Revitalizing Wellness: Fostering Healing in BC’s Residential School Abuse Survivors

by
Amy Coutts
B.A., University of Victoria, 2007

Project Submitted in Partial Fulfillment of the Requirements for the Degree of Master of Public Policy in the School of Public Policy Faculty of Arts and Social Sciences

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SIMON FRASER UNIVERSITY Spring 2016

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Approval

Name: Amy Coutts
Degree: Master of Public Policy
Title: Revitalizing Wellness: Fostering Healing in BC’s Residential School Abuse Survivors

Examining Committee:

Chair: Nancy Olewiler
Professor

Olena Hankivsky
Senior Supervisor
Professor

Doug McArthur
Supervisor
Professor

Kora DeBeck
Internal Examiner
Assistant Professor

Date Defended/Approved: March 29, 2016
Ethics Statement

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Abstract

Survivors of childhood institutional abuse can face a lifetime of physical and mental health challenges. To address the on-going health challenges of claimants during the claims process, the Indian Residential School Settlement Agreement created the Resolution Health Support Program. This study identifies gaps in existing services, and provides policy recommendations for future services after the duties of the Settlement Agreement are fulfilled. Expert interviews and three case studies highlight policy options, and the key issues impacting the wellness of claimants in the Settlement Agreement. Three policy options are assessed using eight criteria based on the objectives of efficacy, equity, and stakeholder acceptability. The creation of a Wellness Fund and funding for survivor cultural revitalization are the recommended options for addressing the immediate and long-term needs of Survivors in BC. Throughout policy implementation, it is important to consider the context of other colonial policies, the diversity of responses to the wellness needs, and to target the intergenerational effects of the IRS system.

Keywords: Indigenous Health; Independent Assessment Process; Indian Residential Schools; Healing; Abuse Survivors Health
Dedication

This capstone is dedicated to my parents.

This research is also for all the Survivors; your stories have been heard and will not be forgotten.
Acknowledgements

I want to thank everyone who has supported me during the research and writing of this capstone. I am grateful in particular for the support and encouragement of my supervisor, Olena Hankivsky, and the valuable feedback of my internal examiner Kora DeBeck.

To my wonderful classmates – I am so glad it was all of you who were on this adventure with me. You have made these past eighteen months the most rewarding experience I could have asked for.

To my ever patient flatmate and dear friend Sinead – thank you for making me tea, and putting up with my inability to contain the piles of books and papers to my desk. I appreciate it more than you know.

To everyone at the IRS Adjudication Secretariat – thank you for listening to me tell you how stressed I was every week. You’ve all been doing this work a lot longer than me, and I have been honoured to be a part of your team. Thanks in particular to John Trueman for suggesting the topic, and Russ Vallee for your continued support and encouragement.

Thanks to my family for always believing in me, despite my round about ways of completing any task.

And finally, I am grateful to everyone who participated in my research. Thank you for the work that you do, and for inspiring me.
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<tbody>
<tr>
<td>ADR</td>
<td>Alternative Dispute Resolution</td>
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<tr>
<td>AFN</td>
<td>Assembly of First Nations</td>
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<td>AHF</td>
<td>Aboriginal Healing Foundation</td>
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<td>CEP</td>
<td>Common Experience Payment</td>
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<td>CICA</td>
<td>Commission to Inquire into Child Abuse</td>
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<tr>
<td>CSW</td>
<td>Cultural Support Worker</td>
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<tr>
<td>FNHA</td>
<td>First Nations Health Authority</td>
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<tr>
<td>FPCC</td>
<td>First Peoples Cultural Council</td>
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<td>IAP</td>
<td>Independent Assessment Process</td>
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<td>INAC</td>
<td>Indigenous and Northern Affairs Canada</td>
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<td>IRS</td>
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<td>Indian Residential School Survivor Society</td>
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<td>Royal Commission on Aboriginal Peoples</td>
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<td>Resolution Health Support Program</td>
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Executive Summary

Survivors of childhood institutional abuse frequently experience long-term negative health impacts. During the 140-year history of Canada’s Residential School system, over 150,000 Indigenous children were sent to institutions intent on extinguishing Indigenous cultures through assimilation and the separation of children from their families and communities. Physical, sexual, and emotional abuse were a frequent reality at Residential Schools, leaving students with lasting health effects. Following years of litigation and negotiation, Indigenous organizations and representatives settled the Indian Residential Schools Settlement Agreement (the Agreement) with the Government of Canada and the main churches involved in operating the schools.

This study focuses primarily on Residential Schools Survivors who have made claims under the Independent Assessment Process (IAP). The IAP was created by the Agreement to grant compensation to those who experienced serious abuse at Residential Schools. Claimants must have their applications accepted to the process, and attend a hearing in which an adjudicator questions them to verify the facts of their testimony. Recognizing the traumatic nature of recounting childhood abuse, the Agreement included health supports, known as the Resolution Health Support Program, and a 24-hour crisis line to be maintained for the duration of the Agreement responsibilities. In requiring claimants to revisit their childhood trauma, often acknowledging it for the first time in their adult lives, the IAP created additional trauma amongst Indigenous communities, despite attempting to address historical wrongs.

There are currently no plans to extend the Resolution Health Support Program beyond the mandate of the Settlement Agreement. This capstone addresses the lack of adequate current and future health supports for Survivors of Indian Residential Schools, particularly those who are claimants under the IAP. This is a national problem, however, to narrow the scope of research and recommendations, this study focuses on the situation in British Columbia.
A literature review revealed the extent of the health impacts of Residential Schools. To identify policy options to ensure that survivors have continued support, the analysis of case studies and expert interviews highlights service gaps and resulted in suggestions for solutions. Three case studies provide examples of multi-jurisdictional approaches to health care for institutional abuse Survivors: Caranua Board in Ireland; Six Nations Mental Health Clinic in Ontario; and the Aboriginal Healing Foundation in Canada. The case studies also provide potential models for policy options. Interviews with nine stakeholders and experts were conducted. The interview analysis identified service gaps, potential policy responses, and implementation themes which are necessary for policy options to be effective.

From the literature review, case studies, and interview analysis, two main themes emerged as essential to supporting Survivors’ healing and well-being. First, health supports provided must address the intergenerational nature of the Residential Schools’ impact, and second, healing initiatives are most successful when rooted in traditional practices.

The study findings combined with the literature review helped formulate three policy options:

1. Individual Application Support Service Funding: Under this option, direct and intergenerational survivors can apply for one-time health-related services, ranging from home modifications for disabilities, to counselling services. Recipients apply on an individual basis, and are eligible to apply for multiple types of services. This option allows Survivors to maintain their privacy while accessing targeted services, and is accessible province-wide.

2. Indigenous Wellness Program: The first part of this program creates a Wellness Fund that grants financial support to organizations providing community-driven health supports that are rooted in traditional healing practices. Counselling services are provided along with cultural activities. This option allows communities to heal together, and create locally-based services that are culturally appropriate. The second part of the program includes additional funding to be transferred to BC’s First Peoples Cultural Council, which oversees funding of cultural and language revitalization programs in the province.

3. Status Quo: The final policy option is to maintain current funding until the IAP closes. This would support claimants still in the process, until the Resolution Health Support Program concludes. Under current government funding, all Aboriginal Canadians are covered for 15 crisis-counselling sessions annually.
This would alleviate some of the service gap, following the program’s closure. In BC, the First Nations Health Authority has a ten-year mandate to provide mental health services to Indigenous communities, mitigating the impact of the program closure provincially.

These policy options are evaluated using ten measured criteria divided into three categories: effectiveness, equity, and stakeholder acceptability. Policy analysis reveals that a Wellness Program including a Wellness Foundation and annual cultural revitalization funding is the strongest option for holistically supporting Residential School Survivors and their communities to revitalize health. This policy option is recommended to address the immediate wellness needs of Survivors, and create a long-term cultural revitalization strategy in BC.
Chapter 1. Introduction

1.1. Foreword

Under the Indian Residential Schools’ Settlement Agreement (IRSSA), funding for former students making compensation claims under the agreement is provided by Health Canada. Through the Resolution Health Support Program, (Resolution Health Support Workers (RHSWs), Cultural Support Workers (CSWs), therapists, and Elders are available to assist claimants. In particular, Survivors making compensation claims for abuse under the Independent Assessment Process (IAP) require the services provided by the RHSP. This includes helping claimants create their future care plan and manage the emotional impact from the process. Claimants also have access to counselling services and the cultural supports of Elders during the hearing process. Further, those impacted by Residential Schools are able to call the 24-hour crisis line, where they can receive emotional support and be connected to local mental health services. Inclusion of health supports in the Settlement Agreement was vital following the suicides of at least one former students during a litigation trail in the late 1990s (Taillon, 2001; Todd, 1998). Because the health effects of childhood institutional abuse are well documented (Bombay et al., 2011; Carr et al., 2010; Elias et al., 2012; Kaspar, 2014), health supports are of the utmost importance to IAP claimants.

The closing date for applying to the IAP was September 19, 2012. For former students of one school, Mistassini Hostels in Northern Quebec, the closing date was extended until September 3, 2013, due to that school’s late inclusion under the Settlement Agreement. The organizational body that administers the IAP, the Indian Residential School Adjudication Secretariat, (IRSAS), received a total of 38,087 applications for compensation, and has resolved 34,565 claims. To date, as of March 31, 2016, $3.004 Billion has been paid in compensation to IAP claimants (IRSAS, 2016). IRSAS expects to hold the final first hearings in the spring of 2016. Some cases require
more than one hearing and as the claims wind down, it is the most complex and challenging cases that will remain.

The services provided by the RSH Program save lives: in the 2012-2013 fiscal year, the crisis line alone received 7,787 calls for support, including 115 which required suicide intervention (Treasury Board Secretariat, 2013). While these services are vital, they are not enough to address the long-term impacts of Indian Residential Schools (IRS). Similarly, the financial provisions of future care awards do not offer long-term treatment solutions. Under future care, survivors can receive $10,000 in additional to their compensation, to use for healing services, including cultural services, elder care, and therapy. If a future care plan includes accessing a psychiatrist, claimants may receive a total of $15,000, though the real value of $15,000 was higher at the beginning of the implementation of the Settlement Agreement than at the end. However, the effects of survivors' experiences are ongoing, intergenerational, and an inextricable component of colonization, which result in persistent and growing health inequalities among Indigenous Canadian communities. To truly face and reconcile Canada with the effects of the IRS policy, long term health supports for former students and their families are necessary beyond the mandate of the Settlement Agreement.

1.2. Policy Problem

The Government of Canada released its 2016 budget on March 22, 2016, with no direct reference to the Resolution Health Support Program (RHSP). Under Health Canada’s 2016/2017 Plans and Priorities, $271,327,728 has been ear marked for First Nations and Inuit mental wellness, and these funds include “health supports for participants of the Indian Residential Schools Settlement Agreement” (Government of Canada, 2016). However, there are no plans to extend services once the duties of the IRSSA have been fulfilled. Further, research has shown that the effects of institutional childhood abuse can last a lifetime, (Carr et al., 2010; Corrado and Cohen, 2003; Elias et al., 2012) and health impacts may not truly present until years after the trauma is experienced. Finally, the IAP application and hearing process reveals traumatization that survivors may have buried, and sometimes has left claimants feeling re-victimized by a complex system. Thus, the policy problem is the lack of long-term health supports
targeting Residential School abuse survivors, leaving Indigenous communities and advocacy organizations without adequate resources to provide care for (re-)traumatized survivors. If this policy gap remains, there will be little mitigation in the continuing impacts of the IRS system on the wellness of survivors. This will result in a lower overall quality of life and health for former students, negatively impacting the well-being of their families and communities. The medical system and Indigenous communities will continue to shoulder an unnecessary burden resulting from colonial policies. Further, while the obligations of parties under the IRSAS may be coming to a close, the work of healing has just begun for many survivors. Without health supports to bolster the commitments to change and reconciliation made under the IRSSA, the effects of Residential School abuse will continue to negatively impact generations of Aboriginal Canadians. Health supports will not cure the impacts of residential school abuse, but they can ease the effects, and reduce the degree to which the harms are passed on through the generations. Further, by fostering health care that involves and is structured by Aboriginal concepts of healing, health supports can be a site of cultural resurgence.
Chapter 2.  Background

2.1. Residential Schools System Overview

In the centuries immediately following European contact in North America, relations between Indigenous leaders and British settlers were dictated through a nation to nation structure, as evidenced in the Royal Proclamation of 1763. By the mid-19th Century however, the crown operated with a policy of assimilation that echoed the belief that North America’s indigenous cultures would inevitably die out. The Indian Residential School policy was an integral part of ensuring assimilation and the destruction of Aboriginal cultures in Canada. Prior to Confederation, the Catholic, Anglican and United Churches ran religious schools for Aboriginal children. Post Confederation, these schools became the federally mandated, church-run Indian Residential Schools (IRS, or Residential Schools). This school system remained in place for well over one hundred years, until the final school closed in Saskatchewan in 1996.

During the 140-year period of operations, over 150,000 Aboriginal children were removed, frequently against their parents' wishes, from their homes and communities and forced to attend schools where they were stripped of their possessions and punished for speaking in their first language. In Park’s 2015 study of the politics of grief, one student recalls being beaten for telling his sister about the death of their uncle, as the staff had asked him to do; he had not known the words in English, and was punished for speaking his language. Further, Residential Schools were underfunded, frequently reliant on student labour, and often did not provide an adequate level of education (Kaspar, 2014). All too frequently students were emotionally, physically, and sexually abused by the staff and teachers. The abuse led to long-lasting physical and psychological injury, in addition to the damage of enforced cultural loss, a process often referred to as cultural genocide.
The Truth and Reconciliation Commission defines cultural genocide as “the destruction of those structures and practices that allow the group to continue as a group” (2015). The endurance of Aboriginal identities, languages, and cultures across Canada is a testament to the defeat of the genocidal intent of the IRS policy. However, no cultures could withstand attempted cultural genocide without lasting effects. The following two sections explore the broad health and intergenerational impacts of Residential Schools.

2.1.1. Health Impacts

For generations there has been a gap between the health status of Aboriginal Canadian and non-Aboriginal Canadians. First Nations, Inuit, and Métis people have higher suicide rates, higher infant mortality rates, and a lower life expectancy, largely due to the continuing impacts of colonial disruption of Indigenous economies, communities, and cultures (Kaspar, 2014; Wilson & Cardwell, 2012). The effects of colonization are seen not only in the unequal health outcomes, but are also reflected in disparities in health determinants across Canada. As Boyer argues, economic measures of health determinants, such as housing, clean water, food security, sewage systems, protection from environmental contaminants, and accessibility of basic health care services are frequently inadequate or missing in Indigenous communities (Boyer, 2014).

Residential School attendance has been shown to contribute to and further exacerbate the effects of social and economic inequality leading to lower health outcomes. Former Residential School students demonstrated significant disadvantages in a variety of socioeconomic status indicators, relative to Aboriginal people who had not attended a Residential School (Kaspar, 2014). Former students often report experiencing a loss of connection with their families, as well as cultural and language loss resulting from IRS attendance. This is evidenced in the study of Juutilainen (2014) in the narrative of one such former student: “I think it’s really impacted the language, which has a profound impact on identity, which has negatively impacted all individuals; self-esteem, motivation, and confidence”. Furthermore, attendance at a Residential School has been shown to be a predictor of lower health status compared to non-attendees (Kaspar, 2014). There is growing evidence showing that the loss of culture
and language is a health determinant itself (Hallet et al., 2007). If a former student experienced abuse while attending Residential Schools, their risk of negative health impacts increases further. Former students who suffered abuse were more likely to have suicide ideation than those who did not experience abuse (Elias et al., 2012). When former students are multigenerational survivors, that is, they had a parent and/or grandparent attend, their risk of health effects are magnified (Elias et al., 2012). And finally, as former students age, their mental and physical health risks increase (Draper et al., 2012).

Research into the connection between ill health and residential school attendance began shortly after the turn of the century with Corrado and Cohen’s 2003 review of health records of 127 formers students living in British Columbia. Their report found that 75% of respondents reported some sort of mental illness, with 64.2% recording post-traumatic stress disorder (PTSD); half of those diagnosed with PTSD were co-morbid with other mental illness such as depression and substance abuse. Further, there has been much research demonstrating that adult survivors of childhood abuse are much more likely to suffer from some form of mental illness and to have suicidal ideation than their peers (Draper et al., 2008, Carr et al., 2010). It has been documented that mental health risks increase with age; former students who have mental illnesses will be increasingly vulnerable in the coming years (Elias et al., 2012). According to the 2008/10 First Nations Regional Health Survey, over 80% of former students of Residential Schools were over the age of 50 (First Nations Information Governance Centre, 2012). As the average age of Independent Assessment Process claimants increases, the demand for suitable and sustainable mental health care supports will grow as well. Not anticipating the demands of mental health care needs has social and economic costs. In 2010, 4.4% of Canada’s GDP was lost due to direct and indirect costs of mental illness (Hewlett & Moran, 2014). Further, a 2010 study of mental health care costs in OECD countries reported that spending on mental health care would save costs in other areas of health care, and lead to gains in productivity (OECD, 2014).
2.1.2. Intergenerational Impacts

The harms of Residential Schools reverberate through generations of descendants of former students. As part of a larger strategy of colonization, Residential Schools have contributed to on-going lower levels of physical and mental well-being in Indigenous populations, even amongst those who did not attend the institutions themselves. As Chandler and Lalonde (1998) demonstrate, youth whose “culture is at siege” are far more likely to attempt suicide than others in their age cohort. By forcing children to attend schools away from their families, generations of former students were denied the opportunity to learn how to parent through their own life experiences. As the TRC makes explicit:

“[Residential Schools] affected the Survivors’ partners, their children, grandchildren, their extended families and their communities. Children who were abused in the schools sometimes went on to abuse others. Many students who spoke to the Commission said they developed addictions as a means of coping” (136).

Lack of parenting skills, substance abuse, and mental health challenges are pervasive themes in survivor testimony. Children of survivors frequently lack the ability to speak their traditional languages, and many cultural traditions have been lost. In a 2014 study, Juutilainen et al. found that Haudenosaunee intergenerational survivors reported negative impacts of residential schools on their health and well-being. When abuse was experienced at an institutional residential school, children are deprived of the familial and community supports that could usually be relied upon to sustain them in the face of such trauma (Moran, 2014). A study of the 2002/2003 Manitoba First Nation Regional Longitudinal Adult Health Survey found that descendants of survivors of residential schools abuse were more likely to have a history of suicide ideation (Elias et al., 2012). Furthermore, the loss of heritage has been correlated with an increase in suicide rates in communities in BC (Hallet et al., 2007).

The intergenerational effect of Residential Schools is also reflected in the current crisis of disproportionately high numbers of Indigenous children in care. At present, there are more Indigenous children in custodial care than were in Residential Schools at the height of their operation, reflecting a continuing lack of culturally-appropriate policies to address the wellness of Indigenous children, but also the lasting harm of removing
young children from their families and communities. At the TRC, children of former students testified to their experiences of being raised by IRS Survivors who did not know how to show love, or how to parent healthily, and to finding themselves passing this dysfunction on to their own children (TRC, 2015). Further, a 2011 study revealed that children with one or more parents who attended a Residential School were at greater risk of experiencing depression (Bombay et al.). The interruption of traditional teachings and knowledge transfer between generations caused by colonial policies such as the IRS system have also been linked to childhood obesity (Ferris, 2011).

Addressing the intergenerational effects of residential schools is an important part of promoting wellness and healing. The continuation of such impacts can be mitigated by fostering cultural revitalization, as well as creating a robust, culturally-appropriate health support system. In a study conducted in British Columbia, nations that reported a majority of members having a conversational knowledge of an Aboriginal language, also reported a low level of youth suicide rates (Hallet at al, 2007). Supporting this study, a 2014 report revealed Indigenous Communities in Alberta that had a high level of cultural continuity, as measured by traditional language use, had lower levels of Type 2 Diabetes (Oster et al, 2009). Accessible and culturally-sensitive health care was instrumental in reducing the rates of hospitalization in an Iroquoian community in Ontario; in its first year of operation, the Six Nations Mental Health Services clinic saw a dramatic drop in off-reserve hospital admissions due to mental illness. A 2003 study indicated that many Aboriginal people “perceive the actual act of participating in cultural activities such as hunting and gathering plants to be beneficial for health” (Wilson as cited in Wilson & Cardwell, 2012).

2.2. International Situations and Responses

The experience of childhood abuse in institutionalized settings is not a tragedy unique to Canada. From abuse cover-up scandals in the Boston Catholic Diocese, and the UK’s BBC, to fact-finding commissions in Ireland and Australia, there are hundreds of thousands of adult survivors worldwide living with the effects of institutional abuse. The following sections review the situations in Ireland and Australia, and their national commissions called to address the historical abuses, as well as the accounts of children
being removed from indigenous families in Finland’s colonization policies. Residential Schools were part of a trend of institutionalizing those who challenged society’s standards of perceived normality, made distinct by their purpose as a tool of colonization.

2.2.1. Irish Residential Institutions

Under British rule in the mid-19th Century, industrial and reformatory schools were established in Ireland to house and educate children who were in government care or who had been convicted of a crime (Caranua, 2016). These schools were run by the Church (mainly Catholic), and funded by the Government of Ireland. Most Institutional Schools were closed by the 1980s (Caranua, 2016). Frequently places of abuse and neglect, it is estimated that 100,000 students were abused physically or sexually at these institutions. The growing number of abuse allegations led the Government of Ireland to apologise to victims of abuse in 1999, and establish the Commission to Inquire into Child Abuse (CICA, or the Ryan Report) in 2000.

At the same time that the CICA was holding inquiries, the Government also set up the Residential Institutions Redress Board (RIRB) in 2002, to provide compensation for survivors of institutional abuse. By December 31, 2013, the RIRB (2013) had received 16,620 applications for compensation, with a total of 15,098 receiving an award following a hearing, review or settlement. In its final report, known as the Ryan Report, the CICA (2009) recommended that counselling and educational services be provided for survivors of the institutional abuse and their families.

In 2012, the Irish Government passed an act to establish the Residential Institutions Statutory Fund of €110 to provide additional support to survivors. Now known as Caranua, the board receives applications from former students for assistance with education costs, shelter, and health concerns. Contrary to the recommendations of the Ryan Report, funding support is not extended to family members of survivors. Program evaluation information is unavailable for the time being, as an evaluative analysis will not be undertaken until the program has been completed (Kane, 2016).
2.2.2. **Australian Institutional Abuse & the Stolen Generation**

In the twentieth century, Australia had dozens of institutional schools, ranging from prestigious prep schools to the schools designed to assimilate Indigenous Australian Children. The schools from Indigenous Australians operated from approximately 1910 and 1970, and were similar in purpose and design to Residential Schools. Children who attended the schools are referred to as the Stolen Generations. In the latter half of the century, former students began speaking about the conditions and abuse at all of these institutions. Initial attempts to address abuse at institutional schools in Australia occurred in the 1990s, and were criticised for keeping the investigations within the jurisdiction of the Churches (Brereton, 2015). In April 2012, police in the province of Victoria linked at least 40 suicides to childhood abuse at the hands of Catholic clergy (McKenzie et al, 2012). Following the revelation that the Catholic Church covered up abuse, then-Prime Minister Julia Gillard called for a national inquiry to investigate the issue of institutional childhood abuse, examining all institutions entrusted with the care of children (Rourke, 2012). The Australian Royal Commission into Institutional Responses to Child Sexual Abuse began in February 2013, preceded by inquiries in Victoria and New South Wales into abuse cover ups in those provinces (Middleton et al, 2014). The Royal Commission handed down a preliminary report on redress and litigation in September 2015. In this report, the Commission offered 99 recommendations on how abuse allegations can be handled through redress or litigation, and legislation that would reduce the chances of institutional abuse in the future. Further, the Commission specifically calls for mental health assistance to be made available for all survivors of institutional abuse in Australia (Royal Commission, 2015).

As in Canada, Australia has a history of separating Indigenous children from their cultures and family as a tool of assimilation. The Australian government officially apologized in 2008 for the Stolen Generations, and the abuses that they endured. No national program offers compensation for the Stolen Generations, though there was a program of compensation in Tasmania in 2008, with a range of $5,000 to $58,000 per claimant, and one in Southern Australia (Dayman, 2015). Neither of these state-run compensation schemes includes health supports for applicants. While the Royal
Commission acknowledged that Indigenous Australians had an additional layer of trauma from their institutional abuse experiences, there is not yet an indication of a particular policy response to this recognition. The leader of the Labour Party of Australia has promised to commit $33 million to a redress scheme if his party is elected (McDonald, 2015). This amount falls far short of the $4.3 billion the Royal Commission recommends. Further, there is no inter-jurisdictional support of a redress scheme; in October 2015, the Southern Australian Labour Party leader announced his party would not contribute to a national redress scheme (Australian Associated Press, 2015).

2.2.3. Children as Tools of Colonization

Canada and Australia are not the only countries to have removed indigenous children from their communities with the goal of eliminating cultures, as “a quintessential model of structural racism is the educational experiences of Indigenous peoples within the residential school and boarding school systems” (Juutilainen, 2014). Sami children in Finland were educated in a system that did not teach their language, resulting in a collective loss of language over the course of one generation (Juutilainen, 2014). While Juutilainen argues that assimilation was not the sole purpose of the Finnish education policy, assimilation and elimination of Indigenous cultures was the express purpose of Canada’s IRS system. Regardless of written intention, both policies used children to undermine and destroy Indigenous cultures, resulting in negative health impacts for former students.

2.3. Canadian Context

As in international cases, Canada has experienced several instances of child abuse occurring at educational institutions, such as Jericho Hill School in BC, and institutional boarding schools in New Brunswick and Nova Scotia (Shea, 1999; Feldthusen et al., 2000). What sets Residential Schools apart was their role as a tool of assimilation and colonization, and the number of children impacted. The harm done through the IRS was system was two-fold for abused former students: first, the loss of family and cultural traditions, and second as a site of institutionalized abuse.
2.3.1. Policy Response: Indian Residential School Settlement Agreement

For the majority of the years that Residential Schools operated in Canada, their existence and impacts were relatively unknown and unrecognized by the broader Canadian public. In an October 1990 interview with CBC, Phil Fontaine, then head of the Assembly of Manitoba Chiefs, became one of the first former students to speak publicly about the abuse he had endured at a Residential School, calling on the federal government to mount an inquiry into the IRS system (CBC Digital Archives, 1990). Subsequently, thousands of other former students began coming forward with their own stories of abuse.

Royal Commission on Aboriginal Peoples and Gathering Strength

In response to the mounting pressure from survivors, in 1991 the Federal government launched the Royal Commission on Aboriginal Peoples (RCAP). The Commission sought to explain the stark differences in the standards of living between settler populations and Canada’s Indigenous people, and provide recommendations for improving living standards for all Aboriginal people and moving forward from the harms done through racist policies. Following the RCAP’s findings, which spoke directly to the impact of the Residential School system, the federal government started several initiatives, such as the Gathering Strength Action Plan, in an attempt to address the inequalities that Aboriginal people face, and slow the growing outrage over the Residential Schools system. Throughout the 1990s, thousands of former IRS students were filing lawsuits against the federal government and the churches for their experiences in Residential Schools. The late 1990s and early 2000s saw the federal government pilot several alternative dispute resolution (ADR) projects as a different option to resolving residential school claims than litigation. These ADR projects were limited in their ability to address the impacts of cultural loss, and were considered too time-consuming for aging former students. Further, under the Gathering Strength plan the Aboriginal Healing Fund was created, leading to the opening of the Aboriginal Healing Foundation (AHF). The mission of the AHF was to provide funding through individual grants to community and other grass-roots organizations working to help heal former residential school students.
Class Actions

While important steps towards redress and reconciliation, the ADR and Gathering Strength initiatives were not adequate to address the harm done by the IRS system. In the mid to late 1990s, groups of students came together to form several separate litigation cases attempting to have Canada and the churches address the wrongs of Residential Schools: Blackwater vs. Plint, Cloud vs. Canada, and Baxter vs. Canada. In December 2004, the Cloud v. Canada class action suit was certified, which also made the certification of Baxter likely (Thielen-Wilson, 2014). This certification, and the threat of other class actions put additional pressure on all the parties to create a comprehensive settlement agreement. Finally, in 2006 the Indian Residential School Settlement Agreement (IRSSA) was signed, setting aside funds for the AHF, forming the Resolution Health Support Program, mandating the Truth and Reconciliation Commission, and creating the compensatory processes of the Common Experience Payment and Independent Assessment Process. Following the implementation of the Settlement Agreement programs, then Prime Minister Stephen Harper apologized on June 11, 2008 to all former students, their families, and communities on behalf of the Government and all Canadians, for the wrongs of the Residential Schools Policy.

Truth and Reconciliation Commission

The IRSSA mandated the Truth and Reconciliation Commission (TRC), partially modelled after the South African TRC that followed apartheid, to travel across Canada, documenting the stories of former students of Residential Schools. As a program of reconciliation, the TRC’s purpose was not only to document the truth of the Residential School system, but also educate and build awareness of the legacy. The Commission held seven national events, and encouraged the process of reconciliation in communities across the country. In June 2015, the Commission released its final report. Containing 94 Calls to Action, the report challenges all levels of government, and all Canadians, to address the harms caused by the Residential School system. In particular, Calls to Action 19-23 speak directly to the health needs of former students, their families and all Aboriginal people in Canada. Acknowledging the inequality between Aboriginal health determinants and those of non-Aboriginal Canadians, the TRC calls on governments to recognize the impacts of residential school on health inequalities. The TRC recommends
that governments provide funding to ensure that all former students receive the appropriate levels of health supports, and that these wellness services include traditional Aboriginal healing methods which have demonstrated benefits for Survivors.

**Common Experience Payments**

The Common Experience Payment (CEP) was one of two compensatory programs under the IRSSA. It was fundamentally important to the success of the Settlement Agreement as it addressed the common experience that all Residential Schools students had of being purposefully removed from their cultures; previous attempts at redress through litigation and ADR did not include mechanisms that were able to fully address this harm. All former students were eligible to apply for the CEP. Claimants were compensated $10,000 per first year of attendance (or part thereof) and $3,000 for each additional year of attendance (or part thereof). Under this process, there was no requirement for a hearing; students were compensated once attendance at an eligible school was confirmed by the federal government. In addition to the 24-hour crisis line, CEP claimants also had access to Resolution Health Support Workers.

**Independent Assessment Process**

The Independent Assessment Process (IAP) is the second compensatory program mandated under the Settlement Agreement. Through the IAP, former students could apply to be compensated for abuse suffered at Residential Schools. The IAP also compensated harmful acts called “Other Wrongful Acts”, which resulted in lasting injury that previously were not compensable through litigation or ADR. In the name of equity and fairness, the IAP was a more rigorous process than that of the CEP; claimants were required to submit an application form detailing the abuse they suffered, the name of the alleged perpetrator, and the school(s) that they attended. These applications were reviewed to ensure the school was covered under the IRSSA, requiring the Government of Canada to research its frequently poorly-kept records. Once accepted into the IAP, claimants could be required to submit medical records, and be evaluated by a physician, depending on the level of harms they were claiming. After the application package was complete, a hearing was scheduled in which claimants would testify before an adjudicator. Once the hearing was completed and all submissions were made, the
adjudicator would make the decision to award based on the level of harms compensation structure set out in the Settlement Agreement.

Throughout this process, claimants would have access to the support of Elders, Resolution Health Support Workers, counselling, and travel assistance as part of the Resolution Health Support Program. The IAP application and hearing could be an emotionally trying experience that would bring memories of trauma to the surface. The health supports were of particular value during this time.

2.3.2. Policy Response Impacts & Criticisms

When the IRSSA was negotiated, the parties recognized the imperative to protect and support claimant’s mental health as much as possible, following the suicides of several former students involved in an early class action suit. To protect the health of claimants as much as possible, the Settlement Agreement included a partnership with Health Canada to provide a 24-hour crisis line, and maintain the Resolution Health Support Program (RHSP), which provided Resolution Health Support Workers (RHSWs) to work with claimants throughout the hearing process. The function of the RHSWs was two-fold: first, claimants would work with their RHSWs to prepare for the hearing itself, as well as work through the emotional aftermath of testifying; second, if the claimant was requesting funding for “future care” (to a maximum of $15,000 under the Settlement Agreement if psychiatric care was required\(^1\)), the RHSW worked with the claimant to create their future care plan, which was a requirement to receive future care funding.

Resolution Health Support Workers were available for any applicant under the Common Experience Payment and/or the Independent Assessment Process. However, given the demonstrated effects of residential school abuse, it is plausible that the RHSWs were more utilized by IAP claimants. As the literature demonstrates, the mental and physical health impacts of childhood abuse last a lifetime. With the IAP closing within the next two-three years, the mandate of the Settlement Agreement will conclude,

\(^1\) This amount is roughly comparable to similar amounts of post-award health support funding seen in other Canadian institutional abuse settlement agreements (Shea, 1999). See Appendix B for a summary table.
and with it the provision of health supports for claimants. This will lead to some claimants being without appropriate mental health supports, and goes against the Truth and Reconciliation Commission’s Calls for Action.

The health support programs provided by Health Canada under the Settlement Agreement have been criticised for their inflexibility towards local community innovation because they are offered on a national scale (Green, 2014). Before its closure in 2014, the Aboriginal Healing Foundation provided a mechanism for Aboriginal-led, community-based initiatives to provide health supports to claimants and their family members. The closure of the AHF created a gap in the provision of services that used Indigenous methodologies, and secured community approval, ensuring cultural safety in its programs (Green, 2014). Because, as Juutilainen (2014) argues, “Indigenous identity, language, and culture are key determinants of health”, providing and empowering traditional healing practices is an important part of health care provision for claimants and those impacted by intergenerational effects of Residential Schools. Thus, as I will explore further in my data analysis chapters, any future policy responses will ultimately be unsuccessful if they fail to address and make room for the diversity of Indigenous communities and their health support needs.
Chapter 3. Methodology

To produce the policy options put forth in this capstone, a qualitative study was completed using two methodologies. Expert interviews and case studies were conducted to identify gaps in existing services and highlight ideas for future services. Case studies were selected through a process of a brief literature review, and an analysis of their potential to suggest policy options for the purpose of this research. In collaboration with the First Nations Health Authority (FNHA), Indian Residential School Adjudication Secretariat (IRSAS), and Indian Residential School Survivor Society (IRSSS), potential interview participants were identified based on their knowledge and experience of claimant experiences under the Independent Assessment Process.

As part of the ethics process, I attended a teleconference with the First Nations Health Authority to provide detailed information about the aim and scope of my research. In October 2015, I received a letter of support from the FNHA to work with some of their staff on my research, shown in Appendix D. Additionally, I spoke with the CEO of the IRSSS several times over the phone to develop a working relationship with the organization, signing their research code of ethics in late November 2015. Both the FNHA’s letter of support, and the IRSSS code of ethics form were included in my ethics application. Ethics approval for this study was provided by Simon Fraser University’s Research Ethics Board.

3.1. Theoretical Framing

At issue when studying health supports and services for Aboriginal IAP claimants is the tension between western concepts of “cure” and the Aboriginal idea of holistic healing as a constant process. Green (2012) summarizes this tension as “a tendency to view Indigenous conceptualizations of healing as synonymous with Eurocentric approaches to therapy” (136, emphasis in original). Further, “cure is defined as ‘a course
or period of treatment” or as ‘recovery or relief from a disease”, clearly indicating an end point to an illness, in this case the trauma of abuse endured at Residential Schools (136, emphasis in original). The IAP, along with the Settlement Agreement and the apology, which evade “the language of colonialism, [have been] problematized as a strategy to contain Indigenous calls for justice and relieve settlers of responsibility by attempting to represent an ending rather than beginning of making amends” (Park, 2015: 276, emphasis added). This theorizing highlights the importance of the context in which the Resolution Health Support Program came about, the diverse impacts of colonial policies, and the setting in which future healing will exist. As a non-Indigenous researcher, my analysis and recommendations are infused by the framework of the Aboriginal Healing Foundation research:

What clearly emerges from our research is the importance of flexibility and eclecticism in the development of treatment models. There is no singular Aboriginal client, as there is no singular Aboriginal individual ... effective treatment programs must be able to accommodate a wide variety of Aboriginal people: individuals from different cultural heritages; individuals who have no practical experience in Aboriginal cultural contexts as well as those who have; individuals who do not speak an Aboriginal language and those who do; individuals with no background in the spiritual traditions that underscore such treatment and those who do; and individuals who are avowedly Christian alongside those who practice Aboriginal spirituality and those who simply are not spiritual.

In an attempt to avoid falling into Eurocentric models of a “cure”, my analysis and recommendations are therefore framed by the idea of healing through reconciliation, revitalization and decolonization, as understood to be a “process that involves addressing historic trauma and unravelling the tragic aftereffects of colonization” (Archibald, 2006: iv).

### 3.2. Case Study Selection

A multi-case study approach was used to explore three organizations providing, or that have provided in the past, health supports to survivors of institutional abuse. Case studies were selected to compare and contrast differing approaches to mental health and wellness. The cases selected best reflected the multi-jurisdictional response
required to address Residential School Survivors health needs (Yin, 2009). Through the case studies, I explore different levels of government involvement, the strategy of survivor organizations, and the type of needs addressed by the support program. Table 3.1 explains the case study selection criteria. Case study data was collected through internet research of publically available materials. Due to the complex nature of the problem and the multitude of potential responses, the cases chosen are not equal in their jurisdictions, structures, methods, or purposes. While this is not the traditional approach to case studies, the data revealed through these three cases provide information that is required for analyzing multi-level jurisdictional responses. The organizations and institutions providing health supports for survivors in the British Columbia are multi-jurisdictional in nature.

The jurisdictional setting, institutional abuse response, intergenerational impacts, health determinants, program diversity and incorporation of traditional practices are the units of analysis for each case study. The case studies selected addressed three areas of potential jurisdictional responsibility for claimants’ well-being, post-IAP. First, the Irish board Caranua was studied to explore a situation where the federal government maintained support for claimants, past the completion of the claims process. While rather removed from Canada, the Irish experience is similar in many ways to the Canadian IRS system, and parties to the Settlement Agreement studied Ireland’s agreement as a model. Secondly, Six Nation Mental Health Services was reviewed to understand the organization and programs provided by a reserve-based organization. Finally, the Aboriginal Healing Foundation used a mixed jurisdictional response, providing funding at a nation level that supported local, community-based initiatives.
Table 3.1. Case Study Selection

<table>
<thead>
<tr>
<th>Selection Criteria</th>
<th>Caranua</th>
<th>Six Nations Mental Health Clinic</th>
<th>Aboriginal Healing Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdiction</td>
<td>Irish survivors who have received compensation from the Irish Redress Board living nationally and internationally</td>
<td>Nation members, particularly Residential School Survivors</td>
<td>Community Organizations across Canada</td>
</tr>
<tr>
<td>Responding To Abuse at Irish Residential Institutions</td>
<td>Canada’s Indian Residential Schools System</td>
<td>Canada’s Indian Residential Schools System</td>
<td></td>
</tr>
<tr>
<td>Approach to Intergenerational Survivors</td>
<td>No support offered</td>
<td>Programs designed to reduce impact</td>
<td>Organizations and projects funded were to address intergeneration healing</td>
</tr>
<tr>
<td>Health Determinants Addressed</td>
<td>Education, Health, and Shelter</td>
<td>Western counseling supported by traditional methods</td>
<td>Any and all</td>
</tr>
</tbody>
</table>

3.3. Interview Methodology

Interviews exploring the issue of health supports and access for IAP claimants were held over the phone and in-person with nine representatives from local stakeholder organizations. These interviews were used to understand how claimants access health supports, how the programs are implemented, and to learn what organizational planning is in place to address the upcoming conclusion of the IAP. The interviews examined the different healing paths of survivors, what services are needed, the gaps and limitations of current health supports, and what further supports could be applicable. Further, interviews were used to gain understanding of the internal processes of support organizations. Interviews were conducted with mental wellness advisors, Resolution Health Support Workers, Cultural Support Workers, and a First Nations counselor. These interviewees were selected to provide a diverse reflection on the issue from experts who have experience rooted in providing health supports for claimants. Support for these interviews was received from both the Indian Residential School Survivor Society and the First Nations Health Authority. Individuals from both organizations were interviewed because of their direct experience with claimants. While some interviewees are survivors of the IRS system, they were asked only to reflect up on their experience...
as health support providers. I chose not to seek out survivors as interview participants because I felt uncomfortable not being able to provide access to health supports, should the interview cause any emotional stress. Further, I feel that some survivors may face an over-saturation of research, and wanted to avoid this if at all possible. The experts I spoke with have significant experience working with IRS survivors, and are well-placed to provide in depth insight on the need for wellness supports. For professionals working in the Residential Schools healing field, I felt that my interview schedule did not ask questions that were outside the realm of what they may encounter during their day to day practice. However, I did briefly confirm with participants that they had avenues for mental support, should any aspect of the interview be emotionally distressing. I identified the participants from my professional networks. Interviewees were asked to confirm whether their names, titles, and organization could be included, or kept confidential. Six interviews took place in person, and three took place over the phone.

All interviews were recorded and transcribed, then coded for thematic analysis (Braun and Clarke, 2006). As Guest, MacQueen, and Namey (2012) posit, thematic analysis focuses on “identifying and describing both implicit and explicit ideas within the data, that is, themes”. In particular, I used exploratory analysis, which involves several careful readings of the data, identifying key ideas, trends, themes or key words that form an outline for thematic analysis (Guest, MacQueen, and Namey, 2012). Accordingly, I reviewed the interview transcripts several times, noting the reoccurring ideas between them. I then categorized the themes into program gaps, potential future initiatives, and strategies for implementation, with the results informing the development of my policy options.

The participatory research aspect of this report was approached through a constructivist paradigm in which interview participants were asked to review the interview findings, and offer clarifications around interpretations (Guba & Lincoln, 1994). A constructivist paradigm assumes that the researched and “object of investigation” are interactively linked, creating the research and results together (Guba & Lincoln, 1994). Both the FNHA and the IRSSS were asked for input on the interview invitation and consent forms, as well as the interview questions. Further, interviewees were given
questions in advance of the interviews to allow time to prepare their thoughts and responses.

The list of interviewees who agreed to the release of their names can be found in Appendix C, and a copy of the interview schedule can be found in Appendix A. Participants were asked open-ended questions on their views of appropriate health supports for survivors and their families. A limitation of this approach is that not all themes were addressed in every interview, inhibiting the generalizability of the data.
Chapter 4. Analysis

4.1. Case Study Evaluative Framework

The case study analysis was conducted using a descriptive investigation into the focuses and processes of the selected cases that compared rival approaches (Yin, 2009). My descriptive analysis generally follows Kaarbo and Beasley’s Steps to Comparative Case Study Research (1999). First I identified the research question the descriptive investigation sought to address: how do different jurisdictions respond to the health needs of institutional abuse survivors? Next, variables were identified from my literature review, and are outlined in Table 4.1. In the third step, I selected the case studies based on my framework. Next I used the selected variables to document the data provided by my case studies. Finally, I compared my findings, and described the policy implications identified. The objective of case study research is to identify the underlying factors of the policy problem (Kaarbo and Beasley, 1999). This analysis highlights the common approaches between all three cases studies, matching patterns that informed the thematic interview analysis and identified possible policy responses (Kaarbo and Beasley, 1999).
4.2. Case Study Findings

Table 4.1. Case Study Evaluation

<table>
<thead>
<tr>
<th>Variable</th>
<th>Definition</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdiction</td>
<td>The organizational structure and responsibility of institution</td>
<td>Whether the organization is municipally-based, regionally, or nationally based</td>
</tr>
<tr>
<td>Intergenerational Impact Present</td>
<td>Descendants and family of Survivors are recognized</td>
<td>Provision of support of intergenerational Survivors</td>
</tr>
<tr>
<td>Traditional Practices</td>
<td>Health and wellness practices such as the medicine wheel, prayer, smudging</td>
<td>Services offered include traditional healing approaches</td>
</tr>
<tr>
<td>Not Compensatory</td>
<td>Supports are not received as part of a compensation scheme</td>
<td>The source of funding for health supports is not from a compensatory agreement</td>
</tr>
<tr>
<td>Addresses Health Determinants</td>
<td>Social, educational, activities</td>
<td>Social and educational opportunities are provided.</td>
</tr>
<tr>
<td>Administration</td>
<td>How the program is accessed</td>
<td>The means to apply for funding</td>
</tr>
</tbody>
</table>

4.2.1. Case Study 1 – Caranua, Ireland

Jurisdiction and Administration

Caranua is an independent fund established through legislation in Ireland in 2013, to provide financial support to people who were abused as children in Irish residential institutions. To be eligible for funding, applicants must have received a settlement, or compensatory awards from the courts or Irish Residential Institution Redress Board which was set up in response to the institutional abuse crisis. It is an Irish-based body that supports survivors living in Ireland, the UK, and overseas.

Caranua’s mandate is to advocate for institutional abuse survivors, and assist them in accessing health, education, housing, and other support services. The organization has €110 million (approximately $170 million Canadian) to provide funding to survivors for education, health, and housing improvement services. Survivors must apply to Caranua for funding before securing the services, and only services that have been approved in advance will be funded. Further, assistance can only be given for services that are not covered by public service providers. Services covered range from
counseling services, educational courses, to home and living adjustments for older survivors.

Caranua opened in January 2014, and by the end of the year €80 million had been paid out to survivors. Applicants self-identify, though an estimated 15,000 people are thought to be eligible to apply for funding from Caranua (Caranua 2014 Annual Report). The majority of survivors are over the age of 60. Survivors apply to Caranua individually. It offers no grants to communities of survivors, though it does work with some survivor organizations to improve their services.

**Intergenerational Survivors**

With a strictly limited fund, Caranua provides no assistance to family members of survivors, going against the recommendations of the 2009 Ryan Report. A prior Education fund did provide assistance to intergenerational survivors, but this was not continued in Caranua. Eligibility criteria were reviewed in 2015, but no policy changes were announced.

**Traditional Practices and Social Determinants of Health**

The Irish Residential Institutional system was not intended as a tool of colonization to break an indigenous Irish culture, and so reconnecting with cultural traditions is not fundamental to wellness as it is in response to the Residential School system. However, reconnecting with family and creating social bonds as a means of healing is addressed by Caranua. The services funded by Caranua extend beyond basic health requirements. Not only are hearing aids, glasses, home modifications, and counselling services funded, but applicants can receive support for social events and to access organizations that research family history, reconnecting survivors with their roots.

**Non Compensatory**

Survivors who apply to Caranua have already received compensation from the Irish Redress Board or through a court settlement. This makes Caranua a distinct program recognizing that the health and wellness needs of survivors extends beyond monetary compensation for harms done.
**Program Impacts**

An in-depth evaluation of Caranua and the impact that it has had on survivors’ lives has not yet been undertaken. On the basis that the majority of the fund has been used since its 2014 opening, it would appear that survivors are accessing the supports and services available to them. However, a review of survivors’ organizations websites reveals that not all survivors feel supported by Caranua. This sentiment is enforced by a news report that survivors feel that the program is not working (The Journal, 2014).

### 4.2.2. Case Study 2 – Six Nations Mental Health Clinic, Ontario

**Jurisdiction and Administration**

The Six Nations Mental Health Clinic offers services to band members living on and off-reserve in the Six Nations community in Ontario. Six Nations Reserve has the largest on-reserve population in Canada. The centre has been providing health services to the Six Nations Reserve since 1997. Management of health services is controlled by the Six Nations Band Council, though this arrangement has not been formalized through a transfer from Health Canada (Weiman, 2009). While the clinic was not set up solely to address the impacts of the Residential School, the community impacts of the IRS system are understood, and therapists are equipped to help survivors with their associated trauma. The clinic mainly serves Six Nations band members exclusively, though some members of nearby communities have been treated as well (Weiman, 2009). Traditional healing supports are not provided directly through the clinic. However, through a collaborative process, the clinic ensures that traditional healing supports are available to clients of the clinic.

**Intergenerational Survivors**

Throughout its practice, the intergenerational harm of residential schools, the Sixties Scoop, and other colonization policies are present in the clinic policies. It treats clients of all ages, many of whom are likely Survivors or intergenerational Survivors of Residential Schools. Directly and indirectly, the clinic is working to heal the harms of Residential Schools. Further, the Six Nations Clinic meets the challenge of
intergenerational trauma in a distinct way. Recognizing that the trauma of Residential Schools has resulted in a divide between Indigenous patients and settler health care providers, the clinic has provided work placements for local youth interested in mental health care provision. This initiative, in addition to connections with university mental health departments, seeks to increase the number of Indigenous mental health practitioners from the Six Nations Reserve.

**Traditional Practices and Social Health Determinants**

Traditional healing services are not offered within the clinic itself. However, its practitioners work with their clients to support an approach to healing that uses both traditional methods and westernized practices of psychology and counseling. Practitioners understand that most of their clients are also being treated by traditional healers, and have received training to better understand traditional healing practices. The clinic also does outreach to promote health and social services within the community, and maintains a database of health information for community members to access.

**Not Compensatory**

The Six Nations Mental Health Clinic pre-dates the Settlement Agreement by ten years. Funded by transfers from the Government of Canada, it is not operating as part of a compensatory process.

**Program Impacts**

Within one year of the Six Nations Health Clinic opening its doors, the rate of hospitalizations due to mental illness dropped dramatically on the reserve. Prior to the clinic opening, patients experiencing mental health crisis would be brought to hospitals in nearby cities. Upon their release, there would be no mental health support on reserve to help these patients, resulting in frequent re-hospitalizations. In the year preceding the opening of the clinic, 17 community members accounted for 54 separate hospital admissions; in its first year of operation, the clinic saw these numbers reduced to 3 individuals requiring 5 separate hospitalizations (Weiman, 2009).
4.2.3. **Case Study 3 – Aboriginal Healing Foundation, Canada**

*Jurisdiction and Administration*

In response to the 1996 Royal Commission on Aboriginal Peoples, the Government of Canada set aside $350 million to fund an organization aimed at providing the financial means to create healing initiatives within and for Indigenous communities. The Aboriginal Healing Foundation (AHF) opened its doors in 1998 with a mandate to fund community-driven healing initiatives’ addressing the health effects of Residential Schools. The foundation guidelines are set out in the funding agreement between the AHF and the Government of Canada. The Foundation was based in Ottawa, and operated as a board that would review and decide which applications to fund. Applications from healing projects in all regions of Canada were accepted. Organizations providing healing services to First Nations, Métis and Inuit people were all covered under the foundation’s scope. To reduce the duplication of services, projects providing services already offered by the federal, provincial or territorial governments were not funded.

*Intergenerational Survivors*

Stopping the transmission of intergenerational trauma within communities was a primary objective of the Foundation. Projects funded by the AHF addressed the issue of intergenerational impacts in a multitude of ways. In addition to healing programs, there were educational initiatives and community-building projects aimed not only at treating acute health concerns, but also building cultural continuity. These projects highlighted the importance of cultural identity and health to the overall wellness of individuals and communities. Throughout the course of operation, the projects funded by the AHF resulted in an increase in community engagement seen through volunteerism, socialization, community event participation, involved youth, and elder support (Indian and Northern Affairs Canada, 2009).

*Traditional Practices and Incorporation of Health Determinants*

The use of traditional practices to help Residential School survivors on their healing path was a fundamental piece of the Aboriginal Healing Foundation. Virtually all projects funded would have involved traditional healing supports in one form or another, frequently integrated with western practices of counseling and therapy. Programs relied
not only upon therapists, but healers with lived experience of Indigenous heritage and cultural knowledge (Indian and Northern Affairs Canada, 2009).

Cultural health was the social determinant of health that was most prominent throughout the Foundation’s operation. Initiatives funded by the AHF established wellness centres, created youth programs, developed health training services, and set up community centres, amongst many other projects. By targeting social relations and cultural development alongside health initiatives like counseling and trauma therapy, the projects supported by the AHF were able to address the multitude of health determinants facing Indigenous Canadians.

**Not Compensatory**

Under the Settlement Agreement, AHF received a funding injection of $200 million. This was not, however, an additional compensatory function of the Agreement, but a funding increase meant to extend the operation of AHF throughout the implementation of the Agreement. Groups funded by AHF did not need to be supporting only survivors who had received compensation, as we see with Caranua.

**Program Impacts**

A 2009 evaluative report commissioned by the Department of Indian and Northern Affairs found that the Aboriginal Healing Foundation had been “very successful at both achieving its objectives and in governance and fiscal management” (4). During the course of its operation, the Foundation engaged tens of thousands of community members in healing initiatives, raised awareness of the history of residential schools, and provided mental health services to thousands of survivors. At the time the report was issued, participation in AHF projects was increasing, an accomplishment managed without an increase in funding (Indian and Northern Affairs Canada, 2009). Reflecting the impact of the IAP and CEP, the need for healing supports was reportedly on the rise at the same time. Further, communities that had benefitted from AFH-funded projects saw marked increases in health determinants over the operation of the foundation. Suicide rates and child apprehension rates declined in some communities, and many saw an increase in community capacity building, documented through increases in volunteerism, trained healers, and interactions between youth and elders.
4.3. Case Study Summary

These case studies reveal the differing approaches that governments, both national and local, have taken to address the health requirements of institutional abuse survivors. Several aspects of these case studies provide insight on the potential pathways of providing health supports to Residential School Survivors, and the impacts that they have on survivors. In all three cases, funding for the organizations came from the federal government. The impacts of childhood institutional abuse were ongoing and recognized in all cases. The direct impacts witnessed in individual survivors were observed to negatively impact the well-being of communities in at least two of the cases.

The first factor in common, to varying degrees, between all of the case studies is the need for a holistic approach to survivors’ well-being. In the most thoroughly documented and evaluated program, the Aboriginal Healing Foundation, the need for health supports that addressed the cultural aspect of survivors’ well-being, as well as the overall health of Indigenous communities, was present in virtually every project funded by the organization. The Six Nations Mental Health Clinic worked to expand its knowledge to work with traditional healers to provide a holistic approach to care for patients, and built up the health of the community by providing care that was more easily accessed than that available in surrounding cities. The funds provided by Caranua support survivors on their healing journey by supporting educational goals and social development.

A second important factor these case studies present is the need for ongoing health supports, separate from compensation agreements. Both the AHF and Caranua are associated with compensatory agreements made with survivors of institutional childhood abuse. However, their existence is acknowledgement of the extent of the harms done through the abuse, and solidification of the notion that compensation for harms done is not, nor should it be, intended to address the continuing healing process. Caranua is more closely linked to the compensatory process of the Irish Redress Board than the AHF is to the Settlement Agreement. This is important to note because Irish survivors who did not receive compensation, and/or were deemed ineligible to apply are not eligible for funding from Caranua. In contrast, both the AHF and the Six Nations
Mental Health Clinic programs allowed for mental health supports for survivors, intergenerational Survivors, and the wider impacted communities.

Another distinguishing factor of the Caranua program when compared to the two Canadian organizations is the lack of Survivors control over the implementation and administration of the fund. To be clear, Survivors and advocacy organizations have been consulted to determine which health supports are most needed, and how Caranua can work best to help survivors. This approach appears top down, however, and is not driven by the healing needs of the communities in which survivors live. The cultural destruction component of the Residential School system drives the need for Indigenous communities to control their own healing processes, as reflected in both the AHF and the Six Nations Mental Health Clinic processes, while perhaps this factor is not as pertinent/vital in the situation in Ireland.

Finally, the programs differed in their approach to intergenerational abuse survivors. Despite an earlier organization providing education funding to direct and intergenerational Survivors, Caranua only offers support to adults who attended the Residential Institutions and have received compensation for their experiences. Caranua has yet to undergo a full evaluation on the impact of its services, but the other two cases, in particular the Aboriginal Healing Foundation, achieved success through healing programs that addressed the health of direct and intergenerational Survivors, as well as the community at large.

In summary, these case studies demonstrate organizational factors that are important to addressing the health needs of childhood institutional abuse survivors – community-driven programs that deal with the cultural and intergenerational aspects of wellness.
Chapter 5. Interview Analysis

To highlight the gaps in services, and provide visions of what care could be, nine semi-structured interviews were conducted. The interview participants included two Resolution Health Support Workers, one social worker, two mental wellness specialists from the First Nations Health Authority, the Executive Director of the Indian Residential School Survivor Society, an anonymous former civil servant, the City of Vancouver’s Aboriginal Policy Analyst, and the Executive Director of Tsow-Ten Le Lum, on Vancouver Island. Interviewees spoke as representatives of their organizations, and as experts with many years of personal experience working with Survivors. Two participants self-identified as Residential School Survivors. Both of these interview participants spoke primarily in their professional capacity, though one did include examples from her personal experience to illustrate her thoughts on services gaps and health supports. Before speaking with these participants, I confirmed they would have access to emotional support if anything we spoke about triggered difficult emotions.

Interview participants identified many different pathways to wellness for Residential School Survivors, both direct and intergenerational, and their communities. They also highlighted the problems with the health supports provided through the Settlement Agreement, and what sorts of health care initiatives are necessary to truly address the legacy of Indian Residential Schools and other colonial policies. The following section explores a thematic analysis of my interview findings, using an exploratory method that does not analyse findings with pre-existing themes, but studies the themes that emerge through reviewing the interviewer-participant dialogue (Guest, MacQueen, and Namey, 2012). The analysis identifies: (1) the gaps in existing services; (2) the impacts of the Indian Residential School Settlement Agreement; and (3) the policy recommendations of my interview participants.
5.1. Existing Service Gaps

Generally, most interview participants felt that when claimants were able to access the Resolution Health Support Program, the services provided were effective. The main problems arose when claimants were unable to access supports, or when the framing of the RHSP imposed limitations on claimants’ healing.

5.1.1. Accessibility

Privacy Concerns

As we have seen, the Settlement Agreement stipulates that health supports, such as Health Support Workers (RHSWs) and/or cultural support workers, are to be available to claimants before, during, and after their IAP hearing. However, most interview participants noted concerns for the privacy of claimants created a barrier to claimants accessing health supports prior to their hearings. To maintain confidentiality, claimants’ personal information was not given to health support providers before the hearings. Claimants had to initiate contact if they wanted to speak to health supports prior to their hearing, meaning claimants frequently arrived at their hearings having never spoken to their health support workers before. This reduced the effectiveness of the health supports by limiting the time support workers had to build trust with the claimants, as evidenced by one participant’s experience:

“That was very difficult, especially when you’re trying to gain trust from somebody that’s been extremely traumatized and had never spoken about their story or what had happened to them. They probably haven’t even thought about it consciously before that day. And you’re having some stranger come in and say ‘trust me, I’m here to help you’” (White, January 21, 2016).

The lack of pre-hearing health supports likely meant additional emotional stress on the claimant in anticipation of their hearing, and limited their ability to create comprehensive future care plans with an RHSW.

Limited Services

In addition to issues of privacy, claimants are also restricted in the amount of services they could access, whether that is due to geography, the capacity of care
providers, a dearth in services, or mobility challenges. Some participants indicated that claimants were unaware of the availability of services, owing in part to a lack of resources for those living in poverty (Knighton, January 15, 2016). Further, the organizations providing supports in BC’s Lower Mainland are limited in their capacity to provide support for all claimants. Jodie Millward of the First Nations Health Authority has witnessed that some communities in her region frequently feel that they do not have access to all the available services, stating “we don’t have any organizations in our communities doing that work directly [; the health supports] are too far removed” (January 12, 2016).

Though organizations such as the IRSSS at times certainly went beyond the confines of the Settlement Agreement mandate to ensure as much as possible that Survivors were given the supports when they were needed, some interview respondents still reported being restricted by boundaries set by funding agencies (White, 2016). At least one organization has been using dwindling funding creatively in order to continue providing much needed services to a traumatized population that had been slated for closure. Nola Jeffries of Tsow-Tun Le Lum spoke of the previous Executive Director re-profiling a drug and alcohol program into a trauma program when funding for the latter was reduced, saving trauma care services, but creating a longer wait list for the drug and alcohol programs (January 26, 2016). For some Survivors, health supports are needed simply to prepare them to access addiction or trauma programs. As one participant recounts:

“The first [barrier] is knowing where to go. The second one is once they figure out where they’re going to go, there are waiting lists that are attached to getting into see a therapist... or going to detox, or getting into treatment. I mean... when you’re talking to someone who wants help, and they want to quit drinking, they can’t go into treatment until they are six months clean. So there’s a timeframe that they have to be clean without alcohol. And they’re saying "well, I’m asking for help now, and I need it today, not down the road. So, how am I…?" ... And for First Nations communities, because of the historical things that we’ve gone through, and powers of authority, once you hit a brick wall and "no", you don’t necessarily try to find an alternative way of doing things. Because you’ve been conditioned, through history, through religion, through government“ (White, January 21, 2016).
Consequently, the funding or administrative limits set by programs can mirror historical colonial relationships, limiting Survivors’ ability to fully access all the supports fully available to them. Speaking of the future care plans, Michael Simpson points out:

“You’re asking someone who has basically had the door closed to them for most of their life to now suddenly say, in this world of rosy-coloured glasses, ‘what would you like to see for care?’...It wasn’t a fair question to ask of them. It takes a lot of thought, and many people...didn’t really understand what that meant” (December 21, 2015).

The full potential of the RHSP and future care planning was likely not reached in part due to the power structures involved in accessibility of care. Any future health supports, along with other types of policies, directed towards Residential Schools Survivors must incorporate the knowledge of history into implementation plans.

**Away From Home Populations**

My interview participants had mixed thoughts on the limits of people living away from their traditional homes accessing culturally-relevant health supports. Several participants recalled Survivors welcoming ceremony rooted in other Indigenous traditions. As the Executive Director of Tsow-Tun Le Lum states:

“People are open, if we don’t have the exact ceremony that they were looking for, they’re open to experiencing ceremony, whatever it is, because even though there are differences, they also know there are similarities. And really, what it is is the connection to creator, and the connection to ancestors through each individual” (Jeffries, January 26, 2016).

However, there was a general acknowledgement that Survivors living away from home could struggle to find services in their own language, or rooted in their cultural ceremony. As two interviewees explained:

“It’s really tough because when they’re living off reserve, and they’re living so far away from their home, they feel disconnected already. So to find service that they can access, or feel safe using, it is really tough. And then a lot of the services that we have here are specifically Coast Salish, so they’re not even really getting the same kind of ceremony or same kind of teachings that they feel connected to back home” (Millward, January 12, 2016).

“There are a lot of different cultural groups living in Vancouver. So different cultural healing practices, like going up to certain sacred places is not always...
possible in Vancouver. Going to do sweat lodges is not always available in Vancouver. And if it is it may not always be accessible. Those different preferences for the cultural means of healing is a barrier” (Knighton, January 15, 2016).

While there is flexibility within ceremony to welcome away from home Survivors, this population are more likely to feel disconnected and isolated. With increasing migration to urban centres, the need for culturally-appropriate supports is likely to grow, and is an important consideration in any policy planning for Indigenous communities. Jodie Millward also spoke of the importance of Indigenous communities working together to share healing resources and strategy, opening up space for those outside of local culture to be included in ceremony:

“We’re trying to...have these conversations and share knowledge... by doing that we’re allowing communities to partner with each other, outside of traditional political boundaries...we’re also allowing people who are outside community to come into community and take part in some of the things happening there” (January 12, 2016).

5.1.2. Limits of Program

Future Care Plans

Several participants spoke highly of the flexibility of future care plans to provide whatever type of health supports requested by the claimant – Elder supports, cultural supports, traditional medicine, or therapies rooted in Western medical traditions. However, interviewees also mentioned the prescriptive, inadequate amount granted for future care plans. As Dr. Hansen summarized “it can be a long-term process for [Survivors] to fully work through their healing, their trauma, the violence, [to] understand their family of origin… it’s not a short-term counselling endeavour” (January 21, 2016).

As mentioned early, due to privacy issues, RHSWs were not always able to meet claimants earlier to assist in creating a future care plan. Meaning claimants, as one participants recalls, “often didn’t know they needed a future care plan until the day of their hearing, [a] very difficult [time to] put thought into something” (Simpson, December 21, 2015). Further, several participants felt that, as one participant noted, “they never really got at what was needed” (Simpson, December 21, 2016). This was in part due to
the lack of understanding of the need to prepare a plan to have at a hearing: as one participant who has been through the IAP herself indicated, she would not have had a future care plan prepared for her hearing, had she not been working with a support services organization and had good legal counsel. Another participant stated that adjudicators mainly wanted to see if the plan “fit within their guidelines [and] what that looks like in terms of a budget” (Knighton, January 15, 2016). Another troubling limit to the future care plans mentioned was that some RHSWs would be discouraged from participating in creating a future care plan, because it was seen as legal advice. Viewing the future care plan support as legal advice, and framing it purely monetary terms is inextricably linked to the nature of the policy response, which several interview participants felt inhibited healing amongst claimants.

**Nature of Policy Response**

While praising the work that service providers do, participants also recognized that it is difficult for court-ordered processes to bring effective health and wellness supports to Survivors, calling instead for an “organic sense of care” (Simpson). Ultimately, a court-ordered process is not conducive to reconciliation on a long-term basis. As another participant articulates:

“We have to be very aware that the health supports that were made available, and the way that government has … historically thought of this issue is in a very litigious way. And so it was seen as rolled-up as part of the Indian Residential School Settlement Agreement, and it was seen as something they had to do. Now that that Agreement [is wrapping up], there are not requirements, legally, on the part of the government to support survivors. Because they feel like they have fulfilled their obligation. Those people have gone through the Settlement process, …they’re received their settlement, they’ve received upwards of 15,000 to support health… and that is it, [duty] has been fulfilled” (Anonymous, February 23, 2016).

Importantly, services designed to support claimants only for the duration of the Settlement Agreement, or a relatively short period of time thereafter in the case of future care plans, are not effective in addressing the re-traumatization brought about by the IAP.
5.2. Impact of Independent Assessment Process

Another theme arising throughout my interviews was a concern about the trauma caused by the IAP. Not only did the IAP bring buried trauma to the surface, but it created new trauma within claimants as well. In some cases, claimants were re-traumatized by the IAP hearings because, as an interviewee states, they were not prepared to “engage and speak about what happened to them” (Simpson, December 21, 2015). Of further grave concern is the wellbeing of those Survivors who had either not been admitted to the IAP, or who had not been awarded compensation after going through the hearing process. Michael Simpson recalled:

“Many adjudicators … really struggled with [writing zero awards] because they understood, that no matter what words they wrote in their decisions, people would view their credibility, on the basis of being believed, on how much money they got… it created trauma in people, and that trauma exists today” (December 22, 2015).

These Survivors who have been re-traumatized, through giving testimony or being denied compensation, are bringing their hurt back into their communities. One participant has received calls from community leaders who say “our survivors just went through their hearings, and its effecting the community, we’re seeing a lot more alcoholism, a lot of violence, we’re seeing a lot residual things coming out of that, and we need some support” (Millward, January 12, 2016). Overall, interview participants agreed that the process of individuals and communities healing from the Residential School system is just beginning. The IAP and other aspects of the Settlement Agreement have opened up wounds that will take generations to heal.

5.3. Wellness Supports Recommendations

5.3.1. Programs

Despite the gaps in accessibility, aspects of the Resolution Health Support Program, such as RHSWs and Cultural Support Workers, were supported by interviewees, and elements from these services featured in some of the programs suggested by participants. RHSWs and CSWs are able to respond to the diversity of
Indigenous communities. The continuation of counselling and therapy for survivors was also recommended by most interviewees.

Further, several participants stated that a wellness centre could be an effective response to the health needs of direct and intergenerational survivors living in the Lower Mainland. A centre would offer a site of integration of traditional healing methods with western notions of mental health services. The design of the wellness centre could incorporate traditional healing methods such as the medicine wheel, and could function as a place of support for survivors returning to their communities after spending time in treatment centres. Currently, at the Vancouver wellness centres that are open, or soon to be opened, traditional healing methods are not funded in the existing business model, nor are programs designed to re-connect Indigenous peoples with their traditions (Gosnell-Meyers, February 12, 2016). Participants’ call for the inclusion of traditional practices and cultural revitalization in health supports is discussed in the following section.

One participant also suggested mobile health units that could travel across the province to provide wellness services to remote communities that do not have the population and infrastructure to support permanent health service providers. This interviewee’s vision reflects a more generally expressed sentiment that communities are in need of services tailored to their requirements, and that have the ability to fluctuate with changes in the community.

5.3.2. Implementation Principles

In addition to programmatic recommendations, interview participants made suggestions for what I call “implementation principles” – idea of how policies need to be designed to maximize accessibility, cultural continuity, and effectiveness. Fundamentally, every interview participant spoke to the utmost importance of health supports rooted in tradition. Interviewees believed that the integration of Western healing methods, such counselling and psychology, and Indigenous healing traditions, such as sweat lodge, smudging, medicine wheel, and brushings, was possible; however, most participants privileged cultural traditions in the healing process. The need for cultural
supports is two-fold: first, it is mandatory for health supports to offer traditional healing methods to all those who wish to access them, and second, the resurgence of Indigenous traditions, teachings, and languages is an important piece to cultural revitalization as a path to wellness for Survivors and their communities. Angela White, a Resolution Health Support Worker with the Indian Residential School Survivor Society, asks “How do you cut a fish, how to jar a fish, how do you skin a deer, what do you use all the parts for, for the deer, to make the moccasins to make the regalia, to make the rattles, to make the drums, to make the hides that you need for whatever purposes?” (January 21, 2016). Ensuring these cultural practices continue to be passed down through generations is a central part of wellness in Indigenous communities, and is an important piece of healing for Residential School Survivors. In a similar vein, participants stressed the need for supports that recognize the intergenerational nature of Residential Schools’ legacy.

Any successful health supports will require emotionally healthy service providers that have a broad understanding of the history of residential schools and trauma of colonization in Canada. Interview participants reported instances of Survivors seeking treatment who had to spend time in therapy explaining the history of the IRS policy to their counsellor. Understanding the significance of historical trauma is required to prevent re-traumatization. Angela White recalled a meeting with a survivor that highlights the importance for health support services to be grounded in an understanding of the traumatic history of Residential Schools:

“For example, I had one where [the claimant] looked at me – and thank god I had an elder with me – he looked at me and said he had issues with women. So, right away, I’m triggering him, as soon as I walk in the door and try to say I’m here. And so what I did was just step back, let the elder move forward, who was male, and let him help him” (January 21, 2016).

Further, to be prepared to assist Survivors with their healing, service providers need not only understanding of the historical contexts, but to also have addressed their own emotional histories (Hansen, January 21, 2016).

In addition to educated and healthy service providers, several interview participants articulated the need for patience with program development, that policy
implementation be flexible and to have a long-term approach to evaluation. Communities and organizations need a space to use a trial and error approach, without fear of funding cancellation. Given the length of time Residential Schools were in operation, health supports will need to be evaluated in a manner that provides room for policy experimentation. As Jodie Millward states, “we know this isn’t something that we need to keep going forever, because you’re going to reach a point where we’re healthier again – but long enough to give us a chance to figure out what it does look like” (January 12, 2016). Angela White and an anonymous participant view health supports as investment in Indigenous populations: the most important outcome would be healthier lives, which would increase the economic returns of health investment. Finally, some participants envision that a successful program of health supports for Residential Schools survivors, direct and indirect, could be expanded to address the wellness needs of all Canadians, reflecting true reconciliation.

5.4. Interview Summary

My interview participants indicated several gaps in services in the health supports available to IAP claimants and their families, particularly in terms of program accessibility. Interviewees suggested several policy responses for the health needs of IAP claimants, including wellness centres and continued RHSW support.

Looking forward, the interview data promotes the idea that providing effective health and wellness services now will reduce the need for such services in the future. Put succinctly, wellness services are an investment in the future. This belief underscores the need for impactful support for not only direct survivors, but also for on-going supports to intergenerational survivors. These supports will have to address health needs from holistic, culturally-grounded approaches. There are many approaches that could be used to address the health needs of Residential School Survivors and their families and communities. The policy options put forth in this capstone will be rooted in the implementation principles outlined by interview participants.
Chapter 6.  Policy Options and Analysis

6.1. Policy Options

This chapter outlines the policy options that are analysed using the criteria and measures developed in Chapter 8. Two new policy options, along with the status quo policy plan, are evaluated to assess which response best meets the dynamic needs of survivors. In keeping with the themes revealed in the data analysis sections, all policy options involving new programs would be made accessible to intergenerational survivors. A Caranua-style individual services application forms the first policy option; a Wellness Program consisting of a provincial Wellness Foundation and cultural revitalization funding for IRS Survivors is the second policy option; the third policy option is for funding to remain as it currently is, and for the funding to finish at the end of the IAP.

Other potential policy options that arose out of the interview data that were not evaluated, such as a healing/wellness centre, are discussed in my recommendations chapter.

6.1.1. Policy Option 1 – Individual Application Support Service Funding

This policy option directly addresses the needs of individual survivors, without relying on community support. As revealed in the interview data, while community is incredibly important to Indigenous peoples, many survivors feel shame surrounding their history, and would benefit from individualized services. Policy Option 1 is an individualistic application-based funding process for direct and intergenerational Survivors. Residential School Survivors and their family members would be eligible to apply for one-time wellness related funding grants, where the products and services are
not otherwise provided by government or medical support. Services and products included covered in the fund would include education grants, therapy, cultural supports, medical equipment (such as eye glasses, hearing aids, walkers) and health-related housing renovations (installing ramps or railings). This option addresses the mobility and physical demands of an aging survivor population, in addition to the mental health challenges they face. Applicants could receive multiple grants for different services/products, but would be unable to receive grants for the same service more than once.

This type of individual-application option is not without precedence in Canada. The Settlement Agreement stipulated that if, once all the Common Experience Payments had been made, there was more than $40 million remaining in the CEP fund, all claimants would be entitled to a $3,000 non-cash education credit. Claimants who chose to receive the credit were required to apply individually, and were given the option to transfer the credit to a family member. The deadline to receive the credit was in Spring of 2015, and all applicable education programs had to be completed by the end of August 2015. This policy option would differ in that funding would not be limited to educational programs, and for the foreseeable future there would be no closing date of the fund, recognizing the diverse needs and ages of survivors, particularly intergenerational ones.

6.1.2. Policy Option 2 – BC Aboriginal Wellness Program

This policy option is a two-part program that addresses the importance of community and community-driven healing activities, and the significance of culture and language continuity on the health outcomes of Indigenous peoples and communities. The first part of Policy Option Two would see the creation of a foundation with the goal of funding community-based healing programs and centres. The creation of an organization similar in structure and scope to the Aboriginal Healing Foundation in British Columbia would address the needs of direct and intergenerational Survivors, as well as the healing requirements of their communities. Wellness programs would be community-driven and created by local providers familiar with both the needs and capabilities of the community, creating a bottom-up growth of wellness, rather than prescriptive, formulaic, top-down
programs. Community-driven programming reduces the disparities in services between rural and urban communities. The foundation will be established in joint partnership between the federal government, and the First Nations Authority. The foundation could exist within the FNHA mandate, or function as an independent board, working closely with the health authority to ensure that the services provided would be complementary and not overlap.

As outlined in the background of this capstone, communities and individuals who actively practice their cultural traditions and regularly speak their traditional languages report a higher level of health and wellness than those who do not have strong cultural continuity. The resurgence and growth of Indigenous languages is frequently accompanied by the strengthening of Indigenous cultural traditions. Shared language is a means to anchor one’s identity and preserve a shared culture. Cultural revitalization policy is a potentially potent means to promote the health and well-being of Indigenous peoples in British Columbia, and address the social determinants of health that impact Indigenous peoples. Currently, funding for language and culture revitalization programs in BC is administered through the First Peoples’ Cultural Council. Programs such as Master-Apprentice, Heritage Toolkits, Culture Camps, and the Aboriginal Languages Initiative receive funding on a grant-application basis to promote Indigenous language and culture through immersion programs, recording of languages, sharing art across generations, and developing cultural curators.

The second part of Policy Option Two provides funding in BC for cultural revitalization and language education for direct and inter-generational Residential School survivors, as a part of an integrated health plan. This is a policy with long-term health objectives, which will be evaluated from a health-in-all-sectors approach. Success will be determined by an increase in Indigenous peoples speaking traditional languages and an uptake in ceremony and arts in the medium-short term (five years), and by a reduction in suicide rates over the longer term (10-15 years).

Combining a health initiative with cultural revitalization funding creates a program that will build community capacity and cultural continuity. Over time, communities will
regain strong cultural roots that will enhance their well-being, and strengthen their abilities to counter impacts of on-going colonial policies.

6.1.3. Policy Option 3 – Maintain Status Quo Health Supports

The third policy option is to remain with the status quo approach, and have health support funding expire with the conclusion of the requirements of the Indian Residential School Settlement Agreement. This will address the immediate needs of direct and intergenerational Survivors while the IAP is still open. Once the process is complete, this policy option will see a reduction in services from health support providers that will no longer receive funding, and do not have adequate non-governmental partnerships in place to maintain service levels. In British Columbia, the First Nations Health Authority has received a funding for a decade to provide health services to BC’s Indigenous peoples, as is done by the federal government in other provinces. The FNHA has regional mental wellness advisors that are mandated to work on a community-based level to improve the health and wellness of Indigenous British Columbians that would be able to fill some of the health support services gap, after the completion of the Settlement Agreement.

Further, this policy option provides funding for crisis counselling for Indigenous peoples. First Nations, Métis, and Inuit people are covered for crisis counselling under First Nations and Inuit Health Canada. This covers up to 15 one-hour counselling sessions for those in crisis, per year, provided they have exhausted all local and existing options (Health Canada, 2015).
Chapter 7. Criteria and Measures

This chapter details the policy objectives of this research, and outlines the criteria used for the policy analysis. The criteria and measures below provide a consistent means to evaluate the strength of the policy options presented in the previous chapter and settle on the recommended policy.

7.1. Objectives

The purpose of this research is to contribute to the work of increasing the well-being of survivors of Residential School abuse, ultimately strengthening Indigenous communities and improving the health outcomes of Indigenous Canadians. There is, of course, no one pathway to wellness for all communities and individuals. Successful health supports will allow for a flexible approach to healing, allowing survivors and communities to address their unique health requirements. The criteria for the policy options are divided into three categories: effectiveness, equity, and stakeholder acceptance.

7.2. Criteria

The ultimate goal of the criteria and measures is to evaluate the effectiveness, equity, and acceptability of health supports available to claimants in the Independent Assessment Process as set out in the Indian Residential School Settlement Agreement, and the human and community-building capacity these health supports engender for Indigenous peoples in Canada. Table 7.1 details the definitions of the criteria and measures for each category. Each criterion is given a score of high, medium, or low. All criteria are weighted equally.
The effectiveness criteria measure the positive impacts of the proposed policy options on the health of survivors, as well as the revitalization of cultures and community involvement. There are four criteria under the effectiveness grouping: survivor health improvement; cultural growth; Indigenous control; and accessibility.

The equity criterion evaluates the extent to which equity is maintained between different survivor groups. Under the Indian Residential School Settlement Agreement, students who did not live at the schools, and who did not experience abuse were excluded from compensation. Health supports are available to them only if they are considered intergenerational Survivors. The main focus of this capstone has been the wellness of IAP claimants and their families. However, the process of reconciliation is damaged when there are further divisions created between members of Indigenous communities. Therefore, this criterion measures whether a policy applies to all direct and intergenerational Survivors of Indian Residential Schools, regardless of the status under the Settlement Agreement of the school attended.

The third group of criteria measures the level of stakeholder acceptability of the policy options. Indigenous communities' policy acceptance is indicated by the number of methods Indigenous communities will have to utilize the supports provided by the policy. Given that the current federal government promised to implement all 94 Calls to Action, federal government acceptability is assessed by the number of Truth and Reconciliation Calls to Action addressed by the policy; the more Calls to Action addressed, the more acceptable the policy. Government acceptability is also assessed by the program implementation and operating costs. Administrative complexity is considered under this criteria group, and is measured by the number of governments, health bodies, and advocacy organizations involved in the implementation and administration of the policy.
Table 7.1. Criteria and Measures

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<tr>
<th>Criteria</th>
<th>Definition</th>
<th>Measurement</th>
<th>Score</th>
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<tr>
<td><strong>Effectiveness</strong></td>
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<td>Survivor Health Improvement</td>
<td>Increase in Survivor health determinant performance</td>
<td>Level of reduction Survivors requiring institutionalization (hospital or treatment centers)</td>
<td>High = 3</td>
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<td>Medium = 2</td>
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<td>Low = 1</td>
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<td>Cultural growth</td>
<td>The services provided encourage/foster cultural connections</td>
<td>The number of cultural services/supports available to claimants</td>
<td>High (5+) = 3</td>
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<td>Medium (3-5) = 2</td>
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<td>Low (1-2) = 1</td>
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<tr>
<td>Indigenous Control</td>
<td>The services are defined by the community in which they will be utilized</td>
<td>Level of community participation involved</td>
<td>High = 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medium = 2</td>
</tr>
<tr>
<td></td>
<td></td>
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<td>Low = 1</td>
</tr>
<tr>
<td>Accessibility</td>
<td>The ease of access to supports</td>
<td>Level of accessibility</td>
<td>High = 3</td>
</tr>
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<td></td>
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<td></td>
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<tr>
<td><strong>Equity</strong></td>
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<tr>
<td>Survivor Group Equity</td>
<td>Survivors not covered under the settlement agreement</td>
<td>Survivors not covered under the Settlement Agreement are included in policy</td>
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<td></td>
<td></td>
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<td>No (Low) = 1</td>
</tr>
<tr>
<td><strong>Stakeholder Acceptance</strong></td>
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<tr>
<td>Indigenous Communities and</td>
<td>Degree of acceptability amongst Indigenous Communities and Advocacy</td>
<td>The number of ways to access the policy (individual/community/group applications)</td>
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<td></td>
<td></td>
<td></td>
<td>Low (1) = 1</td>
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<tr>
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<td>Measurement</td>
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<td>-----------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>--------------------------------------------</td>
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<tr>
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<td>Level of cost to implement</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Medium = 2</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Low (high cost) = 1</td>
</tr>
<tr>
<td>Federal Government Acceptability – Administrative Cost</td>
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<td>Level of cost to administer</td>
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<td></td>
<td></td>
<td>Medium = 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Low (high cost) = 1</td>
</tr>
<tr>
<td>Administrative Complexity</td>
<td>Variety of jurisdictional involvement</td>
<td>Number of governments and Indigenous organizations involved*</td>
<td>High (1) = 3</td>
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<td></td>
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<td>Medium (2) = 2</td>
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<td></td>
<td>Low (3+) = 1</td>
</tr>
</tbody>
</table>

* Governments include federal, provincial, municipal, and Indigenous. The First Nations Health Authority would be considered an Indigenous organization.
Chapter 8. Policy Analysis

8.1. Policy Option 1: Individual Application Support Service Funding

Effectiveness

*Improves Survivor Health*

An individualized system of support funding would likely see a minimal reduction of institutionalization rates of survivors because it does not guarantee the provision of community-based supports, as were seen in the success of the Six Nations Mental Health Clinic. Individuals will be assisted through services that do not address the socio-economic roots of the health challenges survivors face, and nor those that continue to be reproduced intergenerationally. The services provided under this option are similar to the current health supports provided under the Settlement Agreement, which have a limited availability. They address crisis situations, but are unable to target the root of health challenges through collective change.

*Promotes Cultural Growth*

By its single-service limited nature, the Individual Application for Support Services option does not strongly promote cultural growth consistently between recipients. Depending on the nature of services available in the applicant’s community, there is no guarantee of a high degree of cultural content to healing services. Some application may provide culturally-specific content, such as education courses directed at Indigenous peoples, and the services of traditional healers. However, other services provided for under this option, such as home renovations and medical products not otherwise covered, offer no content or means for promoting cultural growth. Therefore, promoting cultural growth and continuity is not a primary function of this program’s mandate.
**Indigenous Control**

An individualized program is designed to provide Survivors a private, confidential means of receiving health supports for their Residential School trauma. In some scenarios, survivors could apply for funding to participate in community-driven healing initiatives. Nevertheless, this program overall is not community-driven. As noted in the interview data, many survivors are not prepared to discuss or share the harm they experienced through residential schools in a group/community setting. This policy option ranks “medium” in terms of Indigenous control because individual survivors could apply, but community associations could not.

**Accessibility**

The ease of access for this program was ranked as a level 2 rather than a level 3 because current accessibility issues around direct-application individualized services (such as RHSWs availability prior to first hearings). While this program is a strong option in terms of openness to all survivors, meaning every survivor would be considered eligible for program funding, the program could remain inaccessible to those that are not aware of the program for various reasons. Hard-to-reach populations such as those without permanent addresses, and intergenerational survivors who may not be registered with the government would not be directly informed of the program, thus limiting their accessibility to it. Media and community-based advertising would partially address some of this issue, but not guarantee a complete roll-out.

**Equity**

*Non-Settlement Agreement Survivors covered by policy*

All Survivors would have access to funding under this program. To fulfill the eligibility requirement, applicants need only to list the name of the school(s) they attended, or, for intergenerational survivors, name the familial relationship they have with a former student.
Acceptability

*Indigenous Communities*

The ranking of Indigenous Community Acceptability is based on the number of ways a program can be accessed. This program has only one way of accessibility – individuals applying for funding. Further, the funding comes directly from the federal government, limiting the amount of Indigenous community involvement. Indigenous community planning and re-building are not addressed with this option, and the single-issue funding response does not address the systematic context of continuing Residential School trauma. Individuals will be supported when they have a crisis, or singular health need, but this option does not create the opportunity for communities to collectively address the wellness legacy of Residential Schools.

*Governmental*

Individual Application funding does not directly address any of the 94 Calls to Action of the Truth and Reconciliation Commission. The Calls to Action signify policy changes that would, in the long term, address some of the systemic issues stemming from the Residential School policy. Collectively, they encourage cultural reconnection and regrowth, targeting the roots of many of the socio-economic disadvantages facing Indigenous communities. In providing health supports that are reactionary in that they do not address the root causes of health problems, this policy option does not go far enough to respond to the systemic issues highlighted by the TRC. Therefore, it ranks low under this criterion.

*Governmental Cost – Implementation*

Under the implementation cost criterion, this policy option ranks medium as it would require the creation of a new program. It would be set up under the First Nations Health Authority, and would likely require the creation of a small number of positions to administer.
**Governmental Cost – Operating**

The operating cost of this policy option is high. If each of the 6,678 British Columbian IAP applicants accessed $35,000 in grants (based on an approximation of $20,000 for mental health supports, $10,000 for education funding, $5,000 for housing adjustments and minor medical supports), it would cost $200,340,000. The annual cost would be lower than this amount because funding would not be allocated within one year. However, this calculation does not include intergenerational and direct Survivors who were not applicants under the IAP, which would increase the on-going operating costs. Specific data on the number of direct and intergenerational Survivors living in BC is unknown, and therefore it is not possible to accurately estimate the potential annual funding. For the purpose of my analysis, I assume the costs are high, and therefore this policy option ranks low under government acceptability in terms of operating costs.

**Administrative Complexity**

An Individual Application fund requires a low level of administrative complexity, giving this criterion a high ranking. Financed by block funding from the Federal Government, this program would be administered by the First Nations Health Authority.

8.2. **Policy Option 2: BC Aboriginal Wellness Program**

**Effectiveness**

*Improves Survivor Health*

This policy option supports the type of community-based healing and wellness organizations that have demonstrated survivor health improvements, as seen in the Six Nations clinic outcomes, and the Aboriginal Healing Foundation evaluation findings. The cultural revitalization funding fosters Indigenous ways of life that are known to improve individual and community well-being. Given the successes of similar programing, and the importance of strong cultural continuity for wellness, this policy option ranks high under the survivor health improvement criterion.
Promotes Cultural Growth

The Wellness Foundation would provide funding for community organizations to promote the use of cultural and traditional ways of healing. With the scope of this program, virtually any cultural and/or traditional activity could be used to aid survivors in their healing. The 2009 independent review of the Aboriginal Healing Foundation revealed that participation in cultural and ceremonial activities increased in communities which had received funding. Vitally, this type of foundation promotes Indigenous diversity by funding community-led programming, and by providing resources for cultural revitalization directly to survivors. Under this criterion, the Wellness Program option receives a high rank for its ability to promote wide, diverse, and culturally specific programs of cultural revitalization.

Indigenous Control

Funding decisions under this policy options would be made by two Indigenous-led boards. Requests for funding would be made directly by Indigenous wellness organizations, individuals, and communities. Organizations that have the drive and capability to provide health support to survivors would be leading the change within their communities. This allows for a wide range of responses to the requirements of survivors and their communities. Given that the initiation of wellness and cultural revitalization plans would originate within Indigenous communities, and the decision on funding provisions would be within Indigenous control, this policy option ranks high under this criterion.

Accessibility

Wellness programs funded under this policy would potentially be longer in duration than the government-provided health supports. Further, as discussed above, initiatives resulting from this policy option would be created for and by the communities, fostering greater accessibility amongst harder-to-reach survivor populations. The survivors may be more inclined to trust or reach out to Indigenous organizations for health supports, and interact with community centres/members to actually learn of the local wellness and cultural activities. Indeed, requests from individuals requiring
supports may well drive the community organizations to begin with. In addition to this wide-range in accessibility, programs rooted in community wellness would have positive benefits even for community members who may not be survivors themselves.

**Equity**

*Fairness to all survivors*

This criterion ranks high. All Survivors would have access to funding under this program. To fulfill the eligibility requirement, applicants need only to list the name of the school(s) they attended, or, for intergenerational survivors, name the familial relationship they have with a former student.

**Acceptability**

*Indigenous Communities*

This policy option provides three pathways for survivors and their communities to utilize the health supports available. Advocacy and wellness organizations, as well as Indigenous nations or band councils, decide the structure the wellness programs, which are then accessible to individuals who need them. Therefore, this policy option ranks high in terms of Indigenous community acceptability.

**Governmental**

This policy option directly addresses four Calls to Action from the Truth and Reconciliation Commission in area of health and cultural revitalization policy:

- **14 iii.** The federal government has a responsibility to provide sufficient funds for Aboriginal Language revitalization and preservation

- **14 iv.** The preservation, revitalization, and strengthening of Aboriginal languages and cultures are best managed by Aboriginal people and communities

- **14 v.** Funding for Aboriginal language initiatives must reflect the diversity of Aboriginal languages
20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Metis, Inuit, and off-reserve Aboriginal peoples.

21. We call upon the federal government to provide sustainable funding for existing and new Aboriginal healing centres to address the physical, mental, emotional, and spiritual harms caused by residential schools...

21. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients.

Further, with the integration of traditional cultural health supports, some aspects of Calls to Action relating to culture, ceremony, and traditions (such as Calls to Action 35 and 36, as well as 48ii) are also supported by this policy option. Therefore, this option ranks high for federal government’s promise to implement the Calls to Action.

**Governmental Cost – Implementation**

Under the cost criterion, this policy option ranks low. The cost to implement would be high, as it would require the creation of one new organization that is considered to be administratively complex. In 1998, $350 million was used to create the Aboriginal Healing Foundation. This equates to approximately $489 million in 2016 dollars, to fund healing initiatives across the entire country. At the time of its inception, there were 12 provinces and territories in Canada, and if we assume that each region had equal access to the funding, BC could receive approximately $41 million. Moreover, BC had a high proportion of the programs that the AHF funded. Therefore, $50 million would be a more accurate, comparable value for the BC Wellness Foundation. There would be no cost to implementing the cultural revitalization funding, as the First Peoples’ Cultural Council is already set up to administer this type of funding.

**Governmental Cost – Operating**

The on-going administrative cost of the Wellness Program would be relatively low. After the initial start-up costs, the funding for the Wellness Foundation will be invested. This allows for the Foundation to be relatively immune from future budget...
fluctuations. An annual increase of $5 million to Heritage Canada’s budget for cultural revitalization funding is minimal in the overall federal budget.

Since 1990, the First Peoples’ Cultural Council has dispersed $20 million in funding for Indigenous language and cultural revitalization initiatives. In 2014-2015, the FPCC received $760,000 from federal ministries, and it spent $3.1 million on grants (2015). To offer a robust program of language and cultural revitalization to residential school survivors, the annual funding provided to the cultural wellness aspect of this policy option should be $1 million. This would provide for $500,000 annually to both language and cultural programs. Each mentor-apprentice language program funded by the FPCC costs $14,600, and under the revitalization funding, approximately 68 grants could be offered per year. Not all grants would be for mentor-apprentice programs, but it provides an estimate of how many grants overall could be offered per year, as the other language, culture, and arts grants range in cost from $5,000 to $30,000.

While additional annual funding of $1 million is almost double the current federal contribution, if each IAP applicant from British Columbia were to partake in a mentor-apprentice program, it would cost $97.5 million. Overall, this policy option ranks medium in terms of government administrative costs.

**Administrative Complexity**

To meet the standards set by the Aboriginal Healing Foundation, reporting mandates for funded projects would be rigorous, as would the reporting demands for the Foundation itself. As well, while a model framework exists, the AHF, the initial implementation work would require hiring the board, and setting down the official mandate and organizational structure. Once implementation of this policy has been completed, administration and evaluation would be the responsibility of the board, reporting to the federal government. An increase in cultural revitalization funding will be administered by a pre-existing organization (FPCC), reducing the administrative complexity of this option. This policy option ranks medium in terms of administrative complexity, due to its multiple-jurisdiction government and evaluation requirements.
8.3. Policy Option 3: Maintain Status Quo Health Supports

This policy is evaluated on a long-term basis, as the current plans for the health supports mandated by the IRSSA is to terminate them upon completion of the Agreement duties.

Effectiveness

Improves Survivor Health

The health supports currently available to survivors under the Settlement Agreement have been effective when survivors have been able to access them. However, these services are currently being wound down, and will not be federally-funded after the obligations under the Settlement Agreement have been fulfilled. Given the evidence that the IAP has both brought trauma to the surface and caused re-traumatization in some survivors, the status quo could only lead to a decrease in health outcomes for survivors. As such, this criterion ranks low in terms of effectiveness.

Promotes Cultural Growth

Cultural support services have formed an important part of the current health supports, though the intention of the status quo policy is not to explicitly to promote cultural growth. By not providing cultural supports in the future, this policy does not promote culture revitalization and growth, giving this criterion a low ranking.

Indigenous Control

There are many Indigenous organizations involved in the implementation of this policy option, and the terms of the Settlement Agreement were negotiated with Aboriginal organizations and advocates. Organizations currently providing supports are making partnership plans to continue to provide healing and wellness services after the close of the Settlement Agreement. However, the current plan to end funding at the close of the Settlement Agreement ranks this criterion low.
Accessibility

Accessibility of services has been a challenge for many survivors over the course of the Settlement Agreement, and the closure of health supports would reduce accessibility almost completely. This criterion is low for the status quo.

Equity

Fairness to all survivors

The closure of services would reduce inequality between those survivors covered under the Settlement Agreement, and those who are not. However, a reduction in services for all survivors is not a positive outcome. This criterion ranks low.

Acceptability

Indigenous Communities

This policy option would leave no pathways to accessing healing services provided by the federal government. Given the need witnessed in Indigenous communities across the country for health supports and wellness services, this policy ranks low in terms of Indigenous stakeholder acceptability.

Governmental

None of the TRC’s Calls to Action are supported by the closure of health support services at the end of the Settlement Agreement. The acceptability of this policy option to the current government is low, as it does not further the program of reconciliation. The implementation cost to government would be nil, ranking this option high in terms of cost criterion.

Governmental Cost – Implementation

As this is an on-going program, there are not costs to implementation. This option ranks high in terms of Government acceptability towards implementation.
Governmental Cost – Operating

According to the 2012-2013 Health Canada Treasury Board submission for the Resolution Health Support Program, the estimated total cost for the program is $357.2 million from start to end date. Given that the annual amount is decreasing as IAP hearings wind down and the duties of the Settlement Agreement wrap up, the operating costs of this policy option are not high. The federal government has included the RHSP in its 2016 budget. Therefore, this policy option ranks high in terms of Government acceptability to operating costs.

Administrative Complexity

Closing the Resolution Health Support Program would certainly result in reduced administrative complexity, as there would be no program to administer. As well, for the time-being, until the program funding finishes, there are administrative structures are in place, requiring no implementation work. Therefore, this option ranks high under this criterion.
Chapter 9. Policy Recommendation

9.1. Issues for Consideration and Limitations

Comprehensive, effective health policy requires actors and strategies promoting wellness in virtually all sectors of society/policy making. This is especially true when addressing the health inequities of Indigenous peoples, who have been so consistently marginalized in Canada. It would be impossible for this capstone to address all of the possible avenues of wellness and healing for IAP claimants, their families, and wider communities. The following section summarizes issues for consideration and further research that are not addressed in the policy recommendation below, as well as strategies that would make the recommendation more impactful.

*TRC’s Calls to Action*

If fully implemented, the Calls to Action provide a holistic framework for change in Indigenous communities, and a regeneration of settler society’s relationship with Aboriginal Canadians in virtually all aspects of Canadian society. The recommendation(s) made in this capstone are a small part of a much larger, nation-wide project of reconciliation that will take years to full bring to fruition. On-going research and analysis would add valuable understanding to the impacts of colonialism and then reconciliation on the Canadians health and wellness, both Indigenous and non-Indigenous.

*Legal recognition of language rights*

With its Calls to Action 13 and 14, the Truth and Reconciliation recommended that the federal government recognize that Indigenous traditional rights include language rights, and enact an Aboriginal Languages Act to protect and promote Indigenous languages. Enshrining the value and importance of Indigenous languages in legislation
would further secure funding for language revitalization, regardless of future changes of government.

**Wellness Centres**

Several interview participants expressed a desire for the creation of wellness centres to provide wellness services to IAP claimants, following the closure of the IRSSA. I did not evaluate wellness centres as an option because there are already two to three similar health centres in operation, or being considered in Vancouver (Interview 8). Further, funding from policy option two could be used to create wellness centres, as was seen under the AHF.

**Limitations**

My study has some limitations based on the scope of the problem, and the restricted means of this capstone to address the many factors influencing the health outcomes of Residential School abuse survivors. This small-scale qualitative study has collected a diverse range of voices to produce potential policy options. However, no one policy will be able to address every aspect of the complex work of providing adequate, effective, and culturally-appropriate health supports to direct and intergenerational Residential Schools Survivors.

Further, in a decentralized nation such as Canada, making policy recommendations for communities as diverse as Indigenous populations is challenging due to issues of jurisdictional responsibility. To reduce the jurisdictional complexity, I chose to look at policy options addressing survivors in British Columbia only. Additionally, BC has one of the densest concentrations of cultural diversity in North America, making a one-size-fits-all policy response impossible. Finally, detailed health statistics on IRS survivors are not readily available, leading to a reliance on studies using data that is out of date and which may not capture the nuances of survivors’ experiences.
9.2. Policy Recommendation

Table 9.1. Policy Evaluation – Summary Table

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<thead>
<tr>
<th>Criteria</th>
<th>Individual Program</th>
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<th>Status Quo</th>
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The above policy analysis indicates that a Wellness Program ranks the highest. Based on the above analysis, the Status Quo response does not adequately serve the well-being of survivors in the long-term, and cannot be recommended as an effective means of providing health supports to survivors. An Individual Application program addresses survivors need for privacy in their receipt of health services; however, it does not impact overarching social determinants of health.

Therefore, I recommend the creation of a BC Wellness program, including a healing foundation modeled after the Aboriginal Healing Foundation, as well annual funding to the First Peoples Cultural Council to increase programing directly targeting Residential School direct and intergenerational Survivors.
The on-going impacts of Residential Schools on current and future generations of Indigenous Canadians are many, and the immediate need of survivors for culturally relevant and appropriate healing approaches is vast. A Wellness Fund provides a consistent, Indigenous-governed, means of enabling community-driven organizations to respond to the healing needs seen within their communities. A consistent theme that arose from my expert interviews was that a one-size-fits-all approach to health supports would not work for the multitude of Indigenous cultures that exist in BC. What is needed in one community is not necessarily what is required in another. Further, interview participants indicated that Survivors consistently want access to culturally-rooted wellness services.

The Wellness Fund allows a diversity of responses between communities, and a means to compare and evaluate the success of each program. High levels of community and survivor engagement was recorded under the Aboriginal Healing Foundation. A similar program in BC would have a positive impact on the wellness of survivors and Indigenous communities. Indigenous-led programs provide survivors with effective, culturally relevant services.

In addition to the Wellness Fund, cultural revitalization funding for Survivors would address the need to improve Indigenous performance in measures of social determinants of health. Cultural revitalization programs provide education and community building that is rooted in traditional activities. The programs supported by the First Peoples Cultural Council promote the expanding use of Indigenous languages and traditions, and provide spaces for learners to be completely immersed in their cultures. Creating and increasing cultural continuity strengthens communities, and has been demonstrated to be beneficial to individuals’ wellbeing.

This policy option forms a framework of care that invests in the wellness of Indigenous peoples in the present and the future. Easing the burden of trauma and harms done by residential schools, while providing opportunities for cultural reconnection will lead to an increase in the overall well-being of Indigenous communities. This in turn reduces the pressure on medical systems providing treatment, and leads to greater economic productivity overall. A wellness program that aims to foster direct and
intergenerational survivors’ connection to cultural heritage will strengthen Indigenous communities. There are still many challenges facing Indigenous communities beyond the need for wellness, such as rights and title debates, political autonomy, self-determination, and infrastructure crises. However, communities, that are made stronger through cultural connection will be better enabled to fight for the broader needs of Indigenous Canadians.

This policy option is deliberately flexible in its implementation to allow for nationwide programmatic expansion. It creates infrastructure that enables grassroots organization to design programming that directly addresses the multi-faceted impacts of Residential Schools on local communities. Further, holistic healing services that are well developed and effective could be further extended to address the well-being of non-Indigenous Canadians.
Chapter 10. Conclusion

In 2015, the Truth and Reconciliation Commission of Canada released two final reports detailing the troubling history of the Indian Residential School system. Beginning in the mid-19th Century until the last school closed in Saskatchewan in 1996, Indigenous children were removed from their families and communities, and forced to attend institutional schools that were often neglectful, and forbid them from speaking their languages of birth and from practicing their culture. Students were frequently subject to horrific abuse at the hands of staff and educators, leading to a life-long impacts on Survivors’ well-being, and the health of their extended communities. Residential Schools in no small way contributed to the health inequities seen in Indigenous communities to this day. In order for Indigenous people and communities to re-gain wellness that was stolen by colonial policies, such as the IRS system, and for Canada to genuinely attain reconciliation, the work of increasing survivors’ well-being must be addressed.

My study initially focused the Lower Mainland/Metro Vancouver region, before expanding to provide recommendations for the whole of British Columbia. For reasons outside the scope of this capstone, BC has set precedence previously in Indigenous policy – notably the creation of the First Nations Health Authority and the First Peoples Cultural Council. Providing policy options to the whole province, rather than only for the Lower Mainland as had been my initial intention, allows for more robust implementation using pre-existing infrastructure.

This study has explored the complex and multifaceted ways Residential Schools continue to impact the wellness of direct and intergenerational Survivors, as well as the effects of the IAP on the well-being of claimants. Interview analysis identified gaps in services, and produced suggestions for wellness programs to address health needs in culturally-relevant ways. The case study analysis detailed the ways in which different
jurisdictions have responded to the health needs of institutional abuse survivors and their communities. This small-scale qualitative study reveals the importance of providing health supports grounded in traditional Indigenous practices, and provides context to inform policy decisions on Indigenous health matters. To further the ideas brought forth in this study, future researchers could explore the inter-generational duration of trauma, the roots of survivor resilience, and the impact of re-connecting with culture on survivors.

Through the literature review and data analysis, I created a framework to analyze four policy options aimed at addressing the health supports required by IAP claimants and intergeneration survivors living in British Columbia. Based on this analysis, I recommended the creation of a Wellness Program to provide funding for community driven wellness projects, and annual funding for Residential School survivors to receive cultural revitalization funding through the First Peoples Cultural Council. Both programs could be expanded across the country to include all Survivors, and potentially reach non-Indigenous populations as well, working towards true reconciliation.

The findings of this capstone contribute to the literature on the negative health legacy of the Indian Residential Schools System by bringing together experts’ voices ranging from Indigenous communities, survivor and health organizations, to local policy makers. This research is one of the first studies to examine the trauma brought to the surface by the IAP, and the dearth of adequate long-term services for survivors facing this trauma. As the IAP comes to a close, future research will be needed to document the value of health supports, study survivor resiliency, and produce intersectional analysis of survivors wellness. From analysing the findings, I have created policy solutions that address the gap in services aimed specifically at addressing survivor’s health needs holistically, reflecting the TRC’s calls to improve Indigenous health services. Further, this study outlined several implementation principles that should be included in the implementation of Indigenous health policy. My findings and recommendations will be presented to the interview participants from the Indian Residential School Survivor Society and the First Nations Health Authority, as well as disseminated amongst the other interviewees. As well, this report will be distributed to federal government employees who did not participate in interviews, but expressed an
interest in my findings. Finally, I intend to prepare a report based on this study for journal publication.

There is no one simple solution to ensure that all Survivors of Residential Schools have access to health supports to help them work towards, or maintain, wellness. Many Indigenous organizations and levels of government all share responsibility in providing effective health supports for direct and intergenerational Survivors. There is also no one healing process. Wellness and healing have different meanings from individual to individual, and between communities. Policy must reflect that working towards and maintaining wellness is not synonymous with recovery and cured, and that what works in one situation may not be appropriate in another. As the country moves towards reconciliation, neglecting the wellbeing of Survivors is an unacceptable continuation of policies that ignored the needs of Survivors, and abandoned the duties of care owed. The recommendations outlined in this study would ideally contribute to the on-going healing work of Survivors, and to reconciling Indigenous and non-Indigenous Canadians and their communities.
References


Dayman, I. (2015, 18 November, 2015). Stolen generation members to have access to $11 million fund announced by southern Australia government. ABC News


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Appendix A.

Semi Structure Interview Schedule

1. Introduction, general thoughts, and knowledge on the health supports available to IAP Claimants
   a. What brought you to this field of work? What is your role, and how long have you been doing it?
   b. How does your role relate the health supports available for IAP claimants?
   c. What experience do you have with the health support programs available to IAP claimants (24 Hour crisis line and/or resolution health support workers)?
   d. How effective do you feel the supports are?
   e. What are the most successful aspects of the health supports?
   f. How could they be improved?
   g. What is required in future care plans?

2. Plans for the health of claimants in the future
   a. What plans, if any, does your organization have in place to provide health supports to claimants once the requirements of the Settlement Agreement have been fulfilled?

3. Process for healing claimants whose claims have been closed
   a. What is the procedure for providing assistance to claimants seeking help, if their claims were resolved for a significant period of time?

4. Unique challenges of Aboriginal peoples living in the Lower Mainland
   a. What barriers exist for claimants living in the Lower Mainland when accessing health supports? Have you witnessed cultural challenges?

5. Initiatives for claimant supports
   a. What specific programs would you like to see made available for claimants following the closure of the Independent Assessment Process?
   b. How would claimants access these programs? (ie, through application individually, or on a community basis)
6. **Thoughts on the sustainability of health supports**
   
   a. What suggestions do you have to ensure that health supports are sustainable on an ongoing basis?
   b. How long should health supports be made available?
   c. Who is responsible for providing the health supports?

7. **The Aboriginal Healing Foundation** - As you know the, the AHF provided funding for many community-based health and healing initiatives for claimants, their families, and communities.
   
   a. What were its strengths?
   b. What were its weaknesses?
   c. Are there any other similar initiatives, either available currently or in the past, that provide similar supports?

8. **Integration of traditional healing supports and western approaches to medicine**
   
   a. What are your thoughts on how aboriginal healing traditions and western health initiatives can address the health requirements of IAP claimants?

9. **Other questions or comments**
   
   a. What, in your view, are the issues that this interview has not addressed?
   b. Do you have any other comments?
## Appendix B.

### Compensation Comparison Table

<table>
<thead>
<tr>
<th>Compensatory Agreement</th>
<th>Mental Health Supports Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Brunswick Compensation Program</td>
<td>$5,000 per victim</td>
</tr>
<tr>
<td>Nova Scotia Compensation Program</td>
<td>$10,000 maximum per victim, conditional on severity of abuse</td>
</tr>
<tr>
<td>Ontario Grandview Training Schools for Girls</td>
<td>$10,000 per victim</td>
</tr>
<tr>
<td>Ontario – St. John’s and St. Joseph’s</td>
<td>$1,570,561 for 468 survivors and family members – approximately $3,355 per person</td>
</tr>
<tr>
<td>Ontario – Reconciliation Agreement between the Primary Victims of George Epoch and the Jesuit Fathers of Upper Canada</td>
<td>$500,000 fund for all victims, over a period not exceeding three years</td>
</tr>
<tr>
<td>Ontario – Sir James Whitney School for the Deaf</td>
<td>$10,000 per victim</td>
</tr>
</tbody>
</table>
Appendix C.

Interview Participants

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<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Michael Simpson</td>
<td>Specialist, Mental Health Programs</td>
<td>First Nations Health Authority</td>
</tr>
<tr>
<td>Jodie Millward</td>
<td>Regional Mental Wellness Advisor, Fraser Salish Region</td>
<td>First Nations Health Authority</td>
</tr>
<tr>
<td>Janice Knighton</td>
<td>RHSW Supervisor</td>
<td>Indian Residential School Survivor Society</td>
</tr>
<tr>
<td>Angela White</td>
<td>Workshop Coordinator/RHSW</td>
<td>Indian Residential School Survivor Society</td>
</tr>
<tr>
<td>Heidi Hansen</td>
<td>Registered Social Worker</td>
<td>HLHansen Counselling</td>
</tr>
<tr>
<td>Nola Jeffries</td>
<td>Executive Director</td>
<td>Tsow-Tun Le Lum Society</td>
</tr>
<tr>
<td>Cindy Tom-Lindley</td>
<td>Executive Director</td>
<td>Indian Residential School Survivors Society</td>
</tr>
<tr>
<td>Ginger Gosnell-Myers</td>
<td>Aboriginal City Planner</td>
<td>City of Vancouver</td>
</tr>
<tr>
<td>Anonymous</td>
<td>Previous Public Servant</td>
<td>Government of Canada</td>
</tr>
</tbody>
</table>
Appendix D.

First Nations Health Authority Letter of Support

First Nations Health Authority
Health through wellness

October 19th, 2015

Dear Amy Coutts:

The FNHA has considered your request to support your graduate research, and we would like to express our willingness to make our staff available for interviews. The proposed research would have benefits for our organization, as we recognize the importance of the research question you are investigating. Policy analysis related to serving and supporting Indian Residential Schools (IRS) claimants, particularly once the Independent Assessment Process (IAP) closes, is an important priority for us.

The FNHA will support your project by providing you with introductions to select key informants for interviews. These individuals include staff working directly with the IRS program, as well as the FNHA’s Regional Mental Wellness Advisors.

Our understanding of this project is that the researcher will acquire informed consent from the individuals being interviewed, and ensure that they are fully aware they are speaking within their professional capacity. The interviewees will be given the opportunity to review summaries of their interviews to validate and contribute to interpretation of findings prior to any publication or submission. We also understand that this project will take reasonable measures to protect the anonymity and confidentiality of all FNHA staff involved.

The FNHA, through its Research, Knowledge Exchange, and Evaluation (RKEE) team, would like to be kept informed of the project’s progress, including when interviews have concluded and when the final manuscript is completed. The FNHA is interested in receiving a summary of the project’s major findings. We suggest that a brief written summary be provided to interviewees and RKEE, and, if the researcher is interested, a presentation to FNHA staff and senior executives could be arranged.

We look forward to working with you on your project as it develops.

In health and wellness,

Richard Jock
Chief Operating Officer