Social Determinants of Health for the Aboriginal families who participated in the Families First Edmonton study

A Families First Edmonton report
for
Alberta Centre for Child, Family and Community Research and Ministry of Human Services

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with forward by
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Families First
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Forward by Bert Auger

Did you know?

The province of Alberta has **45** First Nations in three Treaty Areas (Treaties 6, 7, and 8).

There are **134** reservations located throughout the province of Alberta.

There are over **100,000** Treaty Status Aboriginal peoples in Alberta.

That over half of First Nations people live in urban centres

Over **85,000** Métis people live in Alberta.

Métis people are of mixed European and Aboriginal blood

There are **8** Métis settlements in the province of Alberta.

Approximately **8,000** Métis live on Métis settlements and the rest live in urban centres.

Alberta is also home to a number of Inuit, who are Aboriginal people from Arctic Canada.

6 Aboriginal languages are spoken in Alberta.

It is important to note the diversity of the Aboriginal population in Alberta.

The word *Aboriginal* is used to describe the descendents of the original inhabitants of Canada.[i] While this term does serve a purpose, it also obscures the diversity of the Aboriginal peoples of Canada, and more specific to this report, the diversity of the Aboriginal peoples of Alberta.

It is important to acknowledge and honour the diversity of the Aboriginal peoples of Alberta. What may be a reality for the members of a First Nation in the south of Alberta may not be so for a Nation in the north. Further, what may be a social reality for a person who is Métis may not be so for someone who is First Nations.

This report captures the lived experiences of a collection of Métis and First Nations people who have familial and kin connections that span the entire province of Alberta and for much of Canada (*please take time to study the map on page 1 of this report*). Unfortunately we do not have enough representatives from each Nation to be able to expound on the experiences of specific groups. Thus, it is important that we take pause to acknowledge and appreciate the diversity that is inherent within this collective.

Another point to consider is that each individual who participated in this study will have different degrees of connection to the traditions of their people...

Diagram I: Aboriginal cultural identity and lifestyles

Diagram courtesy of Bert Auger

Aboriginal peoples may identify as either "Traditional", "Transitional", "Bicultural" or "Assimilated/ Mainstream". "Traditional" Aboriginal peoples are those who live a traditional lifestyle of hunting, gathering and trapping and, for the most part, have very little to do with mainstream society. This study does not capture the lived experiences of "Traditional" Aboriginal peoples as the eligibility criteria for the *Families First Edmonton* study required families to live in the city of Edmonton.

However, the families that did participate in the FFE study will range from those who are *transitional* (those who are not strongly tied to either mainstream or traditional culture, perhaps because they have recently moved from a rural area to Edmonton), to others who are better described as *bicultural* (comfortable living in both mainstream and traditional cultures, but may still have strong ties to tradition), or those who live a more *mainstream* lifestyle (those who work and live in Edmonton, with few ties to their Aboriginal heritage).[ii]

It is important to acknowledge that the families that participated in this study may differ from one another in terms of lifestyle. While some may have recently transitioned from a rural community to the city of Edmonton, others may be well-versed and practiced with the customs and ways of city-life.

~ Bert Auger,
Senior Manager of Aboriginal Supports, Human Resources, Government of Alberta

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Bert Auger was born on Whitefish Lake First Nation. He spent his early childhood years living on both Whitefish Lake reserve and East Prairie Métis settlement. His first language is Cree. Bert identifies as a bicultural Aboriginal person. He is well-versed and comfortable both with the traditional ways of his people as well as mainstream culture. Bert began to learn English at seven years of age while attending the Whitefish Lake Reserve school. He graduated from the University of Grant MacEwan in 1986 from the Social Work program and has lived most of his adult life in High Prairie with his wife Juliette. They have four grown boys and three grandchildren - who keep them very busy!

Executive Summary

Overview of the Families First Edmonton study

Families First Edmonton (FFE) is a community-university partnership study that is exploring whether delivery of health, family support and recreation services in a more coordinated way can improve the overall capacities of **low income families**. FFE is a randomized control trial exploring the effects of three different service-delivery "interventions".

Regardless of which intervention a family was randomly assigned to, each family was interviewed by a data collector before randomization occurred and every 12 months thereafter. At each data collection session, information on the same adult and child was collected as well as information about the family, neighbourhood/community and the services used by the family. A single child was tracked by data collectors throughout the study. This child had to be 12 years of age or younger when the FFE study began. The first data collection session with the first FFE family took place in **December 2005** and the last follow-up interview with the final family took place in **June 2011**.

This report summarizes the baseline demographic, education, employment, housing, social inclusion and health information for the 207 Aboriginal families that participated in the FFE study.

More information about the FFE study, including other reports can be found at:
www.familiesfirstedmonton.ualberta.ca

Summary of Results

Self-Identification as First Nations or Métis

Approximately 40% of the FFE Aboriginal caretakers identify as Métis while 60% identify as First Nations.

Considerations for programs and services

Métis families may differ from First Nations families with respect to available resources, opportunities, and challenges to date. Developing services that build on strengths and are sensitive to barriers for each of these groups may improve eventual outcomes for these economically vulnerable families.

Kin connections for First Nations caretakers

83% of the First Nations caretakers report a connection with a specific First Nation. These social networks and communication flows span the entire province as well as neighbouring provinces/territories. FFE participants have ties to Nations as far north as Smith's Landing First Nation to as far south as the Blood Tribe. Approximately 30% of the caretakers have connections with communities outside of Alberta. The majority of these out-of-province affiliations are with Nations in Saskatchewan.

Considerations for programs and services

While some of the FFE Aboriginal primary caretakers were born and have lived their entire lives in Edmonton, many have not. Families transitioning from a reserve to the city may require settlement services, particularly if moving from a remote area of the province. Supporting these families as they adjust to urban life may improve eventual outcomes for these economically vulnerable families.

The FFE data also demonstrate that the Aboriginal caretakers that took part in the study are diverse with respect to their connections to different First Nations. As such, these families will differ from one another with respect to resources, opportunities, and challenges to date. Building services that are sensitive to this diversity may improve eventual outcomes for these economically vulnerable families.

Prevalence of women as lone parents

The majority of the FFE Aboriginal families are lone parent families (81%). Ninety-six percent of these lone parent families are headed by a female, whether it be the biological mother, grandmother, sister or auntie. Overall, **78% of the Aboriginal families are headed by a single (lone parent) woman** (*note*: 15% of families are female-headed lone parent families in the general Edmonton population; 2006 Canada Census).

Considerations for programs and services

The over-representation of lone parent women within the FFE Aboriginal families points to the economic vulnerability of this group. Services that are sensitive to the limited time, energy, and financial resources of these families may improve eventual outcomes for these economically vulnerable families.

Education

Approximately half of the FFE Aboriginal caretakers have less than a high school education (had not earned a high school diploma or its equivalent). This compares to 22% for the general Edmonton population (2006 Canada Census).

Considerations for programs and services

According to a social determinants of health framework, education is strongly connected to income and overall wellbeing. The over-representation of FFE Aboriginal caretakers with low educational levels is a concern and a strong contributor to their vulnerability: economically, socially and health wise. By using a holistic approach, barriers to the educational attainment of these caretakers can be uncovered, understood and addressed.

Childcare: A barrier to employment?

Approximately 75% of the FFE Aboriginal caretakers were not working for pay outside of the home at the time of the interview. Interestingly, when compared to homes where the primary caretaker is working for pay outside of the home, the age of the youngest child in the home is much younger in homes where the primary caretaker is not working (3.7 years compared to 5.8 years).

Considerations for programs and services

This finding suggests that parents may wait until their youngest child is of school age before seeking employment outside of the home. Access to affordable childcare may improve the employment rate for caretakers of preschool aged children, particularly for those who are lone parents.

Clustering in low-paying sales and service jobs

The most commonly reported occupational skill type reported by FFE Aboriginal caretakers is sales and service occupations. Over half of the primary caretakers report (usually) working a sales or service job. Seventy-five percent of the caretakers (usually, if not currently working) work jobs that require at most a high school education (NOC skill level C or D).

Considerations for programs and services

The clustering of these caretakers in low paying, low skill work may in part be related to their low educational levels. The link between education, employment and economic/social/physical/spiritual and emotional wellbeing is well established in the literature. A holistic understanding of the barriers and challenges this group faces with respect to education, and eventual employment options, is needed.

Core Housing Need

85% of the FFE Aboriginal households are in core housing need (this calculation is inclusive of those receiving housing subsidization). Most of these households contend with the single issue of housing affordability (54%). However, 46% of the homes in core housing need are crowded (and unaffordable), in poor state of repair (and unaffordable), or contend with all three housing issues.

Considerations for programs and services

The size, condition and cost of housing is instrumental to the health of all family members. These results demonstrate that the majority of the FFE Aboriginal households are living in suboptimal housing conditions. Evaluating and addressing the housing needs of these families may improve eventual outcomes for these economically vulnerable families.

Social Isolation

92% of the FFE Aboriginal caretakers expressed a desire to be more engaged in their communities. The top five barriers to community participation are, a lack of: money, awareness of what is available, transportation, child care, and knowledge of how to get involved.

Considerations for programs and services

The social isolation noted by the caretakers as well as the barriers to their involvement may be a particular concern for those who have recently transitioned from a more remote area of Alberta/Canada to Edmonton (perhaps a recent move from a rural reservation). While caretakers may benefit from existing programming, a lack of awareness of what is available or knowledge of how to get involved act as significant barriers to service usage. These barriers may be addressed by increasing the visibility and public knowledge of existing programs and services.

Mental Health

The mental health scores for the FFE Aboriginal caretakers are much worse than expected for a non-clinical population. The proportion of caretakers who show "clinically significant" levels of interpersonal sensitivity and psychoticism is 11 times greater than expected. **The mental health scores of the children of FFE Aboriginal caretakers are also much worse than expected for a non-clinical population.** The proportion of children who show "clinically significant" levels of depression and hyperactivity are 7 times greater than expected in a community group.

Mental Health Services for caretakers with clinically significant scores

Very few of the caretakers with "clinically significant" mental health scores were actively seeing a health professional. For example, none of the 32 adults with "clinically significant" levels of depression, anxiety or paranoid ideation reported seeing a health professional. *It is important to note that while they may not be receiving help from a health professional, some of the caretakers with significant mental health concerns may be receiving support from an Elder in their community or partaking in other traditional approaches to mental health and spiritual wellbeing (example, sweat lodges).*

Mental Health Services for children with clinically significant scores

The proportion of children accessing support from a mental health service provider varied depending on the condition. For example, almost 30% of the children with "clinically significant" levels of depression were actively seeing a mental health care professional. This compares to 19% of children with elevated aggression scores and 11% of children with elevated anxiety scores. None of the children with attention problems or conduct problems were actively receiving support at the time of the interviews.

Instead of limiting our awareness to those who have been formally diagnosed and are receiving services, the FFE data reveal that there are many people in our community who are undiagnosed and/or are experiencing barriers with respect to mental health services.

Considerations for programs and services

The over-representation of caretakers with "clinically significant" mental health concerns points to the vulnerability of this population. Eventual outcomes for these families may be improved if the mental health of the primary caretakers and children is assessed and treated if necessary. Barriers to diagnoses and obstacles to obtaining culturally sensitive treatment need to be addressed.

Overview of the Families First Edmonton project

Families First Edmonton (FFE) is a community-university partnership study that is investigating whether delivery of health, family support and recreation services in a more coordinated way can improve the overall capacities of **low income families**. FFE is a randomized control trial exploring the effects of three different service-delivery "interventions".

Over 1,200 families participated in the FFE study.

How did the FFE project define low income?

There is no one way of defining low income. Therefore, the FFE team decided to take a services approach to determine which families were eligible to take part in the study. Families were deemed eligible if they were receiving one of the following: Income Support, Alberta Health Benefits, had a Leisure Access Card, or were receiving housing supports through Capital Region Housing Corporation.

In addition to being low income, were there other eligibility criteria?

In addition to being low income, families who participated in the FFE project had to have a child who was 12 years of age or younger in the home and live in the City of Edmonton.

What did the families experience?

Each family who met the study eligibility criteria and wanted to participate in the study were randomly assigned to one of four groups:

1. Recreation
2. Family Healthy Lifestyle
3. Comprehensive
4. Self-Directed

Recreation

Families who were randomly assigned to the "Recreation" group were paired up with a support worker from the YMCA of Edmonton. These support workers helped parents enrol their children in different recreation based activities. Parents and children were able to choose the activity/activities that they wanted to try! Here are a few examples of the many recreation activities that the FFE families accessed: day camps, bowling, swimming lessons, Tae Kwon Do classes, music lessons, soccer, skating lessons, gymnastics and ballet lessons.

Family Healthy Lifestyle

Families who were randomly assigned to the "Family Healthy Lifestyle" group were also paired up with a support worker from the YMCA of Edmonton. This time the support worker acted as an advocate for the families to help them link to existing health and social services. Examples of some of the services that families accessed include: assistance with child care, Legal Aid, literacy programming, supports for family

members with cognitive or physical impairments, information on food banks, public library programming and respite services.

Comprehensive

Families who were randomly assigned to the "Comprehensive" group worked with a support worker from the YMCA who assisted the family with both "Recreation" and "Family Healthy Lifestyle" programming.

Self-Directed

Families who were randomly assigned to the "Self-Directed" group did not receive additional services from a service worker. These families continued to access programming and services as per usual.

Data collection

Regardless of which group the families were assigned to, each family was interviewed by a data collector before they were randomly assigned to a group and every 12 months thereafter. At each data collection session, information on the same adult and child was collected. The adult who was interviewed at each data collection session self-identified as the person most knowledgeable (PMK)[1] about the child. Usually the PMK was a biological parent. However, sometimes other adults, like grandparents and older siblings, identified themselves as the PMK. In addition to providing information about themselves, the PMK also provided information about the child, family, community, and the types of services that the family accessed. Even though all children in a family received recreational programming if their families were a part of the "Recreational" or "Comprehensive" groups, only one child was tracked by data collectors throughout the study. This child was called the "focus child". The "focus child" had to be 12 years of age or younger when the FFE study began. The very first data collection session with the first FFE family took place in **December 2005** and the very last interview with the final family took place in **June 2011**.

More information about the FFE study, including other reports can be found at:
www.familiesfirstedmonton.ualberta.ca

[1] For ease of readability, this report uses the term "primary caretaker" instead of "PMK".

Identifying Aboriginal families within the FFE project

Families are complex. It is difficult to categorize families as Aboriginal or non-Aboriginal since ethnic and cultural identities can differ within the same household. An example of this is when one parent self-identifies as Aboriginal while the other does not.

Primary caregivers were asked two different questions with respect to their own cultural or ethnic identity as well as their co-partners (if applicable):

Do you (or your partner) identify as an Aboriginal person?

and

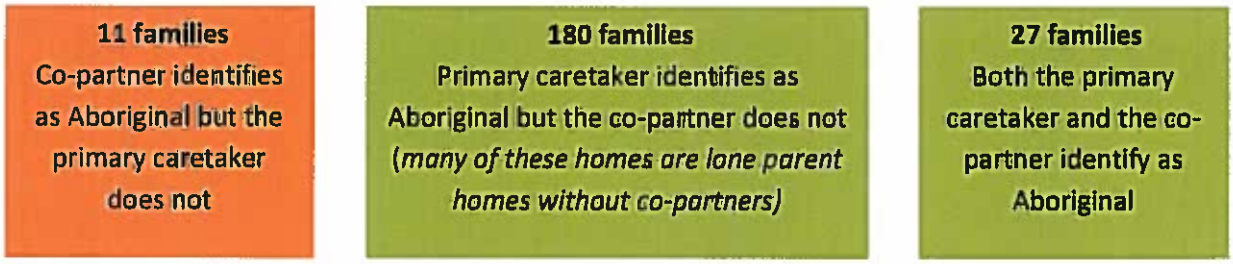
To which ethnic or cultural group(s) do your (or your partner's) ancestors belong?

While a person may report an Aboriginal heritage, (s)he may not self-identify as Aboriginal. This may occur if a person has a distant relative who was Aboriginal. Thus, for the purposes of this report we capture the experiences and responses of those individuals who self-identify as Aboriginal.

As can be seen in Chart 1, 218 families within the FFE study have either a primary caretaker or a co-partner of a primary caretaker who self-identify as Aboriginal. Both the primary caretaker and the co-partner self-identify as Aboriginal in 27 of these families while 180 families have a primary caretaker, but not a co-parent, who self-identifies as Aboriginal.

For the purposes of this report, we define Aboriginal families as *families in which the primary caretaker self-identifies as Aboriginal (green boxes)*. This report summarizes the data for these **207 families**.

Chart 1: Aboriginal families within the FFE study



Social Determinants of Health Framework

A social determinants of health framework recognizes the connection between our social and material living conditions and our mental and physical health. The connection between our social and material environment and our health is central to optimal child development. Young children are particularly vulnerable to unhealthy environments. A child's early social and physical environment impacts the way their brains and bodies develop.[iii]

Income, education, employment, housing and social inclusion are all contributors to the health of parents and children.[iii] Income is arguably the most vital contributor to a person's health. Many of the other determinants depend on a person's ability to afford particular living conditions and opportunities such as, a good home in a safe neighbourhood, nutritious food, educational opportunities and recreational programming.

How does a parent's level of education affect their or their child's health?

Education can mean anything from basic literacy skills to advanced work force training. People with higher levels of education tend to be healthier since higher levels of education usually result in higher income, employment security and better working conditions. Higher levels of education are also correlated with increased community participation.[iv] Parents who struggle with reading may in turn read less to their children. From a child development perspective this can have negative consequences for young children. Reading to a child helps children with language development and fosters the child's confidence with respect to reading. According to Nancy Petersen, Coordinator at the City Centre Education Partnership, "[children who are familiar with books and have been read to by their parents] have a sense of calmness and security when they are learning to read, [while children who have limited experience with books] have a very different reaction when they first confront books and printed words. Their brains trigger stress. They are in a heightened, constant state of anxiety when they are trying to learn to read".[v]

How does a person's employment situation impact their or their family's health?

Adequate employment is one dimension of social inclusion that can positively impact the health of individuals and families. The socio-economic environment (e.g., education, employment, income) is an important predictor of the health status of any population group.[vi] People who are unemployed are likely to describe their health as generally fair or poor.[vii] For example, a Statistics Canada study found that 23% of all premature mortality cases in Canada can be accounted for by income differences.[viii] Those who are ill may be more likely to lose their jobs and find it harder to regain employment because of their ill health.[ix] Further, long-term unemployment is associated with mental health deterioration - even for people who were previously healthy. Overall, unemployment is a stressful life event that is frequently associated with poor health.[x]

How does a family's housing situation impact the health of family members?

There are many ways in which a family's housing situation impacts the health of all family members. High housing costs reduce the financial resources available to afford other social determinants of health such as, recreational opportunities, educational opportunities and food security. Noise and a lack of space due to crowding can hamper a child's school performance.[xi] Overcrowding can also lead to the transmission of respiratory and other illnesses.[xii] Children who live in low quality housing conditions have a greater likelihood of poor health outcomes in both childhood and as adults. Dampness, for example, causes respiratory illness and makes pre-existing health conditions worse.[xiii] Homes that are in poor condition can also have detrimental effects on child brain development. According to Alberta's Chief Medical Officer of Health, "a child exposed to chemicals, such as lead or mercury at key periods of brain development, potentially faces lower intelligence or increased behavioral problems that can be irreversible".[xiv]

How does social inclusion affect an individual's health?

Contemporary research demonstrates a link between social inclusion (e.g., family support, friendship) to recovery and resilience for those who face mental health difficulties.[xv] Social support, particularly within shared identity groups, has been found to have a 'buffering effect' against stress. In addition, resources provided through community engagement affect people's well-being, especially low-income families who experience multiple disadvantages.[xvi] Overall, considerable evidence has revealed social support as beneficial to health. For example, social exclusion may be related to ill health, in part through the development of unhealthy responses to stress (e.g., substance abuse) that substitute for emotional support and belonging.[xvii]

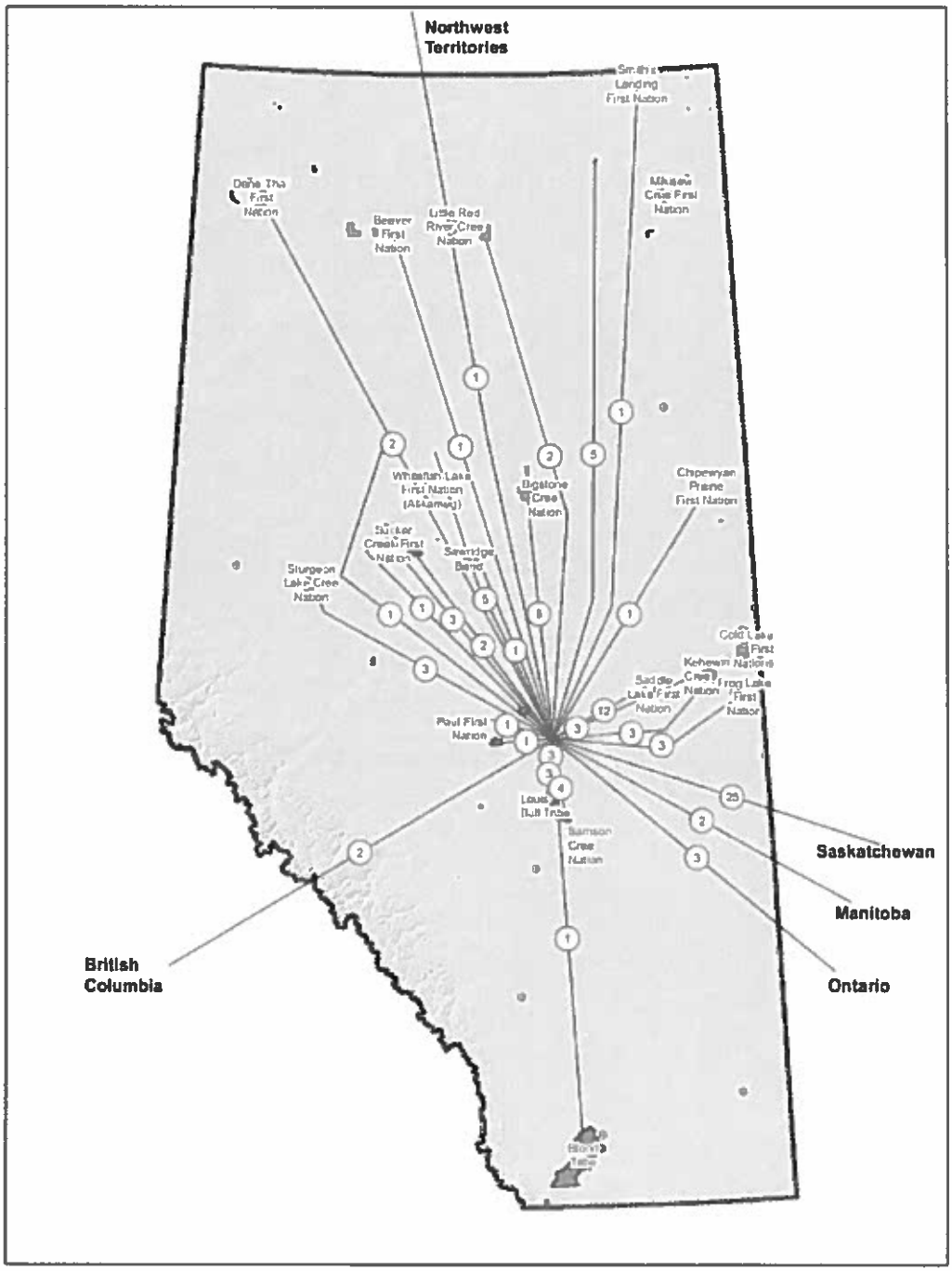
In this Families First Edmonton special report for Alberta Centre for Child, Family and Community Research (ACCFCR) and the Ministry of Human Services, we explore the social determinants of health for the 207 Aboriginal families that participated in the FFE study.

PART I: Demographic profile of the FFE Aboriginal families

1.1: Aboriginal People's Identity

Approximately 60% of the Aboriginal primary caretakers self-identify as First Nations and 40% as Métis. Of those who identify as First Nations, 83% report affiliations with specific First Nations. These social connections are mapped in Figure 1.1.

Figure 1.1: First Nations affiliations for the FFE Aboriginal primary caretakers



Source: *Families First Edmonton*

Social connections between primary caretakers living in Edmonton and individual First Nations span the entire province of Alberta. The two most commonly reported ties within Alberta are with the Saddle Lake (N=12) and Bigstone Cree (N=8) Nations.

While most of the affiliations are with First Nations within Alberta, almost 3 out of every 10 primary caretakers holds membership with a Nation outside of Alberta. The majority of these inter-provincial/territorial connections are with First Nations in Saskatchewan.

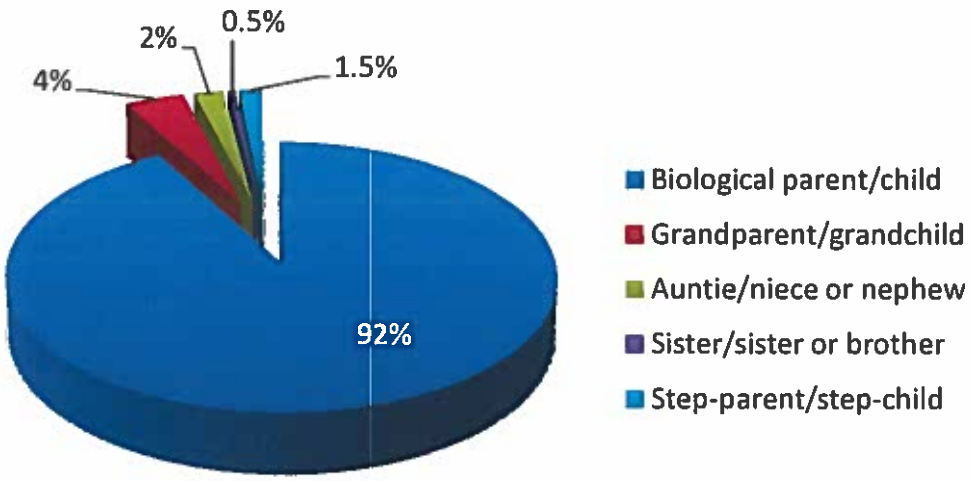
1.2: Knowledge of Aboriginal languages

13% of the primary caretakers learned an Aboriginal language in childhood and are fluent in the language today. The three most commonly reported languages are Cree, Dené and Saulteaux.

1.3: Relationship between the FFE Aboriginal primary caretaker and the "focus child"

In most FFE households, children live with a biological parent (92%). However, in about 8% of the FFE households, a person other than the biological parent identifies as the primary caretaker. These kin relationships are shown in Figure 2.

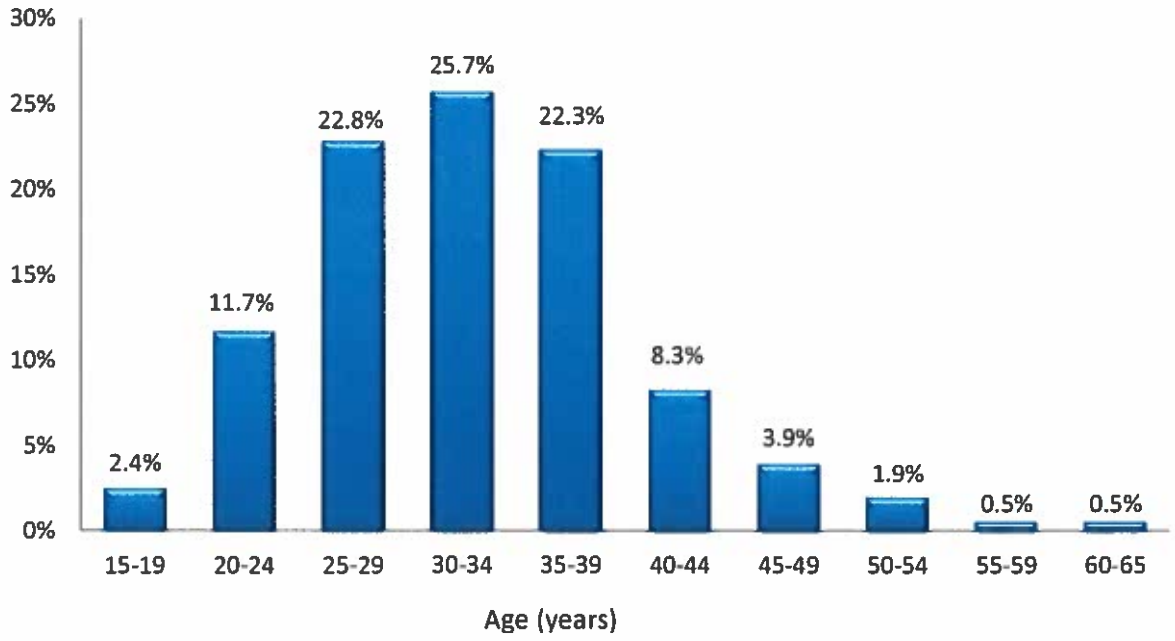
Figure 1.2: Kin relationships between FFE Aboriginal primary caretakers and the "focus child"



1.4: Age profile of the FFE Aboriginal primary caretakers

Figure 1.3 charts the age profile of the FFE Aboriginal primary caretakers. On average, the primary caretakers are 32.9 years. Looking at the two distribution extremes, we can see that approximately 2% of the primary caretakers are teenagers (note: while the age range in Figure 1.3 ranges from 15-19 years, the youngest caretaker in the FFE sample is 17 years of age). Roughly 3% of the caretakers are 50 years of age or older. It is notable that most of the caretakers ≥50 years are grandparents (86%).

Figure 1.3: Age profile of the primary caretakers



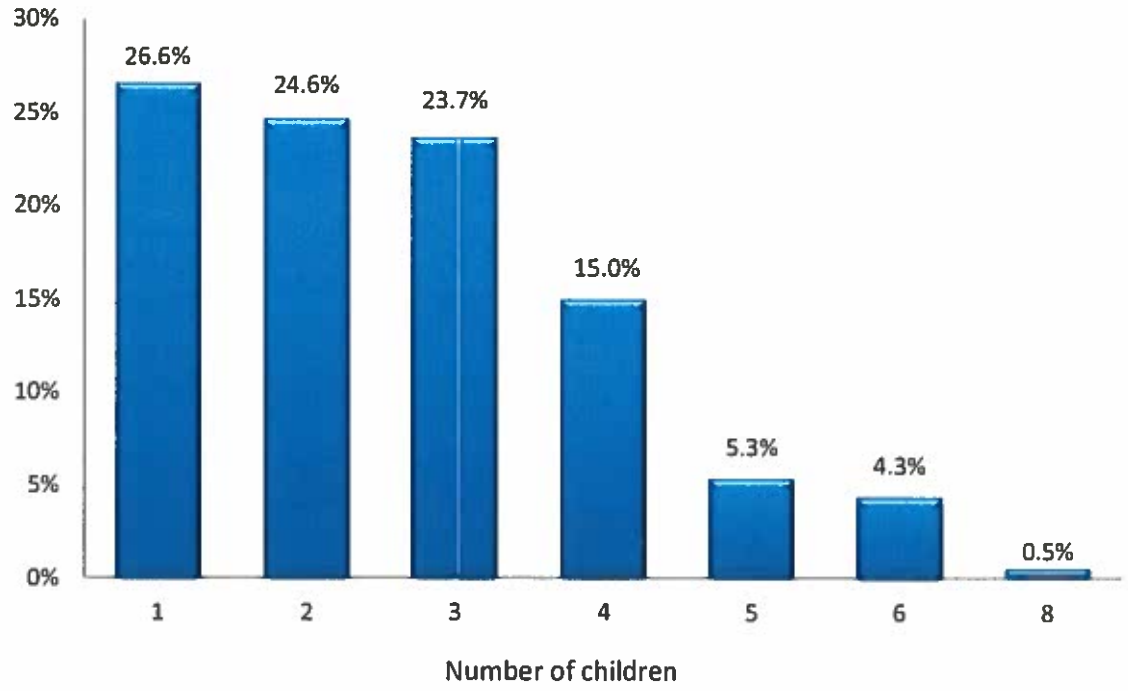
1.5: Household structure

Approximately 4 out of every 5 FFE Aboriginal households are headed by a lone parent (81%). The majority of these lone parent homes are headed by females (96%). When we consider the caretaker's sex and lone/co-parent status together we find that 78% of the Aboriginal families are headed by a single (lone parent) woman.

1.6: Number of children in the home

The number of children living in FFE Aboriginal homes ranges from 1 to 8. On average, FFE Aboriginal homes have 2.6 children. However, as can be seen in Figure 1.4, approximately 1 in 4 homes have 1 child, another 25% have 2 children and another almost 25% have 3 children living in the home. The remaining 25% of the homes have 4 or more children.

Figure 1.4: Distribution of the number of children in the home



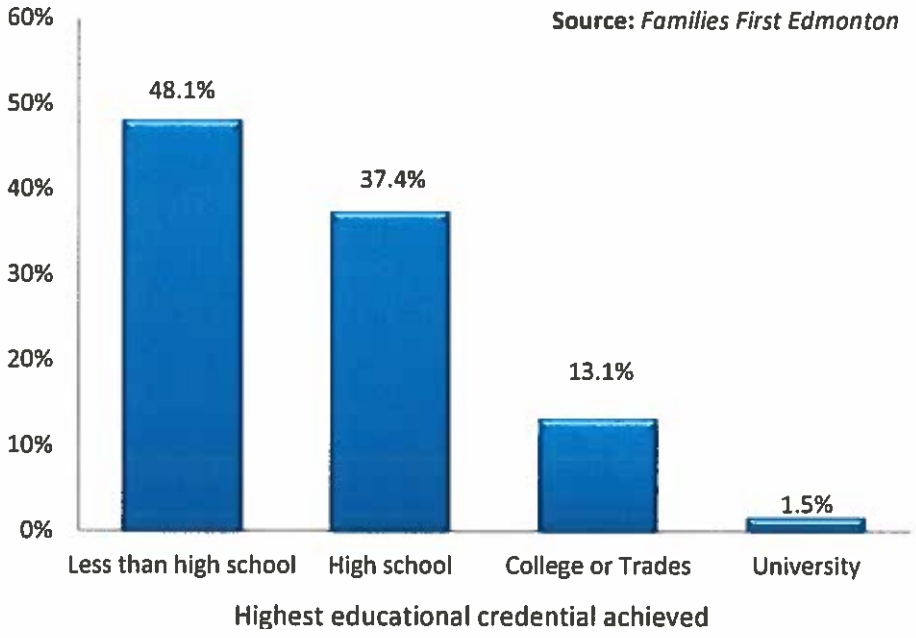
PART II: Social Determinants of Health

2.1: Education

Almost half of the Aboriginal primary caretakers who participated in the FFE study had less than a high school education at the time of the initial interview (i.e., had not earned a high school diploma or its equivalent). The lowest grade level achieved was Grade 6. The majority of those without high school diplomas discontinued their education when they were in their senior high school years (66% discontinued between Grades 10 and 12).

Approximately 15% of the caretakers had earned a college diploma, trades certificate or university degree (Figure 2.1).

Figure 2.1: Distribution of educational attainment for the primary caretakers



2.2: Employment

All primary caretakers were asked whether or not they currently work for pay outside of the home. Approximately **three out of every four Aboriginal primary caretakers indicated that they were not currently employed for pay outside of the home.**

Primary caretakers that were currently working for pay were asked to report the type of job they were currently working while primary caretakers who were not currently working were asked what job they usually work.

Each of the job titles were coded according to the National Occupation Classification (NOC) System.[xvii] The NOC organizes over 500 occupations by the skill type (9 different skill types) and skill level required for that job (4 different skill levels):

The presence of preschool aged children in the home may impede Aboriginal primary caretakers from working for pay...

The youngest child in homes where the primary caretaker is working for pay outside of the home is approximately 5.8 years of age, significantly older than the age of the youngest child in homes where the primary caretaker is not working for pay outside of the home (age=3.7 years). This age difference is statistically significant ($F_{1,204}$=15.32, P<0.01) and suggests that parents may wait until the youngest child is of school age before engaging in work outside of the home.

Skill Type
1: Business, Finance and Administration Occupations
2: Natural and Applied Sciences and Related Occupations
3: Health Occupations
4: Occupations in Social Science, Education, Government Service and Religion
5: Occupations in Art, Culture, Recreation and Sport
6: Sales and Service Occupations
7: Trades, Transport and Equipment Operators and Related Occupations
8: Occupations unique to Primary Industry
9: Occupations unique to Processing, Manufacturing, and Utilities

Skill Level
A: Occupations that usually require university education
B: Occupations that usually require college education or apprenticeship training
C: Occupations that usually require secondary school and/or occupation-specific training
D: Occupations that usually require on-the-job training

With the exception of management positions, jobs can be organized into major groups; a combination of the skill level and skill type. For example, a *cashier* belongs to the major group 6D while a *physician* belongs to the major group 3A.

Since many primary caretakers hold more than one job, primary caretakers were allowed to report up to four different job titles. In this section we summarize the first job title that was reported to data collectors (Table 2.1).

Table 2.1: Percentage of the Aboriginal primary caretakers in each NOC major group

	Skill Type									
Skill Level	1 Business, Finance and Administration Occupations	2 Natural and Applied Sciences and Related Occupations	3 Health Occupations	4 Occupations in Social Science, Education, Government Service and Religion	5 Occupations in Art, Culture, Recreation and Sport	6 Sales and Service Occupations	7 Trades, Transport and Equipment Operators and Related Occupations	8 Occupations unique to Primary Industry	9 Occupations unique to Processing, Manufacturing, and Utilities	Total
A	-	-	0.5%	2.1%	1.1%	-	-	-	-	3.7%
B	3.2%	-	0.5%	8.5%	-	5.8%	3.1%	-	-	21.1%
C	13.8%	-	3.2%	-	-	21.7%	4.8%	1.1%	-	44.6%
D	-	-	-	-	-	27.5%	2.6%	0.5%	-	30.6%
Total	17%	0%	4.2%	10.6%	1.1%	55%	10.5%	1.6%	0%	100%

Source: *Families First Edmonton*

Skill Level A: Occupations that usually require university education

Skill Level B: Occupations that usually require college education or apprenticeship training

Skill Level C: Occupations that usually require secondary school and/or occupation-specific training

Skill Level D: Occupations that usually require on-the-job training

Skill Type

From Table 2.1 we can see that the majority of the Aboriginal caretakers (usually) work "Sales and Service Occupations" (55%). The second most commonly reported skill type is "Business, Finance and Administration Occupations" (17%) followed by "Occupations in Social Science, Education, Government Service and Religion" (11%), and "Trades, Transport and Equipment Operators and Related Occupations" (11%). None of the primary caretakers report working in the "Natural and Applied Sciences and Related Occupations" or in "Occupations unique to Processing, Manufacturing, and Utilities".

Skill Level

The majority of the primary caretakers report working jobs that require at most a high school diploma (Skill Levels C & D; 75%). Even though 1.5% of the primary caretakers report holding university credentials, approximately 4% work jobs that typically require a university degree. Twenty-one percent work jobs that usually require either a college diploma or a trades certificate.

Major Group

The most commonly reported major group when skill type and skill level are considered together is "Sales and Service Occupations" that require on-the-job training (i.e., high school diploma not required).

Occupation

Table 2.2 shows the top five jobs worked by Aboriginal primary caretakers. Two out of every five caretakers listed one of these five jobs as work they are currently engaged in or work they usually do when employed. "Cashier" was the most commonly reported job.

Table 2.2 Top 5 jobs reported by Aboriginal primary caretakers

Occupation title	NOC	Percentage of primary caretakers who reported working these jobs
Cashier	6611	11.5%
Food and Beverage Server	6453	9.4%
Administrative Assistant	1411	6.8%
House Cleaner/Housekeeping Attendant	6661	6.3%
Child and Youth Care Worker	4212	5.7%

Source: *Families First Edmonton*

Unemployment

As stated earlier, approximately 75% of Aboriginal primary caretakers indicated that they were not currently employed for pay outside of the home when baseline interviews took place. Of those not working, **27% experienced unemployment within the past 12 months** (i.e., actively looking for work however unable to secure work).

Services Accessed by the unemployed

Forty-one primary caretakers (27%) reported a spell of unemployment in the past 12 months. Ten of these caretakers accessed an employment-specific service and/or an Aboriginal agency. The names of the services that were accessed are:

General Employment Services

Alberta Human Resources and Employment (5 people)
Distinctive Employment Counselling Services of Alberta (1 person)

*Aboriginal Services**

Ben Calf Robe Society (1 person)
Bent Arrow Traditional Healing Society (1 person)
Canadian Native Friendship Centre (1 person)
Red Road Healing Society (1 person)
Métis Nation of Alberta Association (1 person)

**We list Aboriginal services because many have employment specific programming.*

2.3: Housing

According to Canada Mortgage and Housing Corporation (CMHC), acceptable housing is "adequate in condition, suitable in size, and affordable".[xix] A household is determined to be in core housing need if it falls below one or more of these housing standards *and* the household would have to spend more than 30% of the gross household income to be able to pay the median rent of local acceptable market housing. This second condition is determined by comparing a household's gross income to Core Need Income Thresholds (CNITs).

A CNIT is a calculation of the minimum income a household needs so as to be able to afford an appropriately sized home. Since housing costs are different in different communities, CNITs are location-specific. CNITs are also sensitive to the unit-size (i.e., number of bedrooms needed given the size and constitution of the household). Table 2.3 lists the CNITs for the City of Edmonton for the years 2005-2008.

Table 2.3 Core Need Income Thresholds for the City of Edmonton

Bedroom unit	2005	2006	2007	2008
Bachelor unit	$21,500	$23,500	$27,000	$29,500
1 bedroom unit	$24,500	$26,500	$32,500	$35,500
2 bedroom unit	$30,500	$33,500	$40,000	$43,500
3 bedroom unit	$42,000	$45,500	$51,000	$54,000
4 bedroom unit	$44,500	$50,500	$54,500	$59,000

Source: *Market Analysis Centre, Canada Mortgage Housing Corporation (CMHC)*
According to the National Occupancy Standards, a home is crowded when an adult shares a bedroom with a child. Since the smallest household structure for the FFE families is one adult and one child, the minimum house size for the FFE families is a 2 bedroom unit (blue shading).

State of repair

According to CMHC, homes that are inadequate are those in need of major repairs (i.e. defective plumbing or electrical wiring, and/or structural repairs to walls, floors, or ceilings, etc). **Twenty-one percent of the FFE Aboriginal families are living in homes that require major repairs.**

Crowding

According to National Occupancy Standards (NOS), a home is crowed if it does not have enough bedrooms for each member given the age, sex and relationship composition of the household. The NOS states that:

1. No more than two people can share a bedroom
2. Spouses and couples can share a bedroom
3. Parents cannot share a bedroom with children
4. Dependants aged 18 or more must have their own bedroom
5. Dependants who are of the opposite sex may share a bedroom as long as they are both under five years of age

Crowding impacts approximately 33% of the FFE Aboriginal households.

Affordability

Approximately 64% of the Aboriginal families are unable to afford their homes (spending 30% or more of their gross household income on shelter costs).

It is important to note that *67% of the Aboriginal families who can afford their homes are receiving some form of housing subsidization.*

How many bedrooms do these families need?

Angela has three children (a boy and a girl both 6 years of age - twins) and another daughter who is 20 years of age. According to the NOS this family requires 4 bedrooms. Angela (1), Eldest daughter (1), Twin boy (1) and Twin girl (1).

Michael lives with his mother. He has two children who are 2 and 3 years of age. According to the NOS this family requires 3 bedrooms. Michael (1), Michael's mother (1), two children (1). In this case we do not need to know the sex of the two children since they are both under 5 years of age.

Core Housing Need

As mentioned previously, households that are crowded, in need of major repairs or spending ≥30% of the household income on shelter costs are not necessarily deemed to be in core housing need. It is important to consider each of these housing qualities in combination with the CNIT.

Table 2.4 Core Housing Need breakdown for the FFE Aboriginal households

	Percentage of FFE Aboriginal households....		Income ≥ CNIT		Income < CNIT
... that need major repairs	**21%**	=	**4%**	+	17%
... that are crowded	**33%**	=	**6%**	+	27%
... that are unaffordable *(spend ≥30% of income on shelter costs)*	**64%**	=	**3%**	+	61%

Source: *Families First Edmonton*

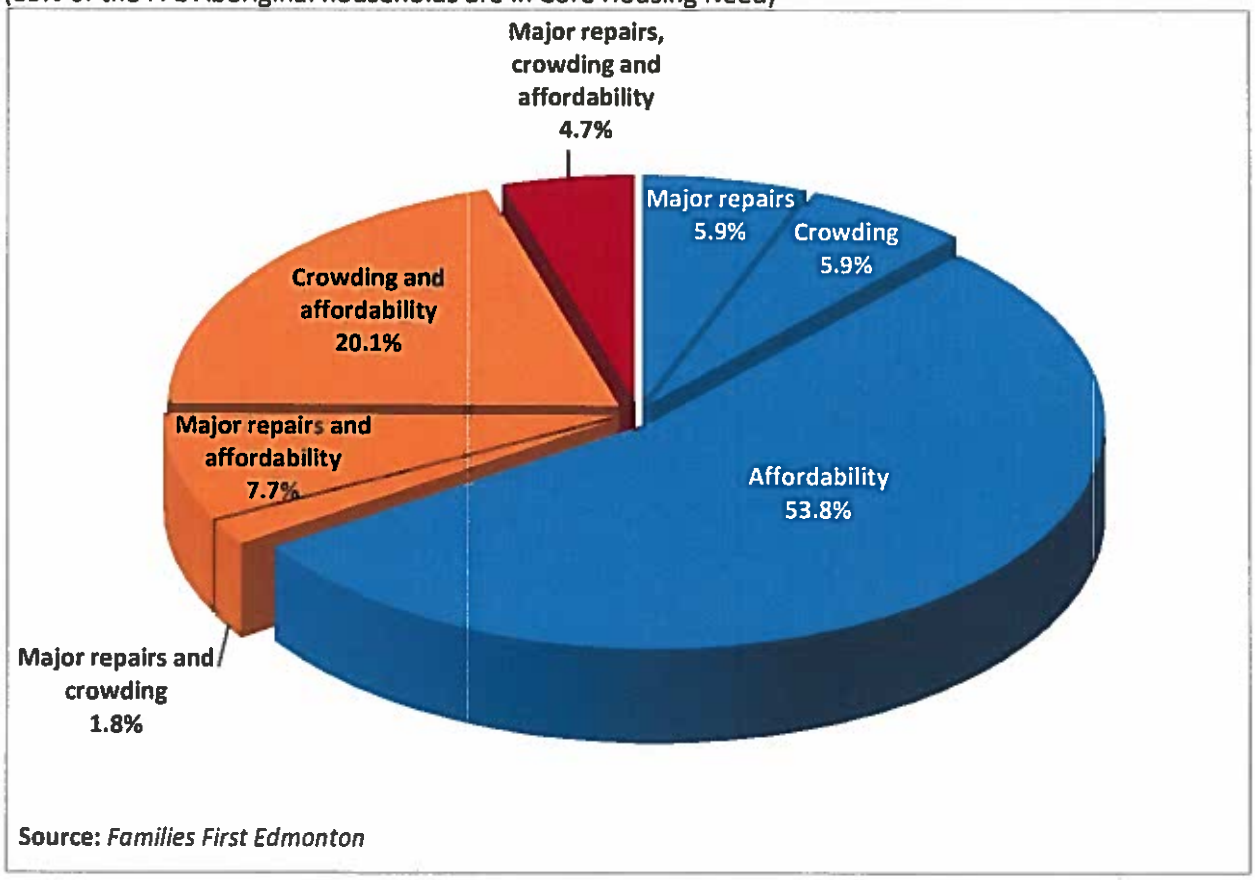
As previously mentioned, and as can be seen in Table 2.4, 21% of the Aboriginal households live in homes that require major repairs. However, these households can be split between those who have incomes equal to or higher than the CNIT (green column) versus those who do not (red column). When we do this we can see that 17% of FFE Aboriginal households are living in homes that require major repairs and do not earn enough to meet the CNIT, while 4% live in homes that require major repairs despite having household incomes that meet or surpass the CNIT.

Similarly, while 33% of the FFE Aboriginal households are crowded, 6% have a high enough household income to be able to afford more suitable housing. Further, while 64% of households are spending ≥30% of the gross household income on shelter costs, 3% have incomes at or above the CNIT.

When discussing Core Housing Need, it is important to separate households that are contending with a single housing concern from those who are contending with two or even all three.

Figure 2.2 outlines core housing need for the FFE Aboriginal families. This figure summarizes the core housing need for the **85% of families who live in homes that require major repairs and/or are crowded and/or are spending ≥30% of their income on housing costs *and have incomes below the CNIT threshold.***

Figure 2.2 Core Housing Need for the FFE Aboriginal Households
(85% of the FFE Aboriginal households are in Core Housing Need)



Source: *Families First Edmonton*

As can be seen in Figure 2.2, most of the FFE Aboriginal families that are in Core Housing Need are impacted by a single housing issue (66%). Approximately 30% of FFE Aboriginal homes are affected by two housing concerns while almost 5% of the families are living in homes that are not only unaffordable, they are also in poor state of repair and crowded.

Unaffordable housing is the number one reason why FFE Aboriginal families are in Core Housing Need. Approximately 79% of the families that are in Core Housing Need are unable to afford their home. Thirty percent of the homes in Core Housing Need are crowded and 18% are in poor state of repair.

2.4: Social Inclusion

The concept of social inclusion can advance our understanding of the social determinants of health. Recently, researchers have linked social inclusion to mental health, recovery, and resilience.[xx] This section explores community engagement and participation as one influencer on the well-being of low-income families.

Barriers to community participation

All FFE primary caretakers were asked questions about their community involvement. First, they were asked how often they participated in individual (e.g., *in the past six months, how often have you used the library?*) and group community activities (*e.g., in the past six months, how often have you been involved in the following group activities? service clubs (e.g., boys and girls club).*

After responding to the community participation questions, primary caretakers when then asked if they would *"like to become more involved in community events and recreational activities"*?

92% of the FFE Aboriginal primary caretakers responded that they would like to be more involved.

To explore why a primary caregiver may not participate more, despite wanting to, the FFE primary caregivers were asked to rate several "barriers to participation" as "very important", "somewhat important", or "not at all important" to their not participating more. The following is a list of barriers that FFE primary caregivers were asked to rate:

I do not have enough time
I do not feel welcome
I do not have enough money
I am not aware of what is available
I have a health problem
I do not have transportation
I do not have child care
I don't know how to get involved
I am nervous about participating
I think the neighbourhood is too unsafe
I think there are cultural or language differences that interfere

In Table 2.4 we inspect the top five barriers to community participation for the 92% of FFE Aboriginal primary caretakers who responded that they would like to be more involved.

Table 2.4 Top Five Barriers to Community Participation for FFE Aboriginal primary caretakers

	Barrier Statement	"Very Important"
1	I do not have enough money	63.2%
2	I am not aware of what is available	48.4%
2	I do not have transportation	48.4%
4	I do not have child care	47.8%
5	I don't know how to get involved	31.7%

Source: *Families First Edmonton*

Overall, 63% of the FFE Aboriginal primary caretakers reported money to be a very important barrier to their community participation. Approximately 48% of primary caretakers felt that their lack of increased participation relates to a lack of awareness of what is available, transportation and child care barriers. Approximately one in three reported that they do not know how to get involved.

Usage of Aboriginal and Métis Services and Programs

Thirteen of the 207 FFE Aboriginal families accessed an Aboriginal or Métis-specific organization during the reference period.

The organizations that these families accessed are:

1. Aboriginal Consulting Services Association of Alberta
2. Ben Calf Robe Society
3. Bent Arrow Traditional Healing Society
4. Canadian Native Friendship Centre
5. Métis Child and Family Services Society of Edmonton
6. Métis Nation of Alberta Association
7. Métis Urban Housing Corporation of Alberta Inc.
8. Oteenow Employment and Training Society
9. Red Road Healing Society
10. Yellowhead Tribal College

3.1: Primary Caretaker Mental Health

The mental health of the Aboriginal primary caretakers was assessed using the Revised Symptom Checklist (SCL-90-R). The SCL-90-R is a 90-item self-report symptom inventory designed to reflect current, point-in-time psychological symptom patterns.[xxi] Of the 207 Aboriginal primary caretakers, 180 completed the SCL-90-R.

Nine different dimensions of mental health were measured, namely:

1. Somatization
2. Obsessive-Compulsive
3. Interpersonal Sensitivity
4. Depression
5. Anxiety
6. Hostility
7. Phobic Anxiety
8. Paranoid Ideation
9. Psychoticism

Global Score. Parent mental health was also measured using the Global Severity Index from the SCL90-R. The GSI is described by the developer of the SCL90-R as the best indicator of overall psychological health of the test taker and the item that "should be used in most instances where a single summary measure is called for" (p.13).[xxii]

All of the raw scores were transformed into T-Scores using norms for a non-clinical, adult population (gender-specific norm values were made available by the maker of the SCL-90-R). Conventionally, a T Score <60 indicates good mental health ("healthy score"). T Scores that are ≥60 but less than 70 indicate a potential problem (at-risk) and T Scores that are ≥70 are "clinically significant" scores. It is important to note that while we refer to "clinically significant" cases, we do not know whether any of these adults have been diagnosed by a health professional.

In a non-clinical sample, we would expect 16% of the population to have T-Scores ≥ 60 (at minimum, 1 standard deviation above a 50-average). Further, we would expect 2% of a non-clinical sample to have T-Scores ≥70 (≥2 standard deviations).

Table 3.1 shows how the T Scores for the nine mental health dimensions as well as the Global Severity Index score for the primary caretakers are distributed across the three different categories ("healthy", "at risk" and, "clinically significant").

Table 3.1 Mental Health T Scores for the Aboriginal Primary Caretakers

SCL-90-R Measure	Healthy T Score<60	"At Risk" T Score: ≥60 and <70	"Clinically Significant" T Score: ≥70
Somatization	50%	35%	15%
Obsessive Compulsive	52%	28%	20%
Interpersonal Sensitivity	46%	32%	22%
Depression	47%	38%	15%
Anxiety	66%	19%	15%
Hostility	54%	30%	16%
Phobic Anxiety	66%	19%	15%
Paranoid Ideation	47%	35%	18%
Psychoticism	52%	26%	22%
Global Severity index	43%	39%	18%

Source: *Families First Edmonton*

16% of non-clinical population

2% of non-clinical population

The proportion of primary caretakers showing "clinically significant" scores is elevated across all of the mental health dimensions. The proportion of caretakers with "clinically significant" levels of **paranoid ideation is 9 times greater** than expected for a non-clinical group and **10 times greater for obsessive-compulsive**. The proportion of caretakers with "clinically significant" scores of **interpersonal sensitivity, and psychoticism are especially high: 11 times greater** than expected for a non-clinical group.

Mental Health Services

Very few of the primary caretakers that scored in the "clinically significant" range reported receiving mental health services during the reference period (Table 3.2). *While these participants show high scores on the SCL-90-R, it is important to remember that they may not have received a formal diagnosis from a health professional.*

Table 3.2 Mental health services used by Aboriginal primary caretakers with "clinically significant" scores

	Number with "clinically significant" scores	Number currently receiving mental health services	Name of service (if applicable)
Somatization	27	0	
Obsessive-Compulsive	36	1	Aboriginal Consulting Services Association of Alberta
Interpersonal Sensitivity	39	1	Psychologist
Depression	27	0	
Anxiety	27	0	
Hostility	28	0	
Phobic Anxiety	27	0	
Paranoid Ideation	32	0	
Psychoticism	39	3	Psychologist Alberta Alcohol and Drug Abuse Commission (2)
Global Severity Index	33	0	

Source: *Families First Edmonton*

From Table 3.2 we can see that none of the primary caretakers with clinically significant scores of somatization, depression, anxiety, hostility, phobic anxiety, and paranoid ideation were actively receiving treatment from a mental health professional.

Of the 39 caretakers with clinically significant levels of interpersonal sensitivity, only 1 was actively receiving treatment from a mental health professional. Similarly, only 3 of the 39 caretakers with high levels of psychoticism and 1 of the 36 primary caretakers who reported clinically significant obsessive-compulsive levels were actively receiving mental health services.

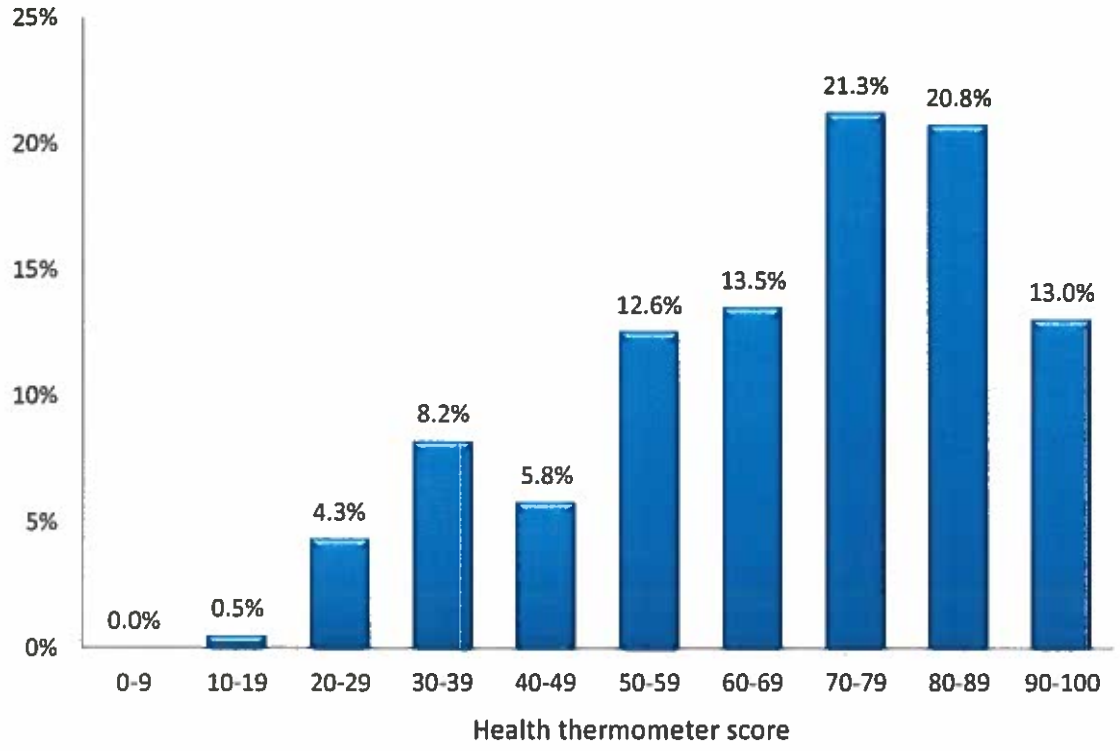
These results suggest that while many of the FFE Aboriginal primary caretakers are presenting with symptom patterns indicative of a "clinically significant" mental health concern, very few are actively being treated. While the percentage receiving supports from an organization or agency are low, it is possible that some of these caretakers are receiving support from an Elder from their community.

3.2: Primary Caretaker Physical Health

Primary caretakers were asked to estimate the health of all family members, including themselves, using a thermometer scale. A picture of a 100-degree thermometer was provided and caretakers were asked to indicate their health level on the thermometer. A score of 100 corresponds to "excellent" health, while scores closer to "0" indicate "very poor" health.

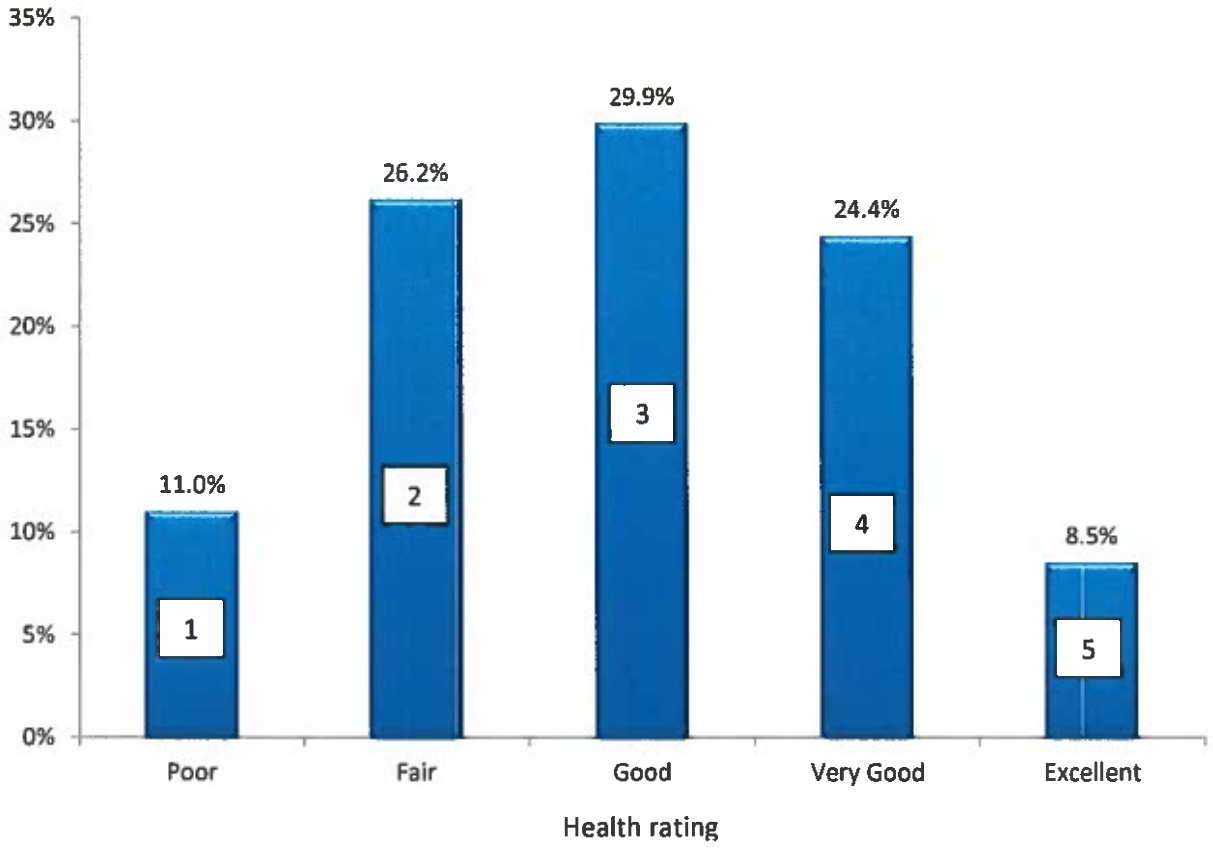
Figure 3.1 shows the distribution of the thermometer scores for the primary caretakers. The average score is 64.9 with 8 primary caregivers reporting perfect health (score=100). The lowest score reported is "10".

Figure 3.1 Health of the FFE Aboriginal Primary Caretakers (Health Thermometer)



Primary caretakers were also asked to estimate their health on a 5-point scale (Figure 3.2), with a score of "1" representing "poor" health and a score of "5" corresponding to "excellent" health. Sixty-three percent of the FFE Aboriginal primary caretakers considered themselves to be in "good", "very good", or "excellent" health.

Figure 3.2 Health of the FFE Aboriginal Primary Caretakers (5-point Health Scale)



3.3: Child Mental Health

The mental health and behaviour of the focus children was assessed using the Behavior Assessment System for Children (BASC-2).[xxiii] The BASC-2 has a number of primary, composite and content scales that assess psychological wellbeing and behavior for children who are 2 years of age or older. In addition to parent reports, children who are 8 years of age or older can also self-report. We summarize parent reports of their child's wellbeing in this report as there are a number of children under the age of 8 years in this study.

The BASC-2 has a number of primary and composite scales that parent reports inform, namely:

PRIMARY	COMPOSITE
Activities of Daily Living	Adaptive Skills
Adaptability	Behavioral Symptoms Index
Aggression	Externalizing Problems
Anxiety	Internalizing Problems
Attention Problems	
Atypicality	
Conduct Problems*	
Depression	
Functional Communication	
Hyperactivity	
Leadership*	
Social Skills	
Somatization	
Withdrawal	

** For children ≥6 years of age only*

All of the raw scores were transformed into T-Scores using age-specific and sex-specific norms for a non-clinical population. For the majority of the scales, a T Score <60 indicates "healthy to average" scores. T Scores that are ≥60 but less than 70 indicate a potential problem ("at-risk") and T Scores that are ≥70 are "clinically significant". However, interpretation of the T Scores differs for the "Adaptive Scales" (Activities of Daily Living, Adaptability, Functional Communication, Leadership, and Social Skills). For these scales, a T Score >40 indicates "healthy to average" scores. T Scores that are >31 and ≤40 indicate a potential problem ("at-risk") and T Scores that are ≤30 are "clinically significant".

It is important to note that while we refer to "clinically significant" cases, we do not know whether any of these children have been diagnosed by a health professional.

In a non-clinical sample, we would expect 16% of the population to have "at-risk" T-Scores (at minimum, 1 standard deviation above/below a 50-average). Further, we would expect 2% of a non-clinical sample to have "clinically significant" T-Scores (at minimum, 2 standard deviations above/below a 50-average).

Table 3.3 shows how the T Scores for the primary and composite scales are distributed across the three different categories ("healthy", "at risk" and, "clinically significant") for the FFE Aboriginal children.

Table 3.3 Mental Health and Behavioural T Scores for the Aboriginal Focus Children

BASC-2 Measure	"Healthy" T Score<60	"At Risk" T Score: ≥60 and <70	"Clinically Significant" T Score: ≥70
PRIMARY			
Aggression	74.3%	14.9%	10.8%
Anxiety	80.0%	14.0%	6.0%
Attention Problems	62.7%	29.3%	8.0%
Atypicality	72.7%	17.3%	10.0%
Conduct Problems*	72.8%	18.5%	8.6%
Depression	69.3%	16.0%	14.7%
Hyperactivity	68.0%	17.3%	14.7%
Somatization	82.7%	11.3%	6.0%
Withdrawal	77.9%	16.1%	6.0%
COMPOSITE			
Behavioral Symptoms Index	66.7%	22.4%	10.9%
Externalizing Problems	70.9%	18.9%	10.1%
Internalizing Problems	74.0%	17.3%	8.7%

Source: *Families First Edmonton*

16% of a non-clinical population will have T Scores ≥60

2% of a non-clinical population will have T Scores ≥70

BASC-2 Measure	"Healthy" T Score>40	"At Risk" T Score: >30 and ≤40	"Clinically Significant" T Score: ≤30
PRIMARY			
Adaptability	66.7%	29.3%	4.0%
Activities of Daily Living	74.7%	14.7%	10.7%
Social Skills	77.3%	18.0%	4.7%
Leadership*	71.3%	23.8%	5.0%
Functional Communication	62.2%	30.4%	7.4%
COMPOSITE			
Adaptive Skills	68.0%	27.2%	4.8%

Source: *Families First Edmonton*

16% of a non-clinical population will have T Scores ≥60

2% of a non-clinical population will have T Scores ≥70

From Table 3.3, we can see that there is a higher proportion of children scoring in the "clinically significant" range for all of the BASC-2 measures. The measures of **depression** and **hyperactivity** show the highest over-representation. Approximately 15% of the primary caretakers rate the "focus child" as having "clinically significant" levels of depression and hyperactivity. These proportions are approximately **7 times higher** than expected for a non-clinical group of children.

It is important to note that the children show less evidence of pathology with respect to the adaptive skills. According to the primary caretakers, a much more limited proportion of the Aboriginal children are rated with "clinically significant" difficulties in the areas of Adaptability (4%), Social Skills (4.7%), and Adaptive Skills (4.8%).

Mental Health Services

Table 3.4 summarizes the mental health services information for the children with "clinically significant" scores. From Table 3.4 we can see that of the children with "clinically significant" levels of depression, 27% were actively receiving treatment from a mental health professional. Eighteen percent of children with "clinically significant" levels of hyperactivity were actively receiving mental health services.

Table 3.4 Mental health services used by Aboriginal children with "clinically significant" scores

	# of children with "clinically significant" scores	# of children receiving mental health services*	Name of service (if applicable)
PRIMARY			
Aggression	16	3	Child and Adolescent Services Association
Anxiety	9	1	Ben Calf Robe Society
Attention Problems	12	0	
Atypicality	15	2	Red Road Healing Society Boyle Street Community Services
Conduct Problems	7	0	
Depression	22	6	Bent Arrow Traditional Healing Society Psychologist Child and Adolescent Services Association Red Road Healing Society Zebra Child Foundation Norwood Child & Family Resource Centre
Hyperactivity	22	4	Bent Arrow Traditional Healing Society (x2) Psychologist Child and Adolescent Services Association McMan Youth, Family, & Community Services
Somatization	9	2	Medical Specialist Alberta Aids to Daily Living Community Options (Children & Families) Young Women's Christian Association
Withdrawal	9	1	Medical Specialist
Adaptability	6	2	Child and Adolescent Services Association Medical Specialist
Activities of Daily Living	16	1	Bent Arrow Traditional Healing Society
Social Skills	7	0	
Leadership	4	0	
Functional Communication	11	9	Optical Specialists (x3) Unity Centre of Northeast Edmonton (x4) Child and Adolescent Services Association Uncles & Aunts at Large Society (UAALS)
COMPOSITE			
Behavioral Symptoms Index (BSI)	16	4	Central Rehabilitation Services Bent Arrow Traditional Healing Society Child and Adolescent Services Association Elves Special Needs Society Kids Kottage Foundation
Externalizing Problems	15	2	Bent Arrow Traditional Healing Society Child and Adolescent Services Association
Internalizing Problems	13	0	
Adaptive Skills	7	0	

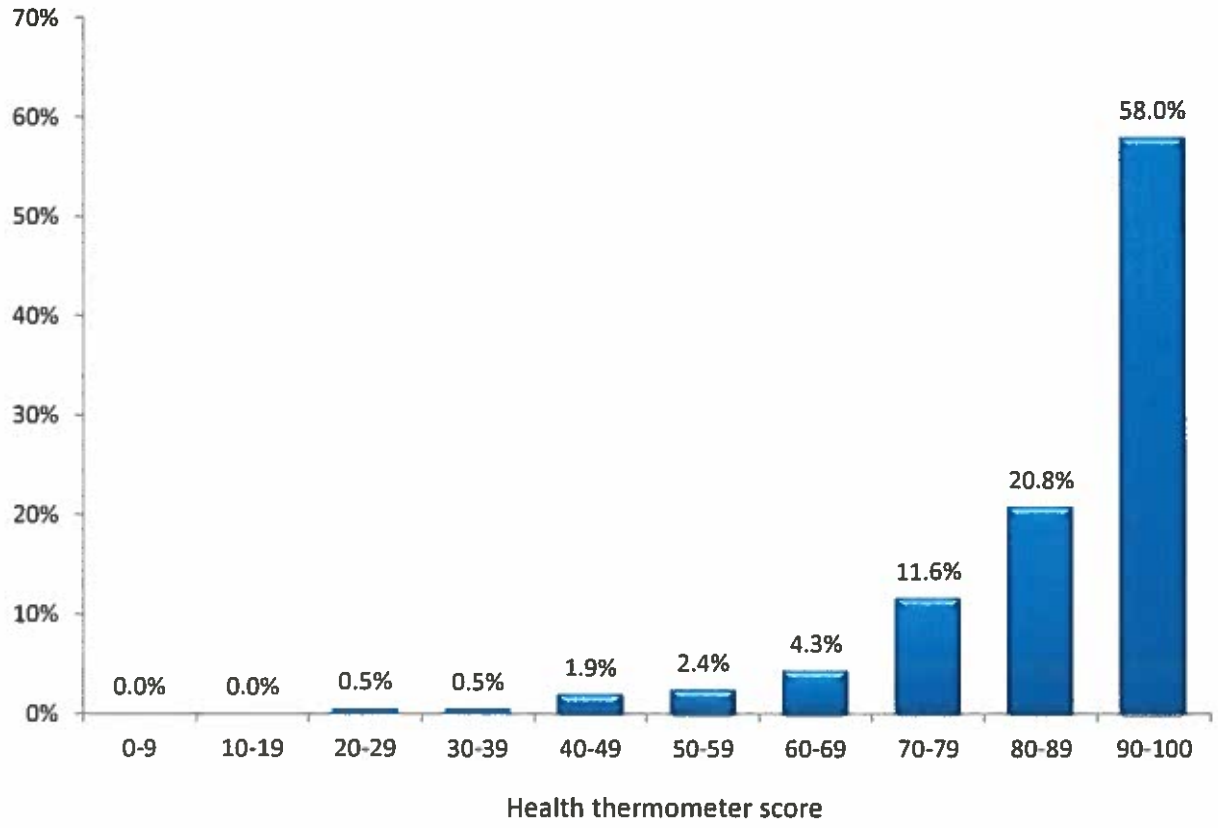
**Alberta Health Services, medical centres, and pharmacies were not included in Table 3.4.*

3.4: Child Physical Health

As mentioned previously, primary caretakers were asked to estimate the health of all family members using a thermometer scale. Participants were given a picture of a 100-degree thermometer and asked to indicate their health level on the thermometer. A score of 100 corresponds to "excellent" health, while scores closer to "0" indicate "very poor" health.

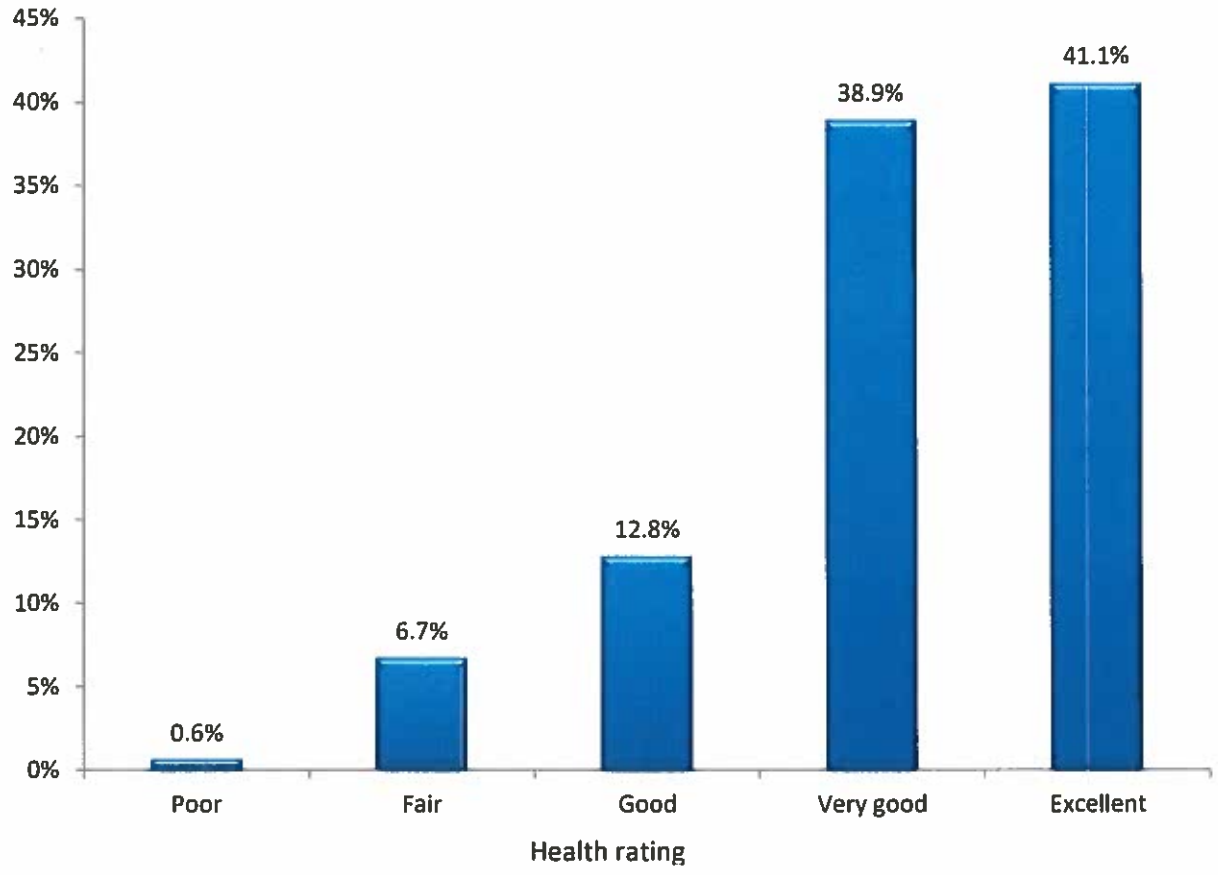
Figure 3.3 charts the distribution of thermometer scores for the FFE Aboriginal focus children as rated by the primary caretaker. The average score is 86 with 65 primary caregivers reporting their children to be in perfect health (score=100). The lowest score reported is "25".

Figure 3.3 Primary Caretaker Assessment of Focus Child's Health (Health Thermometer)



All FFE primary caretakers were asked to report on the child's general health by responding to the following question: *In general would you say your child's health is: poor, fair, good, very good, excellent?*

Figure 3.4 Primary Caregiver's Rating of Focus Child's General Health



As presented in Figure 3.4, 80% of the FFE Aboriginal focus children were rated by their caretakers as being in very good or excellent health.

Early Childhood Services and Programs

Ninety-five FFE Aboriginal families had children in the home under the age of six years. Nine of these families accessed early childhood programs during the reference period. Specifically, 4 families accessed Head Start programs. Head Start (e.g., ABC Head Start) is a comprehensive preschool and family support program aimed at preparing children for a successful educational experience.[xxiv] Another 4 families received infant and preschool immunization services. Infant and preschool immunizations are provided through Alberta Health Services. One family participated in a "Health for Two" program, which is provided by Alberta Health Services and made available to pregnant women with social or economic risks to a healthy pregnancy.

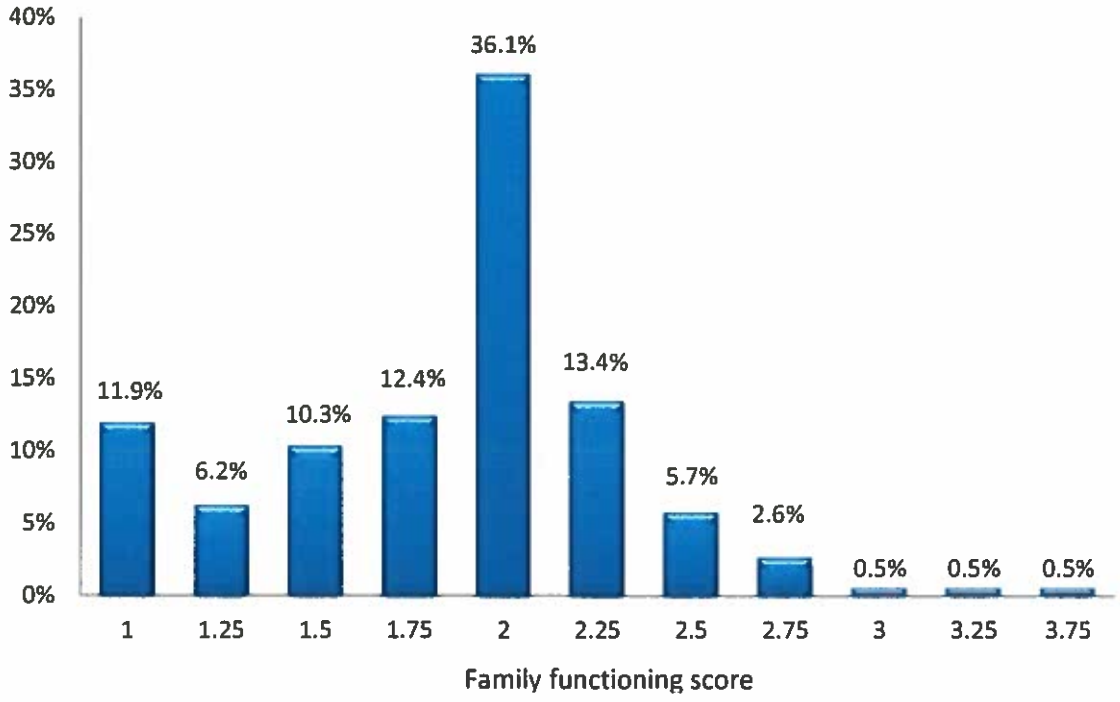
3.5: Family Functioning

The primary caretaker within each family was asked how well each of the following statements describes the family as a whole:

"We can express our feelings to each other"
"There are lots of bad feelings in the family"
"We feel accepted for what we are" and,
"We don't get along well together"

Primary caretakers rated their family on a four point scale, from "very well" to "not very well". A score of "2" is considered an average score. Families with higher levels of functioning will have scores that are less than "2" while families with greater issues with communication and discord will score greater than "2".

Figure 6: Family functioning scores for the FFE Aboriginal Families



As can be seen in Figure 6, almost 12% of the families report the best possible score for family functioning (a score of "1"). Most (77%) of the Aboriginal families score "2" or less, suggesting that 3 out of 4 families have excellent to average family functioning. The remaining 23% of the families have scores greater than "2". These results suggest that approximately 1 in 4 of the FFE Aboriginal families could benefit from community supports that help the family with communication issues and interpersonal difficulties.

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