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Labrador Innu Comprehensive Healing Strategy

Impact Evaluation

Approved by

Senior Management Board

Finance, Evaluation and Accountability (SMB-FEA)

Health Canada

March 24, 2010

Canada 

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MANAGEMENT ACTION PLAN
LABRADOR INNU COMPREHENSIVE HEALING STRATEGY
IMPACT EVALUATION

Project Number: 1570-7/08041 (INAC)

Region or Sector: FNIH – Atlantic Region – RAPB – Health Canada

| Recommendations | Actions (Indian and Northern Affairs Canada (INAC) Actions shown in italics) | Responsible Manager | Time Frame |
|--|---|--|------------|
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| 1. In order to sustain and move forward on the progress made through this Strategy, additional support to the Labrador Innu communities will be required. | Health Canada (HC) will contribute to Innu community-based healing goals by supporting a range of community health programs in the areas of mental health and maternal child health. <i>(INAC will contribute to Labrador Innu efforts in building healthy, sustainable and resilient communities by stabilizing funding for on-reserve programs and services equivalent to that provided to other First Nations.)</i> | Regional Director (RD), First Nations and Inuit Health (FNIH) Atlantic Region, Regions and Programs Branch (RAPB), Health Canada | April 2010 |
| 2. In order to sustain and move forward on the progress made through this Strategy, additional support for community-based healing programs, services and events in Natuashish and Sheshatshiu will be required. | Health Canada will provide financial and human resources support to community-based healing programs and building initiatives to the Innu of Natuashish and Sheshatshiu. <i>(INAC will provide resources to the Innu in Natuashish and Sheshatshiu for on-reserve programs and services, and the Innu will have access to proposal-based program funding available to all First Nations.)</i> | RD, FNIH, Atlantic Region, RAPB, Health Canada | April 2010 |
| 3. The Innu and the Federal Government need to engage in a facilitated process whereby both can mutually develop the key terms and definitions and then respectively share them in an open and constructive dialogue to reach a mutually agreed upon approach to healing for future activities. <ul style="list-style-type: none"> An Innu worldview/perspective should be incorporated into the Strategy and clearly reflected in key healing definitions and related activities. These should inform and influence the design, delivery and implementation of the new phase of the Strategy. | Existing tripartite mechanisms will be used by Health Canada to develop a shared understanding of key terms and definitions such as ‘healing’, ‘capacity’ and ‘capacity building’ in the context of moving forward. <i>(INAC will continue participating in open and constructive dialogue with the Innu and other federal and provincial partners through the existing tripartite mechanisms to contribute to building healthy, sustainable and resilient communities.)</i> | RD, FNIH, Atlantic Region, RAPB, Health Canada | March 2011 |
| 4. Implement a healing needs assessment in the two communities to better understand ongoing and unmet needs. This should include an evaluation matrix and a Performance Measurement Strategy. The findings generated from the needs assessment and associated documents should be presented to the Main Table. | Health Canada in partnership with the Mushuau and Sheshatshiu Innu and other stakeholders, will support a healing needs assessment that will inform the next phase of healing. <i>(INAC will continue participating in open and constructive dialogue with the Innu and other federal and provincial partners to support community-wide Innu goals to build resilient and sustainable communities by participating in the Main Table.)</i> | RD, FNIH, Atlantic Region, RAPB, Health Canada | March 2011 |

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| 5. Based upon the evidence presented and input provided by the Innu, a determination should be made by all partners as to how existing programs and services might be appropriately adjusted, including exploring possible alternatives to existing funding authority arrangements, but remaining consistent with departmental commitments to support Labrador Innu healing. The findings and resulting determinations should be used to guide the new phase of the Strategy. | Health Canada will work with the Innu of Natuashish and Sheshatshiu to determine how healing programs might be adjusted to better align with Innu healing priorities. HC will also work with the Innu to determine how the delivery of ongoing community health programs can better align with Innu healing priorities. <i>(INAC and other federal departments have a range of proposal-based programs that could support the Innu priorities. INAC will provide information and assist the Innu to submit proposals to access this potential programming.)</i> | RD, FNIH, Atlantic region, RAPB, Health Canada | June 2011 |
| 6. The federal government needs to continue to play a substantial role in supporting Innu capacity and self-government. It also needs to provide the resources necessary to implement the training and capacity building activities required, within current authorities and consistent with departmental commitments to support Innu capacity and self-government, and to build the skills and abilities of the Innu, on terms agreed to by the parties in the new phase of the strategy. | Health Canada will continue to support Innu capacity for health program delivery. <i>(Within current authorities and consistent with departmental commitments, INAC will support Innu capacity and self-government by facilitating application to and effective use of INAC proposal-based program funding available to support these goals.)</i> | RD, FNIH, Atlantic region, RAPB, Health Canada | April 2010 |
| 7. The parties need to mutually develop an Agreement regarding how accountability and transparency will be maintained. | Health Canada will work with the Innu of Natuashish and Sheshatshiu through the tripartite mechanism to support enhanced accountability and transparency required to meet the terms and conditions of program and service funding. <i>(INAC will assist the Innu to access the proposal-driven programs which provide support for governance capacity building and could facilitate additional work in developing accountability and transparency practices required to meet the terms and conditions of program and service funding.)</i> | RD, FNIH, Atlantic region, RAPB, Health Canada | March 2011 |
| 8. The Main Table and its subcommittees will continue with more active Innu engagement and develop a means for outreach to the communities at large, to encourage broader participation by community members in healing. | Health Canada's ongoing participation in existing tripartite mechanisms, such as the Main Table, will support Innu capacity to engage broader community membership in building resilient and sustainable communities. <i>(INAC's ongoing participation in the existing tripartite mechanisms, including the work of the Main Table, will support the Innu efforts to engage broader community membership in building resilient and sustainable communities.)</i> | RD, FNIH, Atlantic region, RAPB, Health Canada | March 2011 |
| 9. Health Canada: Government and Innu engage in a process to agree together how best to realign resources currently allocated to the LHS in Goose Bay so that the funds flow directly to the communities and utilize Innu expertise to the extent possible. The overarching rationale is to better serve the communities according to their identified needs. | Health Canada will work in partnership with the Innu on a process to develop a new model of service delivery for capacity building. The Innu have proposed an adjusted capacity development model and renewed tripartite table as the mechanism for intergovernmental collaboration and oversight going forward. Timelines, funding and service functions will be defined through this collaborative process. | RD, FNIH, Atlantic region, RAPB, Health Canada | June 2011 |

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| 10. The parties need to develop a tripartite committee tasked with reviewing and providing feedback to the main partners on any existing and future evaluation and monitoring plans; including developing specific action items and timelines; and with the end objective to have solid evidence to monitor progress, with evaluation and monitoring data owned by the Innu, with continued support from partners. | <p>Health Canada will support the Innu in taking greater ownership of the entire cycle of performance measurement including needs assessments, program management, planning outcomes, and performance monitoring through HC's enhanced health funding.</p> <p><i>(INAC will support the Innu in taking greater ownership of the entire cycle of the performance measurement strategy including needs assessment, management of community programs and monitoring of performance and outcomes, through regularizing funding for on-reserve programs and services and through facilitating access to proposal-based program funding to develop capacity.)</i></p> | RD, FNIH, Atlantic region, RAPB, Health Canada | June 2011 |



Indian and Northern
Affairs Canada

Affaires indiennes
et du Nord Canada

Final Evaluation Report

Impact Evaluation of the Labrador Innu Comprehensive Healing Strategy

(Project Number: 1570-7/08041)

December 7, 2009

Evaluation, Performance Measurement,
and Review Branch
Audit and Evaluation Sector



Canada 

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Acronyms

| | |
|----------------|--|
| ABE | Adult Basic Education |
| AFN | Assembly of First Nations |
| AHF | Aboriginal Healing Foundation |
| CHCH | Community Holistic Circle Healing |
| CHR | Community Health Researcher |
| CMHC | Canada Mortgage and Housing Corporation |
| CWB | Community Well-Being Index |
| CYFS | Child, Youth & Family Services |
| DPR | Departmental Performance Report |
| ECE | Early Childhood Education |
| FASD | Fetal Alcohol Spectrum Disorder |
| FNIHB | First Nations and Inuit Health Branch |
| FRC | Family Resource Centre |
| FTP | Family Treatment Program |
| HC | Health Canada |
| HR | Human Resources |
| HRSDC | Human Resources and Social Development Canada |
| HQ | Headquarters |
| INAC | Indian and Northern Affairs Canada |
| IS | Income Support |
| IT | Information Technology |
| LHS | Labrador Health Secretariat |
| LICHs | Labrador Innu Comprehensive Healing Strategy |
| MIFN | Mushuau Innu First Nation |
| NGG | Next Generation Guardians |
| NL | Newfoundland and Labrador |
| O&M | Operations and Maintenance |
| PAA | Program Activity Architecture |
| PMF | Performance Measurement Framework |
| PSEPC | Public Safety and Emergency Preparedness Canada |
| PSW | Parent Support Worker |
| RCMP | Royal Canadian Mounted Police |
| RDG | Regional Director General |
| RMAF | Results-based Measurement and Accountability Framework |
| SIFN | Sheshatshiu Innu First Nation |
| SOW | Statement of Work |
| TC | Tribal Council |
| TOR | Terms of Reference |

Executive Summary

Background

In November 2000, the leaders of the Sheshatshiu Innu and Mushuau Innu of Labrador asked the federal government and the Province of Newfoundland and Labrador to provide their communities with help to address a crisis of substance abuse and suicide occurring among children and youth. A number of meetings were held between the Labrador Innu leadership and the two levels of government to address the immediate, short, medium and long-term healing needs of the two communities. In response to these meetings, the federal and provincial governments made a series of commitments to the Labrador Innu to help heal their communities, including:

- Assessing the affected children and ensuring access to necessary treatment for gas-sniffing addiction¹.
- Exploring long-term initiatives to support repair of the cultural and social fabric of both Innu communities.
- Registering the Innu of Labrador under the *Indian Act*² and creating reserves for both communities.
- Continuing to implement the Mushuau Innu Relocation Agreement (MIRA), and covering the additional costs associated with housing in the new community of Natuashish.

These commitments, and others, formed the basis of the Labrador Innu Comprehensive Healing Strategy (LICHHS). The commitments outlined above have since been implemented; the most concrete and measurable changes being the registration of both communities under the *Indian Act* and reserve creation, and the relocation of the Mushuau Innu from Davis Inlet to Natuashish in 2002, which allowed for the construction of a proper wharf and airstrip, clean water and indoor plumbing.

The ultimate goal of the Strategy is to restore health and hope to the Innu communities of Natuashish and Sheshatshiu. It is designed to help resolve the serious health, social, safety and economic issues faced by the Labrador Innu, including: high rates of substance abuse, addiction, suicide, teen pregnancy, Fetal Alcohol Spectrum Disorder (FASD), unemployment, and crime, as well as low levels of education, literacy and community-based capacity.

The objectives were to:

- Help ensure that Sheshatshiu and Natuashish are safe and secure;
- Improve the health and social conditions of the two communities;
- Increase the number of children and youth who attend school and graduate;
- Increase the job skills and economic opportunities for Innu First Nation members;

¹ The province placed 19 high risk Sheshatshiu children in care facilities in Goose Bay and 37 Mushuau Innu children in Grace Hospital in St. John's so that they could undergo stabilization, detoxification and assessment.

² <http://laws.justice.gc.ca/PDF/Statute/S/S-20.pdf>

- Increase the ability of Innu to plan, deliver and manage programs and services, in a way that is culturally appropriate; and,
- Improve relations between the Innu of Labrador and the federal and provincial governments.

This evaluation was designed to assess relevance and performance; and more specifically to: (1) assess the effectiveness and impact of the LICHS, and (2) provide guidance and evidence-based recommendations on future directions and next steps. Thus this study sought to measure the degree to which the LICHS has improved the well-being of the Labrador Innu communities of Natuashish and Sheshatshiu; the effectiveness of the programming funded under the LICHS and identification of gaps; and the effectiveness of the integrated management approach used in LICHS to support Aboriginal healing initiatives.

Methodology

Evaluation methodology included:

- Preliminary Consultations (to inform the development of the evaluation methodology);
- Document and File Review (including secondary research sources)
- Literature Review
- Key Informant Interviews
- Community Case Studies (Interviews and Group Interviews)

Information used to inform the evaluation was gathered from multiple lines of evidence:

- Nine Preliminary consultations
- Review of 249 files and documents
- Review of 36 sources of literature
- 27 Key informant interviews
- Two Community case studies with 56 interview participants (32 in Sheshatshiu and 24 in Natuashish)

Findings

Meanings of (community) healing

The findings suggest that healing is a long-term, on-going, holistic and collaborative process. The key concern with respect to the application of healing principles is how the federal partners operationalize the concept of “community healing” and about whether the comprehensive nature and scope of healing is actually reflected in the funded healing initiatives. This implementation approach is often not reflective of Innu concepts of healing. Some key informants suggested that an Innu definition of community healing must guide LICHS efforts.

Relevance

Key informant interviews, case study interviews, and documents reviewed suggest that at a minimum there is a need for continued and long-term, government support for healing. While interviews and reviewed statistics seem to suggest that the Labrador Innu communities have begun the complex process of healing (e.g., improvements in capacity levels and infrastructure), there are still significant gaps between the Innu and their First Nation counterparts, particularly with respect to education and health. While some gaps have narrowed, particular needs with respect to health, education, and infrastructure (and housing in Sheshatshiu) are readily apparent.

Statistics available, as well as interviews and documents reviewed suggest significant support is still required, and there are numerous unmet needs that need to be addressed.

While in line with the Government of Canada, Indian and Northern Affairs Canada (INAC) and Health Canada (HC) priorities, there are concerns that the LICHS is not ‘comprehensive’; that much of its programming is disjointed; that it is limited in its depth and/or breadth; lacks a long-term strategic plan; and that it contains no built-in provisions/flexibility to respond to evolving Innu needs.

Implementation and Delivery

In the last five years, LICHS partners (HC, INAC and Canada Mortgage and Housing Corporation (CMHC) have funded a number of program activities that support the continued healing needs of the Innu, including: infrastructure development (e.g., Safe Houses in both communities); Strategies for Learning (geared toward improving the educational attendance, achievement and ability of Innu children); implementation and/or continued delivery of addictions and mental health programs, maternal and child health programs, as well as healing staff capacity building initiatives delivered by the Labrador Health Secretariat (LHS); and the creation and staffing of an Integrated Management position. These achievements are, however, tempered by a number of existing challenges such as infrastructure limitations (e.g., lack of space, privacy, confidentiality), which affect the ability of front-line staff to deliver effective community-based programming; high rates of staff turnover that negatively impacts on the levels of communication and trust between the Strategy partners, as well as resulting in the constant loss of corporate knowledge; and, limited performance measurements which act as a barrier to effectively assessing the progress toward objectives. A further challenge to the implementation and delivery of LICHS programs and services, discussed by key informants and community interview participants, involves the LHS mandate and the office policies and procedures, as well as the rationale for having the office located in Goose Bay, rather than the communities.

Success

This evaluation revealed evidence of some successes and challenges in the Innu healing process with respect to the four primary Strategy objective areas: health, social programs and education; capacity development; integration, coordination and partnerships; and community infrastructure.

A wide range of successes were noted, including:

- marked reduction in completed suicides;
- increased awareness of healthy behaviours (e.g., exercise);
- increased awareness of the relationship between FASD and alcohol consumption
- availability of culturally appropriate healing programs;
- positive outcomes associated with treatment and health programs (e.g., decrease in alcohol and/or drug use by participants, enhanced self esteem, increase in breastfeeding; increased awareness of Innu cultural practices);
- improvements in educational attendance and achievement by primary school children in Natuashish;
- progress toward the implementation of specific Philpott recommendations;
- devolution of education;
- stronger and more focused leadership with improvements in capacity;
- increased program staff capacity due in part to initiatives and support offered by LHS staff;

- improved relations at the Main Table;
- strong informal healing program partnerships at the community level;
- construction of the Healing Lodge and the Wellness Centre in Natuashish;
- design and construction of the new school in Sheshatshiu; and
- construction and staffing of Safe Houses in both communities.

The Strategy has also experienced a number of challenges, including:

- ongoing concern with substance abuse issues in both communities;
- lack of adequate healing infrastructure in Sheshatshiu;
- limited academic improvements in the upper level grades in Natuashish;
- limited Innu involvement in planning and decision making; and
- inadequacy of resources associated with the LICHS.

Cost-Effectiveness and Alternatives

Attribution of intended outcomes of funds from LICHS is difficult given the limited outcome measures and multiple interventions, both within and exterior to LICHS, intended to improve conditions for the Labrador Innu. Additionally, the absence of a needs assessment makes it difficult to comment on the degree to which LICHS funds were actually spent addressing community needs. Some research does indicate, however, that community interventions such as these are more cost-effective than non-community-based alternatives. Interviewees provided a variety of options for making the LICHS more cost-effective.

Future Considerations

Progress made under the LICHS is considered sustainable beyond 2010 but only with continued support and guidance from the federal government. Although the Labrador Innu communities are still described as being at risk of returning to a state of crisis without continued support for healing and community development, there is a sense that positive momentum has begun to build in the communities.

Recommendations

The evaluation found strong evidence of a need for long-term, government supported Innu healing in order to address unresolved social, health, safety and economic issues and to maintain and build upon healing progress that has already occurred in the two Labrador Innu communities of Natuashish and Sheshatshiu.

1. In order to sustain and move forward on the progress made through this Strategy, additional support to the Labrador Innu communities will be required.
2. In order to sustain and move forward on the progress made through this Strategy, additional support for community-based healing programs, services and events in Natuashish and Sheshatshiu will be required.

Should the Strategy continue, the following recommendations are suggested for improving its effectiveness and impacts:

To incorporate an Innu perspective, a process should be put in place to reach a mutual understanding and agreement on what approach should be developed and what activities should be included as healing initiatives.

3. The Innu and the federal government need to engage in a facilitated process whereby both can mutually develop the key terms and definitions and then respectively share them in an open and constructive dialogue to reach a mutually agreed upon approach to healing for future activities.
 - An Innu worldview/perspective should be incorporated into the Strategy and clearly reflected in key healing definitions and related activities. These should inform and influence the design, delivery and implementation of the new phase of the Strategy.

To ensure that the Strategy continues based truly on Innu healing needs, and is comprehensive and flexible enough to respond to evolving Innu needs.

4. Implement a healing needs assessment in the two communities to better understand ongoing and unmet needs. This should include an evaluation matrix, and a Performance Measurement Strategy. The findings generated from the needs assessment and associated documents should be presented to the Main Table.
5. Based upon the evidence presented and input provided by the Innu, a determination should be made by all partners as to how existing programs and services might be appropriately adjusted, including exploring possible alternatives to existing funding authority arrangements, but remaining consistent with departmental commitments to support Labrador Innu healing. The findings and resulting determinations should be used to guide the new phase of the Strategy.

To ensure that the next phase of the Strategy is community-based and supportive of Innu capacity and self-government.

6. The federal government needs to continue to play a substantial role in supporting Innu capacity and self-government. It also needs to provide the resources necessary to implement the training and capacity building activities required, within current authorities and consistent with departmental commitments to support Innu capacity and self-government, and to build the skills and abilities of the Innu, on terms agreed to by the parties in the new phase of the strategy.
7. The parties need to mutually develop an Agreement regarding how accountability and transparency will be maintained.
8. The Main Table and its subcommittees will continue with more active Innu engagement and develop a means for outreach to the communities at large, to encourage broader participation by community members in healing.
9. Government and Innu engage in a process to agree together how best to realign resources currently allocated to the LHS in Goose Bay so that the funds flow directly to the communities and utilize Innu expertise to the extent possible. The overarching rationale is to better serve the community according to their identified needs.

To provide a solid evidence base for the ongoing healing of the communities and to track changing healing needs and accomplishments.

10. The parties need to develop a tripartite committee tasked with reviewing and providing feedback to the main partners on any existing and future evaluation and monitoring plans; including developing specific action items and timelines; and with the end objective to have solid evidence to monitor progress, with evaluation and monitoring data owned by the Innu, with continued support from partners.

Management Response and Action Plan

Project Title: Impact Evaluation of the Labrador Innu Comprehensive Healing Strategy

Project Number: 1570-7/08041

Region or Sector: Education and Social Development Programs and Partnerships Sector, Atlantic Region

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| | Health Canada will contribute to Innu community-based healing goals by supporting community healing programs in the areas of mental health and maternal child health. | RD, FNIH, Atlantic Region, Health Canada | April 2010 |
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| | Health Canada will provide financial and human resources to support community-based healing programs and capacity building initiatives to the Innu of Natuashish and Sheshatshiu. | RD, FNIH, Atlantic Region, Health Canada | April 2010 |

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|--|---|--|---|
| 7. The parties need to mutually develop an Agreement regarding how accountability and transparency will be maintained. | <p>INAC will assist the Innu to access the proposal-driven programs which provide support for governance capacity building and could facilitate additional work in developing accountability and transparency practices required to meet the terms and conditions of program and service funding.</p> <p>Health Canada will work with the Innu of Natuashish and Sheshatshiu through the tripartite mechanism to support enhanced accountability and transparency required to meet the terms and conditions of program and service funding.</p> | <p>1. Atlantic Region, INAC</p> <p>RD, FNIH, Atlantic region, Health Canada</p> | <p>TBD</p> <p>March 2011</p> |
| 8. The Main Table and its subcommittees will continue with more active Innu engagement and develop a means for outreach to the communities at large, to encourage broader participation by community members in healing. | <p>INAC's ongoing participation in the existing tripartite mechanisms, including the work of the Main Table, will support the Innu efforts to engage broader community membership in building resilient and sustainable communities.</p> <p>Health Canada's ongoing participation in existing tripartite mechanisms, such as the Main Table, will support Innu capacity to engage broader community membership in building resilient and sustainable communities.</p> | <p>1. Regional Director, FNIH Atlantic Region, Health Canada</p> <p>2. Treaties and Aboriginal Government, Social Policy and Programs, Atlantic Region, INAC</p> <p>RD, FNIH, Atlantic region, Health Canada</p> | <p>September 2011</p> <p>March 2011</p> |

| Recommendations | Actions | Responsible Manager | Planned Implementation Date |
|--|---|--|-----------------------------|
| 9. Health Canada: Government and Innu engage in a process to agree together how best to realign resources currently allocated to the LHS in Goose Bay so that the funds flow directly to the communities and utilize Innu expertise to the extent possible. The overarching rationale is to better serve the communities according to their identified needs. | Health Canada will work in partnership with the Innu on a process to develop a new model of service delivery for capacity building. The Innu have proposed an adjusted capacity development model and renewed tripartite table as the mechanism for intergovernmental collaboration and oversight going forward. Timelines, funding and service functions will be defined through this collaborative process. | RD, FNIH, Atlantic region, Health Canada | June 2011 |
| 10. The parties need to develop a tripartite committee tasked with reviewing and providing feedback to the main partners on any existing and future evaluation and monitoring plans; including developing specific action items and timelines; and with the end objective to have solid evidence to monitor progress, with evaluation and monitoring data owned by the Innu, with continued support from partners. | INAC will support the Innu in taking greater ownership of the entire cycle of the performance measurement strategy including needs assessment, management of community programs and monitoring of performance and outcomes, through regularizing funding for on-reserve programs and services and through facilitating access to proposal-based program funding to develop capacity. | 1. Atlantic Region, INAC | September 2010 |
| | Health Canada will support the Innu in taking greater ownership of the entire cycle of performance measurement including needs assessments, program management, planning outcomes, and performance monitoring through Health Canada's enhanced health funding. | RD, FNIH, Atlantic region, Health Canada | June 2011 |

1.0 Introduction and Background to the Evaluation

1.1 Purpose and Structure of the Report

The report contained herein outlines the findings, conclusions and recommendations of the impact evaluation of the Labrador Innu Comprehensive Healing Strategy (LICHS). The period of study for this report is 2004/05 to 2009/10. This report provides a synthesis and analysis of all the data collected from the various lines of evidence described in Section 2.

This report is structured as follows:

- Section 1: Introduction and Background to the Evaluation
- Section 2: Methodology
- Section 3: LICHS Findings
 - Relevance
 - Implementation and Delivery
 - Success
 - Cost Effectiveness
 - Future Considerations
- Section 4: Conclusions and Recommendations
 - Conclusions
 - Recommendations

1.2 Objectives of the Evaluation

The overarching intent of this evaluation was to fulfill a Treasury Board requirement to provide support for accountability to Parliament and Canadians; inform government decisions on resource allocation and reallocation related to LICHS; and inform Indian and Northern Affairs Canada (INAC) and Health Canada (HC) as to whether the LICHS is producing the outcomes it was designed to produce. More specifically, this evaluation was designed to: (1) assess the effectiveness and impact of the LICHS, and (2) provide guidance and evidence-based recommendations on future directions and next steps. Thus this study sought to measure the degree to which the LICHS has improved the well-being of the Labrador Innu communities of Natuashish and Sheshatshiu; the effectiveness of the programming funded under the LICHS and identification of gaps; and the effectiveness of the integrated management approach used in LICHS to support Aboriginal healing initiatives.

The evaluation findings are organized into the following key issues:

- Relevance
- Implementation and delivery
- Success
- Cost effectiveness
- Future Considerations

1.3 Scope

The evaluation focused on the effectiveness of programming funded under the LICHs from 2004/05 to 2009/10. Due to timelines required for reporting back to Treasury Board, data for the fiscal year 2009/10 will be incomplete.

1.4 Context and Background of the LICHs

It is only recently that the Innu parted from their traditional, nomadic way of life, adopting sedentary living and participating in the wage economy. In fact, it has been less than 40 years (1971) since the last group of nomadic Innu was settled in permanent communities and only 42 years since the Mushuau Innu were relocated to Davis Inlet. Many Innu have been living for 30 to 40 years, or more, with the trauma associated with relocation and the process of social and cultural disintegration – the loss of their social, cultural, environmental, and spiritual identity. In addition, many Innu continue to deal with the legacy of generations of substance abuse as well as sexual, physical and emotional abuse.

In the 1990's the media brought the plight of Innu children to national and international attention^{3,4}. In a report produced by Survival International⁵, it was stated that the plight of the Innu was the worst the organisation had seen anywhere, with the highest suicide rate in the world. Additionally, infant and child mortality statistics cited in the report revealed that an Innu child from Sheshatshiu (1983-94 statistics) was three times more likely to die before the age of five than the average Canadian child; and a child from Utshimassits (also known as Davis Inlet, which had no sewage or household running water and only airplane access to the nearest hospital) was seven times more likely to die before the age of five than the average Canadian child (1984-94 statistics). It was also noted in the report that between 1990 and 1998, there had been eight completed suicides; equivalent to a rate of 178 per 100,000, compared to the Canadian rate at the time of 14 per 100,000.

According to Band Council records, at least one-third of adults had attempted suicide. For Mushuau Innu, excessive rates of alcoholism (80-85 percent) were reported to be ravaging community members over the age of 15 years, and 100 percent of Mushuau Innu children over the age of six years were sniffing gas and about 30 percent of those were chronic users.⁶

In November 2000, the leaders of the Sheshatshiu Innu and Mushuau Innu of Labrador asked the federal government and the Province of Newfoundland and Labrador (NL) to provide their communities with help to address a crisis of substance abuse and suicide occurring among children and youth. A number of meetings were held between the Labrador Innu leadership and the two levels of government to address the immediate, short, medium and long-term healing needs of the two communities. In response to these meetings, the federal and provincial governments made a series of commitments to the Labrador Innu to help heal their communities, including:

³ Canadian Broadcasting Corporation. (1992). Valentine's Day tragedy. Aired February 17, 1992.

⁴ Canadian Broadcasting Corporation. (1993). A heart-wrenching cry for help. Aired January 28, 1993.

⁵ Samson, C., Wilson, J. and Mazower, J. (1999). Canada's Tibet: the killing of the Innu. London: Survival International.

⁶ MIFN. (n.d.). The Mushuau Innu Healing Strategy: A Holistic Community Development Plan. (presentation).

- Assessing the affected children and ensuring access to necessary treatment for gas-sniffing addiction⁷.
- Exploring long-term initiatives to support repair of the cultural and social fabric of both Innu communities.
- Registering the Innu of Labrador under the *Indian Act*⁸ and creating reserves for both communities.
- Continuing to implement the Mushuau Innu Relocation Agreement (MIRA), and covering the additional costs associated with housing in the new community of Natuashish.

These commitments, and others, formed the basis of the LICHs. The commitments outlined above have since been implemented; the most concrete and measurable changes being the provision of addictions treatment services to Innu children, the registration of both communities under the *Indian Act* and reserve creation, and the relocation of the Mushuau Innu from Davis Inlet to Natuashish in 2002, which allowed for the construction of a proper wharf and airstrip, clean water and indoor plumbing.

The Healing Strategy, which first received federal approval in June 2001, included representatives from: INAC; HC; Public Safety and Emergency Preparedness Canada (PSEPC); the Royal Canadian Mounted Police (RCMP); and the Province of Newfoundland and Labrador. The current iteration of the strategy includes representation from: INAC; HC; Canada Mortgage and Housing Corporation (CMHC) as funded partners. The Province of Newfoundland and Labrador still has a role to play, especially in the area of service delivery. The Mushuau and Sheshatshiu Innu participate in the management of the Healing Strategy through their involvement in the Main Table.

The ultimate goal of the Strategy is to restore health and hope to the Innu communities of Natuashish and Sheshatshiu. It is designed to help resolve the serious health, social, safety and economic issues faced by the Labrador Innu, including: high rates of substance abuse, addiction, suicide, teen pregnancy, Fetal Alcohol Spectrum Disorder (FASD), unemployment, and crime, as well as low levels of education, literacy and community-based capacity.

The objectives were to:

- Help ensure that Sheshatshiu and Natuashish are safe and secure;
- Improve the health and social conditions of the two communities;
- Increase the number of children and youth who attend school and graduate;
- Increase the job skills and economic opportunities for Innu First Nation members;
- Increase the ability of Innu to plan, deliver and manage programs and services, in a way that is culturally appropriate; and,
- Improve relations between the Innu of Labrador and the federal and provincial governments.

The logic model developed for the 2007 Results-Based Management Accountability Framework (RMAF)⁹ is shown in Figure 1 (Section 2.2). The overarching objectives stated in the logic model

⁷ The province placed 19 high risk Sheshatshiu children in care facilities in Goose Bay and 37 Mushuau Innu children in Grace Hospital in St. John's so that they could undergo stabilization, detoxification and assessment.

⁸ <http://laws.justice.gc.ca/PDF/Statute/S/S-20.pdf>

are more specific to the implementation of the strategy; however the objectives as reflected in the stated outcomes of the logic model. However, the differences and variations are significant enough to shift focus with respect to measurement. Despite the fact that the RMAF and accompanying logic model were designed in 2007, the purpose of these tools is to guide the implementation of the LICHS. Consequently, the objectives stated in the logic model will be the objectives used throughout this evaluation with the caveat that much of the strategy had been designed and at least partially implemented before these objectives were articulated in an RMAF. As a result, some activities and outputs may not directly support the articulated outcomes.

A vision for the strategy further organizes the objectives into the following four activity areas:

- (1) Capacity development, program management, community governance and devolution: build Innu capacity with respect to governance, administration, management and devolution.
- (2) Community infrastructure: improve the physical environment of the Innu communities.
- (3) Health and social programs and education: improve the health, social well-being and education levels of Innu.
- (4) Horizontal integrated management: enhance the efficiency and effectiveness of the delivery of the Strategy through improved coordination of policies, programs and service delivery.

The Healing Strategy was initially funded from 2001/02 to 2003/04, with the federal government providing \$81 million over three years. The first phase focused on five main program components: community health programming (including addressing the gas sniffing crisis and establishing the Labrador Health Secretariat (LHS), a HC office in Goose Bay to support the implementation of the LICHS; Mushuau Innu relocation; registration and reserve creation; programs and services (those available on all reserves across Canada); and community policing. While some progress was achieved during the first three years, an interim evaluation concluded that insufficient effort was made during the first phase to involve the Innu in the planning and development of the Strategy and that more collaboration was required as the Strategy moved forward.

The LICHS was bridged for a one-year period, from 2004 to 2005, and an additional \$20.5 million was provided to ensure the continuation of the programs and services funded under the Strategy (refer to Table 1).

A policy proposal put forward in December 2004 recommended that the LICHS be continued and funding was requested for INAC, HC and PSEPC. While approved, funding in the reduced amount of \$102.5 million was awarded for the period 2005/06 to 2009/10 to INAC and HC only (refer to Table 2 for a breakdown of allotted funds).

⁹ Canada (2007). INAC. Results-Based Management and Accountability Framework – Labrador Innu Comprehensive Healing Strategy.

Table 1: LICHS Program Elements and Budget (2004-2005)

| INAC | Budget | Actual |
|--------------------------------|------------------------|---------------------|
| Education | \$3,354,320.00 | \$8,600,000 |
| Child, Youth & Family Services | \$5,570,801.00 | |
| Income Support | \$703,602.00 | |
| Facilities O&M (Natuashish) | \$4,133,138.00 | \$4,100,000 |
| Reserve Creation | \$192,500.00 | \$192,500 |
| Devolution Tables | \$484,899.00 | \$484,899 |
| New Paths (Outpost) | \$200,000.00 | \$200,000 |
| Strategies for Learning | \$67,000.00 | — |
| Main Table | \$93,740.00 | \$93,740 |
| TOTAL INAC | 14,800,000.00 | \$13,670,139 |
| Health Canada | 2004-2005 | |
| Addictions/Mental Health | \$2,975,035.00 | |
| Public Health | \$1,031,630.00 | |
| Community Health Planning | \$666,790.00 | |
| Labrador Health Secretariat | \$826,545.00 | |
| TOTAL HEALTH CANADA | \$5,500,000.00 | \$4,800,000 |
| RCMP | 2004-2005 | |
| Sheshatshiu Police Detachment | \$200,000.00 | - |
| TOTAL CMHC | \$200,000.00 | = |
| TOTAL SUBMISSION | \$20,500,000.00 | |

Expenditure data shows that the majority of INAC funding received and spent under the strategy was for A-Base services¹⁰. Only about twenty percent of the funds allocated were for enhanced healing programs and services. It is also important to note that actual expenditures for A-Base programs and services were far more than estimated figures, nearly doubling budgeted amounts by the end of the fourth year. Additionally, the proportion of funding directed to healing-specific initiatives relative to A-Base programs and services has decreased steadily over time. By year four, INAC funds dedicated to healing fell to around 10% of its actual expenditures. Funds for the LICHS, while targeted, were delivered through existing authorities making it difficult to track LICHS-specific expenditures and to respond to the changing needs of the Innu (given the limitations of both policy and existing terms and conditions).

The key initiatives that fall within the four activity areas listed above include: additional funding for A-Base and A-Base like programs; safe house construction in both communities intended for women and children at risk; design and construction of a new school in Sheshatshiu; a Healing Lodge and Wellness Centre in Natuashish; reserve creation; capacity development; community health; and integrated management (e.g., Main Table, Director of Integrated Management position).

All partners involved in the current phase of the Strategy (INAC, HC, CMHC¹¹, Labrador Innu, Province of NL) are responsible for ensuring that the Healing Strategy enhances individual, family, community and government resources for healing and for ensuring the sustainability of these resources.

¹⁰ Refers to funding normally provided to First Nations for basic programs and services.

¹¹ CMHC was only involved in the building of the safehouses and has no identified ongoing role in the strategy.

Although the evaluation is only intended to focus on the last five years of LICHS, it is important to consider the historic and current context in order to adequately understand and assess the issues and the outcomes of the Strategy. It is also important to note that the issues that the LICHS has been tasked to address are long-standing, complex and devastating to the Innu who had little, if any knowledge, of such problems (e.g., addiction, abuse, suicide) prior to settling in communities^{12,13}.

Table 2: LICHS Program Elements and Budget (2005/06-2009/10)

| INAC | FTEs | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | Totals |
|--|-------------|------------------------|------------------------|------------------------|------------------------|-------------------------|-------------------------|
| Sheshatshiu School Design | | \$100,000.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$100,000.00 |
| Education | | \$2,262,600.00 | \$2,340,000.00 | \$3,075,000.00 | \$3,485,000.00 | \$3,635,000.00 | \$14,797,600.00 |
| Child, Youth & Family Services | | \$5,570,800.00 | \$5,571,000.00 | \$5,571,000.00 | \$5,571,000.00 | \$5,571,000.00 | \$27,854,800.00 |
| Income Support | | \$438,100.00 | \$1,308,000.00 | \$1,358,000.00 | \$1,508,000.00 | \$1,508,000.00 | \$6,120,100.00 |
| Electrification - Natuashish | | \$2,000,000.00 | \$1,000,000.00 | \$1,000,000.00 | \$1,000,000.00 | \$1,000,000.00 | \$6,000,000.00 |
| Airport Agreement - Natuashish | | \$100,000.00 | \$100,000.00 | \$100,000.00 | \$100,000.00 | \$100,000.00 | \$500,000.00 |
| A-BASE/A-BASE LIKE | | \$10,471,500.00 | \$10,319,000.00 | \$11,104,000.00 | \$11,664,000.00 | \$11,814,000.00 | \$55,372,500.00 |
| Facilities O&M Capacity Building | | \$900,000.00 | \$900,000.00 | \$750,000.00 | \$600,000.00 | \$450,000.00 | \$3,600,000.00 |
| Housing Capacity Building | | \$295,000.00 | \$245,000.00 | \$60,000.00 | \$0.00 | \$0.00 | \$600,000.00 |
| LTS Capacity Building | | \$420,000.00 | \$420,000.00 | \$320,000.00 | \$120,000.00 | \$120,000.00 | \$1,400,000.00 |
| Reserve Creation | | \$220,000.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$220,000.00 |
| Devolution Planning and Transition | | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$750,000.00 |
| New Paths (Outpost) | | \$200,000.00 | \$200,000.00 | \$200,000.00 | \$200,000.00 | \$200,000.00 | \$1,000,000.00 |
| Strategies for Learning | | \$555,000.00 | \$400,000.00 | \$400,000.00 | \$400,000.00 | \$400,000.00 | \$2,155,000.00 |
| Planning and Consultation | | \$100,000.00 | \$100,000.00 | \$100,000.00 | \$100,000.00 | \$100,000.00 | \$500,000.00 |
| Safehouses | | \$100,000.00 | \$100,000.00 | \$400,000.00 | \$400,000.00 | \$400,000.00 | \$1,400,000.00 |
| HEALING | | \$2,940,000.00 | \$2,515,000.00 | \$2,380,000.00 | \$1,970,000.00 | \$1,820,000.00 | \$11,625,000.00 |
| Sub-total INAC Grants & Contributions | | \$13,411,500.00 | \$12,834,000.00 | \$13,484,000.00 | \$13,634,000.00 | \$13,634,000.00 | \$66,997,500.00 |
| Salaries | 9.0 | \$540,000.00 | \$540,000.00 | \$540,000.00 | \$540,000.00 | \$540,000.00 | \$2,700,009.00 |
| EBP | | \$108,000.00 | \$108,000.00 | \$108,000.00 | \$108,000.00 | \$108,000.00 | \$540,000.00 |
| Accommodations | | \$70,200.00 | \$70,200.00 | \$70,200.00 | \$70,200.00 | \$70,200.00 | \$351,000.00 |
| Housing Capacity Building | | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$750,000.00 |
| Planning and Consultation (CFN) | | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$150,000.00 | \$750,000.00 |
| Legal Agent for reserve creation | | \$50,000.00 | \$0.00 | \$0.00 | \$0.00 | \$0.00 | \$50,000.00 |
| Departmental Operations | | \$520,300.00 | \$347,800.00 | \$347,800.00 | \$347,800.00 | \$347,800.00 | \$1,911,500.00 |
| Sub-total INAC Integrated Management | 9.0 | \$1,588,500.00 | \$1,366,000.00 | \$1,366,000.00 | \$1,366,000.00 | \$1,366,000.00 | \$7,052,509.00 |
| TOTAL INAC | 9.0 | \$15,000,000.00 | \$14,200,000.00 | \$14,850,000.00 | \$15,000,000.00 | \$15,000,000.00 | \$74,050,009.00 |
| Health Canada | FTEs | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | Totals |
| Addictions/Mental Health | | \$2,411,000.00 | \$2,520,000.00 | \$2,550,000.00 | \$2,550,000.00 | \$2,550,000.00 | \$12,581,000.00 |
| Maternal/ Child Health | | \$705,000.00 | \$630,000.00 | \$655,000.00 | \$655,000.00 | \$655,000.00 | \$3,300,000.00 |
| Community Health Planning | | \$225,000.00 | \$200,000.00 | \$225,000.00 | \$225,000.00 | \$225,000.00 | \$1,100,000.00 |
| Management and Support | | \$175,000.00 | \$125,000.00 | \$95,000.00 | \$95,000.00 | \$95,000.00 | \$585,000.00 |
| Sub-total HC Grants & Contributions | | \$3,516,000.00 | \$3,475,000.00 | \$3,525,000.00 | \$3,525,000.00 | \$3,525,000.00 | \$17,566,000.00 |
| Salaries | 20.0 | \$1,056,700.00 | \$1,056,700.00 | \$1,056,700.00 | \$1,056,700.00 | \$1,056,700.00 | \$5,283,520.00 |
| EBP | | \$211,300.00 | \$211,300.00 | \$211,300.00 | \$211,300.00 | \$211,300.00 | \$1,056,500.00 |
| Other Operating | | \$578,600.00 | \$619,600.00 | \$569,600.00 | \$569,600.00 | \$569,600.00 | \$2,907,000.00 |
| Sub-total HC Integrated Management | 20.0 | \$1,846,600.00 | \$1,887,600.00 | \$1,837,600.00 | \$1,837,600.00 | \$1,837,600.00 | \$9,247,020.00 |
| Accommodation Costs | | \$137,400.00 | \$137,400.00 | \$137,400.00 | \$137,400.00 | \$137,400.00 | \$687,000.00 |
| TOTAL HEALTH CANADA | 20.0 | \$5,500,000.00 | \$5,500,000.00 | \$5,500,000.00 | \$5,500,000.00 | \$5,500,000.00 | \$27,500,020.00 |
| CMHC | FTEs | 2005/06 | 2006/07 | 2007/08 | 2008/09 | 2009/10 | Totals |
| Safe houses | | \$0.00 | \$800,000.00 | \$150,000.00 | \$0.00 | \$0.00 | \$950,000.00 |
| TOTAL CMHC | | \$0.00 | \$800,000.00 | \$150,000.00 | \$0.00 | \$0.00 | \$950,000.00 |
| TOTAL SUBMISSION | | \$20,430,000.00 | \$20,430,000.00 | \$20,430,000.00 | \$20,430,000.00 | \$204,300,000.00 | \$102,149,000.00 |

[Source: INAC. (2009). Annex A: LICHS Program Elements: LICHS Budget Received by Region. INAC Regional Office, Amherst, N.S.]

¹² Bopp, M. and P. Lane Jr. (2000). The Nuxalk Nation Community Healing and Wellness Development Plan: A comprehensive ten year plan for the healing and development of the Nuxalk Nation. Four Worlds International.

¹³ Aboriginal Healing Foundation. (2006). Summary of the Final Report of Aboriginal Healing Foundation. Ottawa: Aboriginal Healing Foundation.

Table 3 shows a breakdown of budgeted and actual expenditures from 2005-06 to 2008-09.

Table 3: Projected and Actual Expenditures

| | 2005-2006 | | 2006-2007 | | 2007-2008 | | 2008-2009 | | 2009-2010 | |
|--|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|---------------------|------------|
| INAC | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual | Budget | Actual |
| Sheshatshiu school design | \$100,000 | \$90,650 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Education | \$2,262,600 | \$2,135,117 | \$2,340,000 | \$3,865,979 | \$3,075,000 | \$6,562,265 | \$3,485,000 | \$6,792,352 | \$3,635,000 | N/A |
| Child, Youth & Family Services | \$5,570,800 | \$5,570,415 | \$5,571,000 | \$6,070,400 | \$5,571,000 | \$9,072,805 | \$5,571,000 | \$8,262,094 | \$5,571,000 | N/A |
| Income Support | \$438,100 | \$218,525 | \$1,308,000 | \$649,525 | \$1,358,000 | \$988,625 | \$1,508,000 | \$395,000 | \$1,508,000 | N/A |
| Electrification - Natuashish | \$2,000,000 | \$2,321,672 | \$1,000,000 | \$2,950,370 | \$1,000,000 | \$3,318,000 | \$1,000,000 | \$4,057,704 | \$1,000,000 | N/A |
| Airport Agreement - Natuashish | \$100,000 | \$149,616 | \$100,000 | \$200,000 | \$100,000 | \$106,000 | \$100,000 | \$143,000 | \$100,000 | N/A |
| A-BASE/A-BASE LIKE | \$10,471,500 | \$10,485,995 | \$10,319,000 | \$13,736,274 | \$11,104,000 | \$20,047,695 | \$11,664,000 | \$19,650,150 | \$11,814,000 | N/A |
| Facilities O&M Capacity Bldg | \$900,000 | \$797,523 | \$900,000 | \$900,000 | \$750,000 | \$750,000 | \$600,000 | \$600,000 | \$450,000 | N/A |
| Housing Capacity Bldg | \$295,000 | \$256,000 | \$245,000 | \$168,000 | \$60,000 | \$60,000 | \$0 | \$0 | \$0 | N/A |
| LTS Capacity Bldg | \$420,000 | \$510,268 | \$420,000 | \$420,000 | \$320,000 | \$0 | \$120,000 | \$693,299 | \$120,000 | N/A |
| Reserve Creation | \$220,000 | \$449,720 | \$0 | \$150,000 | \$0 | \$0 | \$0 | \$0 | \$0 | N/A |
| Devol Planning & Transition | \$150,000 | \$82,800 | \$150,000 | \$150,000 | \$150,000 | \$150,000 | \$150,000 | \$150,000 | \$150,000 | N/A |
| New Paths (Outpost) | \$200,000 | \$600,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | \$200,000 | N/A |
| Strategies for Learning | \$555,000 | \$194,696 | \$400,000 | \$592,800 | \$400,000 | \$400,000 | \$400,000 | \$500,000 | \$400,000 | N/A |
| Planning & Consultation | \$100,000 | \$244,509 | \$100,000 | \$250,000 | \$100,000 | \$100,000 | \$100,000 | \$100,000 | \$100,000 | N/A |
| Safehouses | \$100,000 | \$35,000 | \$100,000 | \$65,000 | \$400,000 | \$400,000 | \$400,000 | \$400,000 | \$400,000 | N/A |
| HEALING | \$2,940,000 | \$3,170,516 | \$2,515,000 | \$2,895,800 | \$2,380,000 | \$2,060,000 | \$1,970,000 | \$2,643,299 | \$1,820,000 | N/A |
| Total INAC Grants & Contributions | \$13,411,500 | \$13,656,511 | \$12,834,000 | \$16,632,074 | \$13,484,000 | \$22,107,695 | \$13,634,000 | \$22,293,449 | \$13,634,000 | N/A |

| | 2005-2006 | | 2006-2007 | | 2007-2008 | | 2008-2009 | | 2009-2010 | |
|---|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|------------|
| Salaries | \$540,000 | \$540,000 | \$540,000 | \$540,000 | \$540,000 | \$540,000 | \$540,000 | \$540,000 | \$540,000 | N/A |
| EBP | \$108,000 | \$108,000 | \$108,000 | \$108,000 | \$108,000 | \$108,000 | \$108,000 | \$108,000 | \$108,000 | N/A |
| Accommodation | \$70,200 | \$70,200 | \$70,200 | \$70,200 | \$70,200 | \$70,200 | \$70,200 | \$70,200 | \$70,200 | N/A |
| Other Operating | \$870,300 | \$870,300 | \$647,800 | \$647,800 | \$647,800 | \$647,800 | \$647,800 | \$647,800 | \$647,800 | N/A |
| Total INAC Salary & Operating¹⁴ | \$1,588,500 | \$1,588,500 | \$1,366,000 | \$1,366,000 | \$1,366,000 | \$1,366,000 | \$1,366,000 | \$1,366,000 | \$1,366,000 | N/A |
| Health Canada (HC)¹⁵ | | | | | | | | | | |
| Addictions / Mental Health | \$2,411,000 | \$2,018,800 | \$2,120,000 | \$3,455,700 | \$2,150,000 | \$1,908,000 | \$2,150,000 | \$2,001,000 | \$2,150,000 | N/A |
| Maternal / Child Health | \$705,000 | \$1,873,000 | \$630,000 | \$380,000 | \$655,000 | \$320,000 | \$655,000 | \$566,300 | \$655,000 | N/A |
| Community Health Planning | \$225,000 | \$201,500 | \$200,000 | \$419,900 | \$225,000 | \$425,000 | \$225,000 | \$208,000 | \$225,000 | N/A |
| Management & Support | \$175,000 | \$97,800 | \$125,000 | \$0 | \$95,000 | \$242,100 | \$95,000 | \$14,000 | \$95,000 | N/A |
| Safehouses | \$0 | \$0 | \$400,000 | \$400,000 | \$400,000 | \$400,000 | \$400,000 | \$400,000 | \$400,000 | N/A |
| Total HC Grants & Contributions | \$3,516,000 | \$4,191,100 | \$3,475,000 | \$4,655,600 | \$3,525,000 | \$3,295,100 | \$3,525,000 | \$3,189,300 | \$3,525,000 | N/A |
| Salaries | \$1,056,700 | \$799,900 | \$1,056,700 | \$945,900 | \$1,056,700 | \$1,261,100 | \$1,056,700 | \$1,170,000 | \$1,056,700 | N/A |
| EBP | \$211,300 | \$160,000 | \$211,300 | \$189,200 | \$211,300 | \$252,200 | \$211,300 | \$234,000 | \$211,300 | N/A |
| Other Operating | \$578,600 | \$457,200 | \$619,600 | \$437,700 | \$569,600 | \$472,500 | \$569,600 | \$506,000 | \$569,600 | N/A |
| Total HC Operating Costs | \$1,846,600 | \$1,417,100 | \$1,887,600 | \$1,572,800 | \$1,837,600 | \$1,985,800 | \$1,837,600 | \$1,910,000 | \$1,837,600 | N/A |
| Accommodation Costs | \$137,400 | \$137,400 | \$137,400 | \$137,400 | \$137,400 | \$137,400 | \$137,400 | \$137,400 | \$137,400 | N/A |
| TOTAL HC | \$5,500,000 | \$5,745,600 | \$5,500,000 | \$6,365,800 | \$5,500,000 | \$5,418,300 | \$5,500,000 | \$5,236,700 | \$5,500,000 | N/A |

¹⁴ Note that the actual costs do not include additional operating costs for INAC not included specifically in LICHs funding.

¹⁵ Health Canada funded two capital construction projects – the Healing Lodge and Wellness Centre – in Natuashish in the 2005-06 and 2006-07 fiscal years. As a result, Health Canada’s actual expenditures were actually higher than the approved budget for these first two fiscal years, and slightly lower in the following years to compensate, as Health Canada was “cash managing” these capital construction projects (borrowing from future fiscal years).

| | 2005-2006 | | 2006-2007 | | 2007-2008 | | 2008-2009 | | 2009-2010 | |
|--|-----------|----|-----------|----|-----------|----|-----------|----|-----------|-----|
| | | | | | | | | | | |
| Canada Mortgage and Housing Corporation (CMHC) | | | | | | | | | | |
| Safe houses | \$ | \$ | \$800,000 | \$ | \$150,000 | \$ | \$ | \$ | \$ | N/A |
| Total CMHC | \$ | \$ | \$800,000 | \$ | \$150,000 | \$ | \$ | \$ | \$ | N/A |

1.5 Program Profile

The LICHS is a long-term strategy designed to improve health and social outcomes in the two Labrador Innu communities of Natuashish (formerly Davis Inlet) and Sheshatshiu. The strategy was developed in the aftermath of a gas-sniffing crisis in the Labrador Innu communities in the Fall of 2000.

The LICHS recognizes that the issues confronting the Innu have taken generations to develop, and solutions must also be long-term in nature. The strategy draws upon expert advice and evidence from the literature regarding communities in crisis, which confirm that sustained, comprehensive approaches are the most effective means of supporting community healing.

It is important to note that A-base funds aside from LICHS funding has been provided to the Innu by INAC and HC for First Nations Band administration and infrastructure, as well as for direct services related to health, education and social programs. This evaluation assessed where possible the community results that can be attributed to the LICHS as opposed to community investments made through A-base funds. First-level services provided to Innu are those health services provided directly to community members (e.g. addiction treatment, mental health). Second level services are those services provided at a zone or regional level, which support the delivery of health services to community members (e.g. coordination, consultation, supervision). In the context of LICHS, the phrase 'second level services' is used to describe the provision of capacity development, mentoring, support and advice by LHS health professionals to community-based health workers in Natuashish and Sheshatshiu.

Objectives

The ultimate goal of the LICHS is to restore the health and hope for the Innu communities of Natuashish and Sheshatshiu in Labrador.

Achievement of the following objectives will support attainment of the ultimate goal:

1. Increased capacity to plan and manage their affairs in a culturally appropriate manner;
2. Safe and secure living environment for residents in these two Innu communities;
3. Improved health and social conditions of communities;
4. Improved educational participation and attainment;
5. Enhanced employability and increased economic opportunities;
6. Stable and harmonious Innu communities capable of sound governance and effective program and services delivery; and
7. Improved relations between the Innu of Labrador and other levels of government.

Elements

INAC has been responsible for the Relocation of the Mushuau Innu to the new community of Natuashish; Registration and Reserve Creation for both Labrador Innu communities; and other Programs and Services. PSEPC/RCMP has been responsible for Community Policing; and Health Canada has been responsible for the Community Health component, including addictions and mental health; maternal and child health; community health planning; as well as the establishment of the LHS office in Labrador.

Program Clients

Members of the Mushuau Innu and Sheshatshiu Innu First Nations residing in the communities of Natuashish and Sheshatshiu, Labrador.

Partnerships, Roles

First Nation Partners

The Mushuau Innu and Sheshatshiu Innu First Nations - responsible for the delivery of community-based programming. Innu Nation - responsible for representing the political interests of the Labrador Innu, including negotiations towards a land claims agreement and self-government.

Federal Partners

INAC, PSEPC, RCMP, CMHC - responsible and accountable for their respective components of the LICHs. Strategic linkages are also fostered with other federal departments which provide funding to the Labrador Innu, such as Human Resources and Skills Development Canada and Canadian Heritage.

Provincial Partners

The Province of Newfoundland and Labrador and the Labrador-Grenfell Regional Integrated Health Authority - responsible for the delivery of health and social services falling under Provincial jurisdiction.

Snapshot of LICHs programs and associated funding agencies and delivery agents

| Program or Activity Name | Funding Agency | Delivery Agent |
|----------------------------------|-----------------------|---|
| Child Youth and Family Services | INAC | NL |
| Community Health Planning | HC | MIFN & SIFN |
| Education | INAC | NL (until August 2009) MIFN & SIFN (post 2009) |
| Income Assistance | INAC | NL |
| Integrated Management | INAC & HC | INAC & HC |
| Facilities O&M (Natuashish) | INAC | MIFN |
| Fetal Alcohol Spectrum Disorder | HC | MIFN & SIFN |
| Family Resource Centre | HC | SIFN |
| Family Treatment Program | HC | SIFN |
| Healing Lodge (Mobile Treatment) | HC | MIFN |
| Labrador Health Secretariat | HC | HC |
| Next Generation Guardians | HC | MIFN |
| Outpost Program (New Paths) | INAC | MIFN & SIFN |
| Parent Support Worker Program | HC | MIFN & SIFN |

| Program or Activity Name | Funding Agency | Delivery Agent |
|---------------------------------|-----------------------|-----------------------|
| Relocation | INAC | INAC & MIFN |
| Reserve Creation | INAC | INAC |
| Safehouse construction | CMHC | MIFN & SIFN |
| Safehouse operations | INAC & HC | MIFN & SIFN |
| Strategies for Learning | INAC | MIFN & SIFN |
| Wellness Centre | HC | MIFN |

Regional Offices and Labrador Health Secretariat

Regional offices of INAC and HC, and LHS play a lead role in supporting the effective delivery of programs and services in the Innu communities. HC's LHS is responsible for providing capacity development through professional support services using a staff of 14 in Goose Bay and is responsible, with the Innu, for integrating the work of the Secretariat with community based delivery to ensure the maximum benefit from the Secretariat. According to this RMAF, the LHS and the INAC regional office are responsible for:

- Managing and monitoring contribution agreements through established procedures that may include regular contact and discussion with recipients by means of on-site visits and reporting;
- The roll-up and analysis of regularly collected program data as laid out in this RMAF's Performance Measurement Strategy;
- Monitoring the performance of the activities and initiatives for which Regional Offices are accountable, and making informed decisions;
- Communicating evaluation results within the federal government and the communities;
- Supporting communities in program planning, capacity development and other aspects of program delivery and administration;
- Providing an advisory role for program policy activities; and
- Working in partnership with Innu to ensure the effective implementation and delivery of programs.

For HC, the regional office is responsible for overall accountability functions (contribution agreements), senior management functions to the regional office, as well as program coordination with core programs (shared region and LHS).

The Integrated Management of the LICHS is the joint responsibility of INAC, HC, the communities of Sheshatshiu and Natuashish, and the Province of NL. HC's responsibilities under LICHS will be implemented by the First Nations and Inuit Health Branch. The Main Table provides a forum that brings together the political leadership of the Innu with senior federal management and the Special Federal Representative (SFR). The SFR chairs the Main Table and is also responsible for presenting the federal position. The specific mandate of the Main Table is to discuss, address, provide direction, and resolve issues related to the implementation of the LICHS and other emerging Innu-related issues (e.g. reserve creation for Sheshatshiu, land claims). The Maintable Issues arising from the Main Table related to resource, management or policy implications for the department(s) or government as a whole are referred to the LHS Steering Committee for discussion, advice and direction.

HC and INAC have jointly funded a Director at the EX level to oversee and coordinate the implementation of the LICHs. The Director reports to both the regional directors of INAC and HC, and will sit on the Operations Steering Committee.

The Operations Steering Committee comprises members of HC, INAC, PSEPC, Service Canada as well as the Chief Federal Negotiator (CFN). The committee meets as necessary to review issues respecting the LICHs. The federal parties also meet regularly with the Innu leadership and the CFN at Main Table to discuss issues of common interest. Main Table sub-committees have been struck in a number of areas to ensure coordination of policy and efforts.

Evaluation Process

As per Treasury Board requirements, an evaluation of the LICHs was to be completed by the Audit and Evaluation Sector in 2009-2010. However, the schedule was advanced in order to provide the report in the Fall of 2009.

An Interdepartmental Evaluation Working Group (EWG) provided input and feedback on the terms of reference, statement of work, and all key deliverables. The group met as required to review and provide input on deliverables. It was led by a senior evaluation manager, INAC, and included representation from INAC, HC and Public Safety Canada. A Strategic Evaluation Committee provided additional input and feedback on the terms of reference, methodology report, and preliminary findings. It was led by the Chief Audit and Evaluation Executive, AES and included representation from INAC, HC, the Province of NL and Innu leadership.

An independent consulting firm, DPRA, was contracted to provide additional human resources to conduct the evaluation, and to provide additional impartiality. The consultant was primarily responsible for drafting the tools used in the evaluation; conducting all lines of evidence including the on-site case studies in Natuashish and Sheshatshiu; drafting the preliminary findings; and drafting the report.

2.0 Methodology

Evaluation methodology included:

- Preliminary Consultations (to inform the development of the evaluation methodology);
- Document and File Review (including secondary research sources)
- Literature Review
- Key Informant Interviews
- Community Case Studies (Interviews and Group Interviews)

While the evaluation plan originally included two expert panels intended to provide an additional independent source of opinion, this item was dropped due to differences in opinion with respect to whether an expert should be defined in terms of community expertise versus academic expertise and the extent to which external experts could or should speak to the unique situation in the Labrador Innu communities. In addition, the Innu expressed concerns over their past experience with external Panels, the method for selection of individuals, and the limited time frame for analysis and response.

Appendix A shows the lines of evidence used to answer each of the evaluation questions.

2.1 Development of the Evaluation Framework and Methods

The issues and overarching evaluation questions are as follows:

- Relevance
 - To what extent is there a continued need to support Labrador Innu communities with healing?
 - To what extent do the objectives of the LICHS relate to the objectives of the Government of Canada and of the departments involved in its delivery?
- Implementation and Delivery
 - Has the Strategy implementation been appropriate?
 - What are the lessons learned from the LICHS, for the future and for other communities?
- Success
 - What progress has been made towards the Strategy's intended outcomes, as laid out in the logic model?
- Cost-Effectiveness
 - To what extent is the LICHS meeting its medium and long-term outcomes in relation to the resources spent?
 - Are there alternative programs/interventions achieving similar or better results at a lower/similar cost?
- Future Considerations
 - To what extent is the progress made under the LICHS sustainable in the context of the Strategy?

2.2 RMAF and Logic Model

The LICHS RMAF articulates the key objectives of the Strategy as:

- To enhance Innu governance to increase community engagement and enhance program administration (all partners) to increase quality of service delivery;
- To establish a physical environment that lays the foundation for Innu healing;
- To contribute to healthier children, families, and communities; and
- To achieve efficient delivery of LICHS through coordination of policy, programs and service delivery.

Note that the objectives in the RMAF are articulated differently than the objectives articulated in the Treasury Board submission (see Program Profile).

The LICHS RMAF and logic model were developed in 2007 and reflect the current phase (2005/06 to 2009/10) of the Strategy (refer to Figure 1). The logic model, which is intended to guide the Healing Strategy, identifies the key activity areas, measurable outputs and intended short-term, medium-term, long-term and ultimate outcomes of the LICHS. This evaluation drew on indicators of intended outputs, short-term and some medium-term outcomes described by the logic model. Although long-term and ultimate outcomes were not expected to have been achieved at the time of this evaluation, some indicators of early progress of these outcomes are also presented.

2.3 Preliminary Consultations

Preliminary consultations began with the identification of key LICHS stakeholders, in consultation with the Evaluation Manager and the Evaluation Working Group. The evaluation team developed an invitation letter and a set of preliminary consultation interview questions and then contacted each identified individual to schedule a date/time for the interview. Some interviews were conducted in-person and others over the phone. These were conducted with nine key (current and former) representatives from the Mushuau Innu First Nations (MIFN), Sheshatshiu Innu First Nations (SIFN), INAC, and HC. See Appendix B for questions asked.

The purpose of the consultations was to:

- Refine evaluation issues and questions
- Identify existing performance indicators
- Identify potential data sources
- Identify potential expert panel and key informant participants

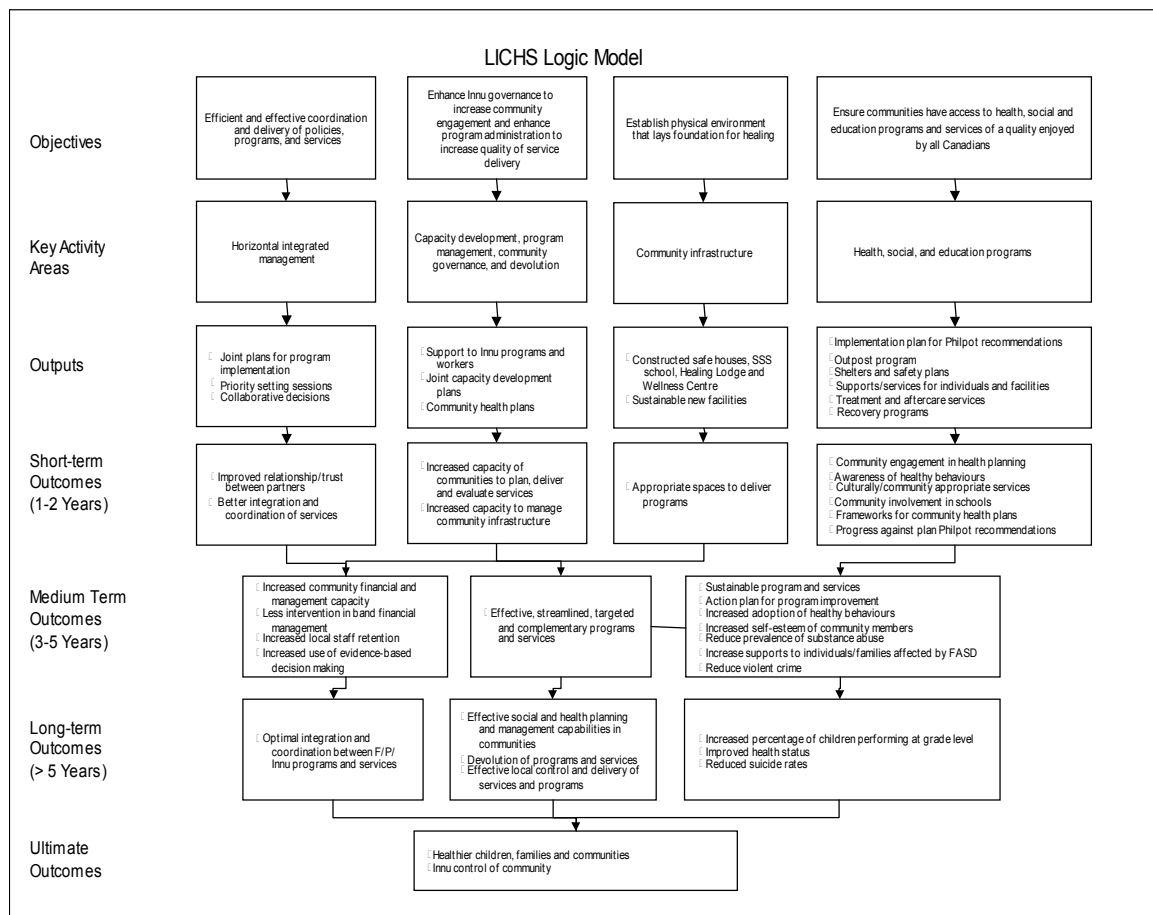
2.4 Document and File Review

The document and file review was intended to provide the evaluation team with material to:

- (1) develop program profiles and background information;
- (2) inform the development of the Detailed Methodology Report (e.g., development/refinement of evaluation questions);
- (3) identify candidates to be queried during key informant interviews;
- (4) contextualize the findings to be included in the Final Evaluation Report; and,
- (5) provide a source of data to answer/partially answer some the evaluation questions.

It also provided information to guide for the other lines of inquiry.

Figure 1: LICHS Logic Model



Documents, files, meeting minutes and email correspondences were obtained from the Evaluation Manager, Evaluation Working Group, Preliminary Consultation participants, Key Informant interview participants, and from the two communities. Hard copies of information were also gathered from the INAC offices in Goose Bay, NL and Amherst, NS. 249 files and documents were reviewed including, INAC policy documents; policy proposals; program research and evaluations; RMAF; education reports, recommendations and implementation plans; the interim LICHS evaluation; secondary sources of data (e.g., Statistics Canada community profiles); and, internal documentation (e.g., memos, Main Table and Sub-committee meeting minutes and emails). Additionally, a variety of reports, presentations, proposals, strategic plans, and correspondence were provided by the Innu communities and an Innu advisor. Appendix C lists the documents and files reviewed for the LICHS evaluation. Documents were utilised in the current report based on their relevance to providing context and background or answering specific evaluation questions; as well as the degree of redundancy between all the documents reviewed.

2.5 Literature Review

Thirty-six pieces of domestic and international literature focusing on topics of Aboriginal community healing and capacity building strategies were examined, including academic publications, national and international journals, documents published by foreign governments, and independent research publications produced for federal government departments.

The literature review was intended to provide the evaluation team with background material to:

- (1) assess the extent of current research and literature on the topic;
- (2) document best practices in Aboriginal community healing, where available;
- (3) note lessons learned from domestic and international experience in Aboriginal community healing; and
- (4) support other lines of inquiry;

The sources of literature were identified by the Evaluation Manager, Evaluation Working Group, Preliminary Consultation participants, and through internet search using the following phrases: Aboriginal community healing and (1) the social determinants of health; (2) comprehensive healing strategies; (3) best practices; and (4) evaluation of community healing initiatives. Additionally, resources were obtained from DPRA's extensive existing bibliography on Aboriginal community healing and comprehensive approaches, which includes grey literature not normally found through internet searches.

The literature was intended to inform the evaluation on the reasons for Aboriginal community trauma; the essential elements of community healing strategies; methods of implementation of healing strategies; successes and challenges observed in the implementation of other strategies.

Appendix D lists the literature review references for the LICHS evaluation.

2.6 Key Informant Interviews

Key informant interviews were conducted from June to August 2009. Preliminary consultations with Evaluation Working Group members and suggestions from the Evaluation Manager and the evaluation team resulted in the identification of key informant participants. The names for additional key informants were put forth by interviewees themselves. Individuals were recommended for inclusion in the key informant interview process based upon their significant involvement in, and knowledge of, the Strategy (particularly Phase II). Some individuals were suggested for inclusion due to their breadth of Healing Strategy knowledge, while others were included because of their depth of knowledge about specific aspects of it (e.g., education). Potential interview participants were contacted and asked to take part. Interviews were conducted by telephone.

A total of 27 individuals participated in the interview process. Key informants included the following current and former LICHS representatives:

- INAC (e.g., Headquarters (HQ), Region) (n=6)
- Health Canada (e.g., HQ, Region) (n=10)
- Public Safety and Emergency Preparedness Canada (PSEPC) (HQ) (n=1)
- Province of NL (e.g., assistant deputy ministers) (n=4)
- Mental Health Commission of Canada (n=1)
- Academic Institutions (Memorial University, Dalhousie University) (n=2)
- Consultant Firm (n=2)

- Lawyer (n=1)

Part of the rationale for this method of selection was the extensive amount of strategy-specific knowledge required to speak to many of the evaluation issues; particularly those of relevance and implementation, but also successes, limitations, cost-effectiveness and future considerations.

2.7 Community Case Studies

Case studies for this evaluation were intended to help assess the impacts of the LICHs on both communities by spending time in the communities and discussing issues, successes, and challenges with people in the communities. Specifically, the intention was to assess the extent to which the programs and services offered under the Strategy are consistent with their objectives and achieving the intended outcomes, and to assess other issues related to the Strategy's overall effectiveness and impacts. The case studies also allowed community members (particularly front-line program staff) the opportunity to express their opinions and experiences in the actual on-the-ground delivery of LICHs programs and services.

The two communities of Natuashish and Sheshatshiu were each visited three times between the months of April and July 2009, with two team members spending a total of 45 person days in the communities. With the assistance of Band managers, a community researcher/translator was hired in Sheshatshiu and a community researcher and a community translator were hired in Natuashish to assist with translation as required; identification and contact of community members to participate in the individual and group interviews; logistics/coordination of group interviews; and with the face-to-face interviews if translation was required.

Specific tools intended for the case studies included: interviews (individual and group), focus group discussions (youth and Elders), youth education survey, and community document/data review. A total of 54 in-person and two telephone interviews were conducted (refer to Table 3).

Table 4: Community Case Study Participants

| Interviewee Category | Natuashish | Sheshatshiu |
|---|------------|-------------|
| Innu Leaders | 1 | 1 |
| Directors/Program Managers/ Program Coordinators | 9 | 10 |
| Program Staff | 4 | 12 |
| Elders | 2 | 3 |
| Community Members | 2 | 1 |
| Others ^(e.g., consultant, crown attorney, non-LICHs program staff) | 6 | 5 |
| Total | 24 | 32 |

The evaluation team developed a series of plain language (i.e. jargon free) interview questionnaires, each specific to: Leaders, Elders, Youth, Program Directors and Managers, Program Staff, and other Community Members.

Case study interviewees were selected for participation based upon their involvement with, and/or knowledge of, the LICHs and/or their knowledge of community health, social, safety and/or economic issues. Other individuals were selected after having approached the evaluation team members to request an interview to express their viewpoints and experiences with respect to healing in their community.

Youth focus group sessions were organized in both communities by the local researchers but there were no attendees. Additionally, initially the evaluators intended to carry out Elder focus groups but once in the communities were told that one-on-one interviews would be more appropriate.

As a component of the community case studies, relevant community-level documents and administrative data were requested. While little documentation was obtained from community members themselves, Innu evaluation working group members shared community-level LICHs program- and service-related reports, presentations, proposals, strategic plans, budgets and correspondence through a consultant, who was included on the working group at their request.

While the case studies were intended to comprise the tools described above, not many of these tools were able to be employed, with the exception of interviews, as described in detail in Section 2.9 on limitations.

2.8 Presentation of Key Informant and Case Study Interview Findings

Where appropriate and possible, findings from other lines of evidence were used to corroborate the opinions, perceptions and experiences of key informant and case study interview participants (i.e., triangulation) in order to strengthen the confidence in the research findings. When referring specifically to key-informant or case study interview observations, viewpoints of respondents will be described as follows:

- High level of agreement – refers to $\geq 2/3$ (66%) of respondents queried
- Several respondents – refers to > 10 respondents
- A number of respondents – refers to > 5 respondents
- A few respondents/Some respondents – refers to ≥ 3 participants

It should be noted that not every question was answered by every community member, as some questions were declined. It should also be noted that due to the fact that approximately half of INAC's Healing Strategy funding is transferred to the Province of NL for their delivery of education, Child Youth and Family Services and Income Assistance to the Innu, the community case study interviews focussed heavily on HC funded community health programs, which the communities are responsible for delivering. This emphasis on health programming was also reinforced by the wording of some interview questions (e.g. the interview guide uses the phrases “community healing” and “community health” interchangeably, contains an emphasis on health indicators and the LHS). As a result of these factors, the key informant and case study findings contain a considerable focus on HC funded health programs.

2.9 Limitations

Attribution

Scientific attribution of healing outcomes to specific program interventions is not possible for a variety of reasons. Healing impacts are complex and interrelated with an array of other individual, family and community factors, and need to be assessed over a longer time frame than that of this evaluation. Additionally, a variety of other programs and services are being delivered in the Innu communities that may contribute towards healing outcomes and thus the incremental impact of any one intervention is difficult if not impossible to fully assess.

While the LICHS includes numerous interventions, its starting points represent a significant change for both communities; specifically, their incorporation into the *Indian Act* and the creation of reserves; and specific to Natuashish, its relocation from Davis Inlet as discussed above. When referring strictly to data on the two communities as well as observed change, it is difficult to attribute this change incrementally to various interventions as they were all applied as part of this strategy and over a short period of time. Thus while commenting on changes stemming from intervention overall may be valid, observing change as a result of any one or combination of given interventions requires significant triangulation and cautious interpretation.

Secondary Data Limitations

Analysis of cost and cost-effectiveness was limited due to a lack of cost-specific data and a lack of any true comparators. Thus discussions on cost-effectiveness are limited to opinion and loosely comparable literature.

Additionally, the lack of performance measurement data made it difficult to determine if progress had been made against some of the intended outcomes identified in the LICHS logic model. As a proxy, data were gathered from the three most recent Canadian censuses (1996, 2001 and 2006), as well as from the Community Well-Being Index (CWB) from the same time period. While these data are rich, there are issues with comparison, as some of the measurements taken via the Canadian census change year by year (see Section 3.2.1), and census and CWB data for Natuashish prior to 2006, and Sheshatshiu for the entire data collection period, may include data not necessarily exclusive to those communities (see Section 3.2.1 for further discussion). Further, CWB statistics for both communities includes data from non-Aboriginals, and the same is true for census data on Sheshatshiu and Davis Inlet.¹⁶

There was also a lack of reliable and consistent data for indicators not explicitly measured by the Canadian census or CWB, including infant mortality, substance abuse, suicide, and teen pregnancy.

Available Documentation and Literature

With respect to reviewed documentation, including literature, much of the materials used for this evaluation were prepared by government departments (in the case of the majority of materials used for the document review); or were grey literature (in the case of the majority of materials used for the literature review) and were thus not necessarily peer reviewed. Additionally, with limited access to all relevant published research on the subject, it is possible that there is relevant literature that was not reviewed for this study.

¹⁶ According to the most recent census, the proportion of non-Aboriginals in both communities is only 6 percent. However, the census area that encompasses Sheshatshiu also includes the community of Mud Lake and without specific knowledge of the size, composition, or changes in Mud Lake, the ability to discern any trends that might fit only SIFN is limited; observed changes in Census and CWB data may be due to changes in Mud Lake and thus it is difficult to establish the dependence of these changes on LICHS, as the data do not allow for disentangling SIFN from Mud Lake. It is unlikely, however, that the non-Innu population in Natuashish would have dramatically changed the overall CWB score for that community.

Primary Data Limitations

With respect to key-informant interviews, as is normally the case with this line of evidence, there exists a risk of bias, given that at least some of those interviewed have a vested interest in the program being renewed and continuing.

It is also important to note that while the intention of the case studies was to provide an array of evidence from various lines of inquiry in the communities, significant issues with scheduling, weather and community interest thwarted many of these. The scheduled focus group sessions with youths had no attendees and youth education surveys were not completed. Posters and web pages advertising the focus groups were distributed for feedback, but none was received, and translation was not completed. Additionally, funding for community coordinators was impeded on INAC's end, and thus with the tight time limitations, the evaluation team went into the communities without having been able to fully prepare with the coordinators.

Additionally, the difficulties coordinating visits at offices for observations meant that the only line of inquiry fully implemented in the case studies was interviews.

3.0 Evaluation Findings

3.1 Meanings of (Community) Healing

In *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*, James Waldram (2008:6)¹⁷ notes that the findings of research on definitions of healing suggest that healing is a concept that is difficult to articulate in part because most people feel there is no need to articulate it and/or have never been asked to. Healing is considered to be an active, not passive, process; it is something that you do, not something that you think or that is done to you. Healing is work and requires dedication from the individual. Healing is often described as a journey (e.g., “Sweetgrass Trail”, “Red Road”) with many challenges. Although the term has different meanings for different individuals, it is commonly accepted that healing is essentially about “reparation of damaged and disordered social relations”. Healing places one’s issues and solutions in the broader context (i.e., considers historical conditions and circumstances). Healing is ultimately about “hope for the individual, the family, the community, and the future”.

Interviewees (both case study and key informant) were asked to articulate their personal and/or departmental understanding of the term ‘community healing’. In keeping with Waldram’s findings, there was no one overarching definition provided to characterize the term. However, there was a high level of agreement among interviewees that (community)¹⁸ healing was a long-term and on-going process that was holistic in nature and could only begin through the efforts of people working together.

Key informant interviewees from all groups also defined community healing as: encompassing the social determinants of health; removing obstacles; moving toward autonomy; acknowledging historical events; and addressing community-level disparity. A few individuals stated that government officials have difficulty with the concept of community healing and that while INAC and HC are the major government players for the Strategy, they take substantially different approaches to implementation. For example, some indicated that INAC took a “bricks and mortar” approach (e.g., infrastructure, regular programming) while HC was taken from a capacity building perspective. Uncertainty was also articulated about whether the comprehensive nature and scope of the term was truly reflected in INAC and HC healing-related activities. A number of key informants acknowledged that an Innu definition of community healing must guide LCHS efforts.

During case study interviews in both communities, individuals also described (community) healing as encompassing such factors as: healthy relationships; the individual, family and community; support from others in the community; access to a broad range of programs and services; capacity building/training; balance between traditional and contemporary ways of life; culturally appropriate and respectful methods; and improvements in community infrastructure.

¹⁷ Waldram, J. (2008). *Aboriginal Healing in Canada: Studies in Therapeutic Meaning and Practice*. Aboriginal Healing Foundation, Ottawa, ON.

¹⁸ Case study interviews (particularly in Natuashish) revealed that the concept of ‘community healing’ was unfamiliar to some and thus definitions refer more to ‘healing’ than ‘community healing’.

In January and February 1999, the MIFN developed their own Healing Strategy based upon the following core principles: meaningful; fair and equitable; based on the determinants of health; accessible; participative; effective; partnership driven; and sustainable¹⁹, and which identified 16 essential elements of healing for the Mushuau Innu:²⁰

| | | |
|------------------------------------|----------------------|------------------|
| Capacity | Education | Justice |
| Labour force development | Innu culture | Family treatment |
| Capacity building | Economic development | Devolution |
| Social (e.g. CYFS, IS, child care) | Youth and recreation | Health |
| Claims and self-government | Policing | Relocation |

These elements of healing are closely aligned with the social determinants of health²¹.

It is also identified as highly compatible with the key factors that enhance success of comprehensive healing approaches:

- 1) A population health/social determinants of health framework;
- 2) A community development framework;
- 3) An intersectoral/partnership approach to planning and implementation;
- 4) Culture-based or culturally competent services;
- 5) Case management and collaboration;
- 6) 'Readiness' of individuals and communities to pursue healing; and
- 7) Building in sustainability of outcomes.

In 2003, the Innu drafted a document titled, *Innu Healing Strategy*²², which was submitted to the federal government for inclusion in an upcoming policy submission. This submission contained the following statements about the meaning of healing:

- "Innu healing is really about the children. No one wants to condemn them to the future that the last generation endured."
- "Innu healing must be based on taking back responsibility - by individuals, families, communities, and the Innu Nation. This can happen by managing basic programs and services and exercising the policy discretion that will allow the design of incentives. These incentives will encourage and reward responsibility in individuals and families."
- "Innu healing plans have been based on the determinants of health. The correlation of certain factors to healthy individuals, families and communities are well documented."
- "Healthy Innu communities need to pay attention and show value to traditional activities – support those who wish to live country-based lifestyles; operate an Outpost to allow those in the community to remain connected to practices; reinvigorate the Annual Gathering as the democratic checkpoint on the community's governance; and support Innu language, culture, and history in the communities and in programs and services."

¹⁹ MIFN. (nd). The Mushuau Innu Healing Strategy: A Holistic Community Development Plan. PPT presentation slides.

²⁰ MIFN. (nd). Mushuau Innu Healing Strategy: Action Plans.

²¹ The determinants of health model considers the following variables to influence overall health and well-being: education and literacy, income and social status, employment, culture, gender, age, biology and genetics, healthy child development, social support networks, social environment, physical environment, personal health practices and coping skills, and health services.

²² MIFN/SIFN (2003). Innu Healing Strategy. Innu Healing Submission, August 2003.

The book, *Gathering Voices: Finding Strength to Help Our Children*²³, which was researched and written by the Innu Nation and the Mushuau Innu Band Council, highlights the findings of the people's inquiry held in the former community of Davis Inlet in order to begin to understand how and why the tragedy in which six children died in a house fire in 1992, had occurred. It is a compilation of words, stories, pictures and photographs gathered from community members, young and old. The report is identified as "a tool to help us solve our problems on our road to recovery". The primary way in which the Mushuau Innu stated they can 'recover' is to gain control over their lives.

We need to stand up, have confidence in ourselves, make our own decisions. We can really work together and be proud of ourselves and who we are. We have to set standards for ourselves and goals for our lives. We can't always blame others. We have to take responsibility ourselves. We should do things ourselves instead of sitting and waiting for white people to make decisions or do things for us. If we can solve one problem, then we will know we are gaining²⁴.

3.1.1 Summary of Key (Community) Healing Definition Findings

The findings suggest that healing is a long-term, on-going, holistic and collaborative process. The key concern with respect to the application of healing principles is **how the federal partners operationalize the concept of 'community healing' and about whether the comprehensive nature and scope of healing is actually reflected in the funded healing initiatives**. This implementation approach is often not reflective of Innu concepts of healing. Some key informants suggested that an Innu definition of community healing must guide LICHS efforts.

3.2 Relevance

3.2.1 Continued Need for the Strategy

The evaluation found strong evidence for continued and long-term government support for healing initiatives in Natuashish and Sheshatshiu. There is evidence that healing has slowly begun to occur as a result of a combination of factors, including the infrastructure put in place, the programs offered under the Healing Strategy and capacity development. However, **there is still much healing to take place in both communities**. Findings from the AHF final report²⁵ reveal that healing is a long-term process that requires an average of 10 years for a community to reach out, dismantle denial, create safety and engage participants. The actual progression and duration of the healing process is affected by the level of community awareness, readiness to heal in individuals, availability of organizational infrastructure, and access to skilled personnel.

A 2009 Senate Report titled, *A Healthy, Productive Canada: A Determinant of Health Approach*, notes that currently Aboriginal Canadians have a health status that is well below the national average. There are significant disparities between Aboriginal and non-Aboriginal Canadians in most social health determinants and the gaps are widening.²⁶

²³ Innu Nation and Mushuau Innu Band Council. (1995). *Gathering Voices: Finding Strength to Help Our Children*. Douglas & McIntyre: Vancouver/Toronto.

²⁴ Ibid. p.121

²⁵ AHF. (n.d.). *The Aboriginal Healing Foundation: Summary Points of the AHF Final Report*, p.18.

²⁶ Canada. (2009). Senate Canada. *A Healthy, Productive Canada: A Determinant of Health Approach*. The Standing Senate Committee on Social Affairs, Science and Technology Final report of Senate Subcommittee on Population Health, June 2009, p. 39.

It was only in November 2002 that both the Mushuau and the Sheshatshiu Innu were recognized as bands under the *Indian Act* and registration of their members as status Indians began²⁷. Reserve creation occurred in 2003 for Natuashish²⁸ after the relocation from Davis Inlet and 2006 for Sheshatshiu²⁹. It was said at that time that the delay in acknowledging Innu First Nation status, along with the loss of their nomadic way of life and the adoption of sedentary living, means that both communities are still in the midst of attempting to close the gap between themselves and other First Nations while at the same time dealing with the consequences of fifty years of non-status³⁰ and lack of access to programs and services available to status Indians from the federal government.

Canadian Census

While census data from Statistics Canada³¹ from 1996, 2001, and 2006³² show disparities between First Nations living on reserve and Canadian averages for various indicators within education, labour, and housing, some of this disparity has been more pronounced for the Labrador Innu communities. As shown in Figure 2, the rates of adults without a high school certificate or equivalent has remained consistently higher for the Labrador Innu communities than for other Aboriginals living on or off reserve, other Canadians or others in the Province of NL.³³ To highlight this even further, analysis of adults between 25 and 34 without a diploma shows a similar discrepancy, as shown in Figure 3.³⁴ It is important to note, however, that these data do not account for individuals who leave the community prior to completing school.

²⁷ Canada. (2007). INAC. Backgrounder - Labrador Innu Registration and Band Creation. (<http://www.ainc-inac.gc.ca/ai/scr/at/irp/bkg-eng.asp>).

²⁸ Canada (2007). INAC. Reserve Creation at Natuashish. (<http://www.ainc-inac.gc.ca/at/irp/rcn-eng.asp>)

²⁹ Canada (2007). INAC. Reserve Creation at Sheshatshiu. (<http://www.ainc-inac.gc.ca/at/irp/shs-eng.asp>).

³⁰ MIFN/SIFN (2003). Innu Healing Strategy. Innu Healing Submission, August 2003.

³¹ Retrieved using Statistics Canada Census data for 1996, 2001, and 2006 from Indian and Northern Affairs Canada Research and Analysis Directorate, Socio-economic and Demographic Statistics Section, October 2009.

³² Note that for the National Census for 2006 and prior, Sheshatshiu was not assessed as a community, nor as a reserve, and the statistics for this area are for "Division 10; Subdivision C", which includes Sheshatshiu, as well as the community of Mud Lake. For 2001 and prior, for the current study, Natuashish is assessed as the geographic area covering the community of Davis Inlet, known as Division 10; Subdivision E, which may have also included a number of additional households.

³³ Note that changes from 1996 to 2001 need to be interpreted cautiously, as these figures are only available for individuals 15 years of age and older for 1996, thus making the figure appear as though it has improved when it may have not.

³⁴ Changes from 2001 to 2006 should be interpreted cautiously, as 2001 data includes those aged 20-24. 2006 data were not extracted for those aged 20-24 because for that year the age cohort for education began at 15-24, which would highly inflate the statistic for those without diplomas, given the number of people in the statistic under 18. Additionally, data for the Labrador Innu communities for 2001 includes non-Innu (such as the community of Mud Lake for the area encompassing Sheshatshiu).

Figure 2: Rates Over Time of Adults without a High School Diploma or Equivalent from Canadian Census – 1996, 2001, and 2006

Notes: Data are for individuals aged 25-64, except 20-64 for NL and Canada in 2001; 25 and older for Aboriginal Canadians; and 15 and older for 1996 figures. Data were not available for Aboriginal Canadians and Canada overall in this form for 1996.

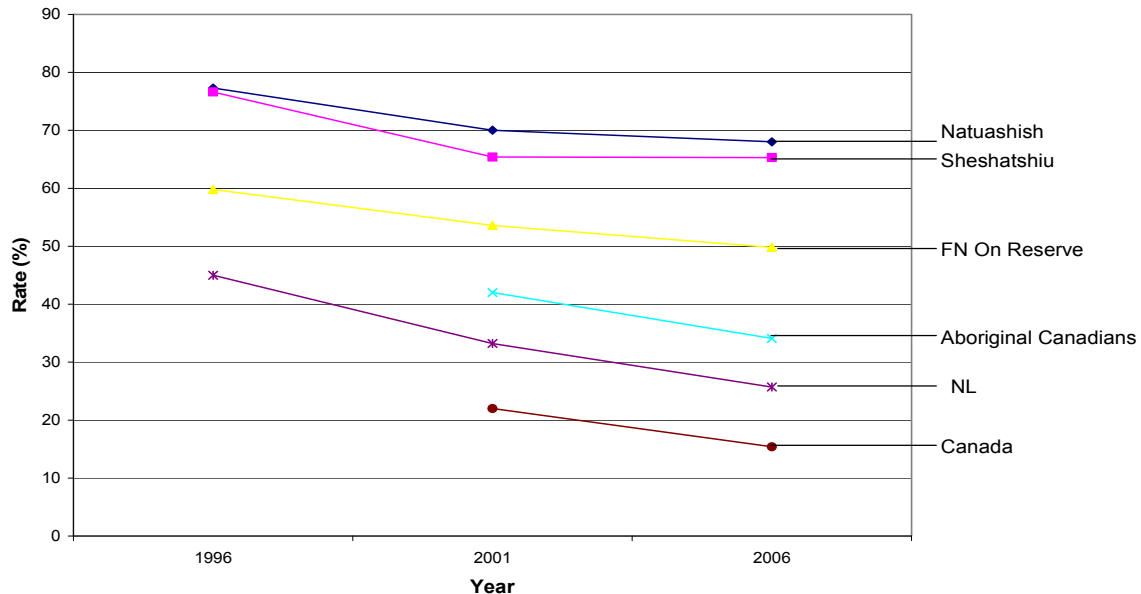
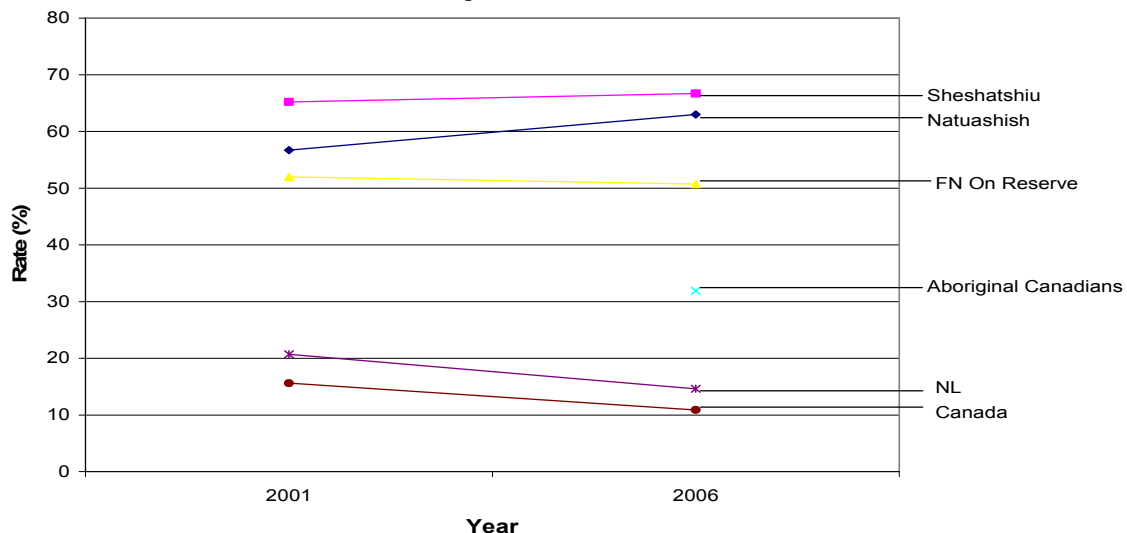


Figure 3: Rates Over Time of Young Adults without a High School Diploma or Equivalent from Canadian Census – 2001 and 2006

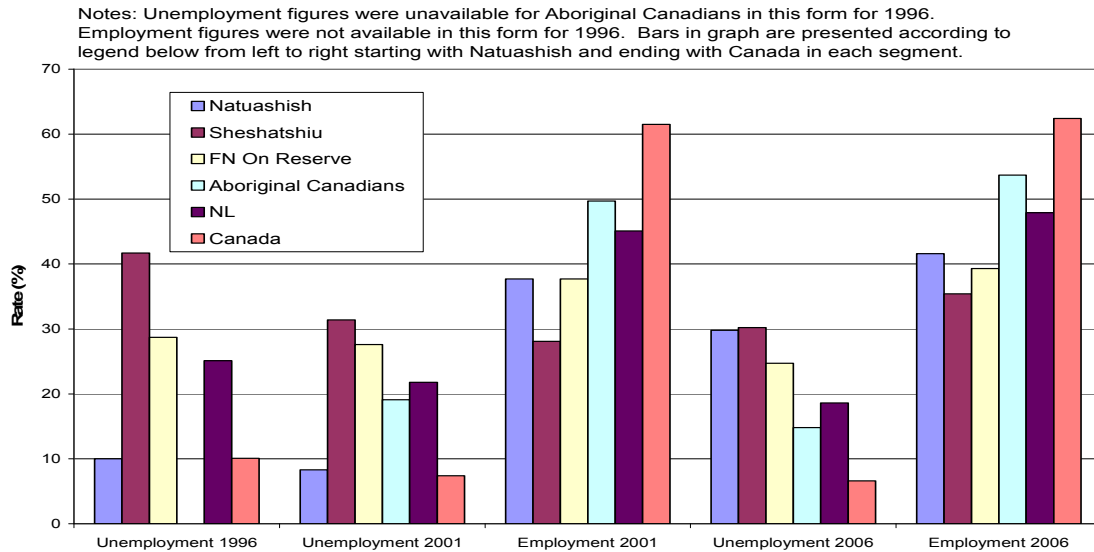
Notes: Data are for individuals aged 25-34 in 2006 and 20-34 in 2001 except FN On Reserve, which is 25-34 in 2001. Data were not available in this form for 1996 and only available in this form for 2006 for Aboriginal Canadians.



While there has also been marked variability in labour statistics (specifically unemployment and employment figures), the data show Sheshatshiu with a much lower employment and higher unemployment rate than other First Nations; a trend that narrowed only slightly in 2006. Natuashish (and Davis Inlet before 2006), however, had an employment rate notably higher than Sheshatshiu and roughly equal to the average First Nation, and an unemployment rate much

lower for 1996 and 2001. As of 2006, however, the unemployment rate in Natuashish was roughly the same as Sheshatshiu and other First Nations, as shown in Figure 4.

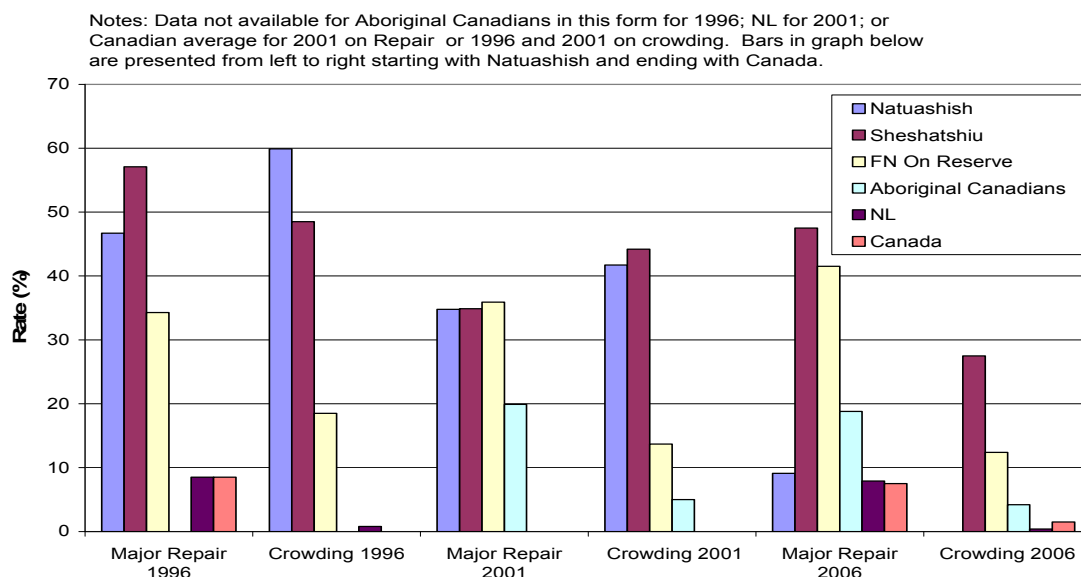
Figure 4: Trends for Unemployment (1996, 2001, 2006) and Employment (2001, 2006)



As shown in Figure 5, housing has been a component where there were marked and noticeable discrepancies between the Innu communities and other First Nations, and wherein discrepancies have narrowed over time. The overall rate of dwellings in need of major repairs for First Nations has increased slightly over time, while the rate for Sheshatshiu has remained high (albeit this rate decreased sharply in 2001 to increase again in 2006). The rate for Natuashish has dropped dramatically to be roughly in line with the average rates for the Province of NL and for Canada. A similar trend is noted with crowding³⁵ in households. In 1996 and 2001, the rate of crowding was markedly higher for the two Innu communities than for other First Nations. This rate has, however, dropped noticeably for Sheshatshiu and has dropped to zero for Natuashish (likely due at least in part to the relocation from Davis Inlet to Natuashish and the construction of new housing).

³⁵ Crowding is defined by Statistics Canada for the purpose of the national Census as a household with a mean of more than 1.0 persons per bedroom.

Figure 5: Rates of Housing Requiring Major Repair and Crowded Households Over Time from Canadian Census – 1996, 2001, and 2006



Community Well-being Index

Extending from census data, the CWB, which is a composite indicator (i.e., combines four dimensions of community well-being into a single index – education, labour force participation, income and housing using National Census data)³⁶, reveals that based on the 2006 census, the census division where Sheshatshiu is located had a CWB score of 51 and Natuashish had a score of 63. The average CWB score for First Nation communities in Canada was 57.25 (SD = 10.34). As shown in Figure 6 below, the vast majority of CWB scores for First Nation communities fall between 45 and 70, and the two Innu communities currently fall within this range. As also shown in Figure 6, both Innu communities fall within the general distribution of scores for their respective geographic zones. Specifically, Sheshatshiu is classified as Zone 1 (located within 50km of a service centre) and Natuashish is classified as Zone 4 (air, rail, or boat access to the nearest service centre). However, while there is no statistically significant difference³⁷ between Sheshatshiu and its Zone 1 counterparts in overall CWB score, Sheshatshiu clearly falls on the low end of this distribution, and Sheshatshiu's CWB score for education is significantly lower³⁸ than that of its Zone 1 counterparts. With respect to Natuashish, while there is no significant difference³⁹ in its overall CWB score and that of its Zone 4 counterparts, it is clearly on the higher end of the distribution, and its CWB score for housing is significantly higher.⁴⁰

³⁶ CWB can be used to compare Aboriginal communities and non-Aboriginal communities, to develop trends over time, and to help identify correlates of well-being, including policies and programs that improve social and economic conditions in communities.

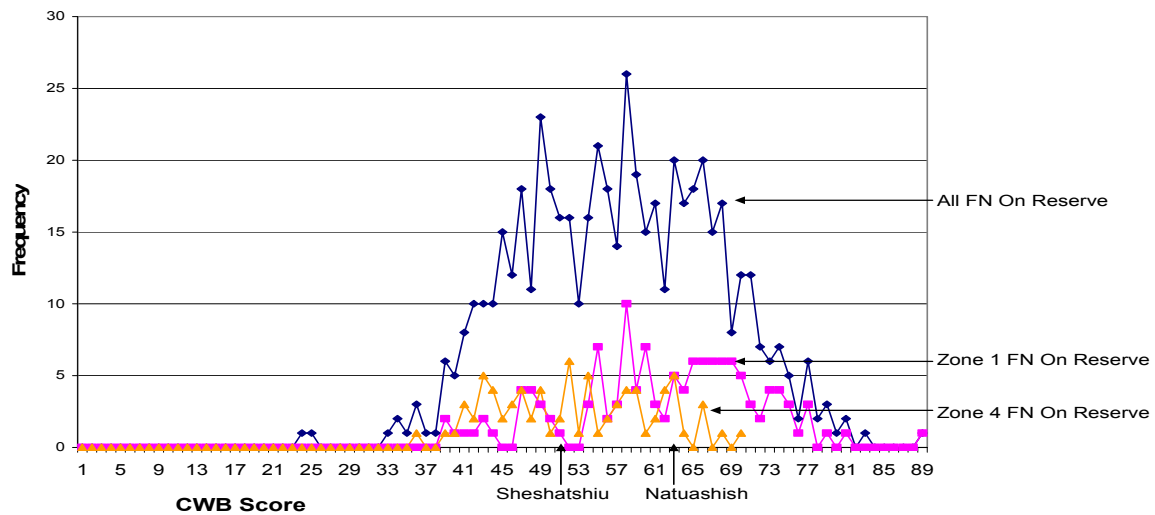
³⁷ Comparing via two-tailed tests of deviation from the mean where μ = Zone 1 First Nations average scores and x = Sheshatshiu, $z = -1.165$; $p = 0.2420$. One-tailed test also reveals no significant difference.

³⁸ Comparing via a one-tailed test of deviation based on a hypothesis that other Zone 1 First Nations will have higher education scores, $z = -1.697$; $p = 0.0456$. Difference is still significant in a two-tailed test at the 0.10 level.

³⁹ Comparing via a two-tailed test of deviation, $z = 1.107$; $p = 0.2670$.

⁴⁰ Comparing via a two-tailed test of deviation, $z = 2.072$; $p = 0.0384$.

Figure 6: 2006 CWB Scores Frequency Plot⁴¹ for First Nations Communities



There were no statistically significant differences⁴² on any of the composite indicator scores for 2006 comparing Sheshatshiu or Natuashish with the average scores for First Nations communities, and as shown in Figure 7, the only notable difference was that Natuashish had a CWB composite score for Housing somewhat above average and above that of Sheshatshiu. It is important to note, however, the large discrepancy between the CWB scores for housing between the two Innu communities, with Natuashish receiving a composite score 33 points above that of Sheshatshiu.

First Nation communities in general score lower on the CWB Index than non-First Nation communities⁴³ and as shown in Figure 7, education is the lowest CWB component score. However, as Figures 8 reveals, there has been a notable improvement in the CWB scores of Natuashish (referring in 1996 and 2001 to Division 10; Subdivision E, which was the area primarily composed of Davis Inlet, later relocated to Natuashish) and Sheshatshiu (referring to Division 10; Subdivision C, primarily composed of Sheshatshiu) relative to their position with the average scores of other First Nations on reserve between 1996 and 2006. While the general distribution of scores show a slightly positive shift over the three census years,⁴⁴ each of the Labrador Innu communities have shifted far more quickly to higher CWB overall scores than the overall trend.

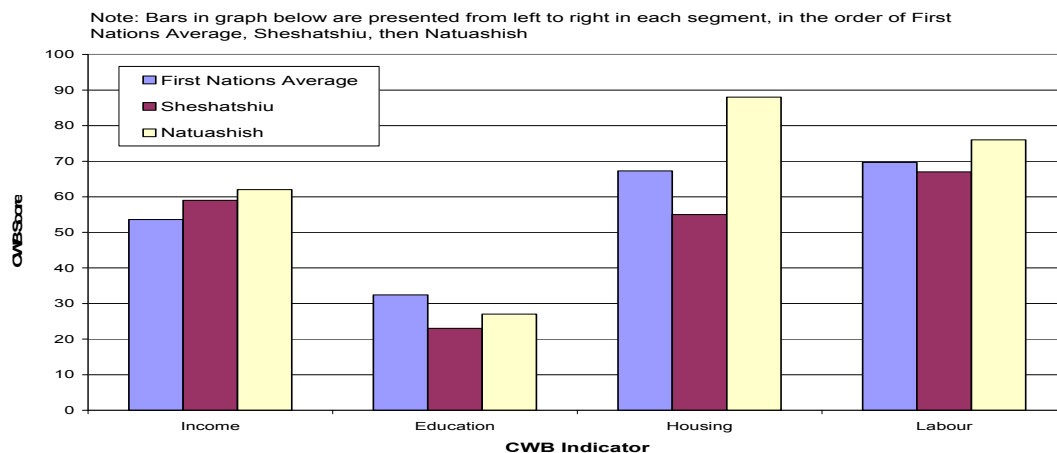
⁴¹ Note the Frequency (y-axis) refers to the number of communities with that particular CWB score.

⁴² Comparing (two-tailed tests of deviation from the mean where μ = First Nations average scores and x = each Innu community's score) First Nations with Sheshatshiu income [$z = 0.4063$; $p = 0.6818$]; education [$z = -0.7623$; $p = 0.4472$]; housing [$z = -0.8132$; $p = 0.4180$]; labour [$z = 0.3006$; $p = 0.7642$] and overall CWB [$z = -0.6043$; $p = 0.5486$]; and with Natuashish income [$z = 0.6319$; $p = 0.5286$]; education [$z = -0.4390$; $p = 0.6600$]; housing [$z = 1.372$; $p = 0.1706$]; labour [$z = 0.7204$; $p = 0.4716$], and overall [$z = 0.5546$; $p = 0.5824$]. A similar comparison was made assuming an alternative hypothesis of higher scores for the First Nations averages than for the Labrador Innu communities, and still no statistically significant differences exist.

⁴³ Information provided by INAC.

⁴⁴ A statistical analysis on this linear trend is not appropriate in this case because of the lack of comparability between like communities (due to renaming, geographic re-zoning, and conflicting CSD numbers) between years.

Figure 7: 2006 CWB Composite Score Comparisons between Sheshatshiu, Natuashish and the Average for First Nation Communities on Reserve



Some improvement of the two Innu communities relative to other First Nations communities is also shown in Figure 9, and as further analysis of differences in composite scores demonstrates, differences have narrowed over time at least slightly in all composite indicators. Further, CWB scores for Housing were significantly lower for both Sheshatshiu⁴⁵ and Davis Inlet⁴⁶ compared to the average for First Nations on reserve in 1996; a gap that narrowed dramatically in 2001⁴⁷ and even more so in 2006,⁴⁸ with Natuashish receiving noticeably higher CWB scores for housing (see Figure 9) than the national average for First Nations (likely related to the relocation and construction of new houses).

⁴⁵ $z = -2.197$; $p = 0.0340$

⁴⁶ $z = -2.404$; $p = 0.0164$

⁴⁷ Differences in 2001 not significantly different between First Nations on-reserve average and Sheshatshiu (Division 10; Subdivision C) [$z = -1.193$; $p = 0.7660$] or Davis Inlet (Division 10; Subdivision E) [$z = -1.163$; $p = 0.1230$].

⁴⁸ Differences in 2006 not significantly different between First Nations on-reserve average and Sheshatshiu (Division 10; Subdivision C) [$z = -0.8132$; $p = 0.4180$] or Natuashish [$z = 1.372$; $p = 0.1706$].

Figure 8: CWB Score Frequency Plots⁴⁹ for 1996, 2001, and 2006 and the Relative Positions of CWB Scores for the Labrador Innu Communities

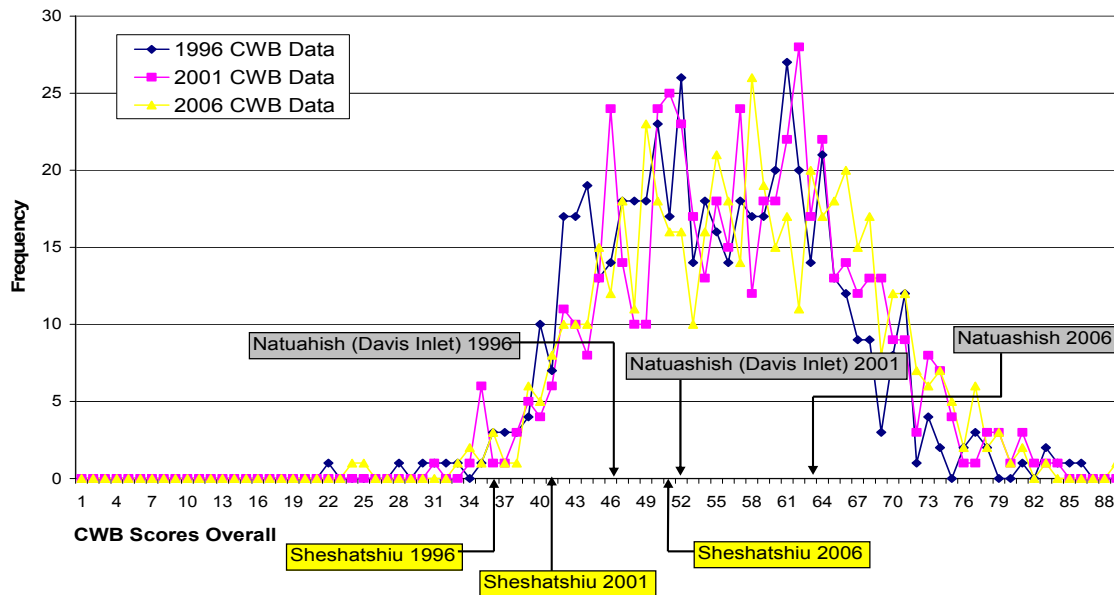
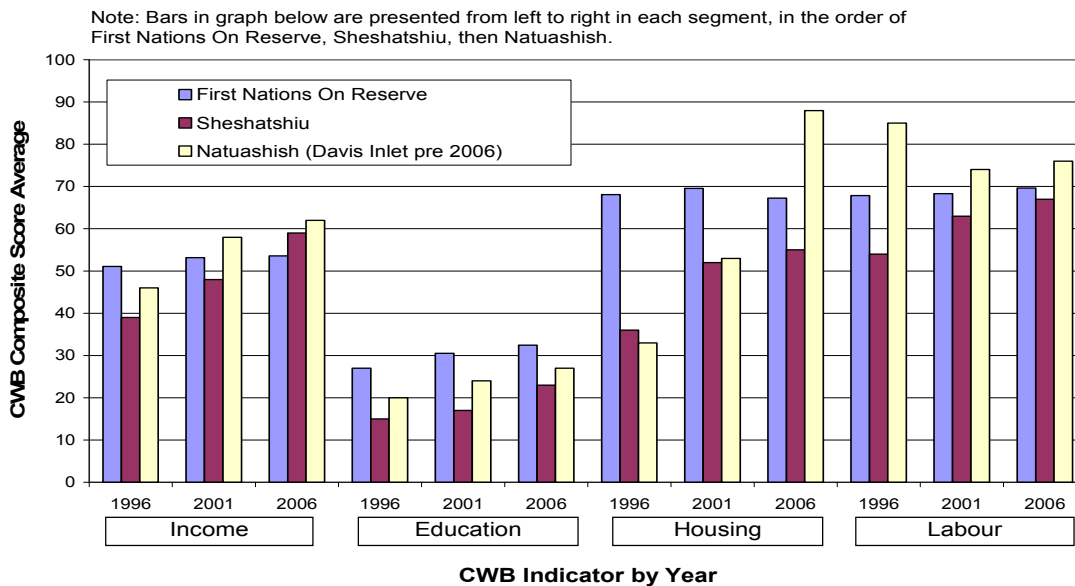


Figure 9: CWB Composite Score Comparisons between Sheshatshiu, Natuashish and the Average for First Nation Communities on Reserve for 1996, 2001, and 2006



As mentioned in Section 2.9, however, it is important to note that data used for CWB includes data from everyone in the community, including non-Aboriginals. As mentioned previously, the data for Sheshatshiu also includes the community of Mud Lake, and thus must be interpreted cautiously.

⁴⁹ Note the Frequency (y-axis) refers to the number of communities with that particular CWB score.

Vital Statistics

With respect to vital statistics⁵⁰ not taken from census data, gaps were also noted between the two Innu communities and First Nations on reserve from the years just before the implementation of the strategy. As shown in Table 5, marked gaps were observed between First Nations⁵¹ and the two Innu communities. It is important to note that while these data are not available for First Nations for more recent years, data for the two Innu communities does show an improvement; although these statistics must be interpreted cautiously, as the data are aggregate over several years and the numbers too small for valid statistical analysis.

Table 5: Vital Statistics Comparisons between First Nations Data (2000) and Data from the Labrador Innu Communities (1997-2001)

| Vital Statistics | First Nations | Davis Inlet | Sheshatshiu |
|---|---------------|-------------|-------------|
| % of babies born to women under 20 | 19.6 | 29 | 38.5 |
| Infant Mortality Rate per 1,000 live births | 6.4 | 18.7 | 17.8 |
| Death Rate per 1,000 | 4.6 | 6.2 | 4.7 |
| Suicide Rate per 100,000 | 24.1 | 171.8 | 127.3 |

Deaths in the table above are presented as "rates" to show the number of deaths that would have occurred if the three populations being compared were the same size. This is a standard way of comparing populations of different sizes, and it shows clearly that the number of deaths by suicide in Davis Inlet and Sheshatshiu, during the period 1997 to 2001, far exceeded those in all other First Nations combined in 2000. However, data for Davis Inlet / Natuashish and Sheshatshiu do appear to indicate some improvement in the infant mortality rate (see Table 6); although a detailed analysis is not possible due to such small numbers and a small population.

Table 6: Vital Statistics for Natuashish (Davis Inlet) and Sheshatshiu Comparison between 1997-2001 and 2002-2006

| | Davis Inlet/Natuashish | | Sheshatshiu | |
|---|------------------------|-----------|-------------|-----------|
| Vital Statistics | 1997-2001 | 2002-2006 | 1997-2001 | 2002-2006 |
| % of babies born to women under 20 | 29 | 27.2 | 38.5 | 37.7 |
| Infant Mortality Rate per 1,000 live births | 18.7 | 6.8 | 17.8 | 10.9 |
| Death Rate per 1,000 | 6.2 | 6.6 | 4.7 | 5.4 |
| Suicide Rate per 100,000 | 171.8 | 219.3 | 127.3 | 171.7 |

What is clear, however, is that the 2002-2006 data for the Innu communities show no improvement, and possibly a worsening of suicide and death rates, and no change in teen pregnancy. It is vital to note, however, that these are aggregate data between 2002 and 2006 and thus there is no way to assess whether or not there were trends over that time period, which is particularly important since the main elements of the strategy began in 2002.

⁵⁰ Figures for First Nations on reserve taken from: Canada. (2003). Health Canada. A statistical profile on the health of First Nations in Canada; and figures on the Labrador Innu communities obtained through a data extraction summary table from the Newfoundland and Labrador Centre for Health Information, February 2009.

⁵¹ Note limitations include underreporting: data only from where available for Atlantic; information system that is voluntary for Ontario; inclusion of Status First Nation population of BC and AB; vital stats not available for 111 of 144 FN communities in the ON region and 29/41 communities in Quebec.

Needs Identified

While interviews with government officials and community members as well as documents reviewed^{52,53,54,55,56,57,58,59}, suggest that both Natuashish and Sheshatshiu have successfully begun the healing journey (e.g., improvements in capacity building, education, infrastructure, health), there is still much to be accomplished. Community members identified a number of current needs with respect to healing that are not being fully addressed through existing healing programs. In order of frequency, these were addictions (alcohol, drugs, gas and gambling); lack of infrastructure (e.g., housing, and healing spaces); limited training/mentorship; lack of recreation programs for children and youth; and, insufficient education and post-secondary education initiatives. Other unmet needs identified by community members included: teen pregnancy; lack of access to healthy food; abuse (e.g., physical, emotional and sexual); family/domestic violence (spouse, Elders); chronic disease (e.g., diabetes); insufficient number of on the land treatment programs; lack of healing-related information; capacity development in the area of addictions treatment (e.g., Nechi training); and justice issues. While mental health and addictions programs are currently offered through the Strategy, some community respondents identified this issue as an ongoing need and stressed that it should be considered a priority, and ultimately that these programs need to continue and even be enhanced since there is still a significant amount of healing required.

Several community members, particularly from Natuashish, noted that there are needs specific to target groups that are not being met: Elders; men; and youth; and that in particular, youth had been overlooked by the current phase of the Strategy. It was noted by a couple of community respondents that although LICHs was developed in response to the gas sniffing and suicide crisis that was plaguing youth and children in the two communities, there now exist very few programs and services targeted specifically at youth. A number of community members called for youth-specific addictions and treatment programs and/or increased training/education initiatives. For example, one community participant stated “that’s why [in reference to lack of youth-focused activities] they’re beating the place up, they’re doing it to get attention”, while another stated that if there were more activities for youth then “...a lot of kids would leave the bad things behind and do some good things. Boredom is leading to bad things.” One mother noted that “...we need more activities for teens rather than having them just stay at home or getting into trouble”. A director

⁵² Belzer, A. & Maringapasi, G. (2009, June 10.) Update on Natuashish FASD Assets & Capacity Building. [Internal report.]

⁵³ Child, Youth & Family Services. (2009). Innu Child and Family Services: Devolution Workplan. February 2009 (date of latest draft).

⁵⁴ Fouillard, C. (2008). Gathering: Healing our Children and Community: A Report on the Next Generation Guardians and Parent Support Worker Programs in Natuashish, Labrador. Prepared for Health Commission Mushuau First Nation. June 2008.

⁵⁵ Fouillard, C. (2008). Family Treatment Program: Follow-up Research on Clients. First Draft Report. [presentation]

⁵⁶ Fouillard, C. (2008). A Place to Go: Healing our Children, Families and Community. A Report on an Evaluation of the Sheshatshiu Family Resource Centre. Prepared for Department of Social Health, Sheshatshiu Innu First Nation. March 2008.

⁵⁷ Bobet, E. (2007). An Assessment of the Immediate Health Effects of the Move from Davis Inlet to Natuashish. May 28, 2007.

⁵⁸ Education Steering Committee. (2007). Draft Agenda, Education Steering Committee, Natuashish, Labrador. February 28, 2007.

⁵⁹ Philpott, D. (2006). Achievement and Attendance Update: Mushuau Innu Natuashish School. Summary Report, September 2006 [presentation].

also commented on the lack of teen activities and the unsafe behaviours associated with youth who have little to do. While groups such as the Next Generation Guardians (NGGs) and the Family Resource Centre (FRC) offer child and youth programming, some case study participants (parents, other program staff) commented that the programs are not consistently available nor are they inclusive or well organized at times (e.g., not enough spaces for all children to participate in an advertised activity). It was also suggested by a few community members that men's physical health needs and Elders' social needs were not being acknowledged or addressed.

An evaluation⁶⁰ of the youth programs offered by NGG and Parent Support Worker (PSW) staff identified a number of other challenges including: the need to constantly provide new events and activities in order to avoid boredom; the need to offer weekend activities; and a lack of activities and programming aimed specifically at boys. Additionally, a greater focus on prevention and sexual education, perinatal education, and cultural activities was called for by program evaluation participants. An evaluation of the FRC programming revealed that the after-school program needs to constantly include new activities to keep the children engaged and that programs should be offered all year round. More generally, the evaluation found that the FRC should include more activities for male youth and should include more activities for children⁶¹.

Government officials interviewed also identified a number of Innu needs that have either not been addressed or have not been sufficiently met: capacity development in the areas of Child Youth and Family Services (CYFS), Income Support (IS), financial management and program management; capital for housing (in both communities) and roads; electrification and decommissioning; administrative training (e.g., Human Resources (HR) and Information Technology (IT)); educational initiatives (adults and youth); and chronic disease (e.g., diabetes). Key informants also noted that more programming was required for youth, Elders and men. It is important to note, however, that CYFS and IS are currently in the process of devolution, as discussed in Section 3.3.1.

3.2.2 Strategy Appropriateness, Gaps and Overlaps

During the community visits, when queried, most community members commented that existing healing programs are suitable to meet the needs of community members. They noted that there are a number of programs available and many supports in place to help address the needs of the Innu when they are ready and able to take part in the healing journey. The majority of program staff noted that the healing programs offered by the Innu are culturally appropriate - incorporating Innu languages and culture; spiritual teachings and traditions; employing the assistance of Elders; integrating an 'on the land' component, when possible; and using smudging, sweat tents and healing/sharing circles⁶². The only exceptions mentioned were those dealing with translation: (1) the lack of certain resource materials (e.g., screening tools) in the Innu language, and (2) the

⁶⁰ Fouillard, C. (2008). *Gathering: Healing our Children and Community: A Report on the Next Generation Guardians and Parent Support Worker Programs in Natuashish, Labrador*. Prepared for Health Commission Mushuau First Nation. June 2008.

⁶¹ Fouillard, C. (2008). *A Place to Go: Healing our Children, Families and Community. A Report on an Evaluation of the Sheshatshiu Family Resource Centre*. Prepared for the Department of Social Health, Sheshatshiu Innu First Nations. March 2008.

⁶² Smudging, sweats and sharing circles are examples of rituals that have been borrowed from other Aboriginal traditions but which have been adapted to fit Innu culture. The findings from Fouillard's 2009 evaluation of the Mobile Treatment and Day Treatment programs in Natuashish, confirmed the importance of the circles and sweats for the sharing of stories and feelings in a safe and trusting environment. These borrowed, and culturally modified traditions, were noted to be helpful for Innu spiritual and physical healing

lack of literal translation of new health and disease concepts (e.g., HIV/AIDS) into the Innu language when there exists no word for them.

Appropriateness and Gaps in Program Design

Previous program evaluations targeting specific healing programs show that programs offered through the Family Treatment Program (FTP), the FRC, the NGG/PSW, and Day Treatment/Mobile Treatment are infused with the cultural elements described above, and incorporate and support elements such as: counseling (group and one-on-one), after care treatment; crisis intervention; Alcoholics Anonymous (AA); justice representation; drop-in centres; retreats; grief counseling; skills development; fitness and recreation; and harm reduction. Programs that involve going on the land – whether they are for treatment, retreats or walks – were identified as being particularly effective in the healing process.

The Mobile Treatment and Day Treatment evaluation⁶³ noted that

...mobile [on the land] treatment provided a healing environment for people to address their addictions issues. They described life on the land as healing. Hunting, fishing, berry picking, food preparation, traditional crafts, storytelling and rituals such as *mukushan*⁶⁴ were described as important in building relationships and a sense of belonging, teaching values and beliefs, and developing a strong Innu identity.

Fouillard's evaluation suggested that mobile treatment was effective in part because it was provided on the land, away from the community, and involved the whole family (parents and children). It was described as being "more focused" and "more peaceful" due to a lack of outside influences. However, the costs associated with running the mobile treatment program were so exorbitant due to travel costs and the number of staff required to support camp life, that it was discontinued. The day treatment program offered at the Healing Lodge in Natuashish was considered advantageous due to the fact that it was: offered on a daily basis (i.e., involved consistent and on-going healing); accessible to a larger client base; and encompassed a wide range of programs and services aimed at different subsets of the population (e.g., men or women), different stages of the healing process and different topical issues (e.g., domestic abuse)⁶⁵.

Nearly half of the key informants indicated that LICHS was not entirely appropriate to meet the changing needs of the Labrador Innu (about a quarter of respondents said it was appropriate or generally appropriate and the remainder declined comment). They noted, for example, that the Strategy was misnamed since it was not 'comprehensive' in nature but included a group of programs that required much more coordination. A few indicated the Strategy is not comprehensive in depth: that it is not focused enough; that there are too many programs being offered; that it tries to do too much; and that it tries to be everything to everyone; while a few others stated it is not comprehensive in breadth: that there are not enough programs to address all of the healing needs. Some spoke about its lack of comprehensiveness with respect to the fact that

⁶³ Fouillard, C. (2009). It opened the door for me: An Evaluation of Mobile Treatment and Day Treatment Programs for the Natuashish Innu, March 2009, p.31.

⁶⁴ In the religion of the Mushuau Innu, every individual animal, fish, and plant, as well as each rock, and the wind, rain, and snow has a spirit. The reindeer spirit, *Katipinimitauch*, assures that the reindeer, who provide food and skin for clothes and moccasins, wander over the plateaus. The *mukushan* ritual, in which the whole camp eats raw marrow from reindeer joints, is held to pay Katipinimitauch respect.

⁶⁵ Ibid.

there is no long-term strategic plan in place to effectively guide government support for the healing process.

Bopp and Lane⁶⁶ state that the roots of Aboriginal trauma (e.g., loss of connection to language, spiritual and cultural foundations; loss of traditional lands and resources, poverty, high disease burden) and their consequences (e.g., substance abuse, sexual abuse, suicide, despair, breakdown of the family function) require a ‘comprehensive’ healing approach in order to be effective. As noted earlier, comprehensive approaches are considered the most suitable because they reflect the intricacy of the challenges and the healing process itself.^{67,68,69}

The appropriateness of the Strategy was also called into question by a couple of key informants who commented on the lack of acknowledgement of the heterogeneity that exists between communities, suggesting that it leads to a ‘one size fits all’ approach to healing. Two other key informants discussed the static nature of the Strategy; specifically that there are no built-in provisions to respond to changes in the type and level of healing support required. Additionally, a couple of key informants remarked on the fact that a comprehensive needs assessment has not yet been carried out in either community, and that this could lead one to question the appropriateness and applicability of current LCHS-funded programs to actual healing needs. Along these same lines, a few key informants stated that the Innu were told what healing programs would be offered to them rather than having the opportunity to choose the most appropriate programs themselves. Consequently, for some, there is a difference between what programs are needed and what programs are actually being offered.

Several key informants spoke about the need to have Innu healing needs and subsequent programming identified by the Innu rather than the federal government. While a few (primarily LHS staff) suggested that this is already happening, others felt that Innu acknowledged needs and priorities should be considered and incorporated to a greater extent. There is, however, evidence of collaborative efforts towards this end such as the 2003-2004 “As Was Said” report series and the FASD asset mapping sessions, which was initiated by the LHS in order to gain input from both Innu communities about what healing programs and services they would like to see offered and how they would like to see these delivered in their respective communities in the future^{70,71,72,73,74}. The FASD asset mapping workshops, held in 2004, 2005 and 2009 in

⁶⁶ Bopp, M. and P. Lane Jr. (2000). The Nuxalk Nation Community Healing and Wellness Development Plan: A comprehensive ten year plan for the healing and development of the Nuxalk Nation. Four Worlds International.

⁶⁷ SGS Economics and Planning. (2007). Evaluation of the ‘Communities in Crisis’ Policy, Volume 1, Evaluation Report. Prepared for the Australian Government Department of Families, Community Services, and Indigenous Affairs. December 2007.

⁶⁸ AFN, ITK and FNIHB, Mental Health Working Group. (2002). Mental Wellness Framework. A Discussion Document for Comprehensive Culturally Appropriate Mental Health Services in First Nations and Inuit Communities.

⁶⁹ Gould, K. (2006). Holistic community development; Wellness for the collective body. *American Indian Culture and Research Journal*, 30(3):59-74.

⁷⁰ Feltmate, G. (2003). As Was Said Report. Joint Planning Meeting Report, March 24-25, 2003. The Communities of Natuashish, Sheshatshui and Health Canada. Goose Bay, NF.

⁷¹ Feltmate, G. (2003). As Was Said Report. Planning Meeting Report, June 26, 2003. Innu Healing Strategy. Halifax, NS.

⁷² Feltmate, G. (2003). As Was Said Report. Joint Planning Meeting Report, September 23-24, 2003. The Communities of Natuashish, Sheshatshui and Health Canada. Goose Bay, NF.

⁷³ No Author. (2003). As Was Said Report Recommendations Summary. Partnership WG Summary of the Innu Healing Vision articulated at the As Was Said workshop. October 2003.

⁷⁴ No Author. (n.d.). Innu Nation/Health Canada Joint Planning Documents (2003-2004).

Natuashish, provided representatives from HC, Natuashish and partner organizations the opportunity to identify the assets that support FASD work in the community and to identify future priority capacity building activities⁷⁵.

Duplication and Overlap

Most of the social programs provided under the LICHS are basic (A base) programs and services generally provided by INAC to all First Nations communities, and are delivered by provinces to non-First Nation communities. The two major social programs funded under the LICHS, Income Assistance and CYFS are delivered through agreements with the Province of NL. To the extent that basic programs and services are required to ensure the provision of basic needs such as food, clothing and shelter, they can contribute to individual and community-based healing. However, upon reserve creation, and even prior, as INAC recognized the Innu as equivalent to First Nations living on reserve, INAC was responsible for funding these programs. Therefore, without the introduction of the strategy funding for these programs and services would have had to come from another source.

When asked about the existence of program/service duplication, gaps and integration at the community level, most key informants who responded to the question spoke about changes in integration and coordination at the federal level (see Section 3.4.3). Those key informants who did reply (primarily HC/LHS staff) indicated that there was little duplication of community-level programs and services. A couple of informants mentioned that initially there were issues between those delivering provincial programs and services and those delivering LICHS programs and services. The province indicated their view that there had been a lack of consultation surrounding the creation of the LHS. Initially, key respondents described a situation in which provincial health capacity was diminished as some of their staff were hired to fill LHS positions. Moreover, at the start, LHS staff were carrying out primary health care responsibilities which have always fallen under the purview of provincial/regional health care system. Accordingly, LHS staff were considered to be “stepping on the toes” of established primary health care workers. Over time, and as LHS responsibilities shifted to focus solely on capacity building efforts, LICHS and Labrador Grenfell Health (LGH) staff have begun to work together in an integrated and coordinated manner. LGH staff were noted as sharing resources and health care tips with LHS staff. One LHS staff member stated that “...if LHS did not provide the current services [referring to capacity building], I don’t think others would.”

Additionally, a couple of government officials stated that program duplication is no longer an issue as they have become increasingly knowledgeable about what each of the players is doing. This has occurred in part as a result of participation in the tripartite sub-committees. In addition to the Main Table, which is the primary vehicle for dialogue among the three key players, there are a number of tripartite sub-committees tasked with the responsibility of addressing Strategy issues such as: reserve creation, education, new school at Sheshatshiu, income support, child youth and family services, economic development, health, and evaluation.

Most community program staff noted that as a result of the informal relationships they have with other community healing programs, they know what services are being delivered and what issues are being discussed. One community staff member, who is not Innu, stated that Natuashish is the “...most collaborative health community I’ve seen – everyone comes together”.

⁷⁵ Belzer, A. & Maringapasi, G. (2009). *Update on Natuashish FASD Assets & Capacity Building*. June 10, 2009.

There was, however, a couple of program staff who indicated a lack of program coordination. One stated “Everybody’s doing their own thing but we should be working towards the same goal to improve people’s lives”. A gap in health care provision that was mentioned by HC/LHS and community program staff was case management and continuum of care. A few key respondents and a couple of community staff noted that a formal case management approach needs to be established in the two communities so as to improve the overall continuum of care. One community Director stated that they need “...each organization communicating with each other to better serve clients – to coordinate care for clients”.

3.2.3 Objectives of the LICHS and the Federal Government

The Labrador Innu Comprehensive Healing Strategy is a horizontal initiative involving the federal government (INAC, HC), the Province of NL and the Labrador Innu (MIFN and SIFN), created to restore health and hope, create strong communities, and ensure a future for the Innu. The Strategy is in line with the Government of Canada priorities outlined in the October 2004 Speech from the Throne regarding addressing the needs of Aboriginal Canadians:

We must do more to ensure that Canada’s prosperity is shared by Canada’s Aboriginal people-First Nations, Inuit and Métis. We have made progress, but it is overshadowed by rates of fetal alcohol syndrome and teen suicide in Aboriginal communities. These are the intolerable consequences of the yawning gaps that separate so many Aboriginal people from other Canadians – unacceptable gaps in education attainment, in employment, in basics like housing and clean water, and in the incidence of chronic diseases such as diabetes⁷⁶.

The speech goes on to address the need for the federal government to work with Aboriginal people and provincial and territorial governments in order to create conditions that are conducive to long-term development in the areas of education, economic opportunity and governance while at the same time acknowledging historical rights and treaties.

A change in Government took place in 2006, and in the 2008 Speech from the Throne⁷⁷, it was stated that the “government will take steps to ensure that Aboriginal Canadians fully share in economic opportunities, putting particular emphasis on improving education for First Nations in partnership with the provinces and First Nations communities.” The 2009 Speech from the Throne⁷⁸ stated that the “government is acting to protect the vulnerable: the unemployed, lower-income Canadians, seniors, Aboriginal Canadians and others hit hardest by the global economic recession.” These priorities are all well aligned with LICHS, as they seek to improve the economic, educational, and governance situations of Aboriginal people.

LICHS also aligns with federal budget priorities; and specifically to stated objectives in improved wellbeing for Aboriginal Canadians, including education, health, social services, and enhanced skills and training.

An analysis of LICHS-funded initiatives and the intent of the program against key government documents shows some clear alignment between LICHS and the priorities of INAC and HC as

⁷⁶ Canada (2004) Privy Council Office. Speech from the Throne to Open the First Session of the 38th Parliament of Canada, October 5, 2004.

⁷⁷ Canada (2008). Privy Council Office. Speech from the Throne 2008: Protecting Canada's Future.

⁷⁸ Canada (2009). Privy Council Office. Speech from the Throne to Open the Second Session of the Fortieth Parliament of Canada.

outlined in their respective current Program Activity Architectures (PAA)⁷⁹ and Reports on Plans and Priorities (RPP)⁸⁰. Specifically, the Strategy is closely aligned with various elements of three of INAC's Strategic Outcomes and specific program activities and outcomes as identified in the Department's 2009-2010 RPP:

- The Government – Good governance, effective institutions and co-operative relationships for First Nations, Inuit and Northerners:
 - Program Activity: Governance and Institutions of Governance;
 - Immediate Outcomes: Capacity in First Nation, Inuit and Northern communities; Financial transfer arrangements matched to First Nations and Inuit capacity and responsibilities; Policy, programs and legislation that are responsive to First Nations, Inuit and Northerner requirements; and
 - Intermediate and End Outcomes: First Nations, Inuit and northern institutions established; Capable and accountable governments and institutions; Self-reliant communities with improved socio-economic indicators.
- The People – Strengthened Individual and family well-being for First Nations, Inuit and Northerners:
 - Program Activities: Education and Social Development;
 - Immediate Outcomes: Meaningful participation by Aboriginal people and Northerners in decisions that affect them; and
 - Intermediate and End Outcomes: Healthier Aboriginal people and Northerners who are better positioned to participate in the labour market and implement effective stewardship over programs and resources; Strengthened individual and family well-being for Aboriginal people and Northerners.
- The Economy – Increased participation of Aboriginal people and Northerners in the Economy:
 - Program Activity: Community Infrastructure;
 - Immediate Outcomes: Community infrastructure that ensures health and safety and promotes engagement in the economy; and
 - Intermediate Outcomes: Participation of Aboriginal people and Northerners in the economy.

This analysis also showed alignment with HC's Strategic Outcome # 4 of their 2009-10 RPP⁸¹ - Better Health Outcomes and Reduction of Health Inequalities between First Nations and Inuit and Other Canadians. The Program Activity for this outcome is First Nations and Inuit Health Programming and Services, the expected results of which are better health outcomes, and reduction of inequalities between First Nations and Inuit and other Canadians. The PAA also states key indicators for this strategic outcome, including many that relate to key concerns with the Labrador Innu communities, such as: life expectancy, birth rate, mortality, diabetes rates, and suicide rates. The stated objective is to improve health outcomes, by ensuring the availability of, and access to, quality health services, and by supporting greater control of the health system by First Nations and Inuit.

Taken together, these lines of evidence suggest that LICHs-funded initiatives are aligned with various INAC and HC priorities.

⁷⁹ Canada (2008). INAC. 2009-2010 Indian and Northern Affairs Canada – Program Activity Architecture.

⁸⁰ Canada (2008). INAC. 2008-2009 Indian and Northern Affairs Canada Report on Plans and Priorities.

⁸¹ Canada. (2009). Health Canada. 2009-10 Estimates, Part III – Report on Plans and Priorities.

3.2.4 *Summary of Key Relevance Findings*

Key informant interviews, case study interviews, and documents reviewed suggest that at a minimum **there is support for continued and long-term, government support for healing**. While interviews and reviewed statistics seem to suggest that the Labrador Innu communities have begun the complex process of healing (e.g., improvements in capacity levels and infrastructure), the evidence reviewed suggests there are **still significant gaps between the Innu and their First Nation counterparts, particularly with respect to education and health**. While some gaps have narrowed, particular needs with respect to health, education, and infrastructure (and housing in Sheshatshiu) are readily apparent. Statistics available, as well as interviews and documents reviewed suggest **significant support is still required, and there are numerous unmet needs that need to be addressed**.

While in line with the Government of Canada, INAC and HC priorities, there are concerns that the LICHS is not ‘comprehensive’; that much of its programming is disjointed; that it is limited in its depth and/or breadth; lacks a long-term strategic plan; and that it contains no built-in provisions/flexibility to respond to evolving Innu needs.

3.3 **Implementation and Delivery**

3.3.1 *Implementation of LICHS Programs and Services*

Table 7 highlights the status of the horizontal results of LICHS program activities, committed to by INAC, HC, and/or CMHC, as indicated in the LICHS Plans, Spending and Results for 2004/05 to 2009/10 (updated March 2008).

The implementation of the LICHS program activities/outputs identified in Table 2 are directly linked to the intended healing outcomes identified in the LICHS logic model. For example, the construction of Safe Houses in the two communities provides a safe place for women and children/youth to stay thereby providing the communities with the opportunity to reduce the incidence of domestic violence and increase empowerment and self esteem. Another example involves the implementation of community-based treatment and aftercare services, intended to decrease drug and alcohol abuse in participants, improve familial relationships, improve child care, and increase levels of confidence.

Table 7: Status of LICHs Programming Components

| Federal Partners | Program Activity | Status |
|----------------------|---|-------------|
| INAC | Strategies for Learning <ul style="list-style-type: none"> Submission of 2004 Final Report: An Educational Profile of the Learning Needs of Innu Youth outlining the findings from an assessment of the attendance, achievement and ability of Innu children Development of 61 recommendations for an Innu educational system by Dr. David Philpott (December 2005) based upon the findings of the 2004 published Final Report⁸² Development of an Implementation Plan for Enhancing Innu Education⁸³ 2006 achievement and attendance update on the Mushuau Innu Natuashish School⁸⁴ Implementation of selected recommendations | Completed |
| | Design and construction of Sheshatshiu school (opened September 2009) | Completed |
| | Facilities O&M (Natuashish – facilities management, hydro agreement, airport, wharf) | Ongoing |
| | Reserve creation | Completed |
| | Registration of Sheshatshiu band members under the <i>Indian Act</i> | In progress |
| | Devolution – Education <ul style="list-style-type: none"> Creation of an Innu School Board | Completed |
| | Devolution – CYFS | In progress |
| | Devolution – Income Assistance | In progress |
| | Sheshatshiu RCMP station construction | Completed |
| | New Paths projects (Outpost) | Completed |
| | Safe House operation | Ongoing |
| Health Canada | Addictions/Mental Health <ul style="list-style-type: none"> Establishment of community-based crisis response protocols and community crisis response teams Addictions treatment and after care programs continue to be offered through the FTC in Sheshatshiu and the Healing Lodge in Natuashish | Ongoing |
| | Maternal/Child Health <ul style="list-style-type: none"> Health promotion programs continue to be available through the Wellness Centre in Natuashish and the FRC in Sheshatshiu Staffing of FASD coordinator positions | Ongoing |

⁸² Philpott, D. F., Nesbit, W.C., Cahill, M.F. & Jeffery, G.H. (2005). Enhancing Innu Education: Report to the Education Steering Committee. Recommendations for an Effective Model of Innu Education and Selected Programs/Models for Consideration in Innu Schools. December 2005.

⁸³ Butt, A.D., Sheppard, W. & Crewe, R.J. (2006). Implementation Plan for Enhancing Innu Education. October 16, 2006.

⁸⁴ Philpott, D. et. al. (2006). Achievement and Attendance Update: Mushuau Innu Natuashish School. Summary Report, September 2006 [presentation].

| Federal Partners | Program Activity | Status |
|-------------------|--|--------------------------------------|
| | Community Health Planning <ul style="list-style-type: none"> Increased community engagement Increased community capacity for evidence-based planning Asset mapping conducted Community health planning activities Evaluation activities | Ongoing Evaluations completed |
| | Management and Support <ul style="list-style-type: none"> Improved coordination of health services Support by LHS staff for community capacity development | Ongoing |
| | Safe House program delivery, policy and operations | Ongoing |
| | Healing Lodge construction in Natuashish | Completed |
| | Wellness Centre construction in Natuashish | Completed |
| CMHC | Safe house construction in Sheshatshiu and Natuashish | Completed |
| Integrated | Roll out of an integrated management approach that helps to improve cooperation between the three main parties as well as coherent and planned use of resources. | Completed |
| | Development of a horizontal Results-Based Management and Accountability Framework (RMAF). | Completed |
| | Creation and staffing of an Integrated Management position | Completed |

The Federal Labrador Health Secretariat, an office of HC in Happy Valley-Goose Bay to provide support for the implementation of the LICHs, is responsible for:

- Supporting community-based health programs:
 - Provide some direct health services; and
 - Provide a capacity development/mentoring role.
- Complementing community-based mental health and addictions programming:
 - Provide professional support and guidance to front-line staff, facilitation of capacity development, strengthen case management to facilitate client care and provision of crisis prevention and intervention services.
- Working with community and provincial resources to strive towards improved maternal/child health outcomes.
- Providing professional health planning and evaluation resources in support of community health planning and evaluation:
 - Support the work of each community's health planning committee;
 - Collect, maintain and assess health data and information;
 - Mentor community health planners; and
 - Increase the effectiveness of program implementation.

5. Managing the implementation of the Community Health component of the LICHS.

Additional responsibilities include:

1. Supporting Innu health workers with their responsibilities in each community;
2. Continue building collaborative relationships between all the stakeholders;
3. Support the implementation of protocols for frontline community health service providers; and
4. Develop and strengthen Innu capacity for health program service delivery.

LHS staff has delivered a wide variety of capacity building initiatives to Innu program staff since 2004. A Health Canada Inventory of Projects and Activities in Support of Innu Capacity Development 2003-2008 itemizes the activities funded through LICHS⁸⁵. An Executive Summary of the Inventory divides the activities into the following categories (examples are provided within each category):

- Workshops/Training:
 - 2004 – Training with PSWs on computer reporting templates – delivered to both communities;
 - 2007, 2008, 2009 – Home Visitation Training (19 modules) – delivered by LHS staff to both communities (11 Health Commission staff completed entire course and four completed 10 modules in Natuashish; seven staff completed course in Sheshatshiu); and
 - 2008 - Youth Camp in Natuashish – four days – addressed issues of healthy sexuality, STIs, safe sex, healthy relationships, and contraception (>50 youth participated).
- One-on-one Support/Mentoring:
 - 2005 – mentoring FASD coordinator to develop FASD work plan; and
 - 2008 – mentoring Registration clerk in Nataushish.
- Development of Community Suicide Prevention Continuums (includes training delivery that is specific to suicide prevention and intervention):
 - 2005 to 2008 – ASIST (Applied Suicide Intervention Skills Training) (153 trained); and
 - 2008 – SafeTALK (suicide prevention training) (25 trained).
- Support/Development of Health Commission Mental Health and Addiction Staff:
 - Case management mentoring, referrals/client information forms development and usage, ISSP support, and SASSI inventory and assessment support, participation on each community's case management project, and supporting staff.

⁸⁵ Canada (2009). Health Canada. Inventory of Projects and Activities in Support of Innu Capacity Development 2003-2008, edited February 12, 2009.

- Participation in and Co-facilitation of Treatment Programs – Land and Community Based:
 - 2007 - Outdoor Program, Women’s Retreat, Relapse Prevention Program, Healing Lodge Treatment Program (topics – alcohol and drug awareness, anger management, rumors and gossip), Sheshatshiu Relapse Prevention Program (40 days).
- Facilitation and Funding of Training Opportunities and Conference Attendance for Community Staff and Members:
 - 2004 – Wellness Facilitators Training (10 trained), Quebec Elders Gathering (10 days), August Cultural Orientation Camp for Youth, Montreal Suicide Awareness Conference; and
 - 2007 – combined PSW workshop in Goose Bay with Mental Health Symposium and funded members to attend both events.
- Partnerships/improving program linkages/program management and evaluation:
 - Evaluations – Family Treatment Follow-up, Immediate Health Effects Project, ODS Report, Day Treatment Program Review;
 - Community health planning – completion of results of SIFN’s community health survey, other steps in community health [planning (108 days); and
 - 2008 - Partner with Innu communities, Labrador Grenfell, Nunatsiavut, Labrador Aboriginal Legal Services, CJAY, College of the North Atlantic, RCMP, and Katimavik on National Addiction Awareness Week – cost shared and supported Innu participation.
- Other support:
 - The Dancer Play (Natuashish) (38 days); and
 - Wendy’s Players (Sheshatshiu) (19 days).
- Major Projects⁸⁶:
 - 2006 - ECE Program (October – December) – no graduates.

Many community staff members indicated that adequate levels of capacity development programs/activities were available to them.

Implementation of other aspects of the LICHs, such as education, income assistance and child and family services (CFS) were undertaken through agreements with the Province of NL. The province administered these programs on behalf of INAC for the Innu while negotiations through tripartite committees for the devolution of these program areas continued. As of August 2009, the devolution of Education is complete with the creation of an Innu school board. Prior to the devolution of education to the Innu, implementation of the Philpott recommendations such as Home School Liaisons and Nutrition Program were implemented and ongoing. In addition, the new school in Sheshatshiu is complete and will be accepting new students in September 2009.

Income assistance and CFS are still being implemented by the province and negotiations with respect to devolution are ongoing. Specific healing components such as New Paths (outpost) are implemented each year and the Innu see this program as an essential element of healing⁸⁷.

⁸⁶ Labrador Health Secretariat. (2008). Executive Summary: Draft Capacity Development Inventory 2003-2008. February 15, 2008.

⁸⁷ Canada (2008). Treasury Board Secretariat. Plans, Spending and results. Available at <http://www.tbs-sct.gc.ca/hidb-bdih/plan-eng.aspx?Org=0&Hi=46&Pl=134>

Infrastructure commitments made under the LICHs have been completed. A youth safehouse was built in Sheshatshiu and a dual purpose safehouse/family violence shelter was constructed in Natuashish. These facilities are operated through annual funding from both INAC and HC. In addition, a wellness centre and healing lodge were built as an addition to the existing health centre.

3.3.2 Challenges to Implementation

Healing Infrastructure

Almost all program staff members in both communities suggested that the delivery of LICHs programs and services is constrained by limited infrastructure. In Natuashish, staff spoke about the lack of space from which to run their programs (e.g., large group meetings) and in which to store program supplies (consequently supplies are getting lost or stolen). A few staff noted that while the newly constructed Healing Lodge is a great success, it does not contain enough space to host large group sessions. This issue is, however, being rectified. The community's Operations and Maintenance staff has approval from Chief and Council, upon request of the Healing Lodge Director, to remove a wall to merge two small rooms into an area to accommodate large groups, showing community flexibility and innovation to adapt infrastructure to demand. Staff also remarked that the community has already outgrown the school and as such the daycare and Adult Basic Education (ABE) programs have been forced out. However, construction is poised to begin on a new daycare, community centre and a FASD building.

The infrastructure issue is particularly acute in Sheshatshiu. Almost all of the program staff spoke about a lack of space in which to deliver healing programs. The FTP staff is currently crowded into a makeshift building with small rooms and limited heat. Staff mentioned that confidentiality is an issue given the close working quarters. The FRC recently burned down and the staff is awaiting the completion of renovations to a new space, which is not big enough to house all of their supplies and run their programs. In a 2008 evaluation of the program, participants noted that the former building was not suitable due to factors such as: lack of space; lack of security; and lack of adequate heating⁸⁸.

A number of Sheshatshiu staff mentioned that they would like to see a social health building constructed that would house programs such as: FRC, FTP, and FASD. They suggested that having all of the social programs under one roof would help to improve integration. They also indicated that such a building would decrease stigma associated with requiring help for addictions and would increase feelings of safety and security among community members.

Concern was expressed by a couple of directors from Sheshatshiu and a couple of key informants that the federal government has not made the same linkage between healing and infrastructure in Sheshatshiu as it has in Natuashish. In 2003, SIFN had spent more than a year seeking to have a joint capital review to clarify capital issues that had arisen and to justify inclusion of capital in both the next funding agreement and the LICHs policy proposal but was eventually informed by the Associate Deputy Minister that "neither the original (federal healing) strategy nor this update was intended to include in its scope the capital needs of the community of Sheshatshiu"⁸⁹. While capital for Sheshatshiu was not a component of the LICHs in its inception, Authority was

⁸⁸ Fouillard, C. (2008). A Place to Go: Healing our Children, Families and Community. A Report on an Evaluation of the Sheshatshiu Family Resource Centre. Prepared for the Department of Social Health, Sheshatshiu Innu First Nations. March 2008.

⁸⁹ September 3, 2003 letter – Associate Deputy INAC Marie Fortier to Chief Paul Rich – cited in Sheshatshiu Innu First Nation; A Request for Special Capital, October 2006

included in 2004 specifically for payments to support supplying public services, including capital facilities and maintenance. Such an Authority was not, however, included in 2005. The creation of a new community for the Mushuau Innu has clearly been facilitative to the healing process, given that new infrastructure tailored to the needs of a population would facilitate programming. The fact that new infrastructure for Sheshatshiu has been far more limited means the community has had to implement its healing programs without the added benefit of new infrastructure. SIFN stated that Sheshatshiu has been asked to heal its social and economic ills without addressing its suboptimal physical conditions and infrastructure⁹⁰. It is also important to note that the current logic model (see Figure 1) from the 2007 RMAF does deal with infrastructure needs and includes a stated immediate outcome of appropriate space to deliver programs. The current iteration of the strategy is not designed to meet that particular outcome.

Staff Turnover

The lack of continuity caused by changing players was identified by key informant and community respondents as impacting on the level of communication and trust between the Strategy partners. High rates of staff turnover that occur in the community, the LHS office and the federal government are affecting the implementation and delivery of the LICHS. It also results in the constant loss of corporate knowledge, skills and networks. Additionally, staff turnover creates hardships for the staff left behind due to increased workload and increased levels of stress.

A couple of LHS staff spoke about the constant turnover of community frontline staff, specifically the PSWs, noting that once these individuals gain experience and confidence, they begin to look for a better job with a better paying salary. As a result of this turnover, there is a need for LHS to constantly train and help build capacity in new staff members.

It is important to note that while capacity may be temporarily lost in this specific program area, trained workers typically move onto other positions within the community.

A review of the staff training, development and support needs of the Innu Uauitshitun and FTP in Sheshatshiu from 2001 to 2005,⁹¹ revealed that high rates of staff turnover result in greater workloads being placed on remaining workers, which in turn contributes to higher levels of stress and often leads to burnout. As a consequence, staff members often take a leave of absence, which creates even greater demands on the workers who remain. The report goes on to note that staff experience additional stress as a result of living and working in the same community. This was also mentioned by community interviewees who noted that their work day never ends, as community members contact them after hours and on weekends. The report also showed that high turnover compromises the quality of training that new recruits receive due to the limited amount of time available for these individuals to attend training sessions.

More than a third of key informant and community interviewees commented on the significant rate of staff turnover occurring in the LHS office. A few key informants specifically mentioned the changes in the Director of Operations position at the LHS, identifying it as a serious challenge to the implementation of the LICHS itself. The turnover in this position was felt to contribute to a lack of management capacity in the LHS office. Other key respondents discussed the difficulties associated with the retention and recruitment of LHS staff. During the November 12, 2008, Main Table meeting, HC provided an update on their staff in Goose Bay. Of the nine positions

⁹⁰ Sheshatshiu Innu First Nation; A Request for Special Capital, October 2006.

⁹¹ N.A. (n.d.). No cover page (Review of IU and FTP Staffing).

listed: three were filled; one was about to be filled by a returning staff member who had been on assignment; four were vacant; and one was being covered until a vacancy could be filled. Innu meeting participants were concerned about the number of LHS resignations, noting that such a high number of vacancies cause major interruptions to services in the communities. The high rate of turnover is thought to contribute to the limited development of trust between staff and the community.

Staff turnover at the federal level was also mentioned during key informant interviews and a few community interviews with leaders and Directors. One key informant identified the issue of succession as a challenge to not only federal capacity but also to a focus on Innu healing.

Limited Performance Measurements

A few key informants suggested that the Strategy has not invested enough time and energy on measuring outcomes. What little data has been collected has tended to document the number of participants and the number of programs offered rather than reporting on actual healing outcomes (e.g., levels of sobriety, rates of crime, number of individuals trained and subsequently employed in related fields). A 2008 RMAF Special Study⁹² questioned participants about the extent to which the data identified in the RMAF's performance measurement framework is currently being collected. All of the responses fell in the 0-25 percent category. A 2007 operational review⁹³ of the LHS noted that as a result of a lack of milestones with respect to objectives, activities were reviewed as a means of assessing progress toward objectives.

Addressing this will be a considerable challenge, however, given the inherent difficulty measuring program outcomes from such a complex intervention; especially considering the challenges with attribution, given the broad array of changes and interventions in these communities, including the recent recognition of the communities as reserves, and given the fact that there are no specific authorities associated with this initiative.

Additionally, while it is extremely important to collect data on outcomes, it is also important to ensure that output data are reliably and accurately collected and to ensure the right information is collected. Work is currently underway to address some of these gaps in performance measurement. Fortunately, baseline data are now being collected in the community and further data collection is slated to begin soon.

As part of the current evaluation, a crosswalk document was recently developed by HC and populated by the Evaluation Working Group. The crosswalk outlines the LICHS Phase II outputs, outcomes, indicators and data sources.

Labrador Health Secretariat

The LHS, which was established in January 2001, is responsible for managing the implementation of the Community Health component of the LICHS and for providing professional health support to both Labrador Innu communities.

⁹² Loizides, S. (n.d.). RMAF Special Study Survey for Program Managers on Data Collection. Labrador Innu Comprehensive Healing Strategy.

⁹³ Canada (2007). Health Canada (Atlantic Region), First Nations and Inuit Health Branch. Labrador Health Secretariat Results of Operational Review.

The idea was that this approach would prevent professional isolation; provide a multi-disciplinary team approach to care; prevent professional burnout and isolation; and increase the opportunities for recruitment and retention of health professionals.

While most program staff had no complaints about the availability of capacity building opportunities provided by the LHS (this is further supported in the Fouillard evaluation reports), a few suggested that the delivery of these capacity building programs was not always suitable for the Innu. For instance, while the Capacity Development Inventory lists a number of practical training sessions, a few respondents indicated that more training activities involving a hands-on component were required. This is very important as some Elders noted that Innu learn by doing. This was raised by a couple of LHS staff members themselves as an issue they were attempting to address. Community members defined capacity development as shadowing someone and as teaching and showing people how to deliver programs and services. Consequently, increasing Innu capacity was thought to be better achieved through more direct support and mentoring.

Some community-level program staff, particularly those involved with health care delivery, questioned the LHS intended mandate to provide second-level service delivery, or capacity development assistance for community staff to manage and implement programs. They asked why LHS staff, who are registered health care professionals, cannot provide first-level service delivery to clients if the need is there (e.g., if the communities do not have mental health specialists why can't LHS personnel assume that role occasionally?). A recent operational review⁹⁴ of the LHS noted that some LHS staff were frustrated and suggested that the work of the LHS is inconsistent with community needs.

More than half of the community program staff described a disconnect between themselves and LHS staff. Secretariat staff were said to be absent from the communities and this absence is perceived to be a barrier to effective implementation of programming aimed at healing. Community leaders, directors, managers and coordinators, said things like "I hardly see them.", "It would be helpful if they were in the community more often.", "LHS come in whenever they want.", and "they [LHS staff] aren't going to the communities so they don't need to be in Goose Bay." A few key informants also indicated that LHS staff spend limited time in the communities.

LHS Community Visit Reports for fiscal years 2004-2005 through to 2008-2009 systematically track the date, staff member(s), location, community staff engaged, purpose/objective of the visit, and program area (e.g., crisis response, community health planning). For the fiscal year 2006-2007, the report documents 55 visits (often times by more than one LHS staff member) made to Natuashish and 136 visits to Sheshatshiu⁹⁵. It should be noted that visits to Sheshatshiu are day trips, while LHS staff typically spend several days in Natuashish per visit. An analysis of LHS staff days spent onsite in 2008, conducted by Health Canada Atlantic Region, showed that LHS staff spent approximately the same number of days in the two communities, even before a regular visit schedule was implemented. In an effort to address the perception that LHS are not in the communities enough, each staff person was recently mandated to visit Sheshatshiu and Natuashish a total of 18 days every three months regardless of whether there is a recognized need to visit the communities (e.g., planned capacity building activity) or whether community staff are actually present in the community (e.g., Natuashish staff at the Annual Gathering). The LHS office now sends out a schedule to the Health Directors to advise them when LHS staff will be in

⁹⁴ Canada (2007). Health Canada (Atlantic Region). Labrador Health Secretariat: Results of Operational Review.

⁹⁵ LHS. (2009). Community Visit Report, FY 2006-2007, cited February 12, 2009.

the community. But according to some key informants and several community members, LHS staff would be able to offer more program and service assistance if they were permanently situated within the communities rather than Goose Bay. Innu have always maintained that the LHS staff should be located in the community directly where the issues are.

Ultimately, however, the existence of the LHS office in Goose Bay has been a continuing point of contention for the Innu. The interim evaluation found that HC and the Innu each saw the value of the LHS differently. The Innu noted that the decision to create the LHS in Goose Bay was never suggested (or agreed upon) by the Innu. They also suggested that the Secretariat does not operate from a community-based approach. Additionally, many Innu expressed concern about the amount of LCHS funding being allocated to the LHS for its program and questioned the value that it would have in the long-term for the Innu. More than five years later, these same concerns were expressed by community members as well as officials from HQ, the Region and the Province. Several interviewees, including Innu leadership stated that the LHS office should be shut down, and some others suggested all of the LHS roles and responsibilities be devolved to the communities and/or LHS funding be transferred directly to the communities. The LHS office issue is a controversial topic that is raised at almost every Main Table meeting.

Throughout the interviews, concerns were expressed about the ability of the LHS office staff to effectively build capacity to the extent required in the communities. Some key informants noted that the LHS office got off to a rocky start because the Innu were not part of the decision to build the office in Goose Bay and they saw a lot of resources being spent on developing and staffing the LHS office. This has cast a negative light over the office ever since. The Innu have built up a considerable amount of resentment toward the LHS office and as a result, they have not been open to working with LHS staff. In turn, this resentment has made it difficult for LHS staff to function to the best of their ability while in the communities. A couple of respondents suggested that the attitudes of some LHS staff toward the Innu have undermined the work and the reputation of the entire LHS office, which has tarnished the relationship between the Innu and the current staff and has proven difficult (almost impossible) to change.

This relationship has been further exacerbated by the fact that funds are used to maintain the Secretariat in Goose Bay and targeted toward rental of office space, staff salaries, travel, and other expenses, instead of directly in the communities.

Additionally, some non-Innu staff suggested the LHS model does not work with the Innu, describing it as not being conducive to community healing; not engaging the Innu; and not being designed to be responsive to Innu needs and desires. Specifically, current and past attempts to work and engage with the Innu were all limited in their ability to engage more closely with the Innu and to build community capacity. The fact that LHS staff are not located in the communities and work Monday to Friday thus not being able to participate in weekend activities, means that they are not able to adequately connect with community members and program staff.

3.3.3 Summary of Key Implementation and Delivery Findings

Multiple lines of evidence reveal that in the last five years, LCHS partners (HC, INAC and CMHC) have carried out **a number of program activities that support the continued healing needs of the Innu**, including: **infrastructure development** (e.g., Safe Houses in both communities); **Strategies for Learning** (geared toward improving the educational attendance, achievement and ability of Innu children); **implementation and/or continued delivery of addictions and mental health programs, maternal and child health programs, and healing staff capacity building initiatives** delivered by the LHS; and the **creation and staffing of an**

Integrated Management position. These achievements are, however, tempered by a number of existing **challenges such as infrastructure limitations** (e.g., lack of space, privacy, confidentiality), which affect the ability of front-line staff to deliver effective community-based programming; **high rates of staff turnover** that negatively impacts on the levels of communication and trust between the Strategy partners, as well as resulting in the constant loss of corporate knowledge; and, **limited performance measurements** which act as a barrier to effectively assessing the progress toward objectives. A further challenge to the implementation and delivery of LICHHS programs and services, discussed by key informants and community interview participants, involves the **LHS mandate and the office policies and procedures**. Interview respondents spoke about issues such as requiring more practical skill development (relative to other forms of capacity building), the inability to provide first-level service care when the need is there, the perception of a lack of time LHS staff spend in the two communities; and the rationale behind having the office located in Goose Bay, rather than the communities.

3.4 Success

Evidence of progress toward the intended outcomes of the LICHHS, as well as challenges, were documented from all lines of evidence, with respect to four key areas: health, social programs and education; capacity development; integration, coordination and partnerships; and community infrastructure.

3.4.1 Health, Social Programs and Education

Health

Community program staff and LHS staff noted the absence of completed suicides in both communities in recent years. LHS staff indicated that this was a strong indicator of improvement in community wellness⁹⁶. This is particularly significant given the suicide rate figures shown in Tables 5 and 6. Unfortunately, community staff suggested that suicide attempts are still occurring and people are still expressing suicidal thoughts.

While Natuashish has experienced a perceived drop in the number of youth sniffing gas, there is some concern expressed among community members that this behaviour is beginning to resurface, as well as a perceived rise in both communities of hard drug use (e.g., cocaine, ecstasy) by youth. In terms of pharmaceutical drug use, however, while limited data are available, an analysis of the NIHB pharmacy claims database prepared by FNIHB Atlantic found that the prevalence of benzodiazepine and opiate use among the Labrador Innu who filled at least one benzodiazepine or one opiate prescription from 2004 to 2008 remained stable or showed a decrease, and was below average for Atlantic First Nations communities^{97,98}.

A couple of interviewees in both communities suggested that, generally speaking, the physical health of community members has not improved over the last five years. In Sheshatshiu, general health was described as 'fair' and a few of respondents indicated that health had actually declined over time as a result of increasing rates of chronic disease (e.g., obesity and diabetes (2006 Sheshatshiu Adult Health Survey revealed that 23 percent of the 246 respondents reported having diabetes), substance abuse (e.g., drugs and alcohol), sexually transmitted diseases (e.g.,

⁹⁶ It should be noted that during the time in which revisions were being made to the Final Report, there was a suicide death in both Natuashish and Sheshatshiu.

⁹⁷ Information is not available on the length of time individuals used the drugs, the amount prescribed per individual, or the specific reason for the prescription.

⁹⁸ Health Information Analysis & e-Health Solutions Unit and Jennifer Ross Makkan Regional Pharmacist, FNIH Atlantic. Benzodiazepine and Opiate Use Among Sheshatshiu Innu and Mushuau Innu Band Members. July 2009.

Chlamydia) and smoking (e.g., of 700 community members 18 years and older surveyed, 70 percent smoked). It was suggested by a couple of health care workers, however, that some Sheshatshiu residents were experiencing a slight improvement in well-being as a result of increased health-promoting behaviours (e.g., increased check-ups, taking medications).

Members in both communities suggested there has been an increase in teen pregnancy in the past year. Data were not available at the time of this report to corroborate these perceptions, as vital statistics were only available to 2006. A couple of individuals from Natuashish indicated there is reason to believe that teen girls are doing drugs while pregnant. Teen pregnancy in Natuashish was described by one community participant as having “hit rock bottom”; stating that six to eight teens were currently pregnant and another five to six teens had only recently given birth.

In Natuashish, the move from Davis Inlet was immediately followed by both increases and decreases in clinic visits for various medical conditions (refer to Table 8).⁹⁹ Research comparing clinic visits three years before the move and three years after the move found: a slight decrease in visits for gastrointestinal conditions, particularly in school age children and adults, but not in children under five years of age; a decrease in visits for respiratory ailments in all age groups with the most substantial decreases in asthma-like conditions, chest infections and ear infections (possibly attributable to decreases in crowding and improvement in home ventilation and heating); an increase in visits for ‘other infections’ due to outbreaks of chickenpox and coxsackievirus; and an increase in visits for treatment of skin conditions¹⁰⁰. While it is difficult to attribute the change in visits to any one factor, it is possible that the increase in visits for certain conditions is related to the creation of a medical clinic in Natuashish, where there was only a nursing station in Davis Inlet.

Table 8: Age-standardized¹⁰¹ rates of clinic visits for the different disease groups before and after the move

| Disease Groups | Number of visits | | Rates (%) ¹⁰² | |
|------------------|------------------|-----------|--------------------------|-----------|
| | Pre-move | Post-move | Pre-move | Post-move |
| Gastrointestinal | 232 | 185 | 13% | 10% |
| Other infections | <5 | 70 | <0.20% | 4% |
| Respiratory | 2035 | 1728 | 117% | 94% |
| Skin | 302 | 502 | 17% | 27% |

[Source: Bobet, E. (2007). An Assessment of the Immediate Health Effects of the Move from Davis Inlet to Natuashish. May 28. 2007, p.15]

⁹⁹ Bobet, E. (2007). An Assessment of the Immediate Health Effects of the Move from Davis Inlet to Natuashish. May 28. 2007.

¹⁰⁰ Note that the author indicated some uncertainty around the numbers associated with the rates of skin conditions and some difficulty in explaining the reason(s) for the increase.

¹⁰¹ The use of a standardised population is needed when comparing the mortality rates to discount the effect of age on mortality. Without using this standardization it would be unclear if differing mortality rates were due to age or other factors.

¹⁰² The rates shown represent the total number of clinic visits rather than individual people and as such, it is possible for the rates to exceed 100% (e.g., for every 100 people in the population, there were 117 clinic visits).

In terms of social programming, a few program staff, specifically those associated with programming aimed at increasing physical activity, noted that they were beginning to see healthier choices being made as a result of the availability of programs such as a women's exercise group, youth soccer and a walking club. These programs are run on a volunteer basis.

LICHs-funded programs in the communities delivered by Innu staff (e.g., FASD program, FTP, NGG/PSWs, Day Treatment Program at the Healing Lodge) have also received positive feedback and have had high levels of interest and apparent positive health results as indicated in the individual program evaluations carried out by Fouillard^{103,104,105,106,107}. In Natuashish, interviews with FASD staff and a public health nurse and a report highlighting FASD assets and capacity building¹⁰⁸ revealed that as a result of creating the FASD coordinator position, there is now an increase in the rate of diagnosis¹⁰⁹, an increase in the level of assistance available to individuals with FASD and their families and teachers, and an enhanced awareness about the relationship between FASD and alcohol consumption during pregnancy. Since 2004, a wide range of FASD-related activities have occurred including: a women's retreat with FASD education; community education workshops on FASD; FASD Day awareness activities and fundraising BBQ; guest speakers; poster contest for FASD; promotion of healthy choices for women; school education sessions, classroom sit-ins, teacher coaching on adaptations for FASD-affected students; and a mini conference with parents/caregivers of children affected with FASD to share resources and discuss implementation¹¹⁰. The Update on Natuashish FASD Assets and Capacity Building document notes that the nature of FASD activity in the community has changed as a result of increasing capacity on the part of the FASD coordinator and community staff. As a result of increased training and networking opportunities, the FASD staff have enhanced their knowledge and skill level in the area of FASD and are now in a position to conduct the majority of FASD-related training programs and workshops. Moreover, the focus of FASD has begun to move beyond harm reduction for pregnancies at immediate risk and diagnosis of children presenting symptoms towards general health promotion activities including exercise, nutrition and smoking cessation.

In Sheshatshiu, the FTP is intended to address mental health and addictions issues. The program, which integrates country treatment with community-based support programs (day programs and after care), aims to help families deal more effectively with issues and emotions through group

¹⁰³ Fouillard, C. (2009). It opened the door for me. An Evaluation of Mobile Treatment and Day Treatment Programs for the Natuashish Innu, March 2009.

¹⁰⁴ Fouillard, C. (2008). Gathering: Healing our Children and Community: A Report on the Next Generation Guardians and Parent Support Worker Programs in Natuashish, Labrador. Prepared for Health Commission Mushuau First Nation. June 2008.

¹⁰⁵ Fouillard, C. (2008). Family Treatment Program: Follow-up Research on Clients. First Draft Report. [presentation]

¹⁰⁶ Fouillard, C. (2008). A Place to Go: Healing our Children, Families and Community. A Report on an Evaluation of the Sheshatshiu Family Resource Centre. Prepared for Department of Social Health, Sheshatshiu Innu First Nation. March 2008.

¹⁰⁷ Fouillard, C. (2006). Uauitetau Steniuni: Let's Share About Our Lives: Two Case Study Stories of Families Healing with the Family Treatment Program. Prepared for Innu Health Services, Sheshatshiu First Nation. March 2006.

¹⁰⁸ Belzer, A. & Maringapasi, G. (2009, June 10.) Update on Natuashish FASD Assets & Capacity Building. [Internal report.]

¹⁰⁹ No rate of diagnosis was provided during the interviews or in the document. One reason for the increasing rate of diagnosis is that as parents learn more about FASD, they are growing more comfortable with the idea of having their child tested.

¹¹⁰ Maringapasi, G. and Belzer, A. (2009). Update on Natuashish FASD Assets and Capacity Building.

and individual counseling as well as traditional and spiritual teachings¹¹¹. A follow-up research study on the FTP revealed some positive healing trends in individuals who took part in the treatment programs¹¹². The study found that of 100 respondents who participated in a 2008 survey evaluating the Family Treatment Program:

- 77 percent said life was better after attending the program;
- 39 percent said the FTP gave them more control over their life, 35 percent said it helped them be a better parent, 32 percent said it was helping them continue on with their healing; and
- 27 percent said that since their last participation in the program they had not relapsed; of the 73 percent who relapsed, 45 percent said they use less alcohol and drugs now.

The study also found that many FTP participants were repeat clients with some having taken part in other treatment programs and some attending as many as four programs.

The NGG and PSW programs offered in Natuashish provide support, education, health promotion, prevention, harm reduction, skill development and recreation programs to women and girls, parents, children and the community as a whole through a variety of services, events and activities. The programs include a variety of activities: educational activities (e.g., workshops, information sessions and sharing circles), cultural activities (e.g., on the land); youth committee (Natuashish Suicide Prevention Awareness Committee); support group, retreats and crisis counseling (e.g., informal sharing and support, self-help, self-care); baby showers; home visits to expecting and new mothers; support to families in crisis (e.g., grief counseling); and other services (e.g., support for Elders). The NGG and PSW programs were identified in the document review and in community interviews as having a positive impact on healing and change in the community. In the 2008 evaluation of the NGG and PSW programs¹¹³, participants suggested a number of positive community outcomes, which they also indicated could be at least partially attributed to the NGG and PSW programs. These included: decrease in violent assaults against women; increased confidence and empowerment in women; decreased alcohol and drug-related incidents and crimes; less bullying among children; increased breastfeeding; increased levels of capacity to assume control of community programs and services; enhanced relationships between individuals and families; higher rates of community socialization; an increased awareness of Innu cultural practices (e.g., role of Elders, traditional food); and encouragement for community members (especially females) to go out on the land and learn traditional crafts, legends and ways of life.

Since 2007, treatment staff with Nechi training have offered day treatment programs at the Healing Lodge located five kilometers outside of the community of Natuashish. Two and four week non-residential, community-based treatment programs are offered to individuals and couples. Up to 22 people can participate in each program, with some individuals taking part in more than one treatment program. The programs involve a blending of traditional Innu, Native and Western methods to address problems of addictions and to allow participants to make healthy changes in their lives. The treatment programs involve approaches such as: AA; one-on-one

¹¹¹ Fouillard, C. (2006). Uauitetau Steniuni: Let's Share About Our Lives: Two Case Study Stories of Families Healing with the Family Treatment Program. Prepared for Innu Health Services, Sheshatshiu First Nation. March 2006.

¹¹² Fouillard, C. (2008). Family Treatment Program: Follow-up Research on Clients. First Draft Report. [presentation]

¹¹³ Fouillard, C. (2008). Gathering: Healing our Children and Community: A Report on the Next Generation Guardians and Parent Support Worker Programs in Natuashish, Labrador. Prepared for Health Commission Mushuau First Nation. June 2008.

counseling and therapy; and harm reduction. Fouillard's 2009 evaluation¹¹⁴ of the treatment programs revealed a number of reasons that individuals decide to take part in these programs, including: to stop drinking and/or using drugs; to improve family life; to regain custody of children placed in foster care; to deal with personal issues; to deal with grief; and to improve physical health. Some of the major successes noted were improvements in: levels of sobriety; emotional and mental health (e.g., confidence, self-awareness); nutrition and physical health; child care; familial relationships; interconnectedness between families in the community; community trust and caring; and re-connection with Innu culture. In the current evaluation, the Healing Lodge Director suggested the fact that individuals who take part in one of the treatment programs, relapse, but then return to the Lodge to ask for help should be viewed as a success. The Director also suggested that participants are leaving the program at the end of each day and applying some of what they learn, which indicates a strong desire to heal.

Although a few interviewees stated that the Strategy is still too focused on treatment (at the expense of prevention), there has been a noticeable shift in attention towards disease prevention and health promotion (in a very broad sense (e.g., breastfeeding, returning to the land, reviving traditions).

Intoxicant Bi-Law

In Natuashish, the intoxicant by-law¹¹⁵ (banning the consumption of alcohol in the community), passed January 31, 2008, was suggested by many community members to be responsible for a significant decrease in alcohol consumption. A number of key informants and a Natuashish community member indicated, as did participants in Fouillard's (2009) program evaluation that it is unlikely that the ban would have passed without the climate of healing and sobriety that has occurred as a result of the treatment and other social programs made available through the LICHs, noting also the importance of having sober and healthy leaders (both elected and running the healing programs) to act as role models for other community members.

Community members suggested that as a consequence of the alcohol ban, there had been a decrease in the number of alcohol-related deaths, a decrease in children on the streets (attributed by LHS and community staff members to increased supervision and parenting), and a decrease in the number of children frequenting the school-based breakfast program (attributed by LHS and community staff members to households having more money to buy food and to more parents being sober and able to provide breakfast for their children). In Fouillard's (2009) program evaluation report,¹¹⁶ treatment participants identified other positive impacts including increases in school attendance and parental involvement in education and school activities; as well as decreases in bullying, gas sniffing, suicides (and attempts), crisis calls to treatment program staff, medical evacuations, criminal activity (including violence) and calls to the RCMP.

Recent statistics received from the RCMP office in Natuashish also suggest a relationship between the passing of the by-law and a decreasing number of criminal incidents occurring in the community. Figure 10 highlights an overall downward trend in criminal charges between

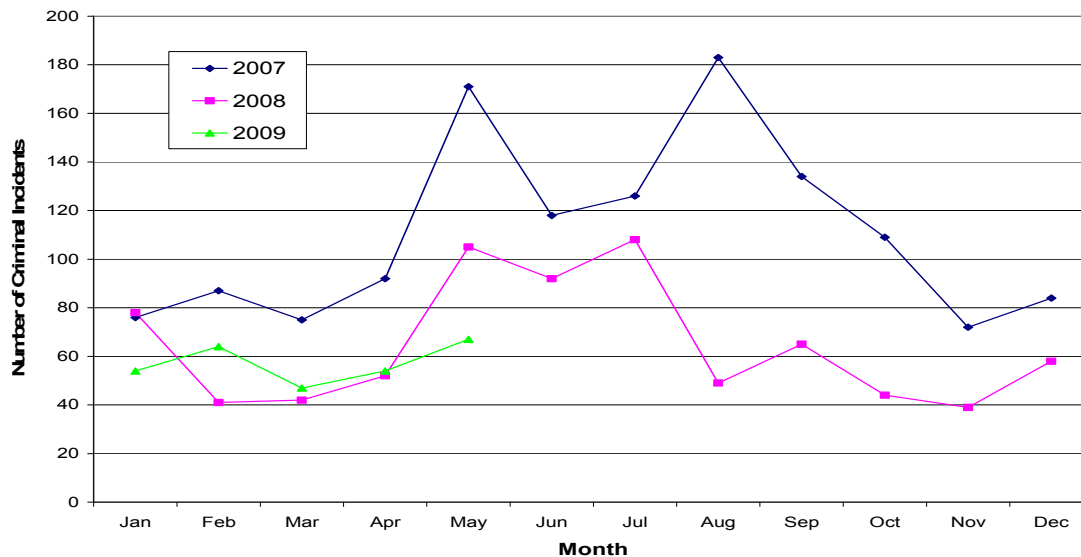
¹¹⁴ Fouillard, C. (2009). It opened the door for me. An Evaluation of Mobile Treatment and Day Treatment Programs for the Natuashish Innu, March 2009, p. 7.

¹¹⁵ While the intoxicant by-law is not an element of the LICHs, it was suggested that it would never have come about without capacity developments in leadership and the availability of treatment programs directly related to the Healing Strategy.

¹¹⁶ Fouillard, C. (2009). It opened the door for me. An Evaluation of Mobile Treatment and Day Treatment Programs for the Natuashish Innu, March 2009, p.26-28.

January 2007 and May 2009 (data were not yet available beyond this point). The number of incidents dropped by 554 from 1327 to 773 (a 41 percent decrease) - from 2007 to 2008 (including January 2008 in which the ban had not yet been put in place). Moreover, the average number of incidents per month decreased from 110.6 in 2007, to 64.4 in 2008, to 57.2 in 2009. While these data only cover a short time frame, a significant¹¹⁷ linear trend is apparent.

Figure 10: Criminal Incidents Over Time by Month for Natuashish 2007-2009



In an interview with the RCMP detachment in Sheshatshiu, the representative stated there was a perceived increase in crime in the community from January to June 2009¹¹⁸. There are a number of repeat offenders whose offences are primarily alcohol-related. The most common incidents occurring in the community include: mischief (e.g., vandalism), domestic assault, sexual assault and assaulting an RCMP officer.

Social Programs

As discussed in Section 3.2.2, many of the programs introduced under LICHs are part of A-Base programming for other First Nation communities. CYFS, for example, provides funding for operations (including preventative services) and maintenance (care for a child outside the parental home) for children 18 years and younger who have been taken into care by the province and placed out of the parental home and into foster/group homes or institutions. CYFS in conjunction with other initiatives funded under the LICHs has the potential to contribute to healing outcomes. The lack of available program data, however, made attribution of these A-base programs to community-based healing difficult.

Tripartite committees have been established to negotiate devolution of Income Assistance and CYFS. The Innu have decided on a model for CYFS and negotiations are continuing with respect to devolution.

¹¹⁷ -2 Log Likelihood χ^2 (df = 2) = 16.13, p = 0.000.

¹¹⁸ This may, however, simply represent a seasonal aberration.

In terms of other social programs beyond basic services, one example is the outpost program, funded under New Paths, which supports the Innu to go out on the land each spring for family, spiritual and cultural renewal. In recent years, with significant social problems, going on the land has become even more crucial for the Innu and is supported as an important parental, family, community, Elders, cultural and language priority. While there is no data to determine the success of this program, 150 Innu participated in 2007-08 and the Innu see this as an essential component of healing.

Another example of a successful healing activity mentioned by a number of key informants and community members is the youth theatre production of the play, "The Dancer". The message of the play is a plea for the survival of the Innu culture. It was presented in the community as well as in Hopedale, Goose Bay, Mingan, La Romaine and at a suicide prevention conference in Ottawa¹¹⁹. This represents an important vehicle for youth to begin to discuss and address issues such as suicide, gas sniffing, alcoholism and drug use and presents opportunities for youth to improve their self esteem and to build linkages between other communities. The youth are currently producing a new play focusing on teen pregnancy.

Educational Attendance and Attainment

In the fall of 2004, Dr. David Philpott released "*An Educational Profile of the Learning Needs of Innu Youth*"¹²⁰, outlining the findings from a two year comprehensive study assessing the educational needs of Innu children in Natuashish and Sheshatshiu. The study highlighted educational outcomes as well as community attitudes, perceptions and aspirations related to education, and it provides baseline information on attendance, achievement and ability.

The study found that of the 908 identified school-aged children, 33 percent (n=301 students) did not attend school at any point during the study and many had been absent from the educational system for the previous five years. Of the remaining 607 students who did attend, their attendance records were poor. For example, 17 percent attended less than 20 percent of the time. Moreover, for those who did attend, average attendance was 54 percent of the total school time¹²¹. Only 30 percent of youth actually reached high school, where they attended 20 percent of the time. Based on these findings, drop out was beginning in the primary grades and continued to escalate as the grade levels increase. The research also revealed limited levels of academic achievement. For example, 66 percent of seven year olds were one to two years behind their appropriate grade level, and 66 percent of 16 year olds were at least five years behind. With respect to reading, 80 percent of seven year olds were at least one grade level behind and 85 percent of 15 year olds were at least five years behind. With respect to mathematics, 56 percent of seven year olds were one to two grade levels behind and 100 percent of 15 year olds were at least five years behind¹²². Additionally, a review of available records showed that since 1993, Natuashish had three high school graduates and 12 graduates from ABE and that Sheshatshiu had 14 high school graduates and eight ABE graduates in about a 10 year period¹²³.

¹¹⁹ Fouillard, C. (2009). It opened the door for me. An Evaluation of Mobile Treatment and Day Treatment Programs for the Natuashish Innu, March 2009.

¹²⁰ Philpott, D. et al. (2004). *An Educational Profile of the Learning Needs of Innu Youth: Brief Summary of Findings*, October 2004.

¹²¹ Philpott, D. and Cahill, M. (2006). *Overcoming Socio-economic Barriers: The Labrador Innu: A Culture "at risk"*, February 2006.

¹²² Philpott, D. et al. (2004). *An Educational Profile of the Learning Needs of Innu Youth: Brief Summary of Findings*, October 2004.

¹²³ Ibid.

What is important to note, however, is that this study used a cross-sectional series of cohorts in one period of time, and thus a relationship between age and dropouts cannot be inferred. Additionally, comparable data are not currently available to show whether or not there have been any changes in the past five years. Additionally, it is difficult to track educational attainment figures from the census, given the organization of data (see Figures 2 and 3 in Section 3.2.1), which tracks completion in large age segments; i.e., for those aged 15-24 and 25-34, etc. This means it would only be reasonable to observe noticeable shifts in educational attainment in Canadian census 2011 or even 2016.

In 2005, Dr. Philpott released a report outlining 61 recommendations for an Innu educational system based upon the findings of the 2004 published Final Report and consultations with Aboriginal academic experts around the country¹²⁴. Following Philpott's report, Andrew Butts developed an implementation plan for recommendations¹²⁵. Key informant and community interviews along with a review of the documents suggest that only selected recommendations were acted upon. Specifically, while many of the Level I recommendations pertaining to immediate concerns and issues in both schools have been implemented or are in the midst of being implemented by the Band Councils, the Labrador School Board central office or the school staff, many of the Level II and III recommendations pertain to Innu self-governance, self-management and bicultural education and accordingly, are complex in nature and as such will be resource and time intensive to implement and thus had not been implemented. However, a follow-up study¹²⁶ in 2006 found that the Labrador School Board had made considerable changes supported through the Strategies for Learning funding provided under the LICHs, including: instructional design (e.g., smaller class sizes); professional development (e.g., development of a career education program); cultural relevance (e.g., Heritage Week and Spirit Week); Stay in School initiative (e.g., structured reward program for attendance; athlete of the month); teacher retention; and the breakfast program. Additionally, student assessments suggested improvements in attendance such that in 2005/06 59.3 percent of students attended more than 60 percent of the time compared to 41.4 percent in 2002/03. In 2006, attendance appeared to remain relatively stable in the primary grades but continued to drop off in the elementary and intermediate grades.¹²⁷ Additionally, improvements in attendance were more pronounced for children who started school in Natuashish than those who began school in Davis Inlet.¹²⁸ The findings further indicated that if children attended school, they tended to achieve. Achievements were noted in the primary grades particularly in reading and writing, while mathematics remained an area of need. Teachers reported fewer discipline problems, improved punctuality and increased parental involvement. The study also found, however, that academic gaps in achievement still exist in the upper elementary grades and that there were no significant academic improvements in the upper grade levels.

While much more improvement is still required, particularly in the elementary grades and higher, the findings of the Philpott report suggest the beginnings of a positive academic trend. Community members spoke about the increasing interest that youth had in education and

¹²⁴ Philpott, D. F., Nesbit, W.C., Cahill, M.F. & Jeffery, G.H. (2005). Enhancing Innu Education: Report to the Education Steering Committee. Recommendations for an Effective Model of Innu Education and Selected Programs/Models for Consideration in Innu Schools. December 2005.

¹²⁵ Butt, A.D., Sheppard, W. & Crewe, R.J. (2006). Implementation Plan for Enhancing Innu Education. October 16, 2006.

¹²⁶ N.A. (n.d.). Summary Report of Initiatives Undertaken by the Labrador School Board at Mushuau Innu Natuashish School, 2003-2006.

¹²⁷ Philpott, D. et al. (2006). Achievement and Attendance Update: Mushuau Innu Natuashish School. Summary Report, September 2006 [presentation].

¹²⁸ Ibid.

suggested that the number of individuals graduating from high school in both communities is increasing. In Sheshatshiu, three students graduated this school year and a further five are currently enrolled in university. In Natuashish, five high school students and three ABE students graduated during the 2008-09 school year.

3.4.2 Capacity Development

Crisis Management

Of key importance with respect to capacity development, almost all key informants who responded to the questions about crisis management (about a third did not respond) suggested that the LICHS has contributed to an increase in crisis management in the communities. The first few years of the Strategy were described as being ‘crisis-oriented’ because individuals in the communities did not possess the capacity (e.g., skills and training) to deal with issues as they arose. Community members and leaders were described, at that point in time, as running from crisis to crisis constantly trying to put out fires. Some respondents stated that the community has now moved beyond the ‘crisis mode’ toward a disease prevention/health promotion approach, and has stabilized. Some individuals suggested that as the communities have become more stable and self sufficient, the number of negative media stories has decreased substantially. The Innu have reached a point at which they are able to deal internally with issues as they arise and as such, are only taking positive community stories to the media for publication.

This stabilization is attributed by key informants to factors such as improved infrastructure, increased levels of capacity, overall community development and the availability of crisis response teams, all of which can be attributed in part (or in full) to the LICHS. Respondents also noted that the availability of suicide prevention programs/events such as A.S.I.S.T., safeTALK and youth suicide prevention conferences in the communities has significantly increased teen suicide knowledge and awareness. More generally key informants noted that the healing programs have provided community members with the skills, knowledge and confidence to deal with potential crises as they occur.

Devolution of Education

A few key informant and community interview participants (e.g., education directors) identified the devolution of education from the province to the communities as a strong indicator of healing success in the communities. It speaks to growing Innu capacity, self-determination and confidence, and successful collaboration between the Innu, the Province and the federal government. While key informant interviewees described the process as long and difficult, they also mentioned that everyone at the table remained committed to the final outcome – an Innu controlled education system. There is an Innu School Board in place with four elected members from each community. The Labrador School Board, while no longer officially involved in the education of Innu children, has offered their continued support and guidance should it be needed. The process of devolving education was identified by a couple of key informants who were involved, as a best practice. Other key informants mentioned that there is now a positive movement toward devolution of CYFS and that the devolution of Income Support is back on the table with an active committee now working on this issue.

However, one key informant and a couple of case study respondents questioned whether the communities would be able to deliver the standard of education required once devolution occurred.

Leadership

Several key informants spoke positively about the emergence of a stronger and more focused leadership in both Natuashish and Sheshatshiu in such a short period of time, and noted that leaders are beginning to adopt more long-term thinking as a result of no longer having to run from crisis to crisis. The consistency that exists in positions of Innu leadership (e.g., Innu Nation, Chiefs, Health Directors) has led to an increase in corporate knowledge (federal, provincial, and local) and networking at all levels. A few respondents noted that the leadership is now leading by example. In the most recent election in Natuashish, the Chief who was subsequently elected and abstains from alcohol, campaigned on a community alcohol ban platform. The intoxicant by-law is considered an exemplary illustration of a strong, continued commitment by leadership¹²⁹. This by-law was the first passed under the *Indian Act* in Natuashish. Given that it passed by only a few votes, it also demonstrates that leadership is willing to take risks for the benefit of their community members. The turnout to vote for this by-law was described as overwhelming, indicating an increasing level of civic participation.

Staff Training

According to LHS staff, community program staff has increased their capacity to administer healing programs through various capacity development initiatives and through experience gained while on-the-job. The LHS staff have delivered a broad range of capacity building initiatives to Innu program staff in the last five years (refer to the Implementation and Delivery section for a listing of some of these activities and further comments on community capacity development). As a consequence, a number of program staff have completed home visitation training modules and have training in suicide prevention train-the-trainer programs such as A.S.I.S.T. and SafeTALK. Additionally, as a result of working with LHS staff, community staff are now developing health promotion posters (e.g., breastfeeding) and brochures and they are designing, preparing and facilitating their own workshops (both within and outside the community). One example of capacity development articulated by both key informants and community members concerns the FRC Coordinator. In 2007, PSWs from both communities, the FRC Coordinator from Sheshatshiu and an LHS staff member visited Eskasoni First Nation in Nova Scotia to find out about their parenting program. After receiving program training, the FRC Coordinator adapted the Eskasoni parenting program to better meet the needs of her community. She then began offering the program in Sheshatshiu. To date, at least 40 parents have gone through her program. She has also delivered this training to other staff members in both communities so they are now able to run the program.

Limits to Capacity Development

There was a need suggested among interviewees for increased support for Innu healing capacity. In particular, key informant and community respondents mentioned the devolution of education, the emergence of a stronger and more focused leadership, and improved skills and capabilities in program staff as evidence of increased capacity.

¹²⁹ The current Chief in Natuashish devoted, during a previous term, considerable time, effort and funds trying to determine feasible methods to regulate alcohol. Because the community was not then an Indian Act Council nor a local government, no feasible local, provincial or federal method could be found. Several years later, after Innu leaders forced a move to the Indian Act, that earlier knowledge and experience allowed the Chief and community to quickly bring about a regulation under the Indian Act (written communiqué from SIFN Evaluation Working Group members).

While some reports indicate that the Innu have made great strides in increasing their capacity over the last five years,^{130,131,132,133} it was noted in key informant interviews that more capacity-building is needed in order for the Innu to effectively address their healing needs. The availability of adequate levels of community capacity is limited as a result of factors such as: low levels of educational attainment; low levels of literacy; small population size relative to community needs; and population composition (almost half of the population is under the age of 20 years). As a consequence, those who do possess skills and training in certain areas are being constantly called upon to help out. This in turn is leading to stress and burn out. A couple of community members noted that capacity levels are still too low, noting that capacity building initiatives need to be extended to the wider community (i.e., beyond leaders and health program staff). Some key informants and community members suggested that the Innu are still buying too much capacity rather than building their own (particularly in Natuashish).

A couple of key informants noted that another limitation to increasing Innu capacity is the lack of a capacity development plan developed by the federal partners. They noted that there is an assumption on the part of the federal government that if Innu take part in certain activities then capacity will be a by-product; rather than having a plan as to exactly how that will happen. A couple of interviewees suggested that a gap analysis be conducted to determine current levels of capacity and based upon those findings, that a plan be developed to map out the processes and expected outcomes and that there be an understanding of why and how those outcomes are expected to be achieved.

The Innu themselves have, however, provided to the federal government long-term capacity enhancement plans. For example, the 2003 Innu document titled, *Innu Healing Strategy*¹³⁴, which was submitted to the federal government for inclusion in an upcoming policy proposal, highlights the need for significant investment in capacity in order to enable Innu to accept regular responsibilities and to be prepared for future ones. The document goes on to note that "...investment must be based on outcomes, their relationships to the determinants of health, and the achievement of thresholds where regular programming is sufficient". The capacity development initiatives/activities/roles identified by the Innu include: management training; human resources; administrative training; mentorships; capacity coordinators; CYFS's supplemental authority; social worker accreditation; Income Support administration development; financial and administrative staff; tribal council advisory services; and, lands and registration clerks. Moreover, the SIFN has developed and/or submitted to the federal government a number of proposals/reports outlining the importance of building Innu capacity in order to acquire the skills and training necessary to take control over basic programs and services that other First Nations have had for a number of years^{135, 136, 137}.

¹³⁰ Fouillard, C. (2009). It opened the door for me. An Evaluation of Mobile Treatment and Day Treatment Programs for the Natuashish Innu, March 2009.

¹³¹ Fouillard, C. (2008). Gathering: Healing our Children and Community: A Report on the Next Generation Guardians and Parent Support Worker Programs in Natuashish, Labrador. Prepared for Health Commission Mushuau First Nation. June 2008.

¹³² Fouillard, C. (2008). A Place to Go: Healing our Children, Families and Community. A Report on an Evaluation of the Sheshatshiu Family Resource Centre. Prepared for Department of Social Health, Sheshatshiu Innu First Nation. March 2008.

¹³³ Belzer, A. & Maringapasi, G. (2009, June 10.) Update on Natuashish FASD Assets & Capacity Building. [Internal report.]

¹³⁴ MIFN/SIFN. (2003). Innu Healing Strategy: Innu Healing Submission, August 2003.

¹³⁵ SIFN. (2003). Report and Recommendations: Staff Interview and Survey: Capacity Building and Learning Services. December 2003.

Federal Capacity

While a few key informant interviewees suggested that the capacity of the federal government to deal with healing in Natuashish and Sheshatshiu has increased to a certain extent over the course of the Strategy, a number of individuals commented on the government's lack of capacity to design, develop and implement the LICHS initially, noting that the federal government had never been tasked with the responsibility of dealing with communities in such a serious state of crisis. Some respondents stated that while the federal government has developed a better understanding of the nature and scope of the issues affecting the Innu, they question their capacity to effectively implement healing programs and services. A couple of individuals expressed the belief that overall capacity has actually decreased in the last few years as a result of staff turnover. One area in which capacity was identified as being absent was in the area of education – an outside consultant is currently providing expertise on educational issues.

3.4.3 Integration, Coordination and Partnerships

Several key informants commented at some point during the interview on the improvements they had noticed in the level of integration and coordination between the players. Within the last five years a more integrated and coordinated approach to Innu healing had occurred. This was attributed by most to the tremendous gains made at the Main Table and in some cases to the various sub-committees (the Health and Healing sub-committee was mentioned most often). Most of those respondents noted that over time the discussions at the Table have become less strained and adversarial and more professional and productive and suggested that the Main Table now represents a place at which higher level dialogue occurs. The players at the Table have become more trusting of one another and consequently have begun to build more collaborative relationships. The fact that people are still at the Table is considered a significant success and speaks to the ongoing commitment of all the players.

While a number of key informants remarked that there have been increased efforts to involve Innu in the decision-making processes occurring at the Main Table, some federal and Innu representatives suggested that the federal government is still 'parenting' the Innu rather than treating them as equals and involving them in planning and decision-making endeavors. Efforts at integrated management need to be tripartite rather than bilateral. This sentiment was expressed by Innu respondents who noted that they often feel as though they are simply being asked to go along with decisions that have already been made (primarily by HC) on their behalf. Innu and some non-Innu participants questioned the extent to which the Innu are truly partners in the LICHS. A few Innu suggested that they will never be equal partners until they have full control of their money (i.e., not co-management and third party management¹³⁸) and until the majority of power and control associated with healing lies with them. A few key informants noted that Innu leadership has demonstrated significant increases in capacity required to manage and control the communities; and thus the capacity to be equal partners in the governing of their communities. One individual pointed to the financial audits conducted in each of the communities over the last five years as an indication of the bands' readiness to effectively govern.

¹³⁶ Sheshatshiu Innu Band Council. (2001). Capacity Development Plan. A Preliminary Proposal. March 2001.

¹³⁷ SIFN. (n.d.). Professional Development/Staff Training – A Proposal.

¹³⁸ Co-management and third-party management represent management structures that fall under INAC purview.

Some respondents identified the creation and staffing of the Director of Integrated Management position as an important step in the hopes of addressing the challenge of horizontal integration and coordination between departments. The position is jointly (50/50) held by INAC and HC. The mandate of this position is to pursue internal and external relationships integral to the healing process. (e.g., determine what roles the various federal departments can play and what responsibilities they can assume).

The majority of community program managers and staff as well as a review of the program evaluation documents indicate a high level of informal relationships between the healing programs offered in the communities. For instance, in Natuashish, program staff and managers spoke about close links between the healing programs funded through LICHS (e.g., NGG, PSW, FASD, Healing Lodge, CYFS, LHS, Safe House) as well as other agencies/programs/individuals within the community (e.g., Elders, Health Commission clinic nurse, Aboriginal Head Start on Reserve, Innu Nation, RCMP, Band Council, school day care, school teachers, Community Health Representative (CHR)/Diabetes Worker, Housing Authority). A few community respondents indicated that more formal relationships would help ensure that everyone was working effectively together to improve the well-being of community members. In Sheshatshiu, program staff and managers also indicated that they work closely with the programs funded through the Strategy (e.g., FRC, FTP, FASD, CYFS, Safe House, LHS) as well as other agencies/programs/individuals (e.g., Elders RCMP, Group Home, School, Health Commission (primary care), Charles J. Andrew Treatment Centre).

3.4.4 Infrastructure

In the last five years a number of structures have been constructed through funds under LICHS in the two communities thereby helping to establish a physical environment that lays the foundation for Innu healing, including Safe Houses in both Sheshatshiu and Natuashish; a new school in Sheshatshiu (based on a design funded by the LICHS); a Healing Lodge in Natuashish; and a Wellness Centre in Natuashish.

Other healing-related structures (not funded through LICHS) that have recently been completed, are in the midst of being constructed, or are poised to begin construction, include: Housing in Sheshatshiu; a Day Care in Natuashish; a Community Centre in Natuashish; and a FASD Building in Natuashish. Based on discussions with program staff working within these buildings and educational staff prepared to begin the 2009-2010 school year in the new school, some individuals expressed the belief that all of these structures will enhance the communities' ability to implement locally-based healing initiatives in safe and appropriate spaces.

During the community interviews, almost all respondents queried indicated a link between community infrastructure and healing. They commented on the need for safe, secure and culturally appropriate buildings from which healing programs could be run. Buildings of this nature create a positive atmosphere for healing to occur. To date, however, the healing structures available in Sheshatshiu are inadequate to meet the needs of the community and the program staff and manager (refer to Implementation and Delivery section for a discussion on infrastructure limitations).

3.4.5 Overall Resource Challenges

The inadequacy of resources is an issue that is recurrent through most LICHS program areas.

Beyond its original funding, a one-year extension of the strategy for 2004-2005 provided an additional \$20.5 million to ensure the continuation of the programs and services funded under the Strategy (refer to Table 1). This extension provided primarily for basic operating expenditures, supplying public services, construction of an RCMP detachment, and the continuation of various health services.

A policy proposal submitted in December 2004 recommended that the LICHS be continued and that funding in the amount of \$166.9 million be provided over a five-year period (2005/06 to 2009/10). However, the Strategy received only \$102.5 million (refer to Table 2), or 40 percent less than the requested amount. As a consequence, the scope of the Healing Strategy was narrowed to focus primarily upon: basic programs and services; improved capacity and collaboration; enhanced integrated management, and construction of a new school in Sheshatshiu and safe houses in both communities.

The Innu identified two key funding issues: A-base/A-base like funding, and “leave on the table” money.

A-Base/A-Base like Funding

One of the issues that arose during key informant and case study interviews conducted with Innu representatives and specific Innu directors/managers was the fact that most of the INAC portion of LICHS programming as laid out in each TB submission is essentially A-base and A-base like programs and services; much less funding is directed toward specific healing initiatives above and beyond basic programming to which the communities were entitled to upon reserve creation.

Approximately 75 percent of INAC’s share of the LICHS budget was designated for A-base/A-base like programming (e.g., education, Sheshatshiu school design, electrification in Natuashish); about 15 percent was allotted specifically for healing projects (e.g., New Paths, Strategies for Learning), and the remaining 10 percent went toward INAC costs (e.g., salaries, accommodation, departmental operations) (refer to Table 2). The Innu have consistently questioned why funding for basic programs and services (those provided to all First Nations) was included in INAC’s portion of the LICHS funding and why this regular programming is considered healing. The Innu have expressed concern about the small percentage of Strategy funding being directed specifically toward what the Innu regard as actual healing. They do not consider this an appropriate or efficient use of healing funds. The Innu contrast this with the fact that the Health Canada portion of the LICHS funds does not include A-base as part of healing.

“Leave on the Table” Money

“Leave on the Table” money refers to the 1999 provincial commitment to leave the money the Province was spending at that time on the Innu of Labrador in place for other Innu purposes, as the federal government takes over financial responsibility for Innu on-reserve programs and services. The Premier of Newfoundland and Labrador at the time, Brian Tobin, stated that the money historically allocated to the Innu would remain available to the Innu¹³⁹. Discussions with some specific key informants about the “leave on the table” issue suggested that as of 2003,

¹³⁹ Backhouse, C. and McRae, D. (2002). Report to the Canadian Human Rights Commission on the Treatment of the Innu of Labrador by the Government of Canada, p.18-19.

approximately \$9.0 million was to remain available to the Innu for education and child, youth and family services. Changes in the provincial political players after that time, however, significantly altered the provincial commitment such that only a one-time payout of \$4.0 million was left on the table to be spent on the new school in Sheshatshiu.

The Province maintains that the contribution was “to a maximum of \$3.5 million” for a period of five years, that the contribution was subject to appropriation by the House of Assembly, and that “[i]n calculating its annual commitment, the Province will take into account any liabilities owed by the Innu to the Province, its agencies or corporation” (there has been no resolution of those debts). The provincial commitment was also based upon the assumption that the federal government would live up to its 1999 commitment to cover the cost of Innu education and that the federal government would assume the cost of delivering income support in both communities¹⁴⁰.

While the Innu have not been involved in “leave on the table” discussions between the federal and provincial government, the outcome of these debates has influenced the amount of funds allocated to programs and services under the purview of the Healing Strategy. Throughout the Strategy, the Innu have been told that ensuring continued provincial funding was a significant factor in federal decisions. The amount of funding assumed to be forthcoming from the Province was thought to be an underlying assumption of services and costing of the LICHs¹⁴¹.

3.4.6 Summary of Key Success Findings

This evaluation revealed evidence of some **successes and challenges in the Innu healing process with respect to the four primary Strategy objective areas**: health, social programs and education; capacity development; integration, coordination and partnerships; and community infrastructure.

A wide range of successes were noted, including:

- marked reduction in completed suicides in recent years in both communities;
- increased awareness of healthy behaviours (e.g., exercise);
- increased awareness of the relationship between FASD and alcohol consumption;
- availability of culturally appropriate healing programs;
- positive outcomes associated with treatment and health programs (e.g., decrease in alcohol and/or drug use by participants, enhanced self esteem, increase in breastfeeding; increased awareness of Innu cultural practices);
- improvements in educational attendance and achievement by primary school children in Natuashish;
- progress toward the implementation of specific Philpott recommendations;
- devolution of education;
- stronger and more focused leadership with improvements in capacity;
- increased program staff capacity due in part to initiatives and support offered by LHS staff;
- improved relations at the Main Table;
- strong informal healing program partnerships at the community level;
- construction of the Healing Lodge and the Wellness Centre in Natuashish;

¹⁴⁰ Communication from Thomas G. Rideout (Minister Responsible for Aboriginal Affairs) to the Honourable Andy Scott (Minister of INAC). October 26, 2005.

¹⁴¹ Written communiqué received from SIFN representatives.

- design and construction of the new school in Sheshatshiu; and
- construction and staffing of Safe Houses in both communities.

The Strategy has also experienced a number of challenges, including:

- ongoing concern with substance abuse issues in both communities;
- lack of adequate healing infrastructure in Sheshatshiu;
- limited academic improvements in the upper level grades in Natuashish;
- limited Innu involvement in planning and decision making;
- contention regarding the existence and rationale for the LHS office in Goose Bay; and
- inadequacy of resources associated with the LICHS (e.g., A-base funding, “leave on the table” money).

3.5 Cost Effectiveness & Alternatives

Attribution of intended outcomes of funds from LICHS is difficult given the limited outcome measures and multiple interventions both within and exterior to LICHS intended to improve conditions for the Labrador Innu. During preliminary consultations, participants noted that indicators for measuring Strategy outcomes had just recently been developed for the 2007 LICHS RMAF. Prior to this, there were no standardized indicators upon which to measure Strategy success. During these consultations, one Health Director responded that the indicators used in the community to assess positive healing outcomes include: number of programs being delivered; number of people attending healing programs; and number of people requesting more programs. During the community interviews, another Director also indicated that the number of program participants is used as a measure of success as is the number of repeat clients. These indicators only measure uptake, and not outcomes or their relationship to expenditures.

Additionally, the absence of a needs assessment makes it difficult to comment on the degree to which LICHS funds were actually spent addressing community needs.

A review of the literature (provincial, federal and international) revealed that while a number of studies have addressed the issue of Aboriginal healing^{142,143,144,145}, there are no other healing initiatives that are directly comparable to the LICHS due to the uniqueness of the Innu situation (i.e., just recently becoming recognized as First Nations (2002) and being granted reserve status – Natuashish in 2003 and 2006 in Sheshatshiu) and the sheer magnitude and depth of the youth solvent abuse and suicide crisis which they faced. It is therefore difficult to comment on whether or not the Strategy could achieve similar or better results/outcomes at lower/similar costs. The long-term nature of the healing process adds to this difficulty due to the complexity in attempting to measure outcomes against funding allocations. Consequently, almost no studies exist that have considered the cost effectiveness of healing programs.

¹⁴² Bopp, Michael and Phil Lane Jr. 2000. The Nuxalk Nation Community Healing and Wellness Development Plan: A comprehensive ten year plan for the healing and development of the Nuxalk Nation. Four Worlds International.

¹⁴³ Lane, Phil Jr., Michael Bopp, Judie Bopp, and Julian Norris (2002). Mapping the Healing Journey: The Final Report of a First Nation. Research Project on Healing in Canadian Aboriginal Communities APC 21 CA (2002) Aboriginal Corrections Policy Unit. Department of the Solicitor General. Ottawa: Supply and Services Canada.

¹⁴⁴ Mussell, Bill. (no date). Restoration of Well-Being for Canada’s First Peoples. Accessed online 31 March, 2009 at: <http://www.caot.ca/pdfs/PaperfAbMentalHealth.pdf>.

¹⁴⁵ Senate Community Affairs Committee Secretariat (SCACS). 2009. Grasping the opportunity of Opal: Assessing the impact of the Petrol Sniffing Strategy. Commonwealth of Australia.

The 10-year cost-benefit analysis of Manitoba's Hollow Water Community Holistic Circle Healing (CHCH) process (designed to address the effects of inter-generational sexual abuse and implemented and run by the community) found that the initiative was a more cost-efficient option than the traditional criminal justice process¹⁴⁶. Researchers found that during the 10-year timeframe, the government contributed approximately \$2.4 million dollars to the community-run program while similar government-run services would have cost between \$6.0 and \$15.0 million. While there are obvious differences in the CHCH program and LICHS, both are intended to improve the health and social well-being of community members. The study implies a significant cost savings associated with Aboriginal community-based programming. As a result of the program, researchers were able to show a positive shift in overall health and wellness, indicated by more members returning to the community, more people completing their education, better parenting skills, the empowerment of community individuals, broadening of community resources, an increased sense of safety, and a return to traditional ceremony. The findings of this study also suggested a decreased reliance on outside resources as a result of prevention and community training. The AHF makes reference to the Hollow Water report noting that "community-based healing saves money"¹⁴⁷.

Most key informant interviewees suggested more cost effective ways to achieve healing in the two Labrador Innu communities:

- Through the development of a better coordinated, structured, and collaborative plan that allows for enhanced dissemination of information and thus leads to more informed decision making (i.e., in other words, a more comprehensive approach).
- Through decreasing LICHS overhead costs (e.g., office space, salaries, training) perceived to be occurring outside of the community (e.g., Amherst, Halifax and Goose Bay).
- Reallocating resources from the LHS in Goose Bay directly to the community (although this may create difficulties with recruitment), and possibly having it operated by Innu staff, or decreasing the number of LHS staff working in the Goose Bay office (e.g., reducing managers and support staff).
- Increased accountability and responsibility on the part of Innu for the manner in which Strategy funds are spent. (A couple of respondents noted that while federal departments like HC must show tangible results in response to Strategy spending, there is little available evidence to show that communities have used LICHS funds effectively and in the way in which they were intended.)
- Focusing the Strategy on health promotion/disease prevention approaches, rather than treatment.
- Other suggestions included: leveraging resources from sources such as crime prevention and Justice Canada; adopting a case management approach; creating a more dynamic Strategy that allows for the termination or decrease of tasks when they are no longer needed (e.g., if things are progressing well at Main Table, perhaps meeting quarterly is not necessary); depending less on the assistance of outside consultants; creating a Tribal Council (TC) to assist with capacity building in the areas of First Nation governance, administration and management (possibly transferring the LHS responsibilities to the TC); and placing more onus on the communities to deliver programs and services.

¹⁴⁶ Couture, J., Parker, T., Couture R., and Laboucane, P. (2001). A cost-benefit analysis of Hollow Water's Community Holistic Healing Circle Process. (Aboriginal People's Collections 2001). Ottawa: Solicitor General.

¹⁴⁷ AHF. (2009). The Aboriginal Healing Foundation 2009-2014 Corporate Plan.

3.6 Future Considerations

3.6.1 *Sustainability of Progress made under the LICHS*

Most key informants indicated that progress made under the LICHS is sustainable beyond 2010 but only with continued support (financial investments and human resources). Interviewees acknowledged that healing was a long-term and uneven process that would involve challenges and setbacks but that there was also the potential for increased capacity and opportunities for Innu development. A few respondents commented that the Innu had slowly built a foundation from which they could continue to heal; that there now exists a level of competency, expectation and confidence that allows the Innu the capacity to move forward. Some key informants suggested that forward momentum has begun to build and that every effort needs to be made to keep that energy focused and on track. A couple of key informants also remarked that for the progress to remain sustainable, LICHS must be continued and must be flexible, dynamic, and fluid such that it is able to respond adequately to evolving Innu needs.

Some key informants and community members suggested that because of devolution, education progress is sustainable. A couple of other respondents suggested that until health, CYFS and income assistance are devolved, they would not be sustainable. A few case study participants questioned the ability of the Innu communities to maintain their level of achieved capacity given the constant pressures they face (e.g., substance abuse, lack of education).

Jiwa et al., in writing on the sustainability of healing programs, noted that capacity building and community ownership are essential for sustainable programming. These elements are further encouraged by implementing systems for sustainable networks, resources and support systems that acknowledge the historical trauma experienced by many First Nations people¹⁴⁸.

One consideration that could be included in a future iteration of the strategy is to link the LICHS to the land claim and self government as it is a goal that has been articulated by the Innu.

3.6.2 *Risks of ending the Strategy's funding*

Several key informant interviewees described the Innu as teetering 'on the cusp', 'on the verge' and 'on the fence' and/or commented on the likelihood of 'slipping back' or 'reversing back'. They said that the Innu were equally poised for success or failure depending upon the level of support and guidance made available. Key informants suggested that while the communities are in a much stronger position (e.g., capacity development in the area of leadership), they are still vulnerable and at risk such that Innu gains may be lost or difficult to maintain without the continuation of Strategy support. A few key informants spoke about the lack of a sufficient critical mass of healthy people required to help sustain a healthy and healing community. Accordingly, these individuals noted that a concerted effort was required in order to help ensure that the Innu continued to move in a positive direction. One respondent captured the sentiment of the majority of participants: "Now is not the time to walk away". Of particular focus is the funding (assuming that INAC would have to fund A base programs and services, regardless), for INAC's Devolution, Planning and Transition funds; New Paths, Planning and Consultation funds; the operation of the safe houses; Strategies for Learning; as well as funding for HC programming under the LICHS.

¹⁴⁸ Jiwa, A., Kelly, L., and St. Pierre-Hansen, N. (2008). Healing the community to heal the individual. *Canadian Family Physician*, 54:e1—e7.

3.6.3 Summary of Key Future Consideration Findings

Progress made under the LICHHS is considered **sustainable beyond 2010 but only with continued support and guidance from the federal government**. Although the Labrador Innu communities are still described as being **at risk of returning to a state of crisis without continued support for healing and community development**, there is a sense that positive momentum has begun to build in the communities.

4.0 Conclusions and Recommendations

4.1 Conclusions

The interim impact evaluation of the LICHS suggested that the federal government and the Innu were divided on a number of issues/interests, perspectives and approaches. What was concluded was that a more collaborative, cooperative and meaningful relationship was required between the two players if they were to find “common ground” and work towards a “blended model” of designing, developing and implementing the LICHS. The recommendations further stated that “As partners, the Labrador Innu need to be jointly responsible for the LICHS”. Moreover, the interim evaluation’s conclusions and recommendations noted that for the Strategy to be successful, the Innu required greater control and day-to-day involvement in the actual healing of individuals, families, and the communities; and more decision-making power with respect to LICHS programming. The study also called for a more community-based approach to healing.

While much has changed in the last five years, many of the overall conclusions and recommendations put forth in the interim evaluation are still germane. For example, there are still no commonly accepted definitions for fundamental terms such as ‘healing’, ‘capacity building’, performance measurement and the role of infrastructure in healing among the LICHS players. The Innu, over the course of different iterations of the Strategy have provided definitions and information that reflect their reality and worldview. Many of these have not been incorporated into the Strategy and consequently some of the items noted in the interim evaluation remain the same. This presents an important limitation in determining the progress of the Strategy.

The available evidence suggests the LICHS remains relevant and that long-term government support is needed. The Healing Strategy has successfully enabled Labrador Innu communities to begin the long and complex process of healing. Existing healing programs were deemed by many community members to be suitable to meet many of their healing needs (e.g., on the land treatment, crisis intervention, training and skills development, and fitness and recreation).

Additionally, there are still several aspects of physical and social health where there are clear gaps between the Labrador Innu and other First Nations and thus an even greater disparity between the Labrador Innu and the general Canadian population. Moreover, there are still several needs that are not being met by existing healing programs, including: abuse; domestic violence; and availability of post secondary education initiatives. Additionally, the needs of specific certain subsets of the Innu communities (e.g., youth, Elders) are not being adequately targeted. Such findings further support the need to continue the Healing Strategy in order to help improve the overall socio-economic and health status of the Innu.

A review of the documents showed the LICHS to be in line with the Government of Canada priorities and those of INAC and HC. At the same time, however, a number of key informant and case study interview respondents believe that this federally funded, horizontal initiative does not represent a ‘comprehensive’ approach to healing for the Innu. They noted that it is composed of a disjointed group of programs; is limited in its depth and/or breadth; lacks a long-term strategic plan; and contains no built-in provisions/flexibility to respond to evolving Innu needs.

In the last five years, LICHS partners (HC, INAC and CMHC) have implemented a number of program activities that have contributed to the healing needs of the Innu, including: infrastructure development; Strategies for Learning; delivery of addictions and mental health programs and maternal and child health promotion programs; staff capacity building initiatives; and the creation and staffing of an Integrated Management position.

There are numerous challenges that affect the ability of program staff to effectively implement and deliver LICHS programs and services. These include limited healing infrastructure (e.g., lack of space, privacy, confidentiality), high rates of staff turnover, and limited performance measurements.

A further challenge discussed by key informants and community interview participants involves the LHS. There are strong indications from interviews that there is a greater need for the LHS to provide more practical skill development (relative to other forms of capacity building), that it should be able to provide first-level service care when the need is there, and that there is a disconnect between the LHS and the community, and hence strong sentiment that its resources should be reallocated directly to the community. While interview participants acknowledged that certain dedicated LHS staff have built capacity in the communities, the extent to which this has occurred given the timeframe (eight years), financial resources and level of effort allocated to this particular endeavour, has been questioned. Respondents commented on issues such as the office location in Goose Bay, the fact that LICHS money was being used to fund capacity building in LHS staff, the negative attitudes expressed by certain LHS staff towards the Innu, and the adoption of a capacity building model that is not considered conducive to community healing or to engaging the Innu. There is concern that the approach employed by the LHS, which is guided by HC policies and procedures, is inadequate to meet the evolving needs of the two Labrador Innu communities and is further constrained by the problems of distance and the need to travel to provide client support.

Some success was noted in all four key activity areas of the logic model, including:

- Health, social programs and education:
 - marked reduction in completed suicides in recent years in both communities;
 - enhanced awareness of the relationship between FASD and alcohol consumption;
 - positive outcomes associated with FTP and Healing Lodge addictions treatment and aftercare programs (e.g., decrease in alcohol and/or drug use by participants, enhanced familial relationships, improved self esteem);
 - positive outcomes associated with health programs offered through the FRC and the NGG/PSWs (e.g., decrease in violent assaults against women, increased feelings of empowerment and self confidence in women and girls, increased levels of breastfeeding, improvements in parenting; youth theatre production);
 - increased awareness of Innu cultural traditions;
 - increased participation in on the land activities offered through the outpost program;
 - increase in crisis management;
 - decrease in crime in Natuashish;
 - improvements in educational attendance and achievement by primary school children in Natuashish; and
 - progress toward the implementation of specific Philpott recommendations.
- Capacity development:
 - devolution of education;
 - forward movement toward the devolution of CYFS and IS;

- increase in high school and ABE graduates;
- increased program staff capacity due in part to initiatives and support offered by LHS staff (e.g., suicide prevention training such as A.S.I.S.T. and Safe TALK).
- Integration, coordination and partnerships:
 - improved relations at the Main Table;
 - strong informal healing program partnerships at the community level; and
 - creation and staffing of the Director of Integrated Management position.
- Community infrastructure:
 - construction of the Healing Lodge and the Wellness Centre in Natuashish;
 - design and construction of the new school in Sheshatshiu; and
 - construction and staffing of Safe Houses in both communities.

The Strategy has also experienced a number of challenges such as a perceived increase in drug use (e.g., cocaine and ecstasy), limited academic improvements in the upper level grades in Natuashish, limited number of individuals involved in capacity building initiatives, the lack of a true partnership between the players (bilateral rather than tripartite), and the inadequacy of resources allocated to/associated with the LICHs for healing-specific initiatives above basic services provided to all First Nations.

The extent to which the funds allocated for the LICHs are responsible for the achievement of outcomes is difficult to determine given the performance of the Strategy has not been adequately monitored or assessed. Only recently have a series of indicators and data sources been developed to help monitor and assess the Strategy outcomes. Prior to completion of the 2007 LICHs RMAF, there were no standardized indicators upon which to measure Strategy success.

The literature suggests that community-based and community-driven healing approaches are most effective and there is some indication that they may also be the most cost-effective way to deliver healing programs and services. Other means of increasing the cost-effectiveness of the Strategy mentioned by interview respondents include: developing a more coordinated, structured and collaborative plan; decreasing overheads costs outside of the communities; increasing the accountability on the part of the communities for how funds are spent; and adopting a health promotion approach rather than one that focuses primarily on treatment.

Progress made under the LICHs is considered sustainable beyond 2010 but only with continued support and guidance from the federal government. Although the Labrador Innu communities are still described as at risk of returning to a state of crisis without continued support for healing and community development, there is a sense that positive momentum has begun to build in the communities. The Innu have begun the long road to healing, and as such, significant collective effort is required to keep that energy focused and on course.

4.2 Recommendations

The evaluation found strong evidence of a need for long-term, government supported Innu healing in order to address unresolved social, health, safety and economic issues and to maintain and build upon healing progress that has already occurred in the two Labrador Innu communities of Natuashish and Sheshatshiu.

1. In order to sustain and move forward on the progress made through this Strategy, additional support to the Labrador Innu communities will be required.

2. In order to sustain and move forward on the progress made through this Strategy, additional support for community-based healing programs, services and events in Natuashish and Sheshatshiu will be required.

Should the Strategy continue, the following recommendations are suggested for improving its effectiveness and impacts.

To incorporate an Innu perspective, a process should be put in place to reach a mutual understanding and agreement on what approach should be developed and what activities should be included as healing initiatives.

3. The Innu and the federal government need to engage in a facilitated process whereby both can mutually develop the key terms and definitions and then respectively share them in an open and constructive dialogue to reach a mutually agreed upon approach to healing for future activities.
 - An Innu worldview/perspective should be incorporated into the Strategy and clearly reflected in key healing definitions and related activities. These should inform and influence the design, delivery and implementation of the new phase of the Strategy.

To ensure that the Strategy continues based truly on Innu healing needs, and is comprehensive and flexible enough to respond to evolving Innu needs.

4. Implement a healing needs assessment in the two communities to better understand ongoing and unmet needs. This should include an evaluation matrix, and a Performance Measurement Strategy. The findings generated from the needs assessment and associated documents should be presented to the Main Table.
5. Based upon the evidence presented and input provided by the Innu, a determination should be made by all partners as to how existing programs and services might be appropriately adjusted, including exploring possible alternatives to existing funding authority arrangements, but remaining consistent with departmental commitments to support Labrador Innu healing. The findings and resulting determinations should be used to guide the new phase of the Strategy.

To ensure that the next phase of the Strategy is community-based and supportive of Innu capacity and self-government.

6. The federal government needs to continue to play a substantial role in supporting Innu capacity and self-government. It also needs to provide the resources necessary to implement the training and capacity building activities required, within current authorities and consistent with departmental commitments to support Innu capacity and self-government, and to build the skills and abilities of the Innu, on terms agreed to by the parties in the new phase of the strategy.
7. The parties need to mutually develop an Agreement regarding how accountability and transparency will be maintained.
8. The Main Table and its subcommittees will continue with more active Innu engagement and develop a means for outreach to the communities at large, to encourage broader participation by community members in healing.

9. Government and Innu engage in a process to agree together how best to realign resources currently allocated to the LHS in Goose Bay so that the funds flow directly to the communities and utilize Innu expertise to the extent possible. The overarching rationale is to better serve the community according to their identified needs.

To provide a solid evidence base for the ongoing healing of the communities and to track changing healing needs and accomplishments.

10. The parties need to develop a tripartite committee tasked with reviewing and providing feedback to the main partners on any existing and future evaluation and monitoring plans; including developing specific action items and timelines; and with the end objective to have solid evidence to monitor progress, with evaluation and monitoring data owned by the Innu, with continued support from partners.

Appendix A

LICHS Impact Evaluation Lines of Evidence

| | Lines of Evidence (Data Collection Methodologies) | | | |
|---|---|-------------------|----------------|------------------------|
| | Document and File Review | Literature Review | Key Interviews | Community Case Studies |
| 1.1 To what extent is there a continued need to support Labrador Innu communities with healing? | √ | | √ | |
| 1.1.1 What are the current needs of the Labrador communities as they pertain to healing? How have these needs changed over time? | √ | | √ | |
| 1.2 To what extent do the objectives of the LICHS relate to the objectives of the Government of Canada and of the departments involved in its delivery? | √ | √ | √ | √ |
| 1.2.1 According to what, the budget or other priority, was the Strategy created? | √ | | √ | |
| 1.2.2 Does the Strategy relate to current GOC priorities? Does the Strategy relate to the priorities of the departments involved in the delivery? | √ | | √ | |
| 1.2.3 To what extent are the Strategy's objectives consistent with the GOC roles and responsibilities? | √ | | √ | |
| 1.2.4 Are current activities duplicating, overlapping or running at cross purposes with other programs? | √ | | √ | |
| 1.2.5 Extent to which the Strategy is appropriate to answer Innu communities' needs? | | √ | √ | √ |
| 2.1 Has the Strategy implementation been appropriate? | √ | | √ | √ |
| 2.1.1 On what basis are the interventions delivered in the communities relevant in reaching the Strategy's objectives? | √ | | | |
| 2.1.2 How is the on-the-ground coordination between the different partners (Innu community leaders, provincial and federal departments involved) working to facilitate the attainment of the Strategy's objectives? | √ | | √ | √ |
| 2.1.3 How are the projects funded in the communities coordinated with other jurisdictional/provincial programs? What are the concrete benefits for clients, providers and funders? | √ | | √ | √ |
| 2.1.4 Are the current governance arrangements improving the delivery of the Strategy (Labrador Health Secretariat and other governance aspects especially those following the interim evaluation)? How? | | | √ | √ |
| 2.1.5 To what extent has the LICHS contributed to the development of crisis management and sustained prevention activities? | | | √ | √ |
| 2.2 What are the lessons learned (including success stories) from the LICHS, for the future and for other communities? | | | √ | √ |

| | Lines of Evidence (Data Collection Methodologies) | | | |
|--|---|-------------------|----------------|------------------------|
| | Document and File Review | Literature Review | Key Interviews | Community Case Studies |
| 3.1 What progress has been made towards the Strategy's intended outcomes, as laid out in the logic model? | √ | | √ | √ |
| Has the relationship / trust between partners improved? | √ | | √ | |
| Has integration and coordination of services improved? | √ | | √ | |
| Is the integration/coordination of Federal/Provincial/Innu programs and services optimal? | √ | | √ | |
| Are the services provided under the LICHS culturally appropriate? | √ | | √ | √ |
| Are the spaces designated to deliver the programs adequate? | | | √ | √ |
| Has the implementation of the Philpot recommendations progressed? | √ | | √ | |
| Has support to individuals/families affected by FASD increased? | √ | | √ | √ |
| 3.1.1 Ultimately, what changes to the general health (health status) and well-being if individuals, families and communities have been observed? | √ | | √ | √ |
| Are community members aware of targeted healthy behaviour? | | | √ | √ |
| Has the gap between Innu health status and health of other First Nations on reserve been closing? | √ | | | |
| 3.1.2 Ultimately, has Innu community control increased? | √ | | √ | √ |
| Are communities' engaged in health planning? | √ | | √ | √ |
| Are community's involved in schools? | | | √ | √ |
| Has community capacity to manage services increased? | | | √ | √ |
| Has capacity to manage community infrastructure increased? | | | √ | √ |
| Has community financial and management capacity increased? | √ | | √ | √ |
| Has effective social and health planning and management capabilities in communities increased? | | | √ | √ |
| 4.1 To what extent is the LICHS meeting its medium and long-term outcomes in relation to the resources spent? | √ | | √ | |
| 4.2 Are there alternative programs / interventions achieving similar or better results/outcomes at a lower/similar cost? | | √ | | |
| 5.1 To what extent is the progress made under the LICHS sustainable in the context of the Strategy? | | | √ | |
| 5.2 What are the risks of ending the Strategy's funding for the healing process? | | √ | √ | |

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Baseline Data Collected Effective January 2006

Data is available for each community unless otherwise specified.

* indicates that a First Nations on Reserve comparator is included

** indicates that an Aboriginal persons comparator is included

*** available but not yet analysed or included in baseline

Maternal/Child Health

1. *Birth weights 2000-2003
2. Babies' risk status (Healthy Beginnings Program) 2000-2003 Davis Inlet/Natuashish
3. Breastfeeding rates at birth and six months, 2000-2003, Sheshatshiu
4. Breastfeeding rates at birth, three months and six months, 2002-2003 and 2005, Davis Inlet/Natuashish
5. Percent of pregnant women by period that prenatal care started, 2002-2003, and 2005 Davis Inlet/Natuashish
6. Percent of pregnant women who smoke, 2002-2003 and 2005, Davis Inlet/Natuashish
7. Percent of pregnant women whose previous pregnancy was within the last 12 months, 2002-2003 and 2005, Davis Inlet/Natuashish
8. Percent of pregnant women who use drugs or alcohol, 2002-2003 and 2005, Davis Inlet/Natuashish
9. Percent of pregnant women who are diabetic, 2002-2003 and 2005, Davis Inlet/Natuashish
10. Percent of pregnant women who sniffed gas, 2002-2003 and 2005, Davis Inlet/Natuashish
11. Percent of infants who are introduced to solid food at greater than 4 months of age, 2002-2003, Davis Inlet/Natuashish
12. *Percentage of Mothers Under 15 Years of Age, 1992-2002
13. *Percentage of Mothers Under 20 Years of Age, 1992-2002
14. *Birth rates per 1000 population, 1991-2002
15. Average parity to mothers who gave birth in each year, 1991-2002
16. Average age of mothers who gave birth in each year, 1991-2002
17. *Percentage of total deaths occurring to children and youth under age 15, 1986-2002
18. *Infant mortality rate, 1994-2002

Addictions/Mental Health

19. Percentage of youth left alone overnight, 1999
20. Percentage of youth with low support, 1999
21. Percentage of youth in high distress, 1999
22. Percentage of youth with low self esteem, 1999
23. Percentage of youth with low mastery, 1999
24. Percentage of youth who smoke, 1999
25. Percentage of youth who had a drink in the past six months, 1999
26. Percentage of youth who report drinking as a source of unhappiness in their homes, 1999
27. Percentage of youth who used drugs in the past six months, 1999
28. Percentage of youth who sniffed gas in the past six months, 1999
29. Percentage of youth who damaged property in the past six months, 1999

30. Percentage of youth who acted violently, 1999
31. *Suicide rate per 100000, 1991-2002
32. Attempted Suicides in Newfoundland and Labrador for total province, Island, Labrador Non Aboriginal population, Innu and Inuit of Labrador, 1998-2000 (NLCHI)
33. Client satisfaction surveys for Day Treatment Programs, Natuashish, 2004 and 2005

General health status/ socio-demographic/ determinants of health

34. * Death rate, 1991-2003
35. Leading causes of death, 1991-2003
36. Hospital separations for all causes, 1995-2003
37. Hospitalizations pre and post move for Davis Inlet/Natuashish 1992-2003 for Skin Diseases, Infectious Diseases and Respiratory Diseases
38. **Population characteristics including age structure, 2001
39. **Population and dwelling characteristics including population per dwelling, percentage of dwellings requiring major repair, percentage of private dwellings with more than one person per room and average number of persons per room, 2001
40. ** Median household income, 2001
41. **Percentage of population 15 years and over with income, 2001
42. **Median total income of persons 15 years and over, 2001
43. **Earnings as a percentage of income, 2001
44. **Government transfer as a percentage of income, 2001
45. **Other money as a percentage of income, 2001
46. **Labour force participation rate 15 years and over, 2001
47. **Employment rate 15 years and over, 2001
48. **Unemployment rate 15 years and over, 2001
49. **Average earnings (all persons with earnings), 2001
50. **Percentage of population 15 years and over who worked full time full year, 2001
51. **Average earnings for full time full year work, 2001
52. **Percentage of population 15 years and over attending school full time, 2001
53. **Percentage of population 15-24 attending school full time, 2001
54. **Highest level of schooling for population 15 years and over, 2001
55. **Percentage with knowledge of an Aboriginal language, 2001
56. **Percentage who speak an Aboriginal language at home, 2001
57. Crime rates with comparisons to other Labrador and First Nations communities, 1996
58. Violent crime rates, 1992-2002

Potential:

1. *Application of the United Nations Human Development Index for 1996 and 2001. Data is available now and 2006 data will be available in 2007/08. NLCHI has data that may fill the need for life expectancy. See INAC Strategic Research and Analysis Directorate's Measuring the Well-Being of Aboriginal People: Application of the United Nations Human Development Index.
2. Analysis of main causes of clinic visits before and after move to Natuashish to determine the direct health impact of the move. Clinic data is available at ICD 9 diagnosis level for Davis Inlet (pre-move) and Natuashish (post-move).

Upcoming:

1. Newfoundland and Labrador Centre for Health Information (NLCHI) publications on hospitalizations for pneumonia by age, and unintentional childhood injuries (2006) for Inuit and Innu in Labrador.
2. Report on monitoring of hospitalizations of residents of Davis Inlet/Natuashish for infectious diseases, skin and subcutaneous diseases and respiratory diseases 1992-2004 (one additional year of post-move data - #37 above). Summer 2006.
3. Updates to births (#s 1, 12-16 above) and deaths (#s 17, 18, 31, 34, 35 above) for 2003 and 2004 and hospitalizations (#s 36 and 37 above) for 2004 will be available in 2006.
4. Numbers 37 through 56 are Census data that will be released in 2007 and 2008.

Other collections – program monitoring

1. Mushuau Mobile Treatment and Sheshatshiu Family Treatment programs monitoring data: families and individuals in treatment, completions, program satisfaction surveys, treatment plans, aftercare services and programming.
2. Community visits by LHS staff to Natuashish and Sheshatshiu.
3. Parent support worker monitoring: number of families seen, types of support offered, training and capacity building undertaken, links with other agencies, referrals made by type of service.
4. Community health: Child and maternal health records, including maternal risk factors, communicable disease notifications.
5. FASD work plans
6. Community health planning activities
7. Mental health therapist case load.
8. HC's Environmental Health Officer's reports on housing condition

RCMP: ongoing crime reports available on number of crimes by community by year and type e.g. criminal code (persons or property) federal offenses (general, drugs), provincial offenses (general, liquor) municipal offenses.

INAC program data

Education

- Nominal Roll data: enrolment by age, gender, grade, special education needs (i.e. how many receiving High Cost Spec. Ed., how many assessed and not receiving), language spoken upon enrolment, language of instruction, reason for leaving school (i.e. graduation, transfer, withdrew etc.), destination after leaving (i.e. employed, post-secondary, occupational skills, etc.)
- Curriculum: compliance with provincial standards, Special Ed. policies
- Education staff: qualifications/certification, % Aboriginal, salary scale (i.e. FN, provincial, federal), HCSE qualifications/certification, HCSE needs not met
- Post secondary: enrolment by gender, age, graduation, qualification sought, length of program

Social

- Income assistance: # of families (and # of persons in families) receiving assistance (annual monthly average), # of singles receiving assistance,
- Housing: # of CMHC housing units on reserve, # of housing units occupied by IA recipients, # of units for which fuel/utilities were paid, total annual rent expenditures funded by INAC to IA recipients, total fuel, utilities and other shelter expenditures to IA recipients
- Child and Family Services: # of children placed in care, by gender, age, voluntary, temporary or permanent, type of care (institutional, group home, foster), # of days, total cost
- Number of children out of parental home
- # and type of protective and preventive services available (i.e. provided by FN or CFS)
- # of families and # of children served by protective and preventive services
- Family Violence Projects Annual Reports: includes purpose, activities, resources expended, results/accomplishments
- Assisted Living: # in program by age, gender, type of care (i.e. in-home, institution, foster), total expenditures, # of days