Nelson House Medicine Lodge Inc.

Project Number: CT-373-MB

Case Study Report

Pisimweyapiy Counselling Centre

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1. Introduction

A series of case studies is being conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF) and is intended to provide a detailed, holistic view of selected projects and their outcomes as well as to cover a range of unique circumstances. The case studies were selected to include representation from a variety of project types and targets (see Appendix 1 for selection criteria). This case study is being done by a community support coordinator (CSC) under the facilitative guidance of Kishk Anaquot Health Research and covers the following project types and targets:

- First Nations
- rural/remote
- west
- healing circles
- traditional activities
- professional training courses

The project that forms the basis for this case study is titled "Pisimweyapiy Counselling Centre" (AHF-funded project # CT-373-MB) and is described as a "community based, nine (9) week, two phase program aimed at enhancing and empowering the personal and social functioning of former students of residential schools and their families, as the means to an overall healthier community."[1]

The report describes Nisichawayasihk Cree Nation (aka Nelson House, Manitoba), service delivery, team characteristics, and what the project hopes to achieve in the short and long terms. The report will also focus on changes in individual participants and the community as well as how those changes were measured. Although efforts were made to include requested social indicators of change (physical abuse, sexual abuse, incarceration rates, suicide, and children in care), only rates of children in care have been reported.

2. Project Description

The idea of having a local outpatient healing and wellness program for the Nisichawayasihk Cree Nation grew out of a series of community discussions and actions taken to address the rise of social problems that many believe are related to the legacy of physical and sexual abuse in residential schools. Therefore, a proposal was sent to and approved by the AHF to create the Pisimweyapiy Counselling Centre, an addition to the existing services of the Nelson House Medicine Lodge and initially funded as a pilot (1 February 2000 to 31 January 2001). Funding continued to 31 January 2002 with a second contribution of $464,526, which is the year of focus for this case study. The target group includes all local Aboriginal (Métis, Inuit, First Nation, and on or off reserve) adults, youth, and families affected by residential schools. The funding application states the purpose of the project as follows:

> Offering services in both the Cree and English languages, the program will run three (3) times over one calendar year and entails individual and family counselling/therapy plus structured group sessions designed to normalize, universalize and depathologize the participants negative life experiences symptomatic of the residential school syndrome. In responding to unresolved and often untreated grief characteristics of post-traumatic stress disorder, the first four weeks of the program addresses the healing and wellness of residential school survivors before incorporating their family and the community in the final four weeks of programming. Thus, phase one of the program limits intake to the fifteen (15) individuals with focus shifting to the participant's family

> and the community during phase two. Upon completion of the program, the participants and their families become part of an expanded self-reclaimed and empowered support network of residential school survivors active in their own journey of healing and wellness. The final week of the program entails providing services to our community.

The objectives outlined in the project's brochure include:

- provide a safe, structured, nurturing environment for counselling;
- develop coordinated and integrated resource material that encompasses all facets of therapeutic process, effective and efficient service delivery, client management, and work schedules;
- provide a local and readily available network of support with service options with linkages to external service providers;
- provide direct, purposefully designed therapeutic support services;
- foster and strengthen communication and relationship skills;
- maximize pride, self-responsibility, and acceptance among participants; and
- provide an environment that will help reduce the number of deaths, family destruction, and cultural genocide resulting from the direct, negative impact of the residential school experience.

The project is purposefully designed and structured to operate as a community-based outpatient therapeutic program. Methods and activities include:

- case management: assessment and treatment planning, individual and family therapy, aftercare planning, and follow-up;
- small and large group sessions: men's and women's healing circles, self-help groups, workshops (e.g., sexual abuse, parenting, family, residential school syndrome, suicide intervention and postvention, communications skills, anger management, grieving, and loss);
- traditional teachings and ceremonies: sweetgrass, pipe, sweat lodge, cleansing, fasting, and cultural camps;
- field trips to Manitoba residential schools and to pick medicines (sweetgrass, sage, and cedar). An Elder/traditional healer will conduct ceremonies on trips to residential schools;
- regular physical exercise and nutrition; and
- home visits to conduct family sessions.

The project is situated on the Nisichawayasihk Cree Nation and operates out of a house trailer on the grounds of the medicine lodge. While the trailer is conveniently located, lack of space and privacy are concerns (i.e., walls are not soundproof and participants are grouped too close together). The group sessions take place in the living area of the trailer and are often over-crowded. Both the medicine lodge and the counselling centre give an aura of peace when one enters. Respect is shown by keeping a cigarette smoke-free, tidy environment and by removing shoes at the door.

2.1 The Project Team—Personnel, Training, and Volunteers

The Nelson House Medicine Lodge Board of Directors consists of five Nisichawayasihk Cree Nation members that hold office for a period of three years or until a replacement is named. The board is ultimately responsible for the welfare and effectiveness of the entire organization and is answerable to leadership, funders, and the community for its actions.

Local leadership has demonstrated their commitment to healing with the building of the Family and Community Wellness Centre with resources from their *Northern Flood Agreement*. At 1,300 square

feet, the centre provides a formidable community focal point for wellness. The centre's activities focus on prevention with the ultimate goal of returning to Cree values and standards by recognizing, honouring, and reconnecting traditional knowledge and strengths. Centre-based programs include child and family services, mental health, Brighter Futures, family violence, and daycare services. The building includes a whirlpool, sauna, Elders' room, conference rooms, and offices.

The executive director of the medicine lodge serves as a working group member of the treatment centre. She holds a Masters in Social Work degree and has experience as an executive director and a senior counsellor at the medicine lodge as well as a post-secondary counsellor for Keewatin Tribal Council and regional child and family services worker for Awasis Agency. The program coordinator is responsible for project implementation encompassing all aspects of the therapeutic process, service delivery, client management, and team work schedules. The present coordinator holds a Bachelor of Social Work degree and has worked and volunteered extensively with Aboriginal organizations.

The team includes three therapists and an administrative assistant. The therapists are responsible for one-on-one, family, and small and large group therapy sessions and workshops using a combination of Western therapeutic and traditional Aboriginal healing practices. One is a trained social worker with 15 years experience in counselling and corrections dealing with First Nations people. This individual has sat on the National Parole Board for a five-year appointment and has worked as a parole officer for approximately 10 years. Another is a Survivor with an Applied Counsellor Certificate who has worked as a counsellor at the medicine lodge, as a head cook, and with the Nelson House Metis Federation in various positions. The third therapist is a Survivor, certified in community social development, who has held positions as community education facilitator, radio broadcaster, and life skills coach and has worked with adults in the education and social services fields. The administrative assistant is responsible for all general office procedures, and there has been at least one turnover in this position.

Elders are in constant use by the project. One member of the board of directors is a respected community Elder and Survivor. As the project continues to evolve, Elder utilization has increased sharply as the need for specific ceremonies pertaining to the healing and wellness journey for Survivors has become apparent.

Employee training began in April 2000 before the first intake in August of that year. Training was provided by Micro-age Computer, Rockhurst College Continuing Education Centre, Inc., Workforce Management for First Nation Communities, "Being You" Inc., and Four Directions International. The type of training included computer skills, supervision/management, time management, therapeutic change and development, as well as working with families and couples. Training is ongoing by way of conferences and workshops in and out of the community.

2.2 Activities and Outcomes

A logical link exists between the activities a project undertakes and what they hope to achieve in the short and long term. In short, the project has undertaken to develop a network of support by providing individual, group, and family therapeutic services (one-on-one sessions, gender- and age-specific healing circles, self-help groups, home visits, field trips, and after and continuing care). They have introduced and practised new and healthier ways of life through workshops and presentations, traditional teachings and ceremonies, exercise, and nutrition. The project has also attempted to expand support for Survivors by networking and sharing with other organizations. Desired short-term results include:

- overcome or reduce denial sufficiently to have the program operate to capacity (exceed 85% of full capacity);
- transform childhood trauma to healing and empowerment;
- deconstruct unhealthy survival patterns; and
- reduce the number of deaths and rate of family destruction and reverse cultural genocide.

A longer-term outcome is to have participants and their families become part of an expanded, self-reclaimed and empowered support network of Survivors active in their own journey of healing and wellness who have learned to live independently and found their spirit. The relationship between project activities and short- and long-term benefits is set out in the logic model on the following page (Figure 1). Following this is a "performance map" that details the project's mission, resources, target, objectives, and goals and highlights what sources of information will be used to note change. The "map" was used to guide information gathering.

Figure 1) Logic Model—Pisimweyapiy Counselling Centre

Activities	Healing	Capacity building
	Conducted community-based, integrated, and holistic outpatient therapeutic program based on Western and traditional therapies.	Employee training and professional care.
How we did it	Normalized, universalized, and depathologized negative life experiences related to the Legacy using case management, group sessions, traditional ceremonies, field trips, exercise, home visits, recruitment and intake, and after and continuing care; and introducing and practicing new and healthier ways of life.	Contacted professional trainers to deliver employee training and address training needs.
What we did	# of sessions and participation in individual therapy and counselling; structured group therapy; traditional ceremonies; ceremonial circles; field trips; self-help groups; regular physical exercise; family therapy sessions and workshops; nutritional therapy; community beautification; follow-up with participants and families through home visits or "walk-ins."	Provided two workshops on professional development and participated in a conference.
What we wanted	Initiate healing process and reduce unhealthy coping behaviours; expanded, self-reclaimed network of Survivors on a healing journey; reduce # of deaths and rate of family destruction; reduce or reverse cultural genocide; reduce denial sufficiently to have the program operate to capacity.	Well-trained employees to be leaders in community healing.
How we know things changed (short term)	Enrollment statistics; self-reported and observed (from perspective of therapists, leaders, Elders, and referral agencies) experience of reclamation; cultural pride and participation; and mutual support.	Feedback from participants and community and measures of skills.
Why we are doing this	To break the cycle of intergenerational abuse and to restore emotional, mental, physical, and social balance for residential school Survivors and their families in Manitoba.	
How we know things changed (long term)	Suicide risk; dependency rate on welfare, and proportion able to live independently and find their spirit; and rate of homelessness and addiction.	

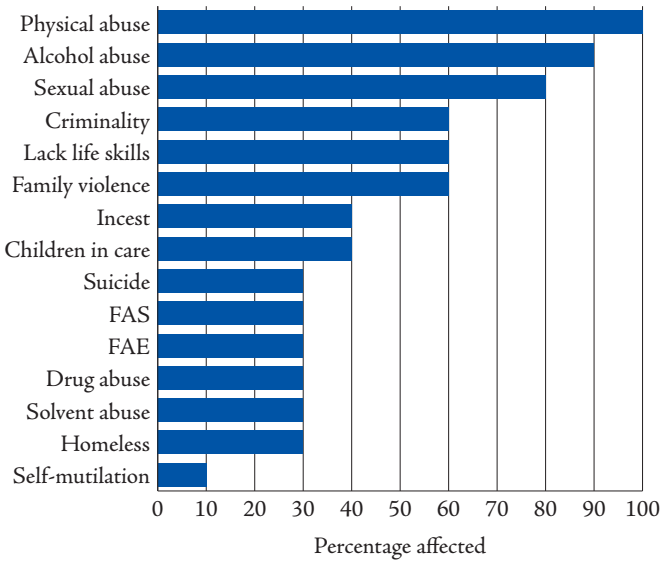
Table 1) Performance Map—Pisimweyapiy Counselling Centre

<table>
<tr><td colspan="4">MISSION: Enhance and empower the personal and social functioning of students of residential schools and their families, thereby contributing to the overall health and wellness of our community.</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>Normalize, universalize, and depathologize the Legacy's impact using case management, small and large group sessions, traditional ceremonies, field trips, exercise, home visits, recruitment and intake, and after and continuing care; introduce and practise new and healthier ways of life; individual and group/family therapy; self-help; and community beautification.</td><td>Survivors, family and community members, and intergenerationally impacted in Manitoba.</td><td>Overcame/reduced denial sufficiently to have the program operate to capacity; increased transformation of childhood trauma to healing and empowerment; decreased participation in unhealthy survival patterns; improved family functioning; increased life-empowering behaviours; initiated healing; reduced unhealthy coping; and expanded self-reclaimed network of Survivors in healing.</td><td rowspan="2">Participants and their families become part of an expanded self-reclaimed and empowered support network of Survivors active in their own journey of healing and wellness who have learned to live independently and found their spirit.</td></tr>
<tr><td>Employee training and professional care.</td><td>Community employees and leaders.</td><td>Increased capacity to deal with the Legacy; increased knowledge and understanding of the Legacy; increased access to and participation in expanding network of support familiar with and capable of responding to those suffering from the Legacy.</td></tr>
<tr><th colspan="4">How will we know we made a difference? What changes will we see? How much change has occurred?</th></tr>
<tr><th>Resources</th><th>Reach</th><th>Short-term measures</th><th>Long-term measures</th></tr>
<tr><td rowspan="2">$464,526 one year only</td><td># of participants from within community (3 intakes per year)</td><td>Rates of participation; observed changes in family functioning; #s or % of population engaged in mutual support; feedback from participants, therapists, leaders, Elders, and referral agencies; and observed or indirectly (self-) reported changes in coping skills and transformation of childhood trauma.</td><td rowspan="2">Suicide and attempted suicide rates; dependency rate on welfare; rate of homelessness; and rate of substance abuse as measured by alcohol- or drug-related criminal offences and participation in treatment.</td></tr>
<tr><td># of trainees.</td><td>Observed and self-reported changes in understanding of and capacity to deal with the Legacy; and feedback from referral agencies regarding changes in access to skilled services to aid, and is appropriate for, Survivors.</td></tr>
</table>

2.3 Participant Characteristics

The most significant challenges facing the participant group included physical abuse affecting virtually all participants and alcohol abuse. Most are also dealing with a history of sexual abuse, family violence, and criminality and a lack of basic life skills. Figure 2 reveals the percentage of participants estimated to be affected by specific difficulties.[2]

Figure 2) Challenges facing Participant Group



There is roughly an even distribution between the sexes, although women still outnumber men and the bulk of participants are in the 25 to 45 age category. Almost all are First Nations on reserve and a large proportion is intergenerationally impacted. Tables 2, 3, and 4 show the participant group by age, sex, Aboriginal identity, and direct or indirect impact of residential schools.

Table 2) Participants by Age and Sex

Project Age Group	Male	Female	Total
12–18 (youth)	1	–	1
18–25 (adults)	6	4	10
25–35	12	16	28
35–45	5	13	18
45+	5	5	1
Totals	**29**	**38**	**67**

Table 3) Participants by Aboriginal Identity

Aboriginal Identity	Participants
Status on reserve	66
Status off reserve	1
Total	**67**

Table 4) Distribution of Survivors and Intergenerationally Impacted

Project Population	Male	Female	Total
Residential school Survivors	5	5	10
Later generation	24	33	57
Totals	**29**	**38**	**67**

Referral packages are completed by referring agencies and include information on personal data, family situation, involvement with the law, history of alcohol and drug abuse, employment and financial situation, influence of residential school, treatment history, and motivation to change(Appendix 2). Referrals are received from child and family services, a public health nurse, a community health worker, the mental health centre, the police, and probation workers.

2.4 Community and Regional Context

Nisichawayasihk Cree Nation is located on the northern shore of Footprint Lake west of Thompson and northeast of The Pas in northern Manitoba. Community access is provided by an all-weather road. The community has a total area of 5,852 hectares (14,460 acres) with a population of 4,581 (August 2001), including 1,169 living off reserve and 1,092 on Crown land.[3] Nisichawayasihk Cree Nation is signatory to the 1908 adhesion to Treaty #5 and has an outstanding treaty land entitlement. Hunting, trapping, and fishing form the economic base of the community and traditional sharing of wealth is still practised by a group that donates wild meat and fish to community Elders. Local businesses include the trappers' association, forest industries, air service, housing development, department and food stores, a convenience store/gas station, local taxi and school bus services, and a daycare. The community development corporation owns and operates a motor hotel and tavern, both located in Thompson.

Hydro development in northern Manitoba has caused significant disruption to traditional harvesting, homelands, and, consequently, social and familial well-being. Although the Nation is covered by the provisions of the *Northern Flood Agreement* (designed to compensate the Cree for the disruption), the impact of relocation is still being felt. In 2001, an agreement in principle was signed to guarantee the Nation's agreement, participation, and compensation for any future development that would affect their lands and peoples. To manage the relationship, a Northern Flood Agreement Trust Office has been established.

Local facilities include a band office, a community hall, a recreation building, and a pool hall. A total of 249 houses have piped water and sewage, 134 have cisterns and trucked septic service, and three have water barrels and no sewage services. There is electricity by land line, single-party telephone service, and daily Grey Goose bus service. The community is served by five First Nations constables and a RCMP

detachment located in Thompson. The Otetiskiwin Kiskinwamahtowekamid School offers levels K–12 with an enrolment of 976; another 18 students attend school off reserve. The nursing station provides medical services by two community health representatives, and there is a dental station on reserve. The nearest hospital is located in Thompson with available ambulance service.

The Nelson House Medicine Lodge was established in 1989 as a community-based, 21-bed, residential alcohol and drug treatment facility servicing Manitoba Keewatinowi Okimakanak (MKO). Over time, other programs were housed in the Medicine Lodge including alcohol and drug prevention programs as well as outpatient counselling services. The evolution and integration of programming at the Medicine Lodge have led to the development of the Nisichawayasihk Healing and Wellness Program that provides more holistic care than residential addictions treatment services could alone.

Further efforts to gather contextual information were more challenging; namely, rates of suicide, children in care, incarceration, as well as physical and sexual abuse. Members were tired of constant study and requests for statistics. When questioned on an informal basis, they were willing to share anecdotal information or their personal views on these issues; however, no hard data was forthcoming despite follow-up attempts. What is clear is that incarceration rates in Manitoba have fluctuated wildly in the past decade due to the resurrection of restorative justice and the increased use of conditional sentencing. Respondents were also willing to share the fact that almost all physical assault and domestic abuse in the community, as well as most crimes committed by Nelson House members in Thompson are associated with substance abuse, and children as young as eight to 12 years old are collected from the community and brought to the "drunk tank." Still, the community is described by outsiders as one with initiative that is organized, advanced with a variety of measures to minimize crime, and can deal with social problems. The leadership is considered "pro police" who regularly support First Nation constables as well as the RCMP and generously commit resources to healing.

Although suicide rates could not be secured, personal opinions were received from the RCMP, nurses, and the program coordinator for the project. The RCMP has noted a decline in suicides in the past decade, and the nurses concur. There have been no suicides for a long time, although there are accidents that are usually alcohol related. While they cannot be identified as suicides, there may be some that are questionable. The program coordinator said that there have been no suicides in the community since the start of the project. The director of child and family services reported that there are currently 62 family cases involving 229 children; and of the 2,058 residents living on the reserve, it is estimated that 242 are residential school Survivors (not counting those affected intergenerationally).

3. Methods

The focus of this case study was to determine what contribution the Pisimweyapiy Counselling Centre has made to the attainment of short-term outcomes, including:

- overcoming or reducing denial sufficiently to have the program operate to capacity;
- transforming childhood trauma to healing and empowerment;
- reducing unhealthy coping patterns;
- expanding the network of Survivors on a healing journey;
- reducing family destruction and cultural genocide;

- increasing team capacity to deal with and understand the Legacy; and
- increasing access to and participation in an expanding network of support that is familiar with and capable of responding to those suffering from the Legacy.

The indicators selected to reflect such changes include: rates of participation; observed changes in family functioning; numbers or percentage of population engaged in mutual support; feedback from participants, therapists, leaders, Elders, and referral agencies; observed or indirectly (self-) reported changes in coping skills and transformation of childhood trauma; observed and self-reported changes in understanding of and capacity to deal with the Legacy; and feedback from referral agencies regarding changes in service access for Survivors.

The development of interview questions (Appendix 3) was based on the project's desired short- and long-term goals (see performance map) and AHF board-mandated questions. The key questions (Appendix 4) and answers used to develop the logic model and performance map were sent to the project prior to the development of the questionnaire in order to confirm any change to project goals from the proposal stage to implementation. The questionnaire attempted to determine if any desired change in participants and community were achieved. Pilot testing was not done in this case, and the majority of questions were based on the assumption that respondents would have some knowledge of the participants. Some questions were clearly misunderstood or repetitive. Interviews generally lasted about an hour and were conducted by the community support coordinator for the region who had not previously worked with the project.

Project files (funding proposal, contribution agreement, quarterly reports to date, and the project's response to the National Process Evaluation Survey), key informant interviews with the project team, and selected community service providers were the primary data sources. The project did solicit participant feedback, but at the time of data collection, only 19 had completed the evaluation forms. In addition, the project did engage in collecting information upon intake. However, no summary was prepared or available for use. Internet searches were conducted to secure information on the community profile, and efforts extended beyond the community to secure social indicator data from the Assembly of Manitoba Chiefs.

One-on-one interviews were conducted with the project team using the questionnaire developed specifically for them (Appendix 5). In addition, a total of six outside agents were interviewed using the general questionnaire (i.e., for respondents not employed by Pisimweyapiy) and who were referred by the project team. Their profiles and reasons for selection are outlined below:

- a community consultant who is a Survivor and had individual counselling by one of the therapists employed by Pisimweyapiy, is a member of a committee that wanted this program in the community, and supports it fully because the counsellors are professionals;
- a band council member who holds the health services portfolio in the community and is a Survivor who helped in planning the program;
- a band council member who holds the justice portfolio and makes referrals to Pisimweyapiy has participated in the program as a Survivor (residential school trip to his old school), has solid experience in the sweat lodge and sharing circle, and is on his own healing journey;
- the director of Programs Health Services Division[4] who has first-hand knowledge of the extent of family dysfunction in the community and sees a definite need to address the Legacy;
- a National Native Alcohol and Drug Abuse Program coordinator who refers clients to Pisimweyapiy and is a Survivor who sees the Legacy's impact first-hand and believes that people have to deal with their addictions first before they can deal with other issues; and

- the executive director of the Family and Community Wellness Centre who has only been on the job a short while and is not very familiar with the medicine lodge.

Others were interviewed on an informal basis, including two nurses who preferred to discuss community issues without the structure of an interview. Although they were not fully aware of the program, they did know of it and would refer people if needed. Other less-structured meetings took place with a community-based police officer and a residential school worker from another funded project that runs out of Thompson, Manitoba; both were unable to provide social indicator data. All interviews took place during the last week of October 2001; a total of five days were allocated to the data-collection effort. Although desirable, little opportunity existed for interviews (formal or informal) with community members that could have been selected more randomly or who might have provided disconfirming evidence.

3.1 Limitations of Our Methods

No direct measurement of participants was conducted by the AHF, its employees, or agents due to ethical concerns about the possibility of triggering further trauma without adequate support for the participant. Because direct assessment was problematic, indirect assessment or the perceptions of key informants were weighted heavily. Furthermore, although the team did secure client satisfaction at the end of treatment, no standardized instrumentation was used to assess changes in related cognitive or behavioural indices of healing. It is highly probable that there is no psychometrically evaluated or standardized instrument to determine the unique healing stages of Aboriginal people recovering from the Legacy (institutional trauma).

Two days of training were offered to the community support coordinators in survey development and interviewing techniques in March 2001, with a follow-up in July 2001. Work began in earnest on this case study in October 2001, and interviews were prepared based on the short-term outcomes identified in the performance map. The CSC was independent in the field and, in this case, no debriefing after each day of interviews took place. Field notes were reviewed and transcribed only after all interviews were conducted. There are really only three lines of evidence in this case study; directly obtained from personnel delivering the program (administration and counsellors), those referred by the team, and participant voice (obtained from client satisfaction surveys). Dissent was encouraged in at least two introductory remarks preceding interview questions:

- that there are no right or wrong answers, only answers that are true from your perspective; and
- the report will ***not be able to identify who said what***, so please feel free to say things that may cause controversy.

However, no special effort was made to secure disconfirming evidence, rival explorations, or negative cases. While it is clear that there are some who are not satisfied with the project, the community support coordinator was prohibited by time, resources, and ethical considerations from gathering direct evidence from those participants. However, it would be useful for the project to profile those for whom the program is not satisfactory. This could be achieved through greater information management of client experience surveys. The only quantitative information obtained was limited to rates of children in care. Although some were initially interested and cooperative, follow-up efforts to secure social indicator data were met with non-responses. Others were clear from the outset that they felt over-studied and thus were unwilling to offer social indicator information, even though they were willing to talk informally about the issues.

The luxury of multiple evaluators was not available within the resource limitations; however, the context and data were reviewed and all responses were recorded verbatim, permitting verification and reanalysis by an external evaluation facilitator. As circumstance would have it, the community support coordinator did not have extended contact with this project, which may have inhibited familiarity and comfort in the data collection phase.

The information was collected and analyzed by Aboriginal people, some of whom may have also been affected by the Legacy, and their perspectives on healing may have influenced how the information was collected and reported. However, in an attempt to decolonize the evaluation effort and to ensure that cultural insiders offered insights that may not have been available to others, the decision to use Aboriginal researchers in this effort can be justified. Although it is not clear if their perspectives had more harshly or leniently judged the program, having the analysis verified and reanalyzed by an external evaluator may have reduced this bias. The CSC was most certainly reliant on information that was most readily available, as only five days were allocated to gathering data. The most important information missing are social indicator data, disconfirming points of view, summaries of intake information, characteristics of those participants who were not completely satisfied with the program, as well as more long-term follow-up of participant progress based on the desired outcomes identified in the proposal.

4. Reporting Results

4.1 Impact on Individual Participants

When respondents (team and community) were questioned about the development of healthy coping patterns, they had varying opinions; some felt that moderate change was obvious for most participants (>75% or more), while others felt that change was slight to moderate for a much smaller percentage (20%–50%) of participants. The observed changes tended to be behavioural, as some interviewees shared that participants appeared able to maintain sobriety, seek employment, disclose past trauma, be more outgoing, seek spiritual fulfillment, and recruit others to participate. Participants have also shared with the informants that they felt increasingly comfortable over the duration of the program. Respondents equally credited team qualities and program environment with any positive change. Counsellors who established a rapport with participants by being non-judgmental, sincere, trustworthy, gentle, respectful, committed, and culturally sensitive clearly facilitated healing. Others felt that the combination of group lectures, one-to-one counselling, and a safe environment created conditions for growth.

All respondents felt that there was a moderate change in understanding of the Legacy among project participants; however, they were in stark disagreement about how many participants have experienced this change. Two felt that the vast majority (75% to almost all) had experienced increased understanding, but other respondents felt that less than one-third of participants left the program with an increased understanding of the impact of the Legacy. One informant felt strongly that it may be too early to expect major changes in understanding, while others noticed an increased openness when discussing the Legacy. They felt that changes in understanding were facilitated by leadership support, Survivor participation (cited as 20% of the Survivor population in the area), and the project's emphasis on education about the Legacy. Their special component on history and education clearly offered an explanation for self-destructive behaviours that people could understand and accept. Once this initial spark of understanding was ignited, participants began to "thirst for more ... then spreads to the older generation." The environment created

at the Pisimweyapiy Counselling Centre led participants to feel safe, allowing them to speak freely about their experiences at residential school.

The team agreed that participants left the program with enhanced self-esteem, even if they do not agree about the magnitude of change or the proportion of participants who experienced this outcome. The behavioural evidence they saw included facial expressions changing from sadness to peace, securing gainful employment, and comfortable displays of physical affection. Others were more nebulous in offering evidence of enhanced self-esteem, but were still convinced of its existence: "You can see the change when you meet them [participants], it's like they just woke up." Although only some have enjoyed improved feelings of self-worth, the team is hopeful for a ripple effect. They credited Legacy education, focusing on responsibility and choice, as well as emphasizing self-trust for the observed changes in behaviour. Participants learned to trust their spirit despite the climate of shame, fear, and guilt in the community: this message is framed in the context of Cree culture that encourages participants to take it seriously. The team also believed that the training they received allowed them to skillfully address the Legacy and help Survivors.

While there was no agreement on how many experienced increased cultural pride or degree of change within individual participants, the team was sure that some change was obvious. The majority of participants were excited about cultural teachings and eager to learn more, with only some being resistant. The project team felt that their program, together with reinforcement from the medicine lodge, was responsible for such change and believed that group dynamics strengthened the impact: "We do our ceremonies and cultural practices in a group. It promotes awareness, helps the individual but it's the group that makes the change."

One team member believed that there was a decrease in all areas of physical abuse, sexual abuse, provincial wardship, and suicide when questioned about participant risk, while another felt that the risk stayed the same. Another team member felt that risk had been reduced in all areas but was unsure about sexual abuse. This uncertainty was rooted in the fact that there are many damaged people still out there who have not disclosed their histories of victimization and possible abuse. The last team member felt that participant risk was reduced for physical abuse and suicide, but was also unsure about sexual abuse and provincial wardship. Although there was no suicide in the community since the program began, they felt it was too soon to see a difference in sexual abuse and children in care.

The project did undertake efforts to solicit formal feedback from participants. At the time of data collection, 19 participants had responded. The majority (11) rated the service as excellent, while others (8) said it was good. Most (18) felt that they generally or definitely got the service they wanted, although one participant did not. Again, almost all (18) believed that the program met most of their needs; however, one participant felt the program addressed only a few needs. There were 15 who were very satisfied, and the rest were mostly satisfied with the service. Suggestions for improvement offered by participants include having a larger meeting room, improving attendance by participants, including more women's groups and cultural teachings, offering home visits in addition to centre-based therapy and as a form of aftercare, offering smaller workshops on addictions, and increasing counselling sessions to a duration of four or five hours.

The majority had an overwhelming amount of positive praise for program content and the project team. Their voice is captured below:

- "Counsellors helped me lots with my healing. I highly recommend this program to anybody."
- "I am very satisfied and happy with the services I received. I will continue to seek help with the counselling services."
- "I have recommended friends/family for this program."
- "... anyone thinking of getting help from this centre will be doing themselves a big favour and a big step towards healing because that's what they will get! Excellent services!!!"
- "I guess the one thing that stands for me was the grieving and loss session. I was able to express my emotions in loss of my mom years ago. I don't know why I held on to this grief for so long ... [The counsellor] was able to assist me in letting go of that pain. I would recommend this program for everyone ... Seeing the old residential school brought back some sad memories and kind of brought a closure to that bad experience ... [The counsellor] has given me confidence and raised my self esteem."
- "I will refer anyone of my friends to this program. I got so much out of it. I realize my problem areas and need to work on them. I especially enjoyed the trip to my former residential school. It has brought some closure to some sad and bad memories over there. I offered tobacco and prayer in one of the rooms. I became emotional but it felt very good. I will continue to seek counselling after this program; however, I would feel much more comfortable if I could be counselled by ...[a certain counsellor]. Thank you."
- "Only wish that my two sisters would come. Encourage mother to speak to them to come, it is terrific program!!"

4.2 Impact on Community

One of the more salient goals of the the project was to sufficiently overcome denial so that the program could operate to capacity. During the period under examination, 67 of a possible 75 participants were engaged and 19 graduated from the program, representing an 89 per cent participation rate and a 28 per cent completion rate. Each successive intake showed increasing enrollment (usual intake is 15 participants), so that by the fourth intake they exceeded capacity by accommodating 20 participants and outgrowing their trailer. Eventually, participants engaged without having been referred by an outside agency. Overall, the project was able to achieve implementation objectives with little difficulty. Their only obstacle appeared to be getting family members involved in phase two of the therapeutic program; however, over the lifespan of the project, an increasing number of couples were participating. They credited positive change to the referral network, the confidential setting, peaked community curiosity, team skills, project visibility, and the example set by recent graduates. The community estimates that there are 242 Survivors in total (not counting those impacted intergenerationally) and recognizes that much work still needs to be done.

The project also wanted to facilitate the development of a support network in the community. The project team has formed self-help groups, enlisted Elders to make themselves available, and contracted therapists for those seeking further clinical support. The project also received many referrals from local agencies, some of which are mandated. Unfortunately, the team estimates that 80 per cent of those mandated to attend do not complete the program. In addition to creating a support network, the project was originally designed to enlist family members during phase two of the project; however, they acknowledge that this segment of therapy did not go according to plan. Support for the project team is provided by the residential school advisory group, Survivors' committee, and the board of the Nelson House Medicine Lodge.

Team and community informants held different opinions about the extent of change in the community's understanding of the Legacy. While some felt that only a few gained an increased understanding, others felt that more than half to almost all the membership more clearly understood the Legacy. When change was not abundantly apparent, respondents still believed that something was happening below the surface,

"They're here (the changes) but not visual yet." When it was clear, noted behavioural change included increased anticipation of monthly newsletters on residential school issues, increased open discussion, different attitudes about the Legacy, as well as clarity that the project is a healing (not compensatory) effort. In addition, the rate of disclosures has precipitated fundamental and structural acknowledgement of the Legacy.

> Recently there were disclosures of a school principal who abused children for thirty years and had the school named after him. The board of education heard the disclosures and changed the name of the school. This is the first invitation for residential school Survivors to talk.

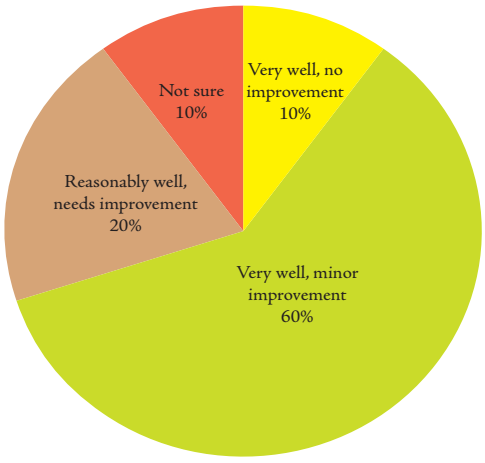
Increased understanding of the Legacy was attributed to community readiness, actions of the ad hoc committee on residential schools, increased resources to address healing, efforts of the project (e.g., conferences, field trips to residential schools, and public relation campaigns), project team members who are skilled Survivors able to inspire healing and make others feel safe; and Elder involvement.

One of the spinoffs was a five-day conference at Troy Lake successfully hosted by residential school Survivors from the community and other organizations around Thompson. Another conference was planned for March 2002 for caregivers that work with Survivors, and they are also planning for another summer conference in 2002.

While the skill of resource people in the community to deal with the Legacy is still unclear, increased openness, awareness, and eagerness to learn is observed. Leaders talk openly about the Legacy in meetings, the project is getting more referrals from other service agencies (e.g., mental health and family violence), and service deliverers ask questions and want to be involved—Pisimweyapiy Counselling Centre is breaking new ground. In other words, Legacy education is unprecedented in Nisichawayasihk Cree Nation, and local agencies and community members are just starting to learn about the Legacy and how to heal from it.

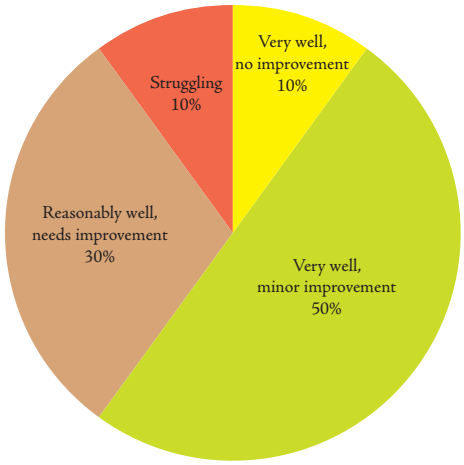
The project got high marks for its accountability to the community. The solid majority felt that the project needed little or no improvement in this regard. Accountability is fulfilled through local radio, community presentations, monthly newsletters, residential school advisory committee meetings, as well as posted program activity schedules. Figure 3 reflects the distribution of opinion on the project's accountability to the community.

Figure 3) Accountability to the Community



About half of the respondents felt that the project was addressing the Legacy very well, requiring little or no improvement, some felt that the program could better address the Legacy, and a small proportion felt that the project was struggling in this regard. Figure 4 reveals the distribution of opinion about how well the project was able to address the Legacy.

Figure 4) Ability to Address the Legacy



4.3 Partnerships and Sustainability

Working relationships have been formed with Native Communications Inc., Swampy Cree Residential School Survivors Program, Opaskwayak Residential Survivors Program, York Landing Residential Survivors Program, Split Lake Band, Nisichawayasihk First Nations Band, Otetiskewin Kiskinwamahtowekamik School, mental health, nursing station, Awasis Agency, RCMP, crisis centre, Keewatin Community College, Manitoba Metis Federation, and probation services in Nisichawayasihk and Thompson area.

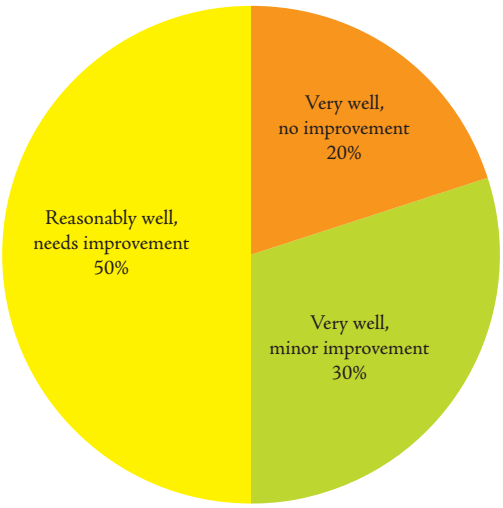
Although there is a strong desire for the project to continue, respondents were unanimously fearful that it might not as it does not receive any additional funding other than what AHF provides. Still, they indicated that there is strong community interest and commitment to healing programs and speculated that alternative funding sources might include $4.5 million from hydro (*Northern Flood Agreement* compensation) to be used for programs, fundraising, doing outreach in other communities for a per diem, being integrated into one of the other programs, government assistance, or forming partnerships with other programs.

4.4 Addressing the Need

The local director for health services believes that Pisimweyapiy Counselling Centre is "a welcome relief" in the community, is eager to adopt their approach, and clearly recognizes the need for identical training for the health services team. The project makes therapeutic decisions based on client feedback, an approach having widespread appeal in the community and may be adopted by the Health Services Division. Still, informants felt that the project could better meet the need by providing whole family therapy versus individual-focused treatment. One felt very strongly that greater efforts need to be made to enlist and target dysfunctional families in the community that are fragmented by alcohol and drugs. He believed whole family treatment is the answer, and he dreams of a system of support and contribution that would

include fixing up their houses while they were away "fixing up their lives" so that they can return to a new life and have pride in their surroundings. The project should play a part in this plan because continuous crisis intervention is not serving the needs of families suffering from the Legacy nor is it serving the needs of the community. Still, all informants were positive about the project's ability to address the need, as responses were evenly divided between believing that little or no improvement was needed or some improvement would be beneficial.

Figure 5) Ability to Address the Need



On a broader scale, the community felt that the proposal writing requirement may have missed some communities in greatest need who do not have the human or financial resources to participate in such a screening process. It was suggested that AHF's efforts be more proactive and outreaching to those communities who suffer the most.

4.5 Successes and Best Practices

The members of the Pisimweyapiy Counselling Centre team are well-respected community members and Survivors who have healing skills. They are described as non-judgmental, sincere, trustworthy, gentle, respectful, committed, and culturally sensitive. The combination of motivated, skilled team members, supportive leadership, community partners, and participants who genuinely want personal transformation sets fertile ground for growth. Emphasizing personal responsibility, the power of choice or free will, the processes of colonization and decolonization, as well as self-trust worked well. Others felt that the combination of group lectures, one-to-one counselling, and a safe environment created conditions for change. Other specific activities that are planned to continue because of their resounding success are:

- healing/sharing circles (for unique groups, men/women, Elder/youth, self-help, and mixed groups);
- cultural ceremonies and traditional teachings;
- bringing in presenters from the outside;
- networking and sharing with other programs and organizations;
- working with the Elders;
- going on residential school trips with residential school Survivors;
- continued employee professional development;

- promoting services in and out of the community; and
- soliciting participant feedback.

Team members were also very clear about the powerful influence of framing the therapeutic process in the context of Cree culture. Field trips, workshops, and Legacy education have also been well received. One informant said that the anger management workshop was an "eye opener." Activities that engage participants in light-hearted activities where they could relax, let their guard down, and simply have fun (e.g., the travelling theatre troupe that educates on the impacts of residential schools using comedy) were very popular. At last, the extent and variability of the program schedule allow for easy access both in the evening and during the day.

4.6 Challenges

Eventually the trailer became too small to accommodate all who wanted to participate, and the paper thin walls stressed confidentiality in one-on-one sessions. The image of Pisimweyapiy Counselling Centre also needs to change, as some still believe it is an alcohol and drug treatment program because of the project's close affiliation with the medicine lodge. It was suggested that a different location with a clearly identifiable billboard be used to separate the project's identity from the medicine lodge. This would eliminate the reluctance to participate due to the fear of stigmatization as a substance abuser.

Informants also believed that the project could engage more actively in outreach efforts by advertising on radio and television as well as using the school as a vehicle for Legacy education: a clearly competing priority to an ever-burgeoning participant group. They expressed fear that many are still hurting and that victimization has not yet come to an end. Efforts to expand the circle of healing to include family members did not materialize as the team had hoped, and treating the individual outside of the context of the family was a challenge. Similarly, those who were mandated to participate came once or twice and then most (80%) dropped out.

Daytime scheduling presented difficulty for employed participants who could only attend evening sessions. After and continuing care in the community were considered essential to preventing relapses but were not as fully developed as anticipated. Informants believed more Legacy education and a higher profile for the project would have helped in this regard.

4.7 Lessons Learned

Informants likened the AHF to "another government hierarchy" partially because funding took so long to secure and they felt that the resources should have gone directly to community agencies. In other words, instead of having a foundation, the money should have gone directly to the communities without having to engage in a proposal-writing process.

Others felt that there should be more community involvement in the development of the program through the use of "coffee nights" and other open gatherings. Also, reinforcing traditional skills, practices, and language should be a stronger focus of future project efforts. Some felt that the project accomplished a great deal in a short time period and that it could fill a continuing care role for those referred out of the community for other services. Greater networking, especially among the directors of health services in the community, would have helped ensure stronger partnerships and greater program complementarity.

5. Conclusions

"Things are happening, but it's slow."

Nineteen of 67 participants have completed the program at Pisimweyapiy Counselling Centre (28%) with clearly enthusiastic impressions about their healing experience. While the age and sex distribution of the graduate group is not known, it is obvious that they, along with other community members at large and the project team, believed several factors were responsible for their success, which included:

- a safe, culturally sensitive therapeutic process that combined group lectures with one-on-one counselling on a variably accessible schedule and emphasized Legacy education;
- a team composed of Survivors from the community who are skilled counsellors, successful on their own healing journey, gentle, committed, and professional without being imposing;
- supportive leadership, reinforcing, complementary partnerships, as well as community commitment to and readiness for healing; and
- Survivor involvement in program development.

The program was able to operate at almost full capacity (89%), which suggests that the project's efforts to dismantle the wall of silence and denial were reasonably effective. While individual progress appears slow, the 28 per cent individual completion rate must be viewed in the context of family and community. Some participants were mandated to attend (most of whom dropped out) and all have suffered from physical abuse; 90 per cent come with a history of alcohol abuse; and the majority (>60%) have experienced family violence, conflict with the law, and lack of basic life skills. Even the tirelessly motivated would struggle with such a legacy. Unfortunately, no data have been collected to explain why those who had most to lose (i.e., their children or their freedom) would leave the program. It is entirely possible that special needs were not being addressed by the project or the "fit" between client and program was not appropriate. In other words, if some were still suffering from addiction or had fetal alcohol syndrome or fetal alcohol effects, the project may not have been able to meet their needs.

Furthermore, informants described a community climate of widespread poverty, addiction, and family dysfunction. In fact, although the project had intended to treat individuals in the context of family, phase two of the therapy (when the family gets involved) did not go as well as planned, which probably has more to do with the pervasive social problems in the community than it does with the skills or commitment of the team. Other events that may have influenced the program's ability to achieve the magnitude of change it desired include clashes between Cree spirituality and Christianity, the socio-economic disruption caused by hydro flooding, low self-esteem, and widespread dependence upon social assistance.

Acculturative forces for the Nisichawayasihk Cree Nation have been recent and swift. The impact of flooding coupled with a rapidly expanding mining industry, the establishment of the city of Thompson in the fifties, and road access to an urban centre meant increased interaction and subjugation by thousands of Euro-Christian Canadians as well as access to alcohol.

With respect to an increased understanding of the Legacy, it is clear that some recognition at individual and institutional levels has occurred. More open discussion and different attitudes about family and history, together with public acknowledgement of high-profile perpetrators, suggest that the climate has changed. Community sentiment about the project is overwhelmingly positive even if the majority felt that some improvements were needed to better address the Legacy. They suggested a bigger facility with a distinct

identity (i.e., separate from the medicine lodge), more partners enlisted in Legacy education, and a process to ensure individual treatment in the context of family and continuing care should be realized. While the skills of the team were not directly assessed, they were clearly well received by program graduates. The community recognizes that outside forces may have had a facilitative influence in increased popularity and use of Cree systems of restorative justice, conditional sentencing, and a regional resurgence of culture. They also strongly believe that guaranteeing success for a few may pay long-term dividends for others who are inspired by their example. However, the resources to sustain the project are in question once AHF has closed its doors.

6. Recommendations

The following recommendations have been classified under three thematic areas: team, project delivery, and evaluation issues:

Team Issues:

- select team members with experience and ensure that they are well trained to address the unique needs created by the Legacy, can make participants feel safe, and are recognized Survivors who have modelled a successful healing journey; and
- counsellors should be non-judgmental, culturally sensitive, and respectful.

Project Delivery Issues: recommendations related to program delivery focus not only on therapeutic content but also upon how to overcome denial and encourage full participation. In no order of priority, they are as follows:

- ensure that facilities are adequate in size, structure (e.g., soundproof rooms for one-on-one sessions), and location with an identity distinct from other more stigmatizing institutions (e.g., alcohol and drug treatment facilities);
- recognize that aftercare is an integral part of the healing process, develop partnerships for or incorporate aftercare as an equally important part of program activity that should include home visits and centre-based outpatient therapy, and strengthen the urgency of securing sustainable partnerships so that healing can continue;
- consider increasing the time available for counselling sessions;
- special needs including FAS/FAE, addiction, and mandated care are often beyond basic programming, so effort must be expended to assess special needs, develop unique treatment plans, or make appropriate referrals;
- expend more effort to learn the characteristic differences of those mandated to participate to discover strategies that will support and engage them to complete the program and, similarly, seek out the opinions of self-motivated individuals for whom the program did not work to guide program evolution;
- facilitate individual and community readiness by recognizing that many are still in denial and by significantly boosting Legacy education and outreach efforts with more high-profile campaigns that enlist community-based partners such as schools, radio, and television;
- include more women's groups and cultural teachings;
- encourage family participation with "family" night or family fun activities;
- maintain Elder involvement; and
- conduct closer follow-up and one-on-one meetings either in the home or in the community with those Survivors who are working and not able to attend afternoon or morning sessions.

Evaluation Issues:

- make use of the *Community Guide to Evaluating Aboriginal Healing Foundation Activity*;
- be clear about the indicators that will be used to measure change;

- use client satisfaction questionnaires and other reliable and valid measurement tools to determine changes in project participants and community;
- increase efforts to explore rival explanations (e.g., What has been the contribution of leadership?); and
- profile those for whom the program seemed to work and identify what is different about those for whom the program worked versus those for whom the program did not work. Is denial the only barrier? What other distinguishing characteristics are clear? Age? Sex?

Notes

[1] Information from the funding application submitted to the AHF, February 2000.
[2] AHF Supplementary Survey, July 2001.
[3] Indian and Northern Affairs Canada, *First Nation Profiles* (accessed August 2001).
[4] This includes child and family, elder centre, resource centre, nursing station, fitness centre, youth leadership centre, and mental health centre.

Appendix 1) Case Studies Selection Criteria

1. Métis, Inuit, First Nation, Non-Status
2. Youth, men, women, gay or lesbian, incarcerated, Elders
3. Urban, rural or remote
4. North, east, west
5. Community services
6. Conferences/gatherings
7. Performing arts
8. Health centre (centralized residential care)
9. Camp/retreat (away from the community in a rural setting)
10. Day program in the community
11. Healing circles
12. Materials development
13. Research/knowledge-building/planning
14. Traditional activities
15. Parenting skills
16. Professional training courses

Appendix 2) Referral Package

Section A: Personal data/identification

- Information on next of kin.
- Who referred you to the program?
  Self, court order, employer, agency, NNADAP, other
- Date of initial contact with referral agency.
- Interview conducted by (referral agent).

Section B: Family situation/history

- Marital status.
- List all family members living at home & away from home.
- List anyone who lives in the home.
- What role do they play in the home and why do they stay there?
- What child care arrangements have been made while you are in this program?
- Family support:
  How do your family members and significant others feel about you coming into this program?
- What type of support do you have while attending this program?
- Please specify any type of family problems that are happening in the home/family:
  Alcohol abuse, drug abuse, gambling, grieving/loss, anger/violence, apprehension of children, custody issues, separation/divorce, spousal abuse, legal issues, health problems, mental health problems, employment issues, lack of family supports, sexual abuse, suicide, depression, other, please specify
- How often does abuse occur as identified in previous question?
  Daily, occasionally, binge, rarely, never
- What is your opinion on abuse, explain.
- List areas you feel should be addressed while in program.
- What areas of the PCC interest you?
  One on one counselling, small group session, family therapy, workshops, cultural/spiritual teachings, field trips to residential schools, other, please specify

Section C: Legal Status

- Current of pending charges, upcoming court hearings, recognizance, probation, parole, conditional or temporary release, children in care of a child care agency.
  Please describe circumstances.

Section D: History of alcohol/drug use

- Abstainer, occasional user, moderate user, problem user, addicted.
- While attending PCC it is expected that all participants abstain from the use of alcohol and drugs. Would you be willing to abstain from the use of alcohol and drugs?
  Yes, no, maybe, other, please explain

Section E: Finance/Employment situation

- Are you employed?
- What is your job title?
- Employers name?
- Address?
- Phone/fax?
- Will you job prohibit you from attending the PCC program?
- Does your employer require you to attend a treatment program?
- Are you willing to take a leave of absence from work if your employer approves your leave of absence?
  Please explain.

- If no, what is your source of income?
  UIC, unemployed, social assistance, pensioner, other

Section F: Residential School History

- Have you or family members ever attended an Indian residential school?
- How did the residential school experience affect your life?
  Check language, cultural beliefs/practices, parenting skills, identity, family relationships, friendship, physical abuse, emotional/mental abuse, alcohol/drug abuse/other addictions, other.
- Please explain what you lost/gained as a result of residential school or any residential school experience that affects your life today.

Section G: Treatment History

- Check off problems that the use of alcohol/drugs and other addictive substances may have caused for you.
  Relationship problems, getting fired, psychological problems, medical problems, legal problems.
- Do you believe you may have a problem with alcohol/drugs? If so please explain.
- What other treatment programs have you attended? specify dates.
- Have you ever over-dosed because of alcohol/drug use? If so please explain
- How ready are you to deal with change while in PCC program?
  Pre-contemplation - unsure at present time; contemplation - thinking about it; determined - willing to participate whole heartedly; action - the process is already being taken place; maintenance; following program gridlines as required

Signatures

- Medical Assessment report
  Physician's data
  Patient data

Appendix 3) General Questionnaire

General Questions (for respondents NOT employed by Nelson House Medicine Lodge)

Name:_____ Profession:_____ Date:_____

Before we begin I would like to assure you:

- that there are no right or wrong answers, only answers that are true from your perspective, we are hoping to learn more about your attitudes toward the program and it's performance and there may be questions that you cannot answer. It is completely acceptable to say that you don't know.
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e., geographic, group representation, project type, etc and ***not*** on past/present performance, this is a case study to help us learn more about the strengths and weaknesses of our effort)
- the report will ***not be able to identify who said what***, so please feel free to say things that may cause controversy
- and, for the most part, it is important to focus your comments or opinions upon things that you have noticed in your position as . . . . . (chief, nurse, etc.)

To start, I would like you to share with me your involvement or knowledge of the NHML, **Nisichawayasihk Healing and Wellness Program**

I would like you to now think about the **community** generally.

1. Have you noted changes in your community's understanding of the Residential School Legacy?

   Yes No

   Thinking very specifically about the community (i.e. ,What have you seen, or heard or felt), that makes you feel this way:

   _____

   _____

Participation	Individual ideas	Individual behaviours	Community conditions

   How many people in the community have been affected?

<10%	<20%	about 50%	more than 75%	almost all

   Why do you think this has happened?

   _____

   _____

2. Have you noticed if more families are indicating a need or willingness to participate in the Nisichawayasihk Healing and Wellness Program?

   Increased Decreased The same Haven't noticed

   Thinking very specifically about community members (i.e. what they have said or done), what have you observed that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

   magnitude of this change?

<10%	<20%	about 50%	more than 75%	almost all

   Why do you think this happened?

Thinking more specifically about the program

3. How well do you believe Nisichawayasihk Healing and Wellness Program has addressed the Legacy of Sexual and physical Abuse in Residential schools including inter-generational impacts? Please circle only one response.

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

Please offer an explanation for why you feel this way:

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

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

Please offer an explanation for why you feel this way:

5. How well has Nisichawayasihk Healing and Wellness Program been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

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

Please offer an explanation and some examples of the projects accountability to the community.

6. Do you see Nisichawayasihk Healing and Wellness Program being able to operate when funding from the Foundation ends? If yes, how and what steps are you aware of

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

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

Please offer an explanation and examples on how you seen this take place

8. What do you think are Nisichawayasihk Healing and Wellness Program strengths? (What seems to be working well, what are the success stories)?

9. What type of change do you see happening in the lives of people who have participated in Nisichawayasihk Healing and Wellness Program? If any?

10. What are some of the challenges that Nisichawayasihk Healing and Wellness Program faces (What are its weaknesses?) Please specify.

11. Are there any other questions or comments about Nisichawayasihk Healing and Wellness Program that you would like to see addressed that we may have missed?

12. Thinking very generally about the community, which answer best describes your opinion about the following rates of:

Physical Abuse:	increased	stayed the same	decreased	unsure
Sexual Abuse:	increased	stayed the same	decreased	unsure
Children in care:	increased	stayed the same	decreased	unsure
Suicide:	increased	stayed the same	decreased	unsure

Please explain:

Appendix 4) Key Questions

✓① ***Why are we doing this?***

(What long term goals are we striving for?)

✓② ***What do we want?***

(What do we hope will happen in next 6 months to a year?)

✓③ ***Who do we expect to influence?***

(Who is most likely to benefit from this activity?)

✓④ ***How are we going to do it?***

(What activities, services, products do we believe will help us get what we want?)

✓⑤ ***How will we know that things have changed?***

(What things will indicate to us that change is happening? What measures and indicators of change will we use?)

✓⑥ ***What will we see, hear and feel?***

(How will we measure change?)

✓⑦ ***How much have things changed?***

(Is there a clear difference from before we started our program? What indicators or measures tell us that?)

✓⑧ ***Who else sees the change?***

(What is the opinion of other people whose perspective is important, e.g. family members, local health professionals, police, social services, youth services?)

Appendix 5) Employee Questionnaire

Nelson House Medicine Lodge
Nisichawayasihk Healing and Wellness Program

Before we begin I would like to assure you:

- that there are no right or wrong answers, only answers that are true from your perspective
- your participation is strictly voluntary and you can choose to answer or not answer questions as you see fit
- the project has been selected based upon the criteria that were important to the board (i.e. geographic, group representation, project type, etc and *not* on past/present performance, this is a case study, not an evaluation)
- we are *only trying to learn from your experience* so that we can help others get what they want from their AHF projects
- the report will *not be able to identify who said what*, so please feel free to say things that may or may not cause controversy
- and, for the most part, it is important to focus comments on *individual* participants.

To start, I would like you to now think about the people participating in this project (please concentrate on those who have completed the program). Please select the answer that best describes how you feel about the development of the following desired changes; remember, there are no right or wrong answers

1. Development of healthy coping skills (life skills)?

Not sure/don't know	No evidence of change yet	Slight change	Moderate Change	Dramatic change

Thinking very specifically about the participants in the program (i.e. What they have said or done), what have you observed that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

If some change is noticeable, about how many participants are experiencing change? (circle one)

<10%	<20%	about 50%	more than 75%	almost all

Why do you think the change has *not* happened/ the change has happened?

2. Understanding the impact of the Legacy?

Not sure/don't know	No evidence of change yet	Slight change	Moderate Change	Dramatic change

Thinking very specifically about the participants in the program (i.e. what they have said or done), what have you observed that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

If some change is noticeable, about how many participants are experiencing change? (circle one)

<10%	<20%	about 50%	more than 75%	almost all

Why do you think this has happened?

3. Self esteem or self-worth?

Not sure/don't know	No evidence of change yet	Slight change	Moderate Change	Dramatic change

Thinking very specifically about the participants in the program (i.e. what they have said or done), what have you observed that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

If some change is noticeable, about how many participants are experiencing change? (circle one)

<10%	<20%	about 50%	more than 75%	almost all

Why do you think this has happened?

4. Cultural Pride?

What have you noted that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

<10%	<20%	about 50%	more than 75%	almost all

Why do you think this has happened?

5. Family functioning (family health, quality of family relationships)?

Not sure/don't know	No evidence of change yet	Slight change	Moderate Change	Dramatic change

Thinking very specifically about the participants in the program (i.e. what they have said or done), what have you observed that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

If some change is noticeable, about how many participants are experiencing change? (circle one)

<10%	<20%	about 50%	more than 75%	almost all

Why do you think this has happened?

6. Which answer best describes your opinion about the participants who have completed the NHWP: Do you believe that as a group, their risk for:

Physical Abuse:	increased	stayed the same	decreased	unsure
Sexual Abuse:	increased	stayed the same	decreased	unsure
Children in care:	increased	stayed the same	decreased	unsure
Suicide:	increased	stayed the same	decreased	unsure

Please explain:

Now, I would like you to think about your own experiences with the training component of the NHWP. Would you say that the training program

1) reinforced what I already knew about the treatment of residential school Survivors

2) helped me to develop new skills to help Survivors

3) helped me to understanding the impact of the Legacy

I would like you to now think about the community involved in this project.

7. Have you noted changes in your community's understanding of the Legacy?

What have you noted that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

magnitude of this change?

<10%	<20%	about 50%	more than 75%	almost all

8. Have you noted that resource people have become more skilled at addressing the impact of the Legacy?

Yes No

What have you noted that makes you feel this way:

Participation	Individual ideas	Individual behaviours	Community conditions

magnitude of this change?

<10%	<20%	about 50%	more than 75%	almost all

MANDATORY QUESTIONS:

We know that you have already supplied information to the Aboriginal Healing Foundation through your quarterly reports, but we would like to offer you another opportunity to provide further insight in the following areas:

1. How well do you believe Nisichawayasihk Healing and Wellness Program has addressed the Legacy of Sexual and physical Abuse in Residential schools including intergenerational impacts? Please circle only one response.

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

Please offer an explanation for why you feel this way:

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

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

Please offer an explanation for why you feel this way:

3. How well has Nisichawayasihk Healing and Wellness Program been accountable to the community? (i.e. engaged in clear and realistic communication with the community as well as allow for community input) Please circle one response only:

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

Please offer an explanation and some examples of the projects accountability to the community.

4. Do you see Nisichawayasihk Healing and Wellness Program being able to operate when funding from the Foundation ends? Please specify.

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

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

Please offer an explanation or examples on how you have seen this take place