditional healing methods would have worked well;
- anticipate and quash efforts by lawyers to secure Survivors' names as a way of boosting participation in class action suits; and
- focus the reach.

Conclusions

Was KPP able to make parents feel more comfortable about their role and send them off with new skills? Well, for some participants, this was the case. For others more resistant to change, a different approach may be required. KPP appealed more to women than men and, while it did spark an interest in Legacy education and increased community understanding of the impact, a wall of denial and silence persisted. Several important ingredients have been credited with the progress KPP was able to achieve that include:

- the commitment, expertise and interpersonal style of the Elder grandparents involved;
- participant motivation to ensure their children's lives would be better than their own;
- the non-mandated, culturally relevant nature of the project; as well as
- a community and program climate, which placed individual struggles within the context of a social injustice.

However, like any healing process, the development of parenting skills take time. This development may require years of investment before KPP could create lasting healing from the Legacy in the La Ronge area.

There was a clear difference between those who were ready to face and heal from the Legacy and those who were not. While initial and resource-restricted efforts should focus on those who are ready, some guidelines should be offered about how to creatively dismantle denial where it exists, and not just in a community context. We know Legacy education works well in this regard, but it could also work well on an individual basis. It has been repeatedly demonstrated that inviting and attracting women to participate can act as a catalyst within the family. However, unique strategies are needed for men who are consistently and significantly underrepresented in healing programs.

Recommendations

The program delivery recommendations are classified under three major headings: team building, project delivery and evaluation issues.

Team Building Issues:

- Select steering committee members who *commit* to the life of the project;
- hire dedicated teams with education and skills that are in for the long haul; and
- consult Survivors in the hiring and program development processes.

Project Delivery Issues:

- Have ***vision*** - emphasize continued services (e.g., 10 to 25 years);
- get local schools involved in Legacy education;
- refer serious issues to the appropriate agencies upon disclosure;
- focus on target groups;
- build capacity and human resources; and
- break down the barriers of denial and enlist the participation of men in healing programs.

Evaluation Issues:

- Use client satisfaction questionnaires and formal evaluation;
- be clear about the distinction between activities and outcomes;
- direct assessment is best. Enlist projects and help them to get and to use tools or information to determine changes in project participants and community. Samples of measures used to assess consumer satisfaction, parenting skills, healing from sexual abuse, self-esteem, employability and other dimensions of change required by projects be secured and available for project use. Structure the evaluation so that project teams can collect the raw data, which can be analyzed externally;
- increase efforts to explore rival explanations;
- profile those for whom the program seemed to work. Identify what is different about those for whom the program *worked* versus those for whom the program *did not work*. Is denial the *only* barrier? What other distinguishing characteristics are clear? Age? Sex? and
- make adherence to the evaluation plan, as stated in the proposal, a condition for funding, as well as for long-term follow-up.

Nelson House Medicine Lodge:
Pisimweyapiy Counselling Centre (AHF Project # CT-373-MB)

Project Description

The Pisimweyapiy Counselling Centre[266] (AHF Project # CT-373-MB) is described as a "community-based, nine (9) week, two phase program aimed at **enhancing and empowering the personal and social functioning of former students of residential schools and their families**, as the means to an overall healthier community."[267] The objectives outlined in the project's brochure are:

- provide a safe, structured, nurturing environment for *direct therapeutic support* and strengthen the *network of local support*;
- develop resource material that covers the therapeutic process, client management and work schedules;
- foster and strengthen communication and relationship skills;
- maximize pride, self-responsibility and acceptance; and
- reduce the number of deaths, family destruction and cultural genocide resulting from the Legacy.

The Pisimweyapiy Counselling Centre (PCC) is purposefully designed and structured to operate as an outpatient community-based therapeutic program. Methods and activities include:

- case management: assessment and treatment planning, individual and family therapy, aftercare planning and follow-up;
- men's and women's healing circles, self-help groups, workshops (e.g., sexual abuse, parenting, family, residential school syndrome, suicide intervention and post-vention, communication skills, anger management, grieving and loss);
- traditional teachings and ceremonies;
- field trips to residential schools and to pick medicines;
- regular physical exercises and nutrition; and
- home visits to conduct family sessions.

The Pisimweyapiy Counselling Centre is situated on the Nisichawayasihk Cree Nation and operates out of a house trailer on the grounds of the Nelson House Medicine Lodge (NHML). While the trailer is conveniently located, lack of space and privacy are concerns (e.g., walls are not soundproof and participants are grouped too close together).

Target Groups: The target group includes all local Aboriginal (Métis, Inuit, First Nation, on- or off-reserve) adults, youth and families affected by residential schools in the area.

Funding: Pisimweyapiy Counselling Centre is an addition to the existing services of the NHML and initially funded as a pilot (1 February 2000 to 31 January 2001). Funding continued to 31 January 2002 with a second contribution of $464,526 of which this period is the focus of this case study.

The Project Team

The executive director serves as a working group member of the treatment centre, holds a masters degree in social work and has experience as a senior counsellor. The coordinator holds a bachelor of social work degree and has worked and volunteered extensively with Aboriginal organizations. The team includes three therapists and an administrative assistant. One is a trained social worker with fifteen years of experience in counselling and corrections dealing with First Nations people. Another is a Survivor with an applied counsellor certificate who has worked as a counsellor at the medicine lodge. The third therapist is a Survivor certified in community social development, as a community education facilitator, radio broadcaster and life skills coach, and has extensive experience working with older and younger adults both in the education field and social services. Elders are in constant use by the project. One member of the board of directors is a respected community Elder and Survivor. Staff training included computer skills, supervision/ management, time management, therapeutic change and development, as well as working with families and couples.

Participant Characteristics

The most significant challenges facing the participant group included physical abuse, which affects virtually all participants, and alcohol abuse (90%). Most (>60%) are also dealing with a history of sexual abuse, family violence, criminality and lack of basic life skills. While there is roughly an even distribution between the sexes, women still outnumber men and the bulk of participants are in the 25 to 45 year age category. Almost all are First Nations on-reserve and a large percentage (85%) are intergenerationally impacted.

Community and Regional Context

Nisichawayasihk Cree Nation (NCN), is located on the northern shore of Footprint Lake west of Thompson and northeast of The Pas in northern Manitoba. Hunting, trapping and fishing form the economic base of the community and traditional sharing of wealth is still practiced through harvest donations to community Elders. Local businesses include the trappers' association, forest industries, air service, housing development, department and food stores, as well as a convenience store/gas station. Also, there are local taxi and bus services and a day care. The community development corporation owns and operates a motor hotel and tavern, both located in Thompson. Local facilities and services include a band office, a community hall, a recreation building, a pool hall, a nursing station, policing and a school (grades K-12). Most houses have water and sewage, some have cisterns and trucked septic service, and three have no plumbing or sewage services. Health programming in the community includes the Nelson House Medicine Lodge (an alcohol and drug treatment facility) and a variety of integrated health services.

Although NCN is covered by the provisions of the Northern Flood Agreement, hydro development has caused significant disruption to traditional Cree harvesting, homelands and, consequently, social and familial well-being. While little was obtained on social indicators, what was clear is that all physical assault and domestic abuse *in the community*, as well as most crimes committed *in Thompson*, is associated with substance abuse and children (8 to 12 years) who are abusing. Still, the community is described by outsiders as one with initiative that is organized and advanced, with a variety of measures to minimize crime and deal with social problems. Although there have been no suicides for a long time, there are fatal accidents, usually alcohol related, that may be questionable. Also, the director of child and family services reported 62 family

cases that were open and involved 229 children. Of the 2,058 residents living on the reserve, it was estimated that 242 are residential school Survivors (not counting those affected intergenerationally).

Outcomes and Measures

PCC has undertaken to develop a network of support by providing individual, group and family therapeutic services (one-on-one sessions, healing circles that are gender- and age-specific, self-help groups, home visits, field trips, aftercare and continuing care). They have introduced and practiced new and healthier ways of life through workshops and presentations, traditional teachings and ceremonies, exercise and nutrition. The project has also attempted to expand support for Survivors by networking and sharing with other organizations. The desired short-term results include:

- overcome or reduce denial sufficiently to have the program operate to capacity (exceed 85% of full capacity);
- transform childhood trauma to healing and empowerment;
- deconstruct unhealthy survival patterns; and
- reduce the accidental death and suicide rates, rate of family destruction and reverse cultural genocide.

A long-term outcome is for participants and their families to become part of an expanded, self-reclaimed and empowered support network of Survivors active in their own journey of healing and wellness, who have learned how to live independently and have found their spirit. The following "performance map" provides a bird's eye view of the project's mission, resources, target, objectives and goals, and highlights what sources of information will be used to note change.

Nelson House Medicine Lodge Performance Map

MISSION: Enhancing and empowering the personal and social functioning of students of residential schools and their families, thereby contributing to the overall health and wellness of our community.			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Normalize, universalize and depathologize the Legacy's impact using: case management, small and large group sessions, traditional ceremonies, field trips, exercise, home visits, recruitment and intake, aftercare and continuing care, introduce and practice new and healthier ways of life, individual and group/family therapy, self-help and community beautification.	Survivors, family and community members and intergenerationally impacted in Manitoba.	Overcome/reduce denial sufficiently to have the program operate to capacity; increase transformation of childhood trauma to healing and empowerment; decrease participation in unhealthy survival patterns; improve family functioning; increase life empowering behaviours; initiate healing; reduce unhealthy coping; and expand self-reclaimed network of Survivors healing.	Participants and their families become part of an expanded, self-reclaimed and empowered support network of Survivors active in their own journey of healing and wellness who have learned to live independently and found their spirit.
Staff training and professional care.	Community staff and leaders.	Increase capacity to deal with the Legacy; increase knowledge and understanding of the Legacy; and increase access and participation in expanding network of support, which is familiar with and capable of responding to those suffering from the Legacy.	
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	**Reach**	**Short-term Measures**	**Long-term Measures**
$464,526 one year only	# of participants from within community (3 intakes per year)	Rates of participation; observed changes in family functioning; numbers or percentage of population engaged in mutual support; feedback from participants, therapists, leaders, Elders and referral agencies; and observed and self-reported changes in coping skills and transformation of childhood trauma.	Rates of suicide and attempted suicide, dependency on welfare, homelessness, substance abuse as measured by alcohol- or drug-related criminal offences and participation in treatment.
Training budget?	# of trainees	Observed and self-reported changes in understanding and capacity to deal with the Legacy and feedback from referral agencies regarding changes in access to services skilled to aid and appropriate for Survivors.	

Impact on Individuals

There was disagreement about the extent and magnitude of change in coping patterns. Evidence of change included some participants who appeared better able to maintain sobriety, seek employment, disclose past trauma, be outgoing, seek spiritual fulfillment and recruit others to participate. Participants shared that they felt increasingly comfortable over the duration of the program. Counsellors who were nonjudgemental, sincere, trustworthy, gentle, respectful, committed and culturally sensitive clearly facilitated healing. Equally important was a combination of group lectures, one-on-one counselling and a *safe* environment.

All respondents felt there was a moderate change in understanding of the Legacy among participants. However, they were in stark disagreement about how many participants have experienced this change. One felt strongly that it may be too early to expect major changes in understanding, while others noticed an increased openness when discussing the Legacy. Change was facilitated by leadership support, Survivor participation and emphasis on Legacy education. The team agreed that participants left with enhanced self-esteem, even if they did not agree about the magnitude of change or the percentage of participants who experienced this outcome. Behavioural evidence that was cited included changed facial expressions from sadness to peace, securing gainful employment and comfortable displays of physical affection. Again, they credited Legacy education, framing therapy in the context of Cree culture, focussing on responsibility and *choice*, as well as emphasizing self-trust for the observed changes. The team also believed that training helped them to skillfully address the Legacy and help Survivors.

While no agreement was clear about how many experienced increased cultural pride or the degree of that change within individual participants, the team was sure that some change was obvious. The majority of participants were clearly excited about culture teachings and eager to learn more, but some were resistant. PCC felt that their program, together with reinforcement from the medicine lodge, was responsible for such change and believed that group dynamics strengthened the impact. When questioned about participant risk for physical abuse, sexual abuse, provincial wardship and suicide, the team concurred that risk for physical abuse and suicide may have decreased, but were not sure about sexual abuse and provincial wardship because of the extent of community denial. Although there were no suicides in the community since the program began, they felt it was still too soon to see a difference in the rates of sexual abuse and children in care.

The majority of participants (11 of 19) rated the service as excellent, while others (8) said it was good. Most (18) felt they generally or definitely got the service they wanted although one participant did not. Again, almost all (18) believed the program met most of their needs; however, one participant felt the program addressed only a few of their needs. The majority of participants (15) were very satisfied and the remainder were mostly satisfied with the service. Very few had suggestions to offer. Those who did make suggestions offered the following:

- have a larger meeting room;
- improve attendance by mandated participants;
- include more women's groups and cultural teachings;
- offer home visits in addition to centre-based therapy as a form of aftercare;
- offer smaller workshops on addictions; and
- increase counselling sessions to a duration of four or five hours.

The majority of participants had an overwhelming amount of positive praise for program content and the project team. Their voice is captured below:

> I am very satisfied and happy with the services I received. I will continue to seek help with the counselling services.
>
> I have recommended friends/family for this program.
>
> Anyone thinking of getting help from this centre will be doing themselves a big favour and a big step towards healing because that's what they will get! Excellent services!!!
>
> I don't know why I held on to this grief for so long.… [The counsellor] was able to assist me in letting go of that pain ... Seeing the old residential school brought back some sad memories and kind of brought a closure to that bad experience. [The counsellor] has given me confidence and raised my self-esteem.
>
> I got so much out of it. I realize my problem areas ... I especially enjoyed the trip to my former residential school. It has brought some closure to some sad and bad memories over there ... I will continue to seek counselling after this program.
>
> Only wish that my two sisters would come. Encourage mother to speak to them to come, it is terrific program!!

Impact on Community

Sixty-seven of a possible seventy-five participants were engaged in the program and nineteen had graduated, representing an 89 per cent participation rate and a 28 per cent completion rate. Each successive intake showed increasing enrollment so that by the fourth intake, they exceeded capacity and had outgrown their trailer. Usually, intake is 15 participants and the fourth intake accommodated 20. Eventually, *participants engaged without being referred*. Their only obstacle appeared to be getting family members involved in phase two of the therapeutic programming; however, over the life span of the project, an increasing number of couples started coming to PCC. They credited positive changes to the partnerships and networks established locally, the confidential setting, peaked community curiosity, team skills, project visibility and the example set by recent graduates/participants. The community estimates there are 242 Survivors in total (not counting those impacted intergenerationally) and recognizes that much work still needs to be done.

To create a network of support, PCC formed self-help groups, enlisted Elders to make themselves available and contracted therapists. Mandated referrals were being made to PCC, but roughly 80 per cent of those mandated did not complete the program. Also, the residential school advisory group, Survivors' committee and the board of the Nelson House Medicine Lodge provide support to the PCC team. The team and community informants held different opinions about the extent of change in the community's understanding of the Legacy. There was an acknowledgement that denial is not completely dismantled; however, when change was clear, it included increased anticipation of monthly newsletters, open discussion and clarity that PCC is a *healing* (not compensatory) effort. The rate of disclosures have also precipitated fundamental and structural acknowledgement of the Legacy.

> Recently, there were disclosures of a school principal who abused children for thirty years and had the school named after him. The board of education heard the disclosures and changed the name of the school. This is the first invitation for residential school Survivors to talk.

Increased understanding of the Legacy was attributed to:

- community readiness;
- actions of the ad hoc committee on residential schools;
- increased resources to address healing from the Legacy;
- efforts of the PCC (e.g., conferences, field trips to residential schools, public relation campaigns);
- PCC team members who are skilled Survivors able to inspire healing and make others feel safe; and
- Elder involvement.

One of the spin-offs is the residential school Survivors from the community and other organizations around Thompson had successfully hosted a five-day conference at Troy Lake. Another conference was planned for March 2002 for caregivers who work with Survivors. They also planned for another summer conference in 2002.

PCC got high marks for its accountability to the community. The solid majority felt the project needed little or no improvement in this regard. Accountability is fulfilled through local radio, community presentations, monthly newsletters and residential school advisory committee meetings, as well as posted program activity schedules. About half of the respondents felt the PCC was addressing the Legacy very well, requiring little or no improvement. Some felt that the program could better address the Legacy and a small percentage felt that PCC was struggling in this regard.

Partnerships and Sustainability

Working relationships have been formed with the local native media, regional Survivors' programs, leadership, the Métis community, a local college and a variety of human services. However, the PCC did not receive any other funding. Possible funding sources include interest from the 4.5 million dollars from hydro, fund-raising, outreach to other communities, charging a fee for services, integration with another program, government assistance or forming partnerships with other programs. There is concern about program sustainability.

Successes and Best Practices

Success of the program had been credited to a team that was well-respected, nonjudgemental, respectful, committed and culturally sensitive who are community members and are also *Survivors* with skills. Supportive leadership, community partners and participants who genuinely want personal transformation set fertile ground for growth. Emphasizing personal responsibility, the power of choice or free will, the processes of colonization and decolonization, as well as self-trust and anger management, worked well. Some respondents felt that the combination of group lectures, one-on-one counselling and a *safe* environment created conditions for change. Specific activities that are planned to continue because of their resounding success are:

- healing/sharing circles (for unique groups);
- using Cree culture as medicine;
- bringing in presenters from the outside;
- networking and sharing with other programs and organizations;
- working with the Elders;
- field trips to residential schools brought closure for Survivors;
- continuing professional development;
- promoting services in and out of the community;
- soliciting participant feedback;
- Legacy education;
- lighthearted, fun activities; and
- scheduling evening and day sessions.

Challenges

The trailer eventually became too small and paper thin walls stressed one-on-one sessions. Pisimweyapiy Counselling Centre also needs an identity *separate* from the medicine lodge to eliminate a reluctance to participate due to fear of stigmatization as a substance abuser. Pressure to more actively engage in outreach efforts did not always win over the competing priority of supporting an ever-burgeoning participant group. Also, efforts to include family in the therapeutic process did not materialize as the team had hoped. Those who were mandated to participate came once or twice and then most (80%) dropped out. Finally, daytime scheduling presented difficulty for employed participants who could only attend evening sessions. Aftercare and continuing care in the community were considered essential to preventing relapse, but were not as fully developed as anticipated. Informants believed that more Legacy education and a higher PCC profile would help in this regard.

Addressing the Need

PCC has been so effective at addressing the need that the Health Services Division is considering adopting its approach and protocols. Respondents were evenly divided between believing that little or no improvement was needed (50%) and believing that some improvement would be beneficial (50%). Whole family therapy and outreach efforts to dysfunctional families were recommended. More generally, the proposal writing requirement of the AHF has caused communities in greatest need, who do not have the human or financial resources, not to participate in such a screening process. It was suggested that AHF's efforts be more proactive, outreaching and supportive to those communities who suffer the most.

Lessons Learned

More community involvement in program development, through the use of "coffee nights," would be beneficial. Cree culture was better medicine than originally anticipated. Also, improved networking, especially among the directors of health services, would guarantee program complementarity.

Conclusions

Nineteen of sixty-seven participants have completed the program at PCC (28%), with clearly enthusiastic impressions about their healing experience. Contributing factors include:

- a safe, culturally sensitive, therapeutic process that combined group lectures with one-on-one counselling;
- accessible scheduling of services;
- Legacy education;
- a team composed of Survivors from the community who are skilled counsellors, successful on their own healing journey, gentle, committed and professional without being imposing;
- supportive leadership, reinforcing, complementary partnerships, as well as community commitment and readiness for healing; and
- Survivor involvement in program development.

The program was able to operate at almost full capacity (89%). Most of those mandated to attend dropped out and all have suffered from physical abuse. Ninety per cent of these participants suffer from addiction and the majority (>60%) have experienced family violence, conflict with the law and lack basic life skills. Informants described a community climate of widespread poverty, addiction and family dysfunction. Phase two of the therapy program (when the family gets involved) did not go as well as planned, which probably had more to do with pervasive social problems than the skills or commitment of the team. Other events, which may have influenced the program's ability to achieve the magnitude of change it desired, include:

- clashes between Cree spirituality and Christianity;
- the socioeconomic disruption caused by hydro flooding;
- low self-esteem; and
- widespread dependence upon social assistance.

More open discussion and different attitudes toward the Legacy, together with public acknowledgement of high profile perpetrators, suggest that the climate has changed. Recommended improvements include: a bigger facility with a distinct identity (separate from the NHML), enlisting partners in Legacy education, treating the individual in the context of family and *ensuring continuing care*. Outside forces that may have had a facilitative influence include: Cree systems of restorative justice, conditional sentencing and a regional resurgence of culture. Sustainability is in question.

Recommendations

Team Issues:

- Select teams with *experience*, train them to address Survivors' unique needs;
- whenever possible, enlist recognized Survivors who have modelled a successful healing journey; and
- counsellors should be nonjudgemental, culturally sensitive, respectful and make participants feel safe.

Project Delivery:

- Ensure that facilities are adequate/appropriate in size, structure and location with an identity distinct from other services;
- ensure aftercare with home visits and centre-based outpatient therapy;

- increase time available for counselling;
- assess special needs, develop unique treatment plans or make appropriate referrals;
- learn differences between mandated and self-motivated;
- strategize how to support and engage mandated participants to complete the program;
- boost Legacy education and outreach efforts by enlisting community-based partners (schools, radio, television);
- include more women's groups and cultural teachings;
- encourage family participation with "family" night or family fun activities;
- maintain Elder involvement; and
- maintain evening and day sessions.

Evaluation Issues:
Referral, intake and follow-up information could be adapted to include:

- **personal information**: age, sex, how referred, source of income, motivation level, personal healing goals (follow-up would rate the extent to which they were able to achieve their personal goals);
- **family and living situation**: marital status, stability of living situation, number of family members in the home and roles; child care arrangements; rating of family and other social support; the history, frequency and intensity of family problems (follow-up would focus on changes in any of these);
- **legal status**: current or pending charges, hearings, recognizance, probation, parole, conditional or temporary release;
- **substance use**: current use, ability to abstain while attending PCC;
- **residential school history**: Survivor or intergenerationally impacted; perceived intensity of Legacy impact on language, culture, parenting, identity, family, relationship skills, mental health, addictions (other follow-up data collection efforts would assess the impact of the program in these areas); and
- **treatment history**: other treatment programs attended/completed and specify dates (follow-up would include other programs attended since participating in PCC).

Centre for Indigenous Sovereignty: I da wa da di
(AHF Project # RB-268-ON)

Project Description

I da wa da di (Mohawk for "we should all speak") provides a range of traditional services to Aboriginal women who have suffered the legacy of sexual and physical abuse in residential schools, including intergenerational impacts. Activities include: healing circles, fasting retreats and healing retreats; training workshops for women who work with Survivors; and an annual gathering for one hundred women Survivors, counsellors and healers. The retreats and circles are held at the beautiful Earth Healing Herb Gardens & Retreat Centre on the Six Nations reserve next door to Brantford, Ontario. The centre, which is neither incorporated nor run as a business, is a result of twenty years of dedication to healing on the part of the project coordinator, and is open to all Aboriginal women who seek healing. The project is sponsored by the Centre for Indigenous Sovereignty (CFIS) as it "seems to fall between the cracks of your [AHF's] applicant eligibility criteria."[268]

This project has been meticulous in gathering feedback from participants through post-activity evaluations, and the results are included in project reports submitted to the AHF. Other sources of information used in this case study include interviews with key informants and the project's response to the National Process Evaluation Survey (NPES).

Target Groups: The project targeted adult Aboriginal women in the province of Ontario.

Funding: The project received pilot year funding of $191,532 (1 December 1999 to 30 November 2000). Bridge funding was advanced in the amount of $47,883 to take the project to 31 March 2001, and a second phase was funded to 31 December 2001.

Project Team

The coordinator/healer is a well-reputed traditional Mohawk woman. She is an herbalist and Elder who worked as a traditional healer at health centres in Hamilton, Brantford and Toronto. She has taught at the University of Toronto, McMaster University, and Mohawk College (Brantford). She is the project's only full-time employee and there is one part-time employee (clerical). Approximately fifteen people helped in the preparation and delivery of the annual gathering. The volunteer services were estimated at fifteen hours per month covering administration, food preparation, maintenance, transportation and cultural/traditional activities.

Participant Characteristics

The project reached 223 people from 62 First Nations and urban/rural communities in Ontario. Eight people were from another province or living outside of Canada. Participants were primarily women (97%); one-quarter were Elders and 6.7 per cent were youth.

Almost three-quarters (74.4%) identified as intergenerationally impacted, while 14.3 per cent identified as Survivors and 11.2 per cent were either not impacted or they did not know. In terms of Aboriginal status,

46.2 per cent were First Nations on-reserve, 47.1 per cent First Nations off-reserve, 3.6 per cent Métis, 0.4 per cent Inuit, 2.2 per cent identified as non-status off-reserve and 0.4 per cent were identified as "other."

Context

The Department of Indian and Northern Affairs reported 146,113 registered Indians, 127 First Nations and 207 reserves in Ontario as of December 1998. Nationally, Aboriginal women constituted 51 per cent of the total Aboriginal population in 2000. The largest populated age group was between the ages of 5 to 29. The Ontario Native Women's Association web site reports the following four "Facts About Aboriginal Women:" there are 40,959 working-age Aboriginal women in Ontario; its 1989 study, *Breaking Free*, found that eight of ten Aboriginal women were experiencing violence; Aboriginal women and children are at the lowest rung on the socioeconomic ladder; and elderly Aboriginal women are the poorest of all Canadians.[269]

The healing centre is located on Six Nations territory, ten miles southeast of Brantford in southwestern Ontario. The community is abundant in resources with numerous programs and services, as well as over 300 small businesses owned and operated by community members, five elementary schools, its own police service, fire and emergency medical services, newspaper and radio station.

Outcomes and Measures

The project's short-term outcomes focussed on changes in project participants (e.g., increased coping skills and well-being), as well as changes in the environment (e.g., increased networking among healers). Measures of these changes include such things as the number of women seeking healing services and changes in participants' self-esteem, coping skills and knowledge of traditional teachings (see performance map).

Centre for Indigenous Sovereignty: I da wa da di Performance Map

<table>
<tr><td colspan="4">MISSION: Aboriginal women, the life-givers and teachers of our society, will live in healthy relationships based on an intolerance of abuse, cultural pride and sobriety.</td></tr>
<tr><th>HOW?</th><th>WHO?</th><th>WHAT do we want?</th><th>WHY?</th></tr>
<tr><th>Resources</th><th>Reach</th><th colspan="2">Results</th></tr>
<tr><th>activities/outputs</th><th></th><th>short-term outcomes</th><th>long-term outcomes</th></tr>
<tr><td>Begin the process of healing from the legacy of physical and sexual abuse in residential schools, including intergenerational impacts through healing circles, fasting retreats and healing retreats; provide a province-wide traditional gathering for women Survivors, counsellors, healers, etc.; and provide culturally based training workshops for Aboriginal women working with Survivors.</td><td>Aboriginal women and Aboriginal women healers/helpers.</td><td>Increased coping skills, positive self-images, physical, mental, spiritual and emotional well-being; traditional healing environment for women to begin the process of healing from the Legacy; stabilize women in crisis; decreased isolation and increased networking among Aboriginal women involved in healing work; and increased traditional and cultural healing skills among Aboriginal women who work with survivors of abuse.</td><td>Aboriginal women living healthy lifestyles free of physical and sexual violence; women will have a strong sense of community and identity, and there will be more women fulfilling the traditional role in all areas of community living, leadership, etc.</td></tr>
<tr><th colspan="4">How will we know we made a difference? How much change has occurred? What changes will we see?</th></tr>
<tr><th>Resources</th><th>Reach</th><th>Short-term Measures</th><th>Long-term Measures</th></tr>
<tr><td>$ 191,532</td><td>223 Aboriginal women</td><td>Self-reported and observed changes in self-esteem, self-image, coping skills, physical, mental, spiritual and emotional well-being (participant feedback forms and views of key informants); # of Aboriginal women seeking traditional healing activities; # of referrals; # of traditional healers/helpers; # of traditional activities (healing circles, retreats, fasts, gatherings); # of women in shelters; and self-reported knowledge of traditional teachings, ceremonies, etc. among community members.</td><td>Reduced rates of physical and sexual abuse/violence; reduced number of women incarcerated; reduced levels of children in care; reduced incidence of depression among women, as well as a reduction in suicide rates; increased number of women living healthy lifestyles and more involved in community leadership and decision making roles; and evidence of revitalized Aboriginal culture.</td></tr>
</table>

Influencing Individuals and Communities

All proposed activities were successfully completed; thus, the project has shown an ability to achieve its service delivery objectives.

Impact on Individuals

Post-activity evaluations and key informant interviews point to the project having an impact on individuals in four areas: 1) participants' knowledge and understanding of residential schools and their impacts; 2) participants' knowledge of traditional healing; 3) participants' healing skills; and 4) evidence of healing. In addition, the project's response to the National Process and Evaluation Survey (NPES) states the project had "some influence" on empowering individual women participants. This was evidenced by the fact that some women left abusive relationships, some facilitated workshops at the annual gathering, others began drumming and singing, and "most women have indicated they have a stronger sense of self upon completion of activity."

Increased knowledge and understanding of residential school impacts: The project's third quarterly report submitted to the AHF stated that 31 of 34 participants (91.2%), who completed evaluation forms after a training workshop, felt the information presented had increased their awareness and understanding of the impact of residential schools on Aboriginal people, families and communities. Moreover, 30 of the 34 respondents identified ways the workshop would help them in working with residential school Survivors and later generations. The comments suggest that the participants' increased understanding will be passed on to clients and family members and that it will allow them to be more empathetic, supportive, compassionate and nonjudgemental in their work with clients.

Of the 70 people who filled out evaluation forms at the annual gathering,[270] 53 (75.7%) agreed that it helped them address residential school or intergenerational trauma. Many stated that this gathering gave them a feeling of empowerment that enabled them to seek help in dealing with these issues. Other responses focussed on intended behavioural changes, such as becoming more attentive to their families, passing on cultural teachings, spending more time with Elders, and starting or continuing the healing journey. The following comment exemplifies how a combined knowledge of the Legacy and traditional teachings impacted one participant:

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

Increased knowledge of traditional healing: When asked how they knew people were more knowledgeable of traditional healing practices than they were twelve months ago, seven of eight key informants stated there was more discussion of traditional healing, people were attending more ceremonies and seeking out medicine and personal counselling.

Increased healing skills: Participants spoke about concrete tools or skills that they gained as a result of their participation in the gathering. In fact, 90 per cent, or 63 of 70 respondents, stated the gathering provided tools to continue their healing. Their responses included references to using the medicines and the medicine wheel, active listening skills, the importance of sharing, self-evaluation tools and fasting. Evaluation summaries for one of the training workshops indicated that 10 of 11 participants felt it had met their learning goals and expectations.

Evidence of healing: Examples of observed behaviour change include more people attending ceremonies in the longhouse and an increase in the number of women seeking personal counselling to further their healing. One woman shared that she had left an emotionally and psychologically abusive relationship/ marriage of 20 some odd years. As a result of her participation in the project, she had gained enough self-confidence and self-love to conclude that she wanted a more healthy life.

In addition to changes in their own lives, key informants observed changes in attitude and behaviour in the project participants. Most notable changes were in levels of self-confidence and self-worth. Other changes include developing a stronger sense of identity and pride, and a stronger commitment to personal wellness. Examples of attitudinal change provided by gathering participants include strengthening their own identity, feeling less alone and, for some, a shift in attitude to one of forgiveness towards a parent or an abuser. With respect to behavioural change, key informants reported that a couple of participants have returned to school to obtain a higher education, others have made movement in their careers, engaged in drumming and singing the traditional songs, are making their own traditional clothing, and have joined the healing movement by facilitating workshops in the community and sharing their own healing journeys.

Impact on Community

Key informants and participant evaluation reports suggest that women are feeling less isolated and more involved in community life. Key informants observed that women were taking small steps toward leadership roles and forming more solid networks in the community. One person commented that their social service agency noticed a decrease in their workload. This was interpreted as evidence that more people were seeking out the aid of traditional healers.

Key informants in the community of Six Nations noted there were more young people in mentorship with healers than in previous years. Also, comments were made that older people had been afraid of stepping out. Now, more Elders are taking an active role in the community and people are more readily able to make a commitment to the longhouse. Also, people have developed the ability to question what they do not think is right or what they do not understand.

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

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

Establishing Partnerships and Ensuring Sustainability

The centre operated without financial assistance prior to AHF funding and has been able to stand alone because of solid networks and the outstanding reputation established by the project coordinator. Each component that was offered by *I da wa da di* was done in partnership with an Aboriginal organization or through community volunteers. The value of volunteer labour was estimated at $2,160.

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

Key informants were asked if the project would be able to operate when funding from the AHF ends. A quote reflects the general response of the informants: "I think so, certainly not as it is now, people will not stop pursuing their healing, they have just gotten a taste of the "Good Life!"" Another general opinion was that the project will continue, but not to this extent. When asked what would improve the project, the response included more staff, more training, expanded facilities, and evaluation by resource people who help in the program delivery.

Meaningfully Engaging Survivors (including the intergenerationally impacted)

The project has no board of directors or advisory committees and there are no formal mechanisms in place to engage Survivors (other than as participants). Data from the NPES revealed that 32 of 223 participants are residential school Survivors and 166 have been impacted intergenerationally. It is evident from the discussion of the project's impact on individuals that it is addressing the Legacy, including intergenerational impacts. Survivors and their descendants are involved at all levels of this traditional healing program.

Managing Program Enhancement

Very informative and extensive evaluation questionnaires were completed by participants at the end of each activity. The gathering generated 70 questionnaires, which represented more than half of the participants for this activity, while response rates for smaller activities were much higher. In general, the evaluation aspect is well utilized by this project and it assisted them in developing their program design. The evaluation allowed the project to track participant characteristics, including age, Survivor status, nation, home

community, and whether or not they have participated in previous project activities. It detailed questions about learning/healing goals, expectations, results, the environment, the facilitators, and the content of sessions and activities. The evaluations are included in regular reports to the AHF, as well as in reports to the community and participants. One possible improvement to the project's evaluation strategy would be to incorporate a follow-up questionnaire inquiring about long-term changes in participants' lives.

Best Practices

Clearly, one of the project's best practices is the safe environment it has been able to create. Over 95 per cent of those who responded to the *Awakening the Spirit* evaluation said they felt safe at the gathering.

Other best practices that were identified are outlined below:

- sharing stories enlightened participants that they were not alone and were connected by different things in many different ways. The majority of respondents (87.1%) felt that group sharing was supportive;
- the project did well in addressing the Legacy. The focus on historical and contemporary impacts of the Legacy appeared to establish a constructive framework for healing and training activities; and
- the project's data collection and evaluation tools were outstanding. Informative and extensive evaluation questionnaires were completed by participants at the end of each activity.

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

Challenges

One of the challenges this project faced was responding to the demand or need for its healing services: the impact of "not anticipating the magnitude of the community's positive response." The retreat centre is equipped to deal with a limited number of individuals; therefore, the project has to set a limit as to the number of participants allowed, especially with respect to the healing circles and the fasting and healing retreats. The project reported there is a maximum waiting list of eight per healing/training activity.

Another challenge noted by key informants was the need to work collaboratively by developing a more structured network around participants. In fact, it was clear that efforts must be made in providing support to participants to continue their healing journey. Key informants were asked what other supports, other than the support received by the project, do people need on their healing journey. They gave high importance to the extended family, immediate family and friends. Participants' comments suggest that these supports must come from a place of health and healing; otherwise, the environment would not be supportive for ongoing healing. Also noted in these comments was the need for abusers to validate the pain they have caused. This reflects the concept of the abuser being held accountable to those whom they have inflicted pain upon. Holistic healing can only happen when everyone in that circle is part of the healing. *I da wa da di* is only one piece of the holistic picture, which is the reality of Aboriginal communities.

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

Sexism was noted by one respondent as a point of contention, since the teachings say that we need to make good use of people no matter what gender they are. There are not enough women chiefs, although many women work behind the scenes.

One of the strengths of this project is the experience and skills of the coordinator/healer. However, one person can only lead so many workshop, training and healing sessions. This could limit the number of participants, but it also means the project is dependent upon this one person. If the coordinator was no longer involved, could the objectives be transferable to another individual, group or centre? It should be noted that one of the project's goals was to increase traditional and cultural healing skills among Aboriginal women. In training sessions, skills were being passed on to women participants. Another goal is to build a network to increase the number of healers.

Ensuring Accountability

Comprehensive evaluation questionnaires were completed by participants at the end of each activity. The evaluations were included in regular reports to the AHF, as well as in reports to the community and participants.

Reaching Those in Greatest Need

The healing programs are open to all Aboriginal women and the target area is the entire province. However, it was unclear whether participation was hampered by the cost of travel or child care. On the other hand, *Gathering the Spirit* participants were from 44 communities across Ontario. This suggested that information about the project was reaching Aboriginal communities and that a good number of people had the means to travel to the Six Nations reserve. The gathering aimed to attract 100 participants and the actual attendance was 120.

This is a small project with one woman to lead the healing and training activities. There is enough evidence to conclude that the project was having a positive impact on participants, but further research would be required to determine if it was reaching those in greatest need.

Lessons Learned

The project coordinator identified the following as important lessons learned while developing and implementing this project:

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

Conclusions

There is evidence that *I da wa da di* is having an impact on the Aboriginal women who participated in the healing and training activities. Contributing to this success are the safe healing environment created by the project and the support, and the sharing and networking that took place among participants. In addition, the focus on historical and contemporary impacts of the legacy of residential schools appeared to establish a constructive framework for healing and training activities.

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

Recommendations

The project's tracking of participant feedback provides a solid basis for assessing its impact on participants. ***In terms of measuring longer term impacts, the development of a 12-month follow-up questionnaire is recommended to enhance the project's current process for gathering and reporting feedback.***

Odawa Native Friendship Centre: When Justice Heals
(AHF Project # 1291-ON)

Project Description

The Aboriginal Peoples' Justice Committee (APJC) was established to provide alternatives to the mainstream justice system for Aboriginal people in the Ottawa region. Through healing and sentencing circles, the APJC hoped to help Aboriginal individuals caught in the justice system to reintegrate into the community. Activities of the project included meeting with mainstream justice officials, establishing separate support groups and healing circles for offenders and victims, and referring clients to needed services and treatment facilities. Overall, the project was intended to break the cycle of incarceration and involvement with the justice system and to establish positive life patterns and relationships with families.

Target Groups: The primary target group was Aboriginal people in the Ottawa region who are in conflict with the law.

Funding: The project was funded from 1 October 2000 to 30 September 2001 with a grant in the amount of $71,165; it operated without funds both before AHF funding (beginning in 1997) and afterwards.

Project Team

The project team, as identified in the application for funding, consisted of ten volunteers with an equal gender split between male and female. Six of the volunteers were Aboriginal and four were non-Aboriginal. The non-Aboriginal volunteers were all representatives from the justice system, while the Aboriginal volunteers were representatives from Aboriginal support organizations and the education sector. Individual volunteers fluctuated over time. At one point, non-Aboriginal members outnumbered the Aboriginal members. The National Process Evaluation Survey (NPES) estimated over 100 hours per month of volunteer time.

The APJC team consisted of two co-chairs (one male and one female), a circle keeper and the circle volunteers. One coordinator was employed with the funding received from the AHF, although there was a time lapse of approximately seven months before the coordinator's position was filled.

Training workshops for the APJC members were to be offered during the course of the project. The project recognized the need for training, especially for the circle keeper and conflict mediation. While this training was not provided, Aboriginal Legal Services of Toronto conducted a general training workshop. The NPES reported that basic and advanced training was needed in the areas of crisis intervention, trauma awareness, counselling skills, Aboriginal language/culture, the history and impact of the residential schools, learning about the *Charter of Rights and Freedoms*, dealing with family violence and advanced circle keeper and sentencing circle. The quarterly reports state: "although the volunteers have a vast amount of experience in their respective fields, we recognize that we are not experts in our work with the APJC and that there is always knowledge that we do not have."

Participant Characteristics

Potential participants were recruited largely through the mainstream justice system. In order to qualify, offenders had to be found guilty, plead guilty or admit responsibility for their actions. At least two community members had to agree to support them throughout the process. Applications were considered from both adult and young offenders. All parties had to be in agreement, including the judge in sentencing cases, the crown attorney in post-charge diversion cases or the police in pre-charge diversion cases. All applicants were advised that if they did not comply with the requirements of the APJC or they breached the conditions of their release, their case would be returned to the mainstream justice system.[271]

The healing process took approximately nine months and up to a year in some cases. Participation rates ranged from two to five, with the NPES reporting that one woman and two men participated in AHF-funded project healing activities and two completed the process. One participant was a residential school Survivor, while the remaining two were intergenerationally impacted.

Context

According to Statistics Canada, the Ottawa population was 774,072 and the Ottawa-Hull region was approximately 875,100 in 2001.[272] Population statistics for Aboriginal people in the National Capital Region (NCR) vary from one Aboriginal organization to another and estimates range from 11,090 to 40,800, with 35,000 being a commonly reported figure.[273]

Aboriginal people come to urban centres for a variety of reasons, including seeking a better life for themselves and their children and pursuing post-secondary education or employment. Some Aboriginal people came to the city after their release from prison, foster care or hospitals, and many were unable or unwilling to make their way back to their home communities. Once here, they may face a myriad of challenges, including homelessness, poverty, unemployment, discrimination, substance abuse, prostitution, inappropriate and inadequate services, substandard housing and conflict with the law.[274] Housing shortages and high rents in Ottawa are creating serious problems for low income individuals and families, and Aboriginal people are overrepresented among the poor. In 1996, the poverty rate for Aboriginal people living in Ottawa was 51.2 per cent.[275]

The NPES reported the following severe challenges facing the community: history of suicide attempts, history of abuse as a victim, history of abuse as an abuser, and drug or alcohol addictions.

Outcomes and Measures

The project's desired short- and long-term outcomes are set out in the following performance map, along with indicators of how change will be measured. The desired short-term outcomes focus to provide an alternative to the mainstream justice system, bringing more cultural relevance to the mainstream system, and working more effectively with both victims and Aboriginal people in conflict with the law. The desired long-term outcomes are related to impact on the cycle of incarceration and to establish positive life patterns.

Odawa Native Friendship Centre "When Justice Heals" Performance Map

MISSION: To provide an Aboriginal-specific alternative to incarceration in the mainstream justice system in the Ottawa-Carleton region.			
HOW?	WHO?	WHAT do we want?	WHY?
Resources	Reach	Results	
activities/outputs		short-term outcomes	long-term outcomes
Hold regular support circles for offenders while in custody, healing circles for offenders, families and victims and sentencing circles; facilitate ceremonies, sweats and feasts; inform providers in the mainstream justice system of Aboriginal ways; connect offenders with Elders; conduct monthly APJC meetings; develop evaluation tools; assist offenders to reintegrate into the community; provide training to the APJC staff and volunteers; provide referrals to treatment services; and assist in the victim/offender reconciliation process.	Members of the APJC; mainstream justice system employees; Aboriginal persons in custody; Aboriginal people in conflict with the law; victims and families; and Aboriginal service providers.	To provide an alternative to the mainstream justice system and work more effectively with Aboriginal people in conflict with the law; to make the justice system more culturally relevant; to assist in reconciliation with victims; to help offenders face their behaviours; to restore relationships wherever possible; to assist offenders regain a positive sense of themselves and their culture and reintegrate into the community; and to increase the skills, capabilities and effectiveness of the APJC and other interested volunteers.	To break the cycle of incarceration and involvement with the justice system and establish positive life patterns and relationships with families.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	Reach	Short-term Measures	Long-term Measures
$77,165	# of Aboriginal offenders, victims and families participating in the program; # of APJC members; and # of Aboriginal service providers and mainstream justice personnel involved with the project.	Evidence that the program has gained trust and credibility with the justice system and Aboriginal service providers (views of key informants, APJC members, justice personnel, # of applicants and court referrals, and # of committed Elders and volunteers involved with APJC); reduced rates of incarceration and recidivism among participants; self-reported or key informant observations of changes in participants' involvement with substance abuse, family violence, sexual abuse, emotional abuse and homelessness; reduced rates of suicide among participants; self-reported and observed changes in knowledge, capabilities and skills of APJC members and in the committee's contributions to the community.	Reduction in incarceration rates and # of Aboriginal people in conflict with the law; reduced rates of addictions, physical and sexual abuse, family violence, self-abuse, homelessness and suicide.

Impact on Individuals

In light of the small number of participants (three to five in total; two had completed the circle process), impact on individuals must be viewed with caution. Yet, as one person noted, "it may not be high numbers but the healing process takes time and needs lots of patience. But we see the result even if it is only one per year."

The majority of respondents felt that participants were *less likely* to be in conflict with the law as a result of the project. Although one person pointed out, "for those that completed the process then the answer is less likely; however, if the client did not follow through then the answer is more likely." Another person distinguished between those with and those without a long history of involvement with the law. A number of respondents credited the circle process as the reason for a reduced level of conflict with the law, including the *"inordinate amount of time"* spent with the accused.

When asked to describe any changes they observed in participants' attitudes, knowledge, skills and behaviour, three respondents noted a greater awareness and knowledge of culture and traditions. There were also references to regaining self-esteem, dignity and confidence, and recognizing the destructive nature of their addictions. One client built his own house on his reserve and another is going back to school. Other changes noted by key informants include the fact that clients express themselves better at the end of a circle. Clients go through a range of emotions, including gratitude, relief, compassion, understanding, respect and a sense of self-worth. Also, the fact that they are required to ask family members to be part of the circle means they must reach out to others. In explaining why such changes have taken place, one person said, "they are given a chance – the court is not a chance." Another said that, in dealing with the committee, clients learned how to negotiate for themselves and that the circle is not an easy way out. Others spoke about the value of teachings and role of Elders.

Respondents were asked if they noticed if victims and their families were more likely or less likely to participate in alternative justice initiatives over the course of the project. Interestingly, there was no consensus and only two of eight people felt it was more likely. It appeared that victims were not necessarily Aboriginal, and non-Aboriginal victims were not particularly interested in alternative justice processes.

In spite of these diverging opinions, respondents unanimously agreed that opportunities for victims and their families to participate in reconciliation were better. Moreover, most respondents felt that the project ensured the safety of women victims (e.g., protection against re-victimization and further harm by the offender) to some degree, although a few were not sure and one person said the project is not addressing the issue at all. Those who felt the issue was addressed, cited the high proportion of female circle members and the fact these women were knowledgeable about resources and support services for women.

Respondents were also asked how well social services and justice-related services ensured the overall safety and well-being of the offender (e.g., safe from community retribution or ostracization). Respondents were divided almost evenly between those who felt some level of safety was in place and those who felt service delivery agencies were struggling or not addressing the issue (one person was not sure).

Impact on Community

All the interviewees recognized the advantages that the project brought to the Ottawa region, especially in light of the growing Aboriginal population. "Community members in conflict with the law now have somewhere to turn and even if they do not want to participate in the circle process, we have other referrals for them." When asked how the project made the mainstream justice system more culturally relevant and responsive, it was reported that awareness sessions at the courthouse were a sensitizing process for the mainstream justice personnel. One crown attorney approached an APJC member and confided that his experience of "the sentencing circle process was more satisfying than anything he had ever done." Another respondent reported greater respect for the medicines and that smudging is now allowed in the courtroom. The number of referrals from the mainstream justice system was cited as another indicator of change; but, even with the increased numbers, the APJC "had to turn away some of … [them] because we had no coordinator – not even a phone number." It was difficult to determine exactly how many referrals could have come before the circle if they had the capacity for client intake.

Despite the unanimous responses from the interviewees on the *benefits* of the project, there were a few dissenting opinions about the influence the project had on both the Aboriginal and non-Aboriginal community. For the Aboriginal community, this was principally because the community as a whole "did not support the project." They believed that the APJC was "comprised mostly of non-Aboriginal members … and they stepped back." One respondent "tried to figure out why … [the APJC] got funded by the AHF … even our support letters were from people who were not active in the community." Inexorably, the cohesiveness of the circle "broke down after a while – it was overwhelming."

There were similar opinions, although not as discordant, about the non-Aboriginal community partners. One interviewee thought the justice officials did have a willingness to learn about the circle process, but that there was never enough time. Some of the justice personnel appeared impatient with the circle process, presumably because of the slower pace of healing throughout the course of the proceedings. Another not so complimentary response maintained that "the mainstream justice representatives liked to have the circle experience just as a notch in their belt. The circle was more or less a token for them."

Establishing Partnerships and Ensuring Sustainability

The application for AHF funding listed three sources of community support: Tungasuvvingat Inuit, Wabano Centre for Aboriginal Health and the Post Charge Diversion of the Ottawa Police Service. Partnership information contained in the NPES cited two key community agencies linked with the project; one was the Bimadiszi Inuujujut Lodge that offered fast-track counselling services to APJC clients and victims, and the other was the Aboriginal Women's Support Centre (AWSC) that offered victim support. Agency partnerships identified in the quarterly reports submitted to the AHF included the Wabano Centre for Aboriginal Health, the Centre for Treatment for Sexual Abuse and Childhood Trauma, Pinganodin Lodge, House of Hope, the crown attorney's office and the police liaison offices.

Respondents did not agree on the level of support that community partners gave the project, but most felt it was at least fair. Support from Aboriginal and non-Aboriginal partners was perceived as following a similar pattern. With respect to Aboriginal partners, one person was concerned that not enough Aboriginal people were involved and another felt there was no sense of ownership by the Aboriginal partners.

The issue of sustainability was addressed separately in the NPES where it was reported that the value of donated labour from community agencies, including the crown attorney, was approximately $9,500. In addition, the court provided a meeting room for the sentencing circles. *When Justice Heals* continued to operate after the second year application for funding was declined by the AHF. Despite the fact that many of the respondents reported major problems with the project, including its accountability to the community and the lack of training for the APJC, most believe that it is a viable program and merits ongoing support.

Meaningfully Engaging Survivors (including the intergenerationally impacted)

Two different views were expressed regarding the involvement of Survivors. Most respondents reported Survivors were involved, especially in the planning phase, and one said the involvement was "significant." However, this view was disputed by another respondent: "I never came across any intergenerational or direct Survivors involved with the project and this made me very upset." When asked how well the project addressed the legacy of physical and sexual abuse, including intergenerational impacts, half of the respondents were not sure. One person stated the project was not addressing the Legacy at all and another felt it was doing poorly. The remaining two reported that the project was doing reasonably well. One of these respondents noted that, while the issue was not dealt with directly, "it gets addressed when we talk about the person's experience about their culture."

Managing Program Enhancement

Responses were split regarding how well the project's methods, activities and processes outlined in the AHF funding agreement led to desired results. Five people were unfamiliar with the funding agreement and, therefore, were unable to respond. Of the three who answered, one said very well, one rated the performance as poor and one claimed it was not addressing the stated methods and activities at all. Such divergence among interviewees probably reflected the conflicts and differences among APJC members. The NPES reported the project measured change in participants through formal (written and recorded) observations and solicited feedback, but the files do not contain these documents. Project administration reportedly suffered because everyone was so busy. One respondent stated that the project was not accountable to the AHF and "in our activities, we could have reported anything." Finally, one person spoke about making the evaluation process more formal:

> At the end of each healing circle, we gave all participants the opportunity of speaking their mind. In hindsight we should have given them the opportunity to speak their mind anonymously, perhaps through the use of an evaluation form. We needed more monitoring and evaluation for clients as well as for ourselves.

Best Practices

When asked to describe the project's successes, respondents spoke of improvements in the lives of clients. There was a big change in how a client dealt with his children and spouse, was smudging for the first time and enrolled in a native studies course. One person felt there was an increase in the community's knowledge of the justice process, and a number of examples were given of successful interactions with the mainstream justice system, including strong partnerships with the police and courts.

The third quarterly report submitted to the AHF stated that the assistant crown attorney, as a member of the APJC, had been "instrumental in having Aboriginal persons diverted away from the mainstream justice system." This suggested a growing recognition by the justice system of alternative processes. Two respondents made it clear that progress did not have to be dramatic for an intervention to be considered successful. "When a person walks through our doors, that is success" and "just because the client did not continue in the circle, I would still consider it a success because the secret was brought out in the community."

The NPES identified the following best practice: "traditional and holistic methods are used for the healing circles and it is often the re-engagement for those individuals to their culture."

Challenges

Interviewees were especially open about the problems they confronted in their various roles within the project. These challenges are summarized below.

Conflicting philosophies: Within the APJC, there were differing views about alternative justice. Some supported the community council model used by the Aboriginal Legal Services of Toronto (ALST) and felt the Ottawa approach was too closely tied to the mainstream justice system. Others strongly disagreed with the ALST model and were annoyed with a two-day training session provided by this organization because they viewed it as advocacy rather than training.

Lack of community participation and support: Three-quarters or six of the eight people interviewed referred in some way to a lack of community support and involvement.

Lack of resources: The project team was composed entirely of volunteers, except for a paid coordinator during five of the twelve months the project received AHF funding. As a result, the volunteer workload was extremely high. At the time of the interviews, there was no funding, no office and the coordinator's position was filled by a volunteer. A lack of resources within the community created additional challenges; for example, the need for a courtworker was mentioned a couple of times during the interviews.

Administrative difficulties: A number of administrative problems were cited; some associated with the lack of resources, while others seemed to be rooted in the ambiguous relationship between the project and its sponsor. The APJC had intended to file for incorporation, but the process was never completed. Odawa provided office space, but other links with the sponsor were tenuous and there was a complaint that the committee operated like an independent board even though it was not incorporated. One person reported problems getting information about the project's finances: "the accounting was done by Odawa and we never had a financial statement at our meetings."

The quarterly reports submitted to the AHF stated that, as a volunteer committee, there was no formal management structure. A report prepared for the APJC identified the need for greater clarity with respect to the roles and structure of the APJC and the need to revise the terms of reference, to review the circle process and to clarify Odawa's role with respect to the APJC.[276]

Lack of training: It appeared that the only training provided was based on ALST's community council model and this was controversial with some members. The need for training for circle members and circle

keepers was reiterated in the four quarterly reports submitted to the AHF prepared by the project. The interviews confirmed that training was an unfulfilled need; only two of eight respondents rated the training received as either very good or reasonably good. Yet, even these two followed up with comments that called their ratings into question: one mentioned insufficient training dollars to meet the need and the other stated that available training was not specific enough. One respondent rated the training as fair, two stated that no training was provided and three were unsure.

Systemic challenges: One person spoke about how defence lawyers did not get paid by legal aid for up to six months if their client went through circle sentencing. In such cases, the attorneys may be reluctant to support the process. Also, non-Aboriginal service agencies showed a reluctance to take on court-mandated clients. Another person stated that "lawyers would approve a conditional release in a heart beat because then someone else would have the responsibility." This approach may have added to the burden of Aboriginal services in the Ottawa region.

Pressures on circle members: Interviewees mentioned the long hours required by volunteers, high levels of stress and the high potential for burnout. Moreover, circle members had access to confidential information that could not be shared with the community and this created difficulties "because of the confidentiality aspect of our work, we were criticized. The committee took unfair abuse." There was also pressure felt by the Aboriginal circle members that related to the information about their community:

> Another barrier is that as Aboriginal people, we know things that the Crown does not. We know where the clients are and know when they abscond from the process. This was a big dilemma because you can't go to the Crown and advise them of all you know about the client.

This person went on to raise concerns about the safety of APJC members:

> And this work was …. dangerous! I often wondered if someone in our community would come after me. It is also very hard to be neutral in the circle when you know the family of the accused. How can you be completely impartial? The committee was constantly under a microscope.

Ensuring Accountability

There were significant concerns about the lack of community participation and support. Only one of eight respondents felt the project was reasonably accountable (e.g., engaged in clear and realistic communication with the community, as well as allow community input); the rest said it was struggling, not addressing it at all or they were unsure.

Reaching Those in Greatest Need

In the NPES, the project reported that it was reaching those who need the service the most, although it could be better. The project stipulated that as a qualification the offender must make an application to the APJC. At the time they completed the survey, the project had two clients and stated they could handle two additional offenders without having to recruit new volunteers. Half of the respondents were unsure about the project's ability to address and meet identified needs. The remaining responses varied significantly: one person said poorly, one said reasonably well and another said very well. One respondent claimed that the

project was doing reasonably well for those clients who made an application, although it was struggling to address the needs of those who did not know about the project.

Lessons Learned

The majority of respondents recognized the need for full participation of the community, both Aboriginal and non-Aboriginal, through regular communication and information sharing. Training was also identified by one respondent who said, "we needed more specific training so that we could fine tune our processes." Other suggestions outlined by respondents or recorded in the project's quarterly reports submitted to the AHF include:

- develop an information package for new volunteers;
- reevaluate and restructure the APJC terms of reference;
- pursue incorporation;
- advisory role only for non-Aboriginal APJC members;
- clearer role for police to ensure safety of participants and victims;
- follow-up with victims and families;
- client follow-up;
- recognize client suitability and return those deemed unsuitable to the courts;
- have an Elder deal with internal conflict between individual APJC members;
- establish a mechanism for possible volunteer burnout;
- bimonthly reports to the committee;
- should have a paid committee;
- regular circle meetings are vital;
- develop an evaluation form for participants;
- explore alternate sources for funding;
- explore circle keeper training;
- outreach to area reserves; and
- visit federal inmates in Kingston.

In spite of the challenges, one respondent summed up the lessons learned in the following quote: "What have I learned? That we are not always going to win, but at least when you participate you give it a shot ... and it is knowing that project outcomes do not necessarily always show project success."

Conclusions

If change is measured by the impact the project had on its clients, then change occurred. Indeed, because of the seemingly inordinate amount of time, care and concern that the circle gave to their clients, they "won them over ... the clients were overwhelmed" and some profound transformations were made. And, if we measure progress by the awareness raised in the mainstream justice system, then progress was also evident. The APJC did break barriers through their work with judges, lawyers and other justice system personnel.

Nevertheless, this case study identified a number of substantive challenges. These included internal conflicts over the sentencing circle model, lack of community support and participation, lack of training and resources, administrative concerns and systemic barriers within the mainstream system. There were some grounds

for concern that the APJC has moved ahead of the Aboriginal community in embracing and implementing a particular alternative justice model without having fully involved the community.

Recommendations

- The APJC should begin to engage the community in discussions about its work to date, as well as present examples of alternative justice models currently in use. Community support and participation were recognized as key components of successful alternative justice projects and, to this end, methods could include organizing a series of community forums and taking advantage of all opportunities to make presentations to Aboriginal community agencies and organizations;
- the community should be involved in a strategic planning process that includes discussions regarding whether the APJC should incorporate or if it should fall under an existing organization;
- the administrative structure, management structure, policies and procedures should be formalized and close attention to safety should be paid, debriefing and burnout prevention for the APJC members. Moreover, job descriptions for both volunteers and paid staff and roles for a board/advisory or steering committee and an Elder should be formalized;
- the APJC members should receive training in a number of areas, including: advanced sentencing circle and circle keeper training, mediation, alternative dispute resolution and any other training needs identified by the committee. Training opportunities should be ongoing to ensure access by new members and volunteers;
- the APJC should conduct a survey of Aboriginal and non-Aboriginal service providers to assess the range of support services available and to identify obstacles and gaps; and
- recognizing the difficulties involved in implementing the above recommendations when the APJC is operating on a volunteer basis and without operational funds, the APJC should seek funding to continue its work.

Evaluation Issues:

- Evaluation procedures and tools should be developed to collect and record confidential feedback from clients and victims, as well as community and APJC members; and
- a process should be put into place for client and victim follow-up and to track aftercare progress.

Council of the Atikamekw Nation: Koskikiwetan
(AHF Project # 1311-QC)

Project Description

The project addressed in this case study is titled "Return to our source" or Koskikiwetan (1311-QC), a continuation of the pilot project entitled Miromatisiwinik. The project activities included:

- training local frontline workers and counsellors in intervention techniques related to sexual abuse, the Legacy, crisis intervention and group facilitation. Trainees were also invited to commit themselves to a therapeutic process in order to be able to provide training to others;
- group therapeutic process involving six on-the-land sessions (15-day canoe expedition, two per month, one for adult Survivors and one for youth) in Atikamekw territory. The winter site at Lac Flamand has eight cabins and the summer site on Roy Island is accessible only by canoe with accommodation in canvas tents. A meeting of the adult and youth groups was planned at the end of each month; and
- individual psychosocial intervention offered through the use of community frontline workers and counsellors who were accessible throughout the process and gave pre-therapy sessions to prepare participants and offered post-therapy sessions to those who opted to attend.

Several other activities were organized in each community, such as sharing circles and more general Legacy education, to include as many people as possible in the healing process.

Target Groups: The target group included members (particularly families) of three Atikamekw communities: Opitciwan, Manawan and Wemotaci. Participants included non-status Indians living on- and off-reserve, Metis and Inuit. The project served participants with special needs and who belonged to the following social groups: residential school Survivors, their descendants who were affected, homosexuals, disabled individuals, non-Aboriginals and Elders.

Funding: This study focussed on the period of operation beginning 1 July 1999 and ending 31 October 2001 with a budget of $1,056,682.

Project Team

The Koskikiwetan team is composed of a project manager, a regional coordinator, three local coordinators, a clinical supervisor, local frontline workers and therapists. There were also support personnel (cook, maintenance person) who worked in collaboration with the Council of the Atikamekw Nation (Atikamekw Sipi) (e.g., education, social services, administrative and consulting services). Before requesting AHF support, a 14-member team, including a psychologist and a lawyer, was gathered to submit a proposal to address Survivors' needs. More than half of this initial team were residential school Survivors. The project also benefited from volunteer Elders from the three communities who offered their spiritual guidance and sat on various committees. The project was conducted in collaboration with the regional council for education and language, Atikamekw teaching services, the Atikamekw Language Institute (Wasikahikan) and Atikamekw Nation Documentation Services.

Participant Characteristics

The Atikamekw Nation has a young population: 60 per cent are less than 25 years old. In the Opitciwan community, children from 0 to 14 did not participate in the healing activities; but, in the other two communities, Wemotaci and Manawan, they did. It is worth noting that women participants from the three communities outnumbered men. During the first year, the majority of participants were registered Indians residing on-reserve. The total number of non-Aboriginal participants in Manawan were higher than the other two communities. By the second year, there was an increase in participants aged 50 and over. The number of non-Aboriginal participants showed a marked decrease in the second year. Overall participation decreased by 3 per cent. On the other hand, the participation of residential school Survivors increased by 1 per cent. Elder participation remained the same for both years. From the beginning of the project, involving the population was an arduous and lengthy process (and still is); many are still reticent.

Context

The three communities of the Atikamekw Nation, where the Koskikiwetan project took place, are situated in the regions of Haute-Mauricie and of Lanaudière. Most members of the Atikamekw Nation live in one of the three communities. The Atikamekw Nation has been colonized by the French and the Catholic, and some communities are accessible by dirt road only. The Atikamekw Nation administers a school system to promote Atikamekw education, language and culture, and to introduce a bilingual teaching system (Atikamekw and French) in each community. A total of 119 children from the community of Opitciwan, 212 from Wemotaci and 125 from Manawan attended residential school (almost a *third* of all community members belonging to the Atikamekw Nation) and went to either the Amos or Pointe-Bleue residential schools.

The healing process began *within* Atikamekw communities *before* the creation of the AHF; it is a *community*-initiated quest, a response to the inordinate illness burden carried by the Atikamekw. The Mikon project was a study on mortality in the Atikamekw communities that was done in 1999. In the three Atikamekw communities under study, suicides were between 3.5 to 5 times higher than in the population of Quebec or Canada. Suicide rates were clearly highest in Wemotaci (103.09 per 100,000).[277] ***Almost three-quarters (67.7%) of the individuals in Wemotaci have attempted suicide in their lifetime***. The Mikon project revealed that the adolescent population was at highest risk of committing suicide. From 1977 to 1998, the age of suicides in Wemotaci ranged from 16 to 42 years of age: 75 per cent were male and 25 per cent were female. In Manawan, the range was the same; however, there was a greater population of suicides among females (33%). In Opitciwan, the age range for suicides was greater than in the other two communities (from 10 to 65) and the gender proportion was similar to that noted in Wemotaci (75% male and 25% female). In Opticiwan, individuals 35 to 49 years of age showed the highest rate of suicide attempts (75%) followed by individuals between 25 to 34 years of age (50%). Men and women attempt suicide with the same frequency, but elevated risk was associated with living as a couple, higher income and education. In summary, violence and suicide represented a significant proportion of the general mortality in the Atikamekw communities: 32.6 per cent of deaths were due to violence and 7.8 per cent of deaths were due to suicide. Death due to violent acts was particularly evident among male individuals in the three communities: 69 per cent in Opitciwan, 83 per cent in Wemotaci and 64 per cent in Manawan. Violent death affected individuals between the ages of two months and 57 years, with ***32 per cent of the victims being children between the ages of two months and 11 years.***

In general, women were physically assaulted more than twice as often as men. Young adults between 25 and 34 years of age were more likely to endure physical assaults. Those at a higher income and education levels were more likely than others to be assaulted.[278] Women endured almost twice as much sexual abuse as men in the Wemotaci community; while in the community of Manawan, it is about one-third more. In the other age groups, it was individuals between 35 and 39 years of age who endured the most abuse in both communities. The rates of sexual abuse and physical abuse were just as alarming: 46.3 per cent had experienced sexual abuse and 32.2 per cent had experienced physical abuse in Wemotaci. In Opitciwan, the rates of sexual assaults and physical assaults were lower.[279] In Wemotaci, almost one-quarter of the individuals who suffered sexual abuse had an annual income of less than $12,000 and 40 per cent have an annual income greater than $30,000.[280]

Outcomes and Measures

The following performance map illustrates how activities were intended to lead to desired results and includes three areas of activity, which corresponds to the three phases of the Koskikiwetan project.

Koskikiwetan Performance Map

MISSION: The Atikamekw Nation project seeks to restore the individual and collective harmony of its members, in order to give them back the pride and dignity that was totally lost in the residential school institutions			
HOW?	**WHO?**	**WHAT do we want?**	**WHY?**
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Legacy education; training frontline workers in suicide prevention, grief work, and supportive counselling, crisis management, group facilitation, sexual abuse; "Inner Child" therapy for future frontline workers; and individual and collective therapy, and psychosocial and cultural interventions.	Frontline workers in the three communities, Survivors and their descendants.	Increased ability to respond adequately to the psychological, psychosocial and cultural needs of Survivors and increase number of healing participants.	Support network established; culturally appropriate service access and need; and restoration of lost identity and family and community harmony.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	**Reach**	**Short-term Measures**	**Long-term Measures**
$672,290	Adults and youth in the three communities.	Increase in the psychological and psychosocial services; increase in cultural activities; and reestablishment of family, intergenerational and community relations.	Reduced rates of suicide, alcohol and drug use, family violence, sexual and physical abuse, children in care and unemployment; and improved family, intergenerational and community relationships.

Influencing Individuals and Communities

Most respondents believed there was an increased awareness and a decreased tolerance for physical abuse, particularly among those who took part in the more intensive land-based therapies:

> [TRANSLATION] In general, it is less hidden, women are more inclined to report it.[281]

> [TRANSLATION] There is an awareness, people are able to make the connection with the residential schools.

> [TRANSLATION] It is difficult to determine, but there is much less tolerance for violent behaviour.

> [TRANSLATION] There is less physical abuse, but on the other hand, there is more verbal and psychological abuse.

Very few respondents believed that sexual abuse had decreased, but they did note an increase in the reporting of sexual abuse:

> [TRANSLATION] The silence is shattered, people are talking about it more and more.

> [TRANSLATION] There is more reporting of sexual abuse, but that does not mean that there is more sexual abuse.

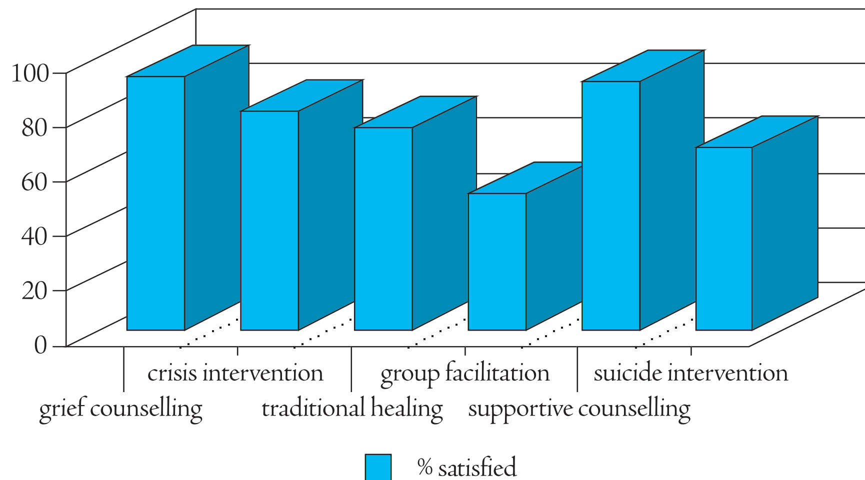
There was no agreement about the rate of children in care; however, most respondents perceived an increase in parental awareness of their roles and responsibilities, together with a noted trend towards collective responsibility for children. Most respondents were not certain if incarceration rates had changed and some felt that it was too early to tell. Others were in disagreement about changes in incarceration and suicide rates. Several pointed out that, in January 2002, there were three suicides, ***the youngest being 11 years old***.

Those who participated in training believed they were better able to:

- recognize and understand the impact of the Legacy, early warning signs of suicide, as well as the characteristics of assault;
- deal with powerlessness;
- be open and share experiences;
- give and receive compliments;
- hold children in their arms;
- perform interventions, listen and offer help;
- facilitate a group;
- use adapted work tools;
- discipline the spirit; and
- live rather than survive.

Still, Koskikiwetan evoked diverse reactions. During the first year, there was a great deal of uncertainty and distrust. Year-to-year funding caused significant staff turnover; however, some team members remained faithful to the project despite job uncertainty. These individuals *understood* the impact of the Legacy and appeared to have improved community relations. Team members also had opportunity to explore traditional healing practices in-depth and made use of these practices. Overall, the majority were satisfied with the training they received, especially counselling and crisis intervention. The following figure reveals the percentage of trainees who reported being satisfied with various training components.

Percent of Individuals Satisfied with Koskikiwetan Training by Training Type



Most of the team was composed of Survivors who directed the project and offered therapy. Informants believe that having Survivors in key roles created a climate of genuine empathy for participants and facilitated project impact through role modelling. Still, Survivor-therapists are human and some in Koskikiwetan were unable to maintain enough composure or strength to facilitate a healing session, leaving others open with no one to guide them. Several informants felt that Survivor-therapists were not receiving adequate clinical support to deal effectively with their issues. Framed within the stages of individual healing, the Survivor-therapists had not fully reclaimed stable, healthy, functional lives before they had embarked upon efforts to heal others. In part, the healing process involved becoming aware of repressed personal issues and collective problems. Because the Atikamekw communities were just gathering momentum on their healing journey, there is still a *shortage* of individual Survivors who had fully healed and could function as leaders without setbacks. Emotional explosions were to be expected in the healing process, which could create upheaval in family and community solidarity, as well as interrupt the healing process.

A regular participant evaluation was done one month after therapy and recommendations were made by local committees on a monthly basis. Participation rates, as well as self-reported ease of suffering and improved quality of intergenerational relationships, spoke well for the project. However, Koskikiwetan team members admitted that they were only touching the tip of the iceberg. [TRANSLATION] "Breaking the silence, healing and proceeding with reconstruction requires a lot of time, energy and resources of all kinds, because the whole nation is affected down to its soul."

The project staff also encountered some difficulties during the first therapy-expeditions. There were several mistakes and shortfalls in the first therapy-expedition: youth mistakenly thought it was a vacation camp and there was a shortage of coaches. Both shortfalls were corrected during the second therapy-expedition. The frontline workers encountered resistance from some to identify as a Survivor, but all participants affirmed they were very satisfied with the therapy and that they would recommend the therapy to others. The skills of the therapists were unanimously recognized by participants.

A new awareness of the Legacy's impact was evident among children as it clearly created more communication between generations. People were more inclined to openly communicate within families and communities about physical and sexual abuse, which led to an increase in the number of interventions and follow-ups. To meet this need, the project staff trained thirty frontline workers to support sexual abuse victims during the first two years of the project. Still, there was no *real* consensus about the project's ability to reduce denial and several suggested that overcoming denial is most difficult with older community members, most of whom are direct Survivors. Informants believed there was a moderate increase in understanding of the Legacy and community spirit, but were fearful that open wounds would not be given sufficient time to heal. They noted greater community participation in project activities and increased numbers of family members providing support to participants during closing ceremonies. However, reestablishing *strong* families would take more time than the duration of the project. Early signs of positive movement in this regard had been noted and included increased parental involvement in their child's scholastic activity, improved rapport between parent and child and parental insistence that children who were apprehended now *stay* in the community with their extended family.

Best Practices

The use of culturally appropriate therapies in land-based environments were credited with the improvement of self and cultural esteem, as well as the personal commitment to engage in a longer term healing process. Audio and video productions were considered effective Legacy education tools that led to some dismantling of denial and increased the number of disclosures of physical and sexual abuse. Koskikiwetan was particularly diligent in soliciting feedback from participants and team members and then making necessary program adjustments based on suggestions offered. For the most part, Survivors directed and delivered the project, which was considered a best practice because they:

- took advantage of the influence of role models;
- relied upon "homegrown" expertise and not imported professionals;
- ensured that *Atikamekw* solutions would be found to address the Legacy; and
- guaranteed moral independence and longevity of healing endeavours.

Challenges

On the other hand, moving forward with Survivors who had not healed sufficiently did, at least on one occasion, leave those in therapy open and lost because the Survivor/therapist broke down emotionally during a healing session. Unfortunately, there was an insufficient number of people who completed their healing journeys in the community to offer a wide selection of healers, therapists or counsellors. Koskikiwetan, like other projects, was faced with the dilemma of having to simultaneously develop local capacity *and* deliver much-needed therapies. While the reasons for selecting community members to lead the healing process were clear, being thrust into the role of Survivor/healer could lead to unintended and potentially harmful consequences. Koskikiwetan's experience in this regard raised an important question for others addressing the Legacy. In short, what risks are tolerable when moving forward with simultaneous training and healing? After all, Survivors are human and there are no guarantees that, in helping others, they will not be triggered to relive their own trauma. Does the need for *community-based* healers mean that some parameters need to be defined for scenarios where training and healing are simultaneous? How will Survivors' safety be guaranteed in such scenarios?

Other challenges experienced by the Koskikiwetan team include:

- lack of expertise to intervene with adolescents;
- difficulty creating solidarity within the community and the Atikamekw Nation;
- insufficient time to support and guide individuals/communities through ***all*** phases of healing; and
- the fear that an abrupt cessation of healing support would aggravate Survivors' trauma.

Partnerships and Sustainability

In each community, there was a support group made up of people working in education, health, police and social services. Managers allowed their teams to participate in therapeutic activity and, although new funding partnerships had not been formally established, pursued future relations with various service agencies was a primary objective of continued activity. Community informants believed that the momentum created by Koskikiwetan will survive beyond the life of the AHF.

Addressing the Need

Pre-therapy activities were intended to prepare and select individuals with the greatest needs. Unfortunately, the details regarding pre-therapeutic evaluation had not been secured.

Accountability

Project partners were either directly involved or regularly informed on project progress. Although screening procedures were in place for selecting team members, they admitted to being confused and unable to respond to questions about AHF requirements regarding the CPIC (Canadian Police Information Centre) clearance for employees. Community-wide communications included presentations at a conference of Elders held in Opitciwan, local meetings organized by the social, health, education and police services, as well as regional meetings of the Atikamekw Nation. At one point, the team realized that local frontline workers were not sufficiently informing the community-at-large and the situation was corrected by using community radio and television, as well as publishing articles in local papers. The video production Miromatisiwinik (Wind from the North), together with sharing circles, proved to be very effective means of Legacy education and raising awareness of project activity.

Evaluation

The project engaged in a review process involving the therapeutic team, local frontline workers, the regional coordinator and other resource people that continuously assessed training and therapy, implemented necessary short-term changes and reviewed the therapeutic approach. Several adjustments were made including greater integration of Aboriginal culture, traditional healing, spirituality and "Inner Child" therapy. They also adapted training to fit better with *individual* needs and accommodated trainees by allowing more time for them to address their issues. This resulted in more active participation and greater satisfaction among participants.

Lessons Learned

The project team recognized deficiencies in their ability to intervene with adolescents, as well as engage in post-therapy and follow-up with people *outside* the community. They learned that trainees needed to be screened to ensure their "readiness" for training and acknowledged the extensive effort required to sustain healing momentum by reducing the number of land-based therapy sessions. They knew that a *reliable and competent* team who *can set limits* to ensure effectiveness and continuity was needed. They believed that such a team included a clinical supervisor, therapists, frontline workers, volunteers and support personnel. The team was convinced that Survivors need guidance and support *over several years* (at least three). In addition, [TRANSLATION] "it would be a good thing to be able to keep the same personnel and that they have a periodic evaluation. There is also a need, at the start of the process, to create an annual schedule of the activities with the team and to evaluate it periodically."

Post-therapy was performed in groups or individually, depending on participant preferences. Parent-child dynamics created some difficulties at the beginning of the post-therapy activities. The frontline workers noted that these parental links became less of an obstacle when the post-therapy was undertaken as a group.

Conclusions

The Atikamekw Nation demonstrated its commitment to the healing process by breaking the cycle of living conditions marked by abuse and violence, a process that began *before* AHF was created. The AHF-funded project, Koskikiwetan, facilitated the nation's ability to gather momentum on the healing journey by increasing skill, community understanding of the Legacy and the number of individuals participating in therapy. The demand for continued therapy and disclosure rates of physical and sexual abuse were growing steadily. Koskikiwetan has provided opportunity for traditional methods and land-based therapies to be offered in Atikamekw and to be integrated with other services. The project was credited with reinforcing cultural pride, practice and motivation to learn more about traditional Atikamekw life; but, fundamental and enduring change takes several years of constant personal and collective investment. The Atikamekw envision a day when acculturation will only be a bad memory. With increased understanding of the Legacy, young people have gained insight about their relationships with parents and grandparents. Still, resistance is strong and high rates of staff turnover inhibit progress. The diversity and creativity of Legacy education strategies were particularly successful, including the video production Miromatisiwinik, radio talk shows, teleconferences, theatrical work and meetings with high school students and primary school teachers. At last, although continuous and regular self-examination led the project to make many corrective actions quickly, the team was keenly aware that improvements still needed to be made. [TRANSLATION] "Continuing training sessions seem to us to be a necessity." [TRANSLATION] "We are also of the opinion that support [e.g., clinical support for the Survivor therapist] must be given to the local workers and workers in the other sectors so that they can be in a better position to provide support for their clients. The activities to raise awareness about the impacts of the residential school experiences must also continue."

Recommendations

Safety and Individual Well-being:

- Ensure that the work of all team members is clinically supervised by a well-trained and seasoned counsellor/therapist;
- ensure criminal history checks are done with all frontline workers; and
- support frontline workers with vacations/cultural holidays, as well as briefings and debriefings before and after each therapy session.

Organizational Development:

- Ensure that project teams are introduced to local inhabitants;
- improve communication between regional and local offices, especially during land-based therapy sessions;
- ensure that the regional office provides clear program direction;
- create an organizational chart;
- enlist the support of a cook and a camp assistant for land-based therapies; and
- select teams trained to intervene with adolescents.

Therapeutic Activity:

- Screen individuals for therapy;
- register clients at least one week in advance;
- organize pre-therapy information sessions with guest speakers on Atikamekw culture and spirituality as a prerequisite;
- modify the application form so that sufficient information is gathered to improve therapeutic follow-up;
- promote regular physical activity to facilitate healing; and
- weave culture into post-therapy and group activities.

Cooperation and Networking:

- Participate in the community on issues regarding education, health, police, etc.;
- make decisions through local and regional interaction;
- develop team spirit;
- increase opportunities to meet with all teams (local and regional); and
- establish a protocol to promote interaction.

Evaluation:

- Create a participant satisfaction questionnaire (adapt the model provided in the "Community Guide to Evaluating Aboriginal Healing Foundation Activity");
- commit to formal planned evaluations and long-term follow-up;
- distinguish between activities and results; and
- identify the differences between those for whom the program worked and those for whom the program did not work.

Big Cove First Nation: "Our Youth, the Voice of the Future" (AHF Project # RB-175-NB)

Project Description

The Big Cove Youth Initiative provided the community's youth with support and opportunity to develop personal, social, mental and physical well-being to combat the effects of unresolved trauma originating primarily from the legacy of residential schools. Activities included: organize and implement a youth council and youth advisory board; develop ongoing activities for youth (with youth input in the planning); organize a support group night; develop an alcohol and drug awareness program; establish substance abuse workshops; provide an outreach and rehabilitative program for alcohol and drug abusers through cultural and spiritual events, alternative activities, traditional values and making referrals; and, provide aftercare and follow-up for alcohol and drug abusers.

Target Groups: The project targeted Big Cove youth between the ages of ten and twenty-nine.

Funding: The pilot year funding of $189,300 was received for the period 3 January 2000 to 31 December 2000. Bridge funding furthered the project to 31 March 2001, and a second phase was funded to 31 December 2001 (AHF project # 1822).

Project Team

The project team included the young people hired by the project, as well as key individuals within community agencies. Together, these individuals made up the Youth Advisory Board and there were connections through agency representatives to the Big Cove First Nation Wellness Committee. Represented on the advisory board were the directors of the community's major health and social service organizations (health services, child and family services, Lone Eagle Treatment Centre and alcohol and drug prevention). Also involved was the coordinator of psychological and community development, who acted as the project coordinator. Four of the board members were from Big Cove and fluent in their language. Some have been directors of their programs for over a decade.

The project coordinator is a registered psychologist who worked in the community of Big Cove since the early 1990s. There were six full-time staff members on the project: one youth development worker; three youth workers and two field workers. Three of the six staff members spoke Mi'kmaq fluently. The two field worker positions required a minimum of two years free from alcohol and/or mind- or mood-altering substances, as well as a certificate or other proof of having completed a treatment program.

All the full-time staff were female. Five of the six positions were filled by individuals of First Nations origin. There were also six part-time staff members: security, arts and crafts facilitator, youth spiritual circle facilitator, jingle dance instructor and two fund-raising assistants. All were First Nations, two were both Elders and Survivors, and the related experience of the group ranged from five to twenty-five years.

Staff training included suicide intervention, first aid/CPR, leadership, work plan development, restorative justice, personal empowerment, medicine wheel teachings, stress management and a "stop bullying" program.

Individual staff members also attended workshops, such as one attended the Youth Action Network (Toronto, ON) and two attended the Environmental Network (Truro, NS). Approximately thirty hours per month of volunteer service was noted. Volunteers donated their time in food preparation, fund-raising, healing circles, transportation and traditional activities.

Participant Characteristics

Participation rates based on gender were about even for most activities, with the exception that sports-oriented activities tended to attract more males than females. As well, some activities were targeted to one gender (e.g., the "Girls in the 90s" program). Others, such as the Santa Claus Parade, sought community-wide participation. Twenty-four distinct programs and activities were reported, including weekly sports, arts and crafts, dance lessons and support groups. The program held monthly sweats, summer and March break programs and one-time events, such as a youth rally. The number of participants in each activity ranged from 9 to 530 and the Santa Claus parade had the most participants.

The project completed the National Process Evaluation Survey and reported that healing and training activities reached approximately 150 people, 69 of which were youth. However, "reports for the final quarter of 2000 estimate the project was reaching approximately one hundred and fifty youth and children on a weekly basis."[282] One-time events, such as conferences or gatherings, were attended by up to three hundred people.

Context

Big Cove is the largest First Nation in New Brunswick with the tribal affiliation being Mi'kmaq. Big Cove's population, as stated by Indian and Northern Affairs Canada in April 2001 was 2,458, with an estimated growth rate between 3.1 per cent and 3.5 per cent. Over half (57.4%) of the population were under the age of 30, and more than one-quarter (27%) were between 15 to 29 years as of 31 March 2000. Coupled with the population growth, the need for housing continued to outstrip the ability to meet the basic human need and demand for proper shelter. Recent figures put the number of houses needed at 515.

Big Cove is located in Kent County, New Brunswick; it is in a location with high unemployment rates that fluctuate with seasonal employment. The surrounding region is primarily French-speaking (70%), further hindering the community of Big Cove, which is largely Mi'kmaq-speaking with English as their second language. A needs assessment cited the unemployment rate at 80 to 85 per cent. According to the 1996 Census,[283] the unemployment rate in New Brunswick was 15.5 per cent and in the community of Big Cove (Richibucto 15 Indian Reserve) the rate was three times greater at 46.2 per cent.

The issue of suicide in this community created extensive media attention and an added burden on community service providers. This was especially true during 1992, which saw the rate of suicide peak. The project coordinator confirmed that, during this period, all community service agencies were essentially doing crisis management. This resulted in burnout and an inability to effectively manage long-term treatment plans for many in need. Over time, with some additional resources and increased coordination within the community, they were able to shift from crisis mode to a more proactive approach.

Between 1975 and 2000, there were 34 deaths as a result of suicide. Since 1992, Big Cove's annual suicide rate was 116:100,000, with a total of 21 deaths as a result of suicide. The age for completed suicides varied, clustering in early or late twenties, then early thirties. Overall, the age range was between 16 to 34. The crisis centre in Big Cove, which staffs a help-line and outreach program, documented an average of three to five attempts per week, suggesting between 150 to 200 attempted suicides each year.

RCMP statistics showed a significant number of assault and sexual assault investigations in 1998 and 1999. However, there were few indications of the actual rates of physical and sexual abuse since reported rates tend to underrepresent the problems. When the case study was completed, a copy of this report was sent to the project team. They subsequently contacted the author to provide additional data on sexual abuse. They included a study on family violence completed in 1992, which indicated "between sixty and ninety percent of the Big Cove population being directly or indirectly affected by sexual abuse." Furthermore, the director of Psychological Services expressed a willingness to go on record to state that child sexual abuse was one of the core dysfunctions underlying the problems of suicide, attempted suicide, family violence, children in care and addiction. This was an important development in that the case study report led to a decision to publicly disclose additional information about the seriousness of the problem of sexual abuse in this community.

No figures were available on incarceration rates for this community. Vandalism and break and enters were identified as common crimes committed by youth. According to a youth survey[284] conducted early in the project, 91 per cent of respondents felt alcohol and drug use was the greatest problem facing youth today, followed by peer pressure (45%) and unwanted pregnancy (35%). When asked about the greatest needs of youth, the majority mentioned alcohol- and drug-free events (57%), fun and safe activities (54%), and recreation and sports (50%). Figures cited in a study of special educational needs[285] showed that one-fifth of the 157 students at Big Cove School had been exposed and affected by alcohol and drugs prenatally. Both parents and teachers who were surveyed provided almost equal observations on the extent of alcohol and drug abuse. Parents estimated that 71 per cent of students had educational problems related to alcohol problems and an equal portion of those surveyed noted an increase in alcohol and drug use in the community in the last twenty-five years, especially during pregnancy.[286]

A second AHF-funded project existed in the community – the "Outreach Program for the Suicidal at Risk Clients of Big Cove." The community also has a project called "Nurturing our Youth," as well as a restorative justice initiative implemented early in 2000. These last two initiatives were *not* funded by AHF, but have related or similar goals and have liaised with the AHF-funded project.

Outcomes and Measures

The following performance map was used as a one-page reference guide to collect information. The map links the desired long-term outcome – youth having the support and opportunities they need to develop personal, social, mental and physical well-being – with long-term indicators of change: reduced rates of attempted and completed suicides, alcohol and drug use, youth crime; an increase in education and skill levels; and an increase in overall community well-being (reduced rates of physical abuse, sexual abuse, incarceration, children in care). Short-term outcomes and indicators are similarly mapped. In this way, the performance map identifies significant measures of change.

Big Cove Performance Map

MISSION: To enable individuals, families and the community to achieve optimal levels of mental, spiritual, physical and emotional wellness by supporting and guiding programs within the community of Big Cove.			
HOW?	WHO?	WHAT do we want?	WHY?
Resources	**Reach**	**Results**	
activities/outputs		**short-term outcomes**	**long-term outcomes**
Provide programs and support for youth, including sports, arts and crafts, babysitting course, activity nights, "Girls in the 90s-2000s" course, youth support group and traditional activities; provide alcohol and drug awareness, outreach and aftercare, alcohol- and drug-free activities and interagency networking; and provide training for project team and develop Youth Advisory Board and Youth Committee.	Youth; project team and community.	Increased skill levels, knowledge, self-esteem, health of youth; increased levels of leadership, peer support, healthy lifestyles and communication with parents/community; build capacity and skills among youth and diversion from alcohol and drug use; reduced alcohol and drug use among youth; increased participation in alcohol and drug treatment; increased community and parental involvement in programs; creating the Youth Council and Youth Advisory Board; and progress towards establishing the youth centre.	Youth in the community have the support and opportunities they need to develop personal, social, mental and physical well-being and healthy youth equals a healthy community.
How will we know we made a difference? How much change has occurred? What changes will we see?			
Resources	**Reach**	**Short-term Measures**	**Long-term Measures**
$189,000	# of youth participating and impacted by programs.	Youth satisfaction with activities (participant feedback forms); # of youth participating in alcohol and drug services, including treatment and aftercare; level of participation in alcohol- and drug-free activities and events; rates of alcohol and drug use among youth; perceptions of key informants and self-reported changes in self-esteem, leadership skills and attitudes of youth; evidence of peer support; steps taken toward establishing a youth centre ($ raised); family and community involvement with youth (# of volunteers and duration of service); active Youth Advisory Board; participation rates and # of cultural and traditional activities, interactions between youth and Elders; and evidence of improved community spirit.	Increase in healthy youth as evidenced by reduced rates of attempted and completed suicides, alcohol and drug use, youth crime and an increase in education and skill levels; increase in overall community well-being (reduced rates of physical abuse, sexual abuse, incarceration, children in care); and healthier youth with a sense of belonging – evidence of changes in community's attitudes towards youth and in youth involvement in family and community affairs, cultural events and traditional activities.

Influencing Individuals and Communities

The project met the majority of its service delivery objectives by providing a wide variety of activities and programs for youth, as well as staff training and establishing a youth advisory board. In addition to the knowledge and skills gained in training, project staff spoke of learning from their involvement with community leaders on the advisory board.

Impact on Individuals

Overall, there was an indication that changes took place during the course of the project, such as knowledge and skill levels (leadership, cultural awareness, goal-setting, social skills), attitudes (self-esteem) and behaviour (parental involvement, mother-daughter communication, family relations and peer support). The highest area where change was noted was in cultural awareness. This was supported by project files, which show that youth sweats and other cultural activities were well attended.

Observed Changes During the Previous Twelve Months

	1	2	3	4	5	# of responses
	Little or no change				Significant change	
Youth self-esteem			3.7			14
Parental involvement		2.8				14
Mother-daughter communications			3.7			14
Family relations			3.0			14
Youth leadership			3.6			14
Peer support			3.5			14
Cultural awareness				4		13
Goal-setting			3.4			13
Social skills			3.3			13

An example was cited of how youth were showing leadership by being assertive enough to challenge traditions. In Mi'kmaq communities, wakes are almost always held in the homes of the family. Youth members of the project team took steps to hold the wake of a suicide victim at the drop-in centre, which they helped to staff on a 24-hour basis for about one week.

Key informants noted that youth "don't fight and throw things" as much as they first did. One person mentioned how project staff seemed to have greater control over the youth, even more than the teachers. Others pointed out that youth were being both listened to and encouraged more. Another noted that the youth showed up on time when they had activities to attend, thereby demonstrating responsibility and suggesting that the activities were relevant and of interest to them.

Some staff spoke of youth confiding in them, that bonding took place and that children are stopping them in the streets to say hello. Since this was relatively new behaviour, they concluded that young people and children were coming out of their shells and beginning to talk more. One teacher noted how some youth were volunteering, which she said was a big thing. Project staff also noted that older youth were now helping to watch the younger ones.

The youth support group showed steady and good attendance, and almost two-thirds of respondents (64.3%) said there were now better opportunities to deal with alcohol and drug issues than in the past. Also, just over one-third (35.7%) of respondents observed a greater willingness for youth to seek treatment.

Impact on Community

The Youth Initiative appeared to be playing a major part in closing the service gap. One informant stated: "there had been no suicide training for youth before this project, it had all been given to adults and staff." Another referred to the crisis management approach before the project. Half of the respondents spoke about a greater awareness of suicide, a new openness to talk about it and the fact that there was now more support available, including the capability for immediate response in a crisis. There were direct references to the Youth Initiative, as well as the fact that a more cooperative, proactive, multiagency approach was now in place. Without a doubt, the Youth Initiative had a role in allowing other agencies to take a pause from the crisis situation that resulted from the rash of suicides in the community.

Key informants described a number of benefits of the project:

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

Establishing Partnerships and Ensuring Sustainability

The Youth Advisory Board was comprised of the project staff (who were youth themselves) and representatives of five community agencies. These agencies, along with representatives from economic development, education, police and the band, were members of the working group of the Big Cove First Nation Wellness Committee. The Wellness Committee is a good example of the interagency partnering that benefited the Youth Initiative. The chief and council supported the youth project through a band council resolution, and key informants felt support from leadership was high. The project was also linked to other youth projects through its membership on the community's justice panel.

The project partnered with the schools (both on- and off-reserve) in many ways by coordinating and delivering alcohol and drug awareness, and by utilizing the Big Cove School to deliver activities. However,

the relationship with the school may require further work; the interviews revealed that communication between the project and the school could be better.

Meaningfully Engaging Survivors (including the intergenerationally impacted)

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

Managing Program Enhancement

The project consulted the community through the Youth Initiative Survey and has clearly responded by providing activities identified in the survey results as priorities (e.g., alcohol- and drug-free events).

Best Practices

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

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

Challenges

Lack of parenting skills, poverty, lack of literacy skills and lack of Survivor involvement in the project were identified as severe participant challenges. With respect to project activities, key informants mentioned the following challenges:

- the need for their own building;
- the need for more activities, more diverse activities, and ongoing funding in light of the high need and the size of the youth population;
- lack of parental involvement or resistance from parents;
- the effort that went into such a high level need and the challenges associated with maintaining momentum;
- burnout;

- alcohol and drug issues, including availability;
- too few volunteers;
- suicide;
- difficulties to reach "the hard-to-reach" ones; and
- working hours (evenings and weekends) created difficulties for staff with children.

Ensuring Accountability

A wide range of activities for and by youth were initiated and the staff on the project team increased their capacity to carry out their jobs through participation in a variety of training initiatives. The community survey conducted by the project in the summer of 2000 served as both a needs assessment and an evaluation tool. A youth advisory board was created.

Reaching Those in Greatest Need

While the exact number of youth participants in this project remained unclear, there was an estimate made of 150 youth and children per week. This meant that the project was serving 16.7 per cent of the estimated target group of 900 youth. In fact, the National Process Evaluation Survey completed by the project stated that, with the proper resources, it could serve 500 youth.

Some informants specifically mentioned hard-to-reach youth and one person said this was the project's biggest challenge. Further discussion among the project team and the community may be required in order to develop effective strategies on meeting the needs of hard-to-reach youth. A clear, open discussion is needed as it is a complex issue and, as the name implies, this group is *hard-to-reach*.

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

While the project had an open-door policy, recruitment priorities were identified as follows: youth aged 12 to 18 years, most needy and first-come, first-served. Events were promoted through local radio, cable TV station, a newsletter and word-of-mouth.

Lessons Learned

One major lesson learned was the underestimation of what effort was actually needed to organize the youth.

Conclusions

The investment in project staff, as evidenced in the large number of training opportunities provided, was a logical and ultimately effective place to begin. As the project begins slowly to raise self-esteem, confidence and skill levels, perhaps new leaders will emerge from this group. The project was having a positive impact in other ways as well. We know, for instance, that it provided other community services with an opportunity

to shift from crisis management to more effective long-term wellness planning and community development. Structured activities, bonding between staff and participants, and the guidance of adults involved in community agencies should support continued short-term changes and help build the foundation for long-term results. The proactive and coordinated approach to community issues taken by this project was also part of the capacity building among youth. Having a seat on the Wellness Committee and liaising with other initiatives could be seen as short-term changes, which can broaden the perspective of the project staff and help reduce gaps in service.

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

Recommendations

- Efforts should be made to secure a male worker and young male volunteers to complement the six female youth members of the project team, which may provide further opportunities for personal growth in two specific areas: role modelling and efforts to address emotional issues that are difficult to talk about (e.g., suicide and sexual abuse);
- a dialogue is needed to explore methods of gaining the trust and involvement of the "hard-to-reach" population and lead to the development of a strategic plan. A comment by the police suggests that many of the crimes in the community are being committed by the same individuals. Perhaps the youth seat on the Justice Panel can be utilized to reach young offenders and, if appropriate, to draw them into the project's circle of activities;
- greater efforts should be placed on working more closely with the Big Cove School, as some teachers were unaware of Youth Initiative events until after they had taken place. This may also help efforts to secure the use of the school's facilities and increase the potential pool of volunteers;
- strategic planning should also occur in the area of volunteer development for, without it, the project team could be hard pressed to maintain the momentum they have shown to date. This could also involve discussions with parents to see how they might become more involved; and
- further community-based research into the specific issues facing youth may provide useful insights, especially if the entire youth population of the community was targeted. This would also be helpful in assessing progress towards healthy lifestyles if the survey included questions concerning knowledge, attitudes and behaviours around issues such as alcohol and drug use. Furthermore, if information on the age and gender of respondents was collected, planning could include specific target audiences within the youth population.

Your Experience on the Healing Journey

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

Today's Date ______________________________

Name of AHF Project that you participated in ______________________________

Age _______ ☐ Male ☐ Female

AHF Project Healing Activity Start Date ______________________________

AHF Project Healing Activity Finish Date ______________________________

Healing Activity completed ☐ Yes ☐ No

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

____

____

____

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

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

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

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

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

☐ Yes (*Go to question #6*) ☐ No (*Go to question #5*)

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

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

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

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

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

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

Goal #1 ______________________________

Goal #2 ______________________________

Goal #3 ______________________________

Goal #4 ______________________________

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

☐ Yes ☐ No If yes, please say how they changed.

COMMENTS

____

____

____

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

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

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

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

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

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

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

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

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

Not Motivated						Very Motivated
1	2	3	4	5	6	7

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

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

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

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

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

COMMENTS

____

____

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

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

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

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

Questions 16 to 22 **Individual Healing Experience**

16. Did you receive individual healing sessions in the AHF Project you attended?

☐ Yes ☐ No

If not, please go to Question 23.

17. How many one-on-one sessions did you have? ____________

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

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

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

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

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

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

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

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

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

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

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

____

____

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

____

____

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

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

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

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

27. How could we improve the program?

____

____

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

____

____

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

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

Mail completed form to:

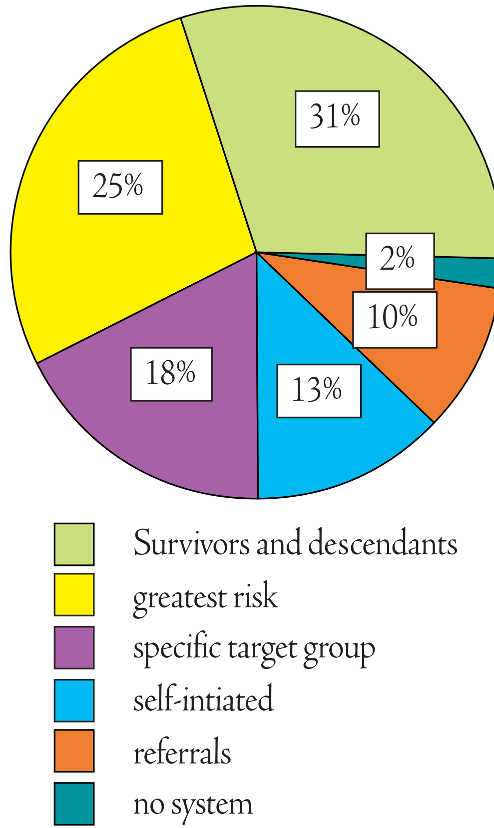
Aboriginal Healing Foundation
801 - 75 Albert Street
Ottawa, Ontario
K1P 5E7

Attention: Research

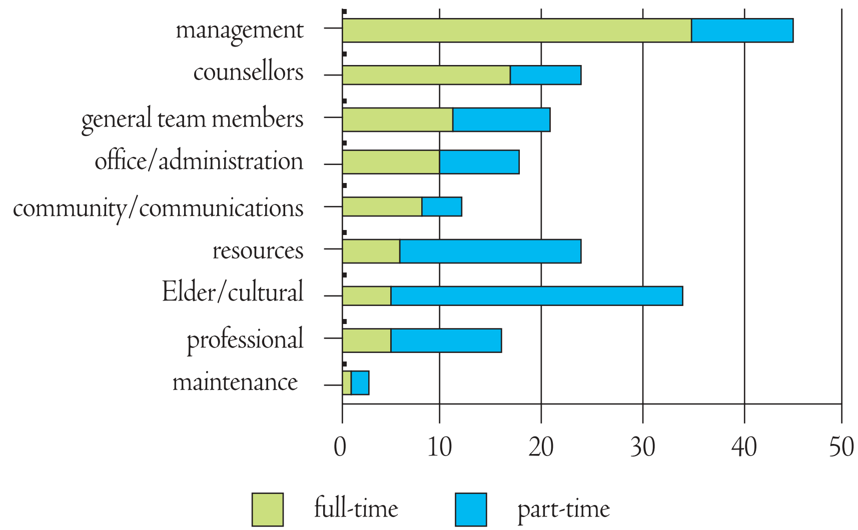
Information Sources, Types and Collection Methods

Source	Type of Information Collected	Collection Method
information management systems of the Aboriginal Healing Foundation	distribution of financial resources by project type, region, Aboriginal identification, and number of projects by year	record review
community-based groups (representatives from teams, Survivors, referral agents)	participation rates and target group profiles for both healing and training projects, community context, extent of special and outstanding need, participant challenges, team characteristics, Survivor engagement, therapeutic approaches and partnerships	national survey, observations done during case studies
project monitoring reports, evaluation reports, funding applications, memoranda, correspondence, needs assessments, eligibility criteria and guidelines, and meeting or gathering minutes (including national gathering)	activity descriptions, number and strength of partnerships, observations on achievement of focussed objectives, social indicators analysis, accountability practices, descriptions of program environment (e.g., infrastructure, team capacity, community context needs and service access), and impressions (e.g., potential impact and methodological merit) related to mandatory criteria (e.g., internal accountability, addressing the Legacy, etc.)	record review
program participants (when collected by the project team)	satisfaction with the program, demographic information, recommendations, service use and preference, experience of residential school, reason for involvement, history of participation in healing programs, types of personal goals, achievement of personal and project goals, motivation and access to support, ratings of individual and group therapy sessions, acquired skills	direct assessment or guided/self-administered questionnaire, IPQ
select communities and organizations, project team members, key informants and their referral agents	detailed contextual information; highlights of unique strategies, communities or circumstances; promising practices and greatest challenges related to unique circumstance or target; program evolution, impressions regarding impact on individuals and community, ability to address need, address the Legacy, be accountable	case studies, national gatherings and focus groups, one-on-one interviews
published and unpublished literature	information related to healing from trauma, community phases of healing, social indicators including rates of suicide, children in care, physical and sexual abuse, incarceration and community context	research
local health and social service agents, RCMP detachments, First Nation police forces	social indicators including rates of suicide, children in care, physical and sexual abuse, incarceration, community context	interviews with key informants
national stakeholders	distribution of resources, outstanding needs, challenges, lessons learned, recommendations	one-to-one telephone interviews

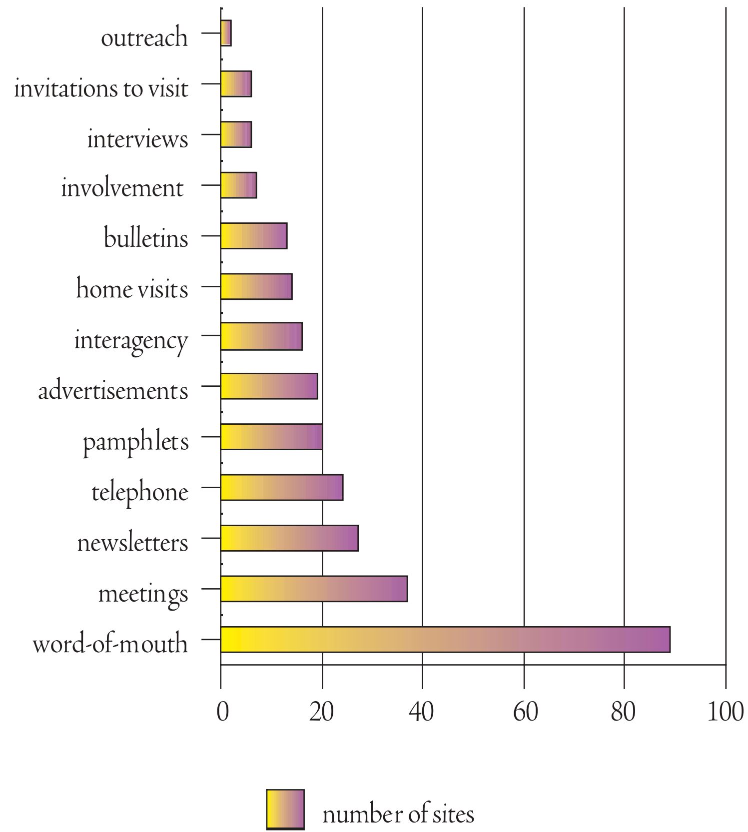
Participant Selection Criteria



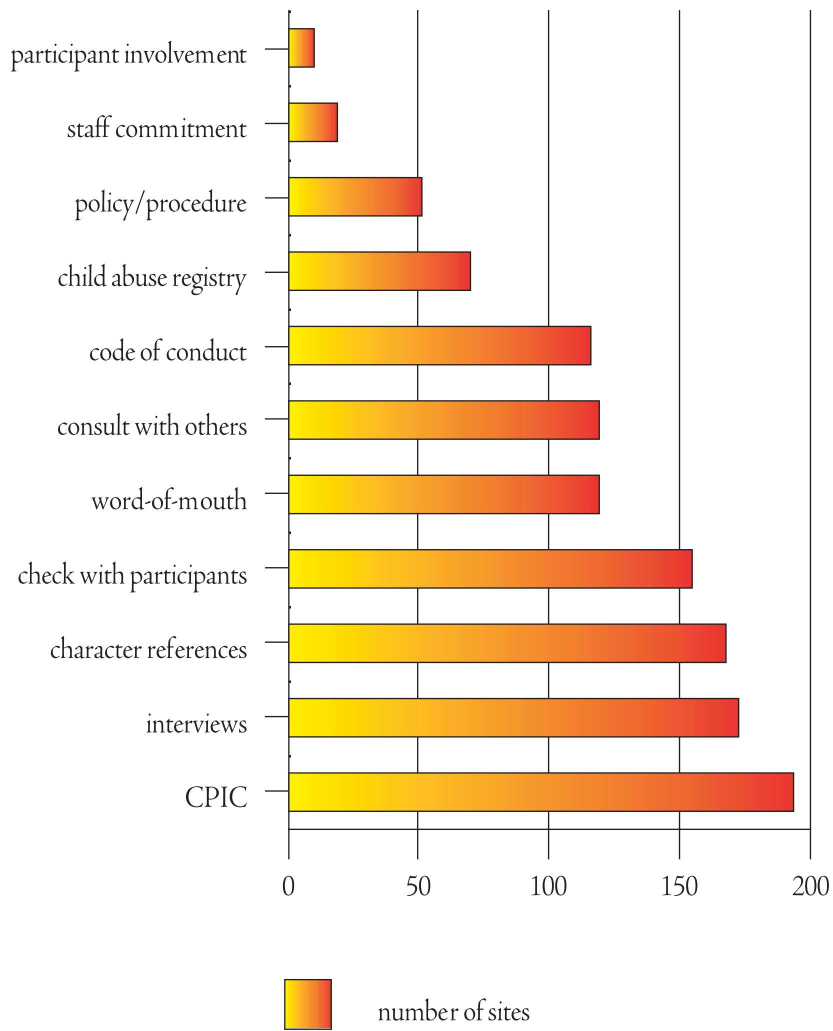
Distribution of Full- and Part-Time Team Members by Position

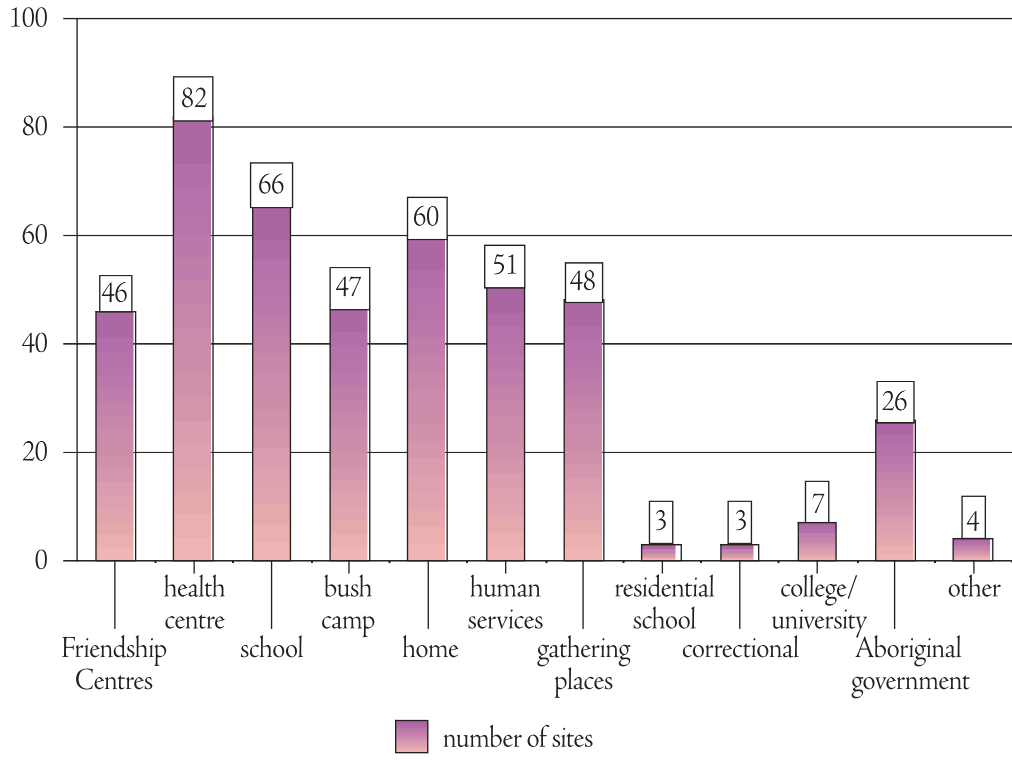


Most Commonly Used Methods to Encourage Survivor Participation



Methods Used to Guard Participant Safety




Project Environments
100
80
60
40
20
0
46
82
66
47
60
51
48
3
3
7
26
4
Friendship Centres
health centre
school
bush camp
home
human services
gathering places
residential school
correctional
college/ university
Aboriginal government
other
number of sites

Perceptions About Community Challenges and Benefits

Figure N-1) Community Response to AHF-funded Activity

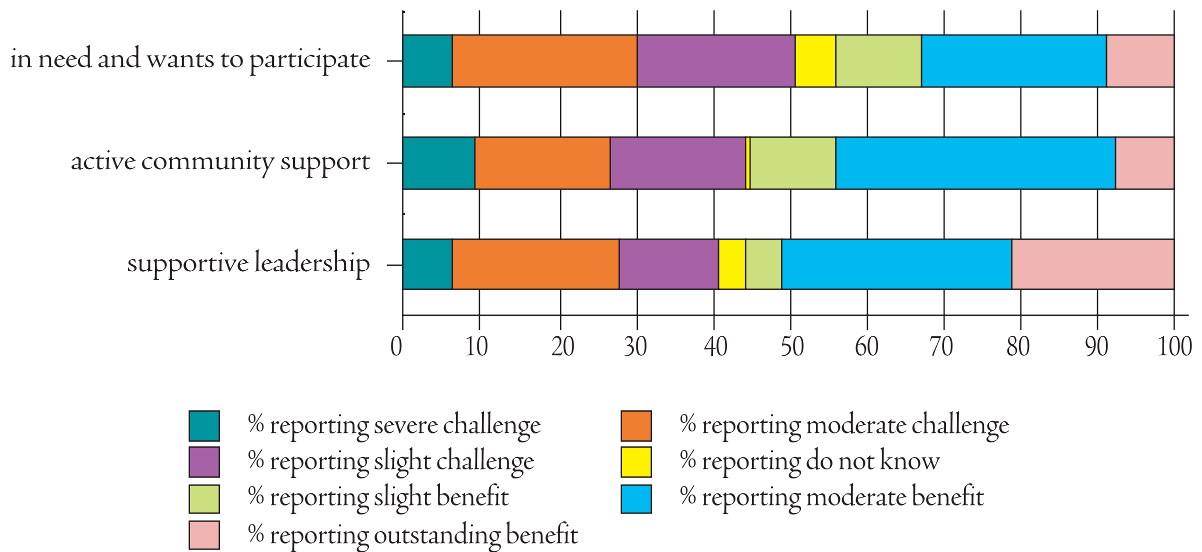
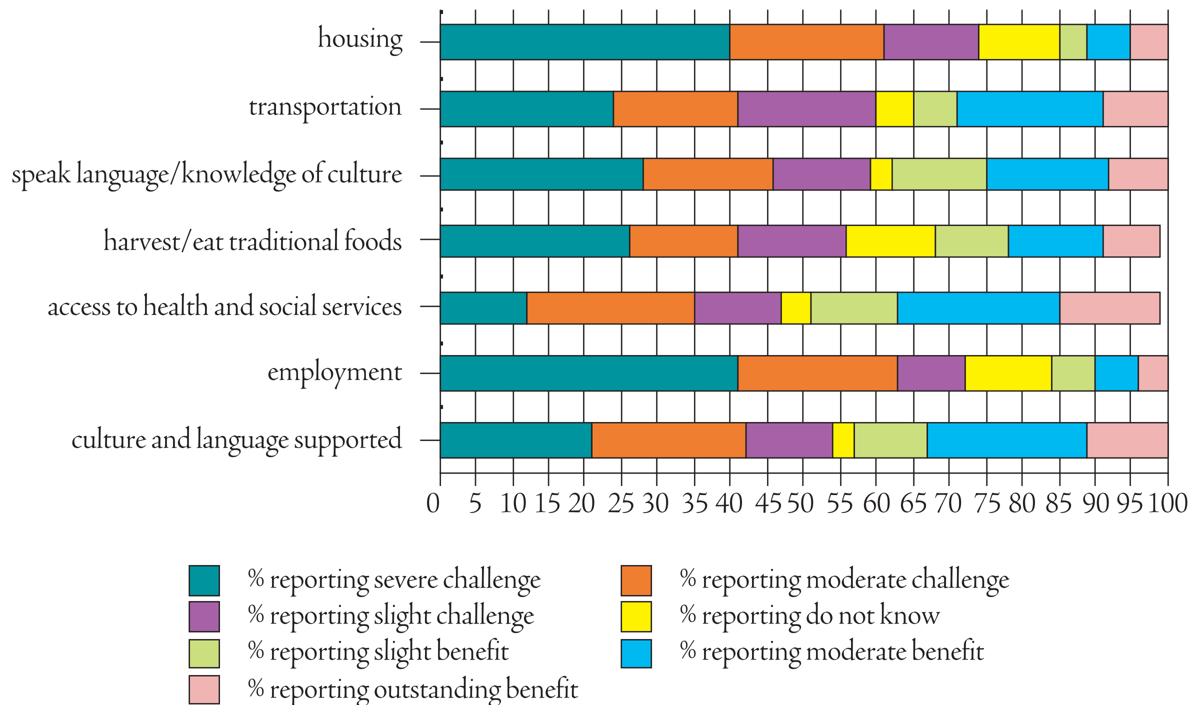


Figure N-2) Community Challenges and Benefits



Frequency of Noted Lessons Learned, Best Practices and Challenges from Thirteen Case Studies

Table O-1) Lessons Learned	Healing and Harmony in Our Families	Two-Spirited Youth Program	Every Warrior's Song	Qul-Aun Program	Tawow Healing Home	Building A Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Team Characteristics													
gender issues (more male-female teams, men working with men)	♦	♦										♦	♦
high quality, trained *Aboriginal* healers and caregivers	♦							♦		♦		♦	
do background checks before hiring			♦					♦				♦	
team care				♦				♦			♦	♦	
challenges associated with simultaneous healing and training						♦						♦	
Culture as Good Medicine													
cultural practices and teachings (including camps, Elders in school)	♦			♦	♦	♦	♦	♦	♦	♦	♦	♦	
physical environment reflects culture				♦						♦		♦	
Therapeutic Approach													
importance of whole family therapy					♦			♦					
include family of origin discussions				♦									
screen participants				♦	♦						♦	♦	
need for behavioural boundaries				♦									
identify and eliminate triggers				♦									
blend traditional and Western approaches	♦			♦	♦			♦		♦			
Service Delivery													
improve communication and networking				♦				♦	♦		♦	♦	
avoid creating service dependency								♦					
focus the reach (e.g., target youth, specific communities)						♦	♦	♦					
increase service and team capacity	♦	♦	♦		♦			♦			♦	♦	
importance of participant evaluation										♦	♦		
enormous time and effort required	♦	♦	♦			♦	♦	♦			♦	♦	♦
need for client follow-up											♦		
need to engage community											♦		

Table O-2) Best Practices	Healing and Harmony in Our Families	Two-Spirited Youth Program	Every Warrior's Song	Qul-Aun Program	Tawow Healing Home	Building A Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Legacy Education			♦	♦		♦			♦	♦		♦	
Team Characteristics													
▸ have team members that participants can identify with (role models)	♦	♦	♦	♦	♦			♦	♦			♦	♦
▸ outgoing, visible, able to engage in active outreach		♦	♦			♦							♦
▸ skilled, caring, respectful team			♦		♦	♦		♦		♦			
▸ team building/care		♦	♦										
Healing Environment													
▸ carefully select setting (home-like, established, land-based, unique for Survivors)				♦	♦			♦	♦	♦		♦	
Therapeutic Approach													
▸ strategies which reinforce feelings of safety	♦			♦	♦	♦			♦	♦			
▸ unique services to meet unique needs	♦	♦			♦	♦	♦	♦		♦		♦	♦
▸ blend traditional and Western approaches	♦			♦	♦	♦				♦	♦	♦	
▸ non-mandated parenting skills option					♦			♦					
▸ whole family treatment					♦			♦				♦	
▸ engaging Elders	♦		♦	♦		♦		♦				♦	
▸ connecting and sharing with others (conferences, group work)				♦	♦		♦	♦		♦		♦	
▸ engaging in remembrance			♦	♦					♦				
▸ emphasize personal responsibility, choice, self-trust				♦	♦	♦			♦				
▸ fun, light-hearted activity	♦					♦	♦	♦					♦
▸ continuity of service						♦							
Project Administration													
▸ adequate planning and preparation		♦							♦				
▸ screening participants				♦									
▸ Survivor involvement (target group as decision makers)			♦	♦								♦	♦
▸ soliciting and responding to participation feedback				♦					♦	♦		♦	
▸ ensuring service access	♦					♦			♦				
Networking and Partnerships													
▸ work with school							♦					♦	
▸ ensure complementary service access				♦	♦	♦			♦				
▸ involve leadership									♦				
▸ use outside expertise appropriately	♦			♦		♦	♦						♦

Table O-3) Challenges	Healing and Harmony in Our Families	Two-Spirited Youth Program	Every Warrior's Song	Qul-Aun Program	Tawow Healing Home	Building A Nation	Willow Bunch Healing Project	Kikinahk Parents of Teens Program	Pisimweyapiy Counselling Centre	I da wa da di	When Justice Heals	Koskikiwetan	Our Youth, the Voice of the Future
Individual resistance/denial	◆				◆		◆	◆				◆	
Community resistance/denial	◆				◆		◆	◆	◆			◆	
Dealing with homophobia		◆											
Uncertainty over funding/inadequate funds, resources, facilities	◆		◆	◆	◆			◆	◆	◆	◆	◆	◆
Community challenges (addictions, economy, lack of services)	◆							◆	◆	◆			◆
Hostile policy or cultural environments						◆					◆		
Programming Issues													
Low attendance, lack of time, extent of services, etc.		◆		◆				◆			◆		
Personnel issues (lack of staff, finding right people, turnover)	◆	◆	◆	◆				◆			◆	◆	
Service need/demand exceeds capacity					◆	◆		◆		◆			
Reaching men (low male participation rates)	◆							◆	◆			◆	
Misunderstandings between/among agencies, partners					◆		◆				◆		
Inability to deal with special needs; high needs target group		◆			◆			◆					◆
Evaluation issues (lack of expertise, time, personnel)	◆	◆		◆	◆			◆			◆	◆	
Lack of involvement by Survivors, parents, volunteers					◆			◆	◆		◆		◆
Need for outreach, aftercare				◆					◆	◆	◆		
Insufficient number of community-based healers												◆	
Conflicting views among team											◆		
Administrative difficulties											◆		
Lack of training											◆		

Vision Plan

Developing unique strategies also requires that the therapeutic team has an intimate knowledge of an individual's needs, hopes and dreams. Having a vision and following a dream is a way of being true to the spirit and a guiding light toward well-being. To solicit this information and to facilitate self-awareness, one project developed a vision plan. Essentially, the vision plan is structured as a card game[287] where each card says: "It would make my life more complete if I had" and finishes off with something that the individual believes would make a positive change in their life. Mentors then provide support and nurture growth toward the vision.

How to Play

Make two piles of cards. One pile is the "yes visions" to consider and the other pile is "those visions" that are not important to the individual at this time. From the "yes vision" pile ask the individual to choose five visions (four visions reinforce four parts of being and one for the centre of the circle). Give the individual enough time to look through the cards, enabling them to choose five visions that he/she believes could make a positive change in his/her life. Keep the remainder of vision cards chosen from the "yes vision" pile.

Be sure the visions chosen are his/hers and not what somebody else wants him/her to do. It is then up to the Mentor and the individual to develop plans to start making those visions come true. Putting the five visions in order of priority is not as important as the actual acknowledgement of the individual's resolve to work on these visions (goals). We must allow for the environment's influences and effects to determine which vision (goal) is more accessible at the time to reduce stress in the achievement of their choices.

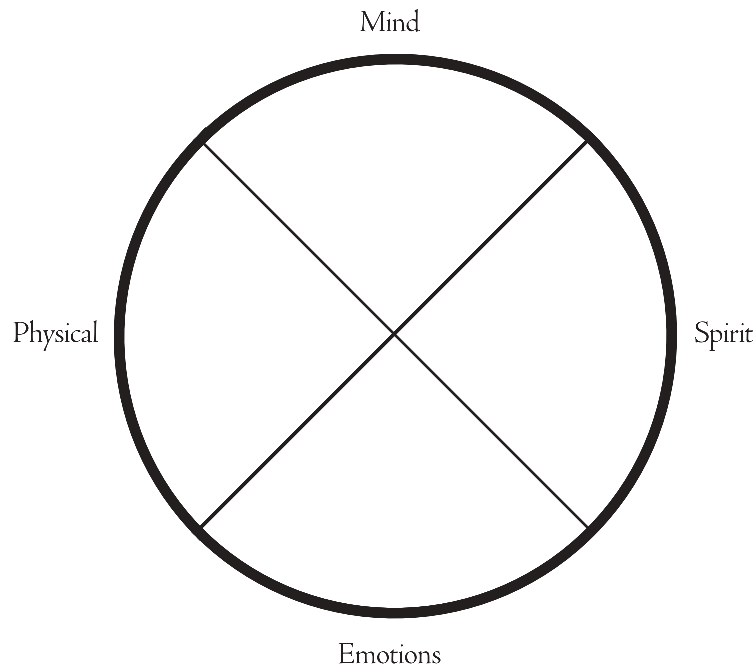
Review the remainder of visions chosen from the "yes" pile. The Mentor will assist the individual in identifying where the remainder of visions affects the individual (Spirit, Emotions, Body and Mind) on the Medicine Wheel.

1st While sorting through the deck of cards mark "Yes" or "No" beside the spaces provided below.

2nd Pick out five cards from the yes pile for highest needs, (four cards for the four directions and one card for centre of the Medicine Wheel). Check off five cards in the "Affirm" column (highest needs). Think to yourself or with a friend/mentor as to what areas these affirmations affect your life in the spirit, emotions, body, and mind.

3rd From the "yes" pile, using remainder of all cards, identify on the Medicine Wheel areas where these needs affect your life in spirit, emotion, body, mind.

4th Set goals on the five cards you have picked with the help of the Mentor.



The Wheel is a symbol of ourselves and the four areas that we try to take care of for our health and well-being. This Wheel is connected to all things and balance is from within and the world in which you live.

ABORIGINAL HEALTH & WELLNESS CENTRE

Family I.D. # ________________ Date: ________________ Mentor/CWW: ________________

NO.	YES	NO	AFFIRM	IT WOULD MAKE MY LIFE MORE COMPLETE IF I HAD ...	AFFECTS ME: (S) (E) (P) (M) *SEE BELOW
1				Someone to help me take care of my child	
2				Dependable transportation	
3				More education	
4				Legal help	
5				Housing	
6				Money to buy necessities	
7				Food	
8				Medical care	
9				Time to get enough sleep	
10				Someone to accept my child no matter how he/she acts	
11				Somewhere else to live	
12				Time for fun	
13				Time to be by myself	
14				Enough clothes	
15				A real friend	
16				Someone to hassle with agencies when I can't	
17				More control of my life	
18				Drug or alcohol treatment	
19				A dependable relationship	
20				A telephone or access to a phone	
21				Affordable day care	
22				A good job	
23				Personal safety	
24				Someone to lend me money	
25				Freedom from abuse	
26				Someone to talk to about the things that worry me	
27				Safe day care	
28				A good man/woman	
29				Birth control	
30				More confidence in myself	
31				A loving relationship	
32				More respect for myself as an Aboriginal person	
33				More understanding of my First Nation, Métis, Inuit culture	
34				Access to traditional/spiritual ceremonies	
35				An Elder to speak to	
36				This blank card can be whatever you choose that has not been listed in the other cards	

* (S) Spirit. (E) Emotions. (P) Physical. (M) Mind. Please insert in the above column as to what area(s) these affirmations may be affecting your life: Spirit, Emotions, Physical and Mind.

Guidelines for the Inductive Analysis of Survivors' Personal Goals

As a way of preparing both an objective and subjective measure of progression for Survivors, their personal goals were examined in greater depth and an inductive analysis was undertaken. Objective statements were those that spoke about *doing* things differently, *being* different or creating change in the external environment. Subjective statements were classified as such if they addressed *feelings* and other cognitive or emotional changes.

There is also some merit in looking at the distinction between those who would like to be free of some negativity in their lives and those that were seeking the addition of a positive element in their lives. In other words, statements that indicated the Survivor wanted to decrease/get rid of/stop a particular behaviour or feeling were differentiated from those who wanted to increase/acquire/improve some situation, behaviour or feeling. The directional influence desired (e.g., reduce negative influence or increase positive influence are thus reflected in each of the objective and subjective categories).

OBJECTIVE: Freedom from destructive *behaviours* and negative consequences

The responses that were classified here express wanting to stop or be free from violent behaviours and their consequences. If they had said "I want children's aid to stop coming to my door," then it was entered under this category. Likewise, the people who expressed wanting to stop violent *behaviour* toward the family, the response was also entered under this category. If they expressed wanting to be free of anger (the feeling), then the response was classified under the subjective category. Some sample responses that might have been classified here include:

- to be addict-free;
- to help keep me alcohol-free and clean; and
- how not to gamble lots of money.

OBJECTIVE: Personal

This section includes those who expressed their easily measurable goal positively. That is, they expressed wanting an increase in some behaviour or the achievement of a goal.

Specific concrete goal: In this section, the goal was stated in specific and concrete terms, such as a home, a car, a job, or to complete the program; others were more generally stated as "reaching financial goals." Some examples of goals classified here include:

- back to work;
- find low rental income housing; and
- complete the program.

Professional skill or education: Responses were classified here if they referred to completing high school, a certification program, university requirements, professional refresher courses and specific training to become an accepted healer, therapist or social worker. Samples classified here included:

- I want to finish my education (upgrading);
- get help in education; and
- complete science degree.

Specific information: Most of these simply said they wanted information on the Legacy while others wanted to learn a craft. Samples included:

- to learn about the impact of residential school;
- to be able to understand the relationship of First Nations who married Métis; and
- to learn how the project helps people.

Support network: The responses in this category all reflected a desire to build a support network. For example:

- someone to confide in confidentially when needed;
- know that others share the same issues; and
- to connect with other Survivors.

Assertiveness: All responses classified here referred to the need to *be* more assertive in their lives. For example:

- help myself be more assertive; and
- learn to say "no."

Cultural identity: In this category, all references to *behaviours* and *skills* associated with culture were included (e.g., sweats, smoking pipes, learning their ancestral language). In addition, any responses related to reclaiming or building a sense of cultural identity were included. Some examples included:

- learning my culture, traditions and languages;
- learn more on my culture; and
- I wanted more knowledge and clearer understanding of what circles are about.

Other/general: Responses classified referred to change in a vague or generic way, such as "new patterns of behaviour" or "better themselves" (53 of the 60), "better health" (2 of 60) or "continue therapy." Some examples included:

- better myself;
- change where need changing; and
- be a better person.

OBJECTIVE: Relationship

Responses categorized under objective/relationship all referred to a desire to improve relationships or to gain relationship skills (e.g., "I want to be a better parent"); this did not include a desire to stop being violent with a partner as this response was classified under freedom from destructive behaviour.

Parent/grandparent: These responses included very clear comments about wanting to improve their parenting skills or be better parents (only 2/51 mentioned being better grandparents):

- to help myself become a good parent and grandparent;
- parenting classes for my child; and
- learn to be a better parent.

Role model/peer: These responses were expressed by people who clearly wanted to improve their relationships with their peers or to become better role models. For example:

- to be able to pass myself off as a role model;
- to be role model or community leader; and
- being a better role model for the younger generation.

Partner/spouse: These responses included statements about learning how to be a better husband/wife or to get along better in "relationships" where "relationships" were assumed to be romantic:

- to be a good husband and father; and
- provide a safe environment/healthy relationship.

Family relationship: A common comment was that people wanted "a better life for their children." Other comments that were included here were "wanting to make a good home" or "improve the family":

- how to communicate better with family.

OBJECTIVE: Community/Family

These responses were clearly about taking *action* (or a willingness to take action) within their community or (less often) their family.

Increase involvement: This level of action referred mostly to socialization. People wanted to:

- attend elder socials;
- visit friends, socialize;
- dance/party;
- tell stories;
- seek elders; and
- enjoy great hospitality.

Share (knowledge/expertise): This level of action indicated that the person was willing to take his or her knowledge, skill, expertise out into the community to share with others. Some examples included:

- I want to teach others;
- to assist in helping to develop the packages; and
- to exchange information how older generations suffered.

Renew culture: These responses referred directly to actions that respondents were willing to take to renew the culture.

Create safe/healed environment: This category was a "catch all" for those who made comments about wanting *to take actions* to create a safe, supportive and healed environment. If vague statements about "wanting the community to be healed" were made, they were not classed here because the statement described the desire for healing without a clear indication of action to heal; statements that described "wants" went into previously described subjective categories. On the other hand, if the statement "I want *to create* a safe environment for young people in my community" was made, it was classified here because the action verb "to create" was included. Although the distinction may seem arbitrary, there is a clear difference in discourse between desires and actions. Some examples included:

- to *assist* in helping to develop the healing package*;*
- to *assist* in helping other Survivors*;*
- to *start* a women's support group*;*
- to *stress* need for action*;*
- to *identify* how I can help my people*; and*
- to *find* something to help the youth.

SUBJECTIVE: **Freedom from or an ability to deal with emotional or cognitive distress:** These responses were almost always related to ending a distressing feeling (e.g., shame, guilt, hate/anger, pain) or to an improved ability to deal with past issues and current distress, particularly grief and loss. For example, freedom from "fear," claustrophobia, a suffocating feeling, bad dreams and flashbacks were included here. Other examples included:

- I want to get over my jealousy and insecurity;
- release past issues and deal with issues; and
- for the claustrophobic/suffocating feeling to leave.

SUBJECTIVE: **An increase in self-awareness and understanding**

All responses grouped in this category expressed wanting to feel better about themselves or have better understanding and knowledge of *themselves.*

Identity: These responses referred to improved (self) identity. Examples included:

- to find me;
- to self-identity;
- re-visit myself; and
- to be myself.

Respect/esteem: These responses included more self-respect, self-esteem, self-love or self-worth. Examples included:

- regain self-esteem;
- self-respect;
- higher self-esteem;
- rebuild my self-esteem/image; and
- être bien dans mon peau.

Trust: Responses included a desire to be more honest, able to trust and share. Examples included:

- openness;
- honesty and commitment;
- being frank about problems; and
- learn how to trust others again.

Forgiveness: All responses grouped in this category referred to an improved ability to forgive. Examples included:

- to forgive my dad;
- I want to forgive the people that sexually abused me; and
- forgiveness to the person I blame.

Healing: All these responses mentioned "feeling healed" or a desire that their families and communities could be healed. Examples included:

- to continue healing;
- I want to heal my inner child;
- move forward/seek other healing;
- community healing;
- family healing; and
- self-help and also for my family.

Awareness/understanding: All these responses referred to wishing for an increase in self-awareness or understanding. Examples included:

- understanding needs and triggers;
- understanding;
- understanding of self and community; and
- awareness.

Empowerment: This category included a broad range of responses related to an increase in power, courage, willpower, satisfaction, freedom, pride and empowerment. Some examples included:

- power (my own);
- "free woman;" and
- to find inner strength.

Hope: This category included belief, hope and spirit. Examples included:

- beliefs/hope/faith;
- stronger faith; and
- hope this is the last workshop.

Happiness: This category was almost exclusively related to the word happy or happiness, but it also included wanting peace and acceptance. Examples included:

- acceptance;
- calmness and peace; and
- I want health and happiness.

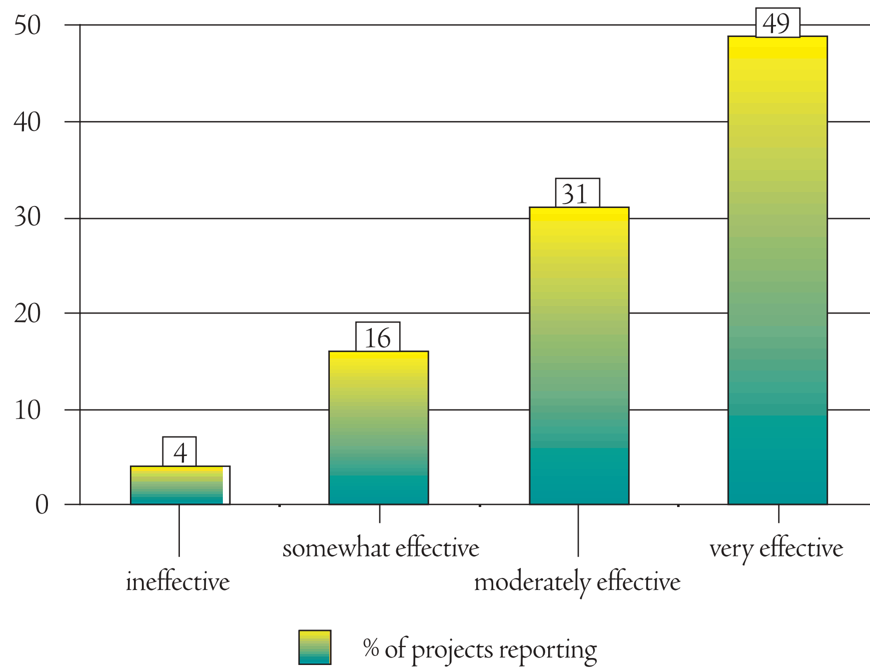
Knowledge: This category referred to SELF–knowledge. If respondents talked specifically about gaining more information or knowledge on a certain subject, then the response was included in the OBJECTIVE section under specific information. Examples included:

- more knowledge about myself;
- answers; and
- self-learning.

Other/general: This "catch-all" category included people who wanted to feel "better, stable or balanced" or wanted to cope better or feel more relaxed. One respondent wanted to "take the necessary time." Others wanted to learn how to feel anything at all and one wanted to learn how to feel pleasure. Examples of responses that fell into this category included:

- changes;
- get used to relaxing; and
- find balance.

How Effective were AHF Partners?



Specific Learning Outcomes Targeted by Legacy Education

Learn history	▶ demonstrate ability to identify colonial mentality (stereotyping, bias) in action ▶ know schools where family or community members attended; how students were enlisted to attend, general conditions and academic standards ▶ know the experiences of family or community members ▶ able to identify problems in family and community associated with the Legacy
Understand the impact of the Legacy	▶ new impression of parents and grandparents leading to forgiveness ▶ identify personal behaviour that is shaped by family and peers ▶ emerging self-image; evaluation of coping strategies; use Legacy knowledge as a basis for self-discovery ▶ make informed choices that will contribute to physical, mental, emotional, and spiritual well-being ▶ set appropriate goals for their healing journey, make *realistic* plans, and keep track of and evaluate their progress
Apply understanding to address the Legacy	▶ offer creative and critical suggestions for action designed to end the Legacy ▶ perform an activity that demonstrates awareness of their responsibilities as healing Survivors (e.g., share with others, teach, participate in anti-racism programs) ▶ demonstrate concern and care for other Survivors ▶ use a variety of forms, media, and languages to communicate knowledge and understanding of the Legacy

Informed Consent

Dear Participant,

We are trying to gather information that will help us to evaluate our efforts to heal from the legacy of physical and sexual abuse in residential schools in (name your community) and we believe that the best information would be the (pick your favourite tool or method) to see if there are differences over time. All information will remain confidential and results will be grouped together so that no individual participant can be identified in the evaluation. In other words, we will be talking about the results in terms of percentages (e.g., 80 per cent showed improved self-esteem) and not by individual (e.g., Mary showed improved self-esteem). If you agree to allow us to use your information to be included in the group, please sign below:

____

Date ____

California Healthy Kids Survey
Section B

For each of the statements below, please mark your answer sheet to show whether you feel that it is not at all true, a little true, pretty much true, or very much true.

		Not at all True	A Little True	Pretty Much True	Very Much True
I have a friend about my own age …					
B1	who really cares about me	A	B	C	D
B2	who talks with me about my problems	A	B	C	D
B3	who teases me too much	A	B	C	D
B4	who helps me when I'm having a hard time	A	B	C	D
In my home, there is a parent or some other adult …					
B5	who expects me to follow the rules	A	B	C	D
B6	who is interested in my school work	A	B	C	D
B7	who believes that I will be a success	A	B	C	D
B8	who is too busy to pay much attention to me	A	B	C	D
B9	who talks with me about my problems	A	B	C	D
B10	who always wants me to do my best	A	B	C	D
B11	who listens to me when I have something to say	A	B	C	D
B12	I feel bad when someone gets their feelings hurt	A	B	C	D
B13	I do fun things or go fun places with my parents or other adults	A	B	C	D
B14	I try to understand what other people go through	A	B	C	D
B15	When I need help, I find someone to talk with	A	B	C	D
B16	I know where to go for help with a problem	A	B	C	D
B17	I try to work out problems by talking or writing about them	A	B	C	D
B18	My friends get into a lot of trouble	A	B	C	D
B19	I do interesting activities at school	A	B	C	D
B20	My friends try to do what is right	A	B	C	D

		Not at all True	A Little True	Pretty Much True	Very Much True
B21	I do things at home that make a difference	A	B	C	D
B22	My friends do well in school	A	B	C	D
B23	I help make decisions with my family	A	B	C	D
B24	At school, I help decide things like class activities or rules	A	B	C	D
B25	I do things at my school that make a difference	A	B	C	D
Outside of my home and school, there is an adult …					
B26	Who really cares about me	A	B	C	D
B27	Who tells me when I do a good job	A	B	C	D
B28	Who notices when I am upset about something	A	B	C	D
B29	Who believes that I will be a success	A	B	C	D
B30	Who always wants me to do my best	A	B	C	D
B31	Whom I trust	A	B	C	D
At my school, there is a teacher or some other adult …					
B32	Who really cares about me	A	B	C	D
B33	Who tells me when I do a good job	A	B	C	D
B34	Who notices when I'm not there	A	B	C	D
B35	Who is mean to me	A	B	C	D
B36	Who always wants me to do my best	A	B	C	D
B37	Who listens to me when I have something to say	A	B	C	D
B38	Who believes that I will be a success	A	B	C	D
B39	I can work out my problems	A	B	C	D
B40	I can do most things if I try	A	B	C	D
B41	I can work with someone who has different opinions than mine	A	B	C	D
B42	There are many things that I do well	A	B	C	D
B43	I enjoy working together with other students my age	A	B	C	D
B44	I stand up for myself without putting others down	A	B	C	D

		Not at all True	A Little True	Pretty Much True	Very Much True
B45	I try to understand how other people feel and think	A	B	C	D
B46	I feel like I am all alone in the world	A	B	C	D
B47	There is a purpose to my life	A	B	C	D
B48	I understand my moods and feelings	A	B	C	D
B49	I understand why I do what I do	A	B	C	D
B50	I am part of clubs, sports teams, church/temple or other group activities away from school	A	B	C	D
B51	Outside of my home and school, I participate in music, art, sports or a hobby	A	B	C	D
B52	Outside of my home and school, I help other people	A	B	C	D
B53	I am confused about what I want out of life	A	B	C	D
B54	I have goals and plans for the future	A	B	C	D
B55	I plan to graduate from high school	A	B	C	D
B56	I plan to go to college or some other school after high school	A	B	C	D

WASEYA HOLISTIC TREATMENT PROGRAM

Initial assessment

Resident's name: ______________________________

Date of interview: ______________________________

Case worker: ______________________________

Elder/Helper ______________________________

This assessment tool is designed to help the Waseskun Healing team evaluate the presence, nature, extent, and seriousness of the resident's sexually aggressive and/or violent behaviours. This assessment tool also enables the interviewer to question the resident in matters such as substance abuse, employment, spousal and family relationship, interaction with peers, community involvement, emotional and personal outlook and, subsequently, to lay out prognostic opinions as to the resident's healing needs. It is important to remember that the clinical opinions that are offered by the interviewer, at the time of the initial assessment, are strictly meant to help the Healing team formulate a Healing Plan. These clinical opinions are meant to provide the team, and the resident with goals, and a way of measuring the resident's progress, throughout his stay at the Waseskun Healing Lodge. These prognostic opinions should in no way be thought of as inalterable. Please consult the Waseya Initial Assessment Protocol before proceeding.

To codify the prognostic status of the residents, in regards to the following area of concerns, the interviewer has three (3) options:

Minimal – 0 : The healing needs of the resident are minimal and his healing potential is encouraging.
Medium – 3 : The healing needs of the resident are significant and his healing potential is mildly encouraging.
High – 6 : The healing needs of the resident are of utmost importance and his healing potential is less obvious.

The first set of questions will help you establish the following:

1. The **level of cooperation** of the resident in the initial assessment process:
   - Does the resident provide an answer to all of your questions?
   - Is there noticeable delay in his responses to your questions (as if he is taking time to better present his answers)?
   - Does the resident attempt to intimidate, control, or threaten the interviewer? If so, did the resident respond to limits or did the interview have to be terminated?
   - Does the resident pretend to be in tears, change the subject, or focus on unnecessary details to avoid directly answering questions?
   - Was the resident attentive during the interview sessions?

Prognostic Status:

Minimal: The resident attends and arrives on time to the interview. The resident usually answers the questions with little hesitation and mostly pays attention during the interview.

Medium: The resident is late for the scheduled interview without an appropriate reason. The resident may avoid answering some questions altogether, is vague on many other questions, and is somewhat distracted during the interviews.

High: The resident doesn't keep his interview appointment, does not contact the interviewer, or continues to avoid making an appointment. He consistently interrupts the interviewer, outright refuses to answer many questions, and/or is disruptive during the interview. He may purposely avoid paying attention to the interviewer such as constantly looking out of the window.

2. The **level of honesty** of the resident in the initial assessment process:

Prognositc status:

Minimal: The resident's description of his offenses matches or adds to the reports provided by his correctional file. An honest resident discloses offenses or history of other types of aggressions that has never been documented. He demonstrates honesty about related problems such as his temper, his drug and alcohol use, etc. He is honest about having gotten something (even if negative) out of abusing his victims and/or the reasons why he has used drugs and/or alcohol as a disinhibitor for the commission of his offenses. The resident does not attempt to feign remorse about his offenses and is able to express anger at being caught, incarcerated and now having to attend the Waseya Holistic Treatment Program.

Medium: The resident's description of the offense indicates less serious or less frequent behaviours than documented. These omissions appear to be related to the more embarrassing or serious components of his offending behaviours. The resident's disclosure increases over the course of the assessment. The resident admits to his offenses but denies most if any past history of abuses and/or substance abuse. He admits to a past history of sexual and/or violent aggression but denies there are contributing factors and a progression to the offending behaviour. The resident presents a confusing history with little in the way of a discernable pattern or progression.

High: The resident completely and consistently denies any occurrence of the offenses, any past history of sexual and/or violent aggression, any substance abuse problems or other problems whatsoever. The resident admits to the least serious component of the offense but completely denies any prior history including having had any sexually and/or violent deviant thoughts prior to the offense.

The second set of questions you will be asking the resident will enable you to establish a clinical prognostic on the following issues:

3. Degree of aggression and violence used in committing the offense(s)
4. Frequency and duration of offenses
5. Length, nature and progression of history of aggression
6. Offense characteristics other than sexual or violent aggression
7. Number of victims in relation to general access to victims
8. Victim selection characteristics
9. Personal responsibility for offending behaviour
10. Precipitating factors to the offenses
11. Substance Abuse Behaviours
12. Substance Abuse and community reintegration potential
13. Employment
14. Spousal and family relationship
15. Interactions with peers and the community
16. Community involvement
17. Emotional and personal outlook
18. Internal motivation for treatment
19. Response to confrontation.

3. Degree of aggression and violence:

Prognostic status:

Minimal: There is no evidence or disclosure of overt violence or physical aggression in any of the offenses or in the resident's past history of offenses. The resident uses psychological means such as manipulation, bribery, or misrepresentation to engage victims in abusive behaviour.

Medium: The resident uses a minimum degree of physical restraint such as holding onto the person's legs but stops if there is any physical resistance. The resident vaguely threatens to become physically aggressive unless the victim complies. The resident demonstrates overt anger during the offense.

High: The offender used a weapon or threatened to use a weapon that is physically present. The presence of any form of brutality such as battering.

4. Frequency and duration of offenses:

Prognostic status:

Minimal: Offenses occur episodically rather than regularly (relative to victim access or offense opportunity) or if regularly than with a relatively low frequency, such as once every two or three months for a high access/opportunity resident. Minimal is also indicated when the occurrence of offenses seem related to or follow the occurrence of external contributing factors such as family crises, loss of employment or other situational crisis.

Medium: Offenses occur regularly (relative to victim access or offense opportunity) but with a moderate frequency, such as one offense per two to four week period for high access/opportunity residents. There is absence of any concrete contributing factors that precede the offenses but some general factors can be identified such as increasing peer isolation over a year period. The duration of the offenses are longer and do not always end if there is a chance of detection.

High: Offenses occur regularly (relative to victim access or offense opportunity) and with a hiqh frequency range. Offenses occur almost every time there is access or opportunity. There is a complete absence of any identifiable contributing factors that either precede or relate to the offenses. The duration of the behaviour is long and persistent during each step in the progression of sexual and/or behaviours. The offenses continue regardless of interruptions, chance of detection, or victim discomfort.

5. Length, nature and progression of history of aggression:

Prognostic status:

Minimal: The resident has a short history (several months) of offending and is in what seems to be the beginning stages of his progression of aggressive behaviours. Offenses are not well thought out and usually include less serious forms of aggressive behaviours.

Medium: The resident has a moderately long history (one to two years) of aggression and has progressed to more serious behaviours. The behaviour has already progressed to some type of direct contact with the victim. The offenses are becoming more thought out and include more extensive planning. Planning includes some indication of more serious behaviours than is already being engaged in.

High: The resident has over two years of history of aggressive behaviour and a clearly established pattern of progressively more serious offenses. Offenses are carefully thought out and almost always involve the more serious forms of sexual abuse and/or violent behaviours.

6. Offense characteristics:

This factor refers to a number of secondary offense characteristics that accompany the aggression.

Prognostic status:

Minimal: There is no indication of any of the behaviours listed below in addition to the direct aggressive behaviour.

Medium: There may be some indication of the following behaviours: mild verbal humiliation of the victim; use of a weapon, without forced; a mildly ritualized pattern to the sequence of behaviours during an offense; soliciting and encouraging others to offend in a gang offense situation.

High: A clear presence of any of the following behaviours during the offense: abduction and containment of the victim; bondage, handcuffing, or blindfolding; use of violence; forcing the victim to consume drugs or alcohol; extensive and profane verbal humiliation of the victim during the abuse; insisting on the presence of the victim's children or spouse when assaulting an adult; a strongly ritualized sequence of actions during the offense in addition to the aggressive behaviour especially if the actions seem bizarre.

7. Number of victims in relation to amount of victim access:

In general, the fewer the number of victims (relative to victim access), the lower the risk. This determination should also take into account the length to the resident's history and the resident's age.

Interviewers should keep in mind that sexual abuse and violent aggression against fewer victims do not diminish the impact of the offenses on those fewer victims as compared to a resident who aggressed many more victims. The purpose of this assessment factor is to determine risk in regards to impulsivity in gaining access to and selecting victims.

8. Victim selection characteristics:

This factor refers to the behavioural, physical, and personality characteristics of the victim that, from the resident's standpoint, effect his selection of a particular victim.

Prognostic status

Minimal: The victim does not show any particular characteristic that the resident uses to select his victim other than coincidental opportunity. The resident seems to choose the victim based more on their availability and proximity. The victim does not outwardly appear especially vulnerable or impaired.

Medium: The victim has some general physical or personality characteristics that the resident uses to select them. The resident chooses victims who show some general characteristics of vulnerability such as being isolated from peers or emotionally impaired.

High: The resident abused a vulnerable person that was other very young or very old. The resident always chooses a victim in a narrow and specific age range, physical appearance, personality type, and/or functioning level. The victim shows direct indicators of vulnerability, especially those who are psychiatrically or physically handicapped, or retarded. The resident consistently chooses complete strangers as victims. The resident, consistently chooses victims that he has formal authority over.

9. Personal responsibility for offending behaviour:

This factor refers to the degree to which the resident accepts personal responsibility for committing the offenses he was charged with. This factor should be less an indicator of the degree to which the resident minimizes the impact or seriousness of the offending behaviours, and more his demonstration of responsibility for the behaviour itself. The interviewer is basically concerned with the degree of acceptance of responsibility for the offending behaviours and the degree to which the resident externalizes blame.

Prognostic status:

Minimal: The resident acknowledges full responsibility for the aggression by admitting to having purposefully committed the offenses as well as having prior intent. The resident similarly assumes responsibility for other problem behaviours in his history. The resident may continue to have little understanding of why or how the behaviours are wrong. The resident makes very little attempt to excuse the behaviours.

Medium: The resident acknowledges only partial responsibility for the aggression by admitting that he committed the offenses, but still assigns some of the blame for the offenses to external events such as the victim's behaviours, alcohol/drug intoxication, or other people giving him responsibility for the victim. The resident is able to accept responsibility for other problem behaviours in his life that are not as embarrassing as the offenses he is at the Healing Lodge for.

High: The resident acknowledges very little responsibility for the offense by admitting that it occurred, but completely blames the victim or others for the offenses. The resident insists on not remembering any aspect of the offense or prior intent due to alcohol or drug intoxication. The resident completely denies the occurrence of the offenses. The resident also refuses to accept any responsibility for other problems behaviours.

10. Precipitating factors to the offenses:

This factor is a measure of the presence of identifiable factors that may have contributed to the commission of offenses or may be related to the particular timing of the offenses.

Prognostic status:

Minimal: The evaluator is able to identify the presence of clear precipitating stresses that are either personal, interpersonal, or familial and that have likely contributed to the resident's aggressive behaviour.

Medium: The interviewer may identify more indirect contributing factors but is unable to identify the presence of precipitating stresses either personal, interpersonal, or familial that seem related to the timing of the resident's aggressive behaviour.

High: The evaluator is unable to identify any contributing factors other than those of a very general and chronic nature. Any presence of apparent stresses appears to be unrelated to the timing of offenses.

11. Substance Abuse Behaviours:

The interviewer should obtain a detailed history of alcohol and drug use, including the amount, type, and frequency of each substance used by the resident. The interviewer should find out as much information as possible about the resident's periods of remission (length of time and circumstances); the events that have triggered relapse; the family dynamics (was there drug and alcohol use in the family); and so on.

Prognostic status:

Minimal: The resident may drink or use drugs but it does not seem to play a direct role in the offense. The resident shows no signs of chronic or addictive behaviour problem secondary to the offense.

Medium: The resident's alcohol and drug use is persistent and he becomes intoxicated regularly. The resident's substance use is related to the commission of the offense.

High: The resident frequently gets intoxicated and this intoxication plays a direct role in the commission of the offense.

12. Substance Abuse and community reintegration potential:

The interviewer should find out if the resident has used alcohol and drugs in an abusive manner during his leisure times and/or while attending social events? Does he use drugs and alcohol to find relief from stress? Does the use of drugs and alcohol have a negative impact on his relationship with his wife and/or his family? Does it have an impact on his involvement in the community? Are his drugs and alcohol use detrimental to his health?

Prognostic status:

Minimal: The resident may drink or use drugs but it does not seem to play a direct role in his being an active member of his community. The resident is either a non-user or uses responsibly.

Medium: The resident's alcohol and drug use has given him minor and/or passing difficulties in being part of the community.

High: The resident has difficulties in many of the areas listed above which results in his having serious adaptation problems to the community.

13. Employment:

The interviewer should gain some knowledge on the resident's past and present work experience.

Prognostic status:

Minimal: The resident has had stable employment and it has had a stabilising influence on the resident's place and role in the community. Chronic unemployment or periods of unemployment did not have any impact on his functioning in the community and/or his daily activities.

Medium: The resident's unstable employment or unemployment has given him minor and/or passing difficulties in being part of the community.

High: The resident's employment difficulties and/or chronic unemployment has had a major impact on his place and integration into the community.

14. Spousal and family relationship:

The interviewer should access the quality of the resident's relationship to his spouse and his family and see how supportive they are to him.

Prognostic status:

Minimal: The resident has satisfactory and warm relationships with his spouse and his family. These relationships are supportive rather than a deterrent to the resident's return to the community.

Medium: There is indifference or lack of affection; there is aggressivity; there are conflicts and altercations between the resident and his spouse and/or family.

High: The trust of the resident's relationship with his spouse and family (as determine above) regularly interfere with his involvement in the community.

15. Interactions with peers and the community:

Are the resident's relationships with his peers and the rest of society of a positive nature?

Prognostic status:

Minimal: The resident has mostly associated with peers that do not have criminal records; his relationship with the rest of society is of a positive nature.

Medium: There is a lack of positive social interactions in the resident's life and many of his peers have criminal records.

High: The lack of positive social interactions in the resident's life and the fact that many of his peers have criminal records has an impact on his functioning in the community.

16. Community involvement:

How successful has the resident been in finding adequate housing for himself, managing his finance, communicating with others, finding leisure and support for himself.

Prognostic status:

Minimal: The resident possesses the necessary skills to take part in a positive manner in the community.

Medium: One of the following: finding adequate housing, managing his finance, communicating with others, finding leisure and support has had a minor or temporary impact on the resident's participation in the community.

High: The above factors have caused grave societal adaptation problems to the residents.

17. Emotional and personal outlook:

The interviewer forms an opinion on the resident's cognitive capability, his concept of self, his overall mental aptitude and mental health, his day-to-day functioning in the community.

Prognostic status:

Minimal: The resident's cognitive capability, concept of self, overall mental aptitude and mental health does not impair his day-to-day functioning in the community.

Medium: The resident has minimal difficulties in the cognitive capability, concept of self, overall mental aptitude and mental health spheres.

High: One of the above factors has a serious impact on the resident's ability to function in society.

18. Internal motivation for treatment:

Prognostic status:

Minimal: The resident demonstrates some appropriate affect about having a problem. He may feel ashamed following the offenses because there is some understanding that what he did was wrong. He recognises that his behaviours have had some impact on the victim.

Medium: The resident's motivation for being in the Waseya Holistic Treatment Program is only to conform to his parole conditions. There is some negative affect about having the problem but only as it relates to the social stigma attached to the behaviour.

High: The resident demonstrates little or no appreciation that the offenses are problematic. He appears annoyed or bothered by the assessment process.

19. Response to confrontation:

This factor refers to the resident's psychological, verbal, and physical reaction to the interviewer's confrontation. The interviewer should keep this factor in mind throughout the evaluation process since his observation of the resident's responses to confrontation is the primary method of addressing this factor.

Prognostic status:

Minimal: The resident is able to verbalize near the end of the evaluation process that he dislikes the confrontation but accepts and understands its purpose. The interviewer observes an underlying sense of relief on the part of the resident that someone in authority has taken control of the subject of offenses.

Medium: The resident's response to confrontation is to become angrier, defensive, rationalizing, superficially compliant, he is later able to absorb only the basic points presented during the confrontation. Over the entire evaluation process, the confrontation only helps the resident to avoid obvious dishonesty with the interviewer. The resident may withdraw and only superficially acknowledge the confrontation without it appearing to have an impact.

High: The resident's response to confrontation is to become outwardly aggressive, uncooperative, challenging and/or verbally attacking with the interviewer. The resident's response to confrontation is to immediately and superficially agree with the interviewer and then attempt to change their attitude to say what they believe the interviewer wants them to say. Or, the resident completely withdraws from the interview.

To grade the initial assessment:

Give the following grades to the various factors.
Minimal = 0 Medium = 3 High = 6

1. The overall challenge to treatment: Add factors 1 through 19 and divide by 19. This scale enables the interviewers to state that the challenge that the resident will encounter in treatment are either **minimal**, **medium** or **high**.
2. The degree of resistance to acknowledging the seriousness of the offenses: Add factors 3 through 8 and divide by 6. This scale enables the interviewers to state that the resident's resistance to acknowledging the seriousness of the offenses is either **minimal**, **medium** or **high.**
3. The overall resistance to treatment: Add factors 1, 2, 9, 10, 11, 18 and 19 divide by 7. This scale enables the interviewers to comment on the resident's overall **resistance** to treatment putting aside the overall challenge to working with the resident.
4. Long-term response to treatment: Add factors 2, 9, 10, 12, 13, 14, 15, 16 and 17 and divide by 9. This scale enables the interviewers to state that treatment is likely to benefit the resident and that the probability that he will reoffend, on a long-term basis, is either **minimal**, **medium** or **high.**

Michel Gagnon, clinical consultant
Waseskun Holistic Treatment Program
Revised 11, 2004

Parent Pre-/Post-Program Questionnaire

It would be very helpful to us if you would take the time to answer the following questions. Knowing more about your life and experiences will help us to improve this program and learn more about what parents and families in our community need.

1. What are the most important things you would like help with in coming to this program?

____

____

____

2. Please circle the words that best describe **how your family handles the following <u>up until now</u>**:

- Speaking and listening to each other respectfully even when we disagree
  we do this really well *we do this okay* *we don't do very well at all*
- Are always there to help each other when we really need it
  we do this really well *we do this okay* *we don't do very well at all*
- Giving each other space when we need it
  we do this really well *we do this okay* *we don't do very well at all*
- Having meals together as a family and enjoying it
  we do this really well *we do this okay* *we don't do very well at all*
- Spending time together in other ways as a family
  we do this really well *we do this okay* *we don't do very well at all*
- Expressing our feelings of love and pride for each other
  we do this really well *we do this okay* *we don't do very well at all*
- Expressing our feelings of displeasure or anger in healthy ways
  we do this really well *we do this okay* *we don't do very well at all*
- Dealing with stress
  we do this really well *we do this okay* *we don't do very well at all*
- Use of fair and appropriate discipline
  we do this really well *we do this okay* *we don't do very well at all*
- Making time for Aboriginal cultural activities in the life of our family
  we do this really well *we do this okay* *we don't do very well at all*

3. Please circle words that best describe **<u>your own parents or the family you grew up in.</u>**

- Speaking and listening to each other respectfully even when we disagree
  we do this really well *we do this okay* *we don't do very well at all*
- Were always there to help each other when we really needed it
  we do this really well *we do this okay* *we don't do very well at all*
- Gave each other space when we needed it
  we do this really well *we do this okay* *we don't do very well at all*
- Had meals together as a family and enjoyed it
  we do this really well *we do this okay* *we don't do very well at all*
- Spent time together in other ways as a family
  we do this really well *we do this okay* *we don't do very well at all*
- Expressed our feelings of love and pride for each other
  we do this really well *we do this okay* *we don't do very well at all*
- Expressed our feelings of displeasure or anger in healthy ways
  we do this really well *we do this okay* *we don't do very well at all*
- Dealt with stress
  we do this really well *we do this okay* *we don't do very well at all*
- Use of fair and appropriate discipline
  we do this really well *we do this okay* *we don't do very well at all*
- Made time for Aboriginal cultural activities in the life of our family
  we do this really well *we do this okay* *we don't do very well at all*

4. If you could ***only choose three of the following, circle the top three*** things on this list you feel might have helped your parents to be better parents.

- Having more money
- Spending more time together as a family
- Handling anger better
- Having programs like this
- More time with the Elders
- Getting more involved with the community and their culture
- Other (your own idea for what they needed)

____

5. Please circle the words that best describe ***how your family handles the following now that you have finished this parent program:***

- Speaking and listening to each other respectfully even when we disagree
  we do this really well *we do this okay* *we don't do very well at all*
- Are always there to help each other when we really need it
  we do this really well *we do this okay* *we don't do very well at all*
- Giving each other space when we need it
  we do this really well *we do this okay* *we don't do very well at all*
- Having meals together as a family and enjoying it
  we do this really well *we do this okay* *we don't do very well at all*
- Spending time together in other ways as a family
  we do this really well *we do this okay* *we don't do very well at all*
- Expressing our feelings of love and pride for each other
  we do this really well *we do this okay* *we don't do very well at all*
- Expressing our feelings of displeasure or anger in healthy ways
  we do this really well *we do this okay* *we don't do very well at all*
- Dealing with stress
  we do this really well *we do this okay* *we don't do very well at all*
- Use of fair and appropriate discipline
  we do this really well *we do this okay* *we don't do very well at all*
- Making time for Aboriginal cultural activities in the life of our family
  we do this really well *we do this okay* *we don't do very well at all*

6. If you could ***only choose three of the following, circle the top three*** things on this list ***that would help you*** to be a better parent:

- Having more money
- Spending more time together as a family
- Handling anger and stress better
- Having programs like this
- More time with the Elders
- Getting more involved with the community and their culture
- Other (your own idea for what they needed)

  ____

7. What have been the most important ways you **have changed as a result of this program?**

Sense of Coherence Scale

		1	2	3	4	5	6	7
1.	When you talk to people, do you have the feeling that they don't understand you?	never						always have this feeling
2.	In the past, when you had to do something which depended upon cooperation with others, did you have the feeling that it:	surely wouldn't get done						surely would get done
3.	Think of the people with whom you come into contact daily, aside from the ones to whom you feel closest. How well do you know most of them?	you feel that they're strangers						you know them very well
4.	Do you have the feeling that you don't really care about what goes on around you?	very seldom or never						very often
5.	Has it happened in the past that you were surprised by the behaviour of people whom you thought you knew well?	never happened						always happened
6.	Has it happened that people whom you counted on disappointed you?	never happened						always happened
7.	Life is:	full of interest						completely routine
8.	Until now your life has had:	no clear goals or purpose at all						Very clear goals and purpose
9.	Do you have the feeling that you're being treated unfairly?	very often						very seldom or never
10.	In the past ten years your life has been:	full of changes without your knowing what will happen next						completely consistent and clear
11.	Most of the things you do in the future will probably be:	completely fascinating						deadly boring

		1	2	3	4	5	6	7
12.	Do you have the feeling that you are in an unfamiliar situation and don't know what to do?	1 very often	2	3	4	5	6	7 very seldom or never
13.	What best describes how you see life:	1 one can always find a solution to painful things in life	2	3	4	5	6	7 there is no solution to painful things in life
14.	When you think about your life, you very often:	1 feel how good it is to be alive	2	3	4	5	6	7 ask yourself why you exist at all
15.	When you face a difficult problem, the choice of a solution is:	1 always confusing and hard to find	2	3	4	5	6	7 always completely clear
16.	Doing the things you do every day is:	1 a source of deep pleasure and satisfaction	2	3	4	5	6	7 a source of pain and boredom
17.	Your life in the future will probably be:	1 full of changes without your knowing what will happen next	2	3	4	5	6	7 completely consistent and clear
18.	When something unpleasant happened in the past your tendency was:	1 "to eat yourself up" about it	2	3	4	5	6	7 to say "ok that's that, I have to live with it" and go on
19.	Do you have very mixed-up feelings and ideas?	1 very often	2	3	4	5	6	7 very seldom or never
20.	When you do something that gives you a good feeling:	1 it's certain that you'll go on feeling good	2	3	4	5	6	7 it's certain that something will happen to spoil the feeling

Question	1	2	3	4	5	6	7
21. Does it happen that you have feelings inside you would rather not feel?	very often						very seldom or never
22. You anticipate that your personal life in the future will be:	totally without meaning or purpose						full of meaning and purpose
23. Do you think that there will always be people whom you'll be able to count on in the future?	you're certain there will be						you doubt there will be
24. Does it happen that you have the feeling that you don't know exactly what's about to happen?	very often						very seldom or never
25. Many people - even those with a strong character - sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?	never						very often
26. When something happened, have you generally found that:	you overestimated or underestimated its importance						you saw things in the right proportion
27. When you think of the difficulties you are likely to face in important aspects of your life, do you have the feeling that:	you will always succeed in overcoming the difficulties						you won't succeed in overcoming the difficulties
28. How often do you have the feeling that there's little meaning in the things you do in your daily life?	very often						very seldom or never
29. How often do you have feelings that you're not sure you can keep under control?	very often						very seldom or never

The Sense of Coherence is, according to Antonovsky, "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence" (2). Each subscale is described below.

(1) Comprehensibility subscale (C): "the stimuli arriving from one's internal and external environments in the course of living are structured, predictable and explicable" (2). Sample item: "Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?" Scale: 1=never and 7=always.

(2) Manageability subscale (MA): "the resources are available to one to meet the demands posed by these stimuli" (2). Sample item: "Do you have the feeling that you're being treated unfairly?" Scale: 1=never and 7=always.

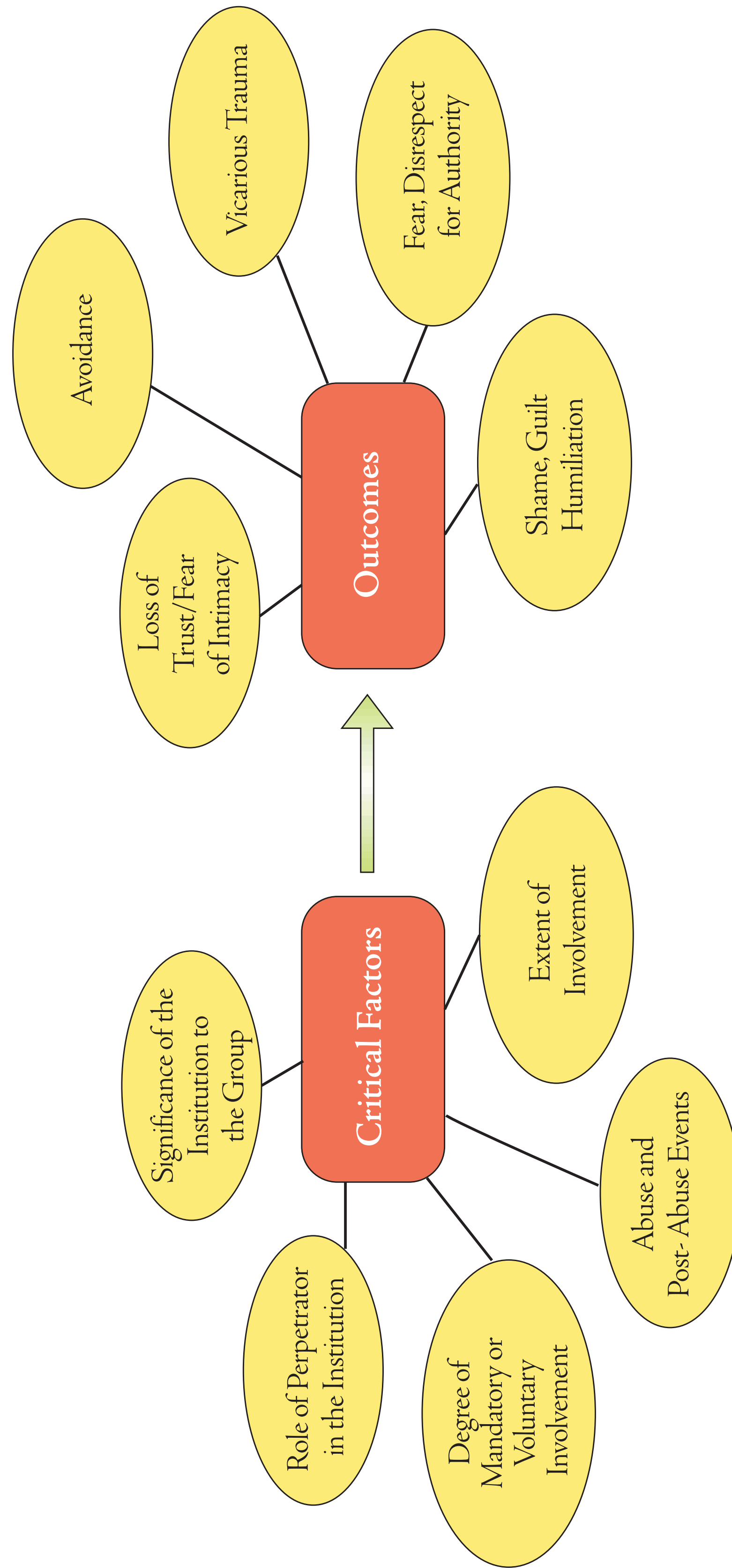
(3) Meaningfulness subscale (ME): "these demands are challenges worthy of investment and engagement" (2). Sample item: "Until now your life has had:" Scale: 1=no clear goals or purpose and 7=very clear goals and purpose.

It is important to note that SOC is not a personality test and that a person's SOC scores change during the lifetime, for example, during psychological stress, anxiety or depression.

Sample Community Wellness Report Card [288]

	Issue	Last Report	This Report	Comments
1.	% of households with persistent alcohol and drug abuse ongoing	79%	62%	Summer work projects gave some adults a focus
2.	% of youth at risk and without adequate support	84%	51%	Outdoor camps and cultural activities have engaged a significant number of youth
3.	% of families living in overcrowded and unhealthy housing	45%	45%	No change
4.	% of working age adults unemployed and on welfare	88%	82%	Summer work programs have employed some people, the basic problem is not being addressed
5.	Number of sexual abuse disclosures and reported sexual assaults	0	0	Sexual abuse is still not acknowledged as part of a community reality, though it comes up frequently in counselling cases
6.	Number of (known) attempted suicides	4	0	Suicide prevention workshops and new youth buddy system has helped
7.	Number of reported cases of spousal abuse	6	2	Less alcohol abuse and more work has made for less stress in families
8.	Number of people participating in healing circles	21	56	Our June recruitment has involved an additional 30-40 people in circles
9.	% of community residents involved or committed on a personal healing journey	15%	26%	New people have joined the healing spring workshops, new healing circles attracting some
10.	Number of people volunteering for anything	81	126	Summer roundups is always a popular venue for volunteers, but overall annual numbers the same

Critical Factors Influencing and Significant Outcomes Resulting from Institutional Child Abuse



Notes

1. Montgomery, Malcolm (1965). The six nations Indians and the Macdonald franchise. Ontario History 57(1):13.

2. Milloy, John S. (1999). A National Crime: The Canadian Government and the Residential School System, 1879-1986. Winnipeg, MB: The University of Manitoba Press.

3. Aboriginal Healing Foundation (2002). The Healing Has Begun: An Operational Update from the Aboriginal Healing Foundation. Ottawa, ON: Aboriginal Healing Foundation.

4. Indian Residential Schools Resolution Canada. Indian Residential Schools in Canada – Historical Chronology. Retrieved 19 January 2005 from: http//www.irsr-rqpi.gc.ca/English/historical_events.html

5. Aboriginal Healing Foundation (1999). Program Handbook, 2nd edition. Ottawa, ON: Aboriginal Healing Foundation, 6.

6. It is important to distinguish *program* evaluation from *organizational* evaluation. *Program* evaluation deals specifically with project activity and the AHF's facilitative role in promoting healing within Aboriginal communities. An *organizational* evaluation would review the AHF and its capacity to function as an institution.

7. Reproduced from Stecher, B.M. and W.A. Davis (1987). How to Focus an Evaluation. Newbury Park, CA: Sage Publications.

8. The impact question added to the second national survey was not pilot tested and was largely misunderstood by respondents. Data obtained were therefore unuseable.

9. The term "promising" was liberally defined to include those with effective therapeutic interventions, responsible accounting practices, and innovative and culturally sensitive approaches.

10. Patton, Michael Quinn (1987). How to use qualitative methods in evaluation. Newbury Park, CA: Sage Publications.

11. 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.

12. Patton (1987).

13. Mayne, John (1999). Addressing Attribution Through Contribution Analysis: Using Performance Measures Sensibly. Ottawa, ON: Office of the Auditor General of Canada.

14. Hendricks, Michael (1996). Performance Monitoring: How to Measure Effectively the Results of Our Efforts. Presented at the American Evaluation Association Annual Conference. Atlanta, Georgia, 6 November 1996.

15. Fawcett, S.B., A. Paine-Andrews, V.T. Francisco, J. Schultz, K.P. Richter, J. Berkley Patton, J.L. Fisher, R.K. Lewis, C.M. Lopez, S. Russos, E.L. Williams, K.J. Harris and P. Evensen (2001). Evaluating community initiatives for health and development. WHO (World Health Organization) Regional Publications. European series. Copenhagen, DK: World Health Organization (92)241:70.

16. When an organization answered more than one survey, the most recent survey data was kept as a way of minimizing duplication especially related to participation rates.

17. The total N varies depending upon the variables being examined. For example, for participation rates by target, additional data obtained from a one-page survey with *only* participation data brings the total N to 483. The N stated here of 467 refers to the weighted number of distinct organizations resulting from the *merge* of the *fuller* three national survey data sets (with all variables contained in the most recent or third national survey). Future analysts are referred to the file entitled SRV-2 Variable Cross Survey Reference in the electronic library of data analysis.

18. These extrapolations must be viewed cautiously as there may be differences between those organizations who responded to the national surveys and those that did not.

19. Citing the number of responses is very important for interpretation when only a few projects have answered a particular survey item. *Generalizations about the information presented here can only be made when a sufficient number of responses are noted.*

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

21. To find the average for the following numbers: 1, 2, 3, 4, 5, 6, 7, 8 and 1,000, add each number and then divide the total numbers (9) to get 115. The median would be the middle number – in this case, "5." Which is the better measure of the middle or usual response (i.e, central tendency)?

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

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

24. An average percentage was calculated from the results of all three surveys.

25. Statistics Canada (2003). 2001 Census: analysis series. Aboriginal peoples of Canada: A demographic profile. Ottawa, ON: Minister of Industry.

26. These percentages have been averaged from the results of all national surveys.

27. These proportions represent the average percentage from all three national survey results. The number of participants in a target group (i.e., intergenerationally impacted) was divided by the *total number* of participants in healing activity.

28. Note of caution to reader: Not all those respondents who answered the question about previous participation also answered the question about total participation in healing. Because the question about previous participation included both healing and training, some assumptions have been made here that the number of participants who identified previous participation are those who have engaged in healing historically. While the wording in the third survey provides better support for this assumption, the wording in the first and second surveys are more inclusive and consider both previous participation in healing and training.

29. This total, n=429, was based upon the fact that only 59 per cent of merged survey respondents indicated they have training participants; therefore, using the assumption that only 59 per cent of the total number of organizations funded (i.e., 725) might also have training, the number of organizations assumed to have training activity was 429.

30. These percentages have been averaged over the results of all three surveys.

31. Survey 2000 results show that the intergenerationally impacted (47%), women (62%), men (24%) Survivors (34%), youth (13%), Elders (16%), incarcerated (1.4%), gay or lesbian (2.3%), and homeless (1.4%) participated in training. Survey 2003 results show that the intergenerationally impacted (57%), women (55%), men (26%), Survivors (28%), youth (24%), Elders (11%), incarcerated (3%), gay or lesbian (1%), and homeless (1%) participated in training.

32. 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, S1). 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.

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

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

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

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

37. The professional category includes psychologist, therapist, nurse, consultant, researcher, mental health professional, contractor and evaluator.

38. 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.

39. Again, the number of projects that identified volunteer contributions is assumed to be proportionately the same as what was reported. In other words, because only 56 per cent or 263 out of a potential 467 organizations claimed to have volunteer services, then it was assumed that only 56 per cent or 408 of 725 would claim to have such contributions. This represents a conservative range of contributions made by volunteers.

40. Aboriginal includes all First Nations (status, non-status, on- and off-reserve), Inuit and Métis people.

41. As self-identified at the time of application.

42. A total of 282 (of a possible 357 respondents to either survey 1 or 2) estimated their financial needs. If we assume that the same proportion (i.e., 79% of the total) of discrete organizations would need the same additional financial resources, then 573 of all 725 discrete organizations funded by the AHF as at 1 September 2004 might need an additional $140,855,595.

43. Note that these costs represent median costs or the half-way mark between all the responses received, which is the better measure of central tendency in this case. For a fuller discussion of what the median means, please see the introduction to this chapter.

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

45. Lane, Phil, Jr., Michael Bopp, Judie Bopp and Julian Norris (2002). Mapping the Healing Journey: The Final Report of a First Nation Research Project on Healing in Canadian Aboriginal Communities. Ottawa, ON: Solicitor General Canada.

46. Archibald, Linda and Phillip Bird (2001). Innovations in First Nations and Inuit Health Systems: Models, Structures and Approaches. Ottawa, ON: Health Canada First Nations and Inuit Health Branch, unpublished.

47. See Figures 18 and 19 for a quantification of community dynamics that help or hinder in Kishk Anaquot Health Research (2003). Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation, 34–35.

48. AHF survey 2002, respondent #42.

49. Where addiction, family violence and sexual abuse are characterized as severe challenges (50% of those responding to S1, n=243).

50. Outright opposition to AHF-funded healing effort was identified as either a severe or moderate challenge for more than 60 per cent of funded projects in 2001 (S1, n=243).

51. Denial is defined as in need and unwilling to participate. Over 50 per cent of the teams who responded to the second survey indicate that this is a challenge. See the Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity, Figure 18, 34.

52. Six per cent (n=156, S2) report that leadership presents a severe challenge and 22 per cent identify leadership as a moderate challenge. The reader is referred to Figure 18 of the Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity, 34.

53. AHF Regional Gathering participant, 26 October 2000, Vancouver, British Columbia.

54. Herman, Judith (1997). Trauma and Recovery: The aftermath of violence—from domestic abuse to political terror. New York, NY: Basic Books.

55. Sensory and cognitive means used to keep the person focussed on present reality and not past trauma that has been triggered.

56. Herman (1997), 188.

57. Mathews, Frederick (1996). The Invisible Boy: Revisioning the Victimization of Male Children and Teens. Ottawa, ON: National Clearinghouse on Family Violence. Retrieved from: http://www.phac-aspc.gc.ca/ncfv-cnivf/familyviolence/html/nfntsxinvisible-e.html

58. Wiltschko, Johannes (1994). Focusing Therapy: Some fragments in which the whole can become visible. Lecture presented at the 3rd International Conference on Client-Centered and Experimental Psychotherapy, Gmunden, AT, September 1994, 12.

59. A body-centred process that moves the trauma away from the body where it resided as a body memory (for further information see: www.focussing.org).

60. All participants in healing have a right to know the criminal histories of their fellow participants.

61. AHF survey 2002, respondent #108.

62. AHF Regional Gathering participant, 26 October 2000, Vancouver, British Columbia.

63. AHF Regional Gathering participant, 26 October 2000, Vancouver, British Columbia.

64. AHF internal project file (2001).

65. As a way of maximizing gain and respecting client preference, project teams used a variety of therapies including, but not limited to, art therapy, psychodrama, massage, relaxation, cognitive and behavioural therapies, healing and sharing circles, ceremonies, sweat lodges, smudging, cleansing, storytelling, retreating to land-based traditional camps together, harvesting and preparing country foods, and cultural celebration, especially those that provided opportunity for song, food and dance.

66. AHF survey 2002, respondent #45.

67. AHF internal project file (2000).

68. AHF survey 2002, respondent #136.

69. Herman (1997), 136.

70. This card game was adapted from the Seattle FAS/E Prevention Program and used by the Aboriginal Health and Wellness Centre in Winnipeg, Manitoba.

71. See Figure 5 of the Third Interim Evaluation Report of Aboriginal Healing Foundation Program Activity (2003), 15.

72. This statement is paraphrased from a participant at the Winnipeg gathering, 8 March 2004.

73. Nyman, Anders and B"rje Svensson (1997). Boys: sexual abuse and treatment. London, UK; Bristol, UK: Jessica Kingsley Publishers; [Stockholm, Sweden]: Rädda Barnen.

74. Mathews (1996) (see n. 57).

75. Phaneuf, Gordon F. (1995). Adolescent Sexual Offenders. Ottawa, ON: National Clearinghouse on Family Violence, Health Canada.

76. Hylton, John (2002). Aboriginal Sex Offending in Canada. Ottawa, ON: Aboriginal Healing Foundation, 77.

77. This percentage represents an averaged per cent from responses to surveys one and two.

78. Kishk Anaquot Health Research (2002). Journey and Balance: Second Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation, 78-79.

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

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88. AHF Regional Gathering Participant #310, 26 January 2001, Yellowknife, NT.

89. Hylton (2002), 192 (see n. 76).

90. Herman (1997), 184 (see n. 54).

91. AHF internal project file (2000).

92. AHF internal project file (2000).

93. AHF individual participant questionnaire respondent (2004).

94. The New Lexicon Webster's Encyclopedic Dictionary of the English Language, Canadian Edition (1988).

95. Kishk Anaquot Health Research (2001). Interim Evaluation Report of Aboriginal Healing Foundation Program Activity. Ottawa, ON: Aboriginal Healing Foundation.

96. Kishk Anaquot Health Research (2002) (see n. 78).

97. Herman (1997), 155.

98. Lane, Bopp, Bopp and Norris (2002) (see n. 45).

99. Kishk Anaquot Health Research (2002), 125.

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

101. AHF internal project file (2000).

102. Herman (1997), 158-159.

103. Where n = the number of responses.

104. Kishk Anaquot Health Research (2002), 31.

105. This rise in the number of individuals might be explained by a variety of influences, including artifacts related to sampling (i.e., different respondents at different points in time with different histories of involvement in healing), as well as inconsistent understandings of what participation in "similar" healing programs might mean (i.e., did respondents, at all points in time, believe that 'similar' referred to healing programs for residential school Survivors only, or was "similar" healing program understood to mean any healing program for Aboriginal people or any healing program at all?). This change may also be explained by the fact that healing programs

for Survivors have had some longevity in select communities, and those who have more recently participated, may have a history of participation in previous AHF-funded projects (or "similar" healing programs specifically designed for Survivors).

106. This total n of 225 was based upon the assumption that the same proportion of organizations (31% or 145/467) would identify participants who had previously participated in healing. This represents a more conservative approach than if the extrapolation were done to consider all 725 organizations funded. In other words, instead of using the fuller universe of 725 organizations in the extrapolation, only 31 per cent of them or 225 were used.

107. 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.

108. Herman (1997), 172 (see n. 54).

109. AHF internal project file (2000).

110. When addressing foster care issues, 44 per cent were completely or extremely satisfied with group processes, while 75 per cent felt that way about individual approaches. When addressing issues related to sexual offending, 50 per cent were completely or extremely satisfied with group processes; however, 88 per cent reported similar levels of satisfaction with individual approaches. Aboriginal Healing Foundation (2002).

111. Kishk Anaquot Health Research (2002), 189 (see n. 78).

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

113. The following rankings are drawn from the average responses to a Likert scale where "0" represents no change, "1" represents very little and "5" represents very dramatic change. Youth self-esteem, 3.7; parental involvement, 2.7; mother-daughter communication, 3.7; family relations, 3; youth leadership, 3.5; peer support, 3.5; cultural awareness, 4; goal-setting, 3.4; social skills, 3.2. Aboriginal Healing Foundation (2002).

114. Herman (1997), 133.

115. 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.

116. This total (n=429) was based upon the fact that only 59 per cent of merged survey respondents indicated they had training participants; therefore, using the assumption that only 59 per cent of the total number of organizations funded (i.e., 725) might also have training, the full range of organizations assumed to have training activity was 429.

117. Kishk Anaquot Health Research (2002), 37.

118. Kishk Anaquot Health Research (2002), 38.

119. Kishk Anaquot Health Research (2002), 38 (see n. 78).

120. Kishk Anaquot Health Research (2002), 38.

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

122. As reported earlier, the *within-groups repeated measures* evaluation design anticipated collecting follow-up data in 2003 to 2004. While this is no longer the case, there are opportunities for community-level projects to follow through by collecting comparable data at three- or five-year intervals. Case study sites, for which some community-level baseline data have been collected, include Big Cove First Nation; Hamlet (now Municipality) of Cape Dorset; Nisichawayasihk Cree Nation (Nelson House, Manitoba); La Ronge, Saskatchewan; Red Deer, Alberta; Saskatoon, Saskatchewan; and the Atikamekw communities in Quebec.

123. Lane, Bopp, Bopp and Norris (2002) (see n. 45).

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

125. Lane, Bopp, Bopp and Norris (2002), 63.

126. Bird, Cynthia E. (2002). Men's Healing and Wellness Program Evaluation Report. Winnipeg, MB: Aboriginal Health and Wellness Centre; First Charger, Francis (2003). Soaring Heart Project: An Evaluation on Aboriginal Healing Foundation—the Project Activities. Francis First Charger and Consultant Group; Robillard, Vince (n.d.). Evaluation of the PAGC Aboriginal Healing Project: Urban FN Education, Healing and Empowerment Project for First, Second and Third Generation Survivors of Residential Schools; Tee-pah-kim-so-win May-yay-yo-win Project (Prince Albert Grand Council, Office of Urban Services, January 2002); Maidman, Frank (2000). Mooka'am Men's Healing Program: An Evaluation Case Study; Thira, Sharon (2002). Program Evaluation Healing Initiatives for Residential School Survivors. Sulsila Lelum Healing Centre; and Wabano Centre for Aboriginal Health (2002). Healing the Children, Restoring the Family, Pilot Evaluation Report for the Child and Family Art Therapy Project. Ottawa, ON: Wabano Centre for Aboriginal Health.

127. It should be noted that the AHF's community support coordinators were available for approximately four years to assist communities in developing their funding proposals and one remains dedicated to northern communities for this purpose.

128. A half per cent noted a decrease, 6.5 per cent noted no change and 7 per cent did not know.

129. Four and a half per cent noted a decrease, 25.6 per cent noted no change and 12.1 per cent did not know.

130. One and a half per cent noted a decrease, 5.5 per cent reported no change and 3 per cent did not know.

131. One per cent noted a decrease, 14.5 per cent reported no change and 11 per cent did not know.

132. One per cent noted a decrease, 20.1 per cent reported no change and 11.1 per cent did not know.

133. Kishk Anaquot Health Research (2002), 45 (see n. 78).

134. Kishk Anaquot Health Research (2002), 45.

135. At the time of the first national survey, teams were operational for less than two years.

136. The reader is reminded that these categories are not mutually exclusive. In other words, any one project could have cited an observed change in knowledge, attitude and behaviour.

137. Other components of the impact evaluation, including the case studies being carried out on 13 projects, will allow for in-depth assessments of the success of individual projects. In addition, some of the projects include detailed evaluations designs to be undertaken by the project team or outside evaluators. The document review is limited in its ability to go beyond describing the successes reported by projects, and it must be recognized that project reports to a funding organization may be biased in their tendency to present best-case scenarios and interpretations.

138. The Tsow-Tun Le Lum Society's Qul-Aun (British Columbia) project has a similar philosophy in that it "believes that healing begins with the individual, extends to the family and moves out into the entire community."

139. Kishk Anaquot Health Research (2002), 46.

140. Kishk Anaquot Health Research (2002), 46.

141. One per cent noted a decrease, 17.3 per cent noted no change and 9.1 per cent did not know.

142. A half per cent noted a decrease, 30.3 per cent noted no change and 4 per cent did not know.

143. Four and a half per cent noted a decrease, 18.5 per cent noted no change and 20.5 per cent did not know.

144. Two and a half per cent reported a decrease, 9.1 per cent noted no change and 21.3 per cent did not know.

145. One and a half per cent reported a decrease, 20.6 per cent noted no change and 4 per cent did not know.

146. One per cent reported a decrease, 9.1 per cent noted no change and 4.1 per cent did not know.

147. Seven per cent noted no change and 3.5 per cent did not know.

148. One and a half per cent noted a decrease, 22.9 per cent reported no change and 8 per cent did not know (re: community use of learning tools to teach about the Legacy); 1.5 per cent noted a decrease, 16.1 per cent noted no change and 14.1 per cent did not know (re: awareness and understanding of the impact of the Legacy in agencies outside of the community).

149. Kishk Anaquot Health Research (2002), 46 (see n. 78).

150. Lane, Bopp, Bopp and Norris (2002) 67 (see n. 45).

151. Canadian Institute for Health Information (CIHI) (1997). Community Health Indicators: Definitions and Interpretations. Ottawa, ON: Canadian Institute for Health Information, 146.

152. The Youth Initiative Survey was conducted during the second quarter (1 April– 30 June 2000). A total of 141 community members responded to the survey.

153. Cox, Lori (1998). Special Education Needs Assessment. Big Cove First Nation, NB: Big Cove First Nation, 51. The study includes a survey of 16 teachers and 56 parents.

154. This total (n=429) was based upon the fact that only 59 per cent of merged survey respondents indicated they had training participants; therefore, using the assumption that only 59 per cent of the total number of organizations funded (i.e., 725) might also have training, the extrapolated number of organizations assumed to have training activity was 429.

155. Kishk Anaquot Health Research (2001), 20 (see n. 95).

156. Two and a half per cent noted a decrease, 27.1 per cent noted no change and 9.5 per cent did not know.

157. A half per cent noted a decrease, 21.4 per cent noted no change and 5.1 per cent did not know.

158. Lane, Bopp, Bopp and Norris (2002), 74.

159. One per cent noted a decrease, 17.3 per cent noted no change and 11.7 per cent did not know.

160. Two and a half per cent noted a decrease, 20.8 per cent noted no change and 15.7 per cent did not know.

161. Two per cent noted a decrease, 14.8 per cent noted no change and 21.9 per cent did not know.

162. It is important for the reader to note that these do not represent mutually exclusive categories; one respondent might have noted several strategies to continue after the life of the AHF.

163. Couture, J., T. Parker, R. Couture and P. Laboucane (2001). A Cost-benefit Analysis of Hollow Water's Community Holistic Circle Healing Process. Aboriginal Corrections Policy Unit. Ottawa, ON: Solicitor General Canada, 44.

164. A half per cent noted a decrease, 21.7 per cent noted no change and 38.4 per cent did not know.

165. Those who did not know if the number of children at risk in the community had been influenced by project activity was 36.6 per cent.

166. Kishk Anaquot Health Research (2002), 55 (see n. 78).

167.

Variable	Pearson Chi-Square (test of statistical significance)	df	N=	Significance Level
1b - Survivors support and encourage others to heal	13.921	3	92	0.003
2a - There are local healing services unique to the needs of Survivors and their families	14.603 (a)	3	93	0.002
3a - Community is using learning tools (e.g., archives, audiovisual materials, a curriculum package, visitor's centre, commemorative site) to teach about residential schools	8.211 (a)	3	94	0.042
3c - Survivors and their families understand how the history of residential schools has affected them, their parents, grandparents, etc.	7.064 (a)	3	94	0.029
5e - Number of children who are at risk in the community (here it is important for the reader to note that, over time, communities are less likely to note an increase in the number of children at risk)	12.313 (a)	3	92	0.006
6a - Community planning for long-term healing	14.473 (a)	3	95	0.002

168. Kishk Anaquot Health Research (2001), 65 (see n. 95).

169. AHF survey 2002, respondent #40.

170. AHF survey 2002, respondent #8.

171. AHF survey 2002, respondent #139.

172. AHF survey 2002, respondent #152.

173. AHF survey 2002, respondent #144.

174. AHF survey 2002, respondent #51.

175. This percentage is an average per cent calculated from survey 2000 where n=230 and survey 2002 where n=160.

176. These percentages are averaged from two national surveys (n=230, S1; n=160, S2).

177. The total n=406 is based upon the assumption that 56 per cent of the total number of discrete organizations funded by the AHF would be unable to service all those in need.

178. There is a positive linear relationship between *family drug or alcohol addictions*, *history of abuse as a victim*, *history of incarceration* and the percentage of project participants that have special needs (covariance 0.437, $p<.05$, n=152, S1). In essence, as projects report having more participants in any of the categories named (e.g., history of incarceration), they also report having a higher percentage of special needs participants.

179. The need for a holistic approach to health and healing is well-developed in the *Report of the Royal Commission on Aboriginal Peoples,* as well as various publications by the World Health Organization. Also, Health Canada supports a population health model that recognizes the impact of nonmedical determinants on individual and community health, including income, social support networks, education, employment, social and physical environments, coping skills, culture, healthy child development, health services and gender. The funding guide for Health Canada's Population Health Fund states on page three: "Collaboration across sectors is essential to successfully address the determinants of health. Existing partnerships should be strengthened, and new ones created, with organizations whose mandate or activities have a direct or indirect impact on health." Health Canada (2000). Rural and Remote Health Innovations Initiative: Population Health Fund: Guide for Applicants. Ottawa, ON: Solicitor General Canada.

180. Lane, Bopp, Bopp and Norris (2002), 43 (see n. 45).

181. Kishk Anaquot Health Research (2001), Table 4 and Figures 40–43 (see n. 95).

182. This includes one project where a curriculum on residential school history and recovery is being developed in cooperation with the Saskatoon Public School resource consultants and teachers.

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

184. Kishk Anaquot Health Research (2002), 56 (see n. 78).

185. Adapted from Grembowski, D. (2001). The Practice of Health Program Evaluation. Thousand Oaks, CA: Sage Publications, 51.

186. Health Canada (n.d.). Still Making a Difference: Interim Report, The Impact of the Health Promotion Directorate's Social Marketing Campaigns 1992–1993. Retrieved from: http://www.hc-sc.gc.ca/english/socialmarketing/pdf/mad1.pdf

187. Fawcett, S.B., V.T. Francisco, A. Paine-Andrews, R.K. Lewis, K.P. Richter, K.J. Harris, E.L. Williams, J.Y. Berkley, J.A. Schultz, J.L. Fisher and C.M. Lopez (1993). Work Group Evaluation Handbook: Evaluating and Supporting Community Initiatives for Health and Development. Lawrence, KS: University of Kansas.

188. For more information on the Likert scale, see: http://www.cultsock.ndirect.co.uk/MUHome/cshtml/index.html

189. For more information on the Beck depression inventory, see: http://www.swin.edu.au/victims/resources/assessment/affect/bdi.html

190. For more information on the Beck anxiety scale, see: http://mail.med.upenn.edu/~abeck/scales.html

191. For more information on the dissociative experiences scale, see: http://www.rossinst.com/des.htm

192. For more information on the post traumatic stress diagnostic scale, see:

193. For more information see: http://www.ywcatoronto.org/develop_skill/lifeskills/pfr.htm

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

195. Antonovsky, A. (1987). Unravelling the Mystery of Health: How People Manage Stress and Stay Well. San Francisco, CA: Jossey-Bass.

196. LaFromboise, Teresa D. (1996). American Indian Life Skills Development Curriculum. Madison, WI: University of Wisconsin Press.

197. Lane, Bopp, Bopp and Norris (2002) (see n. 45).

198. Herman (1997) (see n. 54).

199. In other words, measuring the attainment and retention of knowledge, as well as the ability and motivation to use the knowledge and, finally, the practical use of that knowledge in day-to-day life.

200. Herman, (1997), 121.

201. Syme, S. L. (1994). The Social Environment and Health. In Health and Wealth, Daedalus. Cambridge, MA: American Academy of Arts and Sciences 123(4): 79–86.

202. Frank, J. W. and J. F. Mustard (1994). The Determinants of Health from a Historical Perspective. In Health and Wealth, Daedalus. Cambridge, MA: American Academy of Arts and Sciences 123(4): 1–19.

203. Wilkinson, R. G. (1994). The Epidemiological Transition: From Material Scarcity to Social Disadvantage. In Health and Wealth, Daedalus. Cambridge, MA: American Academy of Arts and Sciences 123(4): 61–77.

204. Renaud, M. (1995). The Future: Hygeia versus Panakeia? In Evans, R.G., M. L. Barer and T. R. Marmor (eds.). Why are Some People Healthy and Others Not? The Determinants of Health of Populations. New York, NY: Aldine de Gruyter.

205. Bandura, A. (1977). Self Efficacy: Toward a Unifying Theory of Behavioural Change. Psychological Review 84(2): 191–215.

206. In the first survey 7,589 (n=160, S1) participants were identified with special needs; in the second survey, 23,603 (n=124) participants were identified with special needs.

207. Herman (1997), 136 (see n. 54).

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

209. Project's fourth quarter final report submitted to the AHF, Section VII, 10.

210. Project files and the National Process Evaluation Survey differ with respect to the number of people the project reached in public awareness and educational activities. The NPES reported 200 individuals. Project files report a reach of 40 organizations in the first quarter and 177, 144 and 137 people in the following three quarters.

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

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

213. UNYA, Annual Report 1999-2000.

214. Vancouver Native Health Society, 2000 Annual Report, 33.

215. Youth Safe House Program Review, Vancouver Native Health Society, May 2001, 15.

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

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

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

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

220. Project's 5th quarter AHF project monitoring transfer sheet, 31 May 2001, 8.

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

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

223. An AHF list of residential schools is a document that is under development.

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

225. Defined as degrees of physical violence, such as pushing, shoving, slapping, kicking, punching, hitting, spitting, pinching, pulling hair, choking, throwing things, hitting victims with an object, and using or threatening to use a weapon. Source: www.gov.ab.ca/just/crimeprev/family _violence

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

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

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

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

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

231. Based on 1996 Census per cent distribution.

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

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

234. Red Deer Native Friendship Society only delivers services to those children living in the city of Red Deer. This information was gathered through the RDNFS community care coordinator in charge of the program that intervenes when an Aboriginal child who is a resident of Red Deer is involved.

235. This information was gathered through the RDNFS community care coordinator in charge of the program that intervenes when an Aboriginal child who is a resident of Red Deer is involved.

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

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

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

239. Ban response to the NPES completed March 2001, question A.10.

240. Statistics Canada. 1996 Census, Fact Sheet, Community Profiles.

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

242. Statistics Canada. 1996 Census, Fact Sheet, Community Profiles.

243. Statistics Canada. 1996 Census, Fact Sheet, Community Profiles, 28.

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

245. Correctional Services of Canada (1996). Community profile, Saskatoon, SK, 5.

246. Major assault is defined as assault causing bodily harm and generally more severe. Common assault is less intrusive and can include spitting, manhandling or crimes that cause much less harm.

247. Correctional Services of Canada (1996). Community profile, Saskatoon, SK, 5.

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

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

250. Correctional Services of Canada. Aboriginal Offender Statistics, Facts and Figures. Updated 25 February 2002.

251. Saskatchewan Social Services. Annual Report, 1998-99, 35.

252. Saskatchewan Social Services. Annual Report, 1998-99, 36.

253. Health Canada, First Nations & Inuit Health Branch. Statistics Fact Sheet: Death Rates Due to Injury & Poisoning by Cause.

254. Health Canada, First Nations & Inuit Health Branch. Statistics Fact Sheet: Death Rates Due to Injury & Poisoning by Cause. Statistics for 1989-1993 showed 479 deaths among First Nations people in Saskatchewan.

255. The Times Observer (2001). Building A Nation: Aboriginal community leader appeals to educators to build cultural bridges, September, 3.

256. BAN application for project funding to the AHF, 15-16.

257. Project proposal for AHF funding, February 2000.

258. Project response to the AHF Supplementary Survey (July 2001).

259. Taken from the Saskatchewan Bureau of Statistics internet site.

260. Statistics Canada 1996 Census.

261. Willow Bunch Healing Project final report of its first year funding to the AHF, October 2001, 1.

262. It should be noted that this agreement was done as a draft letter, but was never formalized.

263. AHF Project Monitoring Report, 4th quarter.

264. Project response to the AHF National Process Evaluation Survey, 2001.

265. AHF Project Monitoring Second Quarterly Report, 2000, Objective # 2.

266. This case study covers the following project type and targets: First Nations, rural/remote, west, healing circles, traditional activities and professional training courses.

267. Nelson House Medicine Lodge's project proposal for funding to the AHF, February 2000.

268. Peters, Gordon (CFIS) (1999, March 30). Letter to the Aboriginal Healing Foundation.

269. Ontario Native Women's Association. Retrieved from: http://www.onwa.org/index_body.htm

270. Of the 120 participants, 20 were residential school Survivors, 75 identified themselves as later generation affected by the residential school legacy, 19 said they were neither Survivors nor later generation, and 6 did not know if they were a later generation affected by the Legacy. *I da wa da di* Project, *Awakening the Spirit* gathering, September 28, 29, 30, 2000, Report of Participant Evaluations, 4.

271. Aboriginal Peoples' Justice Circle (2001). Application for Sentencing and Healing Circles, undated; Sentencing and Healing Circles Guidelines, APJC, January; Information Letter to Community, APJC, undated.

272. Statistics Canada. Retrieved from: http://www12.statcan.ca/english/Profil01/Details/details.cfm

273. Approximately 20 applications for funding from various Aboriginal organizations in the Ottawa area were reviewed for population statistics. Source: confidential internal AHF proposals.

274. Royal Commission on Aboriginal Peoples (RCAP) (1993). Aboriginal peoples in urban centres. Ottawa, ON: Ministry of Supply and Services, 2, 65-90.

275. Lee, Kevin K. (2000). Urban poverty in Canada: a statistical profile. Canadian Council on Social Development. April, page 40. Retrieved from: http://www.ccsd.ca/pubs/2000/up/

276. This February 2002 report was prepared by a member of the APJC for the period 7 May 2001 to 4 February 2002. The AHF-funded project ended 30 September 2001, so this document applied to a period of time after the funded project was over. Nevertheless, the document provided useful insights and some of the required actions were identified during the period the project was operating with AHF funds.

277. Coloma C. (1999). Mikon Project. Mortality in the Atikamekw Communities.

278. Council of the Atikamekw Nation La vie quotidienne et adaptation des Atikamekw de Wemotaci à la modernité, 1997.

279. ANC, Vie quotidienne et adaptation des Atikamekw de Wemotaci à la modernité, 1997, L'adaptation des Atikamekw d'Opitciwan à la modernité, 1997a.

280. Vie quotidienne et adaptation des Atikamekw de Wemotaci à la modernité (1997:102) and Problèmes sociaux, solidarité et entraide à Manawan (Social Problems, Solidarity and Support in Manawan) (1996:115).

281. All quotes were translated from French to English.

282. Project's fourth quarter report to the AHF (2000) Part V, Question iii, 7.

283. Statistics Canada. 1996 Census, statistical profile: income and work statistics for Richibucto 15 (Indian reserve), New Brunswick.

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

285. Cox, Lori (1998), 51 (see n. 153). The study included a survey of 15 teachers and 56 parents.

286. Cox, Lori (1998), 16.

287. This card game was adapted from the Seattle FAS/E Prevention Program by the Aboriginal Health and Wellness Centre in Winnipeg, Manitoba.

288. Lane, Bopp, Bopp and Norris (2002) (see n. 45).