Medicine Wheel Systems

Jurisdiction: New Brunswick Contact: Dr. Lori Vitale Cox, Ivan Augustine

Level: K-12 Theme: Integrated learning

Description of Practice: This is a whole school approach to the problem of identifying and meeting the unique (special) educational needs in a First Nation School. It uses the traditional medicine wheel paradigm to define areas of need within the existing professional practice framework. This is an example of what two Mi'qmaw elders called 'two eyed seeing'*, that is, combining traditional and mainstream points of view. This allows more in-depth perception of children's unique needs and gifts. This practice involves assessment with two assessment tools developed in Elsipogtog over the course of the last 8 years--the Medicine Wheel Student Index and the Medicine Wheel Developmental History. These information gathered from these tools is used as the basis of specialist referrals, program design and implementation, classroom based practices, curriculum implementation, and even changes in nutrition. The principal we follow in providing services to children with a high level of need services is the Mi'qmaw concept of Nogemag that means 'all my relations'-the relation of people to themselves, to each other. This has resulted in stronger relationships in the school and also within the larger community in terms of working with elders and service professionals. Target participants are all of the children in the school in relationship to the teachers, to themselves, to each other, and to their own learning.

* Two-eyed seeing is a phrase used by Mi'qmaw elders from Eskasoni--Murdena and
Albert Marshall. It involves combing traditional understanding with scientific understanding for a truly deeper understanding.

Background: In the 6 weeks from June 11th to July 17, 1992 4 youth in Elsipogtog First Nation committed suicide. By December there were 3 more completed suicides and 40 attempts. An inquest was held and one of the recommendations was the creation of a position at the school to help support the youth in the community. Until 1997, there was a high level of professional burnout and a high staff turnover because of the high level of needs. In the 1997-8 school year a new professional was hired who had research experience at the PhD level and she was asked to undertake a formal needs assessment in response to parents and teachers concerns with the high level of serious psychosocial problems interfering with the learning and behaviour of the children

in the school. She developed two research tools the Medicine Wheel Student Index and the Medicine Wheel Developmental History. These have been used in the school for the last 8 years and are the basis of the Medicine Wheel System Approach to identifying the needs of the children in the school. When the precise needs of the children are identified adaptations and modifications in programming and practice occurred that allowed for easier transitions when the children moved on from the First Nation School to the Provincial Schools. This has led to a lower attrition rate overall and especially among the children with special or unique needs.

Development

Program design, and the system tools that inform it, grew out of consultations with parents, teachers, administration, elders, and other service professionals in the community. There were a series of meetings and the articulation of principles that ground community practice. These are Respect, Relationship and Ritual/Routine--- 3 R's, that ground the practice. These traditional principals were combined with modern pedagogy in terms of researchers like Maria Clay who noted that if children are unable to learn we should assume that we have not as yet found the right way to teach them'

Challenges to this whole systems approach was 1. INAC Funding and Commitment 2. Program Development 3. Staff Spirit 4. Parental Buy In. These are dealt with below.

INAC funding—INAC funding supports individual costs for 'high-cost education students.' There criteria was based on medical model of diagnosis not developmental delays of the children. We are committed to diagnosis and so we did in fact take many children to physicians and we realized that there was a very high incidence of FASD in the school. But we were also convinced that our children should be mainstreamed and that services should be provided to all of our youth with serious developmental delays needs that were not being met in the regular classroom/ So we convinced them to allow us to take a whole-school approach with the funding they provided. We also had trouble with commitment from them in the beginning. We kept statistics and were able to give evidence of the success of our practice but the 2nd year funding was cut drastically despite this. We presented our program to AFN and got their support and then e presented our findings to the Minister of Indian Affairs R. Nault and he committed to 5 year funding for our Initiative. This has made all the difference to us.

Program Development—We had no resource or support programs at the school and our class size was getting bigger. We surveyed the teachers about what their needs were in terms of resources in order to be able to teach and they said they needed 1. smaller classes 2. specialized programs for children with needs 3. More back-up from administration and support in the classroom. A working committee was formed to liaison with larger community and goals were

articulated. We decided that we wanted 1. a whole school-whole community approach 2. a model that integrated services as much as possible 3. a model that built on the capacity of existing services but developed new programs as required 3. a model that provided an interdisciplinary approach built on the community and cultural traditions. The whole school medicine wheel approach has led to the development of the following at the school:

- Small Class Size--12-15 (Sometimes larger or smaller)
- Hot Lunch Program
- Literacy Team Program-Guided Reading Approach in Early Grades
- Resource Program-Every Child With Needs Gets Individual Help Daily
- Traditional Health and Wellness Program-With Elder Involvement
- Youth Mentors-With HRDC Cooperation
- Developmental Playroom and Individual Assistants
- Teacher Awareness/Training
- Alternative Off-Site Programs—Youth –at-Risk to Get Kids Who Dropped Out Back In the System-Cooperation with Province
- Nogemag Healing Lodge Summer and Winter Programs—For at-risk yout Especially those with FASD
- Traditional Drumming and Dancing (taught by the Janitor one year now taken over by Youth Initiative)
- Cultural Program
- Speech and Language Pathology Services
- Counselling Services
- Behavoral Intervention Program in Cooperation with Province

Staff Spirit

Before we started the interventions staff spirit was at an all time low. Administration started listening to teachers and teachers themselves started to commit and stay after school and give a lot of their own time and energy to making changes. For instance they fund snack program for the children. We have two teams in the school Elementary Team and Middle School Team and teachers on these meet and socialize and define for themselves how to improve and articulate concerns. Teachers also had to buy into filling out the Medicine Wheel Index every year and also into using a written referral process for special services and also filling out special education plans and other assessment or program tools as needed. As soon as they began to see changes though they were willing to take the trouble to do the extra work.

Parental-Community Buy-In

Parents were asked to come into the school in terms of coming to meetings every year to sit with teachers and resource workers and to become a part of program planning. At first they refused because they only had been asked to come into the school when their children mis-behaved. This was something entirely different and so now we have much more involvement and buy-in. Also

gradually a shift is occurring in terms of being afraid to find out what is wrong—many parents especially professional parents, were afraid of labels if their children were assessed or diagnosed. This is changing and some parents have become more and more involved.

Evidence

The intervention has changed the fabric of the school and it is now healthy system. Children are in classes and learning instead of wandering the halls and fighting and getting into trouble. These changes are noted below:

- Level of Behavioral and Learning Problems Decrease Dramatically
- Before Interventions in 1996—7 School Year 80% of the Children Grades 1-3 Read Below Grade Level
- Since 1998-9 and After the Interventions In Place 70-90% ;Read On or Above Grade Level in Grades 1-3
- Our Provincial Elementary Assessments Now Equal or Exceed Provincial Average
- Lower Level of Attrition
- Children With Unique Needs Such as FASD or LD Consistently Making Gains as Measured By WRAT-Wide Range Achievement Test given 2x a year
- Children with Unique Needs Now Graduating High-School
- Level of Youth Crime in the Community Down By 30-40% since School Interventions Including Nogemag Initiative

Adaptability

Because the approach was proven to be successful it has received a Crime Prevention funding to develop it as a replicable model to share with other First Nation communities. Presently we are involved with St. Mary's and have been invited to Eskasoni and Woodsock and Oramucto. We are preparing a CD that explains the use of the tools as well as having copies for use. We also have been given funding to make a video of the intervention to help with implementation.

Further Information

Our web-site should be up and running by the end of April: WWW. Nogemag.com. Information and tools and more information about practices and research available there. We also have a formal independent evaluation undertaken by Dr. Don Clairmont on the Nogemag Initiative. Contact Ivan Augustine-Principal or Dr. Lori Vitale Cox for more information right now.