Phase 1 Final Report

May 2024

Community Integration Through Art - *Pissatsinaskssni*

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Lethbridge Polytechnic Research Protocol: LC 23-09

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Gratitude

To begin, the Community Integration Through Art – *Pissatsinskssini* (CITAP) team would like to express our gratitude to the Siksikaitsitapi, the traditional and current keepers of this land on which we work and live. We are thankful for this beautiful land, the opportunity to learn, and the relationships we are building.

Introduction

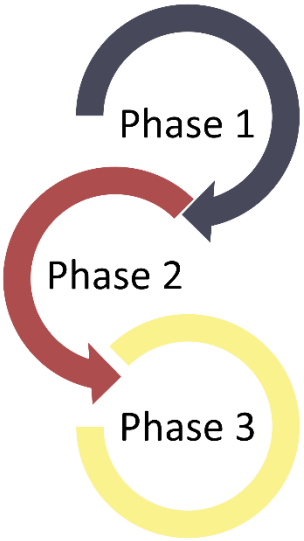
CITAP is the name of both a research project and a community integration program. The research project is three years long and includes creating, implementing, and evaluating the CITAP program. At the end of the three-year project, if the program evaluation demonstrates efficacy, the program will be taken over by the Ninastako Cultural Centre (NCC) to continue operating.

The CITAP program is an arts-based social-recreational peer-support program that was inspired by a local judge and is loosely modelled on the Dudes Club (an Indigenous men's health program that began in Vancouver, BC). CITAP will involve regular meetings in which participants (anyone who feels marginalized or like they need/want to increase their integration to the community of Lethbridge), Elders/knowledge keepers, artists, and other volunteers will come together to share a meal, create art, and learn something new. We will rely on volunteer artists to share their skills and teach their art forms, in much the same way we will rely on volunteers from the community to share their expertise (e.g., doctors, nurses, counselors, nutritionists, etc.) and service providers to share information about their agencies and the services they provide. We will be including components of Blackfoot language, culture, art, or history in every session as guided by the cultural expertise of our community partner, the Ninastako Cultural Centre.

The content of the CITAP program will be co-created, with a significant focus on meeting the needs and wants of our participants, ***as reported by our participants***. To that end, we have already begun gathering data regarding potential participants' needs and wants in terms of program content. We will also conduct ongoing program evaluation surveys and collect content feedback throughout the program, so we can meet new needs or wants as they arise. In this way we will ensure: that CITAP is relevant to our participants; that program content is respectful of participants, our community partner, and our local Blackfoot communities; that we (the CITAP team) take responsibility for ensuring the program is co-created with our participants; and that we are reciprocating by giving our participants a program they want and need.

Project Phases

The CITAP research project will occur over three phases: (1) environmental scan/needs assessment; (2) logistics and planning; and (3) operations.



Sept 23 to April 24

May 24 to Aug 24

Sept 24 to Aug 26

Phase 1 has involved using surveys and talking circles to collect data from our priority population, as well as surveys to collect data from service providers and the judiciary.

Phase 2 involves all logistics necessary to become operational, including securing meeting space, purchasing various supplies, and scheduling meetings.

Phase 3 is scheduled to begin in September of 2024, and will involve running the program, collecting data, and evaluating the program for efficacy.

We are pleased to say that we are currently on track to begin operating the program in the fall of 2024. Next, we will provide a detailed review of the data we collected in Phase 1 of the CITAP Program.

Priority Population Data

We have a total of 91 priority population participants; however, not all participants answered every question. As such, for most questions throughout the survey, there is some 'missing data'; that is, there are some participants who chose not to answer the question.

Demographics

In this section, we will describe our priority population's demographic features.

Gender Identity, Race/Ethnicity, and Age

Most participants identified as men (*n*=36; 39.6%) and most were Indigenous (*n*=31; 34.1%). The mean age of participants was 37.7 years (*SD* = 12.36), with ages ranging from 22 to 68.

Table 1: Gender

Gender	*n*	Percent
Woman	24	26.4
Man	36	39.6
Non-Binary/Two-Spirit	3	3.3
Transgender	1	1.1
No Response	27	29.7

Table 2: Race

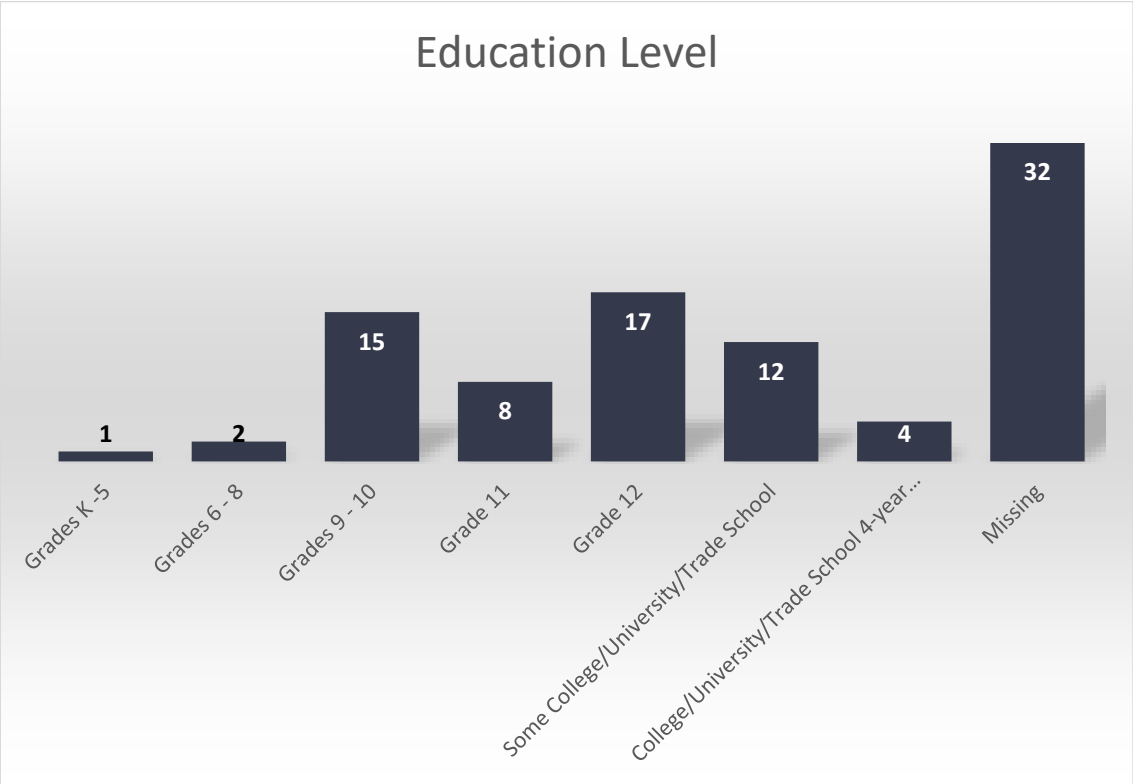
Race	n	Percent
Indigenous	31	34.1
Non-Indigenous	24	26.4

Participants classified as Indigenous identified their unique race/ethnicity as: First Nation, Inuit, Cree-Mexican, White-Blackfoot, Mi'kmaq-Algonquin, Cree, Indigenous, Blood – Kainai, Blackfoot, Indigenous-White, Blackfoot – Bloods, and Certified Indigenous (Indian).

Non-Indigenous participants identified as: White, Punjabi-Sikh, Asian, Jurdean, and White-Mediterranean.

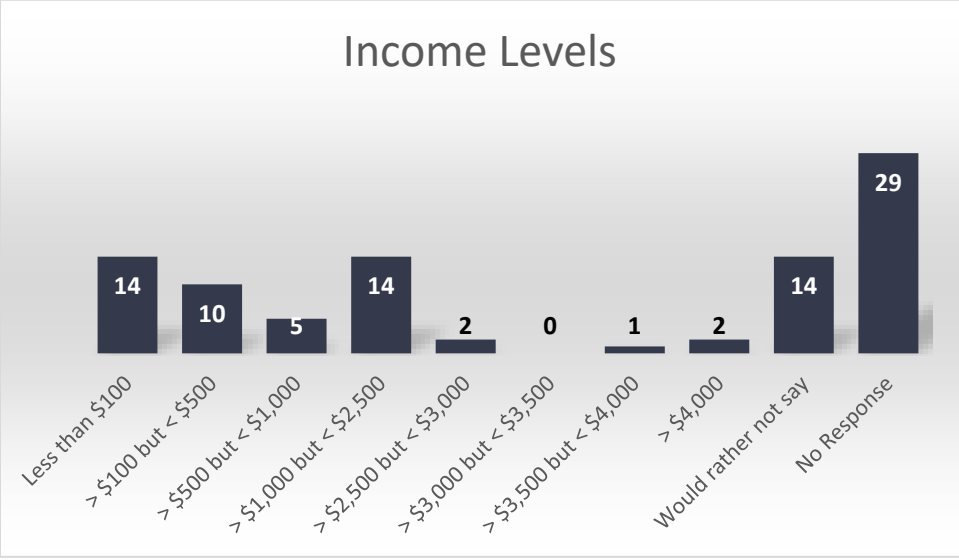
Education

Participants reported a wide range of education levels, from grade 3 to completion of a 4-year degree (or equivalent) from a college, university, or trade school. 32 participants chose not to respond to this question, but of the 59 who did respond, the majority reported grade 12 or higher (*n*=33; 55.9%).

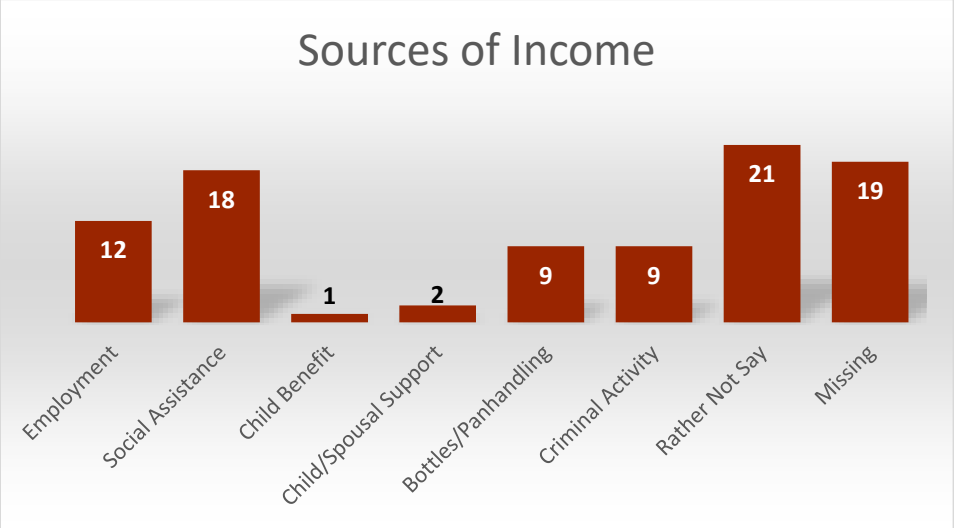


Income & Employment

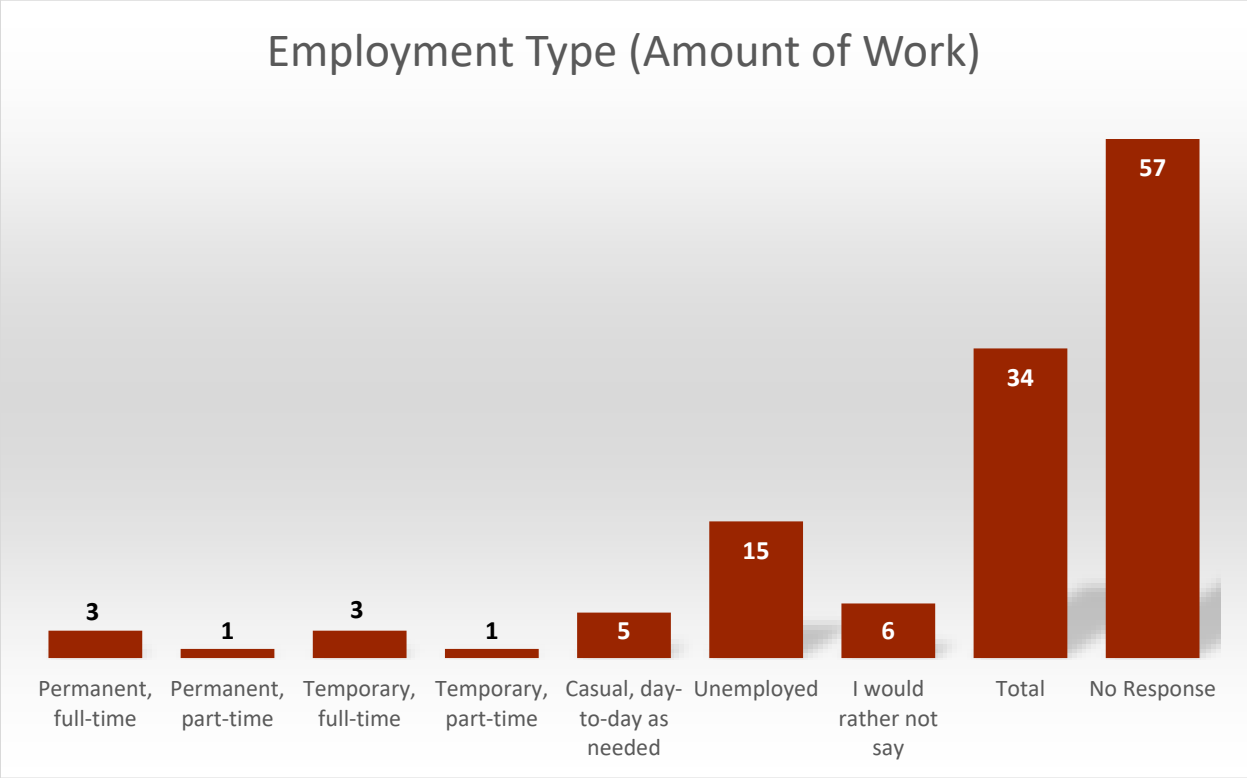
Just over half of participants answered the question about monthly income level (*n*=48; 52.7%). Of these, 28 (58.3%) fell into one of two income categories: (1) less than $100 and (2) more than $1,000 but less than $2,500.



Participants reported seven sources of income, with social assistance being the most common (35.3% of the 51 participants who chose to answer this question).



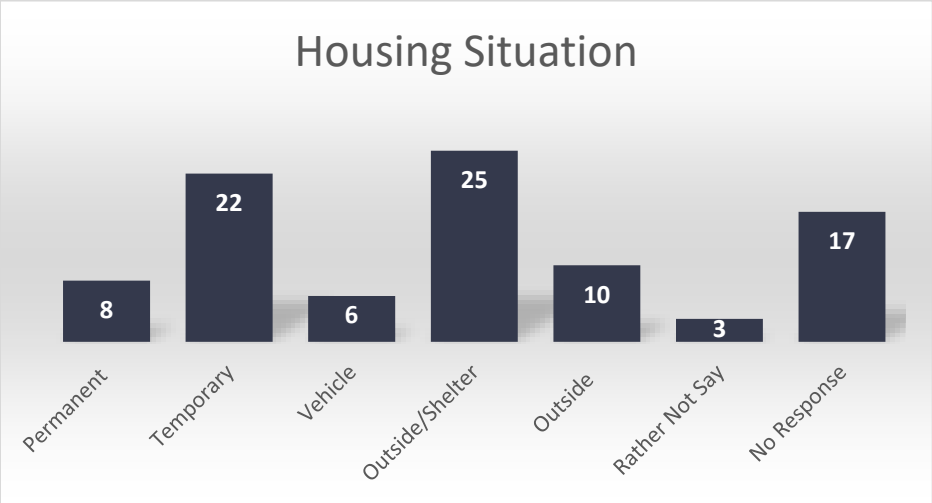
There is a discrepancy in the data, in that 12 (16.7%) participants reported that employment was a source of their income, but 13 participants reported being employed. Of those, most reported being employed casually, day-to-day as needed.



15 (44.1%) participants reported being unemployed, 6 (17.6%) selected 'would rather not say', and 57 chose not to answer the question at all.

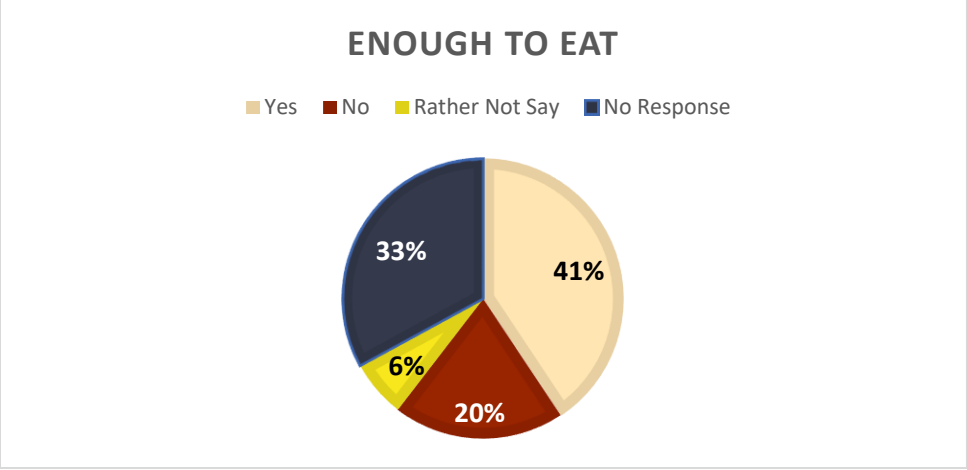
Housing Situation

Of the 74 participants who answered the housing question, 63.5% (*n* = 47) fell into two categories: living outside but sleeping at the shelter (*n* = 25) and having a temporary home, such as staying with friends/relatives or couch surfing (*n* = 22).



Food

We asked participants whether or not they had enough to eat every day and where/how they got their food. We were pleased to learn that 60.7% of the 61 participants who answered this question said that yes, they did get enough to eat every day (*n* = 37). However, 29.5% (*n* = 18) of our participants reported that they do not get enough to eat every day.

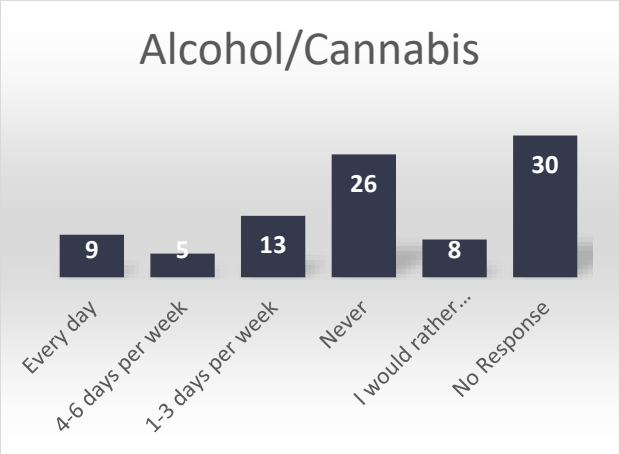


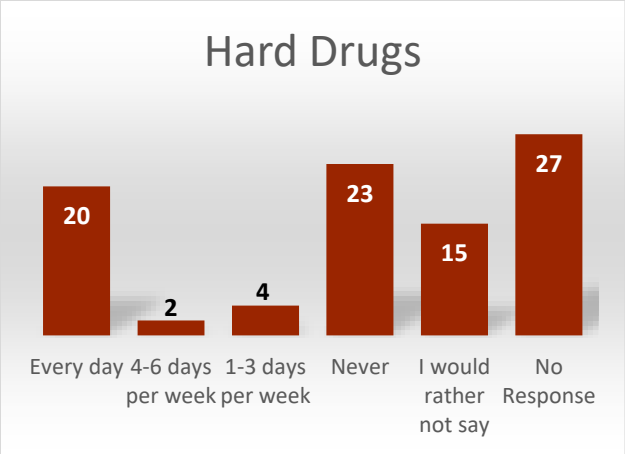
Most participants answered questions about where their food came from. For this question, participants were asked to choose all options that apply, as it was expected that people probably used more than one method of obtaining food. Most participants reported using free food sources (e.g., soup kitchen, food bank, etc.) to access food (*n* = 53; 58.3%). This statistic highlights the importance of free food sources in Lethbridge.

Substance Use

We asked participants about substance use, broken down into two categories: (1) alcohol/cannabis (i.e., legal substances) and (2) hard drugs (i.e., illegal substances). We had several reasons for asking these questions. First, it would help us in creating the topical information component of the program content; that is, are we likely to have participants who would find harm reduction or abstinence information useful? Should we recruit volunteer addiction counselors? Second, it would allow us to investigate potential associations to see if they exist or not; specifically, stereotypical beliefs like 'everyone who is homeless is a drug addict'. Third, depending on the outcome of these investigations, it may help us in busting some of these stereotypes in the city. Breaking down stereotypes can be an important early step to reducing racism and building healthy intergroup relationships.

Contrary to what might be expected, the number of participants who were willing to answer questions about their illegal substance use (*n* = 49; 53.8%) was very similar to the number willing to answer questions about their legal substance use (*n* = 53; 58.2%). Perhaps most surprising in terms of the stereotypical beliefs about our priority population, almost half of those who answered these questions did not use either legal or illegal substances at all: 49.1% (*n* = 25) reported never using alcohol or cannabis, and 47% (*n* = 23) reported never using hard drugs.





Health and Health Care

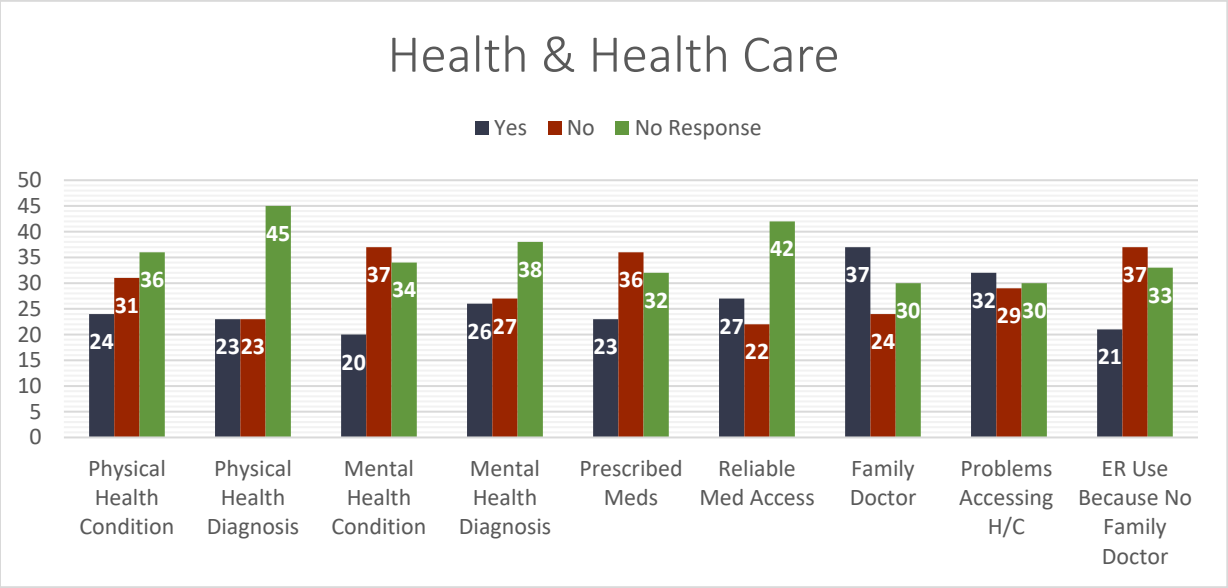
In this section, we asked participants about their specific health situation (both mental and physical health) as well as their access to health care. Once again, we had multiple reasons for asking these questions. First, this data will help us in shaping program content in terms of securing volunteer experts who can share information about health-related topics that are truly relevant to our participants. Second, there are many assumptions about the priority population in terms of both physical and mental health. This data will allow us to see if these assumptions are accurate. And third, we are undergoing a health care crisis in the City of Lethbridge, in that we simply do not have enough care providers for our population. Addressing significant physical health concerns must happen alongside addressing the social determinants of health to increase the overall health and well-being of our populations. Therefore, it is important to understand the barriers that exist for our priority population in terms of accessing health care.

The first thing that jumps out of the data is the proportion of participants who chose not to answer health-related questions, which ranged from a low of 33% (*n* = 31) to a high of 41% (n = 38). Of the 24 participants who reported a physical health condition, 95.8% (*n* = 23) were diagnosed. This is good news, as it seems to indicate that our priority population can get physical health diagnoses when needed. In terms of mental health, we see more participants diagnosed with a mental health condition (*n* = 26; 49.1%) than report having one (*n* = 20; 35.1%). There are two possible explanations for this discrepancy that deserve further investigation: (1) that the stigma around mental health conditions remains significant enough to encourage people to lie about, or disbelieve, their mental health conditions; and (2) people who belong to our priority population are being over- or mis-diagnosed. Future research should explore this issue.

There is a similar situation when it comes to prescribed medications, in that more participants reported having reliable access to prescribed medications (*n* = 27; 55.1%) than report being prescribed medications (*n* = 23; 39%). Again, this may be related to stigma around medications,

particularly if the medications are for mental health conditions or highly-stigmatized conditions (e.g., HIV). Comprehension issues may also have impacted these responses.

Of the 37 participants who answered this question, 60.7% (*n* = 23) reported having a family doctor. This means that almost 40% of participants who chose to answer this question do not have a family doctor (*n* = 37). Additionally, over half of participants who chose to answer reported difficulty accessing health care (*n* = 48; 52.5%). Given the importance of a family doctor in access to medical treatment and health maintenance, it is not surprising that so many of our participants have problems accessing health care. Finally, 58 (63.7%) participants responded to the question that asked if they used the emergency room at the hospital to access health care because they don't have a family doctor, and 36.2% said yes, they do use the emergency room as a stop-gap measure to get the health care they need (*n* = 21).



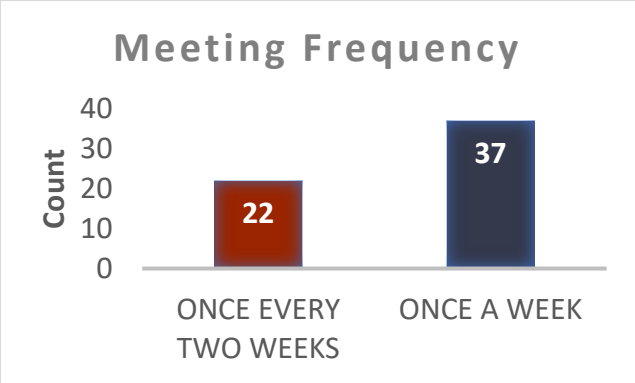
Program Participation & Meeting Logistics

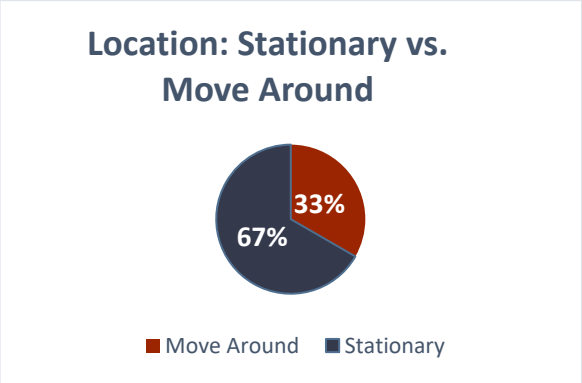
In this section, will discuss our priority populations' preferences for meeting logistics and content. It is important to us that the program is co-created with participants, in the spirit of respect and relevance.

Participation, Frequency, Location

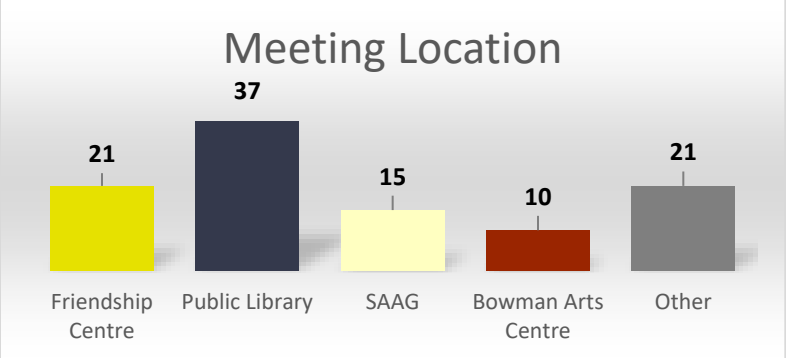
The first question we asked participants in Phase 1 is if they would like to participate in a program like CITAP. Overwhelmingly, participants responded to this question with 'yes' (62 out of the 63 participants said 'yes' while 28 chose not to answer this question). We also asked some specific questions about meeting frequency and locations.

In terms of meeting frequency, 32 (35.2%) participants chose not to answer the question. Most of the participants who answered want to meet weekly. Additionally, most participants would prefer the meetings to be hosted in the same place all the time.





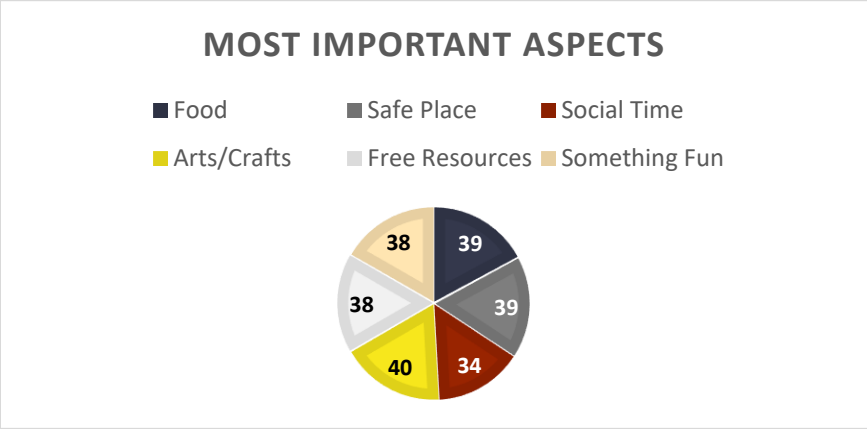
We are still trying to decide the best place to hold these meetings. We provided participants with a list of options in the survey: Friendship Centre, Public Library, SAAG, Bowman Arts Centre, or other. Of these choices, the Public Library was most popular.



21 (23.1%) participants chose 'other' and indicated the following options: BTDH, Shelter, CASA, Red Crow College, Family Centre, hockey rink, IRC, LCC, Mall, Galt Museum, soup kitchen, outside (weather permitting), recreational centre, and Streets Alive.

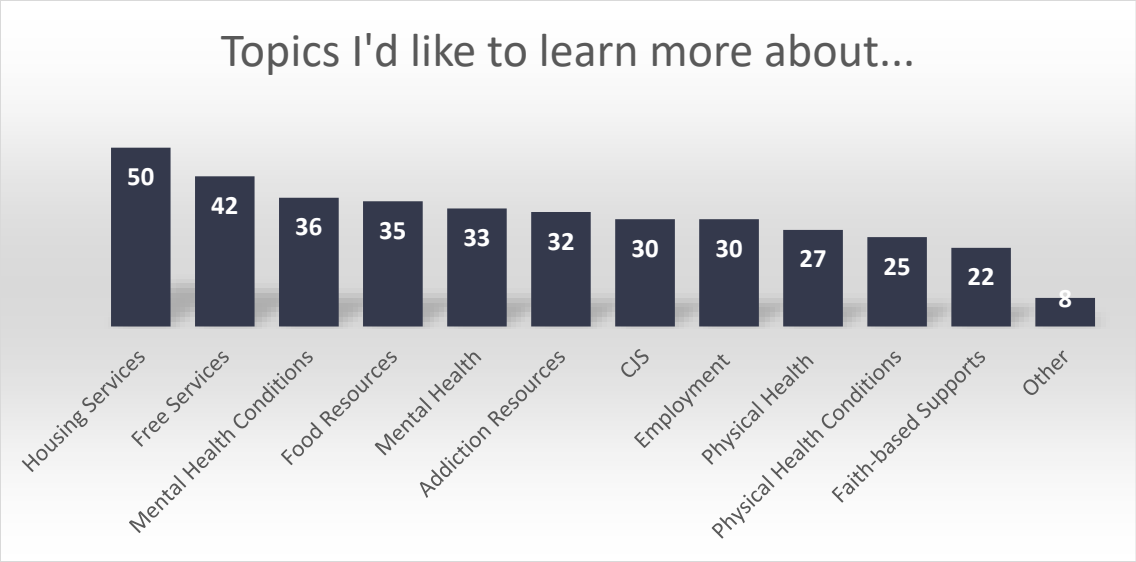
Important Aspects of the Program

We asked participants to choose the aspects of the program that were most important to them from the following list: accessing free food, having a safe place to spend time, having social time, learning arts/crafts, information about free resources I can use, and having something fun to look forward to. Participants were permitted to select as many aspects as they felt were important. As you can see, participants rated most aspects as equally important, except for social time.



Topics

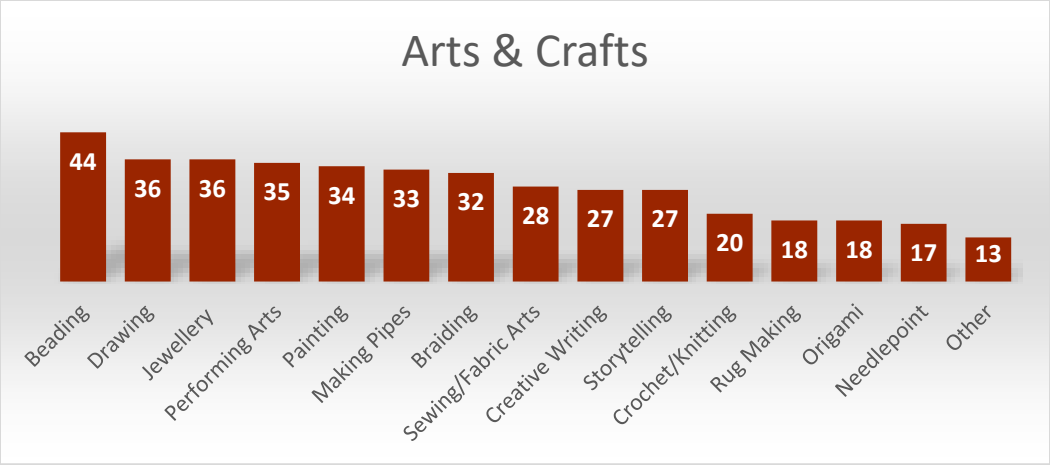
We asked participants to indicate the topics they'd like to learn more about by choosing from the following list: Free Services, Housing Services, Food Resources, Physical Health, Physical Health Conditions, Mental Health, Mental Health Conditions, Addiction Resources, Criminal Justice System (CJS), Faith-based Supports, and Employment. Once again, participants were allowed to select as many options as they'd like. As shown below, housing resources was the top pick, followed by free services.



The eight participants who selected 'other' noted the following topics of interest to them: how to make things to sell, budgeting money including for drugs, and situational awareness. Five of the eight participants who selected other then entered 'N/A' into the text box.

Arts & Crafts

We asked our participants what arts and crafts they would be interested in learning during CITAP meetings. The most requested art form was beading, and the least popular was needlepoint. 13 (14.3%) participants selected 'other', and their written feedback included: animal therapy, goat/puppy yoga, medicine bags, satchels, drum making, dream catchers, puppy therapy, weaving and thread making, shirt making, regalia making, puppets, pow-wow dancing, hip hop, leather goods crafting (moccasins, bags, wallets, purses), making things that are big sellers at markets, buying cheap clothes or getting free clothes and reselling them, how to use Facebook market place, leatherwork, baking, cooking, rattle making and playing, making ribbon skirts and shawls, moss bags for babies, tie knots, and tipi making.



Selling Completed Artwork

We asked participants if they would be interested in selling their completed artwork. Of the 60 participants who answered this question, 78.3% (*n* = 47) indicated they would like to sell their artwork.

Safety Needs

We want to create a safe environment for the CITAP program to operate in. Safety needs can be very diverse, so we decided to ask our participants what they needed, if anything, to make them feel safe during program participation. We grouped responses into categories as much as possible but were left a miscellaneous category consisting of eight responses. Transportation was highlighted as a need, as were housing and food. Some of the needs involved characteristics of the group (e.g., positivity, drug-free, healing focused, varied arts, etc.). The miscellaneous category varied widely, and included the following eight comments: child-free environment, come as you are, introductions, safe supply of drug to transition to total abstinence, help with reading, library, less racism/natives vs whites etc., and smudging.


Safety Needs
4
4
3
3
3
2
2
2
8
Transportation
Varied Art Forms, Art...
Home/Housing
Drug-Free
Positivity, Mentorship
Healing
Food
Safe, Secure, Strong...
Miscellaneous

Service Provider Population

We had a total of 48 service provider participants, all from the Lethbridge area. We asked service providers some basic demographic questions, then asked for their opinions regarding program content. We also included a couple of open-ended questions asking for suggestions or general feedback, which will be described thematically in the section titled “Service Providers' Feedback”.

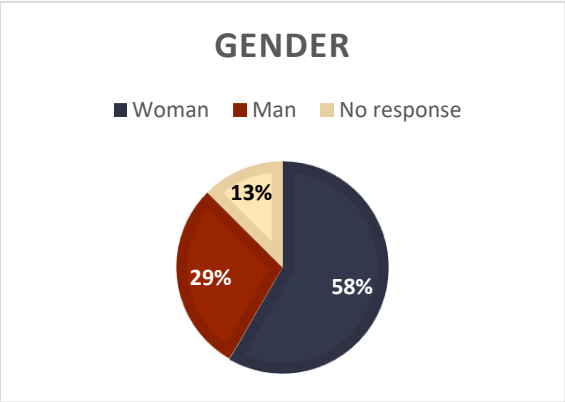
Demographics

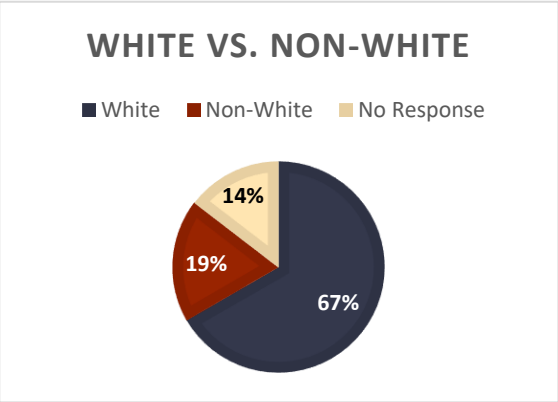
In this section, we will describe our service provider population by age, gender, race, the type of work they do, the marginalized groups they work with, and their years of service working with marginalized populations.

Age, Gender, Race

The mean age of our service provider participants was 42.38 years (*SD* = 10.83), ranging from a low of 24 to a high of 63. As shown below, a small proportion of participants declined to respond to the gender question (*n* = 6; 12.5%) and the majority of respondents were women.

Of the 41 participants who answered the race/ethnicity question, 32 (78%) were White and nine were races/ethnicities other than White: African, Metis, Indigenous, Blackfoot, South Asian, Black, White-Arab, and Latino.

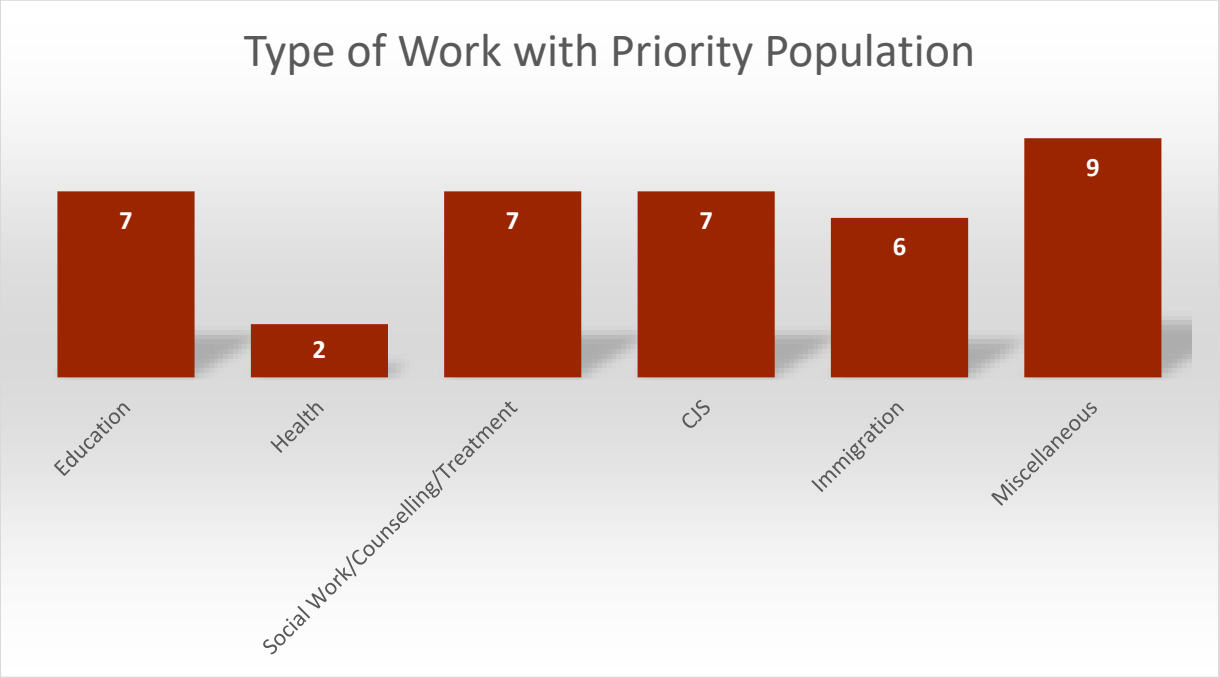




Type of Work with Priority Population

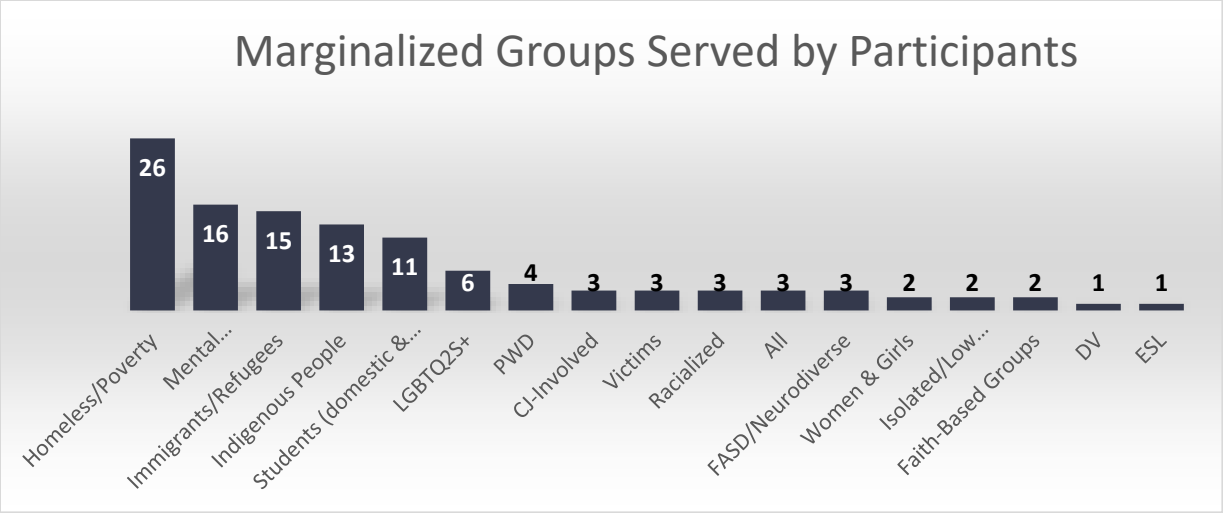
The service providers who participated in our survey worked with our priority population in diverse ways. Many of them held positions that were intersectional in nature and included a variety of categories (e.g., mental health, addictions, education, and counseling). To make the data understandable, we collapsed the type of work into five overarching categories, and then

categorized each service provider in the way that seemed most appropriate. The miscellaneous category included shelter worker (*n* = 1), program management (*n* = 2), free food services (*n* = 1), and direct service (*n* = 5).



We also asked our service provider participants what marginalized populations they provide services to. Almost all participants reported providing services to multiple groups, with a few people simply stating that they served all marginalized groups. The most commonly served categories of marginalized people were: those impacted by homelessness/poverty (*n* = 26; 54.2%), those impacted by mental health issues/addictions (*n* = 16; 33.3%), immigrants/refugees (*n* = 15; 31.3%), Indigenous Peoples (*n* = 13; 27.1%), and domestic/international students and at-risk youth (*n* = 11; 22.9%).

Marginalized Groups Served by Participants



Notes. LGBTQ2S+ = Lesbian, gay, bisexual, transgender, queer, two-spirit, plus; PWD = persons with disabilities; CJ = criminal justice; FASD = fetal alcohol spectrum disorder; DV = domestic violence; ESL = English as a second language.

Years of Service

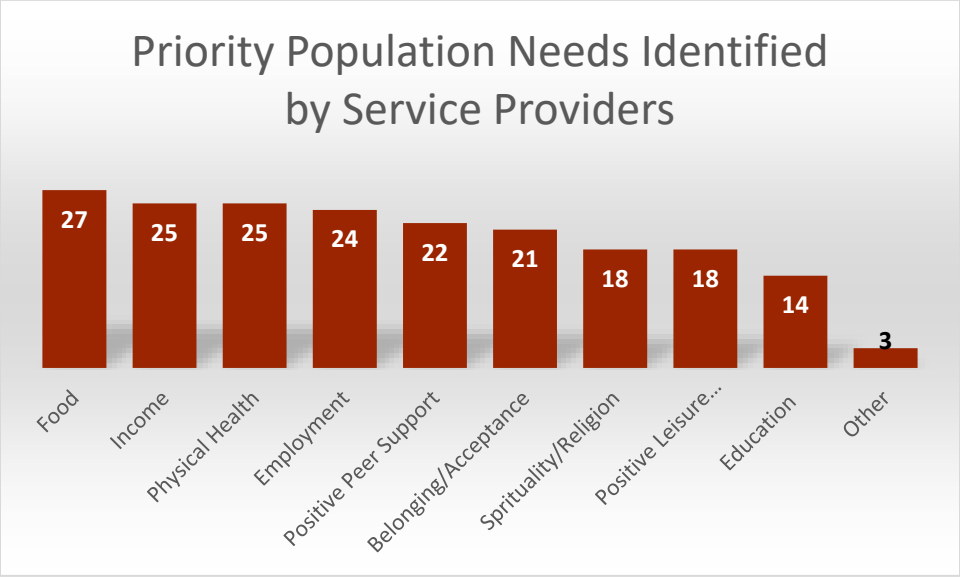
Our service provider participants represented decades of work experience with marginalized populations. Their years of service ranged from six months to 40 years, with a mean of 11.24 (*SD* = 9.44) years.

Program Content Recommendations

We asked our service providers several questions that were similar to those we asked our priority population. The goal was twofold; first, to see what needs service providers are most concerned with, and second, to see how well the opinions of service providers match those of the priority population.

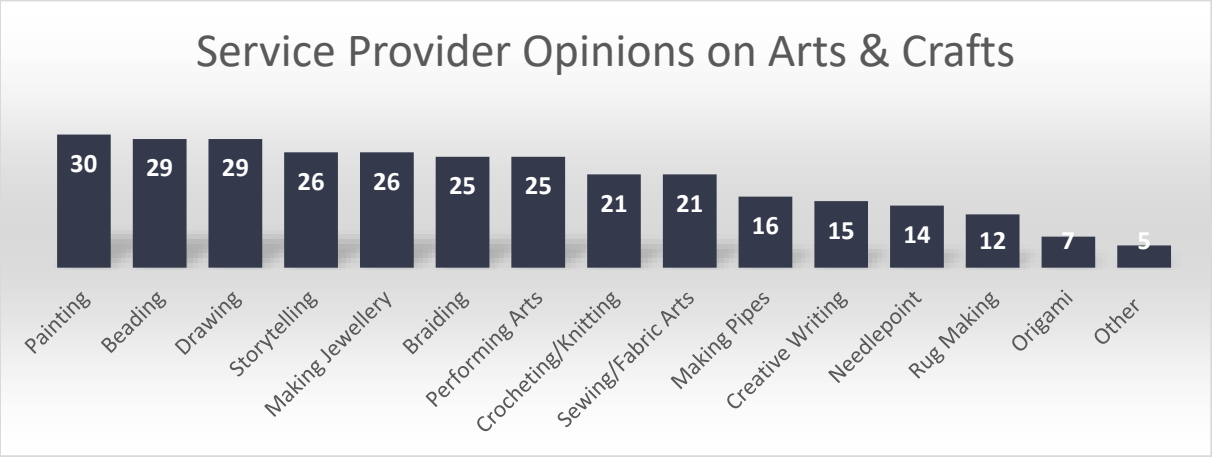
Priority Needs as Identified by Service Providers

First, the top needs identified by service providers were food (n = 27; 56.3%), income (n = 25; 52.1%), physical health (n = 25; 52.1%), and employment (n = 24; 50%). The bar graph below provides details, including noting that three participants selected 'other'. In the text box, participants identified other as: all of the above, healthy adult supports (and support for adults who support marginalized youth), and medical care.



Arts & Crafts of Interest as Identified by Service Providers

Next, we asked service providers what arts and crafts they believed the priority population would be interested in learning. Beading and drawing tied at the top of the list (*n* = 29; 60.4%), followed by storytelling and making jewellery (*n* = 26; 54.2%), then braiding and performing arts (*n* = 25; 52.1%). 'Other' was selected by five service providers, which included: connecting to the land activities and crafts such as drying fish, cooking, etc.; I don't feel competent to answer this - I think each group could be very different and these decisions should be led by them; I



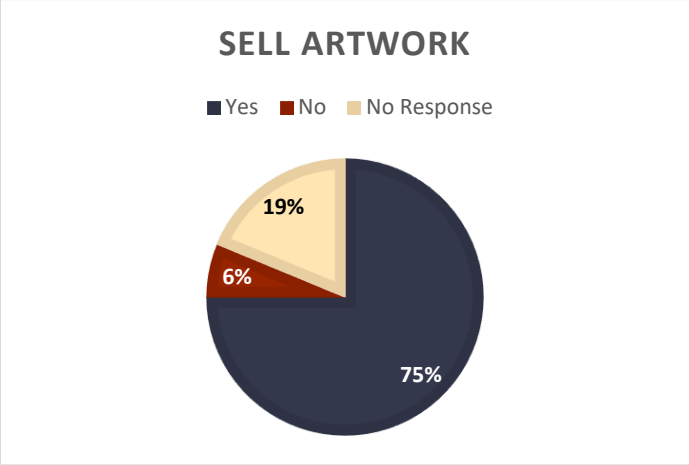
think all of those could be beneficial depending on the individual; poetry clubs; and, they should get to choose/request.

Overall, the service providers appear to have a pretty good idea of what the priority population would want to learn. The main differences are that the priority population ranked performing arts in their top five, unlike the service providers. Additionally, while the service providers put storytelling in the top five, it was quite a bit farther down the list for the priority population (ranked #10). Additionally, the priority population rated creative writing in the middle five (#9), while service providers rated it in the lower five (#11); however, this is only a difference of two rankings on the list. Similarly, service providers ranked crocheting/knitting in the middle five (#8), while the priority population ranked this in the lower five (#11). Otherwise, the differences between the two groups were quite minimal. Below is a table comparing the rankings each group (priority population and service providers) gave to each art/craft. The other main difference is that the priority population had more ideas than the service providers in the 'other' category.

	Priority Population	*Service Providers*
1	Beading	Painting
2	Drawing	Beading
3	Jewellery	Drawing
4	Performing Arts	Storytelling
5	Painting	Making Jewellery
6	Making Pipes	Braiding
7	Braiding	Performing Arts

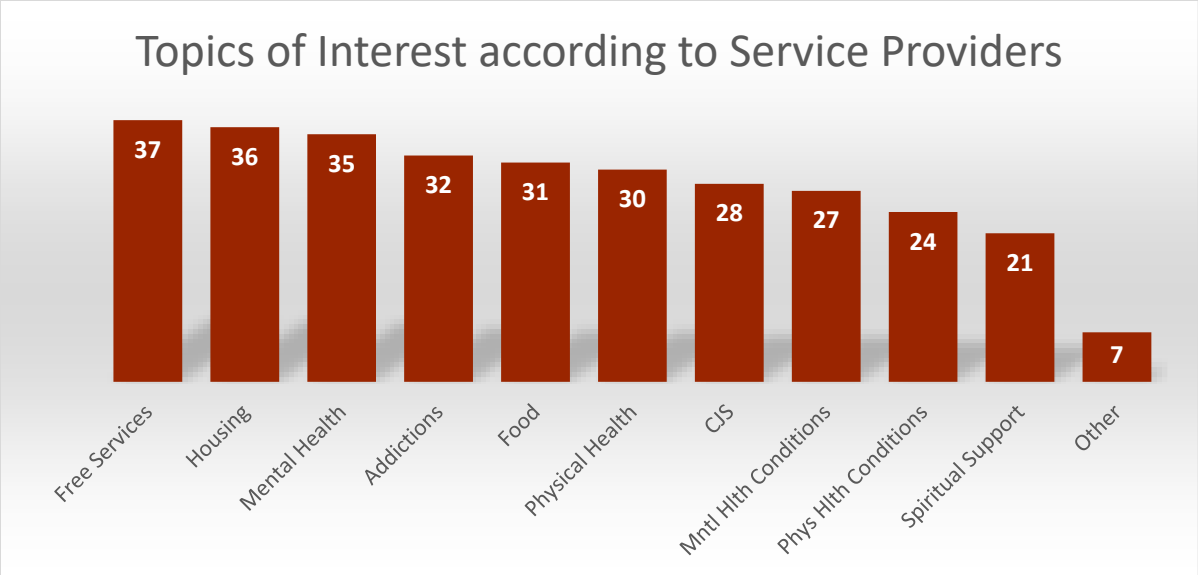
8	Sewing/Fabric Arts	Crocheting/Knitting
9	Creative Writing	Sewing/Fabric Arts
10	Storytelling	Making Pipes
11	Crochet/Knitting	Creative Writing
12	Rug Making	Needlepoint
13	Origami	Rug Making
14	Needlepoint	Origami
15	Other	Other

We also asked service providers if they thought the priority population would be interested in selling their finished art products. Of the 39 participants who answered this question, 36 (92.3%) said yes.



Topics

Service providers were asked the same question as the priority population, regarding what topics the priority population would be interested in learning more about. The top three options were free services, housing, and general mental health information. The bottom three were specific mental and physical health conditions and spiritual support. Seven service providers chose ‘other’ and listed the following: helping the clients to navigate if they have active warrants, check court dates, and legal aid’s contact number; information about conditions first, then information about ways to improve their health; information on how to keep housing or keep a job; legal aid, volunteering in the community (opportunities to "give back" and feel pride in the community); medical resources, self-care; and services for those experiencing or having experienced violence (sexual, domestic).

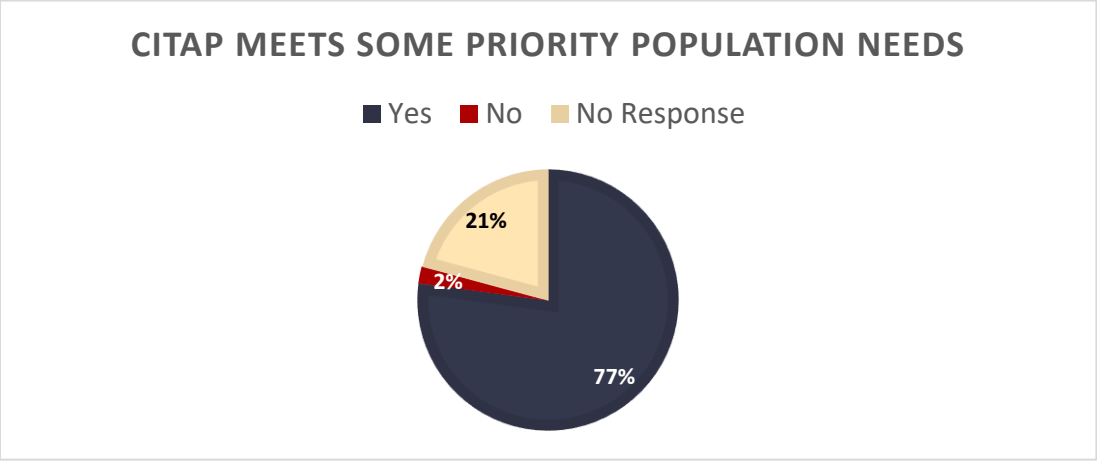


When we look at these topics side by side with the priority population selections, we see some interesting differences. This time, the list is divided into fourths (i.e., the top four, middle four, and lower four). First, the priority population ranked learning about specific mental health conditions in the top four (#3) while service providers ranked it low in the middle four (#8). Next, service providers ranked general mental health information and addictions information in the top four, while both were in the middle four for the priority population. The priority population ranked food in the top four. Service providers ranked general mental health in the middle four (#6) while the priority population ranked it in the lower four (#9). The table below shows the rankings by each group. You will note that there is one less option on the service provider side; due to researcher error, the service provider survey was missing the 'employment' option. As a result, it pops up in the 'other' category.

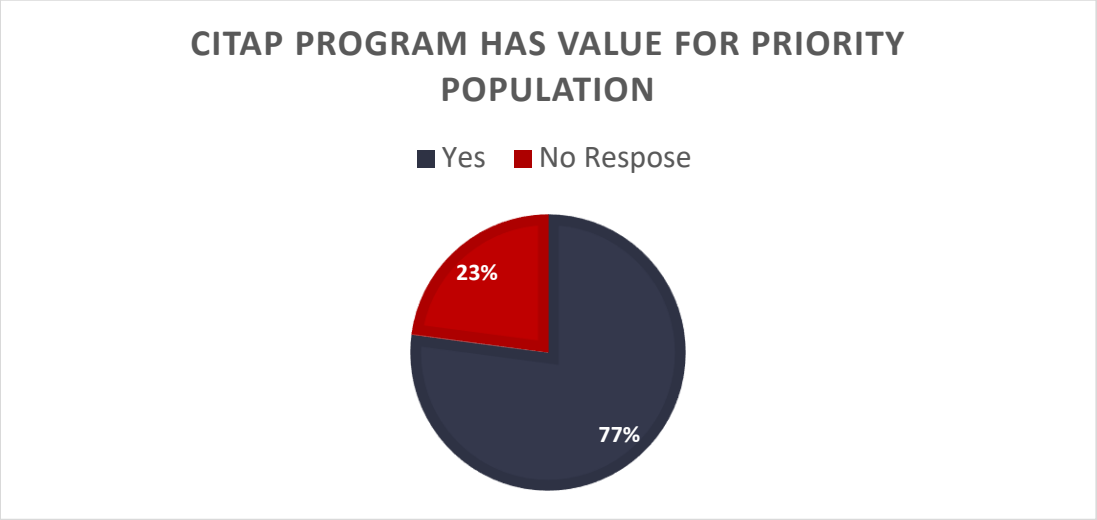
	Priority Population	*Service Providers*
1	Housing Services	Free Services
2	Free Services	Housing
3	Mental Health Conditions	Mental Health
4	Food Resources	Addictions
5	Mental Health	Food
6	Addiction Resources	Physical Health
7	CJS	CJS
8	Employment	Mental Health Conditions
9	Physical Health	Physical Health Conditions
10	Physical Health Conditions	Spiritual Support
11	Faith-based Supports	Other
12	Other	

Program Relevance

We then asked two questions designed to elicit service providers opinions regarding the suitability and relevance of the CITAP program. First, we asked if the program would meet at least some of their clients' needs. 37 of the 38 service providers who answered this question (97.4%) said yes, the program would meet at least some of their clients' needs.



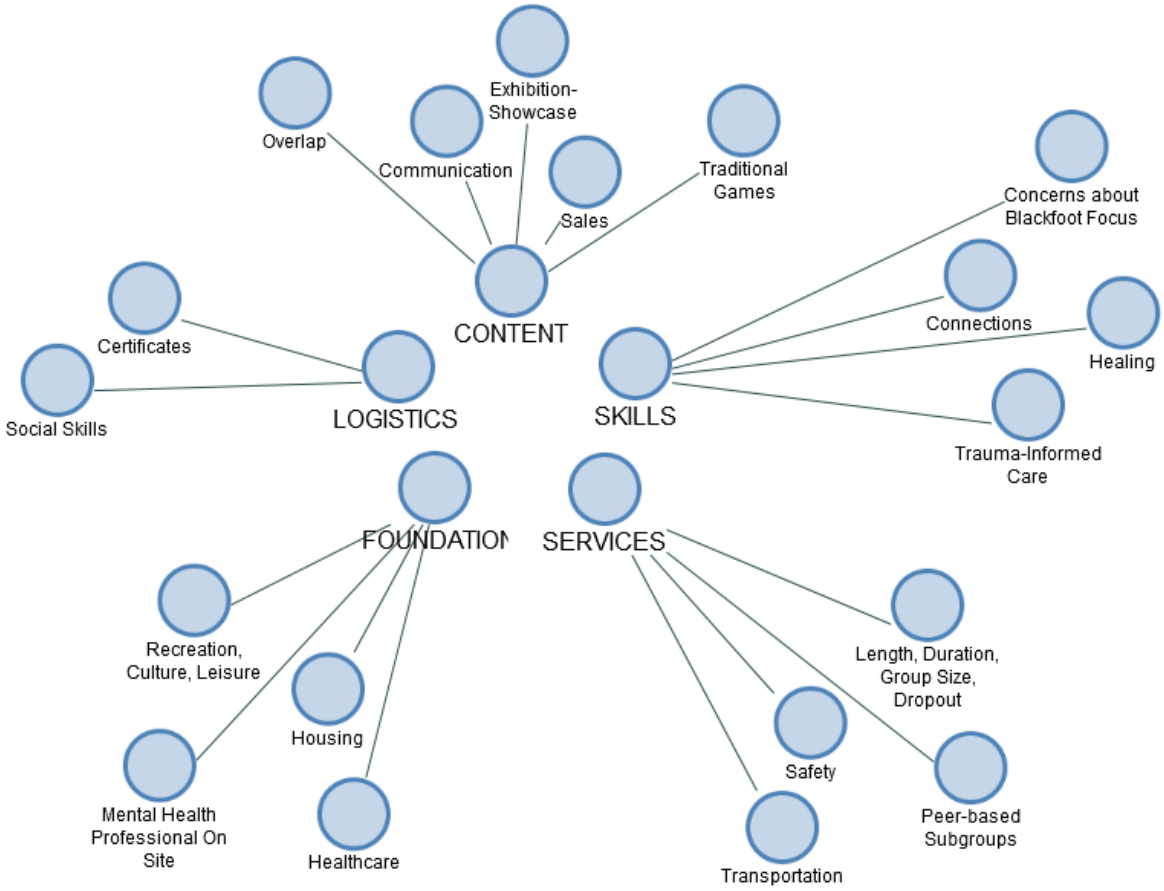
Next, we asked if the CITAP program had value for their clients. In this case, 100% of the 37 participants who answered the question indicated that yes, the program does have value for their clients.



Service Providers' Feedback

We asked service providers two open-ended questions that applied to the program as a whole. The first asked for suggestions for the program, and the second asked for general feedback. Thematic analysis allowed us to identify five main themes in the responses of service providers: content, skills, services, foundations, and logistics. Below is a concept map that highlights the main topics (or codes) that can be found in each theme. Themes can be found in the center of the diagram in all caps, with lines connecting each main topic to the relevant theme.

Concept Map



Thematic and Topic Results

Below is a detailed narrative of the themes and topics that resulted from qualitative analysis of service provider suggestions and feedback. In some cases, topics and concerns have already been considered by the research team, and in other cases service providers highlighted topics or concerns the research team hadn't considered.

Content. One of the main focus areas in this theme was communication. Specifically, including program content that allows participants to practice communication using language. Service providers also suggested content that included traditional games and an exhibition to showcase completed art products. Two main concerns were voiced: first, to investigate similarities with programs that already exist so we don't 'reinvent the wheel' and to exercise caution in promoting this as a way to earn additional income as participant expectations of this could be out of touch with realistic possibilities.

Skills. The main focus in this area was connections. Service providers spoke about using the program to help participants make connections, develop a sense of belonging, create a positive shared space, and encourage long-term connections to Elders and/or traditional knowledge keepers. Additionally, it was suggested that the program could introduce 'community' to the participants. Lastly, it was suggested that we include people who have overcome barriers related to marginalization in the group to provide success stories that will encourage participants and possibly peer-mentors.

Services. This theme was divided into two subgroups: (1) suggestions about services we should provide to participants, and (2) suggestions about services we should teach participants about. Under the first category, service providers suggested we should provide medical care and mental health treatment through on-site access to a counselor/therapist. Under the second category, service providers suggested we share information about the following specific agencies/services: Lethbridge Housing Authority, Recreation and Culture Fee Assistance Programs, Allied Arts Counsel, Volunteer Lethbridge, and Lethbridge Sport Council.

Foundations. The main topic in this theme was connections – specifically, creating connections, relationships, mentorships, and a sense of belonging. Next was the idea of healing being central to the program; non-traditional healing (although the service provider did not explain what they meant by this term) and sharing Canada's history of cultural genocide to promote healing. Trauma-informed care was also mentioned as an important guiding concept for the program. One service provider voiced a concern that the focus on Blackfoot language and culture may create an environment that may negatively impact the engagement/attendance of non-Blackfoot participants. They suggested the inclusion of other languages and cultures.

Logistics. Two main topics accounted for most of the comments in this theme. One included comments about the length, duration, group size, and potential for dropout, and the other included comments about safety. A focus on emotional and physical safety was suggested, with

concerns voiced regarding the potential for participants to try to get their needs met in a dysfunctional/inappropriate way leading to a need for both individual and group safety considerations, as well as ensuring there are sufficient program staff present to manage potential interactions between group members.

Conclusions

Phase 1 data has provided the research team with a great deal of information that will be used to design the first few months of the program. After that, ongoing program design will be flexible, based upon the feedback from participants that we receive in our ongoing program evaluation surveys.

In general, service providers have a good sense of the needs and interests of our priority population. While this paints a picture of highly engaged, caring service providers who are taking the time to really get to know their clients, caution must be exercised in making this assumption. Our sample of service providers was quite small at only 48 participants. The results obtained from our sample may be the result of self-selection bias, where those service providers who chose to participate in our survey are those that are more engaged and more caring than most. If this is the case, it may actually work to increase the validity of the results from our service provider sample as those service providers who are more engaged and more caring are the very ones most likely to accurately represent the needs and interests of their clients.

None of our Phase 1 results are representative; that is, we cannot take the results of the priority population survey to represent all marginalized people, nor can we assume the results of the service provider survey represent all service providers. However, the purpose of our Phase 1 data collection was not to generalize. Rather, it was to give us an informed starting place for creating our program sessions. This process has ensured we move forward according to the four Rs of Indigenous research, as follows:

Respect. We have demonstrated our respect for the autonomy and individuality of our priority population, by asking them directly what their needs and interests are. We have also demonstrated respect for the expertise of the engaged service providers who work with the priority population daily. In doing this, we are using two-eyed seeing by combining the expertise of lived experience with the expertise of professional knowledge.

Relevance. It is very important to the CITAP research team that this program be co-created with our participants, so the end product is a program that is highly relevant to them and useful in their daily lives. Therefore, while the data collected from service providers was useful, our main focus was collecting data from the priority population themselves. By following the blueprint they provided in their surveys, we will be able to create a program that is relevant.

Responsibility. We, the CITAP research team, take responsibility for how we conduct our research and the way we build the program. We will continue to collect data from our priority population by surveying our program participants and we will remain flexible and adaptable in terms of program content, structure, and logistics. In the end, the CITAP program may look different than we are picturing at the beginning, and as long as that difference is driven by the needs and interests of our participants, we will be happy to see it change.

Reciprocity. In Phase 1, we engaged in a reciprocal data collection process whereby participants shared themselves through telling us about their needs and interests and in return, we (1) gave the first 50 participants Tim Hortons gift cards, and (2) will provide all who are interested with a program they can enjoy and co-create, molding it into something born of their needs, interests, and effort.

Next Steps

We are currently in Phase 2 of the CITAP research project, which involves all the necessary logistics. Our research assistants (Amy-Lee, Jarred, and Rexford) are busy recruiting volunteers (artists, professionals, service providers), planning and scheduling program meetings, and will soon begin pricing and purchasing all needed supplies (art and craft supplies, food, etc.).

During this phase, we will be relying heavily on the experts at our community partner agency – the Ninastako Cultural Centre (NCC) – to direct our efforts. The NCC has expertise in Blackfoot language, culture, and arts; art and craft supplies; and traditional Blackfoot foods, knowledge, and processes. Furthermore, the NCC is well-connected to many Blackfoot artists, Elders, and Knowledge Keepers, and we will rely on their assistance in helping us to build relationships between these experts and the CITAP team.

At present, the CITAP program is scheduled to begin operations in September of 2024.