Hamlet of Cape Dorset

Project Number: CT-411-NT/32-NT

Case Study Report

Healing and Harmony in Our Families

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2002

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Acknowledgements

I would like to offer my deep thanks to the people of Cape Dorset, especially to the members of the Community Healing Team and others in the community who gave me the opportunity to talk with them about this project and the issues facing the community. I would also like to thank my colleague for all her help with this case study: confirming figures, taking notes, setting up interviews several times, and especially offering the gloves, scarf, and mitts in minus-50 degree weather.

As with all those interviewed, each brought something special and, often, very personal examples of life experiences. And so I thank you all for sharing this and your community.

1. Introduction

A series of case studies was conducted as part of the impact evaluation of the Aboriginal Healing Foundation (AHF). The case studies are intended to provide a detailed, holistic view of the projects and their outcomes. All data collection, analysis, and synthesis are being done by community support coordinators under the facilitative guidance of Kishk Anaquot Health Research. The project that forms the basis for this case study is entitled "Healing and Harmony in Our Families" (AHF-funded project # CT-411-NT/32-NT). It is described in the funding application as seeking to:

> [P]rovide healing and training to individuals who are committed to personal healing and who will support healing within their family and the community at large; develop and implement a healing strategy that will include training workshops for healers and caregivers, community awareness workshops, healing circles or gatherings for women, teens, Elders and men; and plan and deliver healing camps on the land at least once a year for targeted groups, including youth, women, men, Elders and families.[1]

This report provides a description of the Cape Dorset project, which includes activities, participant characteristics, and environmental factors that may influence the project. It also includes a description of the community and the range of potential indicators of change, including those chosen by the AHF Board to be applied to all projects (physical abuse, sexual abuse, incarceration rates, suicide, and children in care). The project's successes, challenges, and lessons learned are discussed as well as impacts on individuals and the community. The methodology section provides detail on the data collection process and limitations to the methods used. Sources of information include project files (funding proposal and quarterly reports); the AHF National Process Evaluation Survey (February 2001) completed by the project; key informant interviews with the community healing team (CHT) and selected community service providers; and documents and data collected by the community support coordinator as part of the case study process. In addition, the project provided summaries of participant evaluation forms for four of the workshops it held.

2. Methodology

There is a logical link between a project's activities, what they hope to achieve in the short term, and the desired long-term outcome. In essence, a project meets its service delivery objectives when it carries out planned activities. However, further information is required to assess the actual impact of activities. This means linking desired outcomes—what the project hopes to achieve in the short and long term—to indicators of change, such as changes in participant knowledge, skills, attitude, behaviour, and, ultimately, changes in environmental or social conditions. The following summarizes the project's goals and objectives (referred to as long- and short-term outcomes) as well as the indicators that show how change is being measured:

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;
- increased capacity and effectiveness in serving hard-to-reach people, especially men;
- community healing in areas of lateral abuse, violence, sexual abuse, and suicide;
- overcoming powerlessness and hopelessness;

- increased sense of pride in culture and spirituality as it relates to healing; and
- strong, effective community healing team.

Short-term measures (indicators of change):

- number of participants in healing circles, workshops, counselling, and on-the-land camps (# of participants over time for each target group);
- self-reported and key informant perceptions of changes in participants' self-esteem, coping patterns, dealing with depression and suicidal thoughts, and understanding the effects of sexual abuse;
- self-reported and key informant perceptions of change in participants' behaviour (not attempting suicide, getting help for violence and abuse, participating in alcohol and drug treatment, and giving to/receiving support from Elders);
- increased skills and, therefore, reach of caregivers and workers (# of skilled caregivers; key informant and self-reported perceptions of training and skills acquired; and # of people reached); and
- a healing strategy that focuses on hard-to-reach groups, such as men.

Long-term outcomes:

- restored balance and harmony in families and community.

Long-term measures (indicators of change):

- reduced rates of physical and sexual abuse, suicide, incarceration, and children in care; and
- evidence of active, healthy community life (# of elders, youth, women, and men involved in community affairs; and # of and participation in community events).

The focus of the case study is on assessing the impact of the project's healing and training activities; in particular, weekly healing circles for women and girls, healing and training workshops, individual counselling, and on-the-land camps. To a lesser degree, the study addresses planning and evaluation activities, especially since planning meetings were routine and facilitated all other activities. Specific target groups were women, youth, Elders, men, and caregivers. In addition, the community was targeted in a community awareness session, and workshops and healing circles were advertised on local radio. Strategies to address hard-to-reach groups, particularly men, were discussed in planning meetings and two evening groups were offered to men in March. The study relies heavily on key informant perceptions of change in participants' knowledge, attitudes, skills, and behaviour.

All project files were thoroughly reviewed prior to conducting the interviews, starting with the successful application, then all quarterly and final reports. After initial review of all documentation, a logic model and performance map (Appendix 1) were created to provide an overview of the project. These steps then guided the design and finalization of the interview questions (Appendix 2) as well as a list of who would be interviewed. The list was created from project files that provided information on CHT members and project personnel. Preliminary contact was made with key informants through my colleague (fluent in Inuktitut) to introduce us both and begin planning when the interviews would take place. The questions went through several revisions and then translated into Inuktitut. These were made available to an interpreter who was hired to assist during the interviews. Two attempts were made to fly into the community. The first could not be completed, as mild weather and fog prevented landing of the aircraft and the duration of the trip was spent in Iqaluit to secure data from various territorial government offices.

Over the course of five days (26–30 November 2001), in-person interviews were conducted with 10 people. One person opted to take the questionnaire home to complete and then returned it the next day. Two additional people were expected to be interviewed, but outside factors prevented them from being in the community when the interviews were taking place. Some informants were only contacted while in

the community. The project was in the process of reapplying for AHF funding. It was explained by the justice specialist that an AHF request for additional information was not fulfilled by the project due to lack of time or personnel. Consequently, no current project coordinator was in place to interview. The CHT members who were interviewed included the project coordinator for the year this study focuses on. Healing circle facilitators were also part of the group interviewed. The same set of questions was delivered to all informants to solicit their observations, feelings, and opinions as well as their knowledge of the issues facing the project's target audience and of the project's purpose.

Of those interviewed, only one was male (an Elder) as the only other male on the CHT was unavailable. The remainder were female with one being a non-Inuk. Six required interpretative services and four received the interview questions in English, including the person who self-completed the survey. In a follow-up contact with the justice specialist, three of the people interviewed were identified as Elders.

Interviews averaged approximately 45 minutes to one hour in length, with four people present: the study author, his colleague (an AHF employee from Iqaluit), an interpreter (recommended by the community), and the informant. Eight of the 10 people who participated in the planning for the project were also asked mandatory questions set out by the research team. The location for eight of the interviews was at the Justice building. One person was interviewed at the probation offices and one person was met at a school who subsequently took the survey home to self-complete.

Data from Government of Nunavut Bureau of Statistics and Health and Social Services in Iqaluit were collected. While in Cape Dorset, the RCMP detachment, Social Services office, one school, the nursing station, and one business operation were visited to secure further information. Also, informal conversations with several business owners and others who held professional roles in the community (such as a former councillor) were also sources of information used for this study. However, these individuals were not speaking in their professional role but as community members. Finally, the hamlet provided a community profile and an economic development plan mentioned earlier. Summaries of participant evaluations for four of the workshops were made available.

2.1 Limitations and Considerations

Much of the indicator data used in this report were provided orally, as only a few documents were made available. Project personnel provided other details such as children in care rates. It is unclear whether "select" information was shared or if there were more details that could have supported a more accurate assessment of the environment and context where this project operated. Some older data provided by the hamlet suggests no up-to-date population or demographic figures were available.

The interpreter was also interviewed as she held the position of project coordinator for the year in question. However, it is felt that she provided accurate interpretation of the informant responses. My colleague, also fluent in Inuktitut, was present for all interviews and took notes of informant responses that were later compared with the study author's. This lends an increased level of confidence to the interview data. In fact, the skills of the interpreter can be said to be very high, and this case study likely benefited by having such a skilled person involved that is from the community. Translation of the questionnaire provided the interpreter familiarity prior to the interviews. Interview questions were asked in English and the interpreter used her own language and terminology. Inuktitut responses were recorded in English based on the words of the interpreter, and the analysis was done in English.

Ten people were interviewed, although experience from previous case studies recommends at least 12 to 14 interviews to allow a well-rounded perspective. However, because eight of the 10 informants played a key role in planning, they were also asked the mandatory questions set out by the research team. Thus, enough information was collected to support the analysis. The limited time available for gathering data in the community meant efforts were concentrated on interviewing CHT members and meeting with agencies to collect social indicator data. No time was available to solicit views about the project from the community at large or from particular segments of the community who may not support the project. While it appears that respondents were open and honest about the project's challenges and shortcomings as well as its successes, it must be recognized that these are "insider" perspectives, and there may be competing or conflicting views that are not represented here. The project did provide summaries of participant evaluations from four workshops, which proved to be limited in their usefulness as they only addressed the adequacy of workshop delivery and content and contained few other details.

While the case studies are not intended to deal directly with program participants due to ethical concerns about the possibility of triggering further trauma, an exception is made for this case as CHT members were not only involved in planning and delivering programs but also participated in them. This issue was first discussed with the justice specialist to ensure that informants would have access to support people if the need arose. The second AHF employee present was also asked to be vigilant if a person was showing signs of distress. In addition, key informants were told they were being interviewed in their role as a CHT member or in their professional role in the community and not as a project participant. This was reinforced in the wording of the questionnaire.

Finally, if more time was allowed for a longer stay in the community, this would have provided greater insight into community dynamics. What did become clear during the interviews was that not all community members agree with the term "healing," and it can be said that religious influences within the community have differing views on the matter. One other observation was that men seemed not to be as involved as desired by the project. At one point, the study author queried as to whether the Justice building, where most of the project activities are held, was a factor. The response by one informant was, "no." This question was asked because it seemed the Probation offices located at Social Services were having men participate in its activities, such as with courses on anger management. Granted, these individuals were court ordered to participate, but we were informed that some enrolled in the courses voluntarily. This matter could have been explored further had more time prevailed.

3. Project Description

The Cape Dorset project was funded from 1 May 1999 to 30 April 2000 with an agreed-upon contribution in the amount of $121,080 and was sponsored by the Hamlet of Cape Dorset.[2] This study focuses on the same time period. The project was in its second year of operation at the time of writing. The funding application highlighted the need to develop a healing strategy based on a "heal the healer" approach. It described a "very low moral state" and "high levels of abuse, crime and violence, especially against women and children." In particular, it wanted to "heal and train a core group — mainly women." The serious impact that physical and sexual abuse had on some female community members who attended southern institutions was listed as well as the impact of a male teacher who sexually abused male students in the 1980s. It went on to link why some of the victims end up in correctional institutions or commit suicide.

It also spoke of toxic shame as being intergenerational and how many victims feel powerless, useless, and suffer in silent shame and how many experienced a spiritual destruction among the Inuit.

The application further stated that during the past five years a core group (primarily women) had put into place weekly healing circles for women and, more recently, teenage girls who had been victims of sexual abuse. They expected this project to reinforce and expand upon this base:

> We want to draw more men into the Healing Team and involve men in developing and supporting a healing program for men in the community. We want to deliver specific healing activities for Elder's and Youth, and work towards more balanced community healing during the next five years. We would like more individuals in our community to develop their knowledge of self, and their capacity to take care of themselves and foster healthy relationships with others in their family and community. We want to strengthen the Healing Team's capacity through more training and healing, to be able in the long term, to effectively help families in crisis and offenders returning from the correctional institutions to resolve their issues.[3]

The following objectives were included in the work plan:

- healing and training to enhance the CHT and other caregivers' knowledge, skills, and capacities to support therapeutic healing for the community at large;
- weekly healing circles or gatherings for women, teens, and men;
- five on-the-land healing camps for specific groups: men, women, Elders, youth, and families;
- individual counselling; and
- ongoing evaluation and planning.

The planned workshops were mentioned in quarterly reports submitted to the AHF, but few offered participation figures. There were summaries of participant evaluations for four separate workshops, and the project's end-of-year report provided another list with some participation figures (see Table 1). It appears that workshops were planned in the first quarter but held during the remainder. In some cases, no participation figures were available as the project did not seem to have the AHF reporting format that captures statistics per activity. Thus, the first three reports were narratives and only the final report had numbers.

Table 1) Project Activities by Category

Activity by Category	Time Frame	Details
Weekly healing circles:		
Women's healing circle	weekly	10–12 participants (average)
Girls' group	weekly	average of 10 participants
Weekly healing circles (women, teens, and 2 men's groups)		males (13), females (23)
Special circles to close the women and teen groups for Christmas	prior to Christmas	no data
On-the-Land Program:		
Youth camp (on-the-land)	Aug	17 youth
Elders' camp (on-the-land)	Sept	no data
On-the-Land Program (women's)	no data	males (0), females (7)
Planning and evaluation	monthly meetings	19 members of the CHT; (average 8–9 people for planning) developed mission, code of ethics, rules, etc.
Individual counselling*	ongoing	males (15), females (22)
Healing and training: (workshops)		
Team Building	27 Sept–1 Oct	no data
Male Victims of Sexual Abuse	Nov 1–4	no data
3 days: Men's Healing & Healthy Relationships; and 2 days: Community Healing Awareness	Nov 15–19	60 people (at community workshop) including 15 men (most returned for both evenings)
Grieving workshop	no data	males (1), females (10)
Women's Group Process**	Feb 7–11	males (3), females (14)
Healing for Couples	no data	males (3), females (11)
Teen Group Process	Dec 6–10	9 participants completed evaluations

* This was indicated as being volunteer counselling and not documented. Two men started attending healing training in the second quarter.
** This workshop was referred to as Women's Group Process in the quarterly report, but the participant evaluation summaries called it "Group Process and Sexual Abuse Training."

Now that we know what was intended by the project, we shall describe participant characteristics, including the project team, who were essentially members of the CHT. There was only one project employee. The CHT viewed the training as part of the healing process and vice versa. They also saw themselves as both participants in healing and as building their skills and capacity to support others. Moreover, some members of the CHT facilitated groups and healing circles and provided counselling while also participating in healing and training activities. In light of these dual or multiple roles, the CHT is discussed in greater detail in the following section on participant characteristics.

3.1 Participant Characteristics

The project provided healing and training to members of the CHT, and it was hoped that they in turn would use their increased knowledge, awareness, and skills to provide support to other family members and in the community. Thus, the CHT formed the core group that received healing and training. Nineteen people were listed as being members with the following agencies represented:

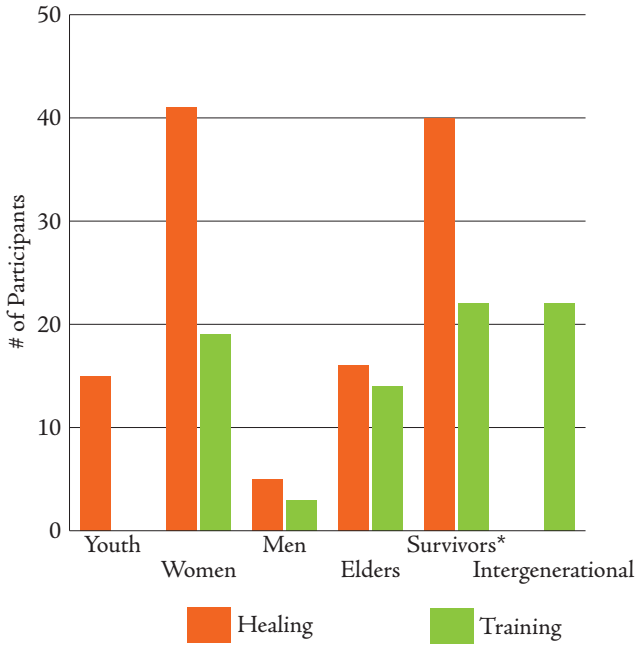
- Uquajjigiaqtiit Justice Committee (six members, including the chairperson and justice specialist);
- social services (Dorset);
- Tukkuvik Women's Shelter personnel;
- community school counsellors;
- Anglican Women's Auxiliary (layperson caregivers); and
- two land guides and two people listed without any affiliation.

Other activities, including larger gatherings and on-the-land camps, targeted the community as a whole or any one of these specified groups: men, women, teens/youth, Elders, or families. Membership on the CHT was open to the entire community, as were all activities stated in Table 1 (on-the-land camps, healing circles, workshops, and individual counselling). In general, recruitment was an open door policy and project activities were promoted largely over the local radio station. A person could participate in an event and not necessarily be on the CHT.

Participation rates based on gender or group varied. It is clear that although men were a priority target group and described as hard to reach, this was the only group not to become firmly established. As illustrated in Table 1, men did not attend as much as women. Although not clear, the one time most men became involved was felt to be during the community awareness session and associated workshop on men's healing (November 1999). However, the final report for the project did list a higher figure for male involvement. This discrepancy with informant interviews, which stated men were not participating, may be that the figure in the final report referred to the one time men requested support at a trial in Iqaluit. (At least two CHT members travelled to Iqaluit to support victims of sexual abuse during the trial of an abuser—a male teacher who targeted young male students.) It is unclear whether this service was listed as part of the 15 males who received counselling sessions mentioned in their reporting to the AHF.

Based on the AHF national survey, the project held both healing and training activities, reaching approximately 107 people in individual and group healing activities. In addition, 67 people participated in training activities. Figure 1 includes breakdowns per target audience under both healing and training categories.

Figure 1) Participation in Healing and Training Activities



* In this project, the term "survivors" refers primarily to survivors of sexual abuse rather than Survivors of residential school abuse.

The AHF national survey stated three people did not complete the ongoing healing component as two had moved away and one person died, and none were identified as not completing the training component. Furthermore, the project reported no severe challenges and identified these participant characteristics as moderate challenges affecting 40 per cent to 80 per cent of participants: history of abuse as a victim, family drug or alcohol addictions, and poverty. The following slight challenges (1%–40%) were: lack of survivor involvement in the project; denial, fear, and grief; lack of parenting skills; history of suicide attempts; history of abuse as an abuser; history of adoption; and lack of communication skills. History of incarceration, history of foster care, and lack of literacy skills were issues identified as posing no problem.

Identified in the project files was the link between many victims of sexual abuse and incarceration. At least six people on the CHT are members of the Justice Committee who obviously have a role in this issue. There is a discrepancy between viewing incarceration as not being a problem for the project, yet stating it was an issue in the funding application for the community. One possible explanation is the national survey responses were describing the core group on the CHT and not the community at large where those in conflict with the law, particularly males, were an issue or target group.

3.2 The Project Team—Personnel, Training, and Volunteers

As noted earlier, the project team was essentially the project coordinator and the CHT, which played a dual role as both participating in the healing and training as well as planning and delivering activities. Many CHT members were also healing circle facilitators or on standby if the main facilitator was not available.

The position of the project coordinator had to be replaced several times, but it is unclear whether this was a factor for the year this study is reviewing. The national survey showed there were no full-time employees and eight part-time employees. During the period this case study focuses on, project personnel were given certain types of training and professional development. The advanced training received by project personnel over and above the workshops listed earlier and reported in the national survey are outlined below in Table 2.

Table 2) Training Provided to Project Employees

Advanced Training Activity	Advanced	Was Adequate	Not Adequate
Trauma awareness	✓	✓	
Counselling skills	✓		✓
Dealing with family violence	✓	✓	
Programs related to family functioning (e.g., child development/parenting skills)	✓	✓	
Other: sexual abuse	✓	✓	

In the national survey, the project reported the need for advanced training in counselling skills and dealing with family violence, and volunteer service was identified as being 534 hours in a typical month. Volunteers donated their time and effort in two key areas: administration (planning and management) and workshops. The local government (hamlet), the Justice Committee, and one community member were identified as donating the largest amounts of goods and services. A vast majority of the project activities were situated at the Justice building, which is likely the identified in-kind contribution for space. Table 3 shows estimates of the value of donated goods and services as reported in the national survey.

Table 3) Estimated Value of Donated Goods and Services

Donated Goods or Services	Value
Food	$ 2,000
Space for project	$24,000

3.3 The Context

Cape Dorset has a population of approximately 1,200, with a high proportion (almost 50%) under the age of 20.[4] Projected population growth is 46 per cent over a 15-year period, which would bring the population to 1,632 in the year 2011.[5] A 1995 community profile done by or for the hamlet broke down the population by gender, with 53 per cent male and 47 per cent female. Age distributions were as follows: 0 to 4 were 16 per cent of the population; 5 to 14 were 25 per cent; 15 to 64 made up 57 per cent; and 65 and older were 2 per cent. The community was 93 per cent Inuit, 6 per cent non-Native, and 1 per cent Dene. Languages spoken were primarily Inuktitut followed by English.

Cape Dorset (also known as Kingnait, which means "high mountains" in Inuktitut) can be found on an island nestled off the southwest coast of Baffin Island in Nunavut. It was at this location where remains

of an ancient culture who flourished between 1000 BC and 1100 AD were first found. They were known as the Dorset culture named after Cape Dorset, which in turn was named by Captain Luke Fox. Captain Fox named the place after Edward Sackville, the Earl of Dorset, in 1631 when the Northwest Passage was being sought. The Baffin Inuit of Cape Dorset are descendants of the later Thule culture, known as Tuniit in their legends.

The hamlet operates a wide range of programs and services with a budget of approximately $9.3 million, as reported in the 1999 RT & Associates' *Community Economic Development Plan*. The report also suggested estimated sales from carvings were a few extra million, but this figure was not further defined.

The Hamlet of Cape Dorset is a transferred community, as confirmed in a discussion with the Department of Health and Social Services of the Government of Nunavut. This means that Cape Dorset manages its resources directly, and funds are transferred from the territorial government to Cape Dorset. The following facilities and services in the community include:

- Sam Pudlat School (K–7) and the Peter Pitseolak High School (7–12)
- health centre (with approximately 7 personnel)
- RCMP detachment
- Nunavut Arctic College adult education centre
- Anglican and Pentecostal churches
- visitors' centre
- post office
- Hamlet office, including Social Services, Probation, Public Works, etc.
- arena
- community hall
- local radio station
- airport and daily air service (Hawker Sidley and Beach 99 aircraft)
- two large retail food stores
- three convenience stores
- one coffee shop/bakery
- two hotels each with their own restaurant/coffee shops
- fire department
- water treatment and sanitation services

Community issues are described in the following table.[6]

Table 4) Issues Challenging the Community

Issue	Severe Challenge	Moderate Challenge	Slight Challenge	No Problem
Adult illiteracy			✓	
Lack of acceptance of Aboriginal language and culture by local institutions				✓
Apathy or lack of active Aboriginal community support				✓
Local community opposition		✓		
Poor local economic conditions		✓		
Substance abuse	✓			
Family violence	✓			
Sexual abuse	✓	✓		
Lack of transportation				✓
Lack of community resources, facilities, services, etc.	✓			
Suicide or attempted suicide	✓			
Fetal alcohol syndrome/fetal alcohol effects (FAS/FAE)		✓		

3.4 Prints and Carvings

Cape Dorset is known for both its printmaking and carvings. In fact, studies have been conducted to try and determine why so many people in the community have this artistic ability. A local businessperson, who had previously served on the Hamlet Council, laughingly shrugged it off by saying, "they [researchers] couldn't figure it out," and suggested that over half the community members are either carving or involved in printmaking. This community is home to Kenojuak Ashevak, whose print, *The Enchanted Owl*, has become world renowned. In fact, during the visit for this case study, news reports confirmed that one of her earlier works had sold for approximately $60,000 at a New York art auction and that a carver from the same community sold a piece for about the same price range.

A West Baffin Eskimo Cooperative employee felt that most of the artists were no younger than early 40s and that many of the young people did not seem interested in establishing prestige or a name in the arts. They appeared to be more interested in making immediate money from their carvings or prints.

The *Community Economic Development Plan* by RT & Associates, as stated earlier, gave an estimated income of a few million for the arts sector, including carvings. Still, a 1995 community profile provided by the hamlet cited, "unemployment at 25%, twice the national average and slightly higher than the regional rate of 22%." The 1999 *Nunavut Labour Force Survey* showed several methods for determining the number of people unemployed by using national criteria to identify a 22.8 per cent unemployment rate.[7] Under the survey criteria "Want a Job," it showed that 42.6 per cent were unemployed in 1999,[8] and under "No Jobs Available," the figure was 33.3 per cent[9] for unemployed in the same period. It is clear that whatever method was used, unemployment remains a challenge for the community. Inuit women tended to have

lower unemployment rates in the 15 to 34 age group than their male counterparts. In the age group of 35 to 44, rates tended to be almost equal for both Inuit men and women. Inuit men between 45 and 64 had lower unemployment rates than their female counterparts. Lastly, Inuit males over 65 had higher unemployment than Inuit women in the same age category.[10]

4. Social Indicators

The AHF Board of Directors has identified five specific areas where it hopes to see an impact over the long term: sexual abuse, physical abuse, incarceration, children in care, and suicide. In the case of the evaluation of AHF-funded activities, the five selected indicators are closely associated with the impact of the legacy of physical and sexual abuse in residential schools, including intergenerational impacts. In general, improvement in rates measured by these indicators can be viewed as evidence of sustainable healing that break this cycle of abuse. All the selected indicators are related to the goals of the Cape Dorset Healing Project and are issues the project will ideally play a role in influencing. What follows are data gained through both local and territorial government sources.[11] In essence, the data provide a snapshot in time, and they may be used as a baseline for any future assessments of changing social conditions at the community level.

4.1 Sexual Abuse

Incidents of sexual abuse, one of the key areas the project is concerned with, were reported at six against minors over the 23-month period the RCMP reviewed in their computerized database.[12] Of those six, five were against females and one against a male. To give some indication of what may transpire after an investigation, Probation Services estimated that only one person per year is charged for sexual abuse. It is important to note that many cases are not reported to police, and of those cases that are reported, not all proceed to charges and trials. For example, the child may be deemed unfit or unable to withstand a court case, they may recant their disclosure, or there may not be enough evidence to proceed with a charge. Also important to note is that police data represent *reported* rates, which can be influenced by a number of factors including a victim's willingness to report; therefore, reported rates can differ substantially from actual rates of abuse. Some informants indicated that, initially, many of the healing circles were meant to deal with sexual abuse.

Twelve incidents of sexual assault against an adult were reported by the RCMP. Probation Services estimated sexual assault at two or three incidences per year. Again, some discrepancy exists between these two figures and with the probation figures being much lower.

4.2 Physical Abuse

Figures were secured on level one assaults (common assault) and level two assaults (indictable offences that usually cause physical harm). According to the RCMP, over a 23-month period there were 195 incidents of level one assaults and 24 level two incidents. A RCMP officer at the Cape Dorset detachment felt that these figures have remained steady over the past few years. A follow-up telephone call to another officer who elaborated that of the 195 common assaults, at least half were felt to be domestic disputes, although no hard data were provided. Further, it was estimated that in cases of domestic violence, two-thirds of

the offenders were male and one-third female. Information was not provided on the number of incidents involving child victims.

As with sexual abuse, reported rates of physical abuse are understood to represent only a portion of actual cases. Social Services stated that between 1999 and 2001, the average number of assaults against women each month ranged from five to eight (includes both reported and unreported cases). This would mean that assaults against women would be between 60 and 96 over the course of a year.

The data, along with the issues identified in the project proposal, indicate that both physical and sexual abuse are problems in the community. With respect to sexual abuse, the project has identified the need to address the needs of both male and female victims. Physical abuse, however, has been discussed primarily in terms of male violence against women. RCMP estimates that one-third of domestic disputes involve female offenders, suggesting further work is required to determine the extent to which men are victims of domestic violence and what their needs are in this area.

4.3 Suicide

Another key issue raised by the project in their application for funding was that of suicide. Both Justice and the RCMP noted that there were two completed suicides for year 2000. Social Services agreed by saying there were one or two per year. Some key informant responses also supported this by saying these figures have been fairly steady over the last several years. Completed suicides, however, are just the tip of the iceberg. The RCMP also stated there were 20 actual attempted suicides reported but receive many more threats of suicide. This was echoed by Social Services in which they state that for each week there are two to three attempts, averaging 10 per month, which translates into 120 attempts per year if the average holds steady.

The project's fourth quarter report made reference to having the "highest rate of suicide in the eastern Arctic."[13] This statement is supported by figures released in a document reporting statistics up to 1996. It states that in Canada, the annual suicide rate was 13 per 100,000 people in 1992. Nunavut has an alarming rate of 77.4 per 100,000 from an analysis of data from 1985 to 1996. The Baffin region, where Cape Dorset is situated, shows the highest male suicide rate in Nunavut at 133.9 per 100,000, close to three times the female suicide rate of 47.1 per 100,000. The suicide rate for females in Baffin is also the highest compared to other regions. For all of Nunavut, the male suicide rate (118.6/100,000) is 3.5 times the female rate (33.8/100,000).[14]

4.4 Incarceration

The funding application included a letter of support from the RCMP detachment that states, "The community of Cape Dorset in the past has been well known for its reputation as having one of the highest per capita criminal statistics in the Northwest Territories." While no data were gathered on the community's incarceration rate, the crime rate in Nunavut is three times the national average, and the violent crime rate is seven times higher than the rest of Canada.[15] There was a minor discrepancy between what was viewed as the number one crime in the community; for example, Justice felt it was vandalism while Probation said it was spousal assaults. Justice also echoed spousal assaults were "really high." Figures provided by the RCMP show that there were five cases of vandalism with damages over $5,000 and 111 with damages under $5,000.

4.5 Children in Care

The Government of Nunavut Department of Health and Social Services provided figures for all of Nunavut, but do not necessarily include transferred communities.[16] For year 2000, there were 62 permanent wards and 138 temporary wards. It also stated adoptions were at five per year for departmental adoptions, 20 per year for private adoptions, and 250 per year for custom adoptions. Health and Social Services also described a new category called "medically fragile," where the department becomes involved when a child requires significant medical care, usually in the south, and is not in need of a social worker. The medically fragile designation is separate from temporary or permanent wards. The role of the department then becomes the timely exchange of information and decision-making ability until the need becomes no longer necessary.

Social Services indicated that there was one child in permanent care and eight to 10 children in temporary care, with one child in disability care. Providing figures over a four-month period between March and June 2001, numbers varied between four to 10 children each month in care. On average, they held three to four investigations per month. Figures provided from Social Services were confirmed in a follow-up conversation and from various sources, including client files, client visits, and referrals from RCMP and the nursing station. Table 5 compares children in care for Cape Dorset and Nunavut. It appears that these figures for Cape Dorset are half of Nunavut's estimates.[17]

Table 5) Comparison of Children in Care

	Nunavut	%	Cape Dorset	%
Children in care, 2000–2001	200/month	100	10–12/month	2.0
Population (projected to October 2001)	28,554	100	1,270	4.4

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, although below the territorial average, is still noteworthy. However, the community has many strengths, including a world-class carving and printmaking economy, a vibrant culture and language, a municipal office, a hamlet council capable of administering a range of territorial programs and services, and an active commitment to addressing social problems through such groups as the CHT and the Community Justice Committee.

5. Reporting Results

The project offered a vision by identifying activities that would serve various groups and by recognizing that at least one group with significant needs—men—was not being reached. A logical place to start was to heal and train a core group of people. The project also took this a step further by wanting a healing strategy that would look at meeting the special needs of the target groups it identified.

Sexual and physical abuse were key issues raised in the application for funding. It also asserted that suicide and incarceration were by-products from unhealed trauma for some victims and described the impact on Inuit spirituality when several losses were felt over time. One of these losses was the cultural autonomy

the Inuit had prior to contact. Forced relocation and the killing of entire dog teams were some of the other devastating losses experienced and described.

CHT members were asked about the needs the project was intending to address. Responses included phrases such as "healthier families," "healthier lifestyles," "helping the community," "supporting victims of sexual abuse," "help lessen crime in the community," and "heal the healers first." Taken together, the impression given is a project that would support the healing of individuals and families and improve the community. When next asked how they would rate the project's ability to meet those needs, the average score was 4.75 on a scale of 1 to 5 (1 low, 5 high).

Before more findings are presented, the reader is reminded that the CHT members played a dual role. First, they used the approach of "heal the healers first." They further stated: "We have supported and sustained our ability to help others heal by first starting to deal with our own issues with the help of resource facilitators whom we have hired to deliver weekly healing and training workshops in our community and to provide individual counselling."[18] Not only did CHT members participate in planning and healing activities, but they also considered much of these activities as training to build their capacity to support others.

Thus, there is a link between efforts to heal individuals and the healing of families and communities. For example, one informant noted that in the process of working on her own healing, her husband changed (i.e., emotionally and in how he responded to her). Likewise, as several Court Elders were actively involved in the project's healing activities, the growth they experienced may have an impact on decisions they were making on behalf of individuals involved in the court process. One elder mentioned being "scared to do these jobs until I took healing." Other responses focused on the home and family:

- "I really liked healing, many times I realized I'm at peace at home, towards my family."
- "Being more open as a parent, trusting yourself more—like who is safe and who is not. You learn these things through healing ... people talk now, as I've learned to talk to my kids."
- "We learned to not only deal with our own depression, once there we learned to cope ... we learn to recognize it instead of saying 'you stupid kids.'"

The project consistently links the healing and training activities and offers no clear distinction of purpose between these two activities. A third level of integration involves the project's use of the word "caregivers," which appears inclusive of both paid and volunteer counsellors. In a booklet on counselling skills, Pauktuutit Inuit Women's Association defines the term as follows:

> We use the terms "caregiver" and "counsellor" throughout this handbook to refer to people who counsel. A caregiver can be anyone – a friend, family member, neighbour, teacher, elder – anyone who cares enough to listen and offer support. Also, anyone can be a counsellor, although some are paid counsellors while others are volunteers.[19]

It is important to note that some of the CHT members also have professional roles within the community, such as working at a women's shelter or being Court Elders, and many spoke of very personal first-hand experiences. In several areas, informants indicated that people approach them on their own time, like on the streets, to ask for help.

5.1 Impact on the Individual

The interviews began by asking people to describe their role in or relationship to the project. This question was asked for two key reasons. First, the process was not aimed at interviewing "clients" or participants directly, and this was mainly for safety reasons and an inability to offer counselling if issues triggered participants negatively. Second, the interview process wanted to identify the professional roles individuals held. Given that CHT members also viewed themselves as participants, there was a need to identify some distinction between personal and professional interests. Key informants included Court Elders, facilitators, standby facilitators, members of the CHT and planning team, and two people who had acted as the project coordinator. One person mentioned he/she began as a participant and then moved on to become a CHT member involved in planning and standby facilitation.

Nine of 10 respondents reported seeing changes in project participants. They provided examples of changes in attitude, such as "growing up emotionally," "people are happier," "healthier," and more positive in their attitude. As well, changes in behaviour were observed, such as more teens participating in groups and talking openly; people being more stable and fun to be with; and the CHT working together and supporting each other during crises. During the interviews, it was noted on at least two occasions that an informant hesitated in responding, seemingly to protect individual confidentiality. Observed changes included the following:

- "I can tell people are able to deal with issues in a way they didn't know before. Very obvious, not just crying and crying anymore."
- "A lot of health, people are happier, more able to cope with own personal lives. Brought more light into our community, more hope."
- "People grew up not in terms of age, but emotionally. They became stable and fun people to be with."
- "I have seen big changes, for example, in a crisis we can work as a team and support each other."
- "This year there were more teens participating, quite determined to take healing circles, start off with crafts, they talk while making them. When it comes time to go, they hate to leave. On average, ten girls attend."

From these examples, it is clear that key informants saw attitudes and behaviours changing as the project progressed. Table 6 shows responses to a list of specific changes sought by the project. All respondents felt that there were improvements in areas of self-esteem, understanding sexual abuse, healthier coping patterns, and dealing with depression. A near consensus (9) also felt improved self-esteem for youth and that both talking about and not attempting suicide were areas offering notable changes for participants. The areas where less change was noted related to abusers/men getting help to stop violence and men and women getting treatment. Questions were asked specifically for each group: abusers, men, and women. Some informants were not sure because they were only involved with one particular group (e.g., teens, women). Of note is the closure of the alcohol and drug abuse treatment centre in Iqaluit that may have affected these response areas.

Overall, it appears that key informants believe the project is leading to improvements in key areas of participants' lives. Issues that can be dealt with through positive, supportive measures and provision of information (education and training) show the highest level of observed changes in individuals: healthier coping patterns, improved self-esteem, understanding the effects of sexual abuse, dealing with depression

and thoughts of suicide, community support for Elders, and a stronger CHT. In each case, either nine or all 10 respondents noted positive changes. The lowest area of observed improvement is men receiving treatment, not surprising since the alcohol and drug treatment centre in Iqaluit had closed. The fact that more people observed changes in women receiving treatment may be due to more women being involved in the healing project and dealing with these issues. Only four of 10 respondents saw improvements in abusers getting help to stop physical abuse and violence. Five saw improvements in men dealing with violent behaviour. This observation may be related to the low levels of male involvement in the project either because men are not addressing these issues or because key informants are *unaware* that men are seeking and getting help elsewhere.

Table 6) Observed Changes in Participants Involved in Healing Activities

Healing Activity	Number of Responses			
	Yes	No	Not sure	No response
Healthier coping patterns	10			
Better self-esteem	10			
Better self-esteem (youth)	9		1	
Understanding sexual abuse	10			
Dealing better with depression	10			
Talking about suicidal thoughts	9		1	
Not attempting suicide	8		1	1
Victims getting help for violence/abuse	8	1	1	
Abusers getting help to stop violence	4	2	4	
Men getting treatment*	3	2	5	
Men dealing with violent behaviour		3	2	
Support from Elders			2	
Community supporting Elders			1	
Women getting treatment		2	2	
Stronger community healing team				1

* The term "treatment" was understood by most interviewees to mean alcohol/drug treatment.

In addition to the changes noted in Table 6, six respondents mentioned other changes they observed, including improvements in how the CHT is working together and in how participants see their worthiness and employment opportunities in the community:

> People are becoming employed who usually were unemployed. Opened up areas to be employed in. For example, "I only speak Inuktitut therefore can only clean or cook" mentality. Now people are going after their dreams. Two Elders/land guides are writing a proposal for "On the Land" project. Women are looking for jobs and believing they can do it.

Respondents were asked how the training workshops helped and to give an example of a skill they learned that could help them support others. Responses show that a variety of changes occurred in participants' attitudes and behaviour:

> Helped me to deal with personal problems, recognize which ones I had. Helped me to make healthier choices, to not commit suicide. I'm worth something. I'm a better parent. More outgoing. I don't know if I'd be alive today to be exact, if I didn't look in that area ... If I didn't have friends in the group, I don't know where I'd be. I have healthy self-esteem, it made me grow. When you are a sexual abuse victim, it can be for years. Call yourself a survivor when you get help, I am one.

A couple of respondents mentioned that other people have seen changes in their lives and now approach them for counselling. This is the essence of the Cape Dorset approach: begin by healing the healers and then the ripple effects will reach out into families and communities.

> I have benefited a lot because I am able to help. I don't advertise it, people see changes I've made in my life and people come to me based on that.
>
> I can listen to people when they talk about abuse/victimization. I'm able to support them through stages so they can better cope. I'm also aware of not feeling responsible or to be a fixer.
>
> Before healing, people didn't approach me. Now, out on the streets, people come up and ask for help. Big difference in my life. We also hear about men's healing sessions on radio. In court, I advise them to attend.

Others spoke about being more confident because of the training, becoming more aware of being a role model for younger people, having increased self-awareness to make better life choices, and being able to share what they learned with others. In terms of concrete skills, listening was most often mentioned, followed by being able to recognize when another is in pain: "Recognizing what the other person's needs are. Very hard time listening, but it's a skill I learned. Haven't learned to do the dishes yet." Others mentioned learning breathing exercises and massage.

Summaries of participant evaluations were provided for four of the training workshops. All four evaluation forms used a scale of 1 to 7 (low to high). The four workshops were: Team Building, 27 September –1 October 1999 (12 completed evaluations); Healing for Men and Families, 15–19 November 1999 (12 completed evaluations); Teen Healing, 6–10 December 1999 (five of nine completed evaluations); and Group Process and Sexual Abuse, 7–11 February 2000 (14 completed evaluations). For each workshop, participants were asked to rate content, delivery, and participation. Average scores ranged from 4.2 to 6.5, with the content and delivery of three of four workshops averaging six or higher. It is clear that since the score was out of seven, most were very satisfied. The evaluation form did not address issues of participant needs and expectations, and summarized responses to questions about participant learning would have benefited from more detail.

5.2 Impact on the Community

While it may be too soon for the project to truly have an impact, there is evidence that some impact is being felt. This observation is supported by two reasons: 1) although the project has only received funding from AHF for the last two years, there were prior efforts on a smaller scale since 1995, allowing greater time for impact on individuals; and 2) many individuals in key roles within the community (i.e., Court

Elders, probation officer, school counsellor) have been involved in healing activities, allowing personal growth to perhaps also influence their professional roles.

Respondents were specifically asked to give an example of how the community has benefited from the project. Several describe an increased skill level or an increased capacity to deal with crises: "Caregivers have a big job, they are available at deaths, crisis. They now have the tools to deal effectively in these situations"; and "I can only use myself as an example. Before, I had a lot of pain but didn't know that. Now I can identify when people are in pain, in need of help. People come to me and I can say I've been there." The collective impact of having a number of individuals involved in healing who live and work in the community and are *walking the walk and talking the talk* is evident in the following response:

> [There is] 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 effect. 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.

At a practical level, the project increased the number of traditional activities available in the community while providing opportunities for community members to be involved in concrete supporting roles, such as transporting people and supplies to camps. In the process, understanding and support for the project may have increased:

> Youth have been able to go on the land. Women's Planning Team group have been able to go on the land too. On both these occasions, community members were offered a chance to participate directly or indirectly [e.g., transporting people/supplies using own gear, hunting for animals, etc.]. Men's group has been started, with struggle. People in the community are leaning towards believing that workshops and gatherings are beneficial to the community as a whole, having seen and heard from those who have taken workshops. More people are beginning to open up and stating that healing needs to be done, by people who have not taken the workshops or those who have participated fully or partially.

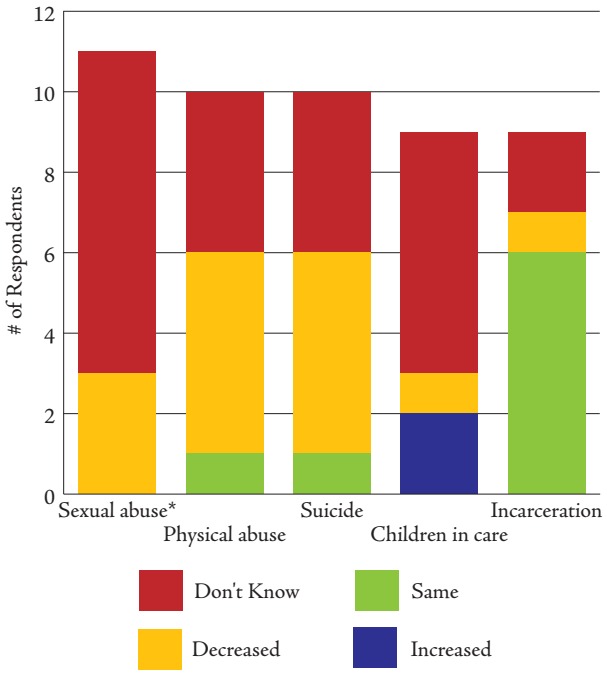
In terms of how AHF funding has supported opportunities to create a positive and meaningful impact, this quote offers some insight:

> Funding for healing has had a big positive impact on community. We gain information we otherwise wouldn't have access to. We come to understand different types of pain. In that way, we can offer support to those in need. I'd like to see dollars come forward, only way to hold our heads up. One goal is to have all community organizations and agencies come together as one, with no barriers.

In addition to asking respondents for an example of how the community has benefited, they were asked to describe any changes they saw in rates of physical and sexual abuse, suicide, incarceration, and children in care since the project began. Based on the program logic (Appendix 1), decreases in rates over time can be viewed as indicators of the project's success. However, Figure 2 shows that there is no clear pattern to the responses, as most did not know whether rates of sexual abuse and children in care had changed, and half the respondents felt that rates of physical abuse and suicide had decreased. Over half felt that incarceration rates (a community problem identified in the funding application) had stayed the same.

While individual perceptions of change can differ from the reported and actual rates of abuse and suicide, they can be important indicators of how safe a community feels of its inhabitants and how key informants feel about the project's impact over the long term.

Figure 2) Perceptions of Changes in Rates Since the Project Began



* One person selected both "gone down" (or decreased) and "don't know."

The majority (8) were uncertain about how rates for sexual abuse had changed, but three people did suggest rates had gone down. When asked to further explain their reasoning, similar responses were provided, such as: "out in the open and talked about more." The following quote from a person who felt rates had gone down further exemplifies this reasoning:

> Being more open as a parent, trusting yourself more, like who is safe and who is not. You learn these things through healing. I think it's lower. If people [abusers] hear they'd have a harder time continuing with that behaviour. More chances of getting caught. People talk now, as I've learned to talk to my kids.

While this quote and others suggest, openness and breaking the silence around sexual abuse leads to lower rates, which may or may not be what actually happens in the short term. For example, it may initially lead to an increase in reported rates, but over the long-term healing process along with talking about the issue more openly, this may eventually prevent actual abuses. For those who did not know, two felt that "it [sexual abuse] wasn't talked about enough," and one person said they were not directly involved in this area. Two respondents gave no explanations, while one said his/her reasoning was because "nobody had disclosed."

On the issue of physical abuse, half the respondents felt rates had gone down. Of those who offered explanations, most responded similarly with, "don't see as many women and kids with visible injuries" or "don't see people with dark glasses and black eyes." Three people did not offer explanations, and one person

who worked at the women's shelter stated, "a lot of women come to the shelter." This person felt that rates were the same. Four respondents said they did not know whether rates had changed. One person who did not know how rates had changed stated that "few people report to the RCMP."

As with physical abuse, half the respondents felt that suicide rates had gone down and several felt that "survivors talk more openly now over the loss of a loved one" or "attempted [suicide] people share their stories." (The term "survivor" in this quote is felt to reflect a survivor of suicide and not a residential school Survivor.) One person responded by saying, "it won't change overnight, we won't fix all that." Again, three people did not offer an explanation and one person chose not to say. One person stated that "one member of the CHT had a child commit suicide," yet felt that rates had gone down.

For children in care rates, more than half (6) said they did not know if rates had changed. However, two people spoke to reasons why children may be placed in care, such as, "I've seen two women who fled abusive situations" or "there's a good and bad side to this. Good when people put their kids in care to protect them, but more kids [in care] means something is wrong." Several respondents who were former foster care parents or grandparents who had taken in grandchildren felt that they did not know if rates had changed.

Slightly more than half (6) of the respondents felt that incarceration rates stayed the same. One person said, "people go out, others come back, just trading places," while another said, "always the same ones in and out." One respondent felt, "men aren't really involved, it [rates] would go down if involved." (Although not directly stated, based on this person's previous responses to questions on the other indicator data, being involved appears to be in reference to being involved in healing.) Another respondent cited an observation by a MLA (member of the legislative government) who thought there were less people from Cape Dorset at the Baffin Correctional Centre. Two people gave no explanations while another stated, "one thing that contributes are court date delays. People are under stress and end up doing things that lead to incarceration. They have court hanging over their head."

Two of several Elders on the CHT offered the following insights: one said, "I can say healing is a major thing, don't joke about it, it's a process, difficult thing to do, especially for new participants." This reflects a sound understanding that shows this project was meant to address serious and difficult issues. The second Elder described behavioural changes in this way: "[the] community has benefited greatly, I see more involved, especially young people. I see them enter healing earlier. The population is growing, and would like to see the healing project carry on. I'm one of the Court Elders, [and it's] not hard to see who needs healing." Again, it speaks to how the needs addressed by the project are being felt and observed.

Without knowing what rates were in previous years leading up to this project, it is difficult to determine why some issues seem to bring a discrepancy between informant observations and figures provided by various other community sources. For example, with physical abuse, half the respondents felt that rates had gone down, yet the RCMP reported 195 common assault incidents over a 23-month period. Likewise, sexual assault figures from the RCMP were at 12 over the same period. Probation Services stated that there were two or three assaults against women each month and that these figures have remained steady. In this case, we are unsure whether the 12 cases cited by the RCMP involve only women or males as well. Therefore, it is difficult to say whether these two figures or if a wider variance is occurring. For suicide, half the respondents also said rates had gone down; yet again, both RCMP and Social Services report high figures, such as one to two completed suicides each year and up to 10 attempts each month.

Although half the respondents did not know if children in care rates had changed, several gave examples such as, "used to take care of them, haven't got any lately so I don't know" and "I've seen two women who fled abusive spouses, never saw them with their kids before until recently. This won't leave here." Two respondents actually felt that rates had gone up by stating that it was, "not the ones [children] of the participants, but it has gone up in the community" and "see a lot of foster parents, don't have too much information." As noted earlier, Cape Dorset rates are lower than the Nunavut average, but the data do not show how rates may have changed over the past few years. Also, without further research, it is impossible to determine the reasons for the lower rates in Cape Dorset compared to Nunavut as a whole.

5.3 Partnerships and Sustainability

The AHF national survey listed several key community agencies as being linked with the project: Social Services, Tukkuvik Women's Shelter, and the Justice Committee. A majority of project activities occurred at the Justice Building, except for on-the-land camps and perhaps community awareness sessions. The funding application itself listed a school community counsellor, lay caregivers from Anglican and Full-Gospel churches, a community health representative, and a health centre as additional supports, partnerships, and linkages.

The application further listed the RCMP and the hamlet under linkages and partnerships. Letters of support were submitted from the RCMP, municipality of Cape Dorset Department of Social Services,[20] the hamlet (municipality), Uqaujjigiaqtiit Justice Committee, and the health centre. Both the hamlet and the Justice Committee were the largest donators of goods and services, with community members being first.

For the year under review, the project's final quarterly report for the year cited that 17 community caregivers had received training while listing 19 front-line workers.[21] There is no explanation as to why there are two different figures here. In keeping with the CHT being largely the project team, this would suggest a total of 17 or 19 members. Several were affiliated with the agencies listed above along with several who had no designated affiliation. A subsequent list from the project's second year of operations provided a list with 12 additional CHT members, which suggests a broadening of the base was occurring. Also, it was stated during informant interviews that an average of eight to 12 people participate in planning on a regular basis. One person mentioned that they liked the fact that many Justice Committee members participated in the project, thereby developing their capacity to deal with offenders.

An interesting observation of a strained relationship was noted between the Justice Committee and Probation Services. One person felt that "a lot of gossip" was coming out of the other office, while another said the relationship was "at a dead end" and that the RCMP would act as a go-between when referrals were necessary.

Another discrepancy is that both churches were listed as being a support, linkage, or partner; yet it was evident through the informant responses that one of these churches was more opposed to or divided on "healing." A colleague, fluent in Inuktitut, suggests that perhaps the discrepancy could be caused by the interpretation of the Inuit word for healing. *Mamisaq* is usually meant as *physical* healing and, thus, some people do not apply it to mean healing from sexual abuse or other trauma. The issue of the usage of the word "healing" was echoed by a couple of informants, as one said, "if it could be changed." Whether or not

this is the case is unclear, as informants gave examples that suggest the church's disagreement on "healing" was based more on seeking repentance for sins committed and less on the need to gather and heal from the traumas experienced. However, there was no opportunity to interview members of this church as they were not members of the CHT. These two discrepancies indicate that some partnerships were not being realized.

From the information gathered, it is unclear whether strong partnerships were developed. If the CHT is examined strictly from a multi-agency perspective (i.e., school, church members, probation, and women's treatment centre), then certainly the Justice Committee with several members on the CHT were strengthening ties within the community. Most of the examples provided during informant interviews seemed to depict a sense of personal growth that could assist individuals in their professional roles. It is also difficult to assess how well ties to other agencies were creating adequate partnerships. For example, no evidence was provided to identify whether referrals were being handled differently. There is, however, the aspect that the CHT seemed "stronger," with responses like, "I've seen the team, they are able to work together," reflecting a cohesiveness. Further, the core group has remained steadily involved. Those involved on the CHT through the healing and training as well as planning have developed a core group who are comfortable enough with each other that partnerships in their professional capacities can be realized. There seems to be a need to increase efforts to bring understanding and, perhaps, to increase cooperation with the opposing church and Probation Services. Without interviewing a broader sampling of community agencies, it is difficult to provide a more accurate assessment of these ties.

In terms of sustainability, there is strong evidence from informant responses that suggest the efforts behind the project could continue, with or without AHF funding. Five of eight respondents either agreed or said something like, "if there is a strong desire to continue with it on a voluntary basis and/or to seek funding elsewhere." Of the remaining responses, most did not state outright that they would close down. 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 level if funding ceased or with volunteers.

5.4 Addressing the Needs

Eight people answered questions about the needs the project intended to address and its ability to meet those needs. While responses varied considerably (and some of the answers did not directly address the question of need), there were two references to improving the community and three to healthier lifestyles or families. Two people spoke about working with or supporting sexual abuse victims; one of them also mentioned the need to "heal the healers first." In addition, one person mentioned training. In rating the project's ability to meet these needs, the average score was 4.75 out of 6, which ranks just below category 5 defined as "very well, but needs minor improvements." In contrast, the project received an average score of only 2.8 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.

While most respondents felt that the project's methods, activities, and processes worked reasonably well, there was a recognizable 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." However, project files and interviews confirm that women's and teen girls' groups are well-established and that Elders are represented on the CHT and have participated in healing and training activities.

5.5 Successes and Best Practices

As noted throughout this study, 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. In the latter case, there was some evidence that participants' families and the community at large benefited. One success noted in the second quarterly report was that the CHT had established a mission statement, goals, objectives, a code of ethics, guiding principles, and CHT rules. All of these show proper planning and orientation for the CHT on how they will operate. It puts into place a safety system to ensure clients and participants will have a greater chance to deal with their issues in a safe environment where everyone knows their role.

Another good practice is the training to identify unique needs for certain groups (teens and men), which demonstrates adequate planning instead of just assuming the group knows what teens or men need or want. The main difference between a good and best practice can be that best practices have approaches with proven track records as their strength. Several other successes were also noted, mostly from quarterly reports. The on-the-land camps were described as "one big family," and an earlier reference was made as to how people and groups helped, such as with transportation. This simple activity obviously succeeded in bringing people together in the community to offer support in tangible ways. Two other successes mentioned were child care for women so they can attend healing activities and the use of local facilitators. In addition, quarterly reports mention special circles to close different components or periods, such as before Christmas. In this way, participants were offered opportunities to mark progress and not be left alone without the group acknowledging the potential stressors that could come during the Christmas holidays; for example, when offices may be closed. In general, it appears that the project carried out its programs in a well-planned and responsible manner.

The national survey responses stated the best practices were: 1) healing and training are well-attended by caregivers and team members; 2) facilitators receive training; and 3) teen group is activity-based fun (i.e., crafts). Although attendance itself is not a best practice, this may allude to the fact that *steady* attendance is a key element to the healing and training for this core group as opposed to an individual attending just once in awhile. This is also true of facilitators who receive training: it would not be a best practice in itself, but may demonstrate that the facilitators who are local people are being adequately prepared before delivering or facilitating circles. Having a teen group that consists of activity-based fun may in fact be a best practice, as it speaks to the need to utilize an appropriate approach that fits the target group. In this case, teens would likely require activity-based efforts as opposed to only counselling or group discussions on heavy and emotional topics. More than one informant described how teens interacted and spoke while making crafts, and their self-esteem grew when they made something.

There may be some slight variation for what a best practice is and what constitutes a success (or good practice). Best practices can be proven methods or securing ideal circumstances that, when properly done, can have the desired results. This means having adequate knowledge of the issues so that ideal services and people are in place to respond to an issue or situation. An example of a best practice could be hiring people who have stopped using alcohol and drugs and who have completed adequate healing work on themselves to work as alcohol and drug counsellors. It allows the client to know that the counsellor understands what they are going through because the counsellor went through it himself or herself. A success (or good practice), can be steps taken that may eventually lead to a desired goal and could be a by-product of

certain efforts. For example, an awareness session may only reach one or two people and could be seen as a success; however, if there are significant issues in the community, then it would not be enough to just stop there. As one informant put it, "one prevention is better than no prevention at all."

The training workshops were provided by outside facilitators, mostly from southern Canada and one from another Nunavut community. There appeared to be a concerted and well-planned effort to bring in qualified trainers and thereby develop the capacity and skills of local caregivers. In one workshop, an Inuit couple from Pangnirtung provided training on men's healing and healthy relationships. While in the community, the couple worked with the CHT to plan and organize a community healing awareness workshop that drew over 60 people, including 15 men. Another workshop described in the third quarterly report as "experiential training" combined healing and training activities for a core group of caregivers. Without detailed participant evaluations, not enough data exist to call this or any of the training sessions a best practice. However, experiential training as an approach is far more emotionally involved than simply presenting theory or information on a subject. It can allow participants to process their own issues and, in turn, improve their ability to understand and support others who may be experiencing similar challenges. This appears to be the thrust behind this project and, based on key informant interviews, is working well.

The most clear example of a best practice was mentioned in the fourth quarterly report. It spoke about how "modern techniques/approaches are chosen based on how they fit within Inuit culture (values, approaches and philosophy of life)." Also, Inuktitut is used as well as simultaneous translation, and many Elders are part of the team. Best practices take into consideration the environment where the work is being done. If only English was used, no Elders were present to speak about Inuit cultural and traditional ways, or approaches were being forced on participants that were not culturally inappropriate then it would be highly unlikely the project would reach anyone. The fact that the CHT includes Elders, the Inuktitut language, and Inuit culture as integral parts of the process and that "modern" techniques and approaches are incorporated to fit within the culture are all felt to be a best practice. For example, when male victims returned home from a trial in Iqaluit of a male teacher charged with sexual abuse, several key groups, including the CHT, "welcomed [them] back with a special community gathering." This shows not only community spirit but also cultural ways of showing support. The following quote further supports this best practice:

> 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.

5.6 Challenges

The national survey listed a challenge of "getting men involved because of their need to appear strong." Involving men still remains a challenge, but having said this, there are several examples that may be deemed progress because they may eventually lead to more men getting involved in healing. One example found in quarterly reports was that men attended the community sessions. If these sessions had not taken

place, then there would have been one less avenue for men to hear about the project. Support was also requested by the male sexual abuse victims of the teacher on trial mentioned earlier. Obviously, there was enough knowledge of the project to recognize that support could be found there. This was taken a bit further with the special gathering that was held upon their return. Also, an experienced male facilitator held two men's groups that were well-attended. All of these can be seen as progress because there were opportunities to offer support.

This project may not be all that unique in their difficulties to recruit men. Reaching men was consistently raised in the documentation as an objective or target group the project wanted to address. Some responses suggest that the men's group did start but not without a struggle. Quarterly reports outline that men have begun attending, although figures were very low.

This study cannot provide an accurate assessment of why men have only become involved under certain instances or circumstances (i.e., community workshops or request for support at Iqaluit trial). Two quotes found in quarterly reports may provide part of the answer. For example, one report stated, "men in the workshop expressed a desire to start up a men's group, but wanted someone experienced leading them." In another report, "more men in our community need to be involved in the healing training workshops over a period of time to gain the knowledge and skills to help counsel other men and lead a men's group." From these two statements it may seem like men were left unfulfilled, first by expressing their need and desire for an experienced facilitator and then to have this need denied because no qualified men were available. A downside to this may be undue pressure on a participant to eventually become qualified enough to lead a group when all he may have wanted is to heal his own personal traumas. This, however, is speculation as informant interviews and other data do not offer any more insight into this matter.

Whether male involvement in healing activities was impeded by group sessions, male/female groups, or other barriers such as fear and denial are a matter for more research. The project's statistics show that 15 men were involved in individual counselling, but there is no explanation into how these men became involved or if it was on a one-time or ongoing basis. With respect to groups, one key requirement when dealing with sexual abuse is the need to keep perpetrators and victims separate. This may also be true for physical abuse to avoid blame, anger, and manipulation until a person is able to safely examine one's own behaviours.

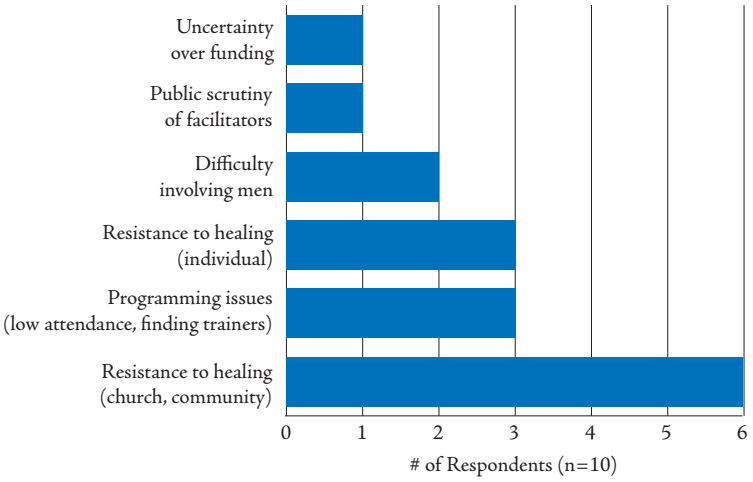
One resource developed to deal with Aboriginal men who abuse their spouses outlined several underlying philosophical perspectives, one of which was, "group work with abusive Native men is the most powerful forum for the confrontation and ultimate healing of men who have been violent. Individual counseling continues the isolation and secrecy around the issue and couples/family work is potentially dangerous prior to substantial work with the abusive male."[22] However, it is unclear whether this barrier was more centred in programming or recruitment approaches or whether emotional barriers were the main factor. One informant reflected, "the time will come for men to move forward, we're just not there yet." Several individuals continued to state the need to target men, and the general feeling was that until they get healing, the community would not be balanced. One person offered this solution: "[we] mostly use radio announcements, maybe personal invites might work to male sexual abuse victims."

The project's difficulty in involving men may be something other healing and training projects also experience, and an opportunity exists to explore the issue in greater detail. For example, it would be helpful

to know whether it is a recruiting problem: *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?* The CHT may wish to pursue these questions with men in the community, perhaps through a survey, needs assessment, or just speaking with a wide variety of men.

When key informants were asked in an open-ended question to identify challenges or obstacles faced by the project, a variety of responses ensued. Figure 3 summarizes these challenges.

Figure 3) Summary of Identified Challenges



Finally, the national survey response to what will improve the project was: family counselling sessions and family retreats out on the land; local healers to provide more healing activities in the community or out on the land; more activities for pre-teens and more recreation and land programs; and to find the approach to get more men in the community to start healing and have more balanced healing for families.

5.7 Lessons Learned

Whether it was a lesson learned before this project began or after, the fact that the CHT wanted to "remain focused on building community capacity," as stated in quarterly reports, is a sound approach. It is unclear if this was prudence or lessons learned from previous attempts that prompted this measure. Several examples of lessons learned were found in quarterly reports, such as: bring in more male/female trainer teams; heal the healers first, recognizing they had to deal with personal issues first (personal growth); and hesitant to start a men's group unless men can get healing and training to support the group.

The NPES stated that "one person cannot heal the community, [it] takes a team approach [and]... [t]eam effort is productive" is a lesson learned. Quarterly reports state that "the men wanted experienced group facilitators." There were two male Elders on the CHT, and quarterly reports indicated that one or two male members attended the circles included at the planning sessions. Given the hesitancy stated earlier to start a men's group unless more men received healing and training could be deemed as a cautious approach or lesson learned derived from program experience. Yet, it is unclear whether this lesson was learned through this project or from other efforts. In one response, an informant noted that teen girls and older women

were being reached, but there was a gap for ages 19 to 30. An attempt was made to seek more funding to cover this age gap in order to reach all women. "[W]e 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."[23]

6. Conclusion

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 crisis;
- strong, effective CHT;
- overcoming powerlessness and hopelessness; and
- increased sense of pride in culture and spirituality as it relates to healing.

Evidence of this progress is found in key informant responses to questions about observed changes in participants, benefits to the community, and skills learned in training sessions. It is corroborated by information submitted by the project in quarterly reports and the national survey. Although progress likely started with those first steps taken prior to AHF funding, what became obvious was that this funding afforded the project adequate resources to firmly establish healing and training to a core group of people. Several informant responses refer to the impact of this, such as: "people grew up, not in terms of age, but emotionally" and "very obvious, not just crying and crying anymore."

Attitudes among participants have changed, which is an important aspect when you consider this description by a Court Elder: "I used to be scared to do these jobs until I took healing ... I used to dislike criminals before I started my healing. I thought they did everything by choice. Apparently it was me who had the pain." Also, behaviours have been affected as other informants indicated through these examples: "I must be a good role model, I shouldn't do things that would turn people away"; "it helped me to make healthier choices, to not commit suicide"; and "I'm worth something. I'm a better parent."

Skills and knowledge have also increased as indicated by the following response during an interview: "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." This respondent gained skills in listening and providing knowledge and skills that could lead toward helping someone who is suicidal. Several others offered learning about what their children may be going through as sexual abuse victims.

The project was designed to "heal the healers first," an approach that can only benefit those the core group comes into contact with: family members, community members, and clients in professional roles. Having a number of Elders on the CHT who also play active roles in planning is another example of designing and implementing both healing and training that invest in its own people. This fact is especially true for remote northern communities that do not always have the resources to fly in outside facilitators. One caution is in regards to men; although there is a need to take a closer look at why male involvement was low, there needs to be continuous well-planned efforts that do not place expectations on an individual to become a group facilitator or role model. In all cases, a person must choose and be supported to enter

healing for personal reasons. Spinoffs such as whether some men eventually assume roles that can lead to supporting others must be a secondary wish.

It is also clear that, for whatever reason, the word "healing" creates some division. Whether the term is misunderstood may be partly at issue, as three informants offered similar observations such as: "When radio announcements about healing happened, there was public resistance. Some didn't like the word 'healing.' I haven't heard that in awhile. Some entered healing when they didn't like that [healing] in the first place." The announcements were amended and it now appears that as the project continues less people seem to be resisting the concept. This shift in the way some community members viewed healing may be found in examples such as community members helping transport people to on-the-land camps. One informant said:

> People in the community are leaning towards believing that workshops/gatherings are beneficial to the community as a whole, having seen and heard from those who have taken workshops. More people are beginning to open up and stating that healing needs to be done by people who have not taken workshops or those who participated fully or partially.

The matter of a "healing strategy" is one that did not become obvious through the case study process. No document was made available and it appears that the healing strategy was more a work in progress that centred around healing and training, community awareness/gatherings, on-the-land camps, and planning and evaluation to discuss how better to reach men particularly. Perhaps a needs assessment, especially dealing with men's issues (as with other target groups), would better define a healing strategy. The CHT did, however, produce a mission statement, goals, objectives, and a statement of values and principles to guide its work.

A number of challenges still remain for this community and project. Evidence suggests that less progress was achieved with respect to increased capacity and effectiveness in serving hard-to-reach people, especially men; and community healing in areas of lateral abuse, violence, sexual abuse, and suicide. Indicator data show that suicide, physical abuse, sexual abuse, and incarceration rates remain high, and there is no consensus among key informants that these problems are decreasing. But a ripple effect is being witnessed as many informants spoke to how their families and partners have benefited.

The healing has begun for many in this small community. The spirit behind this project is strong and was often reflected through the very personal testimony that came through 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 gaining new jobs that they directly attributed to their healing journey. The Elder who inspired the title of this study is, again, quoted here:

> 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.

7. Recommendations

This section will present recommendations in two key areas: 1) programming issues; and 2) evaluation issues.

Programming Recommendations:

- The issue of male involvement was by far the most frequently mentioned area of concern. From a programming perspective, some pieces are falling into place, such as the community awareness sessions and the request for support during the trial mentioned earlier. Ripple effects are being felt for some men, as their partners continue along in healing. Because men are also in counselling (court-ordered) offered by Probation, it is recommended that greater efforts to partner with Probation take place to: a) gain wider access to men in a captive audience; and b) utilize this opportunity to identify and support men in their healing on a personal level first. A secondary focus should be the eventual facilitator role that is being sought for the men's group, so as to avoid undue pressure on men who may be solely interested (at this stage) in personal healing.
- Because men have expressed a desire and/or need to have experienced group leaders, it is recommended that more male facilitators be brought in until such time enough interest is generated to begin a group. In the absence of a group, this may create a key opportunity in providing some support that may trigger a willingness to become more involved.
- Men in the community should be asked directly about their healing needs and preferences. This could be done informally as well as through formal processes, such as a needs assessment or community survey.
- The project has already responded to some community and church resistance to "healing" by amending their radio announcements. As several people seemed to centre on the word "*mamisaq*," there may be opportunity to engage in broader discussions on finding different ways to promote the concept of "healing."
- Improved reporting is recommended to capture and reflect age and gender breakdowns. All project activities should collect this data as a means of self-evaluation to identify where gaps may exist and improve upon.
- A healing strategy should be formalized into a document. It is recommended that findings from the planning events should be reviewed and summarized on paper and that broader community agencies be consulted on what form this healing strategy should take. 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. Several informants echoed this as they felt not enough was being done to seek input and feedback from the community.

Evaluation Recommendations:

- Workshop evaluations need to be collected on an ongoing basis. This evaluation tool can help determine whether participants are gaining the skills and knowledge they need for their healing journey.
- The evaluation forms currently in use should be revised to capture more detail about the skills and knowledge gained in training workshops and other benefits to participation.
- Community surveys should occur to gauge how the community views the project and its activities. It is recommended that short surveys be distributed once or twice a year to chart how perceptions may or may not be changing.
- Community agencies should also be surveyed to better determine interest and willingness to participate in partnerships. If some agencies do not respond, simply asking their opinion may start a process that could lead to improved or stronger relations. It is recommended that occasional surveys be implemented

- to all community agencies as a means of improving relationships and referral systems and of strengthening community ties.
- It is recommended that this study be provided to key related 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. This could lead to greater capacity building and interest in developing a healing strategy.

Notes

[1] Application for funding submitted to the AHF.
[2] Please note that there was an excess of funds at the project end date and, therefore, the full amount was not released.
[3] Application for Project Funding, Part A, Question 6: Expected results of the project.
[4] The 1996 Census shows a population of 1,171, with 583 or 49.8 per cent in the 0 to 19 age group. The *Cape Dorset Community Economic Development (CED) Plan*, done in February 1999 by RT & Associates, cited the population as being 1,118 in 1996. Some community members and business owners estimated the population as being between 1,200 and 1,300, and the national survey response showed the population at 1,270.
[5] RT and Associates (1999). The report cited population projections by the Department of Resources, Wildlife and Economic Development.
[6] This table is based on the project's response to the national survey.
[7] Government of Nunavut Bureau of Statistics (1999:27). *1999 Nunavut Community Labour Force Survey*. "National Criteria," which describe how unemployment is determined, include persons available for work during the week prior to the survey who: 1) were without work and had actively looked for work in the previous four weeks; 2) had been on temporary layoff; or 3) had definite arrangements to start a new job within the next four weeks.
[8] Government of Nunavut Bureau of Statistics (1999:31). "Want a Job" criteria include persons who were not currently employed but say they want a job. For persons who were on temporary layoff or had a job to start within four weeks, "want a job" refers to a different job.
[9] Government of Nunavut Bureau of Statistics (1999:29). "No Jobs Available" criteria include persons available for work during the week prior to the survey who: 1) were without work and had actively looked for work in the previous four weeks or had not looked for work because they perceived no jobs to be available; 2) had been on temporary layoff; or 3) had definite arrangements to start a new job within the next four weeks.
[10] Government of Nunavut Bureau of Statistics (1999:28–32). Tables 8, 9, and 10 detail unemployment differences by age and gender for Inuit.
[11] As reported earlier, community level data were obtained from individuals working in various community agencies, including the RCMP, Probation Services, and Social Services, and the majority of statistics were provided orally rather than in the form of published reports.
[12] All RCMP figures cover the same time period—January 2000 to November 2001—and refer to incidents as opposed to cases where charges have been laid. An "incident" is described by the RCMP as a report that provides grounds for investigation.
[13] Information from the Healing and Harmony in Our Families Project quarterly reports submitted to the AHF.
[14] Isaacs, Sandy, Jamie Hockin, Susan Keogh, and Cathy Menard (1998). *Suicide in the NWT: A Descriptive Report*. Yellowknife, NT: NWT Health and Social Services. This report is based on data contained in the GNWT Suicide Database for the 11-year period from 1986 to 1996 and in coroner's files for the period of 1994 to 1996 (78 cases over a three-year period).
[15] Statistics Canada (2001:6–9). Crime Statistics. *The Daily*, Thursday, 19 July 2001. Statistics Canada shows the combined rate of violent crime and property offences in Nunavut to be 21,190 per 100,000 compared to a national rate of 7,655 per 100,000. Violent crimes show an even greater difference in rates: 6,074 per 100,000 in Nunavut compared to 982 per 100,000 for Canada as a whole.
[16] This means that Cape Dorset manages its resources directly from funds transferred by the Government of Nunavut to Cape Dorset.
[17] The Cape Dorset figures were provided by Social Services. Nunavut population figures were provided by the Government of Nunavut Bureau of Statistics, while Nunavut children in care figures were from Government of Nunavut Department of Social Services.
[18] Application for funding submitted to the AHF.
[19] Pauktuutit Inuit Women's Association (1992:1). *Taimainnut: An Introduction to Basic Counselling Skills*. Ottawa, ON: Pauktuutit.

[20] This letter notes that both Social Services and the Tukkuvik women's shelter had participated in training and healing offered by the CHT.
[21] Information from the Healing and Harmony in Our Families Project quarterly reports submitted to the AHF.
[22] Wood, Bruce and Robert Kiyoshk (1992:5). *A Change of Seasons: A training manual for counsellors working with Aboriginal men who abuse their partners/spouses*. Squamish Nation, BC: Change of Seasons Society.
[23] Information from the Healing and Harmony in Our Families Project quarterly reports submitted to the AHF.

Appendix 1

Logic Model—Healing and Harmony in Our Families

Activity	Provide healing and training to individuals who will support healing within their family/ community.	Planning and evaluation.	Plan and deliver healing camps on the land.
How we did it	Weekly healing circles; individual counselling; and workshops and training sessions.	Develop a healing strategy to target hard-to-reach groups, (men); identify workshop topics/facilitators; and develop mission and ethical code.	Healing camps for youth, women, elders, and men.
What we did	Weekly women's healing circle; weekly healing circles for teen girls; men's healing circle not formed (2 facilitated workshops for men); individual counselling (approx. 37 people); and training (3 weeks, average 11–17 people).	Weekly planning (8–12 people); meetings with key stakeholders such as Crown and Court Victims Worker; Community Healing Team liaised with hard-to-reach males on relevant court proceedings; and community awareness (60 people, 15 men).	5-day healing camp for 17 youth; 5-day healing camp for Elders; 4-day healing camp for 7 women (no healing camp for men).
What we wanted	Increased skill and capacity among caregivers; increased capacity to deal with crisis; community healing in areas of lateral abuse, violence, sexual abuse, and suicide; and overcoming feelings of powerlessness and uselessness.	Strong, effective CHT; and increased ability to reach hard-to-reach people, especially men.	Increased sense of pride in culture and spirituality as it relates to healing.
How we know things changed (short term)	# of participants in healing circles, workshops, counselling (by target group); self-reported and key informant views on changes in attitude, skills, knowledge, and behaviour; and increased # of skilled caregivers.	Evidence of a healing strategy developed and implemented; increased participation of men; and key informant views of effectiveness of CHT.	# of participants by target group; and self-reported and key informant views on changes in participants' knowledge, skills, attitudes, and behaviour related to Inuit culture and healing.
Why we are doing this	Restore balance and harmony in families and communities.		
How we know things changed (long term)	Reduced rates of physical and sexual abuse, suicide, incarceration, and children in care; and evidence of active, healthy community life.		

Performance Map—Healing and Harmony in Our Families

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.			
Resources		**Reach**	**Results**
How?	**Who?**	**What do we want?**	**Why?**
activities		**short-term outcomes**	**long-term outcomes**
Provide healing and support through weekly healing circles; provide on-the-land camps; and provide training and support through various workshops and a healing strategy.	Women, youth, elders, caregivers, and men.	Increased skill and capacity among caregivers; increased capacity to deal with crisis; increased capacity to serve hard-to-reach groups, especially men; community healing in areas of lateral abuse, violence, sexual abuse, and suicide; overcoming powerlessness and helplessness; and increased sense of pride in culture and spirituality as it relates to healing.	Restored balance and harmony in families and community.
How will we know we made a difference? What changes will we see? How much change has occurred?			
Resources	**Reach**	**Short-term measures**	**Long-term measures**
$126, 080 per year	# of people in Cape Dorset participating and impacted by this program.	# of participants in healing circles, workshops, counselling (by target group); self-reported and key informant views on changes in attitude, skills, knowledge, behaviour (e.g., self-esteem, coping, depression, suicide, abuse, participation in treatment); # of skilled caregivers; key informant and participant views of 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, and children in care; and evidence of change in community attitudes as seen by participation in community by healthier role models built upon Inuit culture and spiritual ways.

Appendix 2

Cape Dorset Questions: (CHT = Community Healing Team)

1. Can you please describe your role in or relationship to this project?
2. What changes, if any, have you observed in the project participants? (Changes in attitude? Changes in behaviour? etc.)
3. Please give an example of how the community has benefited by having this project?
4. What are some of the challenges or obstacles being faced by the project?
5. Please describe what the project is doing to deal with these challenges or obstacles?
6. For people who participated in healing activities, have you seen any improvements in the following areas?

Developing healthier coping patterns Please explain:	Yes	No	Not sure
People developing better self-esteem Please explain:	Yes	No	Not sure
Youth gaining better self-esteem Please explain:	Yes	No	Not sure
Understanding effects of sexual abuse Please explain:	Yes	No	Not sure
Dealing better with depression Please explain:	Yes	No	Not sure
People talking about thoughts of suicide Please explain:	Yes	No	Not sure
Participants not attempting suicide Please explain:	Yes	No	Not sure
Victims getting help for physical abuse/violence Please explain:	Yes	No	Not sure
Abusers getting help to stop physical abuse/violence Please explain:	Yes	No	Not sure
Men getting treatment Please explain:	Yes	No	Not sure
Men dealing with violent behaviours Please explain:	Yes	No	Not sure
People getting support from Elders Please explain:	Yes	No	Not sure
Community supporting Elders Please explain:	Yes	No	Not sure
Women getting treatment Please explain:	Yes	No	Not sure
Stronger Community Healing Team Please explain:	Yes	No	Not sure
Are there other areas not mentioned here where you have seen improvements? Please explain:	Yes	No	Not sure

7. For these 5 groups (youth, women, Elders, families, and men) the project wanted to work with, have you noticed if more people are seeking counselling?

All groups Yes No The same Haven't noticed

7a. Why do you feel that way?

8. From your perspective as (a member of the healing team, Justice Committee, a service provider, etc.) what did you like most about this project?

9. What, if anything, would you want to have seen changed?

10. Since the project began, please describe how you feel rates have changed for:

Sexual abuse gone up the same gone down don't know

10a. Why do you feel this way?

Physical abuse gone up the same gone down don't know

10b. Why do you feel this way?

Suicide gone up the same gone down don't know

10c. Why do you feel this way?

Incarceration gone up the same gone down don't know

10d. Why do you feel this way?

Children in care gone up the same gone down don't know

10e. Why do you feel this way?

11. How has this project helped or not helped participants deal with suicide?
12. How has this project helped or not helped families deal with alcohol, drugs, and/or gambling?
13. How has this project helped or not helped participants deal with sexual abuse?
14. For training workshops you have taken, how have they helped you personally?
15. Is there a clear example of a skill you have learned that has really helped you support others?
16. Do you have any other comments to share?

Mandatory Questions:

A) What are the previously identified needs that the project is intended to address?

B) How would you rate the project's 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 minor improvement	Struggling to address physical and sexual abuse	Poorly, needs major improvement	Is not addressing the Legacy at all	Not sure

C) How well has the project been accountable (i.e. engaged in clear and realistic communication with the community as well as allow community input) to the community? Please choose 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 minor 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 why you feel this way

D) How well have the methods, activities, and processes outlined in the funding agreement led to desired results? Please choose 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 minor 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 why you feel this way:

E) Will the project be able to operate when funding from the Foundation ends?

F) How well is the project able to monitor and evaluate its activity? Please choose 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 minor 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 why you feel this way: