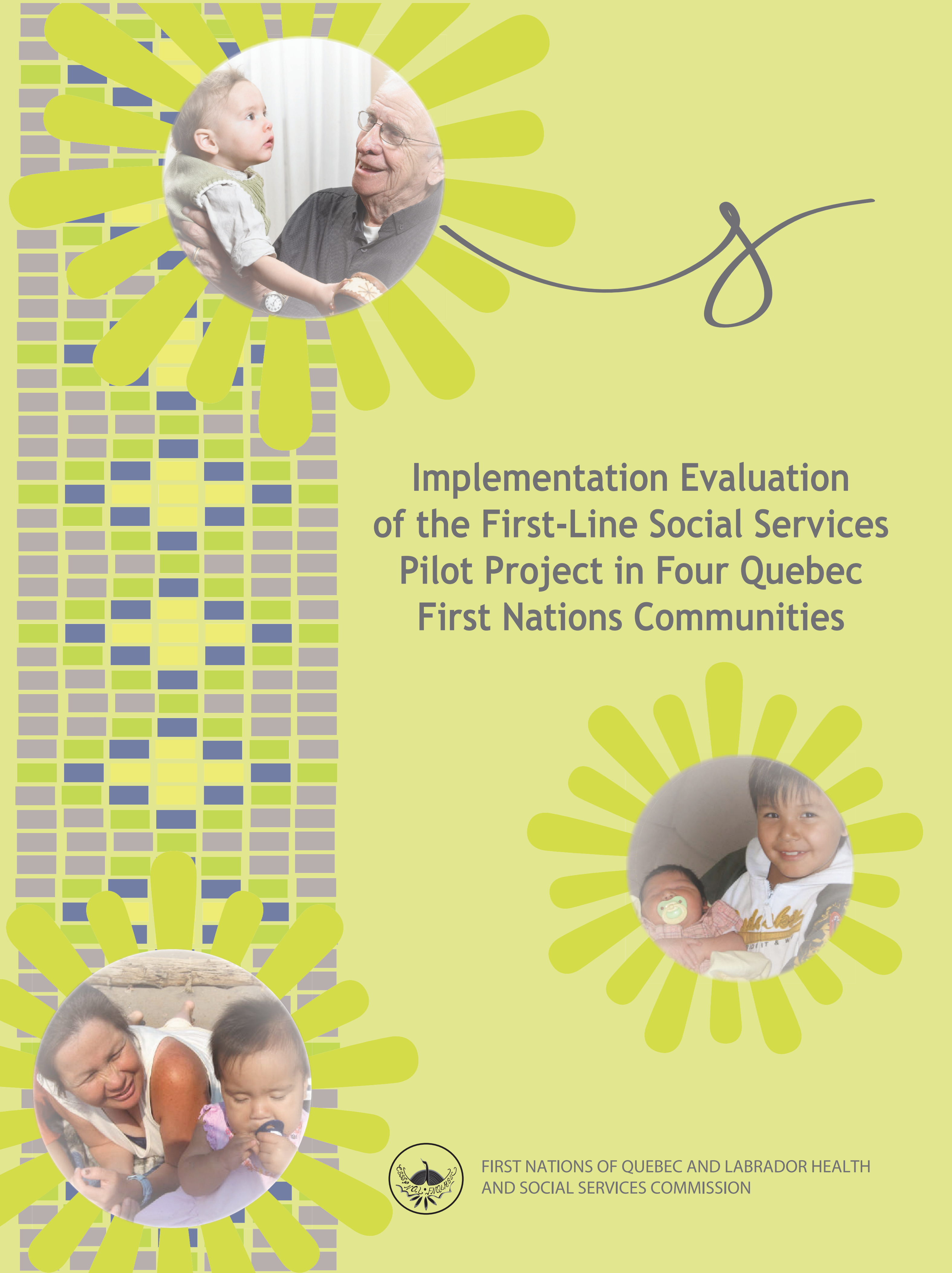

Implementation Evaluation of the First-Line Social Services Pilot Project in Four Quebec First Nations Communities

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

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The use of the masculine gender is intended to lighten the text, without prejudice against women.

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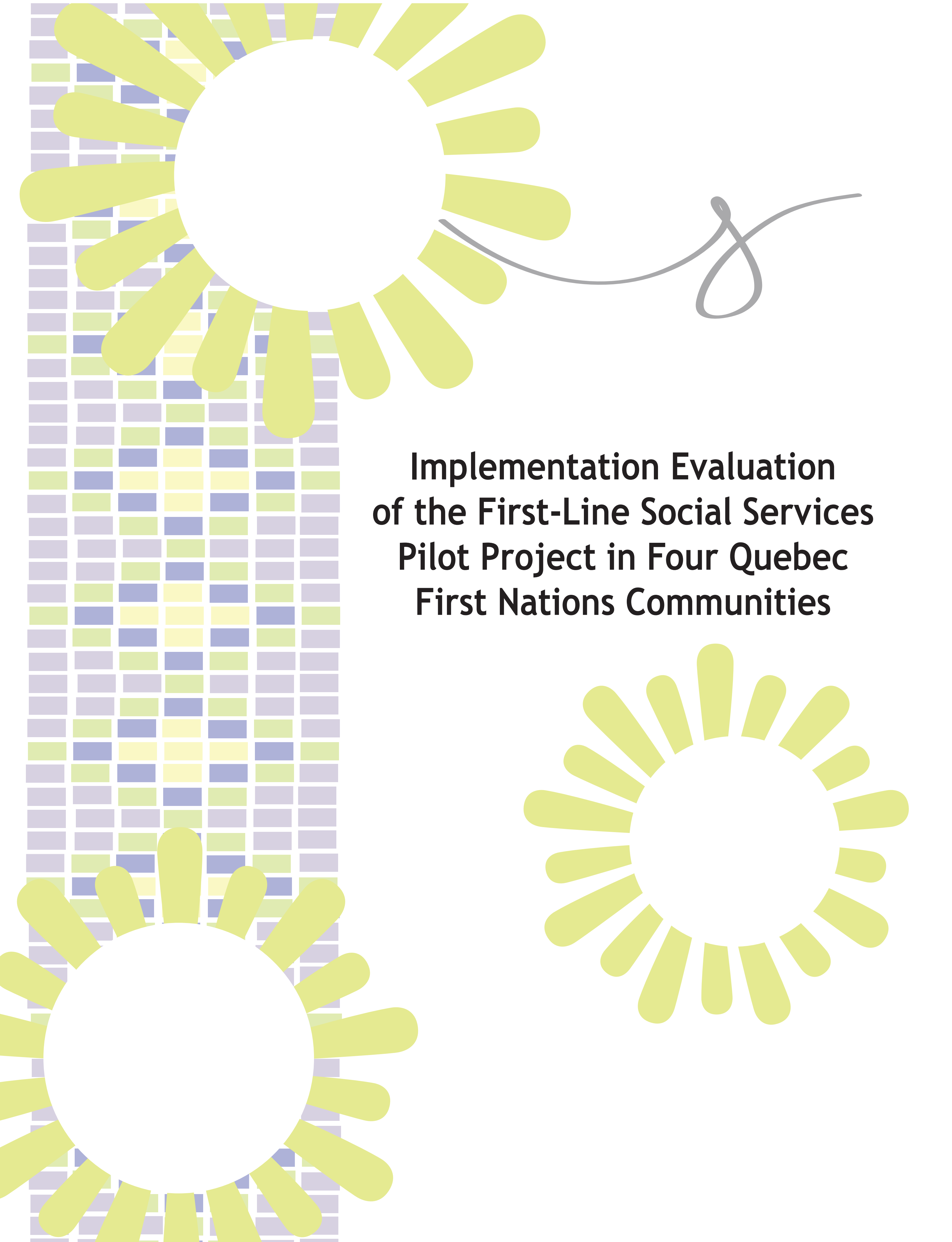


Implementation Evaluation of the First-Line Social Services Pilot Project in Four Quebec First Nations Communities

Summary

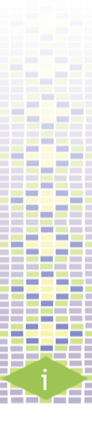
This report describes the results of an evaluation of the implementation of first-line social services in four Quebec First Nations communities. This pilot project with a community development approach was undertaken in 2006 to increase access to prevention and intervention services for First Nations children, young people and families living in their communities, with the services adapted to the needs and culture of the community. The purpose of the evaluation was to draft a portrait of services provided and to document and study the process of implementing and taking ownership of the project and the community development approach.

The conceptual framework of the project was a community development approach that took tangible form in the implementation of first-line social services using four action strategies based on a single guiding principle: empowerment. The four action strategies are 1) mobilization and commitment of local and external stakeholders; 2) involvement and mobilization of the population; 3) intersectoral cooperation, and 4) ownership of the project in all its aspects.

The evaluation was conducted between September 2006 and March 2009, making it possible to study the five phases of the implementation of the first-line social services: pre-implementation, action planning, implementation of services, access to services and services review. A participatory approach involving a wide range of stakeholders at each stage was used for the evaluation. Data collection took place during two periods and included collection of qualitative as well as quantitative data.

The evaluation showed that the nature of the implementation process depended on realities, ways of doing things and dynamics in each of the different communities. It was a challenging task operationalizing the action strategies to implement the services, which had to be continually reviewed and readjusted to ensure integration and application of the community development approach.

By documenting significant changes in the communities during the implementation of services, it was possible for the first-line social services teams and the regional stakeholders supporting them to adjust their actions so the new services met community needs. In addition, lessons were learned from the evaluation that will make it possible to implement first-line social services on a broader scale.



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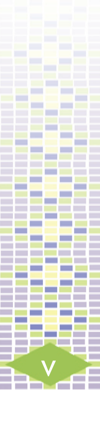

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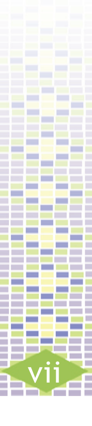

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Glossary

Community development approach: A process of voluntary cooperation, mutual assistance and development of social bonds between the residents and institutions of a community in order to improve living conditions physically, socially and economically (INSPQ, 2002: 16).

Cooperation/collaboration: All structured practices of a group of autonomous, decision-making stakeholders who have agreed to harmonize not only their orientations but also their action strategies and activities in a given field of activity (Belley-Lévesque, 1994: 22).

Empowerment: Appropriation or reappropriation of power by an individual, organization or community in order to take charge of their well-being.

First-line social services: All services that address common health issues are offered to a large number of people and are dispensed directly to community members (Frenk and Gonzalez-Block, 1992; WHO, 2000). According to the World Health Organization (WHO), these are primary care services at affordable cost, accessible to all and with full participation of the community (WHO, 2000; MSSS, 2009).

Involvement: For this pilot project, involvement means a series of actions that lead the members of a community to become actively involved and to exercise the power that is theirs to improve their living conditions.

Land/territory/bush: For Aboriginal peoples, the notion of land or territory denotes more than a piece of earth with specific boundaries. It is a whole comprising the interrelations among species, between species and ecosystems and among ecosystems. Along these lines, the environment includes not only ecological processes, but also social factors that affect the space (Deroche, 2008:38).

Mobilization: For this pilot project, mobilization means the agreement of all stakeholders to put time and energy into the project in order to achieve the goals the community has set.

Ownership: A process whereby an individual, a group or a community gains control of their living conditions. For ownership to be effective, the individual, group or community must possess the official and non official resources required to control their development (CSBE, 2001: 8).

Population/community members: Non-institutional stakeholders or stakeholders active outside their institutional framework.

Introduction

Because of a number of factors (including Indian and Northern Affairs' (INAC) funding formula, which provides little budget for prevention), First Nations child and family services have developed since the 1980s to the detriment of routine and preventive social services (FNQLHSSC, 1998). The Quebec youth protection system has thus become the principal gateway to social services for children and families living in the community, though these services are actually second-line services.[1]

The result is that large numbers of children[2] are removed every year from their families (FNQLHSSC, 1998). According to INAC estimates, close to 5.8% of Canada's First Nations children living in First Nations communities are removed from the parental home (INAC, 2006). According to the report entitled *We are Coming to the Light of Day* (Wen: De, 2005), on the other hand, the placement rate for First Nations children living in First Nations communities is close to 15%.

The high rates of reports, admissions to youth protection care and placements of Aboriginal children by the youth protection system highlight the inadequacy, indeed the inaccessibility, of first-line social services in First Nations communities—including child and family services. In addition those who work with First Nations communities and are called upon to intervene under the *Youth Protection Act* report that it is difficult to intervene because the frame of reference is so foreign to them (FNQLHSSC, 1998). Without help of any kind to keep the family intact, these measures place the well-being of the child at risk and increase family problems (Wen: De, 2005).

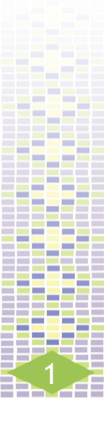
The latter statement is supported by much research denouncing the deplorable situation of First Nations children and families (INAC, 1996; Trocmé et al. 2005; FNQLHSSC, 2007). Admissions of First Nations children to the Quebec youth protection system is a heavy financial burden for the government. INAC's budget for the First Nations child and family services program in the province of Quebec has been growing relentlessly every year: between 2005-2006 and 2007-2008, for example, it grew from $30,283,618 to $42,734,417, a 41% increase.[3] In addition, the special situation in which First Nations find themselves must be taken into account. In effect, the status of the 27 non-treaty communities in Quebec is unique and completely unlike that of other cultural communities. Though applicable standards are defined by Quebec, funding depends on the federal government, which does not provide for special funding for prevention and support services for First Nations families, who thus do not have support comparable to that which the government of Quebec offers to other Quebec families (FNQLHSSC, AFNQL, 2008).

[1] The notion of first-line or primary care services refers to all services that address common health issues which are offered to a large number of people and are dispensed directly to community members (Frenk and Gonzalez-Block, 1992; WHO, 2000). According to the World Health Organization (WHO), these are primary care services at affordable cost, accessible to all and with full participation of the community (WHO, 2000; MSSS, 2009).

Second-line or secondary care services include specialized care and services provided by general practitioners and specialists whose interventions complement primary care services. Third-line or tertiary care services are medical and social care and services considered superspecialized.

[2] For ease of reading, the term "child" is used herein to mean youth as well.

[3] Information obtained on April 16, 2009, from Denise Picard, Social Development Advisor, Indian and Northern Affairs Canada, Quebec office.



It was in this context that the federal and provincial governments agreed to invest in the development of first-line social services. Since then, the Treasury Board has launched the G3 initiative for rollout and implementation of preventive services by child and family services agencies serving Canada's First Nations communities wishing to join the program. Three Canadian provinces have taken advantage of this initiative. This concrete measure aims to break the cycle of unfavourable socioeconomic gaps by acting upstream of problems affecting First Nations children and families so as to reduce the number of placements of First Nations children outside the parental home (FNQLHSSC, 2007). Advocating a holistic and preventive approach to the problems of First Nations children, this initiative is in keeping with First Nations demands (FNQLHSSC, 1998) and the internal review of the First Nations child and family services program (INAC, 2007).

Unlike other provinces, Quebec has allocated funds for experimental pilot projects to develop preventive services in Aboriginal communities. In fact, the Quebec and the federal governments agreed at the First Nations Socioeconomic Forum held in Mashteuiatsh in October 2006 to invest three million dollars over three years[4] to implement a first-line social services project in First Nations communities (FNQLHSSC, 2006). This unique pilot project was also designed to generate lessons to guide the implementation of first-line social services in all of Quebec's First Nations communities. Accordingly, a three-way partnership was filed with the Treasury Board for rollout of first-line services in all Aboriginal communities in Quebec. This large-scale rollout is scheduled for the fall of 2010.

With the launching of the pilot project, FNQLHSSC's research sector was mandated to perform an evaluation that would document the implementation of the first-line social services pilot project in Quebec's First Nations communities. All contextual, methodological and ethical considerations of the evaluation are described in this report. Descriptive and cross-sectional analyses of the elements studied are then given, followed by the results of the evaluation. The report closes with a summary of key conclusions and lessons learned from the evaluation.

[4] This investment corresponds to monies saved by capping rates for Youth Center housing services and an additional contribution from Indian and Northern Affairs Canada (First Nations Socioeconomic Forum Final Report; FNQLHSSC, 2006). The funds were allocated as follows: $500,000 in 2006-2007; $1,250,000 in 2007-2008; $1,250,000 in 2008-2009.

Chapter 1

Context of the Evaluation

Following the implementation of the first-line social services pilot project, it was proposed that the implementation process in the chosen First Nations communities be analyzed and documented. Before presenting the conceptual approach that was chosen, this chapter will provide definitions and present the goals that guided the work of the pilot project, as well as the evaluation.

1.1 Basis of the pilot project and selection of participating communities

Following the provision of funding for the establishment of first-line social services in Quebec First Nations communities, a tripartite orientation committee was set up in October 2006, with the mandate to direct and carry out the follow-up to the commitment made at the Socio-economic Forum held in Mashteuiatsh, which was:

> *"To invest, for some communities, in the development of first-line services in order to produce a springboard effect for increased action to address problems and thereby induce a decrease in the number of children placed."* (Terms of Reference, Tripartite Orientation Committee, February 2007)

The committee was under the authority of the steering committee, which was composed of the leaders of the three government bodies involved in the pilot project: the Ministère de la santé et des services sociaux, the First Nations of Quebec and Labrador Health and Social Services Commission and the Department of Indian Affairs and Northern Development. Guidelines adopted by the tripartite orientation committee for the pilot project required the approval of the steering committee.

The tripartite committee was comprised of representatives from the Department of Indian and Northern Affairs Canada (INAC), the Ministère de la Santé et des Services sociaux du Québec (MSSS) and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).[5] The tripartite committee had a number of roles to play in the framework of its mandate: develop criteria for selecting the communities that would participate in the pilot project, establish guidelines for the development of services, determine the process enabling the four communities to initiate their actions, direct these actions, follow up with communities to support their progress, create a framework for the distribution of funds, develop mechanisms for managing the four projects and finally, produce an annual report of activities (Terms of Reference, Tripartite Orientation Committee, February 2007).

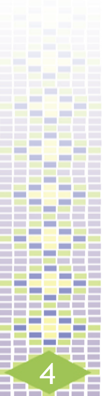
[5] Founded in 1994, the FNQLHSSC is an organization which has received its mandate from the Assembly of Chiefs of Quebec and Labrador. Its role is to promote the physical, mental, emotional and spiritual well-being of First Nations and Inuit people, families and communities while improving access to comprehensive and culturally-sensitive health and social services programs designed by First Nations organisations that are recognised and sanctioned by the people of the First Nations and their governments (FNQLHSSC, n.d.).

In the context of this mandate the tripartite committee developed seven criteria to identify and recommend four communities in which to implement the pilot project. The seven criteria that were used are as follows:

1) Community recognition of problems and the involvement of all stakeholders in addressing them
2) Community and leaders' commitment to take a comprehensive and integrated approach to organizing and developing community services
3) Scope of reporting and placement rates based on the compilation and analysis of statistical data
4) Interest and ability of community services, Youth Centers and CSSSs in working together
5) Interest and ability of regional services, agencies and CSSSs in supporting the community
6) Community willingness and ability to develop more elaborate first-line services
7) Community investment in human, material and financial resources

Although seven criteria were formulated initially, two of these criteria were especially important in guiding the committee's selection of communities: 1) The recognition by the community of the problems affecting children and families and the commitment of all stakeholders to work towards solving them and 2) The scope of reporting and placement rates based on the compilation and analysis of statistical data provided by the Youth Centers.

Although the entire committee worked under the same mandate, each of the involved parties retained their respective roles. INAC assumed responsibility for administering funding agreements for the delivery of social services for First Nations living in the communities and shared its expertise in project implementation. The MSSS provided clinical supervision, access to its regional training programs and shared its expertise in organizing services. Finally, the FNQLHSSC assumed responsibility for overall coordination and served as liaison between the communities and the various partners involved in the project. In addition, the FNQLHSSC was mandated to ensure the evaluation and documentation of the process of implementing the pilot project in the targeted communities.



1.2 Definition of first-line services in the framework of the pilot project

Within the context of the pilot project, first-line services were designed to work through clinical interventions, promotion and prevention activities, addressing the key risk and protection factors to develop people's skills and to break the intergenerational reproduction of social adjustment difficulties (Parazelli et al, 2003). This translates into comprehensive social actions at all levels, from which emerges a series of community and structural changes with the goal of improving the lives of community members. First-line services must be first and foremost related to prevention programs, projects and activities as well as to existing and best practices. In addition, services for children and teen-agers must be developed using a multidisciplinary and intersectoral approach since their issues are generally multifaceted and complex.

For the pilot project, first-line services were defined as being the first level of access. They included two types of services: general services addressing the whole population (short-term services) and specific services for specific problems (medium- and long-term services). These services included prevention and promotion as well as clinical activities and assistance. To respect the reality lived by First Nations, these services were required to be culturally appropriate. Moreover, in the context of the pilot project, the priority clientele for these first-line services were children under 17 years old and their families.

When first-line services are seen through the optic of a community development approach, service components are organized around primary care and rely on the active participation of target populations and working relationships between partners. In the same way that well-being is largely determined by the community environment, the community must be at the heart of the action for it to exercise its powers with respect to the welfare of its members. As well, this is a comprehensive perspective that takes into account all the determinants (social, cultural, economic and environmental) that either undermine or protect children and their families, requiring that all aspects of a problem be addressed in the search for solutions. This is why measures were put in place to ensure that all children have the opportunity to preserve the continuity of their ties to their families, their communities and their culture.

An element that contributed to the definition of first-line services is Jordan's principle.6 Indeed, this principle inspired the pilot project's designers from the outset. This is reflected by the primacy given by the project to the needs of youth. The principle affirms that the interests, needs, well-being and safety of children take precedence over any government and jurisdictional issue (FNQLHSSC, 2007). Actions should reflect the child's reality in maintaining the continuity of its ties to its culture, environment, relationships and individuality. One of the orientations of the pilot project was that all children have access, in accordance with this principle, to preventive, comprehensive and culturally appropriate services.

For the pilot project, the selected communities developed a program that focused on four areas: 1) the development of parenting skills in relation to parental negligence issues; 2) the adoption of a healthy lifestyle to counter the problems of dependence on alcohol, drugs and pathological gambling; 3) child development through early stimulation; and 4) the development of cultural and community life to counter isolation and the erosion of the social fabric. In addition, the

[6] Jordan's Principle was adopted by the Canadian Parliament on December 12, 2007. According to this initiative, the child-first principle ensures that the necessary care for a First Nations child is not delayed or disrupted by a jurisdictional dispute between federal, provincial or territorial governments (INAC, 2008).

following criteria were adopted for the development of the services to be offered: 1) planning and activities defined by local communities according to their needs and capabilities; 2) services accessible to the entire population, but also to clientele considered to be more vulnerable; 3) advocacy, prevention and intervention activities aimed at maintaining the links between children and their families, their community and their culture, 4) services offered within a continuum of services and 5) services based on competent and professional resources working within an organized structure.

1.2.1 Objectives of the implementation of the first-line services pilot project

The proponents of the pilot project were well aware of past experiences of implementing programs in Aboriginal communities elsewhere in Quebec and Canada. The guidance given to the project was therefore based on the experiences of these programs that were characterized by an individual approach and disappointing results. Thus, the tripartite committee believed that the best way to prevent and counter the psychosocial and community-based issues facing children, youth and families was to support the holistic perspective that the First Nations have of wellness. The community development approach, in addition to involving the entire community, enables greater coordination of services and programs providing first-line services. A continuum of services in tandem with other resources in and outside the community is pursued.

Specifically, the short- and medium-term objectives of the pilot project were:

1) *Increase access to prevention and intervention services for First Nations children, youth and families living in community so that they are comparable to those offered to other Canadians.*

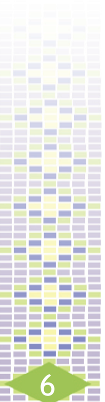
   To do this, it is important to promote and strengthen early intervention upstream of problems concerning First Nations children, youth and families.

2) *Culturally adapt prevention and intervention services for First Nations children and families so that the implementation of services is sustainable.*

   To do this, it is important to define a range of innovative services based on needs expressed by the population and local stakeholders.

3) *Enable First Nations families and communities to exercise their primary responsibility towards their children.*

   To do this, it is important to promote and foster the development of children within their biological families and if necessary, encourage the retention of children in the extended family or community. It is also important to prevent and reduce the number and duration of placements outside the family and outside the community of origin.



4) *Consolidate and develop prevention and intervention programs as an approach to community development.*

   To do this, it is important to establish and consolidate first-line prevention programs within a perspective of continuous service, to promote the establishment of multidisciplinary and interdisciplinary teams who consult and work closely together; to establish networks of partnership, consultation and collaboration that include the targeted communities and external collaborators (Youth Centers, Health and Social Service Centers (CSSS), etc.) and to establish a regional communication plan with those involved.

5) *Act on the key risk and protective factors in the community to promote the security and development of children within healthy families and communities.*

   To do this, it is important to identify and establish prevention and intervention programs that act upstream of the main problems affecting children and families, identify actions in communities that have the effect of countering risk factors and strengthening protective factors that exist locally, prevent and reduce the number of crisis and social emergency situations and prevent and reduce child reporting and placement rates.

In the long term, the objective of this pilot project is to reduce the rate of placement of First Nations children in the four targeted communities.

1.3 Evaluating the first-line services pilot project

It was decided early on to perform an evaluation of the first-line services pilot project implementation. The evaluation measures that were selected are intended to demonstrate the results of the process; in the best of cases to show a reduction of the rate of reporting and placement of children. But they were mostly developed with the goal of identifying the internal and external processes and dynamics generated by the project in each of the four pilot communities and which influence the implementation of services. In portraying these processes, moreover, it became possible to better define the purpose of actions taken to deploy such services in other communities, an awareness that up until now has not been made clear through any other examination. The type of evaluation chosen is a process evaluation. The resulting methodology is detailed in the third chapter of this report.

1.3.1 The evaluation's objectives

The evaluation's main objective is to document the implementation of the first-line services pilot project by reviewing the measures put in place by each community to carry out its project, while drawing connections with their respective unique local contexts.

This general objective comprises the following four specific objectives:

1) *Establish a portrait of each community at the beginning of the project*

   Because community development is by nature a process of change, it is not so much a question of knowing whether the project as it unfolded conformed to the initial design, but rather to understand how actions got organized and what the mechanisms of transformation were along the way (Simard, 2005: 32). In order to accomplish this, it is essential to have a clear portrait of each of the communities at the beginning of the project in order to subsequently reflect their changes.

2) *Study the implementation process of first-line services targeting children and families*

   The evaluation will examine the first-line services that were implemented for children and families in each of the communities in relation to the proposed action plans. It will also study how the organization of services conforms to the principles and action strategies of the community development approach; in what way they were culturally appropriate and how they corresponded to the criteria defined by the tripartite orientation committee.

3) *Review the ownership process regarding the community development approach principle and action strategies*

   The evaluation will review the rationale behind the choice of the community development approach to guide service implementation, and will describe the support provided by FNQLHSSC towards the adoption of this approach in each community. This objective is particularly relevant in advancing the argument that through the principle of empowerment and the action strategies in place (linked both to the community development approach and to the implementation of preventive services), the project will transform the approach to the determinants of well-being of children and youth with a view to improving their living conditions.

4) *Highlight the lessons learned during the course of the pilot project in view of the deployment of first-line services in all Quebec First Nations (except for the Crees, Naskapis and Inuits)*[7]

   The evaluation will highlight the strengths and difficulties encountered by the four communities and the various stakeholders involved over the course of the pilot project concerning the community development approach and the implementation of services. The study of these experiences will enable recommendations to be made for the provision of first-line services to all Quebec First Nations.

[7] These three nations are governed by agreements signed by the premier of Quebec, Canada's prime minister and Aboriginal leaders. In 1975, the Inuit and Cree signed the James Bay and Northern Quebec Agreement and in 1978 the Naskapi signed the Northeastern Quebec Agreement. With the signing of these documents, the provincial legislation regarding health and social services apply to these territories. Given their status as treaty communities, these three nations are excluded from the first-line services program.

To get a clearer picture of the state of Aboriginal child protection, the next section briefly introduces the research gathered on this subject in recent years, and will thus enable a better understanding of the relevance of implementing first-line preventive services in the communities.

1.4 Current research into Aboriginal child protection

1.4.1 Portrait of Aboriginal children entrusted to child protection services

According to a study conducted in Quebec by Tourigny and associates (2007), the characteristics of child welfare reports about Aboriginal children differ slightly from reports involving non-Aboriginal children living in families with similar household incomes. There are six elements that make it possible to identify reports about Aboriginal children. They are characterized by a greater proportion of reports received for social emergencies, families living in subsidized housing, families having a larger number of children and parents with a substance abuse problem. On the other hand, reports involving Aboriginal children include a smaller proportion of children with problems of underdevelopment and whose reporting source is the child's mother.

Moreover, Blackstock and fellow researchers (2004) conducted a similar study in comparing Aboriginal and non-Aboriginal child welfare reports over Canada as a whole. According to the results of this study, Aboriginal children entrusted to child protection services also differ from non-Aboriginal children in various ways. They are characterized, compared to other children, by having a greater proportion of families receiving welfare, living in housing considered unsafe, having already received child protection services in the past, being involved in situations of negligence as well as having families who have moved within the previous six months. The parallel between these two studies (Tourigny et al, 2007 and Blackstock et al, 2004) would seem to suggest that family poverty is a risk factor strongly predisposing Aboriginal children to placement outside the family.

The researchers also state that certain variables related to the parents of these children are also different. With regard to Aboriginal parents, compared to non-Aboriginal parents, significant differences include a greater proportion who have experienced their own abuse during childhood, higher levels of substance abuse, a stronger presence of criminal activity, problems of social isolation, a higher prevalence of mental illness or cognitive functioning problems, and finally, the lower age of Aboriginal parents. In addition, according to these authors, being an Aboriginal child increases the risk that the ill-treatment reported will be judged to be founded, leading, more often than not, to the placement of the child when it is taken into care (Blackstock et al, 2004).

1.4.2 Short- and long-term consequences to Aboriginal children of out-of-home placements

In the short term, children placed outside their family and often outside their community, suffer serious consequences. Separating children from their biological family severs the emotional bonds they have with their parents. This rupture in turn leads to consequences which are often irreversible in children such as the loss of their language, their culture, their spirituality and Aboriginal way of life, but most importantly the loss of their identity (Quebec Native Women & Regroupement des centres d'amitié autochtones du Québec, 2005).

In addition to these short-term consequences, Aboriginal children who have been removed from their family will carry the effects of this separation all their lives. In addition, Aboriginal youth in the child protection system will have to deal with obstacles to reintegration following a placement as well as the difficult economic conditions confronting all Aboriginal youth (Goyette et al, 2009). According to data from the National Council of Welfare (2007), Aboriginal children are more likely to live in poverty as adults than non-Aboriginals, will be between two and six times more likely to suffer from alcohol abuse, will be more likely not to have completed high school and more likely to be unemployed. Moreover, the probability for young Aboriginal women to become single parents is at least three times higher than the general population of young Canadian women (Conseil du bien-être social, 2007).

Thus, in addition to the conditions that affect all Aboriginal children, there is evidence that Aboriginal youth entrusted to the child protection system will also have to deal with obstacles to reintegration following a placement outside the family. These obstacles include a total lack of social support, the presence of domestic violence among young couples, the difficulty of getting a high school diploma, unstable housing, poverty, a high prevalence of mental health problems and substance abuse (Goyette et al., 2009). The combination of these risk factors means that Aboriginal youth coming from the child protection system are an extremely vulnerable group.

1.4.3 Possible explanations for the overrepresentation of Aboriginal children in protective services for children

Over the last ten years, researchers have attempted to demonstrate that Aboriginal children receiving child protection services are overrepresented and that this is true at all stages of the decision-making process (Bennett and Blackstock, 2002). They have shown that child welfare reports about Aboriginal children are twice as likely to be substantiated as those for non-Aboriginal children and thus lead to more interventions (Trocmé, Knoke and Blackstock, 2004). In addition, child welfare reports about Aboriginal children are four to five times more likely to be caused by a form of abuse (Ards, Myers, Malka, Sugrue and Zhou, 2003) or a problem of neglect (in 59% of cases) (Blackstock, Trocmé and Bennet, 2004). Slightly more than half of Aboriginal children reported for child abuse receive services (Blackstock, Trocmé and Bennet, 2004), but it is clear that the main measure of assistance for which they have access is placement in out-of-home care (Earle Fox 2004). In 2003, it was estimated there were more Aboriginal children living in out-of-home care than there were at the height of the residential school movement (Blackstock, 2003).

The impact of certain historical factors on the overrepresentation of Aboriginal children in child protective services has been well documented. According to INAC:

> *"Historical factors such as colonialism and racism have resulted in the breakdown of their identity and traditional values, low individual and community self-esteem, lower levels of education, unemployment and poverty, the frustration that these conditions engender and consequent self-destructive behaviours such as abuse of alcohol and other drugs, suicide and crime* (INAC, 2005)."

These historical events include the establishment of residential schools that contributed to cultural disintegration and eroded First Nations' family life. These residential schools have, in fact, helped to tear apart the family structure and deplete parenting skills which has resulted in the intergenerational transmission of violence (INAC, 2005).

Recent studies suggest that exposure of young First Nations to these multiple risk factors is tied to structural aspects outside the control of Aboriginal communities (Blackstock and Trocmé, 2004: 7). One example is the mismatch between INAC's8 funding formula for psychosocial assistance to children and the communities' needs for psychosocial intervention. Indeed, services are only supplied when the child's situation becomes critical, that is to say when the child's placement is required (MacDonald and Ladd, 2000). Preventive first-line services in the communities designed to avoid the placement of children are rare since funding is not provided for this purpose.9

In the early 1990s work began on "solutions" that would lead to lower placement rates in Aboriginal communities (McKenzie and Seidl, 1995; Wen: De, 2005; Hand, 2006). This work suggests the need to transfer responsibilities to local bodies for the protection of children (McKenzie and Seidl, 1995; Wen De, 2005; Hand, 2006), to address social problems in a holistic perspective emphasizing prevention (Wen De, 2005), to promote models of locally-defined action to ensure a culturally appropriate response to local needs (Blackstock and Trocmé, 2004: 8), to focus on the concept of collective ownership of children's well-being and to promote inclusion and individuals' participation (Wright, 2004: 387). All these elements converge to the development of practice interventions that address social problems from a perspective of social welfare and local development. However, this work did not move beyond describing possible practices. It paid little attention to the process of implementing these initiatives, nor to their effects on the well-being of children and families in First Nations communities.

Initiatives that have a social prevention and local development perspective in relation to children and vulnerable families were the subject of scientific research in the late 1980s (Elderman, 2001: 58; Chaskin, 2003: 62; Gagnier and Chamberland, 2000). These projects, conducted among at-risk immigrant families, were designed to review the intervention practices within these environments (Gagnier and Chamberland, 2000: 5). The studies demonstrated that social problems are best treated by solutions that come from the local environment (Andrew, 2003, cited in Flashpohler et al. 2003: 39), with interventions that address both the psychosocial and socioeconomic determinants (Gagnier and Chamberland, 2000: 5), by actions that strengthen alliances and local capacity (Gagnier and Chamberland, 2000: 5), and by a shared responsibility

[8] Directive 20-1 is the policy of INAC funding for child welfare and family services by First Nations organizations in the communities.

[9] In 2005-2006 the INAC budget for expenditures related to the First Nations Child and Family Services Program was $33 million. Two-thirds of this amount, $21.2 million, was used for the placement of children. One-third of the budget was therefore available for the provision of services including first-line prevention initiatives (FNQLHSSC, 2007).

for problems that does not only call on a response by government institutions but also a response by the entire community (Gagnier and Chamberland, 2000: 4).

As a result of this research, the community development approach was selected as the conceptual framework for the implementation of the first-line social services pilot project. We will further examine this approach in the following chapter.

Chapter 2

The Community Development Approach

This chapter aims to present the rationale behind the choice of the community development approach as the approach governing the implementation of first-line social services within First Nations communities. The guiding principle and the action strategies applied in the pilot project will also be developed.

The literature review conducted as part of the evaluation of the pilot project indicates that:

- The community development approach is a bottom-up approach, where a redefinition of responsibilities is designed to achieve collective and individual well-being.
- The community development approach relies on the participation of all groups within a community: the population, local stakeholders, external partners and political leaders.
- As part of this pilot project, four action strategies were adopted to guide the implementation of first-line services: the mobilization and commitment of local and external stakeholders, the involvement and mobilization of the population, intersectoral collaboration and ownership of the project. Generally, the approach is guided by the principle of empowerment.

2.1 A project based on local needs and solutions

It is evident that the magnitude of problems affecting First Nations children and families is collective in nature. It therefore follows that actions aimed at implementing sustainable solutions must also be collective in nature. Indeed, prevention and promotion of well-being of young people cannot be solely achieved by strengthening individual children and families since some determinants are outside their influence (Trocmé et al, 2005). The community development approach was thus recommended for the implementation of the first-line services pilot project in First Nations communities. The choice of this approach builds on work that has shown that health prevention and promotion cannot be achieved solely through the strengthening of individuals, but that the whole community must benefit in order to develop sustainable solutions (Bourque and Favreau, 2003: 296).

2.1.1 Definition and history of the community development approach

The proposed approach is a social practice that seeks to combat inequality, the centralization of power and structures of domination through community self-development. Communities are regarded as a force with the potential of changing its living conditions. Therefore, this model departs from the traditional "psychopathological" perspective that is interested only in the pathologies and problems experienced by individuals. Indeed, the approach favours a more ecological and positive position that recognizes the real strength that lies in community

(Doucet and Favreau, 1991). Historically, approaches to community development and preventive interventions have been particularly recognized in public health and have been part of important strategic orientations in Quebec.

In Quebec, community organizing got its start in the 1960s when citizens' committees, grassroots groups, housing cooperatives, etc., were formed. These experiences demonstrated that social problems must be the object of collective solutions (Doucet and Favreau, 1991). These practices reached their local and regional peak during the eighties in response to Quebec's structural economic crisis (a crisis of the welfare state), as well as to rising globalization (Bourque and Favreau, 2003). During this period, stagnation of the social services system led the Ministère de la Santé et des Services Sociaux (MSSS) to seek inspiration from early intervention programs. The Ministère's services were restructured to provide a "continuum of care from birth" (Mayer, 1994 cited in Parazelli et al, 2003). The report, "Un Québec fou de ses enfants," published in 1998, had a critical impact on the area of early childhood prevention. Emphasis was placed on the need for better identification of at-risk environments through reliance on the community's involvement (Parazelli et al, 2003).

During the 1990s, the tendency to situate actions within a continuum of services and to design them to act on individual, family and social factors continued to gain acceptance and helped establish the concept of a comprehensive approach that combined the notions of prevention and community development. These years were characterized by the development of a number of local projects of a cooperative/collaborative nature, and the establishment of regional-multisectoral working bodies (Mercier, Bourque and St-Germain, 2009). Moreover, recognition of the community development approach in Quebec's public health community could be seen in the commitments made in the Policy on Health and Well-being (1992) and the Priorités nationales de santé publique 1997-2002 (1997) (Bourque and Favreau, 2003). Thus, the community development approach continued to be incorporated into first-line social services provided throughout Quebec, particularly in the CLSCs (known since 2005 under the name of CSSS). During this period, multidisciplinary and intersectoral interventions were created that were focused on key factors influencing the development of individual skills to break the intergenerational reproduction of social adjustment problems (Parazelli et al, 2003).

By the late 1990s and early 2000s, the conceptualization and implementation of the concept of community development was still in flux. Indeed, the Quebec National Health Program 2003-2012 (2003) offered no definition, and CLSC community organizers were therefore forced to deal with this lack of precision (Bourque and Favreau, 2003). In this context, the approach to community development was conceptualized and developed largely through practical experience.

The "community development" and "community-based development" approaches are two different strategies, but with enough similarities that it can be difficult to distinguish between them. Indeed, these two approaches flow from the same model—community or progressive local development—that has been a part of community organizing in Quebec since the 1960s (Mercier, Bourque and St-Germain, 2009). Thus, community development is defined as any action undertaken by the population to improve their living conditions by means of their own resources and the use of techniques that promote independence, initiative and mutual assistance (Comeau, 2007 Bourque, 2008: 24). Community-based development is conceived of as a form of structured collective action in a given territory which, through the democratic participation of citizens and social actors, targets community issues related to the conditions and quality of life (Bourque,

2008: 42). As can be seen by these definitions, the two approaches have very few differences and rely on the same stakeholders and intervention strategies.

It was therefore proposed that the definition used by the Institut national de santé publique du Québec (INSPQ) be adopted by the pilot project, and that all actions undertaken fall within it. According to the INSPQ, community development can be described as a process of voluntary cooperation, mutual assistance and bridge building between residents and institutions in local communities, to improve physical, social and economic conditions (INSPQ, 2002: 16). This definition highlights the multidimensional nature of this approach through its integration of the various determinants of living conditions that jointly contribute to collective and individual well-being (Bégin, 2002 cited in Bourque and Favreau, 2003). Similarly, it calls for a redefinition of individual and community responsibilities in relation to their well-being (Simard, 2005). In this perspective, the community development approach is a logical extension of the assertion of Aboriginal self-determination and control over services provided to children and families with services provided *by* and *with*[10] the First Nations and adapted to First Nations reality and culture.

2.1.2 Community and development: Two inter-related concepts

The approach joins together two basic concepts: community and development. Generally, the concept of community is key to the First Nations approach to first-line services. The notion of community is defined by the Conseil de la santé et du bien-être (CSBE) as "a group of people living in a specific territory and sharing common interests across that territory" (CSBE, 2001: 7). The idea of territory is important since all members of a community are concerned and not just a group considered more at risk (Bourque and Favreau, 2003). The Assembly of First Nations of Quebec and Labrador (AFNQL), in its research protocol, incorporates the essence of the concepts of territory and belonging into its definition of community. However, the AFNQL also includes the importance of institutions formed by families, clans, etc. (AFNQL, 2005). The concept of community is thus inclusive of the concept of shared responsibility. This orientation specific to Aboriginal culture finds expression, through the perspective of the first-line services pilot project, in the adage "It takes a community to raise a child" (Walmsley, 2001).

The notion of development, in turn, raises some thorny issues in terms of its definition. Even if this concept has been widely accepted, various documents (including from the CSBE and INSPQ) are somewhat reticent on the issue. In health and social services, the most widely-used definition remains that proposed by the Conseil de la santé et du bien-être: «Development is a process, a process by which a community, through initiatives, tries to maintain or improve, according to its values, the collective and/or individual conditions of life" (CSBE, 2001: 11). Bourque and Favreau (2003) underline development's strong endogenous (meaning what is produced from within) character, since the successful development of a community must be rooted in its own initiatives and values. This aspect is a strong argument for the achievement of objectives set for the implementation of first-line services in the four First Nations communities. Indeed, recognition of problems by the community and its stakeholders, and their commitment to get involved and work to resolve them, become indispensable factors in the development of community capacity to take ownership of their process and to be actively involved in it.

[10] According to INSPQ (2002), stakeholders should strive to work with the population rather than for her. In addition, in the pilot project, first-line services must be developed by communities. The use of the term *by* and *with* expresses the desire that the projects are emerging as a "bottom up" approach.

When the two ideas are joined together, the concepts of community and development refer to a process of voluntary cooperation, mutual assistance and bridge building between residents and institutions in local communities, to improve physical, social and economic conditions (INSPQ, 2002: 16). Community development is thus multidimensional and integrates the notions of social, economic, cultural and environmental development that contribute to individual and collective well-being (Bégin, 2002 cited in Bourque and Favreau, 2003). Hancock suggests that the development of a community is possible only if it integrates social, ecological and economic development, which he brings together under the concept of "social capital." Thus, these types of development have as their ultimate objective the development of individuals. According to Hancock, the more fully developed individuals a community has (human capital), the greater the tendency for the community to be in a state of "health" (Hancock, 2001).

The choice of the community development approach as a driver for organizing first-line services is also supported by the fact that we are undertaking social innovation. Indeed, social innovation is defined by its ground-breaking and non-conforming character and by the general objective that it pursues which is that of promoting the well-being of individuals and communities (Cloutier, 2003: 3). Social innovation implies the absence of a model or reference on which to base your actions. In the case of the first-line services pilot project implementation, the community development approach takes as its point of departure what exists locally and builds actions as the process unfolds, since there is no model that has already established the best preventive and culturally appropriate practices for the First Nations of Quebec, and none is needed. This explains why the pilot project implementation asked communities to consider different ways of doing things, taking into account the realities in each community, to achieve their objectives. Furthermore, it must be considered that innovation is a learning process that is not linear and that works by taking communities and stakeholders "where they're at," which necessarily involves allowing local leadership to be freely exercised.

In addition to relying on a community development approach, the first-line services pilot project prioritized deployment of a preventive orientation within the communities. Indeed, the implemented services were intended to prevent the placement of children through the establishment of outreach, planning, coordination, multidisciplinary work and sectoral and intersectoral collaboration in support of family preservation and reunification. In sum, it is only through appropriate local development that elements could be put in place in the communities to achieve early preventive action that would play a role in the development of protective factors for First Nations children and families.

As presented, the implementation of a program under the community development approach was a multidimensional process that required the involvement of local stakeholders. There were certain conditions that favoured its establishment and these are discussed in the next section.

2.1.3 Conditions favouring the establishment of the community development approach

Following the observation of ten projects located in Quebec taking a community development approach, Mercier, Bourque and St-Germain (2009) reported four main characteristics promoting citizen participation and the emergence of effective programs:

1) Citizen participation is at the heart of community development. It can be characterized as a process that comes from below (grassroots democracy).

2) Citizen participation must be supported by the political authorities and decision makers, in places and spaces established for dialogue and debate between different stakeholders. It should take place within respected "ethics of discussion".

3) Community organizations are spaces inviting citizen participation because they stand apart from political issues and focus their efforts on defending their mission and values.

4) Community members do not have easy access to participation. The community development approach requires the establishment of practices that promote mobilization, support and public education at various levels of participation.

To these can be added additional factors influencing the implementation process of community development. First, accumulating expertise is recognized as a winning strategy. Areas of expertise include 1) specific expertise in community development, 2) content expertise, such as knowledge of the people's health, effective models and programs, evaluation of such programs and available technical and financial support, and finally 3) citizen expertise that develops through community action and through the process of defining problems, priorities and means of action.

Secondly, the organization's overall management (provided here by FNQLHSSC) must intervene strategically using top-down as well as bottom-up dynamics. The organization must meet accountability requirements from, among others, its funders, but also foster a sense of community empowerment. The organization should seek to promote a horizontal management style rather than vertical and to provide democratic leadership that is neither passive nor prescriptive. Finally, the implementation of a project under the community development approach must be supported by adequate human, material and financial resources (Bourque and Favreau, 2003).

2.1.4 Reasoning that led to the choice of the community development approach

As noted in the previous chapter, in general the choice of an approach for the pilot project took place in a context of social experimentation and change accompanied by a number of scientific studies that challenged the effectiveness of assistance based on an individual perspective (Dufort and Guay, 2005; Gagnier and Chamberland, 2000). Indeed, the limitations of health and medical services models are widely demonstrated: they place little emphasis on interventions aimed at changing living conditions associated with poverty, social inequality, etc. (Dufort and Guay, 2005).

These adverse conditions are identified as the explanation for the overrepresentation of First Nations youth in the child protection system (Timpson, 1995; Trocmé et al, 2005). For example, the Canadian Incidence Study of Reported Child Abuse and Neglect (2005) shows that the profile of non-Aboriginal families differs greatly from that of Aboriginal families where poverty, inadequate housing conditions and substance abuse predominate. These factors are identified by the authors

as an unhealthy combination underlying the neglect of Aboriginal youth (Trocmé et al, 2005).

The choice of the community development approach for the pilot project was primarily the result of experience in Aboriginal communities by tripartite committee members. The committee agreed that the adoption of a top-down approach was not appropriate for the establishment of new programs in the communities.

> *"We took into consideration some examples of programs taking an individual approach that had already been implemented in Aboriginal communities across Canada and Quebec that did not produce the desired results. We were all convinced that an approach involving community mobilization should be prioritized" (tripartite committee member, T1).*

The emergence of a common definition of the community development approach was a gradual process. Indeed, early in the project, there were a variety of different terms used by tripartite committee members whose conceptual implications led to slightly different approaches: community-based, bi-communal, community development, cooperative/collaborative, etc. Despite the diversity of terminology employed, committee members were in basic agreement that the project should be conducted *by* and *with* the First Nations to create a sense of belonging and community mobilization for the well-being of their youth and their families:

> *"I thought the best approach would be that the project belongs to the communities" (tripartite committee member, T1).*

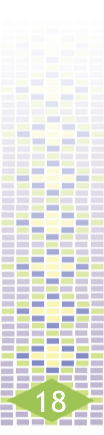
> *"It was clear to all members of the tripartite committee that the project should include both the involvement and the mobilization of the communities" (tripartite committee member, T1).*

It should be noted that from the time the committee agreed on a general "community" orientation, the support of experts was sought. The collaboration of an expert consultant proved to be a valuable asset. The consultant's input led to the term "community development approach" being accepted and used by all. Within a year, the principle of empowerment and the approach's action strategies had been clarified. During this period, committee members also took the time to get a good understanding of local realities and of the project:

> *"At this point, I need someone who has knowledge of the situation on the ground, someone who's an expert on it" (tripartite committee member, T1).*

> *"At first there wasn't enough time to gain a basic understanding, neither for myself nor for the others. The committee has evolved along with us" (tripartite committee member, T1).*

Finally, the choice made by the tripartite committee to embrace the community development approach reflects a way of approaching problems from a more holistic perspective. That is to say, goals such as equitable sharing of resources and responsibilities regarding child protection and community self-determination are prioritized by giving people an opportunity to play an active role, make choices and take actions to improve their living conditions. This choice was made in the context of First Nations demands for self-determination and their traditional values focusing on the community.



2.2 Development of the conceptual framework of the pilot project

Once the general framework was established, it was essential to consider how the approach could be translated into action. The pilot project offers four action strategies (described in section 2.3) based on a guiding principle of empowerment. The empowerment principle and action strategies outline the steps to be taken to implement first-line services while specifying how to bring about change within a sustainable development perspective, and they constitute the core of the analytical framework for the evaluative process.

To construct the project's conceptual framework, two working sessions were conducted by members of the tripartite orientation committee on January 14 and March 7, 2008. The working sessions focused on defining the community development approach as well as first-line services within the framework of the pilot project. At the January 14 meeting, committee members were asked to write down what they meant by community development. The statements were then grouped according to the themes that had emerged. This exercise led to the development of four action strategies and the choice of the principle of empowerment.

2.3 Principle of empowerment

According to the principle of empowerment, both individuals and communities have the ability to exercise or reclaim their power in order to take control of their own well-being. This implies, for this project, a willingness on the part of families and communities to fulfill their primary responsibilities towards their children. Three main types of empowerment are recognized in the literature: individual, organizational and community (Ninacs, 2002). All three types play a role in the implementation of first-line services.

2.3.1 Individual empowerment

Individual empowerment refers to experiences through which individuals acquire or use their abilities to exercise greater power over their lives. Empowerment also reinforces the individual's independence and ability to take action. In order to exercise this power, it is important that the individual recognizes or becomes aware of it. The objective is that individuals take control of their destinies to ultimately become involved in concrete actions that have an impact on their well-being and on that of the community. Empowerment may also imply that individuals receive the support they need to make use of and to develop their capabilities.

Under the pilot project, the involvement and mobilization of the population at all steps of the process is the main approach used to develop individual empowerment. This involvement requires that the first-line services team creates spaces where people can develop their abilities and exercise their power in particular through the establishment of mechanisms for accessing information and by creating space for discussion and involvement in decision making. To facilitate participation, Ninacs (2002) stresses how important it is that individuals develop their technical skills and a sense of competence. These aspects are supported in the project by providing groups of people access to training on a variety of subjects, such as parenting skills, as well as to quality services that are culturally adapted and that meet the expressed needs of the individuals. Ultimately, it is hoped that individuals will develop their social consciousness and become actively engaged in their community through involvement in community initiatives or by attending public meetings, social activities, etc.

2.3.2 Organizational empowerment

Ninacs (2002) points out that individual experiences take place more effectively within a group because the group process enables individual experiences to be consolidated and tested, which he calls organizational empowerment. In fact, it is through a process of appropriating power that an individual or an organization becomes "empowered" (Ninacs, 2003), or in other words, they become "enabled." This type of empowerment in this project refers to that held by the community first-line services team. Like individuals, the first-line services team, as an organization, wants to be an independent entity that has an existence of its own. Its degree of empowerment can be measured by the ability of its members to participate in decisions that affect them.

Organizational empowerment also entails the community's analysis of the people's needs in relation to the problems they are experiencing; a situation that enables the first-line services team to confirm the primary focus of its actions and purpose. That said, it is important that the organization develops competence so as to be recognized as one. Under the project, this competence is developed through access to training and clinical supervision of the first-line team's personnel. It is also supported by the collaborative relationships that enable the first-line services team to consult with a variety of expertise to add to their own and by the emergence of a collective network that can support the various actions undertaken.

A final aspect of organizational empowerment in this project concerns the analytical strategies adopted by the first-line teams to critically examine their services. These strategies provide insight into the challenges they face and as a consequence, enable a better response to the needs of the population. In the pilot project, this has been realized through the establishment of local advisory committees as well as by the local assessments of the provided services. In sum, it is possible to confirm that through the community development approach, the implementation of first-line services contributes to the empowerment of each member and of the entire community.

Moreover, individual and organizational empowerment can be observed using four indicators: 1) *participation*, ranging from silent support to meetings where individuals can participate in decision making. For the organization, this translates into participating in making decisions about issues that concern it; 2) *development of individuals' technical skills* so that they can participate. For the organization, this translates into building on its members' skills; and 3) *the recognition of one's competence and strengths* by the individual, also known as self-esteem. For the organization, this translates into a recognition of its legitimacy and its competencies; and finally; 4) *the development of the individual's critical abilities*. For the organization, this translates into the ability to self-critically analyze its problems and activities for its members (Ninacs, 2003).

2.3.3 Community empowerment

Finally, community empowerment is defined as the power that is given to a community to address the factors that affect the well-being of its members (Ninacs, 2003). In the case of issues affecting First Nations children and families, the resolution of problems composed of well-documented multidimensional factors is beyond any one person's individual skills. Without a change in community dynamics, it is unlikely that we will be successful in reducing the number of Aboriginal children being placed outside their homes (Blackstock et al, 2005).

It is within this context that community empowerment makes sense, because only the community has the power to act on these determinants (Simard, 2005: 16).

There are several conditions that are fundamental to community empowerment. Among them, it is important that the community's political leaders obtain a margin of manoeuvre as well as support from and access to sufficient resources to act (INSPQ, 2002). In the Aboriginal context, it is particularly necessary that the community assumes full control and that it is recognized for its competency in regard to its social responsibility for the well-being of its members (Blackstock et al. 2005). Under the pilot project, the development and full utilization of the capacity of community members (local stakeholders and the general population) are elements that translate into the community's empowerment. Indeed, access to a full range of expertise maximizes the effectiveness of the community's resources. Community empowerment can also be observed by a number of indicators such as: the ability of the community to organize itself; articulate a vision and priorities and act accordingly (Sherwood, 2002: 8 cited by Simard, 2005: 16); actions taken by and for First Nations; deployment of local resources; free flow of information; mechanisms for full participation; the perception of individuals that they can influence decisions; equitable distribution of power and transparency in decision making.

Ninacs (2003) identifies four areas in which community empowerment can be observed: 1) a redistribution of power that promotes the population's participation, 2) the ab*ility of the community to promote individuals' skills* as well as its *ability to mobilize local resources* to strengthen support networks, 3) the establishment of *effective mechanisms of communication*: information flow, access to information and transparency in decision making and 4) a reversal of a state of "disempowerment": building *community capital,* through the development of a sense of belonging to both the community and the environment and the development of each member's awareness of his or her own citizenship (Leroux and Ninacs, 2002).

That said, the approach proposed for the pilot project is neither based on a previously defined program nor on the problems targeted for solution. It is rather based on a logic of ascendancy (termed "bottom up" in the literature), focusing on community empowerment, whereby the needs of the community and its members are better answered if the solutions are generated locally. That is why, in this project, it is the local communities themselves who are asked to define and prioritize the problems as well as the actions to be undertaken to implement first-line services. Solutions are put forward that have local resources and capacities built-in, and thus better adapted to the community's cultural context.

2.4 Action strategies

As mentioned above, the implementation of the first-line services project was based on four action strategies, selected and developed by the tripartite committee, which had as their cornerstone the principle of empowerment. These action strategies were: 1) the mobilization and commitment of local and external stakeholders; 2) the involvement and mobilization of the population; 3) intersectoral collaboration and 4) the ownership of the project in all its aspects. These strategies are defined and characterized in the framework of the implementation of the first-line services pilot project as described below.

2.4.1 The mobilization and commitment of local and external stakeholders

The mobilization and commitment of local and external stakeholders translates into the presence of persons, perceived as potential change agents, who with a shared goal and through planned action strategies commit to mobilizing their resources and energies to meet the objectives the community has defined. Mobilization requires that key stakeholders are willing to invest their energies and resources based on their experiences and mandates. Successful mobilization requires that the stakeholders of a situation requiring action are made aware of the problem in order to come together to deal with it by planning action strategies. Developing a common vision becomes all the more essential since it is the key to moving beyond mere mobilization to an active commitment to a common project. In terms of mobilizing stakeholders, the community becomes a participant and not merely an object of study. Mobilization implies the development of services *by* and *for* the communities. If mobilization is the basic ingredient that gets the project off the ground, commitment is the indispensible ingredient that ensures the sustainability of the project.

The pilot project's first form of mobilization translates into a community's recognition of its problems and its commitment to develop community services in a comprehensive and integrated way (FNQLHSSC, 2007).

The main characteristics of this action strategy are:

a. The participation of the community's main internal and external sectors who have the ability to induce dynamics favourable to development;

b. Places to talk on a regular basis about the action plan and the actions to be carried out to achieve it;

c. Cooperative/collaborative actions carried out with the backing of the community;

d. Stakeholders familiar with the community development approach and the community's vision of its development.

2.4.2 The involvement and mobilization of the population

The involvement and mobilization of the population is achieved[11] through actions that are structured to involve them in all the steps of the project, mainly through the creation of spaces where members of the population can have some power. This commitment requires getting involved as an individual in different ways (talk, act, decide, etc.), at different times during the process in order to improve living conditions. The involvement and mobilization of the population is grounded in a systematic perspective which closely links individuals to their environment and recognizes that each person can make a difference. The project's development is not viable without the involvement and mobilization of the population.

Thus, the involvement and mobilization of the population requires that local leaders provide a zone of influence where the population can exercise its powers of decision making and action. Local leaders need to be aware of a number of factors, including possible power struggles, social dynamics, potential conflicts of interests and political issues that may arise from involving the

[11] In the context of the pilot project, the term "population" refers to noninstitutional stakeholders or stakeholders acting outside the framework of their institution.

population. In addition, caution must be exercised not to create a crisis atmosphere in order to achieve rapid mobilization, and a variety of strategies must be developed to avoid a drop in enthusiasm. The characteristics for the pilot project are:

a. The involvement and mobilization of the population by the first-line services team in all steps of the process;

b. The implementation of actions mobilizing and involving the population.

2.4.3 Intersectoral collaboration

Intersectoral collaboration brings together the two concepts of cooperation/collaboration and intersectorality. Cooperation/collaboration is "an approach that includes all of the practices articulated by a group of independent stakeholders who have agreed that their decisions will harmonize not only their perspectives, but also their intervention strategies and concrete actions within a particular sector" (Belley-Lévesque, 1994: 22). It is through cooperation/collaboration that stakeholders can orient their actions so as to coordinate with the overall direction that the community has adopted. This pooling of expertise is based on the principle that the synergistic whole is greater than the sum of its parts.

Intersectorality, meanwhile, can be defined by using an example from the health and social services system: a formal relationship between one or more components of the health sector and one or more components of another area in order to fight against a problem or achieve health outcomes (final or intermediate) in a more effective and sustainable way than if the health sector was acting alone (Maskill and Hodges, 2001 cited in Simard, 2005: 19). As used here, the concept of intersectorality refers to the notion of inclusiveness and thus overcomes the barriers between sectors, focusing on the addition of expertise and strengths (Bourque and Favreau, 2003: 299).

Intersectoral collaboration is expressed through actions that aim to transform social situations as a whole as well as through the reinforcement of the community's "leadership." It is achieved through functional exchanges between the stakeholders, conducted in order to establish a process of logical actions that meets the community's aspirations. Intersectoral collaboration can bring about a comprehensive and lasting transformation, one that transcends all the sectors affected by a problem. The characteristics of intersectoral collaboration for the pilot project are:

a. A group of stakeholders from different sectors and involved at different levels is formed to deal with a problem;

b. Cooperation/collaboration under the "leadership" of the community to coordinate actions;

c. Cooperation/collaboration where each participant has a role to play in terms of their expertise and strengths; the addition of existing resources to maximize the solutions is put in place;

d. Comprehensive actions, either on all the determinants or on a single identified problem;

e. Upstream and downstream actions to address all the determinants that affect children and families;

f. Multidisciplinary and inter-organizational collaboration.

2.4.4 Ownership of the project in all its aspects

In the context of the pilot project, the definition of ownership that is being used was provided by the National Council of Welfare (NCW), which has characterized it as a process through which an individual, a group or a community gains some control over its living conditions. In order for ownership to be effective, the individual, group or community must possess the official and nonofficial resources that will enable it to control its development (NCW, 2001: 8). In that it encourages that local realities be taken into account in order to develop a strategic action plan, ownership is an essential element that empowers a process of community change (NCW, 2001).

Ownership is a dynamic and evolving process that restores power to communities, a power they give themselves to better know themselves, recognize their strengths, understand what is happening and identify their priorities. This awareness enables them to create ways of effectively acting on their reality, while promoting the optimal use of resources they have at their disposal. It is through developing a vision that stakeholders are able to own their course of action. This shared vision provides general guidelines to determine the desired outcome of actions and to make choices as to how to tackle the problems. Without ownership, collective responses may be inadequate (Bourque and Favreau, 2003).

In the first-line services implementation process, ownership involved a number of stakeholders: individuals; communities; and local, external and governmental partners. In relation to the project itself, the main characteristics of this strategy are:

a. The importance of establishing a common vision so as to have a shared understanding of the dynamics, problems and solutions; a portrait of what the community is and where it wants to go;

b. A vision that is rooted in the local context and based on its actual strengths and resources leading to culturally appropriate solutions;

c. Actions that are prioritized in a realistic way that fully takes into account the entire situation;

d. Returning power to individuals and communities so that they can know and understand each other better.

Table 2.1 shows how each of these four action strategies were designed to be implemented in the project. Indeed, it is possible to observe in each of the pilot project communities, actions that reflect the implementation of each strategy. This implementation of the four action strategies flowed from the tripartite orientation committee's discussions that took place during the working sessions of January 14 and March 7, 2008.

Table 2.1. Action strategies and their implementation

Action strategies	Implementation
Mobilization and committment of local and external stakeholders	➢ Local and external stakeholders are invited to consultation tables ➢ Protocols are set up ➢ Actions that are guided by the principles of community development are established ➢ Actions to ensure first-line services implementation are established ➢ A schedule for consultation tables with sufficient frequency is set up ➢ Stakeholders participate in consultation tables ➢ Responsibilities between stakeholders are shared and there is a commitment to honour them ➢ Benefits to the community can be demonstrated ➢ First-line team designates and activates the consultation space
Involvement and mobilization of the population	➢ Strategies for involving the population in all steps of the project are developed ➢ Mechanisms enabling access to information are created ➢ Mechanisms empowering the population to influence decisions set up ➢ Community initiatives emerge outside the formal structures ➢ The population participates in community initiatives
Intersectoral collaboration	➢ Consultation mechanisms and ways of working that promote cooperation are set up ➢ Spaces where consultation and exchange can occur are created ➢ Stakeholders begin to exhibit cooperative and collaborative relationships of quality ➢ Formal protocols to guide action strategies are developed ➢ A shared major issue is prioritized ➢ Stakeholders carry out comprehensive and coherent actions ➢ Tangible benefits emerge related to the process of cooperation and collaboration ➢ Access to diverse expertise is provided to support the first-line team ➢ Consultation tables and actions are coordinated by the first-line team
Ownership of the project in all its aspects	➢ A shared and comprehensive vision of the well-being of children and families is developed ➢ Action priorities are locally determined ➢ The local community takes ownership of the problems ➢ Culturally appropriate solutions are chosen ➢ Mechanisms for dissemination of the community development approach are put in place ➢ Stakeholders are involved in and adhere to the community development approach ➢ Stakeholders and the population understand the problems, issues and solutions

The figure below provides a summary of the approach adopted for the implementation of the first-line social services pilot project. As shown, the principle of empowerment is central to the project. It is intimately linked to the four action strategies chosen and to the implementation of first-line services. Moreover, this figure presents the idea that the whole community is called upon to work together in order for the services to function well, and that the approach to community development is a process of community change that takes place in cycles. Indeed, the introduction of services requires continual revision and adjustment to respond as much as possible to the needs of the community.

Figure 2.1 Diagram of the community development approach in the context of the implementation of the first-line social services pilot project

The following chapter will explore in detail the methodology adopted to respond to the evaluation's objectives in the context of the community development approach.

Chapter 3

Methodology

This chapter describes the methodology used to evaluate the implementation of first-line social services in the four participating First Nations communities.

Key features of the methodology used are as follows:

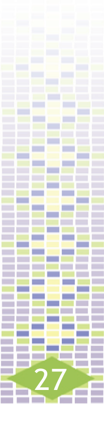
- A process evaluation (Patton, 1997) was used to evaluate the implementation of the pilot project in the four communities;
- A participatory approach involving a wide range of stakeholders at each stage was used for the evaluation;
- Three groups of stakeholders were targeted for data collection: local stakeholders, external stakeholders and regional stakeholders;
- The data collection took place during two periods and included collection of qualitative as well as quantitative data;
- A variety of data collection tools were used or created in collaboration with the first-line services implementation teams: focus group interview, individual interview, document review, satisfaction survey, logbook and electronic databank.

3.1 Type of evaluation

Evaluating a pilot project that takes a community development approach is a huge challenge. There are no preset models for action with projects of this type, which are works in progress. The evaluation method selected must make it possible to identify action planning processes, the evolution of the project and the dynamics between the different internal and external stakeholders involved. Process evaluation was the methodology selected to evaluate implementation of the first-line social services pilot project relative to objectives (CRSC, 1997; Patton, 1997).

According to Michael Q. Patton (1997), process evaluation is one of five types of implementation evaluation[12] and allows investigation of internal dynamics to grasp the strengths and weaknesses of a program. The goal of a process evaluation is not to determine outcomes but rather to understand the processes that lead to them. In addition, a process evaluation makes it possible to determine with which type of population and under what circumstances the program evaluated is more or less effective (Scheirer, 1994). A process evaluation thus looks at what was done to carry out a project and makes links between these activities and changes observed in the short, medium and long term (Simard, 2005: 33). Data collected for this type of evaluation is particularly helpful when the designers or administrators of a program are planning to implement the program on a wider scale in the future (Lazenbatt, 2002). A process evaluation makes it possible to identify "best practices" and any traps to be avoided in implementing the project.

[12] According to Patton (1997) the five types of implementation evaluation are process evaluation, effort evaluation, monitoring, components evaluation and treatment specification.



For the first-line social services pilot project, the evaluation looked at change in each of the participating communities over a given period (Bernoux, 2004: 20). We were not looking to correlate outcomes and methods initially planned but rather to observe how actions evolved and how they related to local circumstances in each community. Another goal of studying these mechanisms was to learn lessons for an eventual province-wide rollout of the first-line social services program.

Accordingly, no attempts were made to demonstrate the impacts of the program; the goal was rather to identify implementation processes crucial to the approach. This was because the evaluation covered such a short period of time, making it impossible to demonstrate the long-term impacts of the program on structural elements—such as a decrease in the number of placements of First Nations children from the communities. The evaluation does nonetheless highlight organizational and community changes during the project based on what the communities consider as positive impacts for children and families.

Thus the objectives of the evaluation cover elements of summative as well as formative evaluation. A summative evaluation is an evaluation that judges the activities of a program, mainly so that decisions can be made about its future. A formative evaluation, on the other hand, seeks to improve a program rather than make a final judgement about it (Patton, 1997); a formative evaluation thus supports local stakeholders in making necessary adjustments to a program in progress (Simard, 2005: 34).

The process evaluation conducted for this project is grounded in a constructivist perspective which holds that reality is constructed and given meaning by each stakeholder involved (Pourpart et al., 1997). In other words, this perspective assumes that no one has access to an objective reality, that we always construct reality based on our perceptions and personal experiences (St-Cyr Tribble and Saintonge, 1999). In this paradigm, stakeholders are recognized as those best positioned to document their experiences (Bernoux, 2004: 6). In our case, this would be those involved in implementing the first-line services.

This said, a qualitative approach was taken, as it allows in-depth exploration of participants' points of view on their actions and the possibility of linking these actions to local circumstances. Though quantitative data were collected, they were used only when scientifically valid and when stakeholders acknowledged their value and considered them significant (Simard, 2005: 31).

To support and provide guidance with the proposed methodology, a partnership approach was used for the evaluation (Clément, Ouellet, Coulombe, Côté and Bélanger, 1995). Partnership research is defined as research conducted by a group of people who work together and cooperate as equals in all stages of the research, from the development of objectives to the validation of results (Clément, Ouellet, Coulombe, Côté and Bélanger, 1995). A partnership approach is in keeping with the conceptual framework of the pilot project, that is, the community development approach, as its goal is also the cooperation/collaboration and mobilization of the different stakeholders involved in or affected in some way by the implementation of the project in order to benefit from the expertise and experience of all. The research partnership for evaluation of the pilot project targeted the members of the tripartite orientation committee (mandated to determine the broad parameters of the project and to stimulate action on a local level) and their partners.

It was along these lines that a research working group was formed to orient and guide the activities conducted during the evaluation of the pilot project. The research working group included representatives of FNQLHSSC's social services sector, two researchers, three clinicians and two representatives from the tripartite committee. The FNQLHSSC research agent and research assistant, who coordinated the evaluation, were also part of the working group. Thus, the working group included members of the tripartite committee so that the opinion of the committee would be represented as well as that of external stakeholders with in-depth knowledge of community development-related issues or the realities of First Nations communities. At each stage of the research, the ideas, recommendations and guidelines issued by the research working group were also shared with the tripartite committee to obtain the committee's approval and to ensure a forum for cooperation/collaboration between the different partners.

There are several reasons why a partnership research approach was selected. First, the research/practice interface can reconcile different interests in the evaluation of a project. In this project, for example, there were the members of the tripartite committee, who wanted to track the evolution of the project; the local stakeholders and action initiators, who wanted support for their work, so they could improve; and the funding body (INAC), seeking convincing data to justify its investment. Second, this type of research provides an opportunity to exchange ideas and to bring together different competencies and expertise (Clément, Ouellet, Coulombe, Côté and Bélanger, 1995: 150). Last, partnership research ensures the methodology used really addresses all general parameters of a project (Cole, 1999; Mulroy and Lauber, 2004) and fosters ownership of the results by the communities involved (Clément, Ouellet, Coulombe, Côté and Bélanger, 1995).

3.2 Population and sample

The purpose of the evaluation was to document the process of implementing first-line social services in four First Nations communities in Quebec.[13] These communities therefore constitute the study population. Three groups of stakeholders were identified:

a) *Local stakeholders:* community members involved at some point in the implementation of first-line social services. These include the members of the first-line services teams, the professionals hired to dispense social services (social workers, educators, street workers, community life workers, etc.), the members of the advisory committees[14] and different formal and informal local partners.[15]

[13] A reminder: the two main criteria for selecting communities for the pilot project were 1) community recognition of problems effecting children and families and a commitment by all stakeholders to work towards solving them and 2) the scope of reporting and placement rates based on the compilation and analysis of statistical data provided by the Youth Centers.

[14] Each of the communities participating in the pilot project formed an advisory committee during the implementation process. These committees were composed of local leaders (social services workers and members of the population) and were mandated to monitor actions taken and to give opinions on these. Note that these committees were not formed at the request of the FNQLHSSC or the tripartite committee but were local initiatives.

[15] Job titles and team composition varied from one community to the next.

b) *External stakeholders:* the main stakeholders outside the community who were asked to work with the first-line services teams in each of the communities participating in the pilot project (exchange of services or expertise, etc.). For example, this included members of the Direction de la protection de la jeunesse, the Centres de santé et de services sociaux and the Agences régionales de santé et de services sociaux.

c) *Regional stakeholders:* employees of the FNQLHSSC (social services team and research sector) and the members of the tripartite committee, mandated to establish the broad parameters of the project and to stimulate action on a local level.

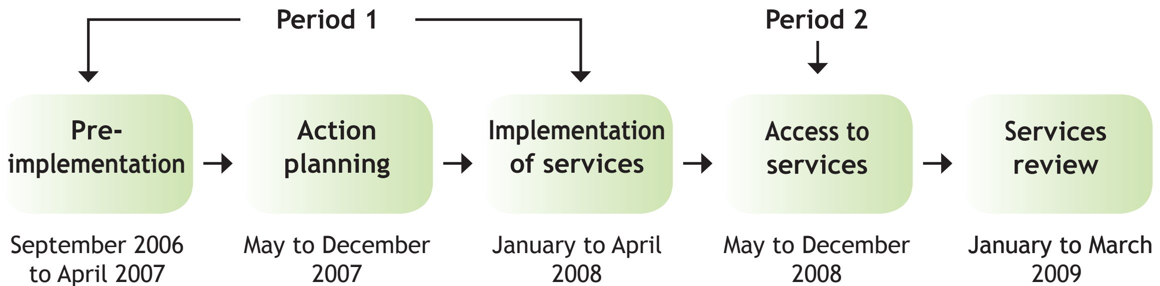
Last, we must mention that the survey respondents from these three groups form nonprobability samples, that is, samples that are not random. In fact, stakeholders were selected for participation in the data collection because of the experience they acquired during the implementation of first-line social services.

3.3 Evaluation plan

The implementation of first-line social services in the four communities participating in the pilot project was planned as a five-phase process. The data collection was structured accordingly. During Phase 1, the pre-implementation phase (September 2006 to April 2007), the members of the tripartite committee determined the general approach of the project and its broad parameters. Key events in this phase were the selection of the community development approach and of the four communities that would participate in the pilot project. The goal of Phase 2, the action planning phase (May to December 2007), was to develop an action plan in each community reflecting a shared vision of the well-being of children and families. The goal of Phase 3, the services implementation phase (January to April 2008), was to develop a continuum of preventive services for young people and families and to hire the interveners required to implement these services. Phase 4 was the access to services phase (May 2008 to April 2009), during which services were made available to community members. The goal of Phase 5, the services review phase (February to March 2009), was to evaluate the extent to which the objectives of the action plans filed by each of the participating communities in December 2007 were met, to comply with INAC's accountability requirements.

Data collection to document this five-phase services implementation process took place during two periods. The purpose of the first period of data collection (Period 1: May 2008 to July 2008) was to document the activities of the pilot project between September 2006 and April 2008, that is, the pre-implementation, action planning and first-line services implementation phases of the pilot project. The second period of data collection (Period 2: October to December 2008) documented pilot project activities between May and December 2008, that is, during the access to first-line social services phase of the project in the four communities.

Figure 3.1 First-line services implementation phases and data collection periods



A variety of data collection tools were used to gather data for the process evaluation from the three groups of stakeholders during the two periods of data collection. Aspects to be covered by the data collection activities were determined based on concerns associated with project objectives and the dimensions of the evaluation:

a) Assess changes during project implementation by drawing a portrait of each community before the initial planning of the pilot project;

b) Understand how action is organized during the implementation from the viewpoint of the community development approach (principle and action strategies) and the implementation of first-line services;

c) Understand change mechanisms that arise during project implementation and their impacts;

d) Understand how the principle and action strategies allow change in the way factors affecting the well-being of First Nations children and families are addressed;

e) Determine lessons learned from the experiences and identify conditions that foster development of a holistic strategy for first-line social services in First Nations communities.

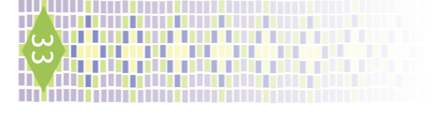
Tables 3.1 and 3.2 summarize the evaluation plan adopted for each data collection period, showing evaluation variables and objectives (draft portraits of the communities before the start of the project, examine the process of taking ownership of the principle and action strategies of the community development approach, study the process of implementing first-line services and show lessons learned).

Table 3.1 Evaluation plan: first period of data collection

Period	Evaluation objectives	Variables	Tools	Stakeholders
First period of data collection (May 2008 to July 2008)	▪ Draft a portrait of communities before start of the project	- Sociodemographic characteristics of the community - Community dynamics	- Focus group interviews - Document review: action plans submitted to the tripartite committee by the communities	- *Local stakeholders* (first-line services teams in each of the communities, advisory committees) - *Regional stakeholders* (FNQLHSSC social services team)
	▪ Understand the process of taking ownership of the community development approach	- Decision-making process in the selection of the community development approach - Activities introduced in keeping with the principle and action strategies - Type of support	- Focus group interviews - Individual interviews - Document review: documents issued by the FNQLHSSC, the tripartite committee and the communities	- *Local stakeholders* (first-line services teams in each of the communities, advisory committee, informal and formal stakeholders) - *Regional stakeholders* (FNQLHSSC social services team, tripartite committee) - *External stakeholders (from outside the communities)* (Youth Centers, Centres de santé et de services sociaux etc.)
	▪ Understand the first-line services implementation process	- Programs and services developed - Training offered to professionals in the communities - Qualifications and expertise of the social services interveners	- Focus group interviews - Document review: documents issued by the communities	- *Local stakeholders* (first-line services teams in each of the communities, professionals) - *Regional stakeholders* (FNQLHSSC social services team)
	▪ Identify lessons learned	- Strengths - Difficulties encountered and strategies for dealing with them - Recommendations	- Focus group interviews - Individual interviews	- *Local stakeholders* (first-line services teams in each of the communities, advisory committees, formal and informal stakeholders) - *Regional stakeholders* (FNQLHSSC social services team, tripartite committee) - External stakeholders (from outside the community)

Table 3.2 Evaluation plan: second period of data collection

Period	Evaluation objectives	Variables	Tools	Stakeholders
Second period of data collection (October 2008 to December 2008)	▪ Understand the process of taking ownership of the community development approach	- Activities introduced in keeping with the principle and action strategies - Type of support	- Focus group interviews - Individual interviews - Document review: documents issued by the FNQLHSSC, the tripartite committee and the communities	- *Local stakeholders* (first-line services teams in each of the communities, advisory committees, professionals, formal and informal stakeholders) - *Regional stakeholders* (FNQLHSSC social services team, tripartite committee) - *External stakeholders* (from outside the community) (Youth Centers, Centres de santé et de services sociaux, etc.)
	▪ Understand the first-line services implementation process	- Nature of programs and services offered - Nature of training offered to professionals in the communities - Clinical supervision - Qualifications and expertise of social services interveners - Characteristics of the clientele - Characteristics of the interventions: continuity and rapidity - Cultural adaptation of the services	- Logbooks - Focus group interviews - Individual interviews - Satisfaction survey - First-line services databank	- *Local stakeholders* (first-line services teams in each of the communities) - *Regional stakeholders* (FNQLHSSC social services team) - *Local stakeholders* (professionals, advisory committees, formal and informal stakeholders) - *External stakeholders* (from outside the community) (Youth Centers, Centres de santé et de services sociaux, etc.) - *Local stakeholders* (participants in first-line services)
	▪ Identify lessons learned	- Strengths - Difficulties encountered and strategies for dealing with them - Recommendations	- Focus group interviews - Individual interviews	- *Local stakeholders* (first-line services teams in each of the communities, advisory committees, formal and informal stakeholders) - *Regional stakeholders* (FNQLHSSC social services team, tripartite committee) - *External stakeholders* (from outside the community)



3.4 Data collection tools

As mentioned, a variety of data collection tools were used for this evaluation. These tools were developed based on concerns related to the evaluation objectives and dimensions selected. These tools are summarized below:

a) *Focus group interview:* A focus group interview is half-way between an unstructured discussion group and a nominal group, which is highly directive (Mayer and Ouellet, 1991: 80). For this process evaluation, a number of focus group interviews were held during the two periods of data collection. Local stakeholders from the communities and regional stakeholders were targeted: as they were actively involved in the services implementation, these stakeholders were best positioned to document actions taken from the community's point of view.

   To draw the baseline community portraits, focus group interviews were organized and facilitated by members of certain first-line services implementation teams. The groups met for anywhere from one to three hours. The first-line teams used the data collected to draft action plans specifying methods to be used to implement the project. The community portrait data were also used for analysis by the research team.

   In addition, during the second period of data collection for the evaluation, focus group interviews were conducted by the research agent and the research assistant. When possible, an audio recording of the group discussion was made, with the consent of the participants. When participants were reluctant to be recorded, notes were taken instead. This method of working helped to establish an atmosphere of trust among the members of the group and encouraged free expression of different points of view.

   Accordingly, during the first period of data collection, focus group interviews were conducted with the first-line teams, the advisory committees and external partners (Youth Centers, tripartite committee and pre-existing social services in the communities). During the second period of data collection, focus group interviews were conducted with the first-line teams, the advisory committees that were still functioning and the different local partners. In sum, for each of the pilot projects, seven to eight focus group interviews were held. The interview guides used to conduct the focus group interviews are included in Appendices 1 to 4. In addition, a questionnaire was administered at the end of each of the group interviews to establish a profile of first-line team members (Appendix 5).

b) *Individual interviews:* These interviews took the form of conversations during which the interviewee was asked to describe his or her experience during the project in response to open-ended questions. During the second period of data collection, interviews were conducted with the main pilot project partners outside the communities who did not participate in the focus group interviews (stakeholders from the Youth Centers, the Centres de santé et de services sociaux, etc.). Because it was difficult to reach a number of people, telephone interviews lasting roughly one hour were conducted. The interview guide used for the focus groups was also used for the telephone interviews. In some cases, individual interviews were also used by the implementation teams in drafting the community portraits and the data collected were also used by the research team.

c) *Document review.* To obtain background for what stakeholders said during the interviews and their accounts of local contexts in which the project unfolded, the content of a number of documents was reviewed. All accessible documents produced by the first-line services teams, the FNQLHSSC and the tripartite committee were collected (action plans, agreements, brochures, flyers, activity reports, etc.). The benefits of collecting existing documents are many. For one thing, it is possible to obtain a better understanding of certain things that are said and a better perspective of what's actually being done. As a result, all documents that could help in the analysis were systematically collected throughout the evaluation.

d) *Logbook*: Logbooks were used to record notes in the field, questions, impressions, etc. Logbooks covering one month and three months were developed by the first-line services team in the communities as well as by the FNQLHSSC social services team, in cooperation with the FNQLHSSC research team. The first-line services teams in the communities then completed the logbooks during their activities and shared them for the evaluation. Given the tight deadlines for the evaluation activities, this tool was only developed for the second period of data collection, that is, the community access to services phase (May 2008 to November 2008) and the services review phase (February to March 2009) of the pilot project. A logbook generates written records of the content of events (ideas, descriptions of facts, decisions, impressions, etc.) and of the context in which they take place (time, people, places, etc.). It also helps in reconstructing the logical sequence of events, their progression and impacts. However, this tool is not suitable in all local contexts. For example, one of the teams in the pilot project was unable to keep a monthly logbook. Thus, in each community, one to twelve logbooks were completed by the implementation team, depending on the community. Appendices 6 and 7 show the logbooks that the first-line teams had to complete.

e) *Satisfaction survey*. A questionnaire comprising mainly of multiple-choice questions was developed to measure user satisfaction with the first-line services received (Appendix 8). The questionnaire included 55 questions in six sections (information about the context of the intervention, individual/family intervention, group activities, and overall opinion of the first-line services, empowerment and general information). The satisfaction survey was conducted during the second period of data collection, in November 2008. The research assistant spent a week at the site where the first-line services were offered (the Maison de la famille or the health centre, depending on the community). As the team responsible for the evaluation could not spend much time in the communities and had limited access to service users, they asked each of the first-line social services teams to ask users of their services if they would participate in the survey and to draft a schedule of meetings. There was a risk of bias with this method. However, it also meant greater participation of users in the survey. Nonetheless, a number of users did not show up for the scheduled meetings.

When a participant agreed to take part in the survey, the social services intervener then obtained his or her written informed consent. The intervener explained the consent form and had the participant sign it. The consent form explained the objectives of the satisfaction survey and provided information about the confidentiality of the responses. It took about 20 minutes to administer the questionnaire. When the questionnaire was completed, the interviewer made sure to remove all identifying information to ensure confidentiality. With these methods, 58 questionnaires were completed in the four communities participating in the pilot project, that is, about 10 to 17 questionnaires per community.

f) *First-line services electronic databank*. Non-identifying data about the nature of the psychosocial services offered to community members was retrieved from the first-line services databank[16] developed for the pilot project in partnership with the coordinators of the local teams and the FNQLHSSC research agent responsible for the evaluation. The data listed in this databank relate to two types of services offered: individual and family psychosocial interventions and group activities. Variables studied were as follows: 1) the characteristics of the services offered; 2) the characteristics of the clientele served; 3) cultural adaptation of the services. These data were extracted from the data base in December 2008. The forms used by the social services interveners to enter data in the databank and the guides to help them with this task are shown in Appendices 9 to 12.

After each of the data collection periods (period 1 and period 2), validation sessions were held with the three groups of stakeholders targeted by the evaluation. These meetings had three specific objectives: to present the main results of the evaluation, to discuss and integrate necessary changes to the analysis and to discuss the main recommendations that should be made for the future. To facilitate the conduct of the meetings, everyone who participated in the research activities received a summary of the results two weeks before the validation session was held. Note that this iterative process between researcher and participants made it possible to create meaning through mutual intelligibility and intersubjectivity, making this qualitative approach more rigorous (Yin, 1994:110).

3.5 Data analysis strategies

The analysis for this process evaluation began with the very first field activities and included a qualitative as well as a quantitative component.

3.5.1 Qualitative data

The qualitative information collected with the different data collection tools was retranscribed and then analyzed using the quality analysis software Nvivo 2.0. The analysis was performed in three steps. The first step in the analysis used a thematic technique based on data distillation[17]

[16] Between March and June 2008, work sessions were conducted with the research team, the FNQLHSSC social services team and the four local first-line services teams. The purpose of the sessions, which used a participatory approach, was to institute record-keeping for the individual and family psychosocial services and the group activities organized in the four communities. From data compiled from these records, a non-identifying digital data base was created so each community could keep statistics on services offered in the community. These statistics helped the communities to evaluate their activities themselves and compare them with their initial action plans. The research team played an active role in this process, supporting and equipping the first-line teams.

[17] The notion of data condensation encompasses all data transformation, categorization and linkage operations.

(Sanséau, 2005: 50). The thematic analysis made it possible to identify those passages in each of the data sources that addressed the different themes selected for evaluation.

The second step in the qualitative data analysis involved logical reconstruction of events on a time line. The history of the processes observed in each of the four communities was reconstructed and the dynamics between the processes as well as the stakeholders involved were highlighted. This type of analysis gives a longitudinal perspective, in keeping with the objectives of this process evaluation of the pilot project.

The third step comprised a horizontal analysis by cross-comparison of processes identified by each of the communities to determine converging, diverging and exceptional experiences. The data that emerged from this analysis made it possible to develop typical services implementation paths and propositions about the overall experience that take into consideration elements specific to each local community.

3.5.2 Quantitative data

Data retrieved from the first-line services digital databank were analyzed using the software SPSS, version 13.0, and different descriptive analyses were preformed, including frequency distribution and averaging. In addition, quantitative data were collected in a satisfaction survey completed by first-line services users and analyzed using the SPSS software.

3.6 Limitations and strengths of the evaluation

3.6.1 Limitations related to the methodology

Any evaluation approach has its limitations. One source of such limitations stems from methodological issues related to choices the researcher makes. As the evaluation described herein is mainly qualitative and the samples studied were small, no generalizations can be made based on the results. Another limitation stems from this: the evaluation did not aim to compare the communities, nor can it be used to do so, as the local circumstances are unique and the experiences in each community differed widely. The evaluation did, nonetheless, highlight certain circumstantial and structural factors that facilitate or constrain achievement of objectives set by the communities. Thus, it was possible to determine issues and challenges that should be considered if first-line services are to be introduced to a wider clientele using the community development approach.

The second limitation that must be considered stems from the subjectivity that any researcher must try to master, or at least lessen as much as possible, through different measures: "*Subjectivity cannot be eliminated from the research process. It is present even when defining the research problem …. In reading the literature, we absorb the opinions of other researchers who have already examined the problem and have come up with multiple interpretations of results and recommendations for successors*" (St-Cyr Tribble and Saintonge, 1999, our translation). In the first-line services pilot project, validation sessions with the different stakeholders concerned greatly diminished the influence of such subjectivity on the interpretation of data collected.

3.6.2 Limitations related to the community development approach

In our current state of knowledge, it is not possible to determine if intervention initiatives undertaken from a community development perspective give better results in terms of improving the well-being of children. Likewise, it is impossible to determine if these initiatives result in more effective services and communities that offer a safer living environment (Elderman, 2001: 58). In fact, research is still today unable to clearly demonstrate the efficacy of such initiatives given the complexity of the problems and the social transformation processes that occur during such projects (Elderman, 2001: 58).

This complexity is definitely a serious methodological challenge when it comes to evaluating a program based on a community development approach. It can be difficult to demonstrate the efficacy of an initiative that incorporates a wide range of strategies, activities and goals (Chaskin, 2003: 62; Flashpowler et al., 2003), as isolating all variables that can affect the implementation of a program and hence its results can be complex (Simard, 2005: 25). These evaluation challenges can be particularly complex in multi-site initiatives where local contexts differ at each site (Chaskin, 2003: 61), as is the case in the project at hand.

Conventional conceptions of program evaluation raise another issue. Conventional methods of evaluation (evaluation of outcomes and impacts) generally try to look at differences between what is observed and what was expected (Bernoux, 2004: 47). These methods of evaluation use predefined models (variables, objectives, methods and results to be achieved) to prove (or at least provide convincing data) that the intervention has or has not achieved the expected results (Simard, 2005: 24; Bernoux, 2004: 47; Flashpowler et al., 2003: 42). However, there are no predefined action models for projects based on a community development approach. Such projects are evolutionary by nature and subject to multiple factors—such as contextual and political influences as well as the influence of other organizations (Chaskin, 2003: 62; Bernoux, 2004). To this must be added the impatience of project promoters, who want to see results quickly (Flashpowler et al., 2003). However, any initiative that depends on community development is going to require time and unfold slowly (Simard, 2005).

As a result, some researchers have begun to reconsider conventional methods of program evaluation and focus more on implementation processes than outcomes (Chaskin, 2003: 62). Such methods pay greater attention to the meaning stakeholders give to their actions (Chaskin, 2003: 62; Flashpowler et al., 2003; Simard, 2005; Bernoux, 2004) through participatory research, action research and empowerment research (Bernoux, 2004; Chaskin, 2003: 62; Flashpowler et al., 2003; Simard, 2005: 25). This new way of thinking about evaluation has many advantages. Among other things, it allows documentation of the planning process, programmatic developments, the dynamics between stakeholders and decision makers, the effects of support obtained, successes, shortcomings, etc. (Chaskin, 2003: 63).

This method also provides greater support to stakeholders in their local community actions, serving as a learning tool so that necessary corrections can be made to a program in progress. The advantage here is that actions or ways of doing things that interfere with the success of the program need not be maintained. In this framework, the methodology selected to evaluate the first-line services project, that is, process evaluation with a partnership approach, is well warranted.

3.6.3 Strengths of the pilot project evaluation

One strength of the process evaluation was the use of multiple data collection tools. In addition, data were collected from three different groups of stakeholders. This method, called data triangulation, is defined as *"a strategy whereby researchers diversify their approach to the phenomenon studied to enrich or validate their interpretation"* (Alain and Dessureault, 2009: 204, our translation). The pilot project evaluation also used the triangulation methodology by relying on quantitative as well as qualitative methods, once again increasing the validity of the data collected and the ensuing analysis (Alain and Dessureault, 2009).

Another strength of this evaluation stems from the participatory approach used. The team responsible for the evaluation tried to involve a wide variety of stakeholders at each stage of the process (the tripartite orientation committee, the research working group, the FNQLHSSC social services team and the local first-line services implementation teams). This involvement ensured greater ownership of the results of the evaluation by the stakeholders and hence the lessons learned from the evaluation are more likely to be translated into action. This participatory approach is in keeping with the community development approach and the partnership approach advocated from the very start of the evaluation of the first-line services pilot project.

Finally, as the evaluation examined an innovative project, lessons could be drawn for a broad rollout of the services concerned. In other words, though the evaluation did not make it possible to document whether the project led to a decrease in the number of child placements, it did nonetheless highlight community and organizational changes along the way. It also made it possible to closely track the evolution of the project within the four communities so that adjustments could be made to continue the project along successful lines.

3.7 Ethical considerations

3.7.1 Informed consent

As specified in the *First Nations of Quebec and Labrador Research Protocol* (AFNQL, 2005), a research partnership must be based on full understanding of the methodology and of the possible consequences the research could have on the community. For this purpose, a consent form was sent to the band councils and those in charge of social services in the four communities to inform them of how the evaluation would be conducted. Given the accountability required by Indian and Northern Affairs Canada, when the communities agreed to participate in the first-line services pilot project, they also agreed to take part in the evaluation of its implementation.

Other consent forms were later developed and administered to all participants in the different data collection activities. All participants were informed that they were completely free to agree or decline to participate in the data collection activities. They were also informed that they were free to withdraw at any time without having to say why and without prejudice.

Obtaining informed consent for participating minors is one of the ethical issues about which a decision had to be made with regard to the pilot project evaluation. Given ethical standards effective in Quebec and standards used by FNQLHSSC, written consent was obtained from a person with parental authority whenever a minor was asked to answer the satisfaction questionnaire. In addition, the minimum age for completion of the user satisfaction questionnaire was 12, an age at which it is recognized that the concepts of anonymity and confidentiality are generally well understood.

3.7.2 Data management

All data collected from participants are and will remain confidential. A code was assigned to each respondent for each data collection activity. Thus the members of the FNQLHSSC research team never knew the names or contact information of participants, and these do not appear in any reports. In addition, to further ensure the confidentiality of the results and to avoid targeting the communities that participated in the pilot project, the names of the participating communities are not revealed, and the sociodemographic and socioeconomic characteristics mentioned do not permit recognition of the communities concerned barring very close knowledge of First Nations communities in Quebec. Last, under no circumstances shall verbatim content or raw data from the questionnaires be rendered public.

Throughout this evaluation, the principles of Ownership, Control, Access and Possession (OCAP) were applied to the First Nations research data and information (AFNQL, 2005). All community data collected for the project thus belong to the participating communities and will be stored under lock and key on their behalf at FNQLHSSC for five years and then destroyed in an appropriate manner.

As part of the presentation of the results of the evaluation of the implementation of first-line social services in the four First Nations communities, the next chapter describes the services implementation process as experienced in each of the communities that participated in the pilot project.

Chapter 4

Analysis of the Implementation of First-Line Services

This chapter gives a detailed summary of activities and actions during the implementation of first-line social services in the four communities selected by the tripartite orientation committee. To preserve the anonymity of the four communities participating in the pilot project, sources that could lead to their identification have purposely been omitted.

The descriptive and cross-sectional analyses of the implementation process are based on data collected throughout the implementation process:

- The group and individual interviews conducted during the first and second data collection periods made it possible to describe each implementation phase based on the responses of local, external and regional stakeholders involved in the pilot project;
- Documents produced by the many stakeholders involved (agreements, terms of reference, action plans and reports of activities in the participating communities) were analyzed;
- Analysis of the logbooks completed by the first-line teams was essential in understanding the context, content and type of events organized;
- The first-line services electronic databank made it possible to identify type and characteristics of services offered.

The analysis of the first-line services implementation process indicated the following:

- The implementation process was different in each of the four participating communities and depended on the realities of life in the community as well as community dynamics and ways of doing things;
- The pilot project is innovative, but tight deadlines and frequent turnover of implementation team staff had a significant impact on the implementation process;
- Cultural appropriation of first-line services depends mainly on social conditions and dynamics within the community;
- Three action priorities were identified to meet the needs of the communities: 1) fight drug, alcohol and gambling addiction; 2) improve parental responsibility (to promote development and retention of children in their biological families); 3) develop community and cultural cohesion through cooperation/collaboration (break the isolation of young people and families);
- Despite proactive measures in the communities (organization and implementation of individual and community activities), reactive measures are the rule in times of crisis and social emergencies.

4.1 The implementation process

A five-phase plan was developed for the implementation of first-line services (Figure 4.1). All five phases were implemented in the communities participating in the pilot project, taking into account local realities. Given local conditions, the sequence of the five phases was not necessarily as initially planned. Each phase and the main activities carried out in each phase are described below.

Figure 4.1 Implementation of the first-line services pilot project

Phase 1	Phase 2	Phase 3	Phase 4	Phase 5
Pre-implementation	*Action planning*	*Implementation of services*	*Access to servicess*	*Services review*
September 2006 to April 2007	May 2007 to December 2007	January 2008 to April 2008	May 2008 to April 2009	February 2009 to March 2009

4.2 Phase 1: Pre-implementation (September 2006 to April 2007)

Before raising awareness in the communities and starting the process of organizing and implementing services, activities were carried out to establish the parameters and general framework of the pilot project as well as the roles and responsibilities of the different partners. This pre-implementation phase, which took seven months (September 2006 to April 2007), made it possible to determine the general approach of the first-line services implementation project. Following the First Nations Socio-economic Forum, held in Mashteuiatsh in September 2006, a tripartite orientation committee was formed in October 2006 to determine the broad parameters of the project and foster regular monitoring of the progress of the work. The main partners involved in this committee are representatives of the Department of Indian and Northern Affairs (INAC), the Ministère de la Santé et des Services Sociaux (MSSS) and the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). The general mandate of the tripartite committee is to develop a framework for implementation of services that can have a positive impact on social problems faced by children, young people and families. The long-term goal of these first-line services is to reduce the high rate of placement of First Nations children in the Quebec child protection system.

4.2.1 Activities

Investment of time and energy by all members of the tripartite committee was crucial during this period. Monthly and sometimes bimonthly meetings were required to reach agreement on project parameters. A variety of professionals worked with the committee in this phase, including an FNQLHSSC advisor specializing in first-line and youth protection services and a community development consultant. A Research Officer was hired in May 2008 to develop the evaluation described herein, which was performed by the research sector of the FNQLHSSC. Table 4.1 recaps the activities during this phase.

Table 4.1 Pre-implementation phase activities (September 2006 to April 2007)

Main activities	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	Apr.
1) **Determine partnership parameters** a) Determine committee mandate b) Identify roles and responsibilities of the partners. The FNQLHSSC will coordinate the project and evaluate its implementation		x	x	x				
2) **Hire an advisor** to work for the FNQLHSSC whose role will be to implement guidelines set by the committee and orchestrate the project					x			
3) **Develop a general frame of reference** for the project and produce the following key documents a) An analysis of models of first-line services b) Terms of reference c) Action plan acceptance criteria					x	x		
4) **Select communities** a) Determine selection criteria b) Analyze statistics on placement and reporting of children c) Select four communities d) Develop a guide for awarding of budgets					x	x		
5) **Select an approach** a) Hire a consultant b) Produce documents on the approach c) Prepare training in the approach					x	x	x	
6) **Launch local projects** a) Contact competent authorities to inform them of the project and ask them to participate b) Have a funding agreement signed by the selected communities and INAC						x	x	x

Two of the six steps outlined above (select communities and select an approach) were particularly crucial in determining the direction of the project. The decision to take a community development approach was determinant in selecting implementation activities that would give power back to the communities to develop their own projects rather than imposing a project model. One of the main reasons for selecting this approach was a general understanding that the traditional approach of the provincial system to health and social services has not given the expected results, particularly when it comes to adapting to local conditions and First Nations culture. In addition, involving and mobilizing the communities seemed essential. This was why a community development consultant was hired to work with the FNQLHSSC first-line services and youth protection counsellor, so that community development would be the guiding principle at each stage in the implementation of the pilot project.

The selected approach was backed by the members of the tripartite committee, who have expertise in this area. This support proved to be a major asset in carrying out the work.

> *"I really felt supported by the tripartite committee. I felt understood... The community development approach is a "bottom up" approach, whereas people from government departments are used to a "top down" approach. The key element here was that First Nations communities are asking for self-governance and that they are aware that existing programs have not given good results and that the government programs are not culturally appropriate. This suggests a decentralized approach will be more successful. A project like this would never get the go-ahead elsewhere, say in an underprivileged neighbourhood in Montreal, as government departments would not agree to this much latitude in deciding on how the project will work. I was surprised this approach was accepted by the committee" (regional stakeholder T1).*

The pre-implementation phase made it possible for the tripartite committee to recommend four communities which would have the opportunity to introduce first-line services by way of a pilot project. Seven criteria were used in selecting the communities,[18] with two in particular weighing heavily in the final selection: a) the scope of child reporting and placement rates based on a compilation of provincial and federal statistics; b) community recognition of problems and a commitment by all stakeholders to work to solve them.

Nonetheless, one community in particular was the subject of much discussion by the tripartite committee. The lack of a basic budget to cover the costs of mobilizing the resources necessary raised questions about whether it would be possible to guarantee the implementation team the fundamental conditions required to introduce the services. However, when political leaders in the community rallied to the cause and offered the space needed by the implementation team, the committee maintained this community's inclusion in the project:

[18] The seven selection criteria were as follows: 1) community recognition of problems and the involvement of all stakeholders in addressing them; 2) community and leaders' commitment to take a comprehensive and integrated approach to organizing and developing community services; 3) scope of reporting and placement rates based on the compilation and analysis of statistical data; 4) interest and ability of community services, Youth Centers and CSSSs in working together; 5) interest and ability of regional services, agencies and CSSSs in supporting the community; 6) community willingness and ability to develop more elaborate first-line services; 7) community investment in human, material and financial resources.

"At first, [name of the regional stakeholders] did not want [name of the community] to be included in the project, because it didn't have the necessary funds or the space for the teams … It was a close call. [Name of the community] almost didn't make it into the project" (regional stakeholder T1).

4.2.2 Accomplishments

The quality of the partnership among the members of the tripartite committee was a major factor in facilitating the work. Equality of the partners and consensus decision making were the basis for the partnership, fostering emergence of a shared vision of the project and establishment of a common frame of reference:

> *"This made it possible to communicate, not only among ourselves but also with those in authority over the project in our government departments, remaining respectful and flexible about the adjustments this type of approach demands (in terms of budgets among other things) and open to learning and understanding what it involves for the communities. Our expertise also helped in proposing solutions to some of the problems encountered by the communities" (regional stakeholder T1).*

Some of the more difficult conditions merit mentioning. Because deadlines were initially very tight, the FNQLHSSC advisor set to work at a frenzied pace that left him little time to plan his actions. The situation was particularly complicated, because the project was a pilot project and there were no models for setting up first-line services in First Nations communities using a community development approach.

> *"The most difficult part of this approach was convincing the committee about the timeframe required. We had to convince the committee, to negotiate with them, to get deadlines extended" (regional stakeholder T1).*

This said, the tripartite committee took this reality into account and eventually adjusted to choices made in applying the community development approach:

> *"For me, the tripartite committee's eventual acceptance of this was another example of their understanding of the approach and their realization that more time was required than anyone had expected at the start. Though the committee members may have been feeling pressured by deadlines or political issues, they nonetheless agreed to give the process more time, which demonstrated their understanding of the approach. I think there was a learning curve to understanding that in the real world if you are going to mobilize you have to get people behind you" (regional stakeholder T1).*

Finally, though the project became clearer with time, the FNQLHSSC advisor played a key role, thanks to his tremendous capacity to adapt and to work with ambiguity and his ease in creating the ties necessary for partnering:

> *"It all happened so quickly. We had to consider the people involved, that is, the members of the tripartite committee as well as the chiefs. The program officer [the FNQLHSSC advisor] played a pivotal role here, and he also had to determine the rules of the game. It was a "work in progress." The project didn't start off with a preset plan of action" (regional stakeholder T1).*

However, as the project was funded for a three-year period (April 2006 to March 2009), the tripartite committee had no choice but to establish firm deliverables for the FNQLHSSC. Even so, the project fell about eight months behind in the 2006-2007 budget year, its first year:

> *"The project was supposed to last for three years, and one year had already passed" (regional stakeholder T1).*

The main steps that were to lay the groundwork for the next phase were developed by FNQLHSSC social services during the pre-implementation phase and presented to the four communities. The following section describes the activities of each of the stakeholders concerned during the action planning phase.

4.3 Phase 2: Action planning (May to December 2007)

The communities began to be actively involved in the project during this second phase. The goal was to develop an action plan reflecting a shared vision of priority actions to promote the well-being of children and families. The action planning took about seven months, from May to December 2007. The communities were originally supposed to complete this task in three months. However, given the scope of the mandate (draft an overall portrait of the community, hire project interveners and train them), the tripartite committee had to modify the project timeframe and give the four communities a few more months to develop their action plans.

The following sections describe the development of this phase in each of the communities, documenting activities and lessons learned by the FNQLHSSC, the tripartite committee and the four communities.

4.3.1 Activities of the FNQLHSSC and the tripartite orientation committee

The principal mandate of the FNQLHSSC advisor was to support the communities and equip them to carry out the tasks that would lead to the drafting of an action plan: for example, 1) presentation of the project to the different Aboriginal and non-Aboriginal decision-making bodies and 2) negotiation of agreements with the National Training Program to train the first-line teams.

The FNQLHSSC advisor also eventually participated in the activities of the pilot project and worked with the tripartite committee on a request for funding for first-line services programs in all First Nations communities in Quebec[19] (G3). The tripartite committee, on the other hand, focused on analysis and approval of the action plans and monitoring of the local activities developed.

[19] This task was carried out by the FNQLHSSC social services coordinator in cooperation with the MSSS and INAC.

At this stage in the implementation of the pilot project, requests for support from the FNQLHSSC were not made in any systematic way. As the advisor was often informed of difficulties encountered after the fact, he decided to form a regional committee in February 2008 composed of the implementation teams of the four communities participating in the pilot project. The purpose of the committee, which met once every three months, was to provide a place to share experiences and help one another.

This initiative helped break the isolation of the teams and fostered development of trust with and among the communities:

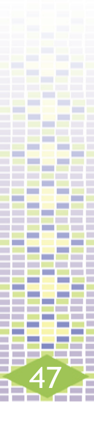
> *"The support was always appreciated, but I think relationships needed to be established with each community—and this went faster in some communities than others. Once the relationship was established, the support was very much appreciated. The hard part was clearly in getting together the different partners or players who needed to participate in this. The geographic distance was clearly a huge obstacle in providing effective support, because there's no warmth in the relationships when meetings are via video or telephone conferencing. This was one of the difficulties I encountered" (regional stakeholder T1).*

As a result, the FNQLHSSC advisor played a critical role, especially when he was asked to help sort out local difficulties:

> *Sometimes we asked for help sorting things out, and the FNQLHSSC advisor played a crucial role in getting the project to move ahead. Because sometimes there were political issues, even threats at times: if this doesn't happen, we're abandoning the project"* (regional stakeholder T1).

Considering the ownership of the project that was required and the scope of the work entrusted to the pilot project implementation teams, the tripartite committee had to adjust the timeframe for this action planning phase. The first-line teams had only eight months to become thoroughly familiar with the community development approach and internalize the essence of the project. This timeframe did not allow the latitude required to take into account the local pace of the four communities.

> *"The biggest [obstacle] was INAC's timeframe. The pressure. The deadlines were too tight. They told us this was what was to be done, and we had to ... it was just not realistic and it put a lot of pressure on us. We had to meet government requirements […] the timing was wrong. It was the beginning of summer. Forget it. When summer arrives, people leave. Also, people start work during this period, because the summer is the time when most people work (local stakeholder T1, Community 4).*



4.3.2 Activities of the implementation teams of the four participating communities

Generally speaking, the communities hired implementation teams at the start of the project, and the FNQLHSSC then presented the pilot project and the community development approach to the teams hired. It was suggested to the communities that an initial team composed of a local project coordinator, a clinical counsellor and a secretary be formed to organize the activities leading to drafting of an action plan based on the community development approach. During the period of planning and drafting the action plan, the implementation teams of the four participating communities felt the need to inform, consult, motivate and mobilize local stakeholders (community members) and external stakeholders working in the community in order to get their suggestions and opinions. This way, the action plans would stem from needs and solutions expressed by the community and reflect actions it recommended. Only one of the four communities did not take this route, deciding instead to begin providing intervention services before drafting an action plan.

The implementation teams thus had to work on awareness raising and sharing of information so that a common vision for the project could be developed. The teams also had to compile needs expressed by community members in order to draft the action plan. In addition, this phase gave rise to the creation of local monitoring committees (advisors), generally composed of community members and informal leaders, whose role was to monitor and guide the activities of the first-line services implementation team.

Table 4.2 outlines the work of the implementation teams during the services planning phase and gives an idea of the scope of the strategies used by the communities. However, predetermined categorization of activities was used in setting up the table, and in practice certain steps overlapped in time depending on experiences in each community. In addition, not all of the activities listed were actually carried out in all the communities. For example, step 5 was never carried out in Community 2. Note that in compliance with confidentiality and privacy agreements with the stakeholders responsible for implementing the first-line services, the communities are identified in this table and throughout this document only by the numbers 1 to 4.

Table 4.2: Action planning phase (May to December 2007) activities in each community

Main activities	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.	C*
1. **Hire implementation team,** ideally composed of three people: a coordinator, a clinical counsellor and a secretary.	x								1
	x				x**				2
	x								3
		x							4
2. **Understand the approach and the project** by attending training sessions given by the FNQLHSSC, reading pertinent documents and meeting partners with expertise in the approach and the three different levels of social services.	x	x							1
	x	x							2
	x	x	x						3
	x	x							4
3. **Present the project and the approach to local and external stakeholders** at consultation tables, sectoral meetings, etc.		x	x						1
					x	x			2
		x	x						3
		x	x	x	x	x	x		4
4. **Present the project to the population** at routine gatherings: annual meetings, kiosks, etc.		x	x	x	x	x	x		1
		x			x				2
		x	x						3
		x	x	x	x	x	x		4
5. **Identify a shared vision** for action through wide-ranging consultation (group and individual interviews, surveys, questionnaires) of stakeholders and community members.			x	x	x				1
									2
			x	x	x	x	x		3
			x	x	x				4
6. **Draft an action plan** and have it approved by community members and local stakeholders.						x	x	x	1
				x	x	x	x		2
			x	x	x	x	x	x	3
						x	x	x	4
7. **Offer intervention for families and social problems** that arise and organize community recreational activities.									1
	x	x	x	x	x	x	x	x	2
				x	x	x	x	x	3
			x	x	x	x	x	x	4
8. **Form a monitoring committee** (composed of representatives of the community and local stakeholders) to support implementation of projects.							x		1
									2
						x			3
					x				4

C* = Community

** Two hiring periods were required in this community due to a complete turnover of the members of the team.

As mentioned, during the phase of planning first-line services activities, each participating community saw the need to develop an action plan that drew a portrait of the community and set objectives and a target clientele for the services to be introduced. During this period as well, most of the implementation teams held consultations with community members to select a name for the pilot project in the local Aboriginal language. This initiative demonstrated the need and the desire to ensure that community members who use the first-line services will understand that the project is "by and for the community" and adapted to the culture of the community.

One of the goals of this evaluation was to document the community portraits in order to situate the contexts and dynamics within which the pilot project developed. The following paragraphs summarize two key aspects of the planning and action plan development phase in each of the four communities:[20]

1) The main sociodemographic characteristics and the social issues raised

2) The essential steps and priorities in this phase

4.3.2.1 Community 1

a) Sociodemographic characteristics and social issues

Community 1 is located close to an urban centre. This community of about 500 people has experienced significant demographic growth in the last five years, and half of the population is currently less than 17 years of age. Families have an average of 3.5 children and 40% are single-parent families headed by women.

Economic development is difficult in this community, considered one of the poorest in eastern Canada. There are no private companies on community land, though there is an economic development corporation and a worker cooperative. The band council is the main employer. Graduation rates are low: more than 90% of residents age 15 or older do not have a high-school diploma and only 8.8% have a post-secondary diploma (Statistics Canada, 2006). The common practice in the community, for close to twenty years, is for children to leave the community to go to school, spending the week in the homes of non-Aboriginal Quebecers. As there is no telephone, electric or water supply system, socio-sanitary facilities in the community do not generally meet recognized Quebec and Canadian standards. In addition, homes are small and overcrowded: generally built to accommodate a family of four, homes in this community often house six to ten people and promiscuity is a serious problem as a result.

The members of the community are affected by a number of problems related to the difficult conditions in which they live, including addiction; parental neglect; debt; generation gap; isolation and physical, sexual and psychological violence. As a result, rates of removal and placement of children by the regional youth protection system are high. However, this must be put in perspective. In addition to the intergenerational impact of the Indian Residential Schools, the poor parenting skills stem from the fact that the children spend most of their time outside the community in order to go to school.

[20] The information that follows is based on a review of the action plans submitted by the four participating communities to the tripartite committee.

Local organizations working to improve the well-being of children and families were leaning towards a community development approach before the pilot project was introduced. This is clear in the local and regional cooperation/collaboration established, the closeness of elected representatives to the population, the existence of decision-making venues, the existence of a long-term vision of the community and social dynamics that rely on cooperation and mutual aid. Finally, despite major social problems, those responsible for implementing the project were confident that the pilot project could be easily integrated in the community.

b) Planning process and action priorities

When the request was made by the tripartite committee, the band council and the health centre quickly mobilized and worked together to hire an implementation team. As the situation of its children is this community's major concern, the reaction to the project by local stakeholders, political representatives and the general population was very positive.

To develop the action plan, a community portrait highlighting needs expressed by community members and local stakeholders was drafted through numerous consultations. Three social problems involving children and families were identified, and this led to identification of three action priorities:

1) Fight addiction;

2) Promote good parenting;

3) Break the isolation of children and adolescents and help them develop pride in their culture and a feeling of belonging.

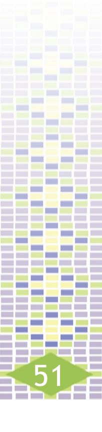
4.3.2.2 Community 2

a) Sociodemographic characteristics and social issues

Community 2 is located less than 50 km from an urban centre. In 2006, there were more than 1500 community residents. Population growth was exceptional in this community in the early 2000s. French is the language generally spoken in the community.

The band council is the community's main employer. In 2006, more than three-quarters of the population 15 years of age and older did not have a high school diploma and 31% held jobs. Of the residents with jobs, close to 150 work in the services sector, about a dozen have jobs outside the community and another 60 are seasonally employed, mainly in forestry. Median income in 2006 was $10,872, and government transfers accounted for 48.3% of total income (Statistics Canada, 2006).

This community has a full complement of health-care and social services facilities. It has a water supply system, a sewer system and electricity supplied by Hydro-Québec. There is a police and fire department that serves the community, and there is also a daycare centre, an elementary school, a high school, a health centre, a church, a Youth Center, community radio services and a private company. Social services are provided by the regional Youth Center. Community members seem to confuse social services and youth protection services, and the term "social services" is regularly used to refer to the Youth Center.



The main social problems identified are related to drug and alcohol abuse. Young people as well as adults are affected, particularly when money comes in—at which times many children are left alone. This situation is disturbing, as drug and alcohol abuse seem to be on the rise among children, with more cases in this community than anywhere else in the region according to the Youth Center. Adding new services is not necessarily the way to improve the well-being of the population, however, according to the action plan submitted for the project. Traditional community practices are considered a better approach for a sustainable solution to the community's social problems.

The community favours vertical organizational structures. In other words, the political sphere is central in this community and many decisions are negotiated in this sphere. Community members often use the band council as a forum for expressing their dissatisfaction or requesting services. In addition, during the implementation of services, the population and the authorities were distrustful of the Youth Center. In 2007, there were several functioning local forums for cooperation, but no shared strategic action plan. A number of stakeholders, however, stressed the need to develop collaborative activities. It also seems that volunteering and mobilization initiatives are rare in the community, except in crises.

b) Planning process and action priorities

The band council of Community 2 agreed to participate in the pilot project using the community development approach. However, this community did not follow the sequence of steps for project implementation called for by the approach. The planning phase in particular deviated substantially from the plan. For one thing, there was a complete turnover of the members of the implementation team in the first few months, and for another, the objectives of the project and the key concepts of the approach were not really internalized by community political leaders. This led to premature hiring of first-line interveners and dispensing of services during the planning phase.

Given the tight deadlines, the second implementation team met individually with certain key people and based its action plan largely on a previously-written report on the community. The plan was nonetheless approved by the tripartite committee. The three action priorities selected were as follows:

1) Promote development of children and young people within their biological families;

2) Promote a way of life free of alcohol, drug and gambling addiction;

3) Promote a safe and violence-free living environment.

4.3.2.3 Community 3

a) Sociodemographic characteristics and social issues

Community 3 is located less than 10 km from a large city. In 2006, the population numbered close to 5000, but less than half were living on community territory. The population is growing rapidly and is relatively young, with more than a third of the community between 0 and 19 years of age. Forty-five percent of the population does not have a high school diploma, and the school dropout rate reached 48% between 2003 and 2007. The child placement rate is high, and local statistics show that most children placed come from single-parent families headed by women.

As part of one of the most urbanized communities in Quebec, this community has access to a full range of services, from schools to diverse community services. There are also many private companies, including a processor of raw materials, a tourist company and an air carrier. The band council is very active; it is a major employer in the community with a complex, hierarchical organizational structure. Generally speaking, the economic development of the community is healthy. Nonetheless, close to one-quarter of the population has been receiving income security payments for more than two years.

Overcrowding in many homes has led to promiscuity issues and indicates a need for construction of new homes in the community. The community is also dealing with other social and health issues such as poverty, obesity, alcohol and drug abuse and the serious consequences of such abuse. Child reporting and placement rates are very high and this affects the construction of identity and parental skills.

The defining feature of the community's social dynamics is the major split between band members who come from the community and those from outside it. This split may be due, in part, to the arrival of new band members following the amendments of Bill C-31 and the superior socioeconomic conditions of one of the groups. The social dynamics are also affected by the very hierarchical political structure.

b) Planning process and action priorities

As the health centre serving Community 3 already offered routine psychosocial services, the first-line services team was mandated to improve the existing first-line services. The goal was better knowledge and use of these resources by community members as well as an increase in prevention and promotion services.

From the start of the project, a variety of service promotion campaigns were organized to inform and involve the population. Work tools were also developed, and the implementation team gave a series of presentations in the community describing the project objectives in detail. This was also the first step in community mobilization. During the presentation to local stakeholders, all participants agreed on the importance of cooperating more.

The implementation team generally followed the steps suggested by the tripartite committee in carrying out the action plan. Training was pursued, partners were met and community needs were targeted. However, many challenges remained. The fact that the project was a "pilot" project was viewed negatively by community members and by those in charge, who took their time integrating the project in the overall social services structure. In addition, as connections between the new first-line services and the existing psychosocial services were slow in being made, confusion about the role of the pilot project gradually took hold. The organizational structure of the community also made it very difficult to mobilize managers. An implementation committee was thus established to focus efforts on the population. Three general objectives were identified in drafting the action plan:

1) Promote prevention, mobilization and cooperation strategies using a holistic approach;

2) Support families, offering accessible and equitable services to improve their quality of life;

3) Ensure child protection services are effective.

4.3.2.4 Community 4

a) Sociodemographic characteristics and social issues

Far from any large urban centre, Community 4 had more than 500 residents in 2007. Like many Aboriginal communities in Quebec, young people account for a substantial portion of the population: nearly 40% of the population was less than 18 years of age in 2007. The birth rate is relatively stable, an average 17 births per year since 2005. In 2000, there were an average of two to three children per family. Forty-seven percent of families are single-parent families and of these 81% are headed by women. These data suggest that community members become parents quite young and are responsible for families that are relatively large compared to the population of Quebec as a whole.

Though the literacy rate has improved in recent years, a large portion of the active population does not have a high school diploma, and young people must go outside the community to continue their education starting in grade 9. Economic development is centred on seasonal hunting, commercial fishing and tourism activities. In 2006, 53.7% of the active population had a job, and 31.5% were supported by government transfers (Statistics Canada, 2006). There is a great deal of employment and income insecurity in the community.

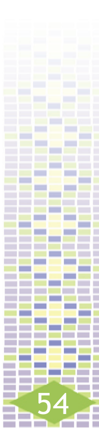
Community 4 has modern infrastructure and access to a variety of services. Though the band council has worked to build single-family homes and apartment buildings, overcrowding has not yet been eliminated and this causes problems with promiscuity. The vast majority of the members of Community 4 understand and speak their native tongue. French is their second language (Statistics Canada, 2006).

Placement of children by the child protection system is Community 4's key concern. In developing an action plan, other social problems were identified by community members: drug and alcohol abuse, violence, drug trafficking, lack of recreational activities and compulsive gambling (including frequent bingo games). From these problems stem other difficulties: lack of parental responsibility, conflicts between children and parents, homeless youth and vandalism in the community.

Before the project was introduced, community dynamics were poisoned by individualism and uninvolvement. Due to the widespread social problems, people had lost hope and become apathetic. Despite the lack of community dynamism, there is still an ability to mobilize rapidly. On the other hand, turnover among staff offering services to the community is high. In addition, as very little work is done in partnership, there are no places where people normally work together, and work relations are sometimes conflictual. There are various informal networks in the community, including natural caregivers and substantial involvement of the elderly. However, these networks appear to be putting less and less effort into providing support for the population.

b) Planning process and action priorities

In Community 4, project coordination was entrusted in March 2007 to an intervener responsible for child protection services. Despite several postings, the other positions in the first-line services team were never filled, and this continued throughout the project implementation phase. The team was thus composed of a single person who had to assume all coordination, clinical supervision and secretarial tasks.



Because the project is designated as a "pilot" project, it was treated with reserve in this community. In addition, the project caused discomfort because it highlighted difficult social problems that affect local stakeholders directly. Project challenges were thus multiplied by difficulties in mobilizing stakeholders and community members, and it was hard to link the project with existing services. In addition, it also proved difficult to bring the members of the community together for a group discussion to gather their opinions and draft an action plan. Though it meant extending the initial project timetable, individual interviews were mainly used instead.

The scope of the tasks to be accomplished coupled with local resistance also provoked some moments of uncertainty about the possibility of carrying out the project. The coordinator, who quickly set to work without having had the time to digest and internalize all the new information about the community development approach, expressed a feeling of isolation. This was partly because the bodies overseeing the project (the tribal council and the band council) had not developed a shared vision of the project. Nonetheless, the FNQLHSSC first-line services advisor stepped in at this point and was able to win their support for the project and get them mobilized. As a result, an advisory committee was formed at the end of September 2007.

In December 2007, an action plan that covered the following four action priorities was submitted:

1) Fight problems related to drug trafficking;

2) Work on parenting skills;

3) Promote a sense of belonging among youth in the community;

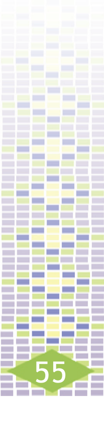
4) Develop community cohesion and collaboration.

4.3.3 Summary

In addition to analyzing the realities of life in the community (drawing a portrait) during the services implementation planning phase, each implementation team was also asked to draft an action plan that set clear objectives and specified methods and partnerships that could be considered to achieve them. It was difficult during this phase for the implementation teams to resist responding immediately to requests for services. One of the four communities did actually hire first-line services interveners during this phase and offered intervention services, even though the action plan for the community had not yet been drafted.

Drafting the action plans proved to be a demanding task for which some of the teams felt ill-equipped:

> *"For sure the writing, I really had to work at it. It was a very demanding task... There were other activities at the same time. I didn't just stop everything and do that. It took a lot of time, but I also had other things to do, luckily. It was good that I sometimes had other things to do. Say once a week, I had other activities. Because at a certain point you are no longer productive. You're not used to sitting down and writing for a whole day at a time. It's hard. So I kept in contact with what was going on in the community. I was in the community at least once a week. That's how I gathered strength to go ahead with the writing."*



Access to the statistics required to draft the community portraits was another major obstacle for some local stakeholders:

> *"It was difficult to gather the data because everyone was passing the buck. I went from one place to the next. I visited, I called, I sent e-mails, and finally I managed it" (local stakeholder T1, Community 1).*

According to the community development approach, objectives must identify action priorities and activities that meet the needs of community members. Planning and development of the program of services to be offered is thus the result of wide-ranging public awareness-raising, information and cooperation campaigns addressed to the population as well as internal and external partners. For the implementation teams, these campaigns were also an opportunity to organize sharing circles and focus groups or conduct individual interviews.

As mentioned, each community has its own dynamics and faces different realities. Hence the methods and partnerships considered reflect the particular characteristics and the expressed needs of each community. Nonetheless, many of the objectives selected for implementation of first-line services recurred in the four participating communities. Three action priorities seem to cover the main objectives of the four participating communities:

1) Fight drug, alcohol and gambling addiction-related problems;
2) Work to improve parenting in order to foster development and maintenance of children in their biological families;
3) Develop cultural and community cohesion through cooperation and collaboration (break the isolation of children and families).

Two other related action priorities were also identified: 1) promote cultural pride, self-esteem and a feeling of belonging to the community; and 2) develop proximity services to change the negative image of social services.

In the end, each of the implementation teams drafted an action plan which was reviewed with the FNQLHSSC. Each team also succeeded in coming up with a vision that led to the development of a basket of services to be offered to the population. The action plans were submitted to the tripartite committee and approved as is by the committee based on presentations by the teams. The next section describes the carrying out of the activities covered in the action plans.

4.4 Phase 3: Services implementation (January to April 2008)

Generally speaking, first-line services comprise general short-term services for the community as a whole as well as specific services to address particular problems in the medium and the long term. The services offered through this pilot project must be consistent with community culture and in keeping with First Nations realities. They must also focus on children, youth and the family.

The objectives set for the services implementation phase were to develop a continuum of preventive services for young people and families and to complete the implementation teams by hiring interveners who meet the needs expressed by the community. This phase ran from January to April 2008.

4.4.1 Activities of the FNQLHSSC and the tripartite committee

During the services implementation phase, the role of the FNQLHSSC advisor consisted in some communities in providing technical support. In others, closer guidance was required. Despite the geographical distance, which meant that not all needs expressed could be answered, efforts were intensified to obtain collaboration from the provincial network through allocation of resources to support the communities at the local level. Certain communities received a positive response when they asked for cooperation from an Agence de santé or the Health and Social Service Centers (CSSS) in their region: for example, the regional network might be willing to share programs or training with the first-line services team. However, a positive response was not given to the FNQLHSSC's request to hire a community organizer for each community who could provide the assistance needed, mainly because of a lack of available resources. The research agent did nonetheless provide help in developing the tools used by the first-line services implementation team and offered support by reviewing the activities reports the communities had to submit to Indian and Northern Affairs Canada (INAC) on March 31, 2008.

The main activities of the tripartite committee consisted in monitoring the budgets and activities of the four communities. During this period, the research department of the FNQLHSSC also intensified its support for the communities. As this evaluation was participatory, the research agent developed a computerized system for keeping group and individual records. This system made it possible to collate information and statistics that could be used to profile the clientele served and describe the services offered.

The following section describes the main elements of the activities of the implementation teams in each of the four communities.

4.4.2 Activities of the implementation teams in the four communities

Generally speaking, the implementation teams had to expand during the first-line services implementation phase to meet the needs of the population and become first-line services teams. There were six stages of activity in this phase. Table 4.3 summarizes the main activities in each of these phases. Each community is identified by a number (1, 2, 3 or 4). Note that not all activities were carried out in each community (for example, in Community 3, the activities in stage 1 were not carried out).

Table 4.3 Services implementation activities (January to April 2008)

Main activities	January	February	March	April	C*
1. Hire interveners (job descriptions and postings, selection interviews and integration of employees).	x	x	x		1
			x	x	2
					3
	x	x	x	x	4
2. Develop and maintain team expertise through management and intervention training and participation in the regional committee organized by the FNQLHSSC (training in the community development approach).	x	x	x	x	1
			x	x	2
		x	x	x	3
	x	x	x	x	4
3. Administrative and organizational tasks (budget, record-keeping, moving to new premises, etc.).		x	x	x	1
			x	x	2
		x	x	x	3
		x	x	x	4
4. Put the community development approach into practice through mobilization and cooperation/ collaboration of all stakeholders and the population.	x	x	x	x	1
					2
	x	x	x	x	3
	x	x	x	x	4
5. Develop support programs and services with the provincial network.	x	x	x	x	1
					2
	x	x	x	x	3
					4
6. Family interventions to alleviate social problems (community kitchens, individual/family interventions, street work, self-help groups, cultural activities, etc.).		x	x	x	1
	x	x	x	x	2
		x		x	3
	x	x	x	x	4

* C= Community

The first-line services implementation activities differed somewhat from one community to the next. The following paragraphs summarize the activities during this phase in each of the communities.

After new Aboriginal interveners were hired in Community 1, the first-line services team relocated outside the community because of lack of space and proceeded to take ownership of its action plan and demonstrate its ability to deliver by setting up services that reflected the local vision. Activities were carried out in partnership with local resources, and a wide-ranging promotional campaign was conducted to increase the visibility of the first-line services and differentiate them from youth protection services. A relationship of trust was built with the population, and requests for services gradually increased. By May 2008, the population had access to a wide range of services, some dispensed in partnership with the health centre.

In Community 2, because of the turnover of personnel and periodic crisis situations, the structure of the services basket, the roles and mandates of the members of the first-line services team and the general objectives of the project went through a period of instability. It was not until the end of the implementation phase and mainly in the access to services phase (phase 4) that the project gained stability and recognition by the population. However, the implementation team never managed to clearly define the basket of services, as they were often called upon to handle situations that went beyond their role. Despite this challenge, over time the first-line services team developed effective strategies. In particular, they succeeded in reducing the rate of placements outside the community by encouraging the creation of respite and foster families within the community.

The initiation of a partnership with the regional Youth Center during this phase demonstrated a shared desire for positive change in the community. The implementation team felt that cooperation/collaboration among diverse local and external organizations as well as the establishment of stable relations between social services interveners and users was crucial to the sustainability of the first-line services and the achievement of promotion and prevention goals. However, they were not entirely successful in making this happen because of the many urgent social situations requiring a sustained effort from the team to keep them in check.

In Community 3, the services implementation and development phase was characterized by efforts at a rapprochement of the services established by the first-line services team and existing psychosocial services in the community. In fact, in addition to sharing the same physical premises, the teams of the different services worked together to establish job descriptions and profiles for the interveners to be hired. This was an important step, because during the planning stages the implementation team had little contact with existing psychosocial services in the community. This step taken, the team gradually became involved in a variety of committees and took advantage of community events to get involved in organizing activities and promoting the project to the people of the community to counter misinformation about the first-line services. Despite the population's initial reticence about getting involved, a community movement gradually grew up around the project even before all the interveners had been hired. Community members began to frequent the Maison de la famille, the place where the first-line services team offers its services.

In Community 4, though the hiring process for the first-line team began in February 2008, by April the turnover in staff had become the main obstacle to carrying out the project. This was aggravated by relocation of the services due to a lack of space and a shortage of housing for staff. Because qualified staff could not be found in the community, all of the first-line services personnel came from outside, and there were thus difficulties integrating.

Activities were nonetheless organized to establish a regional committee that would bring together different outside stakeholders who play a role in helping children and families. This initiative was launched because of a desire to create more cooperation and collaboration in first-line and provincial services that are related. Given the pioneering nature of the project, it remained difficult to mobilize and involve certain regional stakeholders. The majority of the community actions focused on social intervention, and as the project remained in the exploratory phase for a long time, it was not possible to program services as quickly as the proposed timeline demanded. Actions towards implementation of first-line social services gradually began to take place starting in March 2009.

However, Community 4 mobilized strongly around the project, as demonstrated by the creation of a local monitoring committee composed of some thirty local stakeholders. This committee, which played a key role in guiding and monitoring the activities organized by the first-line services team, clearly illustrates the strong commitment and involvement of the members of the community.

4.4.3 Summary

Growth of the first-line services implementation teams essentially involved hiring interveners. Table 4.4 shows compositions of the first-line services teams during the second period of data collection, that is, in December 2008. The table also shows the main methods selected by the teams to develop their implementation programs.

Depending on the community, a complete team was composed of six to twelve members. Initially composed of a coordinator, a clinical counsellor and a secretary, the teams were increased to include social services interveners for individual and family interventions (all four of the communities), special education teachers (three of the four communities), community organizers (two of the four communities), facilitators for community and cultural activities (two of the four communities), street workers (two of the four communities) and a facilitator responsible for reception/evaluation/referral (one of four communities). However, as mentioned, in certain communities the hiring process was a major difficulty for a number of reasons, including geographic remoteness and a lack of available, qualified human resources.

In most of the communities, this phase made it possible to clarify the type of collaboration required to avoid duplication of services offered by other health and social services agencies (health centres, Youth Centers, etc.). Monitoring committees (also called advisory committees) composed mainly of local stakeholders were created in the communities during the planning phase. In the communities in which they remained operative, these committees not only ensured that the services offered were in keeping with needs expressed by community members but they also facilitated necessary adjustments during the services implementation process.

Table 4.4 Composition of first-line services teams in each community (December 2008)

Community	Composition of the first-line services team	Actions taken to develop the program of services
1	(1) Coordinator (1) Clinical counsellor (1) Secretary (1) Family support intervener (1) Community and cultural facilitator (1) Home psychoeducator	➢ Wide-ranging consultation of the population and local stakeholders, including individual consultations with community members ➢ Creation of a monitoring committee to ensure services respond to local needs
2	(1) Coordinator (1) Clinical counsellor (1) Family intervener (1) Family intervener* (1) Youth intervener (1) Special education teacher	➢ No mechanism for expression of opinions and public cooperation/ collaboration ➢ Memorandum of understanding for partnership agreement with the Youth Center ➢ Mobilization of a pool of respite and foster families to reduce youth protection reporting
3	(1) Coordinator (5) Human relations agents (1) Community intervention intervener (2) Special education teachers (1) Proximity intervener (1) Receptionist/facilitator (1) Social intervention intervener	➢ Development of services based on those already existing in the community ➢ Consultation of internal and external partners (discussions, focus groups, sharing circles)
4	(1) Coordinator, who also provides clinical supervision (1) Street worker** (1) Secretary** (1) Social worker** (2) Educators** (1) Community organizer **	➢ Linking of first-line services with those already existing in the community ➢ Constant consultation of the population and the advisory committee

* This intervener joined the first-line team after December 2008.

** These interveners joined the team after March 2009.

On the whole, the implementation of first-line services requires paid, competent, trained professional staff. The success of hiring these human resources depended on conditions in the four participating communities. In some communities, this step was not a problem because there was a pool of trained and competent candidates. In other communities, this was an obstacle to be overcome, mainly because of the remoteness of the communities and the shortage of housing. Frequent turnover of staff was also an obstacle to continuity in the organization of individual/family and community services and was a negative factor in establishing trust between first-line interveners and those using their services. Stability is required in a first-line services team for successful development of action strategies and continuity of satisfactory services.

> *"There were a lot of non-Aboriginals. They were all working on contract and didn't have job security or employee benefits. As soon as they got an opportunity somewhere else, they left. I think that having more structure, more guidance, helps. Also, longer contracts were awarded. Before, it was by the month"* (local stakeholder T2, Community 3).

Analysis of questionnaires about satisfaction with the services showed that whether or not the interveners belonged to the community where the services were offered was not of much importance for most of the service users questioned (see Table 4.5). In fact, depending on the community, there might be advantages to hiring interveners who come from the community (services tend to be culturally appropriate) but there may also be drawbacks: the relationship of trust between intervener and user may be altered or more difficult to establish when the intervener comes from the community:

> *"There are requests with a spiritual component, and one intervener offered wonderful spiritual workshops and education. People like this kind of thing ... we make a big effort to adapt"* (local stakeholder T2, Community 3).

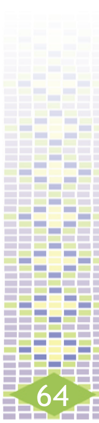
Table 4.5 gives additional information on the composition of the first-line services teams in the four participating communities in December 2008. Local conditions are included in the table to show the existence or absence of a pool of trained and competent candidates in the community.

Table 4.5 Human resources in the four communities and perceptions of users questioned

Community	Number of interveners and type of training	Aboriginals/ Non-Aboriginals	Local conditions	User perceptions
1	➢ (3) Psychoeducation ➢ (1) Multidisciplinary certificate ➢ (2) Related work experience	➢ (3) Aboriginals ➢ (3) non-Aboriginals	➢ Integration of academic training of some staff and wisdom and know-how of local staff ➢ Strong demand for services from the population and team stability ➢ Local interveners: services introduced in keeping with conditions in the community	➢ Users who "agree completely" that the staff are competent: - Individual/family counselling: 8 of 9 users - Group activities: 10 of 15 users ➢ Being from the community can be a problem in establishing a relationship of trust
2	➢ (1) Social work ➢ (1) Special education ➢ (1) Multidisciplinary B.A. ➢ (2) Related work experience	➢ (5) Aboriginals	➢ Lack of trained, qualified human resources ➢ Major staff turnover	➢ Users who "agree completely" that the staff are competent: - Individual/family counselling: 9 of 9 users - Group activities: 8 of 10 users ➢ 7 of 9 users think that whether the intervener comes from the community or not makes no difference

Community	Number of interveners and type of training	Aboriginals/ Non-Aboriginals	Local conditions	User perceptions
3	➢ (4) Social work ➢ (4) Special education ➢ (1) Multidisciplinary B.A. ➢ (1) B.A. through accumulation of credits ➢ (1) Psychology ➢ (1) Not specified	➢ (8) Aboriginals ➢ (3) Non-Aboriginals ➢ (1) Not specified	➢ Large pool of qualified resources in the community ➢ Turnover in staff ➢ Importance of having a motivated team	➢ Users who "agree completely" that the staff are competent: - Individual/family counselling: 1(1) of 12 users - Group activities: 6 of 7 users ➢ 12 of 13 users think that whether the intervener comes from the community makes no difference, and 10 of 13 users would not like to be related to their social services intervener
4	➢ (1) Special education *Data missing**	➢ (1) Non-Aboriginal *Data missing**	➢ Challenge finding trained human resources given the remoteness of the community ➢ Major staff turnover (problems with internal management) ➢ Major slowdown in activities	➢ Users who "agree completely" that the staff are competent: - Individual/family counselling: 1(1) of 12 users - Group activities: 8 of 8 users ➢ 3 of 4 users don't think it makes any difference where the social services intervener comes from

* Though a functional first-line services team was on the job as of March 2009, no data were recorded during the second period of data collection on training and ethnicity of the team members (other than the coordinator) because of staff turnovers.



As mentioned with regard to the planning phase, each participating community adopted an action plan covering promotion, prevention and intervention activities during the implementation of first-line social services. Priorities were set with respect to problems to be addressed and three action priorities were selected: alcohol, drug and gambling addiction; parental responsibility; and community and cultural cohesion. Table 4.6 summarizes local activities and group intervention measures introduced to address the action priorities selected based on needs expressed in the four communities.

The table does not, however, mean to suggest that all the activities listed took place in each of the four communities. In fact, promotion and prevention activities were not systematically organized in some communities because social emergencies had to be addressed. In such crisis situations, reactive rather than proactive measures were required to address the spontaneous needs of the population. Thus, prevention and promotion activities accounted for less than a third of the workload of the first-line services team in the period studied. The rest of the time was devoted to psychosocial interventions. The summaries in Appendices 19 to 22 outline the activities organized in each community to address the community's action priorities.

Table 4.6 Local activities organized to address each action priority

<table>
<tr><th>Action priority</th><th>Promotional activities</th><th>Prevention activities</th><th>Individual and family interventions</th></tr>
<tr><td>Fight addiction</td><td>➢ Walk against drugs
➢ Workshops on gambling
➢ Youth surveys
➢ Day of awareness raising about disorders caused by fetal alcohol syndrome
➢ Drug addiction prevention week
➢ Coffee get-togethers on various topics</td><td>➢ Accompaniment service for trips to town
➢ Support group
➢ Street work
➢ Healing camps in collaboration with mental health services
➢ Clothing banks
➢ Community kitchens</td><td rowspan="3">➢ Individual and family meetings and follow-up
➢ Emergency social services (suicidal crises, domestic violence)
➢ Street intervention
➢ Bereavement support groups
➢ Community resources referral service for youth and families</td></tr>
<tr><td>Develop parental responsibility</td><td>➢ Conference and information on family-related topics
➢ Vignette on installing a child car seat
➢ Promotional activity on infant and maternal health
➢ Lunch-and-learn sessions on topics related to the family, personal development and child development
➢ Promotions in the newspaper and on community radio</td><td>➢ Workshops on parenting skills: tough love, proud parenting, YAPP, DÉLIMA
➢ Visiting of new mothers
➢ Family respite program
➢ Childcare during community activities
➢ Community kitchens
➢ Sex education workshops</td></tr>
<tr><td>Develop community and cultural cohesion</td><td>➢ Open house at the Youth Center
➢ Conference on domestic violence
➢ Traditional activities, community feasts
➢ Cultural education (hunting, language)
➢ Cross-generational outdoor activities (canoeing, hiking)
➢ Walks (Walk of Hope, Walk against Drugs, etc.)</td><td>➢ Tournaments and sports activities
➢ Group accompaniment
➢ Handicraft group at the school</td></tr>
</table>

We must admit that the first-line services teams generally had difficulty during the implementation phase working according to the principles of the community development approach. As there was such a high rate of staff turnover, no mechanisms for on-going training were introduced:

> *"One weakness, and I was partly responsible for this, was that we were not always clear with the communities. The approach had to be developed on the ground. We understood the theory, but how were we to apply it in the communities? We may not have always worked as we should have. It was a "work in progress" and this may have been a problem in certain communities" (regional stakeholder T1).*

In addition, the time allotted to each phase was so short (three months) and the scope of the tasks to be accomplished so large that the teams were constantly racing against time. Some communities focused immediately on hiring interveners, whereas others focused on planning services. There were a number of reasons for this, including difficulty finding experienced personnel, problems related to the organizational functioning of the community and delays in obtaining contribution agreements from INAC. In one case, there was so much red tape that it wasn't possible to post the jobs in the community until May 2008:

> *"The recruiting process was not carried out for two people because there was no letter of agreement from INAC. However, the money was always there" (regional stakeholder T1).*

4.5 Phase 4: Access to services (May 2008 to April 2009)

The term "access to services" is used in this report to mean the moment that first-line services officially became accessible to young people and families. This phase follows directly from the preceding phases of developing and implementing activities for children, young people and families.

It is difficult to set an exact date for access to services. Theoretically, this phase started in May 2008. However, as mentioned, psychosocial services and community activities were gradually introduced depending on local conditions. Note as well that the communities were one year "late" in actually offering services, as the deadline set by the tripartite committee for access to services was initially April 2007.

4.5.1 Activities of the FNQLHSSC and the tripartite committee

During this phase, the FNQLHSSC advisor was mobilized to assist the communities in budget management. The lack of a clearly defined funding arrangement raised many questions and required that special steps be taken when the budgets developed by the communities were presented and analyzed. Numerous work sessions were required to clarify financial statements that could not be understood, causing considerable delays in community access to budgets. Funding for the year 2008-2009 did not become accessible until February 2009.

Despite everything, the support consisted essentially of providing the communities with the necessary tools and supervising the organization of services through implementation of the community development approach. A number of difficulties limited the counsellor's ability to provide a sustained response to the needs expressed by certain teams. One of the main obstacles

was the distance between the FNQLHSSC and the communities participating in the project. In addition, during this phase it was not possible to access the human resources of the provincial network to support the development of local expertise.

The tripartite committee played a critical role in the month of October 2008. Some committee members travelled to meet the teams in two communities to get a better idea of the services introduced and a better understanding of local partnering dynamics. It was also during this period that the tripartite committee launched discussion of promising strategies to allow other communities to integrate the project. In fact, in addition to renewing funding for the pilot project for the year 2009-1010, INAC awarded an additional $300,000 for implementation of first-line services in other Aboriginal communities in Quebec.

4.5.2 Activities of the implementation teams in the four communities

The access to services phase was the period of gradual implementation of the activities called for in the action plans. Table 4.7 summarizes the activities during the period that first-line services gradually became available to members of the four participating communities.

Table 4.7 Activities during the access to services phase (May to December 2008)

Main activities	May	June	Jull.	Aug.	Sept.	Oct.	Nov.	Dec.	C*
1. **Continue to hire interveners** to fill gaps in the team due to staff turnover.							x		1
	x			x					2
	x								3
	x	x	x	x	x				4
2. **Clinical supervision of interveners and participation** in training (e.g. National Training Program).	x	x	x	x	x	x	x	x	1
	x	x		x					2
	x	x	x	x	x	x	x	x	3
	x	x	x	x	x	x	x	x	4
3. **Administrative and organizational tasks:** budget, funding activities, record-keeping, etc.	x	x	x	x	x	x	x	x	1
		x				x			2
	x	x	x	x	x	x	x	x	3
	x	x	x	x	x	x	x	x	4
4. **Put the community development approach into practice** through mobilization and cooperation/ collaboration of all stakeholders and creation of space for the population.	x	x	x	x	x	x	x	x	1
	x					x			2
	x	x	x	x		x	x		3
	x	x	x	x	x	x	x	x	4
5. **Family interventions to alleviate social problems** (community kitchens, individual/ family interventions, street work, self-help groups, cultural activities, etc.).	x	x	x	x	x	x	x	x	1
	x	x	x	x	x	x	x	x	2
	x	x	x	x	x	x	x	x	3
	x	x	x	x	x	x	x	x	4

*C = Community.

The access to first-line social services phase differed somewhat from one community to the next. The following paragraphs summarize the activities during this phase in each of the communities.

In Community 1, the first-line services interveners continued to learn and adopt the principle of the community development approach while clarifying their roles and functions in the community. Starting in May 2008, the entire population of the community had access to a fairly wide range of services dispensed in partnership with the health centre. The group activities

offered were appreciated by the population, as were the addiction-related and parenting skills development activities. A number of urgent individual interventions were undertaken (conjugal violence, runaway, suicidal crisis) outside office hours. A variety of cultural and community activities were offered throughout this stage, and family members gradually got involved. New needs not targeted by the action plan emerged, including support in dealing with bereavement, sexual abuse and difficult couples relationships.

All stakeholders interviewed agreed that certain aspects of the work methods used in organizing the first-line services reflect "the work culture in Aboriginal communities." There is a "here and now" relationship to time, which leads to ways of working that do not give priority to planning. In addition, requests for service are often made informally to interveners—when encountered by chance in the community, for example. Resource people on the ground and informal contacts with the population are crucial, and this requires that the members of the intervention team be flexible and able to adapt. As a result, the team is often required to act reactively rather than proactively, as service users frequently seek help with the immediate needs of a specific situation.

Organizationally, on the other hand, the cultural mix of the first-line services team (Aboriginal and non-Aboriginal, from the community and from outside the community) proved to be an asset, as the strengths of the different team members were complementary. However, adjustments were required to understand one another better and work together, as the interventions had to be locally grounded and suited to the community's ways of thinking, doing and behaving:

> *"I feel the cultural aspect is important... showing people how to trap, how to make things with their hands, how to play a drum, fish under the ice. I think this is how we will be able to reduce the number of child placements, how we will build a feeling of belonging to the community" (external stakeholder T2, Community 1).*

Finally, trust in the first-line services is growing, though promotion of the services must continue and their distinction from the services offered by youth protection still needs to be made.

Between May 2008 and March 2009, the first-line services team in Community 2 continued to work on structuring the services package. Nonetheless, there remained grey areas with respect to the role of first-line services, the limits of first-line interventions and the roles of other community services. Most services dispensed at this time addressed the first action priority of the action plan that is, keeping children in their biological families. A few activities to foster an addiction-free way of life and break isolation were also carried out, such as sewing workshops and weekly coffee get-togethers, and participation rates in these activities were good. Other action priorities, such as fostering a violence-free way of life and prevention and promotion activities, were not developed much.

To integrate aspects of the culture of the community, the first-line services interveners maintained an informal and flexible approach. For example, it was left up to the user to choose the right time to open discussion of difficult subjects. Flexibility with respect to users was also the rule. For example, users were not reprimanded if they failed to turn up for an appointment, and interveners sometimes shared experiences from their personal lives with their clients. Nonetheless, the lack of professional barriers sometimes generated situations that were difficult for interveners to manage.

> *"We offer intervention services, but we are not perfect ourselves and we also have difficulties. We have done things to improve our situation. We sometimes speak of our experiences to let our clients know we are not perfect either. But the non-Aboriginal interveners at the National Training Program say "No, we don't talk about our personal lives" (local stakeholder T2, Community 2).*

The work of cooperation/collaboration between first-line services and the regional Youth Center continues. The negative image of the Youth Center prevalent in the community—its relationship with the band council in particular—is starting to change. Information sessions (for administrators of schools in the community, for example) were organized to clarify how the Youth Center and the first-line services work. However, the role of first-line services and the services package is still somewhat vague, and this has caused misunderstandings among local stakeholders.

A lot of effort was made in Community 3 at this stage by program coordinators and directors to effectively integrate the new social services. This was part of a broader integrated-services initiative on the part of the band council. The reorganization of services led to other initiatives in the community, including a review of action plans and meetings with employees about working conditions. With respect to the first-line services project, new interveners were hired at the Maison de la famille during this period and a number of prevention and promotion services were added to the roster of psychosocial services offered at the health centre.

During the first-line services team's consultation of community members to identify social problems in the community, certain culture-related issues were raised, such as the general lack of knowledge of the ancestral history of the community, especially among young people. According to local stakeholders, not knowing the values of their culture can lead to behaviour such as vandalism, as the values of self-help and respect are no longer cherished the way they once were. In addition, the land is not used in the healing process. It seems that incorporating cultural aspects of the community in the first-line services will make it more possible to reach community members:

> *"We try to adapt as much as possible to what people request" (local stakeholder T2, Community 3).*

Finally, though much effort was made during this period to unify the first-line teams, it seems the pilot project team was still not completely integrated into the project structure by the end of the project. For one thing, the Maison de la famille team sometimes felt isolated and certain partners acknowledged they did not have much contact with this team.

In Community 4, the activities called for in the action plan were gradually carried out. Because of a major turnover in staff, the emphasis was placed on individual and family counselling, to meet a growing demand from community members. Group activities were also organized (fishing and healing activities, Aboriginal celebrations, group education on parenting skills). However, the group education activities on parenting skills only became available in the fall of 2009. The implementation team and its local partners also mobilized to intervene in family crises that were triggered by a massive influx of money into the community (financial compensation related to economic agreements).

Given this particular situation, the first-line services team in this community focused on consolidating its services and stabilizing its staff. Training and clinical supervision were provided,

and efforts were made to ensure personalized case transfers. A number of meetings were also held with local and external partners to continue talks about drafting memoranda of understanding about the administration of services in the community. We must acknowledge, however, that the advisory committee stopped working on cooperation/collaboration and mobilization.

The first-line services team also made efforts to improve the integration of cultural aspects of the community. For example, interventions included more meetings in the home. Healing camps are also an element in the culture of the community, as it relies on use of the land. In addition local stakeholders indicated that access to service became easier when an Aboriginal intervener from another community was hired, as this intervener relied on transmission of Aboriginal values. This had a positive impact on the involvement of community members.

4.5.3 Summary

Accessibility of services to community members was analyzed as part of this evaluation. Table 4.8 shows office hours of the first-line services team, additional services provided, waiting time following a request for help, source of referral or first contact and positive as well as negative factors in gaining access to services.

Table 4.8 Access to services in each community participating in the pilot project

Community	Office hours	Additional services	Average wait	Referral/ first contact	Positive factors	Negative factors
1	8:30 am- 4:30 pm	➢ Emergency services outside office hours ➢ Reception service planning with the health centre	1 week	➢ Local agencies who refer clients to first-line services (gateway)	➢ Outreach by first-line interveners increased visibility and accessibility ➢ Satisfaction of community members with the confidentiality of the services, the quality of the premises and the office hours	➢ Persistence of mistrust about using first-line services ➢ Offices are small and there is no soundproofing at the health centre
2	8:30 am- 4:30 pm	➢ Organized evening activities ➢ Emergency services via a hot line and an on-call schedule	The same week or the same day	➢ Social network (family member or friend) ➢ Direct contact or phone contact	➢ Availability of first-line interveners	➢ Service access depends on visibility of first-line interveners in the community through home visits and the band council
3	8:00 am - 4:00 pm	➢ 24/7 on-call services	1 to 2 weeks	➢ Social network (family member, friend, fellow worker) ➢ Direct contact or phone contact	➢ User-friendly quality of premises where services are offered	➢ The premises are small and are shared with a number of other programs
4	8:00 am - 4:15 pm 8:00 am - noon (Friday)	➢ On-call services ➢ Social emergency assistance services	1 week	➢ Promotional activities (flyer, radio, local newspaper)	➢ Commitment and credibility of first-line interveners	➢ Rare transfer of client referrals by interveners ➢ Lack of visibility: poor knowledge of services available, negative association with youth protection

As Table 4.8 shows, the first-line services teams in all the communities offer on-call services for handling social emergencies outside office hours. One or more interveners who can be reached via a hotline or in person are on call to respond to requests for help, an essential additional service in the communities.

The way that clients find out about the first-line services, however, differs from one community to the next. A user's social network (generally family members, friends or work colleagues) is the most common method of referral, suggesting that information about the existence of first-line services is shared informally. Clients are also referred by youth protection interveners. In addition, to reduce acceptance of reports by youth protection, first-line services interveners make home visits when youth protection authorities inform them of a report and are thus able to give specific referrals to clients who request their services.

Promotional activities also played a significant role. In Community 4, publicity (flyers delivered by mail and information on the radio and in the local newspaper) about first-line services offered helped to position the first-line services team in the community. As mentioned, particularly with respect to Community 1, users are frequently referred to first-line services thanks to partnerships/relationships built with local organizations and external stakeholders. The first contact with a first-line services intervener is also sometimes made directly, the client calling on the phone or just coming to the centre or house where the services are offered.

Average waiting times for appropriate psychosocial services are relatively short. In most of the communities participating in the pilot project, users are seen within a week of the request for help. It was also noted that informal discussions with first-line interveners in a friendly atmosphere are appreciated. The visibility of the first-line services team plays an essential role. In fact, team availability correlates with community access to services. In addition, a location that can ensure privacy and has good soundproofing is an important factor in client satisfaction.

Finally, among the factors that inhibit access to first-line services (see Table 4.8) is the difficulty establishing trust relationships due to misinformation stemming from prior negative or inconclusive experiences. In addition, in some communities a distinction between first-line services and youth protection services must be made to prevent transfer of a negative image to the first-line services.

The descriptive analysis of the phase of access to first-line services in the four participating communities also showed the basket of services offered in each community (Appendices 19 to 22 give summaries for each community). The information collected shows that a full range of services responding to the needs of children, youth and families is offered. The individual/family and community services introduced are a well-adapted response to objectives based on needs clearly identified in each community. Table 4.9 provides detailed information that helps in understanding local realities described by the first-line services teams as well as users in satisfaction surveys. It also summarizes areas where improvement is needed according to survey respondents.

Table 4.9 Local realities and areas in the continuum of services requiring improvement

Community	Local realities	Areas requiring improvement
1	➢ Partnering with all stakeholders involved in implementation of first-line services (regular meetings of managers and work performed in accordance with a strategic plan) ➢ Mechanisms for exchange of information between interveners to ensure continuity of action (multidisciplinary committee) ➢ Users feel there are enough services	➢ Diligence in maintaining formal communication processes ➢ Attention to avoid overlap with other services offered in the community
2	➢ Roles and mandate of first-line services interveners are not always clear ➢ Users feel there are enough services	➢ Mobilization for coordination of services in the community ➢ Establish programs in partnership develop cooperative intervention and avoid overlapping of services
3	➢ Gaps in services (daytime activities for addicts getting out of therapy, after-birth services for young mothers, food safety, weekend street worker services, activities for men) ➢ Users feel there are not enough services	➢ Greater visibility of first-line services, as there is misunderstanding about the type of services offered and distrust of them
4	➢ Lack of certain types of services for children 0 to 5 years of age, no respite resources for families in crisis, little emphasis on development of parenting skills, among fathers in particular ➢ Users feel there are enough services	➢ Consolidation of existing services ➢ Memorandums of understanding to build bridges between existing service points in the community

Analysis of the continuum of services demonstrates the importance of continuing to work on mobilization and information with regard to first-line services. Like any project that is innovative and transformative, without promotion and sustained visibility there will be misunderstanding of the services offered, which puts a brake on the development of promotion and prevention activities. Also, the need to ensure continuous services that improve with time remains essential:

> *"For me, first-line services are something new, it's true, but they address my issues and they are a strong response to what I need at the moment. Sure I'd like them to be better established, to run more smoothly. But they work for me, and probably I will have fewer youth protection reports" (local stakeholder T2, Community 3).*

In addition, in some communities efforts must be made to differentiate first-line services from youth protection services in order to combat the mistrust of the new services:

> *"There's a lot of sorting out that needs to be done, as sometimes there is duplication, even triplication, of services. That's what we realized" (external stakeholder T2, Community 2).*

In fact, a better mesh with other service providers in the community would be beneficial. In Community 1, for example, the development of mechanisms for exchange of information and cooperative interventions, as well as the establishment of partnerships and formal memoranda of understanding, opened the door to consolidation of existing services and significant reduction in overlap of services in the community.

Access to services by community members was improved during this phase through the gradual addition of programs and activities. Due to frequent staff turnovers, there were difficulties putting together some of the teams of first-line interveners. This, coupled with local events (such as massive influxes of money in the form of financial compensation or social crises), often meant that the teams took reactive rather than proactive or preventive measures. In fact, in most of the communities, the teams devoted much of their energy to dispensing individual/family services, to the detriment of planned community activities:

> *"Unexpected events happen often. Someone needs help. It's not included in the schedule. All the little emergencies of the day. We get hung up on these, when we don't really have time for them. There are a lot of little inescapable problems like that (local stakeholder T2, Community 1).*

> *"Because the educator we have now was really only supposed to offer group services. But we urgently needed intensive individual services" (local stakeholder T2, Community 4).*

This phase was also marked by the emergence of a reality that until then had been underestimated by the tripartite committee: the management of crises occurring outside office hours. At first, no funds were provided to cover the expenses of such a service. The first-line services interveners thus provided emergency intervention services on a volunteer basis in the evenings and on weekends when called upon by clients. This was particularly true of staff who were living in the community, and it was a tremendous drain on the energy of the services teams concerned. In some communities, it took months before an emergency services system was developed in partnership with local and regional organizations to respond to the demand:

> *"Yes, sometimes it was not a plus being in the community. You would be disturbed, get calls. When you went out with your friends, to do stuff or for recreation, you remained a first-line services intervener. People would come up to you …. Even when you weren't working, people still saw you as a first-line intervener. People would come and talk to you, a lot. I got a lot of this outside my working hours (local stakeholder T2, Community 3).*

> *"I would tell the client 'Call this number, there's an intervener on duty. I'm not on duty today.' But she wouldn't call. She'd call me back. But I wouldn't go. I don't work when I'm not on duty. I try to stay out of it. 'Here's the number. There's an*

> *intervener available. I'm staying home.' But it bothers you nonetheless. You ask yourself if you're doing the right thing (local stakeholder T2, Community 2).*

A need for training in family intervention became clear. Clinical supervision had to be intensified to provide better support for interveners, and some first-line teams managed this better than others. However, the teams did not all start on an equal footing in terms of access to human resources trained in services management and social intervention:

> *"We asked them to set up a service. They were very willing and competent, and they could draw on experiences from their lives. However, they didn't have the management skills that come with ten or twenty years of experience in an organization. So sometimes it was difficult to develop a service package, even to identify community needs, and then to find staff and retain them by providing the necessary training and supervision" (regional stakeholder T2, Community 2).*

To add to this, the pilot project funding did not allow consideration of the stage the teams were at when they began working, nor did it allow provision of support based on the needs of the teams. To respond adequately to needs in certain communities, close supervision on a daily basis by an experienced professional would have been an effective solution. Given this situation, two of the first-line services teams began helping one another and sharing their expertise in order to improve the quality of their services.

It was also difficult to maintain the mobilization of local stakeholders and the population. Though the work of the monitoring committees (or advisory committees) was considered worthwhile, it was abandoned little by little in most of the communities. Collaborative action continues however, but it is being held back by difficulties related to local dynamics.

On the one hand, a highly hierarchical organizational structure significantly limits a first-line team's authority to act, ultimately making it difficult to establish effective communication networks. In such situations, collaboration doesn't happen just because people want to work together, and it only happens between partners of the same hierarchical level (between social workers, for example). In addition, it generally remains verbal and informal.

> *"Generally, it's always higher up. But with this, I'd say it's among the first-line interveners. They have to submit something to her [the director] and she gives her approval. But she never consults us. When we want to do something, we have to consult them, but when they want something ..." (Local stakeholder T2, Community 3).*

On the other hand, when activities are organized in a silo, confusion about roles and responsibilities tends to persist, making it hard to integrate services available in the community:

> *"I find it hard collaborating with others. We aren't moving in the same direction. We're in the process of building our clientele, and they don't tell us they want to start a community kitchen. So a fight starts. They say we're trying to steal their people ... there's an atmosphere of competition [between sectors]" (local stakeholder T2, Community 3).*

This situation also has an impact on the distinction, in certain communities, between first-line and second-line services. The persistence of confusion is also reflected in the objectives of the pilot project compared to those of youth protection services:

> *"There are roles, a lot of them, that need to be clarified. The Director of Youth Protection (DYP), for sure. The Act respecting health services and social services, the DYP, first-line social services ... it needs to be stated clearly what social services are" (local stakeholder T2, Community 4).*

Finally, despite the various mechanisms established and the creativity demonstrated in each of the four communities, participation and local mobilization were often considerable challenges, a demanding task often complicated by the population's tendency to view services as something to be consumed:

> *"Yes, they will seek services, but to go from there to getting involved, going beyond just coming to get services, that's going to be more difficult" (local stakeholder T2, Community 1).*

> *"We involve the people in our meetings ... It will be the needs that they bring to our attention. We want to work from the bottom up, with a holistic approach that starts with their ideas and feedback. But when we do this, they don't come. Then we hear "They don't do anything. These social services are not helping us" (local stakeholder T2, Community 3).*

4.6 Phase 5: Services review (February to March 2009)

This last phase was used to evaluate whether the objectives set in the action plans filed by each of the participating communities in December 2007 had been achieved and to determine the direction to take with the local projects in the fiscal year 2009-2010. As well, the pilot project accountability reports required by INAC were drafted with the support of the FNQLHSSC research agent between February and April 2009.

4.6.1 Activities

First, the first-line services teams received training on how to evaluate a program. This training was based on a document produced by Dubé, Maltais and Paquet (1995) that includes an entire chapter on program evaluation.

Individual coaching sessions were then held to support the teams in evaluating their action plans and in drafting the accountability reports. During these tasks, the community development consultant hired by FNQLHSSC also provided the teams with expert advice. In addition, an action plan evaluation guide was drafted (see Appendix 23).

Generally speaking, during these training sessions the teams reflected on their actions and activities by considering the following questions:

1) What was done to achieve our objective?

2) What discrepancy do we see between what we were aiming for and what we achieved?

3) What impacts have we observed of the actions undertaken?

4) What are the main guidelines we propose for this objective in 2009-2010?

4.6.2 Summary

The services reviews caused some stress for the first-line services teams. Writing accountability reports was a task that had to be accomplished in addition to the day-to-day tasks in the communities. In addition, some coordinators were less familiar than others with the writing of such reports, which explained the increased support of the FNQLHSSC in developing local competence in this area. Despite the difficulty, the first-line services teams feel that the review is a beneficial requirement that makes it possible to step back and get a better grasp on where to go in the present and the future.

In all the communities, the services review had to be carried out in a very short period of time, given a tight deadline. This was why the teams did not involve local stakeholders more in the discussions held and in the drafting of activities reports. In addition, most of the advisory committees were no longer active by this time.

Nonetheless, most of the teams feel they achieved virtually all their objectives. They also feel they must continue to consolidate the work on the action priorities included in their action plans:

> *"With respect to the action plan we developed, in our daily work, today, probably we have to take it farther. That's how I see it. With respect to the action plan, we did what we planned to do" (local stakeholder T2, Community 1).*

Finally, the challenges faced, the measures taken and the readjustments made in order to implement the first-line social services all bore fruit: the four pilot project teams succeeded in setting up first-line services in their communities. Measurement and analysis of the satisfaction of users of the first-line services was a good way to determine how these services were received in the communities. The results are presented in the following chapter.

Chapter 5

User Satisfaction with First-Line Social Services

The preceding chapter made it possible to understand the first-line social services implementation process thanks to accounts shared by local, external and regional stakeholders involved in the pilot project. This chapter describes the perceptions of users who benefited from the services introduced, that is, members of participating communities.

Analysis of the satisfaction of participants who asked for help and benefited from the services of a first-line social services intervener was essential to do the following:

1) Develop a clientele profile;

2) Measure general satisfaction of users with individual, family and group services;

3) Identify the most and least liked components of the services received.

The following sections look at these three elements in each of the communities that participated in the pilot project, showing how the project was experienced depending on local circumstances. The results must, nonetheless, be analyzed with great caution. The sample of users who agreed to participate in the satisfaction surveys was small and in no way representative of all community members who benefited from first-line social services. In addition, we must not forget that respondents were asked to participate by members of the first-line social services teams and hence do not constitute probability samples.

The data collected concern activities and general services offered to the entire community through promotion and prevention activities focused on culture. These services and activities generally took place over a twelve-month period, between April 2008 and March 2009. Also included are statistics from satisfaction questionnaires completed by service users and the digital platform set up by the FNQLHSSC research sector. This digital platform provided support for the first-line teams and the social services interveners, mainly for the keeping of individual and group records. It also served as an electronic directory and a statistical tool for in-depth short- and medium-term analyses.

Analysis of user satisfaction with activities and services demonstrated the following:

- The services offered in the four communities responded adequately to the expectations of the users surveyed;
- The confidentiality, accessibility, duration and quality of the services offered as well as the people skills of the social services interveners are key factors in satisfaction;
- The first-line social services teams must continue to ensure that services meet the needs of community members and are appropriate to their way of life.

5.1 Clientele profiles and satisfaction levels

This section looks at individual/family services (clinical and psychosocial) and community or group services (promotion and prevention activities organized in the community).

5.1.1 Community 1

We used data collected between May 2008 and March 2009 (10 months) by the first-line social services team in Community 1 to draft a portrait of the clientele served. Note that these data to not allow any generalizations to be made about all users of the first-line social services.

5.1.1.1 Clientele profile

Users of individual/family services

Services were offered to 69 people in the community: 47 adults (average 28 years of age) and 22 children and teenagers (average 8.5 years of age). Among the adults, there were 36 women and 11 men. Among the children, there were 13 boys and 9 girls.

Case analyses for the adult participants show that the main problems that led to consultation were related to the following:

- Alcohol, drug or gambling addiction (21 requests for services);
- Parental and educational responsibilities (17 requests for services);
- Couples problems, including emotional dependence, lack of support, communication problems and violence (9 requests for services).

Of the cases mentioned above, more long-term follow-up was provided for 28 users. Services were also provided on a one-time basis, for which no file was opened. About 20 requests a month were of this latter type.

Participants in group activities

The records show that the first-line services team organized a total of 39 group activities in which about 1,160 people took part. Most of these activities were for families and were designed to promote healing and suggest tools that can bring people closer together. The family respite service and the accompaniment service (errands in town, youth court, meetings with youth protection) were much appreciated by participants. Groups of men, women, parents and adolescents were also successful. However, emphasis was placed on parent-child activities to improve relationships within and between families.

The large number of people who used the first-line social services illustrates the voluntary nature of the requests for help by community members. In addition, a total of 422 people participated in 18 well-being promotion and prevention activities, suggesting that community members are interested in such activities and available to take part in them and that the first-line services team is committed to achieving the objectives set.

5.1.1.2 Client satisfaction

Sixteen users of the first-line social services were questioned about their satisfaction with different aspects of the services they received or are receiving. They were asked about three aspects: individual/family services, group activities and the services in general. Note that the users questioned were preselected by the first-line social services team, whose members checked their availability and organized a meeting with the FNQLHSSC research assistant. In cases where the participants did not show up for the meeting, the research assistant went to their homes and administered the questionnaire there. The data that follow therefore are representative only of the opinions of users who agreed to answer the questionnaire.

Users were asked to give their general assessment of the services they had received or were receiving at the time. The results show that close to half the respondents said they were very satisfied and that the help they received met their particular needs. Seven respondents said the individual/family services gave them tools to solve their problems: *"I was able to stop using"* or *"It gave me a break."* In addition, the respondents underlined the professionalism of the first-line services interveners, specifically their availability, their good listening skills, their welcoming and warm attitude (3 respondents) and their maintaining confidentiality (6 respondents).

Concerning aspects of the services that were least liked, many respondents (7 of 16) did not mention anything under this heading. However, 9 users of the individual/family services did mention problems: 4 respondents mentioned difficulties related to the accessibility of the services, such as obtaining regular meetings and a lack of variety in the services offered. In addition, 3 respondents mentioned lack of confidentiality and fears about a judgmental attitude because the interveners they met were from the community. Two respondents mentioned difficulty communicating with the first-line services intervener they met, making it hard to build the necessary client-intervener bond.

Generally speaking, 73.3% of respondents said they were satisfied with the organization of the services offered. As Table 5.1 shows, most respondents[21] were "very satisfied" or "satisfied" with the quality of the location where the services were provided, the hours services were available and the types of services offered. This is very encouraging and bodes well for maintaining and improving the work of the first-line services team.

[21] The number (N) of respondents differs from one service component to the next, as not all respondents gave an answer regarding their satisfaction with all components. This applies to all the tables in this chapter.

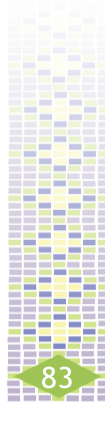


Table 5.1: Overall satisfaction with services received (Community 1)

Service component	N =	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
How easy it is to get an appointment	14	5	8	1	0
Type of service provided	15	4	9	2	0
Quality of the location where the services are provided	14	3	11	0	0
Hours during which service is provided	15	2	12	0	1
Confidentiality and discretion	14	7	5	0	2
Office hours	15	3	12	0	0
Overall quality of the services provided	15	3	11	1	0

Level of satisfaction with individual/family services was measured via questions about how the first-line services interveners took care of their clients. Nine users agreed to share their opinions. As Table 5.2 shows, most respondents were satisfied with the services rendered. Among other things, respondents said they felt accepted, understood, respected and adequately informed. However, responses concerning the following two elements were less uniformly positive: My first-line social services intervener informs me of my progress and I have access to services that correspond to my culture. This second element is discussed in greater detail further on.

Table 5.2 Satisfaction with individual/family services (Community 1)

Service component	N =	Never	Rarely	Sometimes	Usually	Always
My first-line services intervener seems to take my situation to heart	9	0	1	1	3	4
My first-line services intervener really knows what he/she is doing	9	0	0	1	3	5
I get the help I need	9	0	0	2	5	2
My first-line services intervener accepts me as I am	9	0	0	0	1	8
My first-line services intervener seems to understand how I feel	9	0	0	1	2	6
I feel I can speak freely with my first-line services intervener	9	0	0	1	3	5
The help I receive is beyond what I was expecting	9	0	0	3	4	2
My first-line services intervener informs me of my progress	8	2	1	0	3	2
My first-line services intervener gives me all the information I need to cope with my issues	9	0	0	2	4	3
My first-line services intervener gives me all possible solutions to cope with my issues	9	0	0	2	3	4
My first-line services intervener answers all my questions	9	0	0	1	3	5
My first-line services intervener treats me with respect	9	0	0	0	1	8
The time my first-line services intervener dedicates to me is sufficient	9	0	0	0	4	5
My first-line services intervener is accessible in emergencies	7	0	0	2	1	4
I have access to services that correspond to my culture	6	0	2	0	3	1

Users seem to be satisfied with the group activities in which they participated. They especially liked the quality of the information they received and the fact that the facilitator was attentive to their needs. Also, close to 80% of the respondents felt the activities gave them an opportunity to reflect on their behaviour (Table 5.3).

Table 5.3: Satisfaction with group activities (Community 1)

Service component	N =	Very much	Somewhat	Slightly	Not at all
The facilitator was attentive to our needs and expectations	15	9	5	1	0
The activity allowed me to gain new knowledge	12	8	4	0	0
The information I received will be useful for me	13	9	4	0	0
The activity gave me the opportunity to reflect on my behaviour	14	11	2	0	1

Most users who took part in the satisfaction survey felt the content, duration, location, methods and facilitation of the activities were adequate, but not better than that. This suggests improvements can be made in the activities to make them more satisfying (Table 5.4).

Table 5.4 Satisfaction with content of group activities (Community 1)

Service component	N =	Completely adequate	Adequate	Slightly adequate
The content of the activities was	13	5	8	0
The length was	15	4	10	1
The location was	15	3	11	1
The teaching methods (exercises, exchanges, etc.) were	12	3	8	1
The facilitation was	12	3	8	1

The satisfaction survey of users of first-line services also provided an opportunity to find out whether the ethnic origin of the first-line services intervener was important to users. Based on the information collected, users of individual/family services in Community 1 feel the worker's ethnic origin is not important: 7 of 9 respondents said ethnic origin did not matter, and 2 respondents said they would prefer receiving services from a non-Aboriginal social services intervener. The same conclusions can be drawn with respect to the group activities: 13 of 15 respondents said the ethnic origin of the facilitator did not matter.

Regarding the language in which services are offered, respondents prefer French, or French and their First Nations language. Last, as Table 5.2 shows, responses were mixed to the question

about having access to services that correspond to the respondent's culture, suggesting this aspect of the services offered needs improvement.

In sum, satisfaction levels of users of first-line services offered as part of the pilot project implemented in Community 1 are mainly positive and encouraging. This type of appreciation of the quality of the content and facilitation of the services is an indicator of the success of the implementation of preventive and promotional services for the well-being of young people and families.

5.1.2 Community 2

A clientele profile for Community 2 was established from the individual/family services records and the records of group activities kept by the first-line social services team between April 1, 2008 and March 31, 2009 (11 months). These data do not allow any generalizations to be made about all users of the first-line services.

5.1.2.1 Clientele profile

First, we must emphasize that keeping records consistently was difficult in this community. The data collected via the digital platform are incomplete, as many records on paper were never entered and remain inaccessible:

> "[…] *record-keeping* […] *is not always easy when you are called on to act. If someone comes to see me, I can't say 'sorry, I'm busy writing a report'" (local stakeholder T2,* Community 2).

Users of individual/family services

For the year 2008-2009, there are 65 records of individual/family services offered. These include services for 35 children 17 years of age or younger and 27 adults. Among the minors, there were more girls (20) than boys (15). The same was true of the adults (16 women to 11 men). In 39% of the cases, the main problems that led to consultation were substance abuse (alcohol and drugs) and parental negligence.

The data available show that in most cases the source of referral to first-line social services was a family member (43%), the parent of the child (15%) or a third person from the community (11%). Of the 65 cases reviewed, 55 were handled by the first-line services team, and only 2 were referred to youth protection (one via application of measures and the other via a foster home placement). Average length of follow-up for cases that were closed was 119 days. There were 26 respite placements made in 2008-2009, each lasting an average of 18 days.

Participants in group activities

The records of group activities are unfortunately not representative of the range of activities actually organized in 2008-2009 in Community 2. The records also give little information on the profile of participants. However, based on qualitative data collected during implementation of the services, about 400 members of the community participated in one or more group activities (accompaniment, coffee-get-togethers, sports activities, family outings, theme days, etc.). There were up to 50 participants in each of the family outings.

5.1.2.2 Client satisfaction

A total of 15 users of first-line services were surveyed, and their opinions are reflected in the following section. Note that these respondents were preselected by members of the first-line services team, who checked when the respondents were available to participate in the survey and scheduled the meetings with the FNQLHSSC research assistant. The satisfaction survey was administered confidentially in the offices used by the first-line services team.

Generally speaking, the elements with which the 15 respondents were most satisfied were the sociability and the opportunity to break their isolation (4 respondents), the availability of the first-line services interveners and the effectiveness of the services (the services received helped them, 2 respondents). One respondent stressed that he/she really appreciated the placement of his/her child in the community, preventing the child from being taken by youth protection, and another mentioned that he/she appreciated not being judged by the first-line services interveners.

Among the elements with which respondents were least satisfied was the lack of confidentially due to inadequate facilities (2 respondents), the duration of the group activities (2 respondents would have liked the activities to last longer), the difficulty trusting an unknown person (1 respondent) and the lack of choice about receiving first-line services (1 respondent). Note as well that most of the respondents (7 out of 15) answered nothing to the question *What did you like least about the first-line social services?* Table 5.5 summarizes respondents' satisfaction with certain general aspects of the first-line services.

Table 5.5 Overall satisfaction with services received (Community 2)

Service component	N =	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
How easy it is to get an appointment	13	6	7	0	0
Type of service provided	14	9	5	0	0
Quality of the location where services are provided	14	5	9	0	0
Hours during which service is provided	14	7	6	1	0
Confidentiality and discretion	13	6	5	1	1
Office hours	12	5	6	1	0
Overall quality of the services provided	13	7	6	0	0

Table 5.5 shows some dissatisfaction with confidentially as well as with the hours during which service is provided and the office hours. The latter may possibly be due to the many crises handled outside office hours by a reduced staff. In fact, there was no unanimity among respondents regarding the on-call schedule, as some respondents only have confidence in one or two specific first-line services interveners and do not necessarily want to receive first-line services outside office hours. On the other hand, respondents seem satisfied with the ease with which they can obtain an appointment as well as the type and quality of the services provided.

Table 5.6 shows respondents' satisfaction with individual/family services. Eight of nine respondents answered *always* in response to the statement *I feel I can speak freely with my first-line services intervener* and one answered *never.* We can assume that a relationship of trust between client and intervener is crucial. With responses ranging from *rarely* to *always*, satisfaction was also mixed with respect to the following statements: *I get the help I need, My first-line services intervener answers all my questions* and *I have access to services that correspond to my culture*. However, all respondents agreed that their first-line services intervener *always* treated them respectfully.

Table 5.6 Satisfaction with individual/family services (Community 2)

Service component	N =	Never	Rarely	Sometimes	Usually	Always
My first-line services intervener seems to take my situation to heart	9	0	0	0	4	5
My first-line services intervener really knows what he/she is doing	8	0	0	1	3	4
I get the help I need	9	0	2	1	2	4
My first-line services intervener accepts me as I am	7	0	0	0	1	6
My first-line services intervener seems to understand how I feel	9	0	0	1	3	5
I feel I can speak freely with my first-line services intervener	9	1	0	0	0	8
The help I receive is beyond what I was expecting	9	0	0	1	3	5
My first-line services intervener informs me of my progress	8	1	0	2	4	1
My first-line services intervener gives me all the information I need to cope with my issues	9	0	1	0	3	5
My first-line services intervener gives me all possible solutions to cope with my issues	9	1	0	0	2	6
My first-line services intervener answers all my questions	9	0	1	2	2	4
My first-line services intervener treats me with respect	9	0	0	0	0	9
The time my first-line services intervener dedicates to me is sufficient	9	0	0	0	2	7
My first-line services intervener is accessible in emergencies	9	0	0	2	1	6
I have access to services that correspond to my culture	9	0	1	2	3	3

Generally speaking, participants in group activities were *very much* or *somewhat* satisfied with the group activities in which they participated (Table 5.7). Most agreed that the facilitator was attentive to their needs and expectations. However, 2 respondents felt the activity in which they participated did *not at all* allow them to gain new knowledge or to reflect on their behaviour. In fact, there is supposed to be a promotion/prevention component in all group activities, but some (family outings and childcare service, for example) did not incorporate this component.

Table 5.7 Satisfaction with group activities (Community 2)

Service component	N =	Very much	Somewhat	Slightly	Not at all
The facilitator was attentive to our needs and expectations	8	7	1	0	0
The activity allowed me to gain new knowledge	6	3	2	0	1
The information I received will be useful for me	5	2	3	0	0
The activity gave me the opportunity to reflect on my behaviour	6	4	1	0	1

Regarding satisfaction with the content of the group activities offered (Table 5.8), the teaching methods and facilitation were considered completely adequate by the 4 respondents who answered these questions. Some respondents answered *does not apply* or refused to answer the questions. It also seems that the content of the activities and their duration are not exactly what users are looking for. The purpose of these activities is to give community members an opportunity to take part in activities that meet their needs, to break their routines a little and to spend time as a family.

Table 5.8 Satisfaction with content of group activities (Community 2)

Service component	N =	Completely adequate	Adequate	Slightly adequate
The content of the activities was	6	3	2	1
The length was	7	1	5	1
The location was	7	4	3	0
The teaching methods (exercises, exchanges, etc.) were	4	4	0	0
The facilitation was	4	4	0	0

The satisfaction survey also included questions about the cultural suitability of the services offered. All respondents (9 of 9) said they were satisfied in response to the question *Does the language in which the individual and family meetings are held suit you?* However, 4 respondents said they would prefer two languages to be used, French and the First Nations language. All respondents (10 of 10) were satisfied with the use of French for the group activities. In addition, 7 of 9 respondents said the ethnic origin of their first-line services intervener was not very

important to them and the other 2 respondents said they preferred receiving services from an Aboriginal.

To the question about whether the services were adapted to the community's culture, a few respondents (3 of 15) answered that they were and mentioned that they liked the fact that they did not feel judged and that they knew the first-line interveners understood their situation as they too lived in the same community. Other respondents (3) mentioned that healing camps activities are culturally adapted as they take place on the land. According to 2 respondents, the services are adapted to the community because they meet a need and help reduce the placement rate. Respondents said that certain group activities offered by the first-line services were inspired by the culture of the community, such as the community kitchens and the community feasts. However, 4 respondents said the first-line services provided were not adapted to the local culture.

All the respondents (9 of 9) said they were satisfied when asked *Does the language in which the individual and family meetings are held suit you?* However, 4 of 9 respondents said they would prefer French and their First Nations language to be used for individual/family services. All respondents (10 of 10), on the other hand, said they were satisfied with the use of French for group activities.

In sum, even though record keeping was not optimal, the data collected from users of first-line services in Community 2 indicate the services were in general much appreciated. Improvements in certain aspects will only increase the community's confidence in these services.

5.1.3 Community 3

This section describes the profile of the first-line services clientele in Community 3 based on data from records of individual/family services and group activities. The data cover the period between April 1, 2008 and March 31, 2009 (12 months). Note that these data do not allow any generalizations to be made about all users of first-line social services.

5.1.3.1 Clientele profile

As first-line social services have been offered for a long time in Community 3 and the pilot project was integrated into the structure of existing services, it is important to take into account that users of individual services did not necessarily fit the child/family/youth profile for which the pilot project was developed.

Users of individual/family services

There are 170 records of individual/family services offered between April 2008 and March 2009. These include services for 52 children under 18 years of age (average was 12 years of age) and 117 for adults (average was 38 years of age). The children included more boys (29) than girls (23), whereas women (65) were more numerous than men (52) among the adults served.

The data collected show that in most cases people came by themselves to ask for help (67 users) or were referred by a relative (26 users) or by youth protection (16 users). Of the 170 cases reviewed, 102 were handled by first-line services, 63 were referred to the drug rehabilitation program, 4 to mental health services and 1 to psychosocial services.

Participants in group activities

Parenting skills workshops were attended by 37 parents. There were an average of 5 participants in each of the weekly community kitchens, the maximum number for the capacity of the kitchen where the activity was held. The participation of young mothers (17 to 20 years of age) in the group activities (the community kitchens and the respite families in particular) is particularly noteworthy, as the participation of older women in these activities promotes intergenerational dialogue. Last, several hundred community members were reached at one point or another through different promotion and prevention activities.

5.1.3.2 Client satisfaction

This section looks at the general satisfaction of users with the first-line services they received. A total of 17 users of first-line services answered the survey on satisfaction with individual/family services received. However, the statistics given below cannot be generalized to all users of these services. The first-line services team organized the meetings between respondents and the research assistant. The meetings took place at the health centre, where psychosocial services are usually offered, as well as at the Maison de la famille. Participants in group activities, such as parenting skills workshops, healing camps activities and community kitchens, were surveyed after the activity.

Given staff turnover, long a problem with the existing psychosocial services, some user responses relate to interveners who were no longer on the job when the satisfaction survey was administered. In addition, it was difficult to find respondents: many users refused to take part in the survey whereas others initially agreed but then never showed up. When the questionnaire was administered, some respondents receiving individual/family services failed to mention they were also receiving youth protection services. These respondents informed the interviewer of this informally after the questionnaire was completed, saying they did not want this information to appear or they were uncomfortable talking about it at the beginning of the meeting.

To gauge general user satisfaction, questions were asked about which components the respondents liked most and which they liked least. To the general question *What do you like about the services you are receiving*? most respondents (13 of 17) said they liked the way they were treated by their first-line services intervener: respect, willingness to listen, understanding, availability and kindness were among the qualities mentioned. Close to one-quarter of respondents said they are satisfied with referrals, solutions and advice suggested by the first-line services intervener and a few respondents (3) said they were satisfied with the services themselves and with the benefits they derived from them (learning, breaking of isolation).

To the question *What do you like least about the services you are receiving?* most users said *nothing* or *I don't know.* However, several respondents (3) mentioned the lack of confidentiality with certain first-line services interveners and the lack of time slots for certain group activities, such as during the weekend (2 respondents). Other respondents mentioned they were unhappy with the frequent changes in staff, the inadequacy of the waiting room in the health centre or a refusal to a request for service.

Table 5.9 corroborates the dissatisfaction with regard to confidentiality and the quality of the premises where services are provided. However, Table 5.9 also shows that most respondents are "very satisfied" or "satisfied" with the quality of the services they received.

Table 5.9 Overall satisfaction with services received (Community 3)

Service component	N =	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
How easy it is to get an appointment	15	7	7	1	0
Type of service provided	17	8	8	1	0
Quality of the location where the services are provided	17	9	6	2	0
Hours during which service is provided	17	8	8	1	0
Confidentiality and discretion	17	10	4	1	2
Office hours	17	8	8	1	0
Overall quality of the services provided	17	9	7	1	0

As Table 5.10 shows, most respondents were satisfied at all times with the individual/family services they received and felt their first-line services intervener really knew what he or she was doing. In addition, all respondents felt accepted as they are and said the first-line services intervener who provided the individual/family services was respectful to them. However, the responses to certain questions were more mixed, suggesting that some users would like to see some changes in their first-line services worker's attitude to them or in the way the services are provided to them.

Table 5.10 Satisfaction with individual/family services (Community 3)

Service component	N =	Never	Rarely	Sometimes	Usually	Always
My first-line services intervener seems to take my situation to heart	12	0	0	0	4	8
My first-line services intervener really knows what he/she is doing	12	0	0	0	1	11
I get the help I need	13	0	0	2	2	9
My first-line services intervener accepts me as I am	13	0	0	0	1	12
My first-line services intervener seems to understand how I feel	13	0	0	2	4	7
I feel I can speak freely with my first-line services intervener	13	0	0	1	2	10
The help I receive is beyond what I was expecting	13	0	0	0	4	9
My first-line services intervener informs me of my progress	13	1	0	0	4	8
My first-line services intervener gives me all the information I need to cope with my issues	13	0	0	1	5	7
My first-line services intervener gives me all possible solutions to cope with my issues	13	1	0	2	3	7
My first-line services intervener answers all my questions	13	0	0	2	3	8
My first-line services intervener treats me with respect	13	0	0	0	0	13
The time my first-line services intervener dedicates to me is sufficient	13	0	0	1	2	10
My first-line services intervener is accessible in emergencies	11	0	0	2	4	5
I have access to services that correspond to my culture	11	1	0	3	2	5

As Table 5.11 shows, the facilitator's people skills were again a key element in user satisfaction. Close to three-quarters of the respondents (5) felt the facilitator of the group activity in which they participated was very attentive to their needs and expectations. In addition, many respondents felt the group activities in which they participated allowed them to gain a great deal of new knowledge (5 respondents) and that the information they received would be very useful to them (5 respondents). However, 3 respondents felt the group activity in which they participated gave them little or no opportunity to reflect on their behaviour.

Table 5.11 Satisfaction with group activities (Community 3)

Service component	N=	Very much	Somewhat	Slightly	Not at all
The facilitator was attentive to our needs and expectations	7	5	2	0	0
The activity allowed me to gain new knowledge	7	5	0	2	0
The information I received will be useful for me	7	5	1	1	0
The activity gave me the opportunity to reflect on my behaviour	5	3	0	1	1

Table 5.12 shows user satisfaction with the teaching methods used in the group activities. Most respondents (4 of 6) felt these were completely adequate. Respondents were also satisfied with the content and the facilitation of the activities. Once again, respondents seem less satisfied with the location where the services were offered, with many indicating the facilities were only slightly adequate or adequate.

Table 5.12 Satisfaction with the content of group activities (Community 3)

Service component	N =	Completely adequate	Adequate	Slightly adequate
The content of the activities was	6	3	3	0
The length was	7	2	5	0
The location was	7	2	4	1
The teaching methods (exercises, exchanges, etc.) were	6	4	2	0
The facilitation was	6	4	2	0

The responses to the satisfaction questionnaire suggest that ethnic origin of the first-line services intervener is not very important to the people of Community 3 (12 of 13 respondents). Only one respondent said he or she prefers a non-Aboriginal intervener. Along the same lines, 12

respondents prefer services to be provided in French, and only one respondent said he or she would like the services to be provided in French and in the First Nations language. Last, as Table 5.10 shows, responses to the statement *I have access to services that correspond to my culture* were much more mixed, demonstrating that cultural adaptation of services goes beyond the ethnic origins of the service providers and the language used.

Respondents who answered the question about the adaptation of services to their culture said services were adapted when the social services intervener was an Aboriginal and transmitted traditional knowledge. They also added that services are adapted when the activities are community activities, when they take place in the bush or when recipes used in the community kitchens are made with game. In addition, they feel that the approach of an Aboriginal social services intervener is more egalitarian than that of a non-Aboriginal intervener. As mentioned above, however, respondents said the ethnic origin of their social services intervener was not very important. On the other hand, close to half the respondents asked about this were hesitant to answer and said they did not know if the services were adapted to the culture of their community. Last, we must say that community members were not unanimous about the importance of the cultural aspect.

In conclusion, despite the variations in satisfaction expressed by the respondents, the first-line services introduced in Community 3 are used by community members and seem to meet their needs. As in the other communities that participated in the pilot project, some adjustments to the services offered seem required to improve user satisfaction.

5.1.4 Community 4

A portrait of the clientele served was drafted based on statistics about first-line social services offered in Community 4 between May 2008 and March 2009 (10 months). Note that these services include individual/family psychosocial services as well as community and group activities. Once again, these data do not permit generalizations to be drawn about all users of first-line social services.

5.1.4.1 Clientele profile

Users of individual/family services

Individual/family psychosocial services were provided to 39 people in the community, 30 adults (average 36 years of age) and 19 children (average 12 years of age). There were more women (11) than men (9) as well as more girls (13) than boys (6).

In most cases, people sought the services of a professional on their own, which may indicate confidence in the services. The main reasons for consulting and seeking the services of a first-line social services intervener were as follows:

- Parent-child relationship issues
- Problems related to alcohol and drug abuse
- Child/youth behaviour problems

Of the 39 files studied, 31 were referred to the family/child/youth program, 1 to legal services and 1 to psychological services.

Participants in group activities

Group activities were offered to all members of Community 4 in 2008-2009. These comprised 15 activities for prevention and promotion of the well-being of young people and families, with the focus on parent-teenager relationships, violence, drugs and healing camps. Radio vignettes promoting a healthy lifestyle were also produced. In addition, about 230 people participated in the Walk for Hope. Meetings were also held to improve parenting skills, and family and cultural activities were organized to strengthen community bonds.

5.1.4.2 Client satisfaction

A total of 10 people were surveyed about their satisfaction with the social services they received. Note that the data in this section are representative only of the opinions of these 10 respondents. These respondents were preselected by the first-line services team, which was responsible for organizing meetings with the FNQLHSSC research assistant.

Half the respondents said they greatly appreciated the skills of their first-line services intervener, that they felt listened to and welcomed and that they were counselled well (5 respondents). The services offered also helped respondents to break their isolation and share their experiences with people having similar difficulties (3 respondents). Two respondents felt the help given by their first-line services intervener was appropriate to the personal difficulties they were experiencing and gave them the tools they needed to solve their problems.

On the other hand, problems were raised about the accessibility and availability of the services, mainly outside office hours, and about the time accorded to users by the social services interveners (5 respondents). Difficulties with the skills of the social services intervener (*interrupting,* for example) were also raised (1 respondent). Another respondent mentioned that the staff turnover had an impact on the services he or she received. Note that 3 respondents did not answer the question about which aspects of the services they liked least.

User satisfaction with the quality of the services, the ease with which an appointment can be obtained and the way users are treated is very encouraging for continuation of the work of the first-line services team. Once again, some users were dissatisfied with the location where the services are offered, the hours during which they are offered and the confidentiality of the services (Table 5.13).

Table 5.13 Overall satisfaction with services received (Community 4)

Service component	N =	Very satisfied	Satisfied	Dissatisfied	Very dissatisfied
How easy it is to get an appointment	6	2	4	0	0
Type of service provided	10	4	6	0	0
Quality of the location where the services are provided	10	4	5	1	0
Hours during which service is provided	9	4	3	1	1
Confidentiality and discretion	9	3	5	1	0
Office hours	10	3	7	0	0
Overall quality of the services provided	10	5	5	0	0

Satisfaction with the individual/family services was measured via questions about the way the first-line services interveners dealt with their clients. Four respondents agreed to share their opinions. Their responses show the majority were very satisfied. Among other things, the respondents said that they receive the help and responses they need and that they feel accepted and appropriately informed. However, there seems less satisfaction with the connection of the services to the culture of the community. These results must, however, be interpreted with caution given the small number of respondents.

Eight people agreed to give their opinions about the organization of group activities. These respondents found the content, duration, location and methods for these activities more than adequate. They were also very satisfied with the facilitation of the activities and the attention paid by the facilitator to their needs and expectations. Seven of the eight respondents felt they had gained new knowledge, acquired useful information and participated in an activity that gave them an opportunity to reflect on their behaviour.

In Community 4, few respondents answered the questions about whether the services were appropriate to the needs and way of life of community members. Generally speaking, responses indicate that the ethnic origin of the first-line services intervener is not very important. However, respondents in Community 4 prefer receiving their services in the First Nations language (4 of 4 respondents).

Though the sample was very small and not representative of users of first-line social services in Community 4, most respondents seem satisfied with the first-line services they received.

To conclude this chapter, analysis of the satisfaction of first-line social services shows that the services offered meet the expectations of users surveyed, even though certain changes will generate greater user satisfaction. Cross-sectional analysis of the data show that certain aspects seem appreciated by virtually all users of the first-lines services offered through the pilot project: the people skills of the first-line social services interveners and the type and quality of the services offered.

On the other hand, responses to certain aspects were repeatedly more negative: the location where the services were offered, the lack of confidentiality, the hours during which users could obtain help and the duration of the meetings/activities. Though respondents do not feel that the ethnic origin of the first-line services intervener is important, they do want the first-line services to take the ways of doing things and lifestyle in their community into account.

Chapter 6

Process analysis of the community development approach ownership

One objective of this evaluation is to examine the process of ownership of the community development approach, and analyse the ownership of the empowerment principle and the action strategies that were implemented to improve the lives of children and families. This chapter will present an analysis of the ownership of the community development approach by asking:

1) How has the process of ownership of the approach unfolded in the four communities?

2) How was the principle of empowerment developed in the four communities?

3) How has the support offered by the FNQLHSSC social services sector encouraged greater ownership of the approach by the four communities?

The community development approach is defined in the pilot project as a process of voluntary cooperation, mutual assistance and bridge building between residents and institutions in local communities, to improve physical, social and economic conditions (INSPQ, 2002: 16). Four action strategies were chosen to oversee the implementation of first-line social services and specify how to induce change in the communities in a sustainable development perspective.

The action strategies correspond to:

a) The ownership of the project

b) The mobilization and commitment of local and external stakeholders

c) Intersectoral collaboration

d) The involvement and mobilization of the population

Throughout the implementation of first-line services, the action strategies were continuously being developed as opposed to being announced at a given moment in time. Action strategies became the main vehicle through which the ownership of the community development approach was realized.

The analysis presented in the following sections will show how the strategies came to play this role, how the principle of empowerment developed in the four communities and finally, to examine the significance of the support offered by the FNQLHSSC's social services sector. The descriptive and cross-sectional analyses of the process of ownership of the community development approach are based on a variety of data collected throughout the implementation:

- The group and individual interviews conducted during the first and second data collection periods made it possible to describe the process of ownership of the approach based on the responses of local, external and regional stakeholders involved in the pilot project;

- Documents produced by the many stakeholders involved were analyzed (brochures and leaflets created by the implementation teams, action plans, logbooks and reports of activities in the participating communities);

The analysis of the ownership process of the community development approach shows that:

- The actualization of the action strategies represented four significant achievements during the services implementation;
- The "bottom-up" approach (from the bottom to the top), based on the premise that communities and local stakeholders are in the best position to decide and act on the implementation of solutions adapted to the local context was crucial;
- The action strategies are an iterative process and their continual updating is necessary to ensure that the approach is integrated and applied within the community;
- The principle of empowerment must remain the conceptual framework in the development of action strategies which are inspired by them.

6.1 The actualization of the action strategies

6.1.1 Strategy: Ownership of the project

Theoretically, the success of the ownership of a project depends on the involvement of the key stakeholders at all levels, including band councils, first-line services teams, local and external stakeholders and the population (CSBE, 2001; Latendresse and St-Pierre, 2006). This strategy remains essential beyond the early stages of the project since it is important that it be continually updated during all steps of the implementation process. Indeed, whether we are trying to establish an action plan, develop programs, build teams or provide services to the population, it is necessary to properly evaluate what we want to do, consider the resources at our disposal and develop strategies that are best suited to the realities and that embody the overall vision and local values.

For first-line services teams, it was necessary to understand the problems they wanted to act on and how to translate this understanding into action within a prevention and community development perspective. Therefore, the strategy demanded that the teams take the time and space to determine what they wanted to do, train and educate themselves, and create a network with sufficient expertise to support them when necessary. The provincial social services system (including the CSSS, the CLSC and Youth Centers) was one of the main stakeholders challenged in this way.

> *"As for me, I wasn't really familiar with the services offered by the CLSC. I had more experience with Youth Centers and rehabilitation centres. When we met with [name of the CLSC contact person], we wanted to find out 'What services are currently offered in town for the general population?' They described the different programs they had for young people, for families. Then they offered us their support, if ever we needed ideas or help to develop a program. To avoid*

reinventing the wheel, the CSSS told us that they were ready to support us in what we were doing" (local stakeholder T1, Community 1).

In Community 1, the first-line services team's familiarity with the concepts inherent to the community development approach enabled the rapid ownership of the project. The approach aligns the project with the working model that had been chosen by the community to guide local organizations as to how to work to improve the well-being of children and families. Mechanisms providing information about the needs of the population have also been supported throughout the pilot project. The consultation of the population represented a step forward in the implementation of this work model and enabled the development of an action plan that identified local action priorities based on needs expressed by the population and by local and external stakeholders:

"They [the implementation team] looked at what ideas should be prioritized [...]. It's rare that people see that, I mean that we actually see them implement programs based on what they said" (external stakeholder, Community 1).

Accustomed to receiving programs designed by funders, the first-line services team in Community 2 had little previous experience in implementing programs using a community development approach. The fact that the initial implementation team was completely replaced by another put the process of ownership into question. To address this, FNQLHSSC social services provided support adapted to the needs of the second team so that it would develop confidence in its abilities and succeed in developing services in response to the community's needs. Drafting the action plan was a real challenge given that tight deadlines and staff turnover did not allow awareness raising or consultation with local and external stakeholders or the population. Moreover, a climate of mistrust in relation to the youth services centre also demonstrated the importance of differentiating first-line services from existing youth protection services:

"[...] [There] is a lot of fear too: youth protection equals having your children taken away" (local stakeholder T2, Community 2).

In Community 3, different project stakeholders experienced different degrees of ownership, which took place more in terms of the organization of services than at the decision-making level. Given the fact that the first-line services overlapped existing psychosocial services, a reorganization effort was needed to ensure the implementation of the project. Even though the band council tried to develop guidelines and an advisory council, the new guidelines did not really respond to the needs of the population. The first-line team felt that it wasn't sufficiently involved in the reorganization and could have contributed more to the ownership of the project by all stakeholders:

"We're the ones who know what our clients need, but working together with the advisory council, our management decided on a major reorganization plan. [...] I'm not saying it's bad, but it would have been nice to have been consulted" (local stakeholder T2, Community 3).

In Community 4, the process of ownership of the approach encountered difficulties because the project was not well understood by members of the community, who raised questions about its nature and approach. An extensive campaign designed to promote and clarify the objectives of the project was then implemented. The use of a variety of communications mechanisms served to inform the population of the evolution of the project and also helped to obtain information that enabled appropriate services adapted to local needs and context to be offered. However, staff turnover in the community continued to pose challenges to the ownership of the project and the approach.

Main findings

- Ownership of the project and the approach promotes the establishment of a clear and realistic action plan and the setting up of mechanisms (surveys, advisory committee, etc.) that guide action according to local needs throughout the project and enable, if necessary, making adjustments. In some projects, inadequate mechanisms of information flow have prevented actions from being adjusted in response to changing local needs.
- For some communities, the local process of ownership of the project and the approach required a longer period of time. This was mainly reflected by the development of an unfocused action plan and difficulty in developing a realistic range of services.
- The team coordinator's experience and knowledge about community development has influenced the implementation of strategies.
- The presence of functional communication mechanisms has made it possible to validate the actions during the project and adjust them as needed.

6.1.2 Strategy: The mobilization and commitment of local and external stakeholders

To get the mobilization under way, it was necessary that stakeholders be given a clear understanding of the aims of the project and the implications of the approach. Only with the certainty that this approach represented an effective solution to the problems affecting youth and families in the long-term was mobilization possible. The ability of local teams to explain the project and to rally key partners around it proved to be the cornerstone of successful project implementation. It was therefore a mobilization oriented around a desired change, rather than around the project *per se* (Benazera, 2005).

In order for community stakeholders to be successfully mobilized, it proved essential to ensure that key community leaders—particularly political leaders and managers of various sectors of activity—were willing to support the project. Once this core of stakeholders was supportive of the project, mobilization efforts were directed towards the population and towards local and external stakeholders who could act as levers. Mobilization is a process in constant change and operates so as to continuously expand the stakeholder network through a multisectoral partnership bringing together different sectors and including members of the population. As noted by Latendresse and St-Pierre (2006), the more that partners are diverse and come from different backgrounds, the more that actions will be comprehensive.

In Community 1, throughout the implementation, the team invested in strengthening its partnerships in order to mobilize local and external stakeholders who already represented a force in the community. Within the context of the pilot project, the partnerships with the health centre, the band council and the Youth Center became key drivers supporting the work of the first-line services team. To promote the involvement and mobilization of the population, the team created a space for informing the population about the project and to increase volunteer involvement. A monitoring committee consisting of members of the population was formed to guide the necessary actions:

> *"There are some committees and activities that I find mobilize a lot of people. People are there, things get going, it works pretty well. But there's others that ... Like action tables, it all depends. We had some good tables, others not so good. We saw a little bit of both; sometimes we saw some very beautiful things, people were there, they had ideas, they were involved. And other times, it's like pulling teeth, it seems that everyone goes their separate ways for different reasons that are not malicious"* (local stakeholder T2, Community 1).

However, ensuring the continuity of the mobilization was a challenge. Indeed, maintaining the monitoring committee itself was difficult, particularly during the implementation phase, because the committee's role had not been sufficiently clarified when the implementation of first-line services began.

In Community 2, local and external actors were mobilized to a greater extent during the access to services phase than they were in the planning and action implementation stages. During the access to services stage, the community's political leaders showed an increased commitment to the project and strongly encouraged all sectors of the community to involve first-line staff in their efforts. This support greatly encouraged the involvement of local and external actors in the implementation of first-line social services.

> *"In the beginning, we had a hard time getting the council to mobilize the designated people. But after we managed to contact the chief, in fact, the former chief, I think things improved. Consultations took place and many young people were advised about the first-line services project when they went to the council, for example. They were pretty much promoting the service"* (local stakeholder T2, Community 2).

Concerning the mobilization of local stakeholders in Community 3, a number of external partners got involved with the first-line services team by co-organizing thematic activities around prevention and promotion, providing training and helping to negotiate agreements. On the other hand, the team expressed that it had less credibility in relation to some internal partners. The team's heavy workload also limited its promotion activities in relation to some stakeholders, putting stress on these relationships. Improving the mobilization of internal stakeholders is one of the targets that was set for 2009-2010.

In Community 4, mobilization and commitment of local stakeholders developed slowly. In fact, the lack of sustainability of many previous pilot projects undermined the credibility of the pilot project. This type of resistance could also be observed among the team itself, which questioned the realism of the tasks undertaken due to constraints imposed by local dynamics. In this respect, support provided by the first-line services advisor from the FNQLHSSC social services sector was

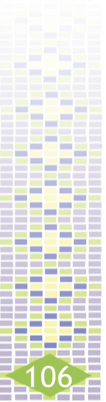
essential in mobilizing the local political leadership. In addition, the creation of a local advisory committee, which included the decision-makers, ensured a high quality of communication between all stakeholders involved in the pilot project and enabled them to take collective action to meet the converging collective needs expressed by the population. Nevertheless, although some stakeholders mobilized, the Youth Center stayed on the sidelines. Also, the adoption of a formal memorandum of understanding concerning the administration of first- and second-line services proved difficult.

> *"I discovered it was a big project and it seemed to me that we shouldn't miss the boat. You have to mobilize people. Mobilize the community. At the beginning of the project, what was important in my opinion, was to mobilize the council. So that they would agree with the goals of the project and understand its importance. After that, we needed to mobilize the leaders, various directors: the school, police, health, radio, all that. I met with people and informed them about the steps, about the why and wherefore of the project"* (local stakeholder T1, Community 4).

In sum, in most of the pilot project communities, the establishment of partnerships between various local and external stakeholders took time and consistent effort. Indeed, the most difficult task was ensuring that the stakeholders' interests were constantly front and center. Finally, mobilization efforts enabled the pooling of the community's strengths and thereby positioned the involved stakeholders to improve the well-being of children and families.

Main findings

- The credibility and recognition given to the project and the first-line services teams positively influence the mobilization of stakeholders.
- The project's "pilot" status has made people who don't perceive that the project has a future slow to commit, and held back the mobilization of local stakeholders in some communities.
- The quality of intersectoral links influences mobilization. The more that links are harmonious and based on respect, the more success there is in mobilizing. In contrast, a culture of working in silos makes mobilization difficult.
- In general, the mobilization of local and external stakeholders is achieved in partnership with interveners from the social sectors, i.e., people with whom the teams have already developed working relationships (health centres and Youth Centers).



6.1.3 Strategy: Intersectoral collaboration

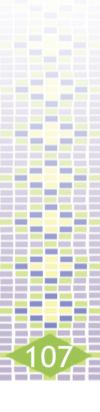
According to Latendresse and St-Pierre (2006), once the main stakeholders are mobilized, it is important to define action strategies based on common objectives, namely to develop a plan that will become the path to follow. The plan, which may take different forms, involves the skills and expertise present within the network of partners and the population. It also clarifies the mandates and responsibilities of members of the partnership. In this context, communication is essential for the partnership to maintain harmonious interpersonal relationships and consistency in action.

Successful intersectoral collaboration is based on the first-line team's abilities to lead and coordinate dialogue (Benazera, 2005; Latendresse and St-Pierre, 2006). Although the success of these consultations is also based on the stakeholders' commitment, the fact remains that they have different mandates and responsibilities. They cannot therefore devote themselves entirely to action (Latendresse and St-Pierre, 2006). Where the first-line pilot project teams were able to secure a role in coordinating and monitoring, the implementation of the action strategy was easier. Moreover, within the communities, the development of consultation and cooperation flowed directly from the process of mobilization. These two action strategies were also experienced in several communities simultaneously, especially when meetings were organized involving various stakeholders during which the first-line teams were able to promote the pilot project.

In Community 1, intersectoral collaboration was already part of the way things were done locally, which facilitated the implementation of an action plan based on verbal agreements between partners. Indeed, several tables and committees were already active in the community and contributed to the development of intersectoral cooperation. In addition, the first-line services coordinator had already attended a number of tables outside the community. This way of working is considered normal because of the harmonious relations between local stakeholders. The participation of the first-line services team in various tables coordinating programs within the community contributed to the harmonization of services offered to community members. Moreover, the strong effort made to establish a formal working agreement between the first-line services and the regional Youth Center is a key development that demonstrates the progress of the collaborative process within Community 1.

In Community 2, local leaders heavily promoted the project during the implementation phase in order to set the stage for cooperation/collaboration. Thus, an increased willingness was expressed to set up new committees and roundtables. A number of committees and tables were created but most of them did not in fact last over time. One of the challenges remains to maintain the collaborative approach even when social emergencies are reduced.

> *"[...] we had a fair amount of trouble with mixed tables because the Aboriginals were undecided. I think that's in the culture. They don't want to vote right away, they want to think about it and after that come back to the topic. With other people, right away they're ready for action"* (local stakeholder T2, Community 2).



Nevertheless, by the end of the pilot project, the first-line team and the Youth Center had begun to work together to reduce the retention of reports. The first-line team was specifically responsible for verifying and evaluating the risks following an initial report made to the Youth Center. In another vein, the first-line team emphasized the difficulties involved in collaboration between Aboriginals and non-Aboriginals due to perceived differences in their ways of doing things.

For Community 3, cooperation/collaboration was greatly facilitated by the multidisciplinary nature of the team providing psychosocial services. However, the fact that managers weren't always on the same page and the continued resistance to eliminating silos seemed to hold back intersectoral collaboration efforts despite a reorganization of health and social service programs. The first-line services team participated in various committees and intersectoral meetings were regularly held. In addition, communication with the Youth Center improved throughout the project implementation; verbal agreements were negotiated, and the signing of a protocol is expected.

> *"[...] before, it didn't happen at all. [...] This year, it was much easier [...], the confidence was there. People saw it getting organized, that it was structured so the door was open and there was good collaboration"* (local stakeholder T2, Community 3).

In short, intersectoral collaboration in Community 3 occurred more among stakeholders working with the population, and less with decision-making bodies such as sector management.

In Community 4, the unresolved disagreements that dominated the work of the advisory committee suggest that establishing collaborative relationships remained a challenge. Before the project began, exchanges on ways of working or on a referral system between the different services offered were few and far between. Despite the challenges faced by the local advisory committee, the decisions taken by the first-line services team responded to the results of the surveys conducted among the population. In addition, the change in bingo hours and the passage of various resolutions by the band council are examples of positive changes brought about by an increased dialogue within the community.

Nevertheless, we must recognize that much was accomplished since the beginning of the project as a result of the creation of common work space for local stakeholders enabling them to break their isolation and eliminate their work silos.

> *"There's enthusiasm, I'd say, to review the action plans for each sector and for sector collaboration, because we know that there was none before. The advisory committee has really led the sectors to work collaboratively. So now there are a lot of discussions leading towards collaboration. You, what are you going to do, and you, what are you going to do? We pretty much agree on what to focus on and what direction the service should take [...] and not to duplicate efforts either"* (local stakeholder T2, Community 4).

Main findings

- A hierarchical organizational structure is one of the main obstacles to consultation and collaboration, because it makes it difficult to establish the necessary communication networks.
- The usual ways of conducting partnerships, based on informal agreements, constrain the implementation of formal written agreements, most importantly with Youth Centers.
- The majority of the monitoring committees (advisory) dissolved or were under-utilized. The first-line teams emphasize that they misunderstood the role of the committees, particularly in relation to the provision of services.
- Development of collaborative relationships remains the major challenge, especially to go beyond the traditional definition of roles and mandates and focus on action planning.

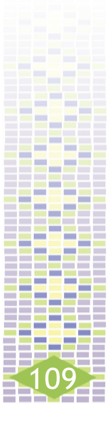
6.1.4 Strategy: The involvement and mobilization of the population

Local stakeholders and the population become activated when their common ground is elaborated and the actions to take are planned. A new reality is created when a group takes an identified action following a precise plan (Benazera, 2005). The role of the *mobilizer* assumes its full importance. Indeed, involvement of stakeholders and the population does not come about naturally. Through the responsibilities they assume and the events that take place, the mobilizer stimulates in a sustained way the participation of all concerned (Latendresse and St-Pierre, 2006). This requires creativity, flexibility and an investment of energy. Moreover, as pointed out by Benazera (2005), stakeholder involvement can be facilitated by the use of opportunities that arise in the community.

In Community 1, various social crises (inflow of drugs and money, attempted suicides) occurring in the community over the last two years have been opportunities for first-line teams to get stakeholders and the population involved in cooperative action. In addition, a monitoring committee consisting of members of the population was formed at the beginning of the implementation of services and contributed to the orientation of services offered:

> *"The child/family action roud-table is a new round-table. [...] The first meeting was before Christmas because they wanted to prevent an increase in the inflow of drugs. We wanted young people to have a nice holiday so we got together before Christmas to see what could be done"* (local stakeholder T1, Community 1)

The involvement and mobilization of the population in Community 2 was mainly expressed through family-respite. This program mobilized several families who offered 24/24 availability. Participation in family and group activities was also significant and the voluntary request for services increased throughout the project. However, the voluntary work has yet to develop. As well, the work of the monitoring committee was gradually abandoned because its members had different political perspectives.



In Community 3, involving the population was a challenging step. Certainly, there are a few examples of people being involved in this community (the formation of a committee of women and the success of community kitchens), but overall, it was hard to engage people outside their role as consumers of services. Two main factors that limited the sense of ownership and use of the Maison de la famille by the entire population were mentioned: the pejorative connotation associated with social services and the limited availability of space which led to people having the feeling that they were disturbing others.

> *"Yes, they want services. [...] They've wanted them for a long time, but when it comes to concrete things, oops, nobody's around"* (local stakeholder T2, Community 3).

To encourage the involvement and mobilization of the population, the project coordinator in Community 4 focused his energy on developing new ways to counter individualism within the community and to get input from the population. In fact, the community radio and newspaper became an essential public forum through which the voice of the people could be heard. However, the involvement and mobilization of the population remains a constant concern of local stakeholders. Indeed, although people responded to surveys, participated in community activities and respected the prohibition against drinking in the spaces used by the project, it must be noted that community initiatives run by informal local groups have not emerged. Participation in project activities was also reduced because of bingo which takes place six days out of seven in the community:

> *"What I find difficult is to have to go out to find the men in the community who need help. I'm going to work mostly with men in difficulty. The involvement of men is pretty limited. So we [including the first-line services] decided some time ago, to collaborate, to work with a psychologist and a nurse. There were three of us to help the men who needed it. We changed our tactics now, we put up some bait to get them to come, by giving a supper, some surprise giveaways"* (local stakeholder T2, Community 4).

The teams from the four communities used a variety of means to increase the involvement and mobilization of the population. Despite these efforts, experience has shown that it is not easy to maintain this level of involvement over the long haul.

Main findingss

- As of the last year of implementation, despite the mechanisms put in place, it must be acknowledged that difficulties were experienced in terms of the quality of the commitment of some stakeholders. Several stressed that responsibilities weren't shared evenly and fell too heavily on a single sector. In some projects, the first-line teams had too many responsibilities and were in too high demand. This was undoubtedly frustrating.
- In each community, there were different degrees of involvement on the part of stakeholders and the population in terms of taking action. There were few community initiatives. Generally, mobilization of the population was mostly experienced in the context of consuming services.

6.2 The development of the principle of empowerment and its benefits in the four participating pilot project communities

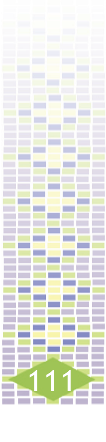
According to the principle of empowerment, both individuals and communities have the ability to exercise their power or to reclaim it in order to take control of their own well-being. As mentioned previously, three main types of empowerment are recognized in the literature: individual, organizational and community (Ninacs, 2002). The strategies employed in the communities have had an impact on the power to act at all levels: individual (users of services), community (the population) and organizational (first-line social services).

Individual empowerment refers to experiences through which individuals acquire or use their abilities to exercise greater power over their lives, while reinforcing their independence and ability to take action.

Community empowerment is defined as the power to act that a community gives itself in order to impact on the determinants of its members' well-being. Its characteristics are: 1) a redistribution of power that promotes the population's participation, 2) the ability of the community to promote individuals' skills as well as its ability to mobilize local resources to strengthen support networks, and 3) the establishment of effective mechanisms of communication: information flow, access to information and transparency in decision making and 4) a reversal of a state of "disempowerment": community capital, through the development of a sense of belonging to both the community and the environment and the development of each member's awareness of his or her own citizenship (Leroux and Ninacs, 2002).

Finally, as Ninacs (2002) points out, individual experiences take place more effectively within a group, because the group process enables individual experiences to be consolidated and tested. Organizational empowerment can be seen in the community's analysis of the people's needs. The first-line services team, through its expertise, can provide an orientation for the organization's actions and purpose.

The following sections will discuss how the principle of empowerment was realized in the four participating communities, and a summary of the main benefits will be presented.



6.2.1 Empowerment in the four participating communities

Several observations can be made concerning the experience in Community 1. At the individual level, empowerment was realized through the creation of decision-making spaces, particularly the formation of a monitoring committee that was able to contribute to decisions about the orientation of services. There was an increase in the level of confidence the population felt towards health and psychosocial services, which reduced their feelings of isolation and was expressed through a greater willingness to seek help:

> *"Just the fact of consulting the population to see what services they want, what their needs are, gives them the power to act, to change things. We are consulted, we participate, we're not just clients"* (regional stakeholder T2, Community 1).

In terms of community empowerment, members of the community showed little initiative in developing new projects, such as taking concrete steps to change the community. However, members did demonstrate a capacity to rapidly organize in response to a crisis situation (such as a death in the community).

Regarding organizational empowerment, the support and credibility granted to the first-line services team was an essential component of the team's ability to make decisions and gave the team a degree of flexibility to take effective action. The involvement of members of the population targeted by first-line services is considered essential and must be constantly encouraged:

> *"I think there are people who really would like to, but it's difficult, they don't know how and they might not always do it the best way"* (local stakeholder T2, Community 1).

In Community 2, the principle of empowerment was especially enhanced at the organizational level. At the beginning of the project, the band council assumed the entire administrative management. Over time, the first-line services coordinator was given access to the budget and participated in the selection of interveners. Moreover, the request of the first-line services team for management responsibilities to be transferred from the band council to the health centre was approved. Although political upheaval slowed the process, this approval was significant and demonstrated that the organization of work had changed. As some misinformation was circulating, it would have helped to avoid misunderstanding about the nature of the services if the team had done a better job keeping local stakeholders informed.

In terms of community empowerment, families expressed a strong desire to contribute to keeping children in the community, which represents a powerful potential on which the community can build. Nevertheless, community mobilization would have benefitted from more encouragement. In relation to individual empowerment, the accompaniment service for meetings with the Youth Center enabled parents to better express their needs, but mutual misunderstanding about the ways of doing things persists.

Concerning the question of empowerment in Community 4, although the team members felt they were not sufficiently involved in the restructuring of services, they still had the ability to make changes in their own departments. Nevertheless, an imposing organizational structure can still limit the power of some stakeholders to act and the "pilot" character of the project weakened its credibility with the band council leadership.

> "*Because it's a project, it was like 'this will pass,' but the team is still there and we're going to keep it going and we're going to grow*" (local stakeholder T2, Community 3).

In terms of individual empowerment, developing the capacity to act takes time, especially in a context where many people have been disempowered in relation to their needs.

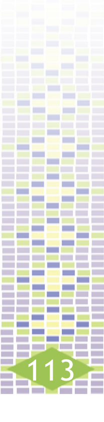
> "*It's a long road and there was a lot of work to do at the level of the population because there is a mentality that the council is going to solve all our problems*" (local stakeholder T2, Community 3).

Concerning participation in community activities, several activities were successful, including the creation of a clothing bank and a women's committee. The formation of a women's committee that supported a number of initiatives is a good example of community empowerment. Yet, apart from the creation of this committee, it proved difficult to mobilize the community. One possible explanation is that despite the fact that a number of people were motivated and attended the implementation committee meetings, they had problems understanding their role and were more comfortable listening than in taking initiatives. Currently, one of the goals of the first-line services team is to ensure that participants in activities have an increasing sense of ownership of them.

Finally, in Community 4, the implementation of first-line social services has encouraged community and individual empowerment. Indeed, from the beginning of the pilot project, an early form of community empowerment was demonstrated by the mobilization of local members seeking a greater degree of consultation and collaboration and to ensure a greater convergence of their actions. In this context, the community conducted a self-analysis and has developed locally-based solutions to effectuate change. The establishment of an advisory committee facilitated the flow of information, increased involvement and redistributed the power to make decisions.

> "*I'm thinking just of the actions that were taken in relation to bingo, it's a simple change to change the hours of bingo, but even if it seems like no big deal, I've seen communities who tried to do it and it was quite a mess. […] It means that the community was very aware of and involved in the analysis of the problems and the actions to be taken*" (regional stakeholder T1, Community 4).

In terms of individual empowerment, the majority of users interviewed affirmed the importance of having a say on how services are offered, as well as on the decisions affecting them. In the same vein, the mechanisms put in place to engage the population in making decisions were a certain form of taking ownership. The strong participation in community activities and the increased requests made to first-line services for help are also clues that suggest that many members of the community have the tools they need to deal with their difficulties and to improve their skills.



6.2.2 Key benefits associated with the development of empowerment in the four participating communities

In the four participating communities individual empowerment was generally the predominant form. The population took part in the work of the project monitoring committees and there was a steady increase in requests for help. It must also be noted that community empowerment developed gradually, and that it came into play mainly during periods of crisis.

a) Individual empowerment

Initiatives identified in the framework of the implementation of first-line services have given the population more power to take actions that affect their lives. One of the earliest changes to take place was the creation of spaces where every member of the community could express themselves, take part in decisions and participate in projects. This was facilitated by various means, including the taking of surveys, the establishment of monitoring committees (advisory) and community groups and the organization of general assemblies.

Thus, the creation of spaces for participation led members of the community to begin to take responsibility for acting on their problems. In fact, the gradual increase in the voluntary request for psychosocial services suggests that the mobilization of the population is real and justified. With the support of the first-line services, the emergence of community initiatives also confirms the commitment and involvement of local stakeholders. The next two statements clarify these observations:

> *"There were some grandparents who came and said 'my grandchildren are being neglected.' They didn't need to go to social services, they came to see us, they were seeking help for them" (local stakeholder T1, Community 2).*

> *"It started with the discussion group. There were five people there and they decided to establish a community bazaar, and we were able to support them in their activity. In three weeks, they got the community bazaar up and going, and after that, a clothing bank" (local stakeholder T1, Community 3).*

In addition, several first-line teams emphasized the positive impact of their interventions with clients. These interventions helped to reduce the clients' sense of isolation and helped them to improve their parenting skills:

> *"They come to see us because we can help them, for example with the accompaniment service, go to town with them and help them do their grocery shopping. We help them and encourage them, and they're happy they were able to do a big shopping, they tell us, 'I bought lots of things for my children.' They're happy. It enhances their self-esteem in their role as parents and it encourages them to want to work harder"* (local stakeholder T2, Community 1).

Improved self-esteem can also be seen in the development of greater ability of parents to assert themselves in relation to youth protection services:

> *"I see parents who are beginning to assert themselves. I met with a couple of parents this week who disagreed with the measures proposed by the case worker during the evaluation. They came to us and said, 'what can we do?' I told them 'go for it, call your lawyer or go see the head of the evaluation department.'[...] People want to do more and more often. It's so big, the PJ [Protection de la Jeunesse], that system is so big that you have to be more assertive. Before, it was 'well, whatever,' people were more passive"* (local stakeholder T2, Community 1).

Ultimately, the fact of offering services that seek the opinions and expressed needs of the population encourages the creation of a space for exchanging views. Users of first-line services expressed the importance of having a say about the services they receive and to participate in the decisions that affect them. The continued development of individual empowerment has had positive consequences on the process of promoting healthy lifestyles in the communities.

b) Community empowerment

Benefits to the local community under the pilot project mainly concern the community's capacity to organize itself to improve the well-being of youth and families. From the outset, by participating in the creation of first-line services, communities have expressed their desire to maintain children in their surroundings and at the same time have assumed greater responsibility for achieving this.

> *"It was time for something like this, services like that, where people could try to get help before their children are placed. There are too many children who are no longer in the community"* (local stakeholder T1, Community 1).

In some cases, a number of families contributed to the collective effort by volunteering as respite or foster families for fixed periods of time. Such concrete actions demonstrate the community's potential and the capability of community members to organize themselves quickly if necessary.

Furthermore, collaborative relationships initiated in the communities contributed to encouraging local and external stakeholders to work together, rationalizing community resources. In addition, the establishment of consultative bodies such as orientation tables, multisectoral and monitoring committees, maximized resources and local expertise. Actions responding to the priorities that had been laid out were therefore able to be undertaken:

> *"What is different is that we got together as a group. Because before, we never met all together. Also, people are more comfortable. They see the committee as a working committee but also something that can help them solve problems. I can see it, because people have approached me with this in mind. [...] It is through the committee that we can act to solve our problems"* (local stakeholder T1, Community 4).

The pilot project was also an opportunity to develop a course of action supported by local and political leaders that gradually set its sights on improving living conditions in the communities. The introduction of a curfew and the change in bingo hours to encourage parents to be present at mealtimes are examples of community initiatives and resolutions that emerged.

> *"Currently, the [curfew] resolution has been passed and we're ready to enforce it; the tasks have been defined since January. I couldn't tell you if the kids come out later in the evening, though. [...] What I can say, on the other hand, is that there's less action in the community, in terms of negative things. I don't hear about young people hanging out late at night any more"* (local stakeholder T1, Community 4).

Finally, as reported in the literature, it is necessary that the community assume full control and that it is recognized for its competency in regard to its social responsibility for the well-being of its members (Blackstock et al. 2005). The benefits outlined above demonstrate the importance of using existing resources and expertise within communities because they promote the establishment of mechanisms for consultation, collaboration and involvement that have significant impact.

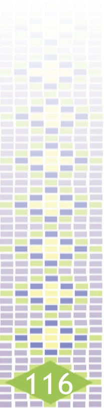
c) Organizational empowerment

Under the pilot project, the first-line services team, as an organization, is an autonomous entity that expects its members to participate in decisions that affect them. According to the experiences in the communities, organizational empowerment begins with the credibility granted to the first-line services teams by their local and external partners. Such support was illustrated by a concrete commitment of these stakeholders to: 1) share resources (e.g., the "loan" of a speaker from a health centre), 2) distribute financial resources (e.g., the cofinancing of a social emergency service), and 3) make material resources available (e.g., the donation of free office space). The development of collaboration between various sectors and agencies working in the communities is a significant benefit to the local communities:

> *"The collaboration between the first-line team and the health service ... It seems that we form one big team. We meet on average once a month with the health centre. I call it the expanded team that includes both the first-line service project and the regular health centre people who have been there a couple of years [...]"* (local stakeholder T2, Community 1).

The hiring of Aboriginal interveners in some communities has fostered the development of services that were appropriate to the local context and people were able to be served who otherwise would have been more difficult to reach. This contributed to expanding the scope of first-line services in the community:

> *"Empowerment? I see it. You know where I see it in the community? In the people we have gotten involved. I think they have power and influence in their community through their role and they use it well. Sometimes, I see empowerment as developing tools, going to see people, getting people involved in projects. That's how I see it these days"* (local stakeholder T1, Community 1).



Finally, the growing relationships between local and regional stakeholders have led to partnerships. They have also provided support to the first-line services teams by giving them access to development expertise (training, coaching, first-line services regional committee, FNQLHSSC support, etc.). The acquisition of new skills thus contributes to the teams' increased empowerment.

> *"Through this training we learned what to do with a child with behavioural problems, what approach should be used, a child who's aggressive, wild... these are the kinds of subjects the girls talked to us about"* (local stakeholder T2, Community 2).

6.3 The impact of support provided to the communities by the FNQLHSSC social services sector

The FNQLHSSC assumed a leading role in coordinating and supporting the development of first-line services in the four participating communities. Specifically, the support provided by the FNQLHSSC advisor was crucial in developing and implementing first-line services. Indeed, the first-line services teams recognize the importance of this resource that played such a pivotal role in the success of the projects. This consultant was hired by the FNQLHSSC during the initial phase (pre-implementation) in January 2007 and was mandated to implement guidelines established by the tripartite orientation committee, to orchestrate the project and support the four pilot project communities in their work.

An analysis of interviews conducted with members of first-line services teams helped to highlight four key support functions provided by the FNQLHSSC advisor. The first three support functions corresponding to those developed by Boucher and Laprise (2005). The fourth—the mediating function—reflects a reality experienced by the teams and expressed during various interviews. Table 6.1 provides a summary of the various forms of support offered by the FNQLHSSC first-line services advisor.

The first-line services stakeholders had positive overall impressions of the support provided by the first-line services advisor and two elements were particularly appreciated by the teams. On the one hand, the advisor's availability was noted.

> *"I felt that the Commission was there to support us. They were our back up, and when we needed him, [name of the advisor] was very available"* (local stakeholder T2, Community 1).

On the other hand, the advisor's ability to relate to the communities proved to be both an asset that was well-recognized by the stakeholders and a necessary skill for establishing a trust relationship:

> *"Whenever we need to, we're comfortable to call. The support, I know it's there. We rely on it, when we need to, we pick up the phone, send an email, in the end we get some answers"* (local stakeholder T2, Community 1).
>
> *"We feel the respect of the Commission, the support, the lack of judgment, the spirit of mutual aid"* (local stakeholder T2, Community 1).

Table 6.1 Summary of support provided by the FNQLHSSC social services advisor to the pilot project communities

Type of support	Actions taken by the FNQLHSSC first-line services advisor	Feedback examples
Emotional Enable first-line teams to speak their minds, to express their emotions and to feel heard and supported	• Establishment of a regional committee to brake the teams' isolation • Regular telephone contact with the communities to keep them up to date about the project • Field visits to the communities to support their activities	*"It's all about listening, because he [advisor] listened to us talk about the difficulties we encountered"* (local stakeholder T2, Community 2). *"When I went out of town for training or meetings, that was a real lift"* (local stakeholder T2, Community 2).
Material Facilitate access to human and material resources as well as services available to help support the first-line teams solve their problems	• Creation of tools and reference documents • Support for drafting action plans • Creation of forms for keeping individual and group records and an intervention database • Networking with different partners in order to provide support for local expertise	*"[FNQLHSSC] called to remind me. Just to make sure we didn't forget"* (local stakeholder T2, Community 2). *"We always had someone who would say, "hey, if you want me to help you to write, to formulate the project, I'll help you"* (local stakeholder T1, Community 3).
Informational Provide information, counsel and recommendations to help the first-line teams make decisions about what to do and acquire skills	• Creation of a training program dealing with the community development approach and providing access to other training • Recommendations for resolving local disputes • Technical support for establishing local budgets	*"The Commission has helped us a lot. It gave us information on how to analyze the needs of the community. It was very supportive represented us to the tripartite commission. It explained many things we needed to change. We could see how it could work differently with them"* (local stakeholder T2, Community 1).
Mediation Play a facilitating role between different levels in the local and provincial hierarchy in order to support the first-line teams in their local actions	• Negotiation of deadlines with the tripartite orientation committee • Sending letters or conducting meetings with political leaders to help resolve problems encountered by the first-line teams • Liaison between the communities and the tripartite orientation committee: provide information on the evolution of the project so that measures could be adopted in response to local conditions and needs	"Sometimes we asked for help sorting things out, and the FNQLHSSC advisor played a crucial role in getting the project to move ahead. Because sometimes there were political issues, even threats at times: if this doesn't happen, we're abandoning the project" (regional stakeholder T1).

6.4 Elements of synthesis in the ownership of the community development approach

By examining how the approach was implemented in the communities, we can say that the four action strategies were developed according to a sequential and iterative logic over the three years of the pilot project. The first-line services teams essentially served as project managers and the action strategies targeted all levels of community stakeholders. Following an ascending logic, problems were identified locally and solutions were implemented to enable power to be redistributed. Nevertheless, we must recognize that each community is unique. Although the implementation of services was initiated in a logical sequence, after that, the projects in the different communities continually developed in response to their own situation, which required constant updating on the part of first-line teams.

In sum, the choice of approach was instrumental to implementing the project. The approach advocated is bottom-up (from bottom to top), and relies on the premise that communities and local stakeholders are best placed to decide on and implement solutions in the local context.

It also became possible to observe that two communities experienced more difficulty in implementing the strategies. For example, by the end of the third year of implementation in Community 2, the approach was still not well understood by either community stakeholders or the project team, forcing the community to take a step back in order to better understand and implement the strategies. As for Community 3, it proved difficult for the first-line team to develop and assume "leadership" of the collaborative process with the top-level of decision-makers because the existing hierarchical way of doing things inhibited communication.

It is within this context that the FNQLHSSC first-line services advisor was called upon to provide active support to the communities. However, this support was constrained by the geographical distance between the FNQLHSSC and the four communities. It was impossible for the advisor to respond to all the needs when difficulties sometimes occurred simultaneously.

> *"One challenge is geographic: the distance between the communities and the FNQLHSSC [...] sometimes you give your support to a community, but in doing so, other communities are forced to wait. And by the time you get to the other problem, a degree of discomfort has settled in and you didn't see it happen or you hear about it later. Regardless, this puts a limit on the effectiveness of community action, it seems to me" (regional stakeholder T1).*

Furthermore, the FNQLHSSC first-line services advisor proved invaluable by ensuring that the objectives and scope of the pilot project were understood by the existing decision-making bodies in the communities:

> *"The power of the FNQLHSSC is the power to influence things. Sometimes, there's not much we can do in relation to the structures already in place in the communities. This is an obstacle in the sense that we could not as effectively help the [name of the pilot project] as we would have liked. The structure is too imposing and we didn't have any power there [...] I tried to support the coordinator as much as possible so that he/she would stay, to give him/her whatever help he/she needed, but respecting the fact that he/she lived in that community and if I stirred the pot too much, the consequences would fall on*

> *him/her. I talked to the managers as often as possible to influence and advance the work" (regional stakeholder T1).*

Ultimately, the community development approach refers to a new practice to promote a reownership of the power of communities to act on the determinants that influence the well-being of youth and families. The ownership of the approach, the involvement and mobilization of the population, the mobilization and commitment of local stakeholders and intersectoral collaboration constitute an iterative process, which means that updating is necessary to continually ensure that the approach is integrated and being applied in the community. The principle of empowerment, in turn, must remain the underlying principle guiding the development of the inter-related action strategies that flow from the approach.

In summary, the integration of the community development approach through the action strategies and, by extension, the principle of empowerment has enabled:

- *strengthening of technical skills of* 1) persons in need through access to services, 2) members of the first-line team through access to training and 3) the entire community by adding expertise and improving the way local resources combine forces;
- *democratic participation* of the population on issues concerning access to forums to make decisions, take action and influence the direction of the first-line services they receive;
- *enhancing the community's self-esteem*, especially through the implementation of solutions that have helped keep children in the community and strengthened parenting skills among clients;
- *development of a more critical awareness* that led, by way of example, communities to position themselves and to adopt measures involving the whole community, and to work together in the fight against major social issues (e.g., adopting community resolutions against the sale of narcotics).

The analysis of the first-line social services implementation process and the ownership of the community development approach have made it possible to construct an accurate picture of the operations and activities that took place during the pilot project. It has also made it possible to identify influential factors and the benefits to each of the participating communities of the respective first-line services. These two key elements are addressed in the following chapter.

Chapter 7

Factors that influenced the implementation of first-line services and initial local benefits

The analysis of first-line social services implementation within the four participating communities has identified characteristics related to the implementation process and ownership of the community development approach. In seeking to deepen the interpretation of data collected and analyzed, a summary is presented to outline the factors that facilitated and constrained the implementation of the pilot project in the four communities.

As mentioned in the evaluations objectives section in the chapter on methodology in this report, the evaluation of the first-line services implementation looked at change in each of the participating communities over a given period (Bernoux, 2004: 20). The goals of the evaluation were to document and analyze the processes of the pilot project implementation. We were not looking to correlate outcomes and methods initially planned, nor to demonstrate the program's impacts, but rather to identify implementation processes crucial to the approach. Due to the time allocated for the process evaluation, it is not possible to demonstrate the long-term impacts of the program on structural elements—such as a decrease in the number of placements of First Nations children from the participating communities.

Although the study of potential impacts has not been the subject of this process evaluation, some initial benefits can be identified in connection with the implementation of new first-line services and the community development approach. The evaluation highlights organizational and community changes during the project based on what the communities consider as positive impacts for children and families.

It is important to emphasize that all possible local benefits have probably not been identified because their documentation was not an objective of the evaluation. Starting with the pre-implementation phase, the tripartite orientation committee was in agreement that the collection of data on the presence of local benefits was not part of the expectations related to the pilot project and its evaluation, mainly in consideration of the novelty of the project and the need to allow time for the communities to organize services.

Moreover, because of the deadlines imposed on the process evaluation, observations of local benefits were based solely on the results analyzed during the first year's access to first-line services phase, between May 2008 and April 2009. The benefits presented below are thus a reflection of an initial period of observation covering the very short term, and it is expected that there will be many more local benefits to come as promotion and prevention activities and further services for children and families in the participating communities come on line.

Generally speaking, the following observations can be made:

- Each community experienced favourable influences and constraints unique to their realities and their socio-economic, political and cultural dynamics;
- All stakeholders (local, external, and regional) involved in the pilot project had a significant influence since services began to be implemented in 2006;
- The factors of influence identified in the four communities especially reflect the importance of the quality of the first-line social services team, the time granted to develop ownership of the project and the completion of the implementation phases, organization, the support of community leadership and the involvement of members of the population;
- The implementation of first-line social services has created significant organizational and community change in the four communities.

Throughout this report, we have seen that conditions differed in each of the participating communities. In order to be able to clearly understand the experience of the implementation process in each community, the factors of influence and the local benefits will be presented separately for each of the communities.

7.1 Community 1: An implementation and access to services adapted to the community's cultural values and responding to the needs of the population

7.1.1 Factors influencing the implementation of services

Throughout the two years of implementation, the pilot project in Community 1 was developed around general services directed to the population as a whole and specific services to address issues related to addiction, parental neglect and social isolation. Given the centrality of the issue of children in this community, the project became a priority and, through acceptance of a community development perspective, a wider range of promotion, prevention and intervention services was implemented. Table 7.1 summarizes the factors that facilitated and constrained the implementation of the pilot project in Community 1.

Table 7.1 Summary of factors either facilitating or constraining the implementation of first-line social services (Community 1)

Community 1	
Facilitating factors	⇒ Community dynamics; ⇒ Quality of the first-line services team; ⇒ Support of local stakeholders and political leadership; ⇒ Quality of relationships established with the provincial system; ⇒ Presence of mechanisms for cooperation/collaboration.
Constraining factors	♦ Large number of programs executed, implemented or in the process of being implemented simultaneously; ♦ First-line services team members' closeness to and identification with the community; ♦ Poor quality of facilities and lack of space in the community; ♦ Generation gap between youth and elders; ♦ Improvised reactions to situations.

On the one hand, as shown in this summary table, five facilitating factors can be identified. In fact, it appears that the *social dynamics* of the community—imbued with mobilization, a tradition of mutual aid and community support during hard times and a desire on the part of many to cope, adapt and identify their needs—greatly contributed to the progressive implementation of first-line services. Moreover, well before the pilot project, local and external stakeholders were familiar with the community development approach. Local and regional cooperation/collaboration, the presence of a long-term community vision and proximity of the population to elected officials enabled the first-line services team to implement the action strategies previously set out in the action plan. Also, the interveners' credibility grew over time due to the *quality* of their work, which contributed to the esteem and support granted to them by the community. Finally, thanks to its diversity and complementarity—in terms of ethnicity, academic background, and close ties to the community—the team was able to offer a range of skills that facilitated the implementation of culturally appropriate services adapted to the local context.

Moreover, *the support of local and political leadership* greatly facilitated organizational empowerment within the community, and represents a powerful lever to facilitate implementation through concrete actions of support and collaboration.

Building *partnerships* with external stakeholders (such as the Youth Center) and the *quality of relationships* established with the provincial system enabled the first-line services team of Community 1 to avoid service shortfalls and duplication of services offered by other support services to children and families. Moreover, this fostered a greater sharing of expertise between all stakeholders within the community. In addition, the harmonization of local resources with those of the first-line services provided a continuum of services for children and families. The creation of a monitoring committee and *roundtables* also played an important role in implementing the pilot project.

On the other hand, five constraining factors are identified. First, the sustainability of long-term services is challenged by the existence of numerous programs available to the public. The *large number of programs* running, implemented or in the process of being implemented simultaneously in the community may also have had the effect of restricting access to the pool of human resources.

Within the first-line services team half of the stakeholders live in and come from the community. This *proximity* and *sense of community*, however, forced the ongoing efforts to prove themselves worthy of trust. In addition, the first-line services team, which proposes actions that are planned ahead of time and aim for consistency, must also take into account the pace of the community which is rooted in the principle of "*here and now*," and generates actions that are *reactive and situational*. It can often be challenging for non-Aboriginal interveners to adjust to the differences between the two cultures, while increasing the number of mobilization activities aimed at stakeholders and the population.

Moreover, *poor facilities* and *lack of space* within the community created privacy concerns that were amplified by the persistent low level of knowledge about first-line services among a portion of the population and a general mistrust of youth protection services. Finally, the existence of *generational conflict* has been expressed, and appears to be a factor that may have hindered the mobilization and commitment in the population.

In sum, although the constraining factors listed in the framework of implementing the pilot project in Community 1 are challenges to overcome, the facilitating factors have concretely helped the first-line services team to establish a set of services and local actions that are adapted to the culture of the community. In addition, the services established specifically address the needs expressed by the population. The team has achieved its objectives and is ready to increase its efforts and build on its achievements.

7.1.2 Benefits of the program in Community 1

The implementation of first-line services in Community 1 resulted in positive benefits in terms of local community dynamics. Despite the possibility of the existence of other benefits not documented in this evaluation, three direct and indirect effects can be observed.

1-The community's desire to improve the well-being of children and families

First-line services implementation in Community 1 was based on the desire of community members to have at their disposal adequate support for families and young people in difficulty in order to provide a foundation for a better future. The implementation of first-line services aimed specifically to prevent the further deterioration of the problems that lead to the placement of children. Before this project, the community had few services and these were limited to the development of parenting skills. With the project, parents have been able to learn skills that enable them to regain control of their situation and pride in themselves. Along the same lines, the adaptation of services to local cultural values has allowed community members to reconnect with a part of their culture. This acts as a protective element in solving problems, while maintaining and strengthening links with other communities.

2-The strengthening of cooperation and collaboration

First-line social services contributed to community development. Specifically, they served to create a space for dialogue to coordinate actions on issues concerning children, youth and families. This dialogue space helped to clarify the roles and responsibilities of local, regional and external stakeholders which enabled common goals to be achieved.

A number of mechanisms put in place have provided an opportunity to strengthen collaboration between local partners, while fostering the emergence of community initiatives such as the financing of the arena and the establishment of a community kitchen. In addition, various programs have been implemented to support parents in caring for their children, as well as an emergency program providing social services outside working hours. The establishment of co-intervention partnerships between community stakeholders has been observed in the group activities.

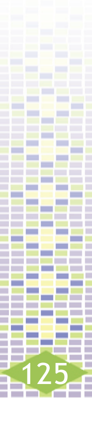
3-Increased involvement of the extended family

During their interviews, stakeholders made observations that enable us to conclude that in the effort to avoid placing children outside the community, the extended family is now much more involved than before. This would seem to be linked to the reduced number of cases taken in charge by youth protection.

> "We still need to work on the whole report culture, but despite that, a good spirit of collaboration was created with the Youth Center, to everyone's benefit. We all made an effort to see that when families are in need, the first services offered to them are the first-line services (local, T2, Community 1).

Several participants in group activities expressed their satisfaction and noted that their self-esteem had improved (such as the satisfaction experienced by a father who took advantage of the support offered by the accompaniment service to get his shopping done and who used his money for the welfare of his family).

Finally, the main local impacts identified within the community underline the importance of having adequate first-line social services that are responsive to the needs expressed by the population, but also the need for the population's involvement to guide and support the progress of the desired changes in order to develop empowerment within the community.



7.2 Community 2: Services to break the cycle of crises

7.2.1 Factors influencing the implementation of services

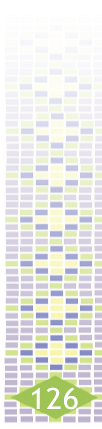
First-line services implementation in **Community 2** has not come easily. Indeed, the community context and other elements played a big role and it is important to highlight the critical factors that have acted either as a facilitator or as a constraint during the process. Table 7.2 summarizes them briefly.

Table 7.2 Summary of factors either facilitating or constraining the implementation of first-line social services (Community 2)

Community 2	
Facilitating factors	⇒ Links between the first-line services team and the community; ⇒ Community involvement; ⇒ First steps in the development of cooperation/collaboration; ⇒ Quality of the first-line services teams; ⇒ Relations with local partners.
Constraining factors	♦ Difficulty of hiring interveners and the absence of a coordinator; ♦ Lack of common strategy; ♦ Large volume of cases handled by youth protection; ♦ Reactive and situational actions; ♦ Problems related to the first-line services team's burnout and lack of experience.

On the one hand, there were five elements that had a facilitating effect. According to the statements made during the interviews, it appears that the *links* that bind the members of the first-line services team *with the community* made a difference. Being from the community and thus immediately recognized by their peers as someone you can trust, these resources were able to make the local population aware of the new services. However, first-line services in Community 2 suffered from high staff turnover and a total changeover of the implementation team. Burnout was one reason. The *stability of the first-line services team* during the access to services by the population phase helped to focus the team and ensure the launch of implementation activities. Thus, the population came to know about and ask for first-line services. In addition, *the involvement and mobilization of the population* in the pursuit of the common goal of reducing the placement rate of children outside the community helped establish the respite families service.

In addition, several stakeholders from various sectors of the community recognized the importance of working collaboratively and involving a variety of stakeholders. In this we can see the beginnings of the *development of cooperation/collaboration* and supportive *relationships* among *local partners*. Indeed, the support and recognition of the Youth Center for the efforts and goals of the first-line services team have greatly facilitated the harmonization of the services offered.



On the other hand, five constraining factors have in turn been identified. At the beginning of the implementation of the pilot project within Community 2, a major constraint was the *lack of a coordinator* and the *difficulty of hiring interveners*. Indeed, this step became a real challenge and it would seem that services were provided to the population prematurely. The lack of a coordinator also contributed to a delay in initiating the consultation processes between the various sectors. At the beginning of the process, the *lack of a common strategy* prevented the development of ongoing consultation and collaboration involving the local, regional and external stakeholders in order to implement prevention activities and activities promoting well-being. The first-line services team thereby found itself compelled to respond to repetitive emergencies. Focused on *reactive and situational interventions*, it proved difficult for the team to plan and develop a service offering consistent and appropriate short- and medium-term services. This aspect represents a serious challenge.

In addition to the *large volume of cases* handled by youth protection for the community, the first-line services team's *lack of professional experience* and its growing risk of *burnout* represented significant constraints. While it is true that the team's closeness to community stakeholders was instrumental in quickly generating support for the project that could be sustained over the long term, it also was a factor in the high degree of staff turnover, and therefore, has had negative impacts on access to services.

To conclude, in light of all the factors presented here, it may be argued that the pursuit of first-line social services in Community 2 depends on the stability of the team and its access to continuing education. Nevertheless, cooperation between local stakeholders to find common strategies to break the cycle of crises remains a challenge. However, it should be noted that the efforts made so far show a desire for change that will need further time to reach its full potential.

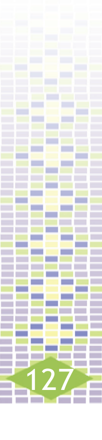
7.2.2 Benefits of the program in Community 2

Although one of the tools used during data collection— the logbook—wasn't used by the first-line services team, both periods of qualitative data gathering were able to substantiate local benefits. Despite the possibility of the existence of other benefits not documented in this evaluation, three direct and indirect effects can be observed.

1- Involvement of many families to provide alternatives to placing children outside the community

The action plan developed by the first-line services team recognized the virtual absence of host families within the community. The criteria for youth protection agreements do not correspond to the reality of the community and this service has had trouble creating links with the community. However, in the pilot project, the fact that the first-line services team was composed mainly of people from the community, combined with the development of a partnership with youth protection to establish an emergency (short duration) service, enabled the recruitment of a number of host families in Community 2:

> "*At first, communication with the Youth Center was poor. We worked hard to turn that around* (…)" (local stakeholder T2, Community 2).



In light of this experience, it was determined that many families felt challenged by the problem and wanted to be part of the solution. However, since there was a high-level of demand among community members, the few available resources began to burn out.

Despite the difficulties, the emergency service and family respite program contributed to a decline in the community's placement rate, and demonstrated the ability of community involvement to take on serious problems.

> *"I would say yes, it probably avoided some placements and postponed some others. The advantage of postponing a placement, even if it ends up as a placement, is that when parents come to our services, it's not so much as a reaction to another process, it's more like they see that their community is trying to give them a hand" (external stakeholder T1, Community 2)*

2- Small steps toward better local consultation and collaboration

Several people pointed out that before the pilot project, the lack of information and common action plans for promoting the well-being of youth and families was the rule of thumb in the community. The development of consultation and collaboration is a process that takes time and requires personal, professional, community and political involvement. In the case of this community, because this way of working together is new and the early forms were inherently unstable, a much longer period than was allocated by the pilot project was necessary. The first-line services team was aware of this difficulty from the beginning of the project and worked hand in hand with community leaders. Once these leaders came to understand the importance of working together, they increased their efforts and better results followed.

It is important to note that the lack of local consultation and collaboration is not due to a lack of good will, but more to a lack of experience in the field, a tendency to be constantly reacting to emergency situations and the lack of a common long-term strategic plan.

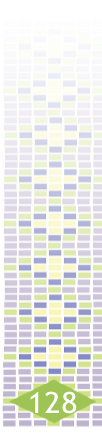
3- More openness and willingness to work with external resources

At the beginning of the implementation of the project, an adaptation period was necessary. Local dynamics were characterized by the centralization of power among political bodies, and there was a climate of mistrust of external resources. External stakeholders also mentioned that they found it difficult to work in partnership with the community. However, in connection with efforts made to develop greater collaboration, we must emphasize the increasing openness of the community vis-à-vis external resources.

The pilot project has thus contributed to the development of external links, particularly with regard to youth protection services and the FNQLHSSC:

> *"[As far as working together] I would say that over the year I went from darkness to light" (external stakeholder T1, Community 2).*

The experience of Community 2 shows that organizing and implementing first-line services provides a means to develop and implement mechanisms that were not necessarily present in the community at the time the project was started. In this community, there has been a significant increase in collaborative efforts in response to actions taken by the first-line services team. In addition, community empowerment can be largely demonstrated by the efforts made by the



community's families and their spirit of solidarity. These are significant benefits that can, over time, contribute to improving the welfare of children and families.

Finally, instability on various levels (political, community, well-being, etc.) jeopardizes the sustainability of these benefits. One possible way forward is that small steps, even if sometimes passing through periods of decline or stagnation, may in time make a difference and lead to an improved ability to act in the community.

7.3 Community 3: Challenges and conclusions drawn from the integration of first-line social services with an already existing system

7.3.1 Factors influencing the implementation of services

The implementation of the pilot project in Community 3 was especially distinguished by the impact of the contextual elements. Table 7.3 provides a summary of factors that significantly influenced the project implementation.

Table 7.3 Summary of factors either facilitating or constraining the implementation of first-line social services (Community 3)

Community 3	
Facilitating factors	⇒ Presence of qualified and skilled human resources in the community; ⇒ Recognition and willingness of management and teams to work collaboratively; ⇒ Formation of a multi-agency team; ⇒ Creation of intersectoral organizing committees and the holding of prevention and promotion activities; ⇒ Ability to work with a diverse range of external partners; ⇒ Voluntary involvement of members of the population in family activities.
Constraining factors	♦ Difficulty in integrating the team into pre-existing service structures; ♦ Bureaucratic and hierarchical organization that limited the ability of stakeholders to act; ♦ Comprehensive restructuring of social services; ♦ Work overload for team members; ♦ Difficulty in mobilizing the entire population.

Within Community 3, a *multi-agency team* including all child-youth-family services was formed with the goal of harmonizing the existing services. The creation of intersectoral organizing committees and the carrying out of prevention and promotion activities as part of occasional themed events also played a role in the development of the involvement and collaboration of various local and external stakeholders. Such partnerships greatly contributed to improving the ability to *work in collaboration* with a diverse range of external partners.

On the other hand, five elements constraining the implementation of first-line services can be identified. Despite the collaborative efforts and the involvement of all local and external stakeholders, *integrating* the first-line team into the existing structure did not always take place

as hoped. The *bureaucratic and hierarchical organization* of the community weakened the ability of stakeholders to act (examples include the exclusion of the first-line services team from the hiring process and the difficulty mobilizing stakeholders who occupied higher positions in their organization). In addition, the *comprehensive restructuring of social services*—which took place simultaneously with the implementation of the pilot project—took place with little involvement of the team leaders and stakeholders.

Moreover, the failure to replace the first-line team coordinator and the subsequent *increased workload* for the psychosocial services team leader negatively impacted on promoting the project and mobilizing internal stakeholders. The *active involvement of the population* in taking certain initiatives, such as community kitchens, represented an additional challenge for the first-line team.

In summary, for Community 3, it is apparent that the process of restructuring the social services being offered in the community is an element to monitor to ensure the sustainability of first-line social services.

7.3.2 Benefits of the program in Community 3

Throughout the project, the process evaluation has enabled us to document the actions that were undertaken and to identify changes that have taken place. Some psychosocial services were already available in Community 3, and following the implementation of the pilot project it is possible to identify certain changes in the perception of first-line services. Among others, five local benefits, which are as much on the community level as on the organizational level, can be found in Community 3.

1- Increased use of first-line psychosocial services by the population

When the action plan was completed, people raised the lack of trust in social services staff and the fact that these personnel were associated with the placement of children. People commented on the inconvenient location of psychosocial services and it was proposed that the name "social services" should be changed. As a result of the pilot project, the offices of the psychosocial services were relocated to the health centre. Thus, the first-line services team became closely tied to the Maison de la famille and one large service was created. Through various approaches, such as the promotion of social services by first-line interveners and their partners, the population acquired a better understanding of these services. Indeed, according to a local stakeholder, it seems that the first-line services have gained the confidence of the population during the past year:

> *"I know a lot of people. What I can tell you is that these reports where we decided not to send them to youth protection, but we decided to refer them to the first-line service [...] I can tell you that based on my experience [...] that since the first-line service was created, I have some reports that I close because I have some confidence in what's going to happen. And people actually end up with services, unlike the times when we closed the files and told them to go, even strongly recommended it, but people didn't go" (local stakeholder T2, Community 3).*

Although there is still work to be done to create a clear distinction between the first-line

social services and those of youth protection for the population and for some members of the organization, it is nevertheless possible to assert that this work is well underway and that it promotes the voluntary request for services.

2- Structuring the first-line social services

The first-line social services offered to the community were clearly structured during the implementation of the pilot project. In addition to providing a better framework for stakeholders, the pilot project enabled the development of new services:

> *"Before we had the project, the services were focused a lot more on intervention, putting out fires. We've been more able to focus on prevention and promotion and to offer group activities, which we had not been able to before" (local stakeholder T2, Community 3).*

As a result of the efforts to structure first-line services, there has been a better distribution of tasks and ability to implement a structured prevention plan:

> *«(...) It's no longer like 'we have to do something, it's Addictions Awareness Week' and then nothing else the rest of the year" (local stakeholder T2, Community 3).*

3- Harmonizing child-youth-family services

The project required that the various children, youth and family services work more collaboratively. Although some challenges still need to be dealt with by the teams sharing the Maison de la famille, in general, team meetings involving psychosocial services, mental health and First Nations Head Start (FNHS) have contributed to better coordination of records. This is an outstanding example of a community benefit directly related to the pilot project.

4- Co**mmunity initiatives**

During the first phase of the pilot project, the first-line services team conducted a dozen discussion groups with community members. Following these meetings, where several points concerning the improvement of social conditions were addressed, women who shared certain concerns agreed to meet again to organize a clothing bazaar. This group was maintained over time and their work led to the 2009 opening of a non-profit clothing bank. In addition, the same group of women got involved in the organization of an activity which encourages the more comfortable members of the community to provide a Christmas gift to a child living in poverty.

5- Raising the awareness of businesses to the realities of people in need

On several occasions, the private sector contributed to the financing of activities organized by the first-line services team, which represents a significant social benefit. Indeed, entrepreneurship is flourishing in this community and a greater sharing of financial resources could possibly make a difference in terms of social development but also in terms of community dynamics.

Finally, the benefits described here show that first-line service implementation in Community 3 is the result of efforts to harmonize the community's already existing social services structure. Furthermore, analysis shows that organizational and community empowerment has grown within the community.

7.4 Community 4: A progressive implementation of first-line social services in spite of significant challenges

7.4.1 Factors influencing the implementation of services

Despite facing problems that seriously held back the implementation of first-line services, the pilot project within Community 4 succeeded in mobilizing a large number of community stakeholders. Table 7.4 provides a summary of the factors that influenced the implementation of services.

Table 7.4 Summary of factors either facilitating or constraining the implementation of first-line social services (Community 4)

	Community 4
Facilitating factors	⇒ Involvement of the first-line services team; ⇒ Creation of mechanisms for mobilizing the population and creation of space promoting the involvement and mobilization of the population; ⇒ Creation of an advisory committee capable of stimulating collaborative action at the community level; ⇒ Development of a convergence of interest among local stakeholders.
Constraining factors	♦ "Pilot" status of the project; ♦ Staff turnover; ♦ Problems of access to and retention of trained human resources; ♦ Poor facilities and lack of space in the community; ♦ Working in silos and individualism within the community.

From the project's outset, organizing and implementing first-line services faced a number of challenges, particularly the lack of human resources. Certainly, the *involvement* of the project coordinator made a difference. Through his/her knowledge of the community and the use of various media for promotion (radio, newspaper, pamphlets, etc.), the progressive phased implementation of services within the community development perspective proved possible.

A *newly-created advisory committee* conducted promotional activities that helped move the community into taking actions by working together. In fact, through the establishment of a *decision-making space*, the implementation of first-line services was facilitated by the presence of decision-makers, including the band leader, who had an influence on the credibility accorded the project and the decision-making process. The frequent use of surveys of the population enabled the advisory committee and the first-line services team to better orient and validate their actions. Including stakeholders, heads of services and coordinators, this committee was an essential mechanism for consultation with the population because, when people feel involved, they are more motivated and commit themselves to a greater extent in organized activities. Indeed, all decisions taken by the advisory committee began with public consultation.

In this sense, the development of a *convergence of interests* on the part of local stakeholders—focused on the interests of children—led to a better mobilization of the population. Through working on a common vision and shared goals, it became possible to think about and develop appropriate services.

As mentioned before, the implementation took place under the shadow of a good number of challenges and constraints. One of them was the difficulty in establishing the credibility of the project in the community due to its *status as a "pilot" project*. This raised questions and contributed to partners' reluctance to get involved. This type of status has shown through past experiences to lead to ephemeral results or outcomes with few practical benefits for the community. Despite efforts to develop a convergence of interests of all stakeholders related to the project, *individualism within the community* and the *tendency towards working in silos* limited intersectoral work and forced the first-line team to be more proactive in promoting first-line social services.

Moreover, the *poor quality of the facilities* and the *lack of space* in the community constituted a challenge for stabilizing and administering the project. In addition, the *difficulty in finding and retaining trained human resources* in Community 4 slowed the pace of implementing services. Finally, the high rate of *staff turnover* in most sectors of the community severely limited the efforts to create collaborative relationships. Indeed, circumstances such as these require the roles, mandates and objectives of all partners and stakeholders—local, external and regional—to be constantly redefined. These factors had a constraining impact on the organization and implementation of first-line services.

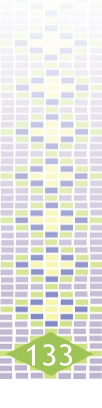
To sum up the experiences in Community 4, it is clear that the constraints that the first-line social services team were required to deal with had a considerable impact on the implementation process and access to services. Nevertheless, the commitment and mobilization of local stakeholders contributed to a growing sense of ownership of the community development approach, and an intensification of promotional activities paved the way for the development of preventive actions.

7.4.2 Benefits of the program in Community 4

An analysis of statements collected from participants in this evaluation highlights the positive effects of the community development approach developed on the basis of local dynamics. Despite the possibility of the existence of other benefits not documented in this evaluation, three direct and indirect effects can be observed.

1- Greater cooperation/collaboration

First, we address the issue of cooperation/collaboration and links between local stakeholders. In this regard, the stakeholders that were interviewed affirm that the advisory committee proved to be effective at bringing together key local stakeholders and coordinating actions in the community. In particular, the committee served to counter the old style of management within the community, which until recently was based on working in silos. The work of the committee therefore promoted greater collaboration between sectors. Moreover, collective decision-making enabled a number of comprehensive actions to be carried out in the community and social issues affecting the well-being of children and families to be addressed. It is apparent that the group's strength lies in the presence at the table of stakeholders with decision-making power that is capable of generating action.



2- Community empowerment

Secondly, it is clear that countering the magnitude of social problems associated with the sale of drugs and parental neglect requires a collective response focusing on networked actions. Indeed, the solutions associated with these social problems are beyond the responsibility of any one person or any social organization. That responsibility lies with the entire community and includes all its components: families, individuals, organizations and leaders.

Community 4 has distinguished itself through the collaborative nature of the actions taken in order to provide comprehensive solutions. A significant achievement was the agreement made with community radio to change the hours of bingo. Indeed, several years of pressure had been brought to bear on this problem, but unsuccessfully. The times at which bingo was played resulted in cases of parental neglect, as they coincided with meal time. If at first glance this action may be perceived as trivial, a second look will reveal its significance for children who can now rely on parents being available during meal hours. Such action is the result of a community being more aware and involved.

Other actions of this kind have emerged, including the adoption of protocols giving power to the Quebec Provincial Police to intervene in the community and the adoption of a curfew. Such interventions are the fruit of a "bottom up" style of decision making that provides an opportunity for people to express their needs and to propose solutions that can meet them.

3- An effort to create services that are culturally adapted

Finally, community cultural activities have, in turn, helped break the isolation of families and reach some of the more vulnerable clientele who are usually difficult to reach within the community. These activities include family healing camps, fishing and family days. The activities were an opportunity to strengthen ties and develop the skills of families.

> *"Community action began from there and the project plays an important role in getting these people together. Break the isolation" (local stakeholder T2, Community 4).*

In sum, despite the delays noted in first-line services implementation, the pilot project within Community 4 represented an opportunity to initiate a process of change and develop the community's capacity to act.

In conclusion, following the presentation of the key factors (facilitating and constraining) that influenced the project in each of the pilot communities, it is apparent that first-line service implementation was carried out according to the conditions and dynamics existing in each individual community and depended on the orientations and efforts of the population and all the stakeholders who were involved. The maintenance of community and organizational change in the four participating communities will require a constant effort on the part of all stakeholders and is subject to the influence of various contextual elements. An analysis of the key factors of influence can help identify what is essential in order to improve first-line social services and consolidate the initial benefits previously documented. The following section aims to complete the picture of the key factors influencing the implementation process and ownership of the pilot project and the community development approach.

7.5 Factors of influence among different groups of stakeholders involved in the pilot project

We have previously seen that the factors of influence varied from one community to another. Depending on their involvement in the project, the factors also varied from one stakeholder group to another. The analysis is performed based on the groups of stakeholders involved in the pilot project: local stakeholders (first-line services teams, community members, etc.), external stakeholders (Youth Centers, health centres, health and social services agencies, etc.) and regional stakeholders (tripartite orientation committee, FNQLHSSC).

7.5.1 The first-line social services teams

According to the process analysis of the services implementation characteristics and of the ownership of the community development approach, first-line services teams play the key role in planning, coordinating and providing access to services to members of their community. They have a direct influence on the process of implementation.

Several factors were identified in the experience of the four participating communities that exercise a favourable influence, mainly:

- Stability of the staff hired;
- Training in social intervention or experience as a natural caregiver;
- Credibility with the community and the community's awareness of the first-line services;
- Understanding the community development approach;
- Presence of support and power to act;
- Feeling of belonging and commitment to the project;
- Capacity of mobilization and leadership.

On the other hand, several limiting factors can be identified:

- Frequent staff turnover;
- Difficulties in recruiting and retaining staff;
- Lack of knowledge and a clear understanding of the difference between the three lines of social services (first-, second- and third-line);
- Lack of training (particularly in the field of social action);
- Lack of credibility;
- Lack of understanding of the approach;
- Lack of support and power to act.

The stability of first-line services teams would appear to be an indispensible factor essential for the implementation of services. Not only does it help to foster trust relationships with community members and users, but the team's credibility and the population's awareness of the team grow

proportionately to the team's stability. The academic training in social intervention of some team members complements the professional and life experiences of others and creates an environment conducive to the development of support services to the population. For example, the complementary expertise of the members of first-line teams facilitated the smooth running of the implementation process and the achievement of objectives. In this context, based on the realities and needs of communities, the alliance of Aboriginal and non-Aboriginal stakeholders working together for a common goal can be a winning strategy.

Moreover, it is easier to get people to understand and put in motion the community development approach when team members have had some time to become increasingly familiar with each other. This factor is intrinsically linked to the importance of the existence of a sense of belonging and commitment to the project on the part of the first-line services team. Moreover, teams that have distinguished themselves by their ability to mobilize and offer leadership were able to implement services that better met the needs expressed by members of the population and other local stakeholders.

In light of the activities that were organized, first-line services teams also benefit from focusing their efforts while taking into account the community's rhythm and the social and cultural characteristics of the community, since the consideration and integration of cultural values is expressly desired by the population.

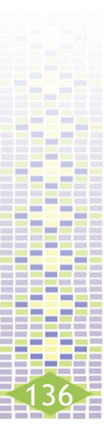
Finally, teams of frontline social services represent a key element, because they have a significant influence and impact in their preparation and planning throughout the process of service delivery and organization of promotional activities and prevention for families and youth in their communities.

7.5.2 The community: Its decision makers and its members

In basing itself on the community development approach, first-line service implementation required the implementation of various action strategies characterized by the mobilization and commitment of local and external stakeholders, intersectoral collaboration, the involvement and mobilization of the population, and ownership of the project in all its forms.

The members of the community and the local formal and informal partners have significant influence. From the four participating communities' experience, the following facilitating factors can be observed:

- The existence of bottom-up organizational management and policy-making;
- The support and credibility given by the community's political leaders;
- The creation or existence of multi-agency/intersectoral relationships;
- Community mobilization and the presence of informal social networks;
- Good networking among the local resources and agencies working in the community;
- The presence of entities of cooperation/collaboration between members of the population and service sectors in the community.



On the other hand, the following factors may represent a constraint in the implementation of first-line services:

- The existence of top-down organizational management, or the absence of a clearly defined management style;
- Lack of support from the community's political leaders;
- Working in silos;
- Lack of community and local mobilization;
- The remoteness of the community in relation to major centres (for recruitment and retention of personnel to work with the first-line services);
- The presence of projects that are being implemented at the same time as first-line services and compete for scarce human resources.

Community conditions and dynamics have an important influence on first-line service implementation. In fact, with regard to the community—whose members play a key role in mobilizing the commitment and desire to change as well as participation—its management and organizational policy influences the level of involvement of the population. In fact, by focusing on a bottom-up as opposed to top-down management style, members of the community are able to contribute to their own development and can speak out on issues that concern them. This way of working is supported by the community development approach. Indeed, support from political leaders for first-line services implementation has proved to be a significant influencing factor in establishing the credibility of the project in the communities.

In addition to community mobilization and the presence of informal social networks, the establishment of good multi-agency/intersectoral relationships is an element that facilitates the implementation of services. Indeed, the existence of informal leaders and their increased participation through various consultation mechanisms and entities (radio, newspaper, advisory committees, roundtables, etc.), played a positive role. The relationships between the various sectors and service networks within the communities encouraged local resources to combine and rationalize their efforts. Thus, through on-going communication between the various local stakeholders, a common vision and set of objectives were able to be identified and met. Building partnerships is a factor of considerable influence.

Working *in silos* and individualism within the community are, in turn, constraints or hindrances to implementation. Under such situations, mobilizing the population and local stakeholders is often difficult. It's possible to form working groups but if they work without consulting and collaborating there is the risk that the same services will be supplied by different groups—or that none will—if all sectors respond the same way to social issues.

Finally, the question of the role of culture and the integration of its aspects in the implementation of first-line care is mainly dependent on the social conditions and dynamics of each community. Upon analysis, the process of cultural adaptation may represent an important element in the success of first-line service implementation. The cultural diversity, collaboration and involvement of all stakeholders involved in the implementation of first-line services are factors that exercise favourable influence and that require a spirit of openness and on-going communication.

7.5.3 Regional organizations from the health and social services system (outside the community)

The support of regional organizations from the health and social services system based outside the community but who provide services to community services was solicited by the first-line services teams. Among others, these were mainly health and social services centres (CSSS), health and social services agencies, and Youth Centers.

In the pilot project, the community development approach promotes the involvement and commitment of all parties providing or receiving child and family services to ensure effective collaboration leading to positive and targeted results in the communities. The exchange of information and expertise is one favourable factor for success.

The positive influence of the following additional factors can also be noted:

- The quality of relationships established over several years with regional organizations;
- Regional organizations' willingness to support communities through providing access to training and exchange of expertise with the first-line services teams.

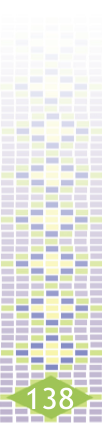
On the other hand, other factors may constrain the implementation of first-line services, such as:

- The existence or persistence of a negative perception of the capacities of other services, including of the expertise of the first-line services team;
- Issues related to provincial and federal jurisdictions that make it difficult for the health and social services system to lend resources to support the efforts of the communities.

In sum, in terms of regional health and social services organizations, it appears that the quality of their relationships with the community has an important influence on the development of first-line social services. Indeed, when the provincial system has been willing to share its expertise and provide access to training and the community has been receptive, establishing channels for communication and information exchange has been possible. On the other hand, negative perceptions about the expertise of the first-line services team have generally hindered the sharing of knowledge needed to successfully implement the services. As well, the existence of issues related to provincial and federal jurisdiction has made supporting the communities through the loan of resources difficult. Finally, taking into account the factors of influence outlined above could have a significant impact on the development of services adapted to the needs of the communities.

7.5.4 The tripartite orientation committee

The tripartite orientation committee played a key role in the planning and organizing stages of the pilot project before its implementation in the four selected communities. The framework for the implementation of the project was thus a partnership between federal, provincial and regional levels. Throughout the first-line services implementation, the tripartite orientation committee functioned through consultation and constant communication. Moreover, the committee had a direct and indirect influence on the implementation process.



Several factors contributed to the success of the implementation of services, including:

- The existence of a framework of equal partnership and decision making by consensus;
- The flexible attitude of the committee's members and partners demonstrated by an ability to reconsider its decisions, particularly in terms of the schedule of implementation phases;
- The quality of relationships between members of the committee;
- Transparency in communication between members.

On the other hand, constraining factors can be noted:

- The establishment of tight deadlines;
- The mobilization of committee members in activities related to project monitoring.

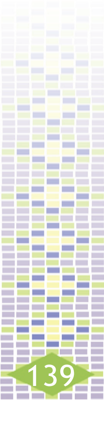
As a regional player, the tripartite orientation committee was responsible for ensuring the smooth running of the project in the four communities and for making its expertise available. The committee established an equal partnership structure where decisions were made by consensus. With a flexible attitude, transparency and good working relationships among its members, the committee demonstrated the ability to review its decisions in order to adjust to the needs expressed by the communities. These factors impacted positively on all steps taken during the implementation of services.

However, it turned out that the establishment of unrealistic deadlines actually represented a major constraint since due to the innovative nature of the project, the development of empowerment as well as an understanding of and ownership of the action strategies and the community development approach took more time than anticipated. In addition, key challenges within each community, such as frequent staff turnover, difficulty in retaining professional resources and unexpected social crises or emergencies have also had a substantial negative impact on planning, implementing and providing access to services.

Moreover, the same members of the tripartite orientation committee were asked to monitor the project's financial sustainability, ensure access to the new approach and to organize the implementation of the project in all communities in Quebec. So the committee's efforts were spread across a number of projects which, therefore, had an impact on the monitoring and guidance that could be provided.

7.5.5 The FNQLHSSC

The FNQLHSSC assumed an important role in the first-line services implementation within the communities. Indeed, the FNQLHSSC managed, structured and coordinated the pilot project. It provided participatory coordination of and leadership for the ownership of the community development approach and activities organized within the communities. The FNQLHSSC was active in all phases of project implementation, and provided support to the communities in particular through the actions of the first-line social services advisor and youth protection. In fact, several factors favouring the implementation of services can be identified:



- Playing a role as a conduit of information at all levels (local and regional);
- Providing support to resolve problems and develop skills;
- The presence and quality of links created with the communities;
- Establishing a relationship of trust with the communities.

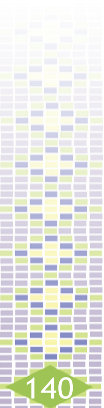
On the other hand, constraining factors include:

- The geographic distance between the communities and the FNQLHSSC;
- Insufficient time provided for the creation of trust;
- The role and mandate of the FNQLHSSC is sometimes unclear to some communities.

Finally, establishing a relationship of trust with the communities was a key factor, and the first-line social services advisor represented a channel for information to all levels of the services implementation. In addition, support to resolve the various difficulties encountered over the course of the project was a significant factor. The presence and quality of previously established links between the communities and the FNQLHSSC also played an important role.

However, the distance between the communities and the FNQLHSSC headquarters was at times a constraining factor in that it was not always easy to provide support as quickly as desired. In addition, the first-line social services advisor had to adapt his/her interventions according to the needs of the communities, which proved to be a challenge due to the different needs expressed by the four communities.

In conclusion, the influences that played a facilitating or more constraining role over the processes of implementation and ownership of the community development approach are key elements to consider in relation to the possible deployment of first-line services on a large scale. The general conclusion that follows is a summary of the observations developed throughout this report and presents the main impacts and lessons learned from the process evaluation.



Conclusion

The implementation of the first-line social services pilot project in four First Nations communities was a challenge because of its novelty in terms of the community development approach and the lack of an earlier model on which to rely. The results presented in this process evaluation clearly demonstrate that the process of ownership of the approach is dynamic and continually changing. Indeed, the dynamics and the stakeholders involved have evolved in the unique contexts and different realities of each community.

The full range of implementation activities in each community has been presented throughout this document, and conclusions and general lessons related to the main phases of the implementation of first-line social services can be drawn.

8.1 General assessment

The overall objective of this process evaluation was to document the implementation of first-line services in the four pilot project communities taking into account each community's actual situation. Four specific objectives were chosen: 1) establish a profile of the communities at the beginning of the project, 2) study the implementation process of first-line services for children and families, 3) review the ownership process regarding the community development approach principle and action strategies, and 4) highlight the lessons learned from the pilot project that will be useful for deploying first-line social services to all First Nations communities of Quebec (with the exception of the convention communities).

The first-line services pilot project relied on the community development approach, a bottom-up approach where the participation of all stakeholders involved in and around a community is put to good use. Under this project, four action strategies guided by the principle of empowerment were identified: 1) the mobilization and commitment of local and external stakeholders, 2) the involvement and mobilization of the population, 3) intersectoral cooperation, and 4) the ownership of the project. To closely adhere to this approach, the evaluation's methodological choices were oriented towards a participatory approach. Along these lines, the views of all stakeholders involved in the pilot project were collected, using a variety of collection tools.

The information that was collected was instrumental in analyzing the implementation process of first-line social services and ownership of the community development approach. This analysis covered a period between September 2006 and March 2009 and included the five phases of the pilot project implementation, namely: pre-implementation, action planning, implementation of services, access to services and services review. This analysis revealed that the course and pace of implementation were specific to each community and that the implementation was carried out according to the realities, dynamics and ways of doing things specific to each community. The services implemented by and in the communities focused on three main issues: addictions, parental empowerment and community and cultural cohesion. In addition, analysis of the implementation process has demonstrated that various factors have impacted on the pace of services implementation, such as, for example, crisis situations (social emergencies), difficulties in hiring and retaining staff, and the presence of organizational challenges within the communities.

In terms of the satisfaction of the users of the newly introduced services, information obtained from respondents to the satisfaction questionnaire indicated that the first-line services that were offered meet the needs expressed by the population. Regarding the elements most appreciated by users, the social skills demonstrated by stakeholders, the type of services offered and their quality, these have mostly been identified. On the other hand, according to the users that were surveyed, certain elements need to be improved, including: facilities, confidentiality, hours in which services are offered and the duration of interventions. There was also mention of the desire that services adhere to the values and ways of doing things in the community.

The review of the ownership process of the community development approach revealed that the appropriation of power by communities enables them to act on the determinants that influence the well-being of youth and families. Similarly, appropriation of the four action strategies have also proven to be major steps in the implementation process, and the principle of empowerment represented the unifying element that enabled this. Moreover, this evaluation has led to the observation that continuous actualization of the action strategies was needed to ensure that the approach stayed integrated and relevant to the communities.

The analysis of the processes of first-line services implementation and ownership of the community development approach has identified the key facilitating and constraining factors that lead to different groups of influential stakeholders involved in the pilot project (see chapter 7). Although the socio-economic dynamics and realities of each of the four participating communities made the implementation and ownership specific to each local environment, it appears that all stakeholders (local, external, regional) had significant influence on all stages of the pilot project. This outcome is an example of the idea that all actions taken within this pilot project are interrelated, and demonstrates the importance of openness to dialogue, involvement, commitment, communication and collaboration between stakeholders at all levels.

The following section discusses the lessons that were learned through the evaluation that can help guide any future approach to project development on a larger scale.

8.2 Lessons learned from the first-line social services implementation

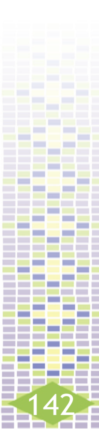
As a result of the observations made during the course of this evaluation, it is apparent that certain courses of action better support the unique process of development that takes place in each community. In fact, nine important lessons were learned during this experience.

⇒ **Make sure the communities are given enough time**

The time given to each phase of implementation must take into account the magnitude of the tasks to be accomplished, the pace of the community as well as the time needed to implement the approach. In this regard, the tripartite orientation committee was able to maintain enough flexibility to adjust certain deadlines when necessary, thus taking into account the specific dynamics of individual communities as the project unfolded.

⇒ **Consolidate the understanding of the community development approach**

The degree of understanding of the approach and the three lines of service (first, second and third), considerably affects the actions that are carried out. Marked differences were found



within the teams in this regard. Implementation is more straight-forward when a degree of mutual understanding of the project and its approach is developed among all levels of stakeholders. In contrast, when this understanding is not shared, the way services are implemented begins to deviate from the objectives of the pilot project. In the same vein, it is important to raise awareness among the population of the community development approach. The evaluation also revealed that the time allowed for the implementation teams to assimilate their training was too short, negatively impacting on the team's ability to transfer their knowledge.

⇒ **The composition of the first-line services team is important**

The first-line services team is the cornerstone of the project. The preservation of the team's human resources is essential to avoid burnout. When the team's abilities and profile are consistent with the approach, they become factors that help to promote the implementation of the project. Among the necessary skills, the ability to exercise leadership to create partnership structures and the mobilization of the population is essential. There is also the team's credibility with the community, directly related to the credibility given to the services themselves. On the other hand, the presence of one or more deficiencies at this level leads to considerable difficulties in implementing the project.

⇒ **Promote the project's credibility**

The credibility given to the project is of fundamental importance. Communities that have lost hope that living conditions can be improved are reluctant to commit to the project. This aspect can be observed by a hesitancy to get into action and to properly integrate the project with local resources, because the project is considered to be a transient phenomenon. In this sense, the support of political and decision-making authorities such as the band council becomes a positive factor contributing to the success of the implementation, because these authorities are capable of seeing that the project is given its proper importance, in other words, that people believe in it and get involved.

⇒ **Take the community's organizational and policy-making structures into account**

How the community development approach is implemented depends on the existing management and policy-making structures through which a community is governed. When this mode is predominantly top-down, local decision makers tend to set the project's broad guidelines, leaving little room for those involved at the base of the project to express themselves. On the other hand, when the local administration is closer to the bottom-up approach, there already exist mechanisms for the redistribution of power and spaces for collective decision making that are needed so that the implementation of services better reflects the needs of the population. It is important that teams have some decision-making leeway in order to carry out implementation projects (for budget management and participation in the hiring of staff, for example) and develop their skills. Moreover, it is necessary to ensure that all external and regional stakeholders have acquired a good knowledge of how the community functions in order to be able to choose the right time to launch the implementation of such a project.

⇒ **Continue the regional support provided by the FNQLHSSC**

The support offered by the FNQLHSSC first-line social services advisor was necessary to resolve problems that hindered the smooth functioning of some of the projects. Moreover, the creation of a forum for first-line teams was essential to develop trust and break the isolation (regional committee). This medium of exchange increased the opportunities for finding common solutions to the problems they faced.

⇒ **Promote the development of intersectoral collaboration**

The development of intersectoral collaboration depends mainly on the quality of the relationship between first-line teams and their partners, but also between the partners themselves. This aspect proved to be indispensible for networking during the project implementation, because the resulting consultation and cooperation can be supportive of the first-line teams in their actions and approaches. In communities where there is a tendency towards individualism, working in silos and conflicts between stakeholders, the establishment of a collaborative effort has proved more difficult.

⇒ **Ensure the quality of available facilities**

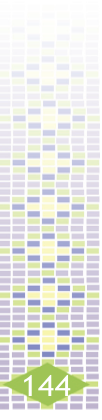
For optimum performance, it is important that first-line services teams have adequate and properly-equipped physical space and access to tools and intervention protocols. Access to material and human resources in sufficient quantity is a constraint for many communities. Often, the facilities available in the communities do not offer enough space for the team to function adequately. This is doubly problematic in that the funding formula for first-line care provides no budget to address this.

⇒ **Promote access to local support**

Access to local expertise and support can be a challenge. Professional resources in some communities are inadequate and therefore unable to offer support, such as providing coaching to first-line services teams who need help. Another factor was that the training offered by the FNQLHSSC during the first two phases of the project was newly developed and therefore in flux. Some needs were identified, enabling solutions to be proposed for the third phase. However, there are diverse needs and so many of them that they cannot be met by the training provided nor by the type of support that the FNQLHSSC first-line services advisor can offer.

Finally, it is essential to ensure the sustainability of training provided to first-line teams. In short, in order to get new projects off the ground and to ensure local implementation by and with communities, a number of challenges must be faced by involved stakeholders in their initial planning:

- Develop the full potential of community innovation and collective action using local and external resources optimally;
- Overcome the unique challenges of dealing with the consequences for sustainable development and promoting sustainable living environments;



- Support the coordination of multiple local and regional stakeholders to ensure their cohesion and that their actions have an impact;
- Provide the support of the FNQLHSSC first-line services advisor to communities in their priority needs while assuming a democratic style of leadership to boost community development.

Finally, in light of these challenges, it is also important to 1) ensure that deadlines and expectations are set and agreed to, and 2) to take into account the community's calendar and rhythm.

8.3 Some observations

One of the positive outcomes of the implementation of first-line social services in the four participating First Nations communities has been the growth that can be observed in practices that are based more on partnership and prevention. These services have been established to meet a serious challenge: the creation of a gateway to preventive and psychosocial services that also reflects the community's cultural approach with the aim of generating, over the long-term, lower placement rates of First Nations children by the youth protection system.

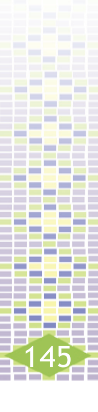
Research shows an overrepresentation of First Nations youth in youth protective services, with twice as many reports likely to be substantiated as for non-Aboriginal children (Trocmé, Knocke and Blackstock, 2004). According to data from the Youth Centers of the four communities participating in the pilot project, for the years 2007-2008 and 2008-2009, there was an increase in the number of reports for three of the four communities (ACJQ, 2009[22], see Appendix 24[23]). Yet, despite the introduction of first-line social services, the continued increase in reporting rates was predictable.

Indeed, after barely two years of implementation, the first-line services of the four pilot project communities are far from reaching optimal capabilities and services provided to the population. The growth rate of reports received can nevertheless be seen as a sign of increased awareness in communities whose members, more aware of the importance of prevention, have become more involved in identifying children in need. On the other hand, some stakeholders emphasized the importance of increasing public awareness to make first-line services the gateway of choice for cases of children in difficulty and thus curb the "culture of report" that may exist within a community. As a local community stakeholder said: "We still have to work on the culture of reports" (local stakeholder T2, Community 1).

Moreover, according to the results from the Youth Center reports for 2007-2008 and 2008-2009, a decline in retention rates was observed in two of the four participating communities (ACJQ, 2009). While studying the impact of the first-line social services implementation was not an objective of this evaluation, we might suggest that the implementation of activities aimed at developing parenting skills may have played a role in the lower retention rates. For example, as a local stakeholder points out, the organization of an accompaniment service for the purchase of foodstuffs at the time of the arrival of income has enabled individuals to develop their parental responsibility:

[22] Data from the internal document data *Aboriginal Results: Specific Bands* (June 2009), for youth centers in Saguenay/Lac St-Jean, Abitibi/Témiscamingue, Côte-Nord. Prepared by the Association of Youth Centers of Quebec.

[23] As additional information, summary tables presenting the data in the four participating communities are appended.



> *"In my opinion, as [head of DYP] had said, there are certainly reports that have not been retained or were not made because parents have taken steps to avoid this. When you have young families who are in town to shop returning with food for two, three weeks, a month, well previously, there were many reports because of this. And now, we have fewer that are related to the lack of food"* (local stakeholder T2, Community 1).

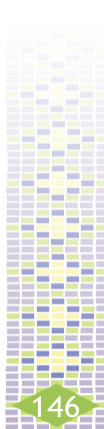
This example shows the emergence of solutions that should be documented and thoroughly studied. With respect to the types of placement resources generally recommended, placement in foster care—usually located outside of communities—by the Youth Centers, is the most common practice. Indeed, for all placements made over the last two years in the four communities, foster care was used in 50% to 90% of the cases (ACJQ, 2009). The practice of "entrusting to a third party," that is to say to a member of the extended family or a volunteer family from the community, is less common. However, the evaluation of the implementation process of first-line social services has revealed the emergence of significant new resources within the communities to keep children in their community and create more placement resources available for families and children in need, including through respite families. As a local stakeholder pointed out:

> *"Obviously, we are entrusting a lot to the community. I gave you a sheet of statistics yesterday. There are a lot of children who are entrusted to the community. I'm developing my network of foster families in the community"* (local stakeholder T2, Community 2).

On the other hand, statistics show that the grounds leading to the application of measures to protect children in the four communities participating in the pilot project for 2008-2009 were: 1) the risk of neglect and neglect (75% of cases for which services were rendered), 2) the risk of abuse and sexual, physical and psychological abuse (15% of cases), 3) behavioural problems (6% of cases), and finally, 4) abandonment (3% of cases).

Specifically, between 2007-2008 and 2008-2009, the proportion of services rendered on the basis of "risk of neglect" increased from 49% to 55% (while for "neglect" the proportion decreased significantly from 28% to 19% (ACJQ, 2009). One possible explanation is that such a decline could reflect the development of a preventive reflex in these communities. Although such observations cannot in any event be generalized, this hypothesis deserves further study.

Moreover, according to data from the Youth Centers in the four communities participating in the pilot project, it appears that recourse to the legal system was the most common practice between 2007 and 2009. In fact, this outcome represents 63% to 96% of retained files for the year 2008-2009 (ACJQ, 2009). However, it is important to take into consideration that in two of the four communities there was a slight increase in the use of voluntary measures from 21.8% to 23.1% and from 0 to 3.7% between 2007-2008 and 2008-2009 (ACJQ, 2009). Reliance on voluntary measures means that voluntary measures and agreements are made jointly between the direction of youth protection and parents without going to court, which, among other things, demonstrates an increased commitment to work together and to take steps to correct the situation for the welfare of the child. It became evident that with the implementation of first-line social services, efforts were initiated to develop or improve intersectoral collaboration and coordination between the various stakeholders working with youth protection services and with the community's families.



We could anticipate the further development of positive outcomes through the continuation of such efforts, which could lead in the long term to a significant decrease in child placements.

It would be premature after only two years of first-line social services implementation to expect there to have been a significant impact on the care of children by the youth protection system. In fact, although one of the long term objectives of the implementation of first-line social services is to decrease the rate of reporting and placement of Quebec First Nations children, a review of the positive impacts and tangible benefits would require a longer period of access to services and the monitoring of the project over a longer period of time. Recent data from the Youth Centers mentioned above provide summary information on the situation of First Nations children and youth in the youth protection system. The challenges represented by these figures and those cited as part of this process evaluation demonstrate the importance of continued efforts in the development and improvement of first-line social services to ensure the well-being and healthy lifestyles of the families, youth and children of the First Nations of Quebec.

8.4 The impacts of the evaluation

Like all research, the evaluation conducted under the framework of the first-line social services pilot project has its limits. This evaluation was primarily qualitative research focused on a limited sample. This methodological choice does not enable the results to be generalized across the province and does not permit the comparison of results between the different communities. However, this choice reflects the need to take into consideration the heterogeneous nature and unique contexts and dynamics of each participating community.

Moreover, some interesting aspects could be measured in a different way. Indeed, it became clear during the analysis of user satisfaction with first-line services that the questions on "the cultural adaptation of services" were too imprecise to lead to an understanding of how the services met the expectations, values and traditions of users. In fact, it would be an interesting approach to identify and measure characteristics of how cultural aspects related to community skills and know-how are included or incorporated in the delivery and organization of services. Questions such as these would go beyond, for example, an analysis of the cultural identity of speakers or preferences related to the language used for the delivery of services. It might also be interesting to analyze the cultural approach and the consciously-chosen cultural elements incorporated in the implementation of new services using a community development approach.

Despite these limitations, the evaluation of the first-line services pilot project implementation has had significant positive impacts. These aspects are presented in the following sections.

8.4.1 Review the actions undertaken and support the pilot project's orientations

The evaluation of the results of the two periods of data collection, which took place between May and July 2008 and from May to December 2008, enabled the FNQLHSSC, its partners and the first-line services implementation teams to make adjustments during the later phases of the pilot project. Indeed, during the data collection periods, the actions that had already been taken and those scheduled to be taken in the future were reviewed, especially during the drafting and implementation of community action plans. In addition, the observations generated by the evaluation's collection of data indirectly supported the FNQLHSSC first-line social services advisor to better orient the pilot project in terms of the training offered, to influence the objectives of

the action plans (portrait) and finally, to offer, whenever possible, supervision and monitoring tailored to community needs.

8.4.2 Develop local capacity in the participating communities

The evaluation has contributed to the development of local capacity within the implementation teams. For example, the development of useful tools to help the daily work of the first-line services teams (record keeping, logbooks), in collaboration with them, had multiple effects. Indeed, the teams incorporated the tools much more quickly and had the opportunity to make improvements over time and according to their needs. The availability and technical support of the FNQLHSSC's research department was appreciated by the communities' first-line services teams. In addition, the data collection periods illustrated the importance of documenting the activities performed by the implementation teams and of recording the number of participants, which was able to give statistical support to the expressed needs in communities and for their request for continued financing of first-line social services.

8.4.3 Construct a general and detailed portrait supported by a wide range of data

The use of a wide variety of tools for data collection, which yielded critical information about all groups of stakeholders involved in the pilot project, has contributed greatly to developing a thorough and accurate descriptive analysis. This methodological approach enriched the evaluation that could be carried out based on a general and detailed understanding of the implementation process and ownership of the community development approach. Monitoring the progress of the pilot project carried out by regional stakeholders benefited from the descriptive analysis.

8.4.4 Implement a participatory approach

Finally, one of the greatest strengths of this evaluation has probably been its participatory approach. Indeed, the process evaluation involved a wide variety of stakeholders, including members of the tripartite orientation committee, the research working group, the FNQLHSSC social services team and the local first-line services implementation teams. This participatory approach joins together the action strategies advocated by the community development approach and a partnership approach, particularly through the notions of commitment, involvement, cooperation/collaboration and ownership.

8.5 Final conclusions

Overall, the process evaluation of the first-line social services implementation in the four First Nations communities has met its objectives. The establishment of first-line services was documented through the creation of community portraits and a review of the process of ownership of the principle of empowerment and the action strategies of the community development approach. The analysis of the first-line social services implementation process for children and families also took into account the various systems implemented in each community and allowed us to draw the lessons outlined above.

We know that the establishment of first-line services in First Nations communities based on a community development approach is a new model. The greatest contribution of the evaluation will probably have been to collate the results needed for a deeper understanding and systematic monitoring of the process as it goes forward.

For the benefit of the communities, this process evaluation documents the beginning of a process of significant change committed to improving the well-being of the population and the adoption of healthy lifestyles. It is reasonable to believe that the short-term benefits presented in this process evaluation may be the result of factors outside the scope of the pilot project. Yet the fact that some initial benefits can be demonstrated illustrates the importance of a documentation effort that has proven useful for all local, regional and external stakeholders involved in the implementation of services.

Finally, the evaluation of the implementation should be continued. Further study could undertake an analysis providing an overview of results and local benefits directly related to the development of first-line social services. In the long term, the results of such an ongoing evaluation represent a significant tool for the planning, implementation and review of actions for positive, sustainable and effective change. The pilot project proved to be a program of services that brought about direct and indirect benefits to the communities involved. The deployment of such services on a larger scale and the optimal development of their capabilities based on an inclusive approach to community development will surely have positive consequences leading to healthier lifestyles and the improved well-being of the children and families of Quebec First Nations.

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APPENDICES

APPENDIX 1 Interview guide for the implementation phases 1 and 2: External stakeholders

1) How would you describe the role of your organization in this project?

2) According to you, before the project was undertaken in May 2007:

   1.1) What were the main problems affecting youth and families in this community?
   1.2) What were the strengths and weaknesses of this community?
   1.3) How were the dynamics between the community members and stakeholders?
   1.4) How were your relations with the internal stakeholders of this community?
   1.5) What do you think of the action plan produced by the first-line team of your community? Does it reflect well this community's reality?

3) Did someone tell you about the project approach?

4) What did you find important in this approach?

5) How would you qualify your involvement in this project in order for this community to reach the objectives it had set out in the action plan?

6) Tell me about your concertation with other sectors in the project:

   a) Did you implement specific agreements? If so, which ones?
   b) What are the work objectives you set yourself with this community?
   c) How is the communication between you?

7) Based on the services that the first-line team wishes to implement in this community:

   a) According to you, what results can be expected by the end of the project (March 2009)?
   b) According to you, how should first-line services be culturally adapted in order to meet the needs of the users?
   c) According to you, what are the main obstacles, challenges that you foresee for the project's future?
   d) According to you, on what strengths of this community will you be able to rely in the future to carry out this project?

APPENDIX 2 Interview guide for the implementation phases 1 and 2: Advisory Committees

1) When was your advisory committee created?

2) How were you approached to get involved in the committee?

3) How would you describe the role of your committee?

4) Tell me about your meetings, how does it go?

5) According to you, before the project was undertaken in May 2007:
   1.1) What were the main problems affecting youth and families in this community?
   1.2) What were the strengths and weaknesses of this community?
   1.3) How were the relations between the members of your community?
   1.4) How were your relations with assistance services: health and social services?
   1.5) What do you think of the action plan produced by the first-line team of your community? Does it reflect well this community's reality?

6) Did someone tell you about the project approach?

7) What did you find important in this approach?

8) As a committee how do you make this approach a reality in your community?

9) Based on the services that the first-line team wishes to implement in this community:

   a. According to you, what results can be expected by the end of the project (March 2009)?
   b. According to you, how should first-line services be culturally adapted in order to meet the needs of the users?
   c. According to you, what are the main obstacles, challenges that you foresee for the project's future?
   d. According to you, on what strengths of this community will you be able to rely in the future to carry out this project?

APPENDIX 3 Interview guide for the implementation phase 4: Local and external stakeholders

It has been almost two years now since the first-line services pilot project has been implemented in the community of *[name of the community]*. The goal of this meeting is to get your point of view on the implementation of first-line services that can now be accessed since May 2008. Your opinion is valuable since you collaborate with these services and you have a good knowledge of the project's evolution.

I would like to remind you that everything you will say to me during this meeting will remain confidential. Regarding this point, I would like to take the time to read the consent form with you (*read the form and ask if the person has questions*).

This interview is composed of five questions and sub-questions. When you answer, please think of the period between May 2008 and now, i.e. since the time first-line services have been available to the population in the community.

Do you have any questions before we start?

Start the questions by: *"Since May 2008"*…

1) What has been your role (as an organization) in this project?

2) How would you qualify your involvement[24] in this project in order for [*name of this community*] to reach the objectives it had set out in the action plan?

3) Tell me about intersectoral collaboration[25] with the first-line team?

   a) According to you, in what circumstances and how frequently did you work with the first-line team?
   b) According to you, what were your work objectives? To what degree do you feel you have met them? Give me some examples.
   c) How would you qualify your work relations with the implementation team?
   d) Did you implement specific agreements? If so, please explain.
   e) Are you satisfied with the concertation work achieved? Please explain.
   f) According to you, what have been your concertation main outcomes for the community or for the youth and the families?
   g) According to you, what have been the main difficulties encountered?
   h) According to you, what have been the main facilitating factors?
   i) According to you, what challenges do you foresee regarding your partnership in this project for 2009/2010?

[24] *Mobilization and involvement* of local stakeholders translates into the presence of persons, perceived as potential change levers, who in a shared goal and planned action strategies commit to mobilizing their resources and energies to meet the objectives a community set out.

[25] *Intersectoral concertation* is involved in actions that aim to transform social situations as a whole as well as through the reinforcement of the community's "leadership". It is possible through functional exchange mechanisms between the stakeholders, in order to establish a logical action process that meets the community's aspirations.

4) Based on the services implemented by the first-line team in this community:

   a) According to you, are all the services offered through the pilot project sufficient to address the issues affecting youth and families? If not, what services should be added or reconsidered in the next action plan?
   b) If you look at all of the services available in the community, do you consider there is a variety of organized services and actions that meet the needs of youth and families? Are there any gaps? If so, which ones and for what type of problems?
   c) According to you, are first-line services based on qualified and trained human resources? Why?
   d) According to you, what have been the main outcomes of this project?
   e) According to you, how are first-line services culturally adapted to meet the needs of the users (in terms of values, ways to do business or activities implemented)?
   f) According to you, what are the main obstacles and challenges you foresee for this project's future?
   g) According to you, on what strengths of the community will it be possible to rely for this project in the future?

5) In light of the experience with this project, which lessons can be learned from its implementation?

Names	Position	How much time in this position

APPENDIX 4 Interview guide for the implementation phase 4: Advisory Committee

It has been almost two years now since the first-line services pilot project has been implemented in the community of [name of the community]. The goal of this meeting is to get your point of view on the implementation of first-line services that can now be accessed since May 2008. Your opinion is valuable since you collaborate with these services and you have a good knowledge of the project's evolution.

I would like to remind you that everything you will say to me during this meeting will remain confidential. Regarding this point, I would like to take the time to read the consent form with you (read the form and ask if the person has questions).

This interview is composed of four questions and sub-questions. When you answer, please think of the period between May 2008 and now, i.e. since the first-line services are available to the population in the community.

Do you have any questions before we start?

Start the questions by: *"Since May 2008"*…

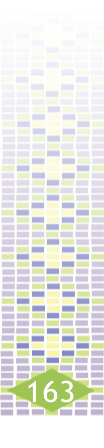
1) What role did your committee play in this project since then?

2) Tell me about the activities you have carried out with the first-line team?

   a) How frequently did you meet?
   b) What were your work objectives? What did you do to meet them? To what degree do you feel you have met them? Give me some examples.
   c) Are you satisfied with the work achieved? Please explain.
   d) According to you, how does your committee contribute to improve the wellbeing of the youth and families in the community?
   a) According to you, what have been the main difficulties encountered in this project?
   b) According to you, what have been the main factors that have facilitated the project's implementation?
   e) According to you, what will be your committee's challenges in 2009/2010?

3) Based on the services implemented by the first-line team in your community:

   a) According to you, are all the services offered through the pilot project sufficient to address the issues affecting youth and families? If not, what services should be added or reconsidered for the next year?
   b) If you look at all of the services available in the community, do you consider there is a variety of organized services and actions that meet the needs of youth and families? Are there any gaps? If so, which ones and for what type of problems?
   c) According to you, are first-line services sustained by qualified and trained human resources? Why?
   d) According to you, what have been the main outcomes of this project?
   e) According to you, how are first-line services culturally adapted to meet the needs of the users (in terms of values, ways to do business or activities implemented)?
   f) According to you, what are the main obstacles and challenges you foresee for this project's future?



g) According to you, on what strengths of the community will you be able to rely on for this project in the future?

4) What lessons can be learned from the implementation of this project?

Names	Group represented	How long in the committee

APPENDIX 5 Personal description sheet of first-line social workers

Name

____

1- Are your origins…?
- ☐ Aboriginal / Métis
- ☐ Non Aboriginal

2- If you are Aboriginal, do you live…?
- ☐ In the community
- ☐ Outside the community

3- What is your position (work title) for the project?

____

4- What is your age group?
- ☐ 25 years old or less
- ☐ 26 to 35 years old
- ☐ 36 to 45 years old
- ☐ 46 to 55 years old

5- What type of training do you have?
- ☐ Social service
- ☐ Psychology
- ☐ Special education
- ☐ Psycho-education
- ☐ Other: ______________________

6- What level of schooling did you reach?
- ☐ High school not completed
- ☐ High school completed
- ☐ Vocational training
- ☐ College not completed
- ☐ College completed
- ☐ University, 1st cycle (certificate and bachelors) not completed
- ☐ University, 1st cycle (certificate and bachelors) completed
- ☐ University, 2nd cycle (masters) not completed
- ☐ University, 2nd cycle (masters) completed
- ☐ Other, (specify): ______________________

7- Number of years of experience within your current position?
- ☐ Less than 5 years
- ☐ 5 to 14 years
- ☐ 15 to 20 years
- ☐ Over 20 years

8- Concerning your weekly tasks:

How many hours/week do you dedicate to intervention with the clientele? ________
How many hours/week do you dedicate to prevention/promotion? ________
How many hours/week do you dedicate to administrative tasks? ________

9- According to you, what training would help you in your position?

10- What are the main stress factors you deal within your work?

Related to your tasks	*Related to work organization*
☐ Overload of active files	☐ Staff turnover
☐ Intensity of cases	☐ Clinical supervision frequency too low
☐ Time management	☐ Absence of clinical supervisor
☐ Travelling	☐ Team meeting frequency too low
☐ Imbalance between intervention time and time dedicated to report writing (paper copy)	☐ Team coordination meeting frequency too low
☐ Intervention in case where I am emotionally involved (family, acquaintances, etc.)	☐ Isolation
☐ Other	☐ Other

Related to your role as a social worker	*Related to your personal life*
☐ Weight of responsibilities	☐ Behavioural issues
☐ Intervention in a context of authority (towards a non-willing clientele)	☐ Emotional issues
☐ Lack of training	☐ Relationship issues
☐ Receive calls from clients outside working hours (at home)	☐ Other
☐ Other	

11- On a scale of 1 (mediocre = deep professional exhaustion) to 10 (exceptional = motivation, ready to take on new challenges), please spontaneously qualify your current state of health at work.

❶ ❷ ❸ ❹ ❺ ❻ ❼ ❽ ❾ ❿

Comments:

Thank you for your collaboration!

APPENDIX 6 Monthly logbook

MONTHLY LOGBOOK

PHASE: ACCESS TO SERVICES

NAME OF THE COMMUNITY

Pilot project for first-line services implementation in four First Nations communities of Quebec

COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

Narrative logbook #: ____________________

Period: ____________________

Documented by: ____________________

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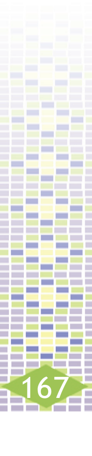


SECTION A: Access to services phase

Activities listing

Describe the main activities you carried out during the last period.
Which stakeholders were involved in these activities?

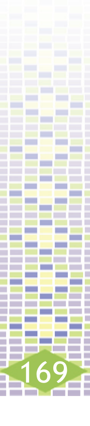
Date	Brief description of activities	Stakeholders present

SECTION A: Access to services phase

Activities listing (continued)

Describe the main activities you carried out during the last period.
Which stakeholders were involved in these activities?

Date	Brief description of activities	Stakeholders present



APPENDIX 7 Quarterly logbook

LOGBOOK
TO BE FILLED EVERY 3 MONTHS

PHASE: ACCESS TO SERVICES

NAME OF THE COMMUNITY

Pilot project first-line services implementation in four First Nations communities of Quebec

COMMISSION DE LA SANTÉ ET DES SERVICES SOCIAUX DES PREMIÈRES NATIONS DU QUÉBEC ET DU LABRADOR

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

Narrative logbook #: ____________________

Period: ____________________

Documented by: ____________________

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SECTION B: Access to services phase

Realization of the approach

Components to evaluate	Observations (facts)	Opinion	Things to do
Mobilization: **Identify the partners who got involved in the project and specify how.** Example: co-intervention; financial support; participation follow-up committee.			
Involvement: **What was done to involve the population? How did the population react to our actions?** Example: participation rate in an activity; participation of volunteers.			
Cooperation: **How was the cooperation with the C.J./CSSS?** Example: memorandum of understanding; egalitarian work relationship; Table.			
Ownership: **How did we continue to disseminate the community development approach?** Example: training; dissemination; how our activities met local needs.			

SECTION B: Access to services phase

Realization of the approach (continued)

Components to evaluate	Observations (facts)	Opinion	Things to do
<u>Individual empowerment:</u> **Which actions enabled a reinforcement of the population members' capacity to act?** Example: mutual help among parents; voluntary request for services; increase of the autonomy.			
<u>Community empowerment:</u> **Which actions enabled a reinforcement of the community's capacity to act?** Example: clothing bank; participate in a collective movement to change things.			
<u>Organizational empowerment:</u> **Does our organization have the power to act?** **In which way did we give power?** Example: support autonomy efforts; have members participate in the decisions; ensure stakeholders have a good understanding of the project and the approach.			

SECTION C: Access to services phase

Support received

Components to evaluate	Observations (facts)	Opinion	Things to do
From whom did we receive support and how?			

SECTION D: Access to services phase

Service implementation

Components to evaluate	Observations (facts)	Opinion	Things to do
Where are we at with our activities considering the objectives we have set in the action plan?			
How is the work going with the community's internal and external partners to ensure people have access to a continuum of services? - Is there a gap in the services? - If so, what has been done? N.B.: The example can also be part of the concertation.			

A few definitions:

Mobilization and involvement of local stakeholders:
It translates into the presence of persons, perceived as potential change levers, who in a shared goal and planned action strategies commit to mobilizing their resources and energies to meet the objectives a community has set out.

Involvement of the population:
Actions that aim to involve the population in all the steps of a project through, for example, the creation of spaces where the members of the population can have some power. This requires getting involved as an individual in different ways (talk, act, decide, etc.), at different times during the process in order to improve living conditions.

Intersectoral cooperation:
It is involved in actions that aim to transform social situations as a whole as well as through the reinforcement of the community's "leadership". It is possible through functional exchange mechanisms between the stakeholders, in order to establish a logical action process that meets the community's aspirations.

Ownership of a project in all its aspects:
Process through which an individual, a group or a community gains some control over its living conditions. In order for ownership to be effective, the individual, group or community must possess the official and non official resources that will enable it to control its environment.[26]

Empowerment:
Designates a capacity of action as well as the process to reach it, i.e. the succession of steps through which an individual or a community appropriates power as well as the capacity to exert it in an autonomous manner. The concept of empowerment is based on the idea that individuals and communities have the right to take part in the decisions that concern.

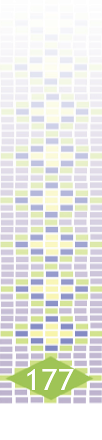
Individual empowerment:
Corresponds to the power appropriation process of an individual or a group. Takes place on 4 aspects: participation; skills; self-esteem; and critical consciousness. It is a simultaneous series of steps on each aspect that, as a whole and through their interaction, create the passage from a state without power to a state where the individual is able to act based on his/her own choices.

Community empowerment:
Corresponds to the control taking of the environment by and for all of the community. It is the means through which communities increase the collective power. It is a process experienced simultaneously by the community and its members.

[26] The definitions of the 4 action strategies were taken from the study design of the First-line services implementation pilot project in four First Nations communities of Quebec, August 2008, p. 14

Organizational empowerment:
Represents both the power appropriation process by an organization and the community in which a person or an organization takes the risk of acting (becomes *empowered*). Space where people, both individually and collectively, share their capacities and resources, which leads ultimately to the community's competence. A competent community is a place where the various systems succeed in meeting the needs of the individuals and where the individuals succeed in using the systems in an efficient manner.[27]

[27] All the definitions of empowerment are taken from: Ninacs, William A., Empowerment: Cadre conceptuel et outil d'évaluation de l'intervention sociale et communautaire, Community services council of Newfoundland and Labrador, "Welfare to Work: The Next Generation, A National Forum", 2003, 26 p.



APPENDIX 8 Questionnaire on the satisfaction of parents

Pilot project for the first-line services implementation in four First Nations communities of Quebec

Questionnaire on the satisfaction of parents

"Time 2 of the data collection"

Note for the coding: 97: Does not apply
98: Does not know
99: Refusal

Date of the interview: ______________________________

Identification number: ______________________________

Respondent: ______________________ [Father or mother]

Name of the community: ____________________________

Context:

First I wish to thank you for your participation in this interview. I would like to remind you that this survey aims to provide a better understanding of your experience with first-line services. Your opinion is valuable since it will contribute to implementing services that meet your needs and those of your child.

As mentioned previously in the consent form, I wish to remind you that all your answers will remain confidential. In no way will it be possible to identify you or your child. Moreover, the answers you will give me will not be transmitted to your social worker and will not cause you any prejudice regarding the services you receive.

This interview will last approximately 30 minutes. If you do not wish to answer certain questions, you can just tell me.

Before we start, do you have any questions?

MODULE A: INFORMATION ON THE CONTEXT OF THE INTERVENTION

The following questions aim to determine how you first contacted the first-line services.

A1- Why did you request 1st-line services? ______________

____

____

____

A2- Who informed you that 1st-line services existed in your community?

Network of professionals:

- ❑1 Probation officer
- ❑2 Therapy Centre
- ❑3 Nurse
- ❑4 Info-social
- ❑5 CSSS (CLSC) worker
- ❑6 Worker with women
- ❑7 Community worker
- ❑8 DPJ worker
- ❑9 School-based worker
- ❑10 Mental health worker
- ❑11 HSSSA worker
- ❑12 YCJA
- ❑13 Youth Center
- ❑14 FNHS
- ❑15 Parents
- ❑16 NNAADAP
- ❑17 Police
- ❑18 Psychiatrist
- ❑19 Psychologist
- ❑20 RPR
- ❑21 Other: *[specify]* ______________
- ❑97 Does not apply

Informal network:

- ❑1 Spouse
- ❑2 Child
- ❑3 Family
- ❑4 Neighbour
- ❑5 Other (specify): ______________

A3- How did your first contact with 1st-line services occur?

- ❑1 You requested help by phoning or directly meeting with the workers
- ❑2 A worker referred you to these services (Centre jeunesse, Health Centre, etc.)
- ❑3 Someone in the community introduced you to the services (friends, spouse, family, etc.)
- ❑4 Other (*specify*) ______________

A4- How much time went by between the moment you requested help and the first meeting with the 1st-line services resource person?

____

A5- Since you have been receiving first-line services, which service(s) have you received?

- ❑1 Individual/family meetings *[skip to module B]*
- ❑2 Group activities (*specify*): ______________ *[skip to module C]*
- ❑3 Other (*specify*): ______________

[Please check all the answers that apply]

MODULE B: INDIVIDUAL/FAMILY INTERVENTION

I would like you to refer yourself to the resource person with whom <u>you currently receive</u> individual/family services to answer the next questions while.

[Please fill out this section only if the person has received or is receiving individual/family services]

B1- When you meet with the 1st-line resource person, <u>most of the time</u>, who is present?

- ❑1 Only me
- ❑2 My spouse
- ❑3 My child/children
- ❑4 One or a few of my family members (*specify*): ______________
- ❑5 Other members of my community (*specify*): ______________
- ❑6 Other (*specify*): ______________

[Please check all the answers that apply]

B2- Has it occasionally happened that people other than those you have mentioned were met?

- ❑1 Yes
- ❑2 No ______________

If so, specify:

- ❑3 Only me
- ❑4 My spouse
- ❑5 My child/children
- ❑6 One or a few of my family members (*specify*): ______________
- ❑7 Other members of my community (*specify*): ______________
- ❑8 Other (*specify*): ______________

[Please check all the answers that apply]

B3- When you have individual/family meetings with the 1st-line resource person, where do these meeting occur most of the time?

- ❑1 At my home
- ❑2 In the offices of the first-line services
- ❑3 Other: (*specify*): ____________

B4- Has it ever happened that the meetings with the 1st-line resource person were held at another location? If so, where?

- ❑1 At my home
- ❑2 In the offices of the first-line services
- ❑3 Other: (*specify*): ____________

[Please check all the answers that apply]

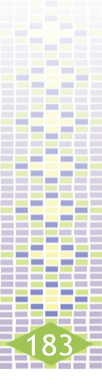
B5- Did the 1st-line resource person refer you to other services in the community? If so, which one(s)?

- ❑1 Yes *[please specify who in the list below]*
- ❑2 No
- ❑97 Does not apply (*specify*): ____________
- ❑1 Probation officer
- ❑2 Therapy Centre
- ❑3 Nurse
- ❑4 Info-social
- ❑5 CSSS (CLSC) worker
- ❑6 Worker with women
- ❑7 Community worker
- ❑8 DPJ worker
- ❑9 School-based worker
- ❑10 Mental health worker
- ❑11 HSSSA worker
- ❑12 YCJA
- ❑13 Youth Center
- ❑14 FNHS
- ❑15 Parents
- ❑16 NNAADAP
- ❑17 Police
- ❑18 Psychiatrist
- ❑19 Psychologist
- ❑20 RPR
- ❑21 Other: *(specify)* ____________
- ❑97 Does not apply

[Please check all the answers that apply]

B6- Your 1st-line resource person is:

- ❑1 Aboriginal
- ❑2 Non Aboriginal
- ❑98 Does not know



B7- If your 1st-line resource person is Aboriginal, where does he/she come from:

- ❑1 Your community
- ❑2 Another community
- ❑98 Does not know

B8- If your 1st-line resource person is Aboriginal, does he/she live:

- ❑1 In your community
- ❑2 Outside your community
- ❑98 Does not know

B9- Do you prefer receiving services from:

- ❑1 An Aboriginal person
- ❑2 A non Aboriginal person
- ❑3 It does not matter
- ❑98 Does not know

B10- Do you prefer receiving services from:

- ❑1 A person who lives in your community
- ❑2 A person who lives outside your community
- ❑3 It does not matter
- ❑98 Does not know

B11- Do you prefer receiving services from:

- ❑1 A person with whom you have a kinship bond
- ❑2 A person with whom you have no kinship bond
- ❑3 It does not matter
- ❑98 Does not know

B12- In which language do you prefer individual/family meetings to be held?

- ❑1 French
- ❑2 English
- ❑3 First Nations language
- ❑4 Other (*specify*): ____________________

B13- Does the language in which you receive individual and family services appropriate for you?

- ❑1 Yes
- ❑2 No (In which language would you like to receive services?): ____________________
- ❑98 Does not know

B14- The next questions address your appreciation of your 1st-line resource person. On a scale of 1 (1= never) to 5 (5= all the time), to what extent do you agree with the following assertions:

	Never	Rarely	Sometimes	Most of the time	All the time	Does not apply
My 1st-line resource person seems to take my situation to heart	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person really know what he/she is doing	❑1	❑2	❑3	❑4	❑5	❑97
I get the help I need	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person accepts me as I am	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person seems to understand how I feel	❑1	❑2	❑3	❑4	❑5	❑97
I feel I can speak freely with my 1st-line resource person	❑1	❑2	❑3	❑4	❑5	❑97
The help I receive is beyond what I was expecting	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person informs me of my progress	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person gives me all the information to cope with my issues	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person gives me all the solutions to cope with my issues	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person answers all my questions	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person is respectful towards me	❑1	❑2	❑3	❑4	❑5	❑97
The time my 1st-line resource person dedicates to me is sufficient	❑1	❑2	❑3	❑4	❑5	❑97
My 1st-line resource person is accessible when I have urgent needs	❑1	❑2	❑3	❑4	❑5	❑97
I have access to services that correspond to my culture	❑1	❑2	❑3	❑4	❑5	❑97

B15- On a scale of 1 (1= Totally agree) to 3 (3=Totally disagree) what is your opinion of the following assertions:

	Totally agree	Maybe	Totally disagree	Does not know
I consider my 1st-line resource person to be competent	❑1	❑2	❑3	❑97
I would deal with the same 1st-line resource person if I needed help again	❑1	❑2	❑3	❑97
I would recommend this 1st-line resource person to a friend	❑1	❑2	❑3	❑97

MODULE C: GROUP ACTIVITIES

I would like you to refer yourself to the group activities you currently take part in to answer the next questions.

[Fill out this section only for people taking part in group activities]

C1- When you have group activities with 1st-line services, most of the time, they are held:

❑1 On the territory
❑2 In the community
❑3 Outside the community (urban setting)
❑4 In the facilities of the 1st-line services
❑5 Other: (*specify*): ____________________

[Please check all the answers that apply]

C2- On other occasions, are group activities with the 1st-line services ever held somewhere else? If so, where?

❑1 On the territory
❑2 In the community
❑3 Outside the community (urban setting)
❑4 In the facilities of the 1st-line services
❑5 Other: (*specify*): ____________________

[Please check all the answers that apply]

C3- Is your group facilitator:

❑1 Aboriginal
❑2 Non Aboriginal
❑98 Does not know

[If so, skip to A12, if not, skip to A13]

C4- Is your group facilitator from:

- ❑1 Your community
- ❑2 Another community
- ❑98 Does not know

C5- Do you prefer taking part in group activities lead by:

- ❑1 An Aboriginal person
- ❑2 A non Aboriginal person
- ❑3 It does not matter
- ❑98 Does not know

C6- Do you prefer taking part in group activities lead by:

- ❑1 A person living in your community
- ❑2 A person living outside your community
- ❑3 It does not matter
- ❑98 Does not know

C7- Do you prefer taking part in group activities lead by:

- ❑1 A person with whom you have a kinship bond
- ❑2 A person with whom you have no kinship bond
- ❑3 It does not matter
- ❑98 Does not know

C8- In which language do you prefer having your group activities?

- ❑1 French
- ❑2 English
- ❑3 First Nations language
- ❑4 Other (specify): ____________

C9- Does the language in which group activities are held suit you?

- ❑1 Yes
- ❑2 No (In which language would like to receive your services?): ____________
- ❑98 Does not know

C10- To what extent do you agree with the following assertions regarding the group activities in which you have taken participated?

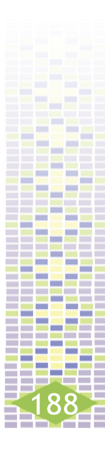
	Completely adequate	Adequate	Slightly adequate	Inadequate	Does not apply
The content of the activities was	❑1	❑2	❑3	❑4	❑97
The length wasThe location was	❑1	❑2	❑3	❑4	❑97
Le lieu était	❑1	❑2	❑3	❑4	❑97
The teaching methods (exercises, exchanges, etc.) were	❑1	❑2	❑3	❑4	❑97
The facilitation was	❑1	❑2	❑3	❑4	❑97

C11- On a scale of 1 (1= Very much) to 4 (4= Not at all), what is your opinion of the following assertions:

	Very much	Somewhat	Slightly	Not at all	Does not apply
The facilitator was attentive to our needs and expectations	❑1	❑2	❑3	❑4	❑97
The activity allowed me to gain new knowledge	❑1	❑2	❑3	❑4	❑97
The information I received will be useful for me	❑1	❑2	❑3	❑4	❑97
The activity gave me the opportunity to reflect upon my behaviours	❑1	❑2	❑3	❑4	❑97

C2- During group activities, did you feel comfortable asking questions?

❑1 Yes
❑2 No If not, because of: ____________
❑3 The group
❑4 The facilitators
❑5 Shyness
❑6 Others [*specify*]: ____________



C13- On a scale of 1 (1=Totally agree) to 3 (3= Totally disagree), what is your opinion of the following assertions:

	Totally agree	Maybe	Totally disagree	Does not know
I consider the group facilitator to be competent	❑1	❑2	❑3	❑97
I would recommend this group activity to a friend	❑1	❑2	❑3	❑97

MODULE D: OVERALL APPRECIATION OF 1ST-LINE SERVICES

The following questions aim to determine your overall appreciation of first-line services.

D1- I would now like to know your opinion regarding first-line services in general. On a scale of 1 (1= Very satisfied) to 4 (4= Very unsatisfied), what is your degree of satisfaction regarding the following assertions:

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied	Does not apply
How easy it is to get an appointment	❑1	❑2	❑3	❑4	❑97
The type of service that was provided to you	❑1	❑2	❑3	❑4	❑97
The quality of the location where the service was provided	❑1	❑2	❑3	❑4	❑97
The hours when the service was provided	❑1	❑2	❑3	❑4	❑97
Confidentiality and discretion	❑1	❑2	❑3	❑4	❑97
Opening and closing hours	❑1	❑2	❑3	❑4	❑97
The overall quality of the services provided	❑1	❑2	❑3	❑4	❑97

D2- To what extent did the services contribute to improve the situation for which you consult:

❑1 Very much
❑2 Somewhat
❑3 Slightly
❑4 Not at all
❑5 Does not know

D3- Do you have other needs for which you would like some help? If so, specify:

- ❑1 Yes, specify: ______________
- ❑2 No
- ❑98 Does not know

D4- In general, do you think there are enough services in your community for youth and families experiencing difficulties?

- ❑1 Yes, absolutely
- ❑2 Yes, I think
- ❑3 No, I don't think so
- ❑4 No, absolutely not
- ❑98 Does not know

D5- What do you appreciate in the services you receive?

____

____

____

D6- What do you least appreciate in the services you receive?

____

____

____

D7- According to you, are 1st-line services adapted to your community's culture?

If so, what makes you say they are culturally adapted?

____

____

____

MODULE E : *EMPOWERMENT*

The following questions aim to determine your involvement in first-line services

E1- To what extent do you have your saying in the way services and programs are provided in your community?

- ❑1 Very much
- ❑2 Somewhat
- ❑3 Slightly
- ❑4 Not at all
- ❑98 Does not know

E2- Do you believe it is important that people have their saying in how services and programs are provided in the community?

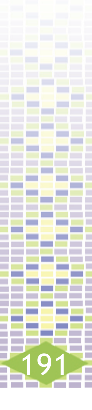
- ❑1 Very much
- ❑2 Somewhat
- ❑3 Slightly
- ❑4 Not at all
- ❑98 Does not know

E3- To what extent does your 1st-line resource person involve you in the decisions that concern you or your child?

- ❑1 Very much
- ❑2 Somewhat
- ❑3 Slightly
- ❑4 Not at all
- ❑98 Does not know

E4- Do you believe it is important that people have their saying in the decisions that concern them or their child/children?

- ❑1 Very much
- ❑2 Somewhat
- ❑3 Slightly
- ❑4 Not at all
- ❑98 Does not know



MODULE F: GENERAL INFORMATION

In conclusion, the next questions aim to develop a profile of the parents who answered this questionnaire.

F1- Please specify the following information for each child for whom you receive first-line services.

Age	*Gender*	*School level*	*Currently attending school*	*Lives with*
______	❑1 Male ❑2 Female	______	❑1 Community ❑2 Outside community	❑1 Both parents ❑2 Mother ❑3 Father ❑4 Shared custody ❑5 Foster family (c)) ❑6 Foster family (oc) ❑7 Rehabilitation centre ❑8 Other, *[specify]*: ______
______	❑1 Male ❑2 Female	______	❑1 Community ❑2 Outside community	❑1 Both parents ❑2 Mother ❑3 Father ❑4 Shared custody ❑5 Foster family (c)) ❑6 Foster family (oc) ❑7 Rehabilitation centre ❑8 Other, *[specify]*: ______
______	❑1 Male ❑2 Female	______	❑1 Community ❑2 Outside community	❑1 Both parents ❑2 Mother ❑3 Father ❑4 Shared custody ❑5 Foster family (c)) ❑6 Foster family (oc) ❑7 Rehabilitation centre ❑8 Other, *[specify]*: ______
______	❑1 Male ❑2 Female	______	❑1 Community ❑2 Outside community	❑1 Both parents ❑2 Mother ❑3 Father ❑4 Shared custody ❑5 Foster family (c)) ❑6 Foster family (oc) ❑7 Rehabilitation centre ❑8 Other, *[specify]*: ______

Age	*Gender*	*School level*	*Currently attending school*	*Lives with*
________	❑1 Male ❑2 Female	________	❑1 Community ❑2 Outside community	❑1 Both parents ❑2 Mother ❑3 Father ❑4 Shared custody ❑5 Foster family (c)) ❑6 Foster family (oc) ❑7 Rehabilitation centre ❑8 Other, *[specify]*: ________
________	❑1 Male ❑2 Female	________	❑1 Community ❑2 Outside community	❑1 Both parents ❑2 Mother ❑3 Father ❑4 Shared custody ❑5 Foster family (c)) ❑6 Foster family (oc) ❑7 Rehabilitation centre ❑8 Other, *[specify]*: ________

F2- Please indicate the number of children under the age of 18 who live in your household at least half of the time:

___ Children aged 0 to 5
___ Children aged 6 to 12
___ Youth aged 13 to 17

F3- Please indicate the number of adults aged 18 and over who live in your household at least half of the time:

___ Spouse
___ Family member
___ Other members of the community without any kinship bond
___ Other (specify): ________________

F4- How many rooms does your residence have?

____

[Make sure to ask whether the basement is a room in itself and, if so, how many people sleep there]

F5- What is your family status?

❑1 Two-parent family (both natural parents)
❑2 Single-parent family
❑3 Blended family
❑4 Other (specify): ________________

F6- Are you?

❑1 Aboriginal
❑2 Non Aboriginal
❑3 Other (specify): ________________

F7- What is your age group?

- ❑1 18 to 24 years old
- ❑2 25 to 29 years old
- ❑3 30 to 34 years old
- ❑4 35 to 39 years old
- ❑5 40 to 44 years old
- ❑6 45 to 49 years old
- ❑7 50 to 54 years old
- ❑8 55 to 59 years old
- ❑9 60 years old and over

F8- What is your gender?

- ❑1 Male
- ❑2 Female

F9- What language is spoken most often at home?

- ❑1 French
- ❑2 English
- ❑3 First Nations language
- ❑4 Other (specify): ____________

[Please check only one answer]

F10- What is your <u>main</u> occupation?

- ❑1 Parent at home
- ❑2 Full-time job
- ❑3 Part-time job
- ❑4 Studies
- ❑5 Convalescence or invalidity
- ❑6 Job search
- ❑7 Other (specify): ____________

[Please check only one answer]

F11- What is the highest schooling level you have reached?

- ❑1 Primary school not completed
  High school not completed
- ❑2 High school diploma
- ❑3 Vocational diploma
- ❑4 Partial studies in a college
- ❑5 College diploma or certificate
- ❑6 Partial studies in a university
- ❑7 Bachelors obtained
- ❑8 University certificate obtained
- ❑9 Masters obtained
- ❑10 Doctorate obtained
- ❑11 Other (specify): ____________

[Please check only one answer]

APPENDIX 9 Data collection form for individual files

COLLECTION FORM:
Individual file

This form must be filled out by the worker for all the individual files in his/her caseload. The identification sheets for all new participants must be completed and entered every month. It is suggested to fill out the Reception / Evaluation / Orientation and Management parts as soon as the intervention phase is completed.

PART 1: IDENTIFICATION OF THE PARTICIPANT (11 À 9))		
11	File number allocated by the community:	________
12	Reception date of the request (Date of the first contact for the request)	___ / ___ / _____
13	Date of birth:	___ / ___ / _____
14	Gender:	❑1 Male ___ ❑2 Female ___
15	Civil status of the adult participant	❑1 Married ❑2 Single ❑3 Divorced ❑4 Common law ❑5 Widow(er) ❑6 Other: (specify) ________ ❑7 Does not apply
16	Participant's occupation *(check all the answers that apply)*	❑1 Student (specify the degree): ____ ❑2 Worker ❑3 Other: (specify): ________
17	If child: type of custody at the time of the request for help	❑1 With the mother only ❑2 With the father only ❑3 With both parents ❑4 Shared custody ❑5 Tutor ❑6 Other: (specify): ________ ❑7 Does not apply
18	If child, siblings living in the same household	Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female Age ___ Gender: 1- male 2- female ❑1 Does not apply

PART 2: RECEPTION / EVALUATION / ORIENTATION (AEO1 À 15)

AEO1	File number:	______________________
AEO2	Date (Date of R/E/O)	____ / ____ / ______
AEO3	Referred to first-line services by:	❑1 Probation officer ❑2 Therapy Centre ❑3 Nurse ❑4 Info-social ❑5 CSSS (CLSC) worker ❑6 Worker with women ❑7 Community worker ❑8 DPJ worker ❑9 School-based worker ❑10 Mental health worker ❑11 HSSSA worker ❑12 YCJA ❑13 Youth Center ❑14 FNHS ❑15 Parents ❑16 NNAADAP ❑17 Police ❑18 Psychiatrist ❑19 Psychologist ❑20 RPR ❑21 Person himself/herself ❑22 Other: (specify) ____________ ❑23 Does not apply
AEO4	Workers involved at the time of the request	❑1 Probation officer ❑2 Therapy Centre ❑3 Nurse ❑4 Info-social ❑5 CSSS (CLSC) worker ❑6 Worker with women ❑7 Community worker ❑8 DPJ worker ❑9 School-based worker ❑10 Mental health worker ❑11 HSSSA worker ❑12 YCJA ❑13 Youth Center ❑14 FNHS ❑15 NNAADAP ❑16 Police ❑17 Psychiatrist ❑18 Psychologist ❑19 RPR ❑20 Other: (specify) ____________ ❑21 Does not apply

AEO5	If Youth Protection was involved at the time of the help request for the child	❑1 YPA ❑2 YCJA ❑3 Does not apply
AEO6	If YPA or YCJA: stage at the Youth Protection:	❑1 Reporting ❑2 Retention of reporting ❑3 Evaluation/Orientation ❑4 Application of measures ❑5 Does not apply
AEO7	If YPA or YCJA: placement of the child at the time of the request?	❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other [specify]: ________ ❑5 Does not apply
AEO8	If YPA child placement: *placement in or outside the community?*	**Location of the placement** ❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other [specify]: ________ ❑5 Does not apply
		Locality of the placement ❑1 In the community ❑2 Outside the community ❑3 Does not apply
AE08.1	This placement was done by the first line	❑1 Respite family ❑2 HSSSA placement ❑3 Other [specify]: ________
AEO9	If child placement by first line: start date of the placement	____ / ____ / ______
AEO10	If child placement by first line: end date of the placement (planned or real)	____ / ____ / ______

PART 2: RECEPTION / EVALUATION / ORIENTATION (continued)

AEO11	Problem identified through the evaluation (Check 1 box in each column: 2 boxes maximum)	**Main problem** ❑1 Lack of social support ❑2 Alcohol abuse ❑3 Drug abuse ❑4 Sexual abuse ❑5 Criminal activities ❑6 Self-mutilation behaviour ❑7 Inappropriate sexual behaviours ❑8 Emotional dependence ❑9 Mourning ❑10 Runaway ❑11 Couple issues ❑12 Mental deficiency ❑13 Mental health issues ❑14 Physical health issues ❑15 Gambling issues ❑16 Housing issues ❑17 Parental negligence issues ❑18 Financial issues ❑19 Parent-child relation issues ❑20 Educational role issues ❑21 Prostitution ❑22 Suicide attempt / ideation ❑23 Child behaviour disorder ❑24 Child development disorder ❑25 Violence ❑26 Other (specify): ______	**Secondary problem** ❑1 Lack of social support ❑2 Alcohol abuse ❑3 Drug abuse ❑4 Sexual abuse ❑5 Criminal activities ❑6 Self-mutilation behaviour ❑7 Inappropriate sexual behaviours ❑8 Emotional dependence ❑9 Mourning ❑10 Runaway ❑11 Couple issues ❑12 Mental deficiency ❑13 Mental health issues ❑14 Physical health issues ❑15 Gambling issues ❑16 Housing issues ❑17 Parental negligence issues ❑18 Financial issues ❑19 Parent-child relation issues ❑20 Educational role issues ❑21 Prostitution ❑22 Suicide attempt / ideation ❑23 Child behaviour disorder ❑24 Child development disorder ❑25 Violence ❑26 Other (specify): ______

PART 2: RECEPTION / EVALUATION / ORIENTATION (continued)

AEO12	Orientation	❑1 Family/Childhood/Youth Program (individual) ❑2 Family/Childhood/Youth Program (group): (JP not required) Youth Protection Program ❑3 Mental Health Program ❑4 Community Support Program ❑5 Addiction/Gambling Program ❑6 Other (specify): ______________ ❑7 Does not apply
AEO13	File priority code	❑1 Urgent ❑2 Moderately urgent ❑3 Not urgent ❑4 Does not apply
AEO14	Is it an intervention outside business hours?	❑1 Yes: (If so, specify the number of hours of intervention) ______________ ❑2 No ❑3 Does not apply
AEO15	End date of evaluation	____ / ____ / ______

PART 3: MANAGEMENT (PC1 À 13)

PC1	File number:	________________
PC2	Start date of management (Date when the coordinator assigned the file to the worker)	____ / ____ / ______
PC3	Worker(s) involved in the management	Worker 1: ________________ Worker 2: ________________ Worker 3: ________________
PC4	Referral of the child to YP by first line during management	❑1 Yes ❑2 No ❑3 Does not apply

PART 3: MANAGEMENT (continued)

PC5 à PC8	Information relative to the new placement(s) of the child during management		*(PC5)* Location of the placement	*(PC6)* Locality of the placement	*(PC7)* Start date of placement	*(PC8)* End date of placement
		#1	❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other: ______ ❑5 Does not apply	❑1 In the community ❑2 Outside the community ❑3 Does not apply	__ / __ / __	__ / __ / __
		#2	❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other: ______ ❑5 Does not apply	❑1 In the community ❑2 Outside the community ❑3 Does not apply	__ / __ / __	__ / __ / __
		#3	❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other: ______ ❑5 Does not apply	❑1 In the community ❑2 Outside the community ❑3 Does not apply	__ / __ / __	__ / __ / __
		#4	❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other: ______ ❑5 Does not apply	❑1 In the community ❑2 Outside the community ❑3 Does not apply	__ / __ / __	__ / __ / __
		#5	❑1 Foster family ❑2 Group home ❑3 Rehabilitation centre ❑4 Other: ______ ❑5 Does not apply	❑1 In the community ❑2 Outside the community ❑3 Does not apply	__ / __ / __	__ / __ / __

PART 3: MANAGEMENT (continued)		
PC9	Workers involved during management	❑1 Probation officer ❑2 Therapy Centre ❑3 Nurse ❑4 Info-social ❑5 CSSS (CLSC) worker ❑6 Worker with women ❑7 Community worker ❑8 DPJ worker ❑9 School-based worker ❑10 Mental health worker ❑11 HSSSA worker ❑12 YCJA ❑13 Youth Center ❑14 FNHS ❑15 NNAADAP ❑16 Police ❑17 Psychiatrist ❑18 Psychologist ❑19 RPR ❑20 Other: (specify): ____________ ❑21 Does not apply
PC10	Is there an action plan in the file?	❑1 Yes ❑2 No
PC11	Is there an individualized service plan in the file?	❑1 Yes ❑2 No ❑3 Does not apply
PC12	Interventions carried out during follow-up	Number of interviews at home ____________ Number of interviews at the office ____________ Number of interviews outside the office ____________
PC13	End date of management (file closed or referral)	____ / ____ / ________

PART 3: MANAGEMENT (continued)

PC14	If referral, after file is closed. File is referred to	❑1 Probation officer ❑2 Therapy Centre ❑3 Nurse ❑4 Info-social / social emergency ❑5 CSSS (CLSC) worker ❑6 Worker with women ❑7 Community worker ❑8 School-based worker ❑9 Mental health worker ❑10 HSSSA worker ❑11 YCJA ❑12 Youth Center ❑13 FNHS ❑14 NNAADAP ❑15 Police ❑16 Psychiatrist ❑17 Psychologist ❑18 RPR ❑19 Other: (specify): ____________ ❑20 Does not apply

APPENDIX 10 Assistance guide to fill out the form for individual files

PART I: IDENTIFICATION OF THE PARTICIPANT

1.1 The file number allocated by the community is the one allocated by your services, for example, by your community's health and social services system

1.2 Reception date of the request: Day/month/year

1.3 Date of birth of the participant: Day/month/year

1.4 Gender of the participant

1.5 Civil status of the adult participant (18 years and over):

Married:	Civil or religious marriage
Single:	No spouse living in the same household as the adult
Divorced:	Legal dissolution of the civil or religious wedding
Common law:	Adults living in the same household
Other:	Specify any other situation that is not listed above
Does not apply:	Check if the file concerns a minor

1.6 Occupation of the participant (minor under 18 or adult):

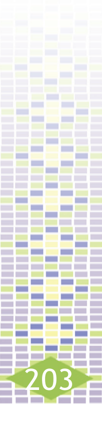
Student:	Attending school on a part-time or full-time basis
Worker:	Not attending school and with a paid full-time or part-time job
Other:	Indicate any other situation that applies and explain the nature of the person's occupation, for example, at home, etc.

*** If more than one situation applies, please check all the corresponding boxes

1.7 Legal custody of a minor (under 18):

With the mother	Only the biological or adoptive mother has custody
With the father	Only the biological or adoptive father has custody
With both parents	When both biological or adoptive parents live together
Shared custody	The biological or adoptive parents do not live together anymore and the child lives with his parents on a shared basis
Tutor	The biological or adoptive parents are deceased or legally disqualified from their parental role until the child's majority
Other [specify]:	Any other situation not listed in the categories above. Do not include foster family if the child is placed

1.8 For the participant aged under 18, write all the siblings (half-brothers and half-sisters) aged under 18 and living in the same household. If the participant is placed, write all the siblings aged under 18 living with the parent(s) who has(have) legal custody of the participant



PART 2: RECEPTION/EVALUATION/ORIENTATION

AEO1 Ensure the participant number matches the one in section 12

AEO2 Date of the reception/evaluation/orientation: Day/month/year

AEO3 Indicate the person who refers to first-line services

AEO4 Check all the workers already involved with the client at the time of reception/evaluation/orientation

AEO5 If the child is minor at the time of the R/E/O: please indicate whether he/she receives services under the Youth Protection Act (YPA) or the Youth Criminal Justice Act (YCJA)

AEO6 Specify in which phase the minor's file is:

Phases	*YPA*	*YCJA*
1- Retention of reporting	There has been a reporting, but it has not been retained yet	A complaint is under review by the Attorney General's office
2- Reporting	A reporting has been retained and is pending evaluation	The file is pending evaluation or court appearance
3- Evaluation/ Orientation	The file is currently being evaluated to determine whether the facts reported are true and whether the child's security is compromised	The file is being evaluated for remedial action or for pre-decisional report
4- Application of measures	The child's security is compromised and youth protection services are required	Execution of alternative measures or probation follow-up

AEO7 If the child is minor at the time of the reception/evaluation/orientation, location of the placement under the YPA or YCJA

Foster family: Child is placed by the youth protection in a family-type resource, excluding a member of the child's extended family
Group home: Child in a group home
Rehabilitation centre: Child placed in a rehabilitation centre
Other: Specify any other situation not listed in the categories above
Does not apply: Does not apply because the child is not placed

AEO8 Specify if the minor's placement is in the community or outside the community

AEO8.1 If the child placement occurs at the REO, specify who executed the placement

AEO9 Start date of the placement: Day/month/year

AEO10End date of the placement: Day/month/year

Date planned by the youth protection measure: voluntary or judicial

OR

Real end date of the placement (i.e. it took place within the REO)

AEO11 Check all the answers that apply to the problems identified by the client at the time of the REO and for which he requested help

AEO12 Indicate to which service the file was transferred for case management

AEO13 If help is required for childhood-youth-family first-line services, indicate the date when the file was referred to the clinical consultant for case management: Day/month/year

AEO14 If the file was retained for childhood-youth-family first-line services, indicate the level of urgency. Services are required:

Within 7 days: Code 1 (urgent)	Rapide interventions are required in situations where: • There is immediate and serious threat to the person's life or security • There is immediate and serious threat to another person's life or security (child, spouse or any other identifiable person) • The person's basic needs are not met (housing, food, etc.) • The uneasiness is so great that there are hints of severe disorganization of the person or the family system For example: Suicide scenario Aggression / imminent violence No shelter, no food Disorganization of the person, loss of control
Within a delay of 7 to 14 days: Code 2 (moderately urgent)	Rapide interventions must be carried out in situations that, being urgent, represent a threat to the security of the persons, represent a risk of disorganization or prevent meeting basic needs (physical and mental) in a foreseeable future For example: Suicide ideation without any precise plan The person has a shelter or food only on a temporary basis
Within a delay of 21 days: Code 3 (Not urgent)	The person or family needs help to resolve a problem that is preoccupying, but there is no risk of serious disorganization and no threat to the security of the persons. Basic needs are met For example: Vague suicide ideation Anxiety of the person, but no disorganization Emotional disorders Self-esteem issues

AEO15 Corresponds to the end date of the REO if services are not required. In cases where services are required, this date corresponds to the date the clinical consultant referred the file for case management: Day/month/year

AEO16 Specify if the intervention carried out was done outside the office's business hours

PART 3: MANAGEMENT

PC1 Ensure the participant's number correspond to the one in sections I2 and AEO1

PC2 Date when the file was assigned to the childhood-youth-family first-line worker for follow-up: day/month/year

PC3 Indicate the code of the worker assigned to the file management

PC4 Indicate if the child was referred for a new follow-up or reporting to youth protection during case management (information included in the activity report / progress notes)

From PC5 to PC8 for all new placements of the child during case management, please indicate the following information for each placement:

PC5 If the child is minor, indicate the location of the new placement during case management

Foster family: Child placed by youth protection in a family-type resource, excluding a member of the child's extended family
Group home: Child placed by youth protection in a group home
Rehabilitation centre: Child placed by youth protection in a rehabilitation centre
Other: Any other situation not listed in the previous categories
Does not apply: Does not apply because the child is not placed

PC6 Specify whether the minor child's placement is in the community or outside the community

PC7 Start date of the new placement during case follow-up: Day/month/year

PC8 Indicate the end date of the new placement when it occurs before the end of the case management: Day/month/year

PC9 Presence of a completed action plan in the file

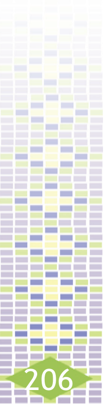
PC10 Presence of a completed individualized service plan in the file

PC11 Calculate the number of interviews corresponding to the categories below, from the case management start date to the end date

Number of interviews at the participant's home
Number of interviews in the facilities of the first-line services
Number of interviews outside the office (ex: at school)

PC12 End date of the case management in the childhood-youth-family first-line program: Day/month/year

PC13 Referral to another service following the end of the case management



APPENDIX 11 Data collection form for group files

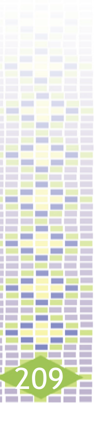
Data collection for a group file. This form must be filled out for all the activities related to group files. The group file concerns any activity with a group of individuals in a community.

Identification of the group activity

DC1	File number	______________	
DC17	Start date of the activity's development	____ / ____ / ______	
DC2	Name of the activity	______________ ______________	
DC3	Collaborators involved in the process	*Function* ______ ______ ______ ______ ______ ______	*Sector / Organization* ______ ______ ______ ______ ______ ______
DC4	Start date of the activity	____ / ____ / ______	
DC5	End date of the activity	____ / ____ / ______	
DC6	Number of activities carried out	______________	
DC7	Location of the activity / meetings * It is possible to check more than one box	❑1 In the community ❑2 On the territory ❑3 Outside the community ❑4 Other (specify): ______	
DC8	Type of activity	❑1 Promotion activity: ❑2 Prevention activity: ❑3 Treatment activity ❑4 Cultural and community activity ❑5 Other (specify): ______	
DC9	If group activity, please indicate the type of group	❑1 Open ❑2 Closed	

DC10	Target issue or theme	**Mental health** ❑1a Suicide ❑1b Depression ❑1c Anxiety ❑1d Other (specify): ______ **Dependence** ❑2a Alcohol ❑2b Gambling ❑2c Romantic relationships ❑2d Drugs ❑2e Other (specify): ______ **Violence** ❑3a Domestic ❑3b Family ❑3c Taxing ❑3d Vandalism ❑3e Street gang ❑3f Other (specify): ______ **Childhood/youth/family** ❑4a Negligence ❑4b Child developmental delay ❑4c Children or youth violent and aggressive behaviour ❑4d School failure or drop-out ❑4e Adaptation difficulties related to family break-up ❑4f Hyperactivity ❑4g Difficult parent/children relations ❑4h Abuse: physical, psychological, sexual ❑4i Teen pregnancy ❑4j Other (specify): ______ **Other (specify):** ❑5 ______
DC11	Target age group * It is possible to check two boxes	❑1 General population ❑2 0 to 5 years old ❑3 6 to 12 years old ❑4 13 to 17 years old ❑5 18 to 24 years old ❑6 25 to 59 years old ❑7 60 years old and over ❑8 Parents ❑9 Family ❑10 Couple ❑11 Other (specify): ______
DC12	**Gender of the target population**	❑1 Woman/girl ❑2 Man/boy ❑3 Mixed

DC13	Number of participants	Number of participants ______ Average participation ______ ❑ Does not apply
DC14	Is it a program from somewhere else?	❑1 Yes ❑2 No
DC15	How is this program culturally adapted? Fill out only if yes at DC14	______ ______ ______ ______
DC16	Actual expenses	______ $



APPENDIX 12 Assistance guide to fill out the form for group files

IDENTIFICATION OF THE GROUP ACTIVITY

DC1 Indicate the group file number allocated to this activity

DC17 Start date of the development of the activity with the target population: Day/month/year

** Write only once in the case of an activity that runs over several years

DC2 Indicate the name of the activity and give enough information so we are able to identify the nature of the activity(ies) carried out

Example:

Mental health promotion week: radio vignettes, information stand, information pamphlets

Support group for bereaved parents

DC3 Indicate all the collaborators involved in carrying out the activity: function of the collaborator (job title) as well as the sector and the organization where he/she works

Example:

Function	***Sector / Organization***
Social worker:	NNAADAP, first line Mashteuiatsh
Nurse:	CLSC Val-d'Or

DC4 Start date of the activity with the target population: Day/month/year

DC5 End date of the activity of with the target population: Day/month/year

DC6 Indicate the number of activities carried out between the start and end dates

DC7 Indicate if the activity carried out was held (check all the answers that apply):

- In the community: in the geographic location recognized as the community
- On the territory: in the forest
- Outside the community: for example, in a nearby locality
- Other: specify any other situation that does not apply to the previous categories

*Check up to two boxes, if required

DC8 Please check the type of activity (check only one answer):

- Promotion activities refer to activities that target the whole population of the community: ex: family promotion on the radio
- Prevention activities target a specific group at risk: ex: single mothers
- Treatment activities refer to a series of interventions and clinical activities organized to solve a psycho-social and adaptation issue in order to avoid having it repeat itself: ex: group for violent men
- Other: specify any other situation that does not apply to the previous categories
- Community and cultural activities aim the reinforcement of social bonds between individuals (and cross-generational) as well as the transmission of the traditions and culture specific to First Nations (ex: language, hunting and fishing techniques, etc.). Social bonds and culture are identified as a protection factor for the wellbeing of children and families

DC9 In the case of a group activity, please indicate whether the group is:

- Open, meaning it allows the addition of participants at any time
- Close, meaning it does not allow the addition of new participants

DC10 Please check all the answers that are related to the issue targeted by the activity

Check a maximum of two answers

DC11 Please check the target age group of the activity

Check a maximum of two answers or use the Other box

DC12 Indicate the gender of the target group

DC13 For the activity(ies) carried out, please indicate:

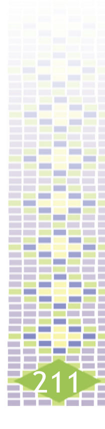
- The number of participants reached (when you can access the information)
- The average number of participants reached, in particular when they are group activities
- Does not apply if it is an activity for which you cannot tell how many people were reached: ex: promotion on the radio

DC14 Please indicate if this activity is used in the context of a program delivered elsewhere: ex: YAPP, Sentinelle, etc.

DC15 Fill out only if DC14 = yes

Please briefly specify which components of the program were culturally adapted to your community. If this is not the case, simply indicate "does not apply"

DC16 Please indicate the actual amount of the costs generated by the activity



APPENDIX 13 Summary of services provided based on the axes of action - Project 1

Priority intervention axes	Promotion activities	Prevention activities	Intervention activities
Reduce addictions to drugs, alcohol and gambling in order to foster better mental health of parents	• Survey activities among youth • Workshop on gambling • HIV/AIDS account by a woman from the community	• Accompaniment service for grocery and errands in town • Street work during periods of cash flow in urban settings • Support group for addictions: optimists' gang	• NNADAP Agent referral service
Allow parents to exercise their basic responsibilities towards their children by providing them with various services and programs	• Lunch and learn with themes on family, personal and child development, and parenting • Promotion activities on maternal and child health	• Family-respite program • Collective cooking • Group on parental skills: DÉLIMA, parents of adolescents, "proud to be parents" • Accompaniment of parents to the Centre jeunesse • Workshop on sexual education • Visit to new mothers • Accompaniment to the food bank	• Individual and family follow-ups • Social emergency services in collaboration with the Health Centre • Group on bereavement
Allow youth to have a better understanding of their culture and to develop a sense of pride and belonging to their community	• Cross-generational community activities: canoe outing, Pow Wow • Teaching of culture: hunting, language, etc. • Cultural and family community activities • Community feasts • Special activities: interband games, etc.	• Community activities with groups at risk: youth, parents, etc. • Accompaniment of group in the community: women, men • Handicraft group at school: making of a drum, dream catcher, etc. • Reinstallation of the ice rink	• Community resources referral services for youth and families

APPENDIX 14 Summary of services provided based on the axes of action – Project 2

<table>
<tr><th>Priority intervention axes</th><th>Promotion activities</th><th>Prevention activities</th><th>Intervention activities</th></tr>
<tr><td>Foster the development of children and youth in their own family</td><td></td><td>• Resourcing on the territory with youth in foster families and their parents
• Family outings (Montréal, Québec)
• Collective cooking
• Family-respite
• Babysitting during community activities</td><td rowspan="3">• Emergency interventions (suicidal crisis, family violence)
• Individual and family follow-ups</td></tr>
<tr><td>Foster a way of living without any addictions to alcohol, drugs or gambling</td><td>• Coffee-Get together on various themes (ex.: Maslow’s pyramid)</td><td>• Accompaniment in town (avoid bars, run errands and help with management of budget)
• Resourcing in the forest in collaboration with the mental health services targeting depression and addictions (alcohol)
• Workshop on sewing and knitting
• Organization of leisure and sports activities</td></tr>
<tr><td>Foster a safe and violence-free living environment</td><td>• Cultural activity (community meal based on an ancestral tradition which aims to bless the population so the year to come is filled with peace, joy, love and respect)</td><td></td></tr>
</table>

APPENDIX 15 Summary of services provided based on the axes of action - Project 3

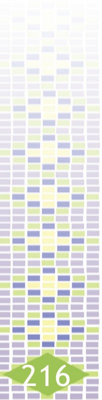
Priority intervention axes	Promotion activities	Prevention activities	Intervention activities
Parental responsibility / child-youth development	Activities within the context of: • Family Week • International Child Day • Vignette on how to install car seats for babies • Documentation Centre • Conference and information on family-related themes • Gathering (games 6-12 years old) • Youth Gathering	• Workshop parental skills: stimulation, YAPP, parents of toddlers, communication = efficiency, parents of teens, a journey; from discipline to love • Supervised visits • Parent respite • Little school	• Individual and family meetings and follow-ups • Social emergencies
Fight addictions	Activities within the context of: • Fetal Alcohol Spectrum Disorder Awareness Day • Addiction Prevention Week	• Street work • Collective cooking (women, men, children and adolescents) • Clothing bank	
Fight mental health issues among families and youth	Activities within the context of: • Promotion of Life Week • National Mental Health Week • Conference on domestic violence		
Cross-generational and community bonds	• Christmas activities: Sharing balls, Christmas baskets • Traditional activities (ex.: root gathering)		

APPENDIX 16 Summary of services provided based on the axes of action – Project 4

Priority intervention axes	Promotion activities	Prevention activities	Intervention activities
Develop a sense of belonging among youth	• Open door activity at the Youth Center	• Support activities at the Youth Center to facilitate its opening and access to resources • Ping-pong tournaments • Workshops on drugs for 1st and 2nd year of high school students in collaboration with the NNAADAP agent • Movie night at the Youth Center • Sports activities with youth (badminton)	• Individual and family follow-ups • Street intervention • Social emergency service
Develop parental skills among families	• Promotion activities in the newspaper and the community radio on the themes related to parental responsibility	• Workshops on parental skills "From discipline to love" • Program (6-12 years old, 12-18 years old)	
Promote and involve the role of extended families in the education of children	• Family Celebration Day • Three days of community activities on Aboriginal Day	• Resourcing activity • Family fishing activity	
Develop concertation work to energize the community and foster community cohesion	• Creation of the 1st-line newsletter (monthly home distribution; information on the project, report of the Advisory Committee) • Survey activities with the population on various issues related to substance abuse, etc. • Walk of Hope • Pamphlets on resource available, 1st-line services and workshops on parental skills		

APPENDIX 17 Action plans assessment grid

The questions to answer	Type of information required	Where to look for it
A) Did you do what you had planned?		
Did you use the human, material and financial resources you had planned? If not, explain why and describe the resources used.	• Budget • Human Resources • Partnerships • Infrastructures	• Logbooks • Action plan • Minutes of meetings
Did you carry out the activities and interventions you had planned? If not, explain why and describe the activities and interventions carried out.	• Description of the activities implemented based on the three axes : promotion, prevention and intervention	• Logbooks • Action plan • Group file
Did you reach the clientele you had targeted? If not, explain why and describe the clientele reached.	• Age and gender • Target issues • Number of files and activities carried out • Presence of YP services	• Individual file • Group file
B) If you had to start over, would you do it the same way?		
Did you carry out the adequate intervention based on the objectives set out and the targeted clientele? If not, what intervention should you carry out next time?	• Gaps in the continuum of services • Use of partners and the population • Needs not met in the community • Discontinuance of activities • To reach the clientele • Optimal use of resources available	• Through a team discussion • Logbooks • Minutes of concertation tables • Discussion with the Advisory Committee



The questions to answer	Type of information required	Where to look for it
C) Did you reach the objectives set out by your program?		
Were the original objectives reached with the clientele targeted by the services?	• Assessment of the improvement or reduction of an issue among the clientele: ex. Reduction of reporting rate, # of files closed after follow-up, etc. • Utilization rate of services by the clientele • Satisfaction of the clientele with regards to services	• By examining the behaviour of the clientele • By questioning the clientele • Individual file • Group file • YP data
Did the program have unforeseen beneficial or negative impacts on the clientele? If so, describe the impacts	• Individual and community outcomes noted by the workers or expressed by the clientele • Implementation of community initiatives: ex. tables, clothing bank, etc.	• By examining the behaviour of the clientele • By questioning the clientele • By questioning yourself or the Advisory Committee • Individual file • Group file • YP data

APPENDIX 18 Supplementary information - Data on youth protection

The following tables are taken from an internal document produced by l'Association des centres jeunesse du Québec (ACJQ): *Résultats des données autochtones : bandes indiennes spécifiques (June 2009)*, for Youth Centers in Saguenay/Lac St-Jean, Abitibi/Témiscamingue and Côte-Nord. It should be noted that an examination of the data should take into account that the evaluation of the first-line social services implementation was not designed to determine the project's impacts on the care of children by the youth protection system. These figures thus provide a general description of the situation and open up avenues for reflection.

*** Reports**

Table A shows the number of reports received and retained for the period from April 1, 2007 to March 31, 2008 and from April 1, 2008 to March 31, 2009 for each community having implemented first-line social services.

Table A: Number of reports received and retained in 2007-2008 and 2008-2009

	2007-2008		2008-2009	
	Received (N=)	Retained (N=)	Received (N=)	Retained (N=)
Community 1	86	66	117	60
Community 2	248	163	252	149
Community 3	161	81	207	107
Community 4	61	20	76	35

*** Number of cases taken in charge**

The following table covers the number of cases handled by the Youth Centers between 2007 and 2009. Note that this is the total number of cases that required the application of measures for at least one day in the year (active transferred cases are included, which may explain a sometimes higher number of cases taken in charge compared to the retained reports). For each case, the final ground for applying measures is considered (users are distinct and a user is counted only once even though he or she had two episodes of different "application of measures" services).

Table B: Total number of cases requiring protective measures in 2007-2008 and 2008-2009

	2007-2008	2008-2009
	(N=)	(N=)
Community 1	99	116
Community 2	267	286
Community 3	108	115
Community 4	23	27

*** Types of proposed measures**

Regarding the type of measures proposed for taking charge of a child's situation, Table C reveals that recourse to the system of judicial measures has remained the most common practice throughout the communities that implemented the pilot project.

Table C: Total number and proportion of cases covered by voluntary or judicial measures in 2007-2008 and 2008-2009

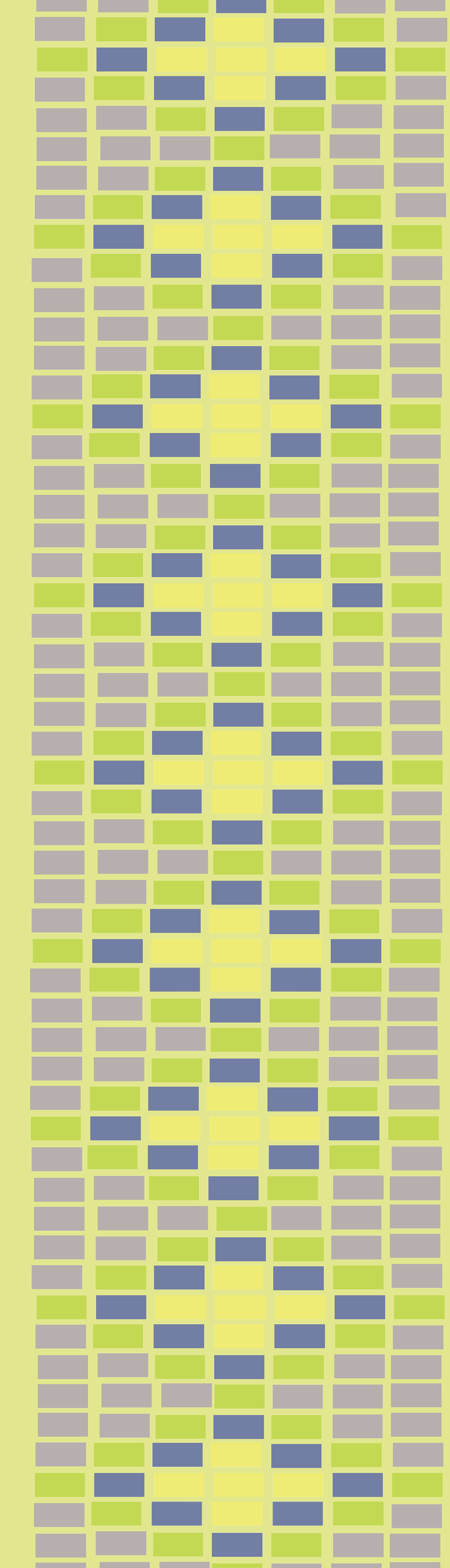
	2007-2008				2008-2009			
	Voluntary measure	Judicial measure	n/a	Total	Voluntary measure	Judicial measure	n/a	Total
Community 1	39,4% (n=39)	60,6% (n=60)	-	100% (n=99)	36,2% (n=42)	63,8% (n=74)	-	100% (n=116)
Community 2	21,8% (n=58)	77,8% (n=207)	0,4% (n=1)	100% (n=266)	23,1% (n=66)	76,2% (n=218)	0,7% (n=2)	100% (n=286)
Community 3	21,3% (n=23)	78,7% (n=85)	-	100% (n=108)	18,3% (n=21)	81,7% (n=94)	-	100% (n=115)
Community 4	0 (n=0)	100,0% (n=23)	-	100% (n=23)	3,7% (n=1)	96,3% (n=26)	-	100% (n=27)

*** Placement of children outside the home**

Table D shows the number of children placed in a resource or in the care of a third person between 2007 and 2009. Note that this is the number of distinct users placed during the year for a period exceeding 30 days. Regardless of the number of placements, the child is counted only once.

Table D: Number of placements according to type of resource in 2007-2008 and 2008-2009

	2007-2008		2008-2009	
	Placed in a resource	Placed in the care of a third person	Placed in a resource	Placed in the care of a third person
Community 1	85,1% (n=40)	14,9% (n=7)	82,6% (n=57)	17,4% (n=12)
Community 2	68,5% (n=85)	31,5% (n=39)	61,3% (n=119)	38,7% (n=75)
Community 3	87,6% (n=71)	12,4% (n=10)	89,5% (n=77)	10,5% (n=9)
Community 4	53,3% (n=8)	46,7% (n=7)	56,3% (n=9)	43,7% (n=7)



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