Integrating Indigenous Healing and Western Counseling: Clinical Cases in Culturally Safe Practice

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Research has shown that effective counseling interventions for many Indigenous Peoples infuse Indigenous worldviews, values, and practices into treatment. Research has also shown that the use of only mainstream or Western therapeutic interventions has often proved ineffective for Indigenous clients, as indicated by an under-usage of services and high dropout rates. In response, many scholars working in Indigenous mental health have called for an integration, or harmonization, of Indigenous healing approaches and Western therapeutic frameworks in counseling. However, clear examples demonstrating the effectiveness of successful integration are required to guide mainstream Western psychology toward culturally safe practice in this regard. This chapter presents the background and context for an integrative healing movement, as well as case studies of integration grounded in examples from two counseling settings in Toronto, Canada, where these authors have worked providing mental health care. This chapter identifies obstacles to, and the facilitation of, counseling environments which support the work of Indigenous Healers, Elders, and counselors, and discusses next steps for the successful practice of integrated mental health counseling.

Indigenous Peoples of North America have had systems and practices in place to address and ensure the health and well-being of communities for generations. As with all populations, Indigenous Peoples encountered a diverse range of physical and mental health problems prior to contact [1], and Indigenous groups had comprehensive systems and methods in place for healing. However, with the arrival of European colonizers and the enduring and devastating impacts of colonial policies, the nature, etiology, and occurrence of such health problems transformed

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D. Danto, M. Zangeneh (eds.), *Indigenous Knowledge and Mental Health*,
https://doi.org/10.1007/978-3-030-71346-1_15

substantially. In addition to the introduction of new infectious diseases through colonization, such as influenza and tuberculosis, legislated efforts at cultural genocide by colonial governments have had severe and long-lasting impacts on the mental health of many Indigenous peoples today.

Although Indigenous populations represent a small percentage of Canada's total population, Indigenous communities experience a wide range of health problems at disproportionately higher rates than non-Indigenous peoples. While much variability and diversity exist within Indigenous families, between rural and urban groups, and across First Nations, Inuit, and Métis communities in Canada, general trends continue to indicate substantial health inequities. Physical health ailments representing serious chronic diseases, including heart disease, cerebrovascular disease, diabetes, cancer, and AIDS, are issues of current concern in many communities [2, 3]. Mental health challenges are also seen in many communities in the form of higher rates of depression, anxiety, and other psychiatric disorders, suicide, self-injury, substance abuse, violence, and trauma [4–6].

As with all population health trends, these findings should be contextualized with an understanding of historical and social trends. First settlers to North America in the sixteenth and seventeenth centuries were aided in their survival in large part by Indigenous Peoples, who assisted with navigating new climates and environments [7]. In time however the governing European authorities began to see the "Indians" as an impediment to new immigrant settlements [1]. The enforcement of colonial policies to "manage" the Indigenous Peoples throughout contact was oppressive, racist, and paternalistic. Two notable pieces of legislation, the *British North America Act of 1867* and the *Indian Act of 1876*, enabled the Canadian government to classify Indigenous Peoples as wards of the state, to determine who could identify as "Indian," to eradicate Indigenous forms of governance, to secure title to the land and its resources, to force Indigenous Peoples off their traditional lands and onto designated "reserve" lands, and to restrict and control essential components of healthy living, such as access to food, recreational activity, and the practice of cultural customs and traditions—including the use of healing practices and ceremony [1, 3, 8]. In essence, the principal goal of this legislation was the assimilation of Indigenous Peoples to Euro-Canadian beliefs, customs, and values.

One pronounced and grave example of legislated assimilation is the establishment of the residential school system in the late 1800s. This was an effort by the Canadian government, with the assistance of Christian institutions, to assimilate Indigenous children into the dominant culture. Children were forcibly removed from their homes, separated from their families, and enrolled in these institutions. The curriculum included training in academics, domestic tasks, and manual labor, as well as indoctrination into Christian values [8, 36]. Indigenous languages and spiritual practices were denounced and specifically targeted for eradication in these schools, as they were perceived as a principal vehicle for the transmission of Indigenous cultures. Rampant physical, psychological, and sexual abuse was well documented through the national Truth and Reconciliation Commission (2008–2015), which heard from more than 6000 witnesses who were affected by this multi-generational assimilation policy [36]. Children also experienced

malnourishment, neglect, inadequate medical care, and high rates of child mortality related to medical crises such as tuberculosis. Residential schools began to close their doors in the mid-twentieth century because of financial constraints and growing awareness among the population of the depraved conditions of the schools. The government then changed its welfare policy toward mass adoption of Indigenous children into non-Indigenous families; commonly referred to as the "Sixties Scoop," this practice lasted well beyond that decade. The last residential school closed its doors in 1996, and the thousands of court cases against the government by survivors and their families led to the largest class-action lawsuit in Canadian history [36] and the establishment of the Truth and Reconciliation Commission.

The attempt to fully assimilate Indigenous Peoples into the dominant culture in residential schools was unsuccessful, and many families and communities were able to maintain ties to culture, language, and land. However, as a result of the intergenerational effects of trauma, many communities experienced lasting psychological and spiritual wounds. Also, the graduates of the residential school system often found themselves on the periphery of two distinct worlds, ill-equipped to navigate either completely. Survivors noted an inability to thrive in mainstream culture thanks to a fractured educational experience and ongoing racism in the dominant culture. Those who lost their language struggled to return home to build a life in their community. The effects of these colonial efforts have had long-lasting impacts on individuals, families, and communities as a whole. Indeed, the deleterious effects of European settlement in Indigenous lands across the continent are well documented in the psychological literature (see, for instance, [9–11]) and across health disciplines. As Canada moves toward reconciliation, turning our gaze toward healing is paramount.

Healing Perspectives

Indigenous Medicine

While Indigenous approaches to healing were driven underground by Canadian legislative acts that banned cultural ceremonies in the twentieth century, Indigenous knowledges and practices continued to be passed down through the generations. Indigenous Elders, often viewed as the bearers of cultural knowledge and tradition, have played a pivotal role in the transmission of Indigenous cultures, and in the practice of Indigenous healing. The revitalization of Indigenous healing practices and community-based approaches to healing over the past 50 years speaks to the undeniable strengths of Indigenous communities in Canada in surviving assimilationist policies aimed at cultural genocide.

As we have noted, significant diversity exists among First Nations, Inuit, and Métis peoples, and the hundreds of communities that exist across Indigenous Nations. While recognizing this diversity in worldviews and practices, scholars and

Healers have also highlighted several important over-arching similarities. Central values that comprise Indigenous worldviews include the importance of relationship and the role of family and community; an emphasis on holism and balance between the sacred aspects of the self (physical, emotional, mental, and spiritual); and a recognition and respect for the interconnectedness of all things in the natural world, including plant and animal worlds, ancestral and spiritual worlds, and the cosmos [6, 12, 13, 37].

One of the most commonly identified defining features within Indigenous conceptions of healing values and health is the notion of holism and balance. An individual is viewed as consisting of four sacred parts of self, including the physical, emotional, mental, and spiritual, and it is the balancing of these aspects of the self that constitutes well-being [3, 37]. If one of these dimensions is out of balance, the remaining three aspects of the person will be impacted, and the person may become unwell. For instance, if an individual is not eating healthy foods or is not eating routinely, her mental and emotional health may become compromised by malnourishment and life stress. In this view of the self, these dimensions of health are not viewed as independent entities, but as interconnected elements that together comprise an individual's health. It is for this reason that some Indigenous Healers struggle to define mental health concretely because mind-body dualism is not a concept that is readily found within many Indigenous cultures historically [14].

Another important healing value is the centrality of spirituality and spiritual health in Indigenous conceptions of wellness. As noted, spiritual health is one of the dimensions of well-being and it represents a central tenet in Indigenous healing. All things in creation evolved through spirit and heal through spirit; the human condition is interpreted through spiritual understandings of existence, and Healers use spiritual relationships in their helping work and in order to make meaning of illness [9, 15]. In some cultures, illness is thought to originate in spirit and is indicative of spiritual disconnection. In these cases, healing therefore takes place through spiritual reconnection [9]. These are but a few examples of the critically important nature of spirit as an aspect of overall health and wellness. However, a focus on spirituality is often absent in Western mental health practices [13, 14], suggesting that Western mental health interventions lack balance in caring for the sacred aspects of self. While healing through the spiritual dimension is unique for each individual, generally individuals derive healing from relationships to Creator or Gitchi Manitou (the "Great Spirit" in Anishnawbe cultures), to ancestral spirits and spirit guides, and to one's own spirit.

Indigenous medicine also includes a diverse system of practices for healing [1], including the use of plant medicines and hands-on medicines for curing illness and treating physical wounds and injuries. As in all Indigenous cultures around the globe, plant medicines have been used in healing for generations; in fact, as much as 80% of the world's population relies on herbs for their primary health needs [16]. Other practices to heal the sick body include curing ceremonies, bone-setting, massage, and the removal of disease objects [1]. Spiritual ceremonies are facilitated by Healers and or Elders in the community; the type of ceremony performed depends on the nature of the problem presented by the individual who is in need. There are

numerous Indigenous ceremonies that Indigenous practitioners may prescribe to address the healing needs of an individual. Ceremony is often embedded within other medicinal practices, such as talk therapy with Elders, counselors, and Healers, and hands-on medicine. These are only a few examples of the vast array of healing modalities used across Indigenous cultures. As Garrett and Wilbur [17] note, "Medicine is everywhere. It is the very essence of our inner being; it is that which gives us inner power. Medicine is in every tree, plant, rock, animal, and person. It is in the light, the soil, the water, and the wind... There is medicine in every event, memory, place, person, and movement. There is even Medicine in 'empty space' if you know how to use it" (p. 197–8).

We have offered a brief overview of Indigenous models of healing and practices. Next, we consider Western approaches to mental health service provision.

Western Mental Health Services

Many Indigenous individuals and communities possess strengths and community-based healing approaches that prevent or remedy mental health problems. However, the vast majority of available mental health services in Canada are rooted in a Western paradigm and approach to health. The majority of Indigenous Peoples who seek help for mental health problems are therefore sent to Western mental health service providers. Western counseling services vary considerably in theoretical orientation, framework, and technique; for instance, therapies may include a focus on cognitive restructuring, unearthing social oppressions, improving communication, solving problems, building self-esteem, managing trauma and grief, and gaining self-awareness of thoughts, feelings, and the body. In the following section, we consider the fundamental assumptions behind the models of health that have dominated the field of Western psychology and psychotherapy throughout the twentieth century.

The notion of mental health and mental illness in a Western context tends to be defined in relation to disorder; that is, the absence of disorder is often an indicator of good mental health. The field of psychotherapy and psychology have been largely informed by psychiatry's dominant text on disorders, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM), currently in its fifth edition. This text is so central to the profession of mental health in North America that many insurance providers in the United States, and some in Canada, will not offer financial coverage for mental health services if clients are not first diagnosed with a DSM disorder. Within this diagnostic text, each mental disorder is conceptualized as a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability [18]. A variety of concepts are used in the assessment and diagnosis of mental health issues, including distress, dysfunction, disadvantage, disability, inflexibility, irrationality, etiology, and statistical deviation. In this regard, mental health challenges are assessed through a pathological lens where the location of the disorder lies within the

individual, often has a biologically based etiology, and represents a deviation from a population "norm."

Within Western mental health practice, a practitioner may spend time evaluating and assessing the client's cognitive and personality features through the use of psychodiagnostic tools and using interventions that are designed to facilitate individual change. As in the practice of physical medicine, where the disease is confirmed through lab tests, psychodiagnostic tools are used to determine the presence of psychological "disease." Treatments focus on finding cures rather than on helping individuals find meaning in their suffering, or on seeking to understand the underlying imbalance, unlike some Indigenous approaches that prioritize wider contexts of understanding and healing of the "whole" person and community [19]. In Western practice, the goals for change focus on the individual client, as opposed to other units (for example, family) or systems (for example, the Canadian child welfare system) the client may be influenced by, and which may be contributing to mental health distress [20].

Western psychology and psychotherapy also values and prioritizes evidence-based practice. Evidence-based practices are forms of treatment that use an empirical base of evidence to document their efficacy. These practices tend to be seen as most "valid" in terms of therapeutic approaches and are often employed on this basis in managed care settings. There are some challenges in determining the evidence base of Indigenous medicine, including the often inappropriate use of a Western research paradigm and the potential clash with Indigenous community ethics in terms of, to give but one example, documenting sacred practices.

A related concern is the bureaucratization of Indigenous healing methods. As Waldram [21] and Gone [22] note, the institutionalization of Indigenous health practices and services of Healers has the potential to result in the formalized surveillance of Healers and Indigenous health practices, which leads to concerns related to contracting the services of Healers and Elders, remuneration of Healers and Elders, and documentation of Indigenous health practices. In sum, the growing emphasis on empirical validation of therapeutic interventions and practices affects how Indigenous healing practices are perceived by Western health-care systems, practitioners, and government funding agencies, and the formalization of Indigenous medicine will impact its practice.

Lewis-Fernandez and Kleinman [23] note several dominant culture views in North America that influence mental health. These include "mind-body dualism" (the mind and body are separate, with little influence on one another), the "egocentricity of the self" (people are individuals and are not affected by the web of relationships around us), and the view that culture does not influence our biology, among others. Western mental health systems look to scientifically informed approaches that strive for an "objective" and "value-free" encounter between practitioner and client, and which tend to result in the client being seen through a pathological lens. Despite technologically sophisticated medical practices and forward movements in health care, many patients have reported feeling alienated from their health-care professionals, who now seem more technicians than Healers [24]. This contrasts starkly with the holistic, socioculturally informed, and wellness-based

conceptions and approaches to health and healing that are integral to many Indigenous cultures [13].

In order to assist in the healing work, any counseling endeavor with those who have experienced mental health issues must consider the specific value systems and unique culture(s) of the client; the most appropriate ways of dealing with various mental health challenges in a dominant culture context, for instance, might not be entirely appropriate or ideal for members of other cultures [25]. Accordingly, Stewart [11] noted that most mental health services in urban areas have not been adapted to meet the needs of Indigenous clients. This lack of cultural appropriateness of services has resulted in lower rates of mental health service use as well as higher dropout rates from counseling among Indigenous Peoples [26–28]. The use of Western approaches to healing with Indigenous clients has indeed often proved ineffective, as indicated by an under-usage of services, high dropout rates, and Indigenous Peoples' reports of low quality of care and services received [26–28]. Numerous scholars have offered potential explanations for why Western approaches to healing have proven ineffective, including the absence of an Indigenous worldview and conception of health [11], culturally insensitive practitioners [9], and difficulties in establishing trust between the client and practitioner [10]. To tailor and enhance counseling services for Indigenous Peoples, researchers, administrators, and practitioners alike have begun to call for an integration, or harmonization, of Indigenous and Western approaches to healing (see, for example, [1, 9, 29]).

The Integrated Healing Movement

In the following section, we review the movement toward integrating Indigenous and Western paradigms and practices of healing. We outline the rationale for integration and its merits. We also consider the various pathways through which integration may occur, including training epistemologically hybrid practitioners, integrating mental health programs, and the harmonization of healing paradigms and services.

Rationale for Integration

For many decades, Western mental health systems have failed to adequately serve Indigenous Peoples' needs [11, 26, 36]. Studies that consider attitudes of Indigenous clients toward Western mental health services have noted that participants lack confidence in Western mental health services and that some use these services only as a last resort [14, 28]. Also, fostering or strengthening spiritual identity and spiritual relations with other beings (for instance, Creator and ancestral spirits) has been identified as a core component of healing for many Indigenous peoples [12, 13, 22]. This understanding has been absent from Western treatment models, which tend to

fragment medical, psychological, and spiritual healing approaches. Integrating Indigenous medicine and healing with Western mental health services would provide a more holistically oriented approach to health and wellness that would better serve Indigenous Peoples. It is likely that if Indigenous approaches to healing were made available in Western mental health or counseling settings, Indigenous clients interested in pursuing Indigenous medicine may be more likely to access these services. If Indigenous clients see Western practitioners working collaboratively with Indigenous Healers and Elders in these settings, obstacles related to developing trusting relationships between client and counselor may be assuaged.

While Indigenous healing systems, including the services of Healers and Elders, continue to be accessed and identified as a successful option for healing [12, 29, 30], relying solely on Indigenous Healers and Elders for treatment is no longer a viable option. Among the primary obstacles to accessing the services of Indigenous helpers are the cost and accessibility of Indigenous medicine [30]. Additionally, given the complexity of health challenges among many Indigenous communities today, and mental health challenges in particular, the singular use of Indigenous medicine may not be adequate to address contemporary health needs.

Interestingly, many Indigenous clients who use both Indigenous and Western services simultaneously often fail to inform their helpers of their multiple service use [3]. Multiple service use potentially poses a risk when one considers the possible negative interactional effects between Western and Indigenous medicines, including opposing treatment approaches and differing care instructions. Developing systems in which both Western and Indigenous practitioners work collaboratively could provide the client with clearer treatment guidelines and a greater range of treatment options, presumably increasing the retention rate of Indigenous clients. Centralized systems would also allow for communication, case consultation, and treatment planning between helping professionals, which would decrease the chance of a client receiving contradictory treatment.

Finally, an inspiring motivation for the integration of Indigenous and Western healing paradigms is that these approaches have the potential to complement one another and to enhance the healing process. A study by McCabe [13] identified 12 therapeutic conditions that facilitate the successful implementation of Indigenous Healing methods. Several of these conditions, such as empathy, genuineness, acceptance of the client, readiness to heal, and trust and safety, also represent the core conditions of many Western psychotherapies. Given the congruence between these models of healing, some of the foundational elements for an integrated approach are already in place. Psychologists working in Indigenous community contexts have noted that all healing approaches (including Western approaches) offer value to clients, and that Indigenous clients, who often present with complex challenges related to a history of oppression, can benefit from complex solutions [1, 9, 10]. If Western mental health services and Indigenous medicine can work together in a hybrid model, this harmonized healing approach for clients, families, and communities may be more effective than any one approach alone.

Levels and Forms of Integration

Epistemological Hybridism

In Eduardo Duran's groundbreaking text *Healing the Soul Wound* [9], Duran outlined the philosophical tenets of what he refers to as "hybrid psychotherapy." He stated that the term "hybrid" emerged from postmodern thinking, and referred to the idea that there can be two or more ways of knowing, and that these different views can exist harmoniously with one another. He noted his belief that the mental health profession must transcend the practice of culturally sensitive psychotherapy and engage in what he calls "epistemological hybridism," which is the ability to think or see the truth in more than one way ([9], p. 14). Duran notes that practitioners adopting an epistemologically hybrid stance take "the actual life-world of the person or group as the core truth that needs to be seen as valid just because it is. There should never be a need to validate this core epistemology or way of knowing by Western empiricism or any other validating tool" (2006, p. 14).

Embracing and practicing hybrid psychotherapy means that a mental health practitioner commits to creating space for the expression of diverse forms of knowing and healing while being able to accept the client's beliefs, perspectives, and experiences as legitimate, valid, and authoritative sources of truth and knowledge. This approach to integration allows both the practitioner and client to explore the client's worldview and to identify the healing needs and preferred methods or strategies for healing work. It is this collaborative and conceptually flexible space which allows for the co-occurrence, integration, and acceptance of both Western and Indigenous healing knowledges and practices.

Importantly, Duran [9] wrote that objectives and definitions of healing in Western and Indigenous paradigms are related: the meaning of the term psychotherapist is "soul healer," and the task of the soul healer is to help individuals overcome psychopathology, or "soul suffering." Duran noted that the primary objective for all helpers is to recognize and "engage in the healing tradition that is part of our genetic memory and be true to that tradition" ([9], p. 44). Although this notion of a genuine alignment between Indigenous and Western paradigms of healing may be ideal, it is unlikely that the Eurocentric model of healing will be abandoned by the disciplines of Western psychology and psychiatry. While training programs may work to ensure that practitioners develop the appropriate skills to be culturally sensitive or competent, this is still fundamentally different than a practitioner who is epistemologically hybrid and is able to accept multiple forms of knowing and healing as valid and legitimate.

One challenge within the integration discourse is whether mental health interventions (such as cognitive therapies and Indigenous ceremony) can be used conjointly if integration at a paradigmatic level has not occurred. For instance, Western practitioners, as part of culturally sensitive training procedures, are instructed to be open to client worldviews and values related to healing, and the possibility of working or consulting with Healers and Elders [20, 29]. However, simply because a

practitioner refers a client to the services of an Indigenous Healer, or communicates with a Healer from time to time, does not necessarily mean that the clinician is practicing as an epistemologically hybrid practitioner, where Indigenous medicine is viewed as equally legitimate as Western medicine. Even Western practitioners who refer Indigenous clients to Indigenous Elders, Healers, and counselors may continue to take a stance of Western elitism [31].

This type of criticism and skepticism of Indigenous healing methods has, of course, been present throughout history. The maltreatment of Indigenous Healers and Elders began with European contact in the late fifteenth century [3] and has continued to date with ongoing Eurocentric epistemological racism. Although the Western mental health system and its practitioners have made strides in terms of acknowledging and validating diverse systems of knowledge and healing, some authors have commented that Indigenous health practices continue to be stigmatized and viewed as "magical," irrational, and illegitimate forms of healing [3, 32]. Given the relative newness of the integrative healing movement, questions about how paradigms of healing may be integrated in practice remain, and combined interventions continue to be experimented with.

Program-Level Integration

It has become a commonplace recommendation that Western practitioners remain open to the possibility of referring, consulting, or collaborating with Indigenous Healers and Elders (for example, [20, 29, 33, 34]). Referring a client to an Indigenous Healer without the establishment of a formal relationship between the Healer and clinician however likely does not capture the true spirit of integrative helping. Consulting with Indigenous Healers and Elders to learn of a client's cultural background, developing a culturally informed understanding of the presenting psychological issue, and collaborating with Healers in the design of a treatment plan (such as incorporating the use of ceremony as part of a client's healing work), better represent an integrated approach to treatment and healing.

A study by Shore, Shore and Manson [29] identified how Western mental health practitioners and Indigenous Healers can establish collaborative working relationships. The study outlined how Western and Indigenous helpers work together to serve Native American war veterans in a culturally competent care model. In order to begin working relationships, psychiatrists made multiple trips to the community to meet with community figures, members, and Healers. The psychiatrists, with the aid of a cultural informant who was part of the clinical team, attended community events such as powwows and Indigenous ceremonies. Participating in such events allowed the psychiatrists to come into contact with Healers and demonstrate an interest in Indigenous activities and culture. Thereafter, the psychiatrists continued to have ongoing meetings with Healers and collaborated on models of healing, perspectives on symptoms, the development of treatment plans, case consultation, and mutual referral. This form of integrated care proved effective for client retention and in the reduction of symptoms.

Another example of integrated mental health services relates to the Knaw-chi-ge-win mental health program on Manitoulin Island in Ontario [30]. Knaw-chi-ge-win services are coordinated by two regional Indigenous health organizations, which place an emphasis on community-based Indigenous approaches to care. The Knaw-chi-ge-win core team is made up of professionals working in the areas of psychology, nursing, and social work, as well as a coordinator of Indigenous Healing services who has expertise in the area of Indigenous medicine and healing. The core team is also complemented by consultants who possess expertise in the areas of psychiatry and Indigenous healing, and who visit monthly. The core team's home office is centrally located within the region, and satellite clinics are located throughout the seven First Nations on the island; clients can access services either through the home office or the various clinics. Services are provided within a holistic Indigenous framework that recognizes the sacred aspects of the self (physical, emotional, mental, spiritual) and considers client context (cultural, historical, and socioeconomic factors). At intake, the client is assigned to the most suitable health-care provider(s) (for example, nurse, psychologist, Healer). The healing team coordinates specialized care for the individual and team members attend psychiatric consultations and Indigenous Healing services with their clients to ensure continuity of care and a collaborative approach to healing.

To evaluate the Knaw-chi-ge-win program, Maar and the research team (2009) conducted focus groups with community service providers and interviewed clients. Their study found that in order to effectively integrate Indigenous and Western healing services, the health-care professionals needed to accept and have an in-depth understanding of both paradigms of healing. One clinician noted that it can indeed be challenging to fit the paradigms together when one of them is poorly understood ([30], p. 7). The inclusion of Indigenous medicine in the program and the training given to staff in this approach removed the "mystique" of Indigenous medicine and eased integrated practice (p. 7). Clinicians reported that they were more comfortable referring clients to Indigenous services once training in this healing approach was given and protocols for Indigenous Healing practices had been established. Other evaluation results indicated that the Knaw-chi-ge-win program improved the cultural safety of services, increased access for clients to receive care in an Indigenous language, decreased stigmatization in using Indigenous medicine, improved quality of illness management, reduced wait time, and reduced number of patient admissions to acute care psychiatric hospitals, among other benefits. Challenges included a lack of stable funding for Indigenous health services and a lack of qualified mental health professionals in the area.

In this section, we have reviewed epistemological hybridism and integration in services and programs as distinct aspects of integration. In the following case studies, we describe examples of integration on the paradigmatic level, the clinic level, the program level, and the individual practitioner level.

Clinical Cases in Integration and Harmonization

In addition to collaborations at the program level similar to those described in the case examples of the Knaw-chi-ge-win program and the promotion of mental health among war veterans, we (Beaulieu and Reeves) have also worked in psychological roles within health programs in the Toronto area that integrate at the paradigmatic, program, and practitioner levels. Integrated health programs have begun to emerge over the past 20 years, and Toronto has seen the rise of several community-based health and resource centers designed by, and for, Indigenous clients from the "roots up." Aboriginal Services at the Centre for Addiction and Mental Health (CAMH) and Anishnawbe Health Toronto (AHT) represent two community health centers that offer access to a diverse range of health-care practitioners, including psychiatrists, psychologists, nurses, Healers, Elders, and medicine people. In this section, we describe harmonized mental health care for clients at these agencies.

Aboriginal Services, Center for Addiction and Mental Health

Chapter coauthor Tera Beaulieu is of Métis, Hungarian, and Ukrainian ancestry and is currently completing her PhD in clinical and counseling psychology at the Ontario Institute for Studies in Education (OISE) at the University of Toronto. Beaulieu learned of her Indigenous ancestry as a young adult and spent the better portion of 10 years on a learning and healing journey to reconnect with her Indigenous lineage, culture, and community. Parallel to this personal journey was Beaulieu's academic and clinical training journey. Over the past 10 years, Beaulieu has held administrative and clinical roles in several of the programs at CAMH, including the Youth Addiction and Concurrent Disorder Service, the Aboriginal Engagement and Outreach Program, the Women's Program, the Psychological Trauma Program, and, most recently, Aboriginal Services.

CAMH is located in Toronto, Ontario, Canada, and is the largest mental health teaching hospital in Canada. CAMH is a leader in research innovation and is fully affiliated with the University of Toronto; it is also a Pan American Health Organization/World Health Organization Collaborating Centre. CAMH provides a full range of hospital and community-based services, including inpatient and outpatient care and services for children, youth, families, and adults. Speciality clinics serve individuals with diverse mental health and addiction issues, including anxiety and depression, substance use, psychosis, and concurrent disorders, among others.

Established in 2000, Aboriginal Services (ABS) at CAMH provides culturally safe clinical and Indigenous health care using a holistic approach that is based on Indigenous values, beliefs, and traditions. Serving individuals who self-identify as First Nations, Inuit, or Métis, the program focuses on taking care of the spiritual, emotional, physical, and mental health needs of its clients. ABS's client population comprises individuals from the urban Indigenous community of Toronto as well as communities throughout Ontario and abroad. Clinical offerings include outpatient

groups, individual therapy, and Indigenous Healing services, with support being offered to Indigenous inpatient clients throughout the hospital. The team is comprised of Indigenous social workers, an occupational therapist, and a Healer, with allied health support from various other disciplines, such as psychiatry. Clients who access the service may present with a range of concurrent mental health and substance use issues, including complex intergenerational trauma.

ABS clinicians collaborate to identify holistic healing and treatment plans that focus on spiritual, emotional, physical, and mental wellness. Clinical interventions offered are founded on Indigenous worldviews and values, including Indigenous Knowledge systems and healing practices, and are culturally integrated alongside mainstream interventions. In 2016, ABS at CAMH established an on-site Sweat Lodge for Indigenous clients to access as part of their healing and treatment journey; it was the first hospital in Ontario to do so. Also on site are an Indigenous medicine garden and sacred fire pit where ceremonies may be held throughout the year. ABS practices self-determination in service design and delivery, and aims to use promising and wise practices in its clinical programming to address the diversity of issues that have affected Indigenous people's health and well-being. In the following vignette, coauthor Tera Beaulieu describes her personal experiences working as a clinician and administrator in various CAMH programs to design and deliver clinical services for First Nations, Inuit, and Métis peoples.

Vignette 1 *My learning journey and immersion into Métis culture, community, and Indigenous Knowledge systems paralleled the beginning of my master's program in clinical and counseling psychology at OISE-University of Toronto. At the time, I had learned of my Indigenous ancestry but did not have a thorough understanding of my ancestral community or culture. I set out on a healing journey in which I researched my ancestral lineage and the historic Métis communities that my family originated from (Qu'Appelle, Saskatchewan, and St. Laurent, Manitoba). I also contacted the Métis Nation of Ontario and the Toronto and York Region Métis Community Council to establish connections and begin to develop a sense of community within urban Toronto. Part of this process entailed developing relationships with Indigenous Knowledge Keepers, both First Nations and Métis Elders and Senators, who supported and nurtured me along my pathway of healing.*

As I began to learn about Métis culture, spirituality, and healing, I was simultaneously learning about Western approaches to mental health and healing through my academic program. I spent as much time as possible with Indigenous Knowledge Keepers as I could, attending teaching circles, ceremony, and engaging in my own ceremonial and healing work, while also engaging in psychotherapy with Western trained health-care professionals. As I learned and experienced diverse approaches to health and healing, my worldview and framework for understanding knowledge systems and healing processes took shape synergistically: my lived experience as a Métis woman, alongside participating in Indigenous healing and Western health care, informed the development of my epistemologically hybrid approach to health, well-being, and healing. For instance, as I began to work with clients of various ethnic and racial backgrounds, I would often conceptualize their health and healing

needs from a holistic lens that accounted for their mental, emotional, physical, and spiritual well-being. As I began my PhD in counseling and clinical psychology, I continued to meet with Indigenous Knowledge Keepers, both to learn about Indigenous approaches to healing and well-being, such as the use of sacred medicines and the transformative properties of Indigenous ceremony, and to deepen my understanding of spirituality and how it relates to mental health.

A great deal of my clinical work during my early training was with non-Indigenous individuals. Despite this, I would often share with them my approach and understanding of health and well-being, including my assumptions and biases regarding spirituality. I would frequently introduce the concept of a Medicine Wheel to discuss the different aspects of the self (mental, emotional, physical, and spiritual) and how imbalance in different areas of one's life can impact overall health. I kept Indigenous medicines and ceremonial items in my offices at all times (next to the "coping tools box" on my desk), both for my own spiritual health and well-being and for my clients'. I also maintained a strong focus on self-care practices and regularly engaged in my own healing and ceremonial work. As I progressed in my practice through my PhD training and began to conduct psychological assessments that surveyed symptomatology and psychological functioning, I also attempted to assess and conceptualize psychological presentations from a spiritual lens. This meant attempting to understand specific symptoms from a spiritual/cultural perspective, and also coming to understand mental health distress and unwellness as a spiritual imbalance and or wound. I regularly consulted Indigenous Knowledge Keepers to discuss clients' psychological presentations and to conceptualize treatment and healing plans. This activity, on occasion, included attending ceremonies with Indigenous clients to complete a spiritual consultation whereby the respective Indigenous Knowledge Keeper would provide a spiritual explanation (or diagnosis) with spiritual and ceremonial prescriptions being given as part of the client's treatment and healing plan. In the beginning, it often took great effort and time to consolidate the different perspectives and approaches that I was practicing (that is, Western and Indigenous frameworks) as part of an epistemologically hybrid practice. However, I learned early in training and clinical work that I could not divorce myself from, or "turn off," my Indigenous worldview and lens regarding psychological health. Instead, I chose to share this with both my non-Indigenous and Indigenous clients and invite them into a process of co-constructing and understanding their mental health functioning and well-being.

In my position with Aboriginal Services (ABS) at CAMH, I supported the program and staff with a review of its clinical programming. As noted above, clinical offerings included outpatient therapy groups, individual therapy, and Indigenous Healing services, with support offered to Indigenous inpatient clients throughout the hospital. The team was comprised of Indigenous social workers, an occupational therapist, and a Healer, with support from allied health professionals in areas such as psychiatry. At the time I was engaged with the program, the clinical team had expressed interest in further defining the therapeutic goals and milestones of their therapy groups, and was looking for a clearer articulation of how Indigenous healing and knowledges intersect with the Western clinical elements of their

programming (for example, with the cognitive-behavioral interventions that are used in Western groups). The discussions that ensued included the importance of ensuring that Indigenous Knowledges and healing practices are valued equally, are as readily accessible, and comprise a proportionate share of the programming in comparison to Western interventions. For instance, all ABS clients would be offered, in addition to standard group therapy offerings, Indigenous healing services if the clients were interested and the services were appropriate (for example, unless medical complications prevented them). Indigenous ceremonies, such as sweats and full moon ceremonies, would be offered on a monthly basis for Indigenous clients at CAMH to access, with additional culture-based groups being developed and offered as part of the program (for example, teachings and drumming circles).

Also, the epistemological foundation of each of the standard group offerings in the service was altered to be rooted in Indigenous worldviews and Indigenous Knowledge systems. For instance, all "groups" were run as "circles," with Indigenous teachings guiding the formation and operation of the circle. Each circle included an opening and closing prayer, drum song, and purification ceremony. The content for most circles would include a cultural integration of both Indigenous and Western knowledges and practices. For example, clinicians might introduce the concept of a substance use continuum to discuss various degrees of substance use but would contextualize the discussion of why Indigenous Peoples have used substances within the historical narrative of colonization. Another example would be a circle focused on coping tools that included a discussion of holistic coping strategies and detailed examples of spiritual and/or cultural coping tools for clients to use. Additionally, certain circles might be strictly dedicated to ceremonies or Indigenous teachings by the Healer, or other Knowledge Keeper working with the service, to support clients in achieving therapeutic and developmental milestones in their healing. It was obvious that the ABS clinicians had embraced an epistemologically hybrid praxis in their clinical work, which significantly influenced program-level integration.

In my work with ABS, I was also asked to lead the cultural adaptation of a mainstream trauma and substance use treatment. In its clinical program review, ABS staff had identified as a priority the addition of a trauma treatment to its clinical offerings. The ABS clinical team participated in a training session of the mainstream cognitive-behavioral treatment and piloted a cycle of the treatment with ABS clients with minor cultural adaptations made, such as including an opening and closing prayer, drum song, and purification ceremony. Following the completion of the pilot cycle, I met with the ABS team to debrief their experiences facilitating the group and ask for their perceptions of the challenges and strengths of the treatment. ABS team members reported that, overall, clients benefited from the treatment; however, they felt that significant adaptation work was required to ensure that the materials were culturally relevant and safe for First Nations, Inuit, and Métis people. For instance, team members noted challenges with the literacy level required for handouts, the abstinence-oriented approach of the treatment, and the overall tone of treatment (for example, deficits-based, focusing on pathology and problems). The cultural adaptation process consisted of ABS team members, including the Healer,

participating in weekly meetings in which the Western treatment materials were reviewed in detail. The cognitive-behavioral interventions and treatment materials that the team felt were most appropriate and relevant for Indigenous Peoples were retained, with additional suggested edits put forward by team members. Treatment materials were then recreated, with the new culturally adapted content integrated into preexisting materials, such that the adapted content became more culturally relevant for First Nations, Inuit, and Métis people, and increasing the level of cultural safety for clients. Additionally, new materials, including exercises and handouts, were created by the ABS team, and new culturally specific examples, skills, and strategies were identified. Circles dedicated to Indigenous teachings and ceremony were also built into the program to address certain healing needs, such as a doctoring ceremony to heal trauma wounds.

At the end of the cultural adaptation process, it became apparent that the ABS team had created substantially new content, so much so that the groundwork for a new trauma and substance use treatment had been completed. As a result, I turned my attention to focusing on developing additional materials to bolster the new clinical treatments. Although the cultural adaptation process was challenging, the journey of examining a mainstream treatment, and attempting to integrate Indigenous Knowledge and Healing practices into it, was enlightening. The challenges that emerged related to the cultural adaptation of treatment materials, including issues related to the cultural appropriateness, relevance, and safety of materials for Indigenous peoples, highlighted the need, and resulted in, the development of a new clinical intervention that is grounded within Indigenous knowledge systems. The development of innovative and culturally founded treatments, led by Indigenous Knowledge Keepers and health professionals, is a promising practice for addressing the mental health and healing needs of First Nations, Métis, and Inuit people.

Anishnawbe Health Toronto

Chapter coauthor Dr. Allison Reeves is a registered clinical and forensic psychologist in Ontario. She joined Anishnawbe Health Toronto (AHT) in 2011 as the program coordinator for a province-wide cultural safety training program developed by AHT. This program trained health professionals and post-secondary students in the health professions in culturally competent health service delivery for Indigenous clients. Dr. Reeves then transitioned into the role of psychologist on staff at AHT after completing her licensing exams. She continued in this role for the following 4 years.

AHT is a culture-based multidisciplinary health center that has been servicing the Indigenous community in Toronto since 1989. In the urban city of Toronto, there exist numerous Indigenous individuals representing various Nations and Indigenous affiliations, varying in socioeconomic, linguistic, and cultural backgrounds. AHT offers health and well-being services in various Indigenous languages and offers clients a sense of Indigenous identity as well as a place to engage in physical, emotional, spiritual, mental, and social healing. This facility offers Indigenous cultural

teachings, ceremonies, access to Elders and Healers as well as mainstream Western health-care services. The facility also exposes clients to social justice issues facing Indigenous peoples through Anishnawbe teachings on the political, social, and economic histories of Indigenous peoples in Canada, and therefore serves an additional role in community empowerment [38]. The mental health services offered at AHT place Indigenous culture and traditions centrally by using a client-centered, strength-based approach to assist in healing [35].

AHT offers primary care services (general practitioners, physiotherapy, chiropractic, nursing, and others) at the Waash-Keshuu-Yaan[1] unit. AHT also has social workers who offer housing supports for clients in search of stable housing and who help connect clients to outside health services. AHT houses a learning center where young adults who have not yet obtained their high school diploma can work toward this. For individuals struggling with addiction issues, AHT offers a day treatment program at the Chayuuwaytim unit that involves both Indigenous medicine and Western addiction mental health services.

AHT's mental health services at the Babishkahn unit are built around Indigenous cultural practices. The Indigenous practitioners, including Healers, counselors, and Elders, are employed through stable government funding and stand at the core of the programs. The medicine storage area is plentiful and includes tens of plant medicines used by Healers, much of which is picked by the Healing team in the summertime. Clients can obtain counseling services from Healers and Elders, can be given healing services or medicines from Healers, and can participate in various cultural practices and ceremonies, including community circles, a Sweat Lodge (on-site), a Shake Tent (on-site), and fasting (off-site). Clients can access Western mental health services in addition to Indigenous Healers and counselors at the Babishkhan unit, including counseling, psychology, and psychiatry services.

All staff, Indigenous and non-Indigenous, must complete a cultural competency training module upon joining the organization, and all staff have access to participation in healing activities through the Sweat Lodge ceremony, as well as other ceremonies such as the Shake Tent, fasting in the bush, naming ceremonies, and so on. All staff can also book themselves in to see Healers and Elders at the center for personal support and healing. In this sense, staff are encouraged to take on the challenge of being epistemologically hybrid themselves. The following vignette shares the personal experiences of coauthor Allison Reeves in her experience of working in a harmonized psychology model.

Vignette 2 *As a psychologist who is deeply involved in cultural psychology, I am also personally involved in a continuous process of discovering my own culture and identity. Born in the Toronto area, I was encouraged by my Indigenous Elders*

[1] *Waash-Keshuu-Yaan* is an Anishnawbe term that refers to the deer hide that covers a traditional hand drum. *Babishkahn* refers to the lacing, also made of hide, that holds the hide in place on the drum. The hand drum is sacred in the culture and is seen as having its own spirit. *Chayuuwaytim* translates to "the shadow that speaks wisely" and is the name gifted to the mental health and addiction workers by an Elder.

(Anishnawbe, Haudenosaunee, and Cree) to engage in a lifelong process of self-discovery into my own ancestry and my spiritual path. Under their guidance, I have learned more about my diverse European ancestry, as well as my mother's Afro- and Indigenous-Caribbean ancestry. In sharing my spiritual engagement with my ancestry with my Elders, they interpreted that my blood memory guided me into my psychology work with Indigenous Healers and community members.

My lived experience in Indigenous communities on Turtle Island is varied and includes time in Mi'kmaq communities through my work at Healing Our Nations and my years of working and having close friendships in the Anishnawbe community in Toronto. I attended Anishnawbe language classes, participated in Sweat Lodge and Shake Tent ceremonies, received my spirit name, received cultural gifts and teachings to mark rites of passage in my life (for example, I passed my hand drum along when instructed by my Elder when I became married, and later made a new drum with materials gifted to me by community members), met with Elders regularly for guidance in my life, and sought help from Healers when I was mentally and physically unwell. All of this occurred while I was completing a PhD and post-doctoral fellowship in psychology at the University of Toronto, and carried over into my time working as the psychologist at AHT. In this sense, I learned the practice of Western psychology while experiencing first-hand the emotional, spiritual, and mental health benefits of engaging with Indigenous medicine and culture-based healing.

As the psychologist at AHT, I had the great fortune of working down the hall from four Indigenous Healers who rotated through the program, Elders at the three sites in Toronto, and the eight Indigenous counselors who used Indigenous teachings and approaches in their therapy work. I also had the support of three culturally safe psychiatrists (one of whom was Indigenous) who took historical trauma and family context into account in their work, and a team of social workers who operated from a social justice lens. Our case consultations involved a diverse team of practitioners, and we met regularly, formally and informally, to support one another in client care. These staff interactions were facilitated by the close quarters we shared at the community health center, the natural and friendly collegial relationships among staff, the egalitarian tone among staff (from the Healers to the psychiatrists to the receptionists), the mutual respect shown between practitioners of different schools of medicine, the genuine curiosity among staff about different ways of helping, the commitment to client healing, and, of course, humor. That being said, no workplace is idyllic, and we did have our interpersonal challenges from time to time. But overall, the through-line of commitment to community wellness and prizing Indigenous ways of knowing and healing kept our ship on course.

As a clinical psychologist, my duties included psychological assessment, diagnosis, psychotherapy, research, case consultation, and clinical supervision. Psychological assessment referrals came from external agencies and from other practitioners within AHT. Also, if a practitioner and client felt stuck, they could request diagnostic clarification from me to offer perspective on case conceptualization and some insight into the therapy work. Educational assessments helped clients

understand their areas of strength for returning to school or potential cognitive or learning challenges that might require accommodation in post-secondary studies. Disability assessments could provide insight into psychiatric challenges or cognitive issues (for example, posttraumatic stress disorder, fetal alcohol effects, attention deficit hyperactivity disorder, learning or memory challenges) and could help to secure resources such as housing and government support payments for clients in need.

Some clients found these psychological assessment services useful for helping to clarify challenges they had long since struggled with, or for determining next steps in their lives. Some clients were uninterested in Western diagnostics and preferred to opt out of these services, which was their prerogative. When discussing assessment and diagnosis in a culturally safe way, I felt it important to have a lengthy discussion with clients about the benefits of these Western psychological services (for example, in providing access to further helping resources), but also warned about the culture-bound nature of the Western psychological approach. In much of my work with clients, whether through assessment or psychotherapy, we discussed the history of colonization and how it affected their families and communities, the nature of Eurocentric medicine, the veracity of Indigenous Ways of Knowing, and the usefulness of seeing and understanding through multiple frameworks. These discussions would occur over many weeks and clients would oftentimes impress me with their insight into these topics. Others would be less interested in these sometimes philosophical discussions. As one of my colleagues noted, when given the choice between Western and Indigenous services, many of our community members simply say, "Just help me."

As a psychologist, I also met with clients for psychotherapy. I am trained primarily in emotion-focused therapy, feminist therapy, and cognitive behavior therapy. With all new therapy clients, the effort toward building strong therapeutic relationships is always paramount. Through training in feminist therapy and Indigenous ways of knowing, I take on an anti-oppressive lens in my work, which acknowledges social injustices and which promotes egalitarian relationships in therapy, largely through therapist authenticity and self-disclosure. This aligns well with Indigenous epistemologies and teachings around humility and sharing stories. In this sense, I would self-disclose in ways that would let me be seen and known by my clients (for example, by sharing family history, marital status, community involvement). As noted earlier, in my therapy practice, I would also incorporate decolonizing discourse by discussing the shortcomings of Eurocentric worldviews (which have often included racism, sexism, and homophobia, for instance) and by honoring Indigenous cultural knowledges. I would also share with clients that I work with Healers for my own healing, that I participate in ceremony, and that I have benefited from Indigenous medicine generally. I did this in an intentional effort to validate and normalize these varied approaches to care, which in many cases were foreign to Indigenous community members who had previously become culturally dispossessed through colonization.

Throughout treatment, I would check in with clients about their health-related needs and offer to refer them to a Healer or Elder. For those who worked with me

and a Healer concurrently, I would honor the Indigenous teachings clients received from Healers in our psychology session, and would reinforce and support those wisdoms. I would also attend community ceremonies with clients, including the Shake Tent ceremony and the graduation ceremony at the Chayuuwaytim unit, where Healers and clients would honor the program participants.

AHT also offers group therapy to clients in the Chayuuweytim unit, and this process is harmonized, since both Western trained addictions counselors and Healers co-facilitate the group. The Western psychoeducational group, which is typically didactic, is adapted to include interactive components, personal sharing, storytelling by the facilitators, the use of metaphor and Indigenous teachings, and Indigenous languages. These programs carry at their core the philosophy of respecting the teachings of all peoples. Practitioners bring in teachings from cognitive therapy, motivational interviewing, mindfulness meditation and Buddhism, 12-step programs, Mohawk teachings, Anishnawbe teachings, Cree teachings, harm reduction teachings, Reiki teachings, Christian teachings, queer theory, feminist theory, decolonizing therapies, and others. Practitioners speak of the synergistic effects of Western, Indigenous, and other therapies, and note that using the best of different ways of knowing and harmonizing can result in a "one plus one equals eight" effect.

My experience in this setting taught me that Indigenous and Western approaches can work together effectively. When the practitioners of different medicines engaged in respectful knowledge sharing, there were rarely conflicts between Western and Indigenous medicines. In cases of questions or confusion, or if clarification was needed from an Indigenous perspective, we would consult with a Healer regarding client care or the appropriateness of the psychological services. If ever a disagreement surfaced between Western approach and Indigenous therapeutic approaches, we would discuss it–the client, the Healer, and I–and we would, each in our own way, consider these varying perspectives and engage in a deeper dialog with one another. Are Western and Indigenous practitioners working together vastly different than psychiatrists and social workers collaborating? Typically, a psychiatrist takes an illness model lens to her work and a social worker takes social determinants and social justice lens to her work; yet these clinicians are always seen working side by side in a Western health-care setting. It seemed from my experience that the necessary ingredients to work in a cross-cultural and cross-disciplinary manner were these three essentials: harmonized services at the programmatic level; healthy relationships involving mutual respect between practitioners, encouraged through the normalizing and equalizing of services at the policy level; and openness to engage in hybrid thinking/feeling/being at the individual practitioner level. I would also add that self-discovery and decolonizing work at the individual level (no matter the practitioner) is also necessary for social justice practice at centeres like AHT.

Throughout my time with the organization, I received many teachings from Joe Hester, the executive director of AHT. He shared his insight that culture and identity are the "sign posts" that walk us through life in a good way—especially when we need healing. Culture teaches us about who we are, our responsibilities, and how we relate to creation. For Indigenous peoples, these sign posts were knocked down and outlawed through colonization. The communities are now rebuilding culture

and identity in many ways, and AHT offers one such pathway in an urban context. He notes that when you are exposed to culture, it often strikes a chord and resonates deeply. Suddenly, through cultural engagement, clients experience a place of belonging and community healing. Immersion in tradition and community acceptance is part of the healing journey, and this opportunity to connect is a unique offering at AHT compared to mainstream mental health treatment centeres. He says that, although Indigenous and Western services can disagree at times, with patience and respect, they can work together. He feels that our people deserve the best and that the "best" treatment is a combination of both Indigenous and Western medicines.

Discussion and Concluding Remarks

One of the most obvious challenges related to the integration of Indigenous and Western mental health-care services is the differences in epistemological and conceptual understandings of mental health and healing [22, 32]. As has been outlined previously, significant differences exist between Indigenous and Western paradigms of healing, including an emphasis on holism versus mind-body dualism, the role that spirituality, relationship, culture, and community plays in each paradigm, and the formulation of illness etiology.

This last point raises the issue of both Indigenous and Western practitioners' willingness to collaborate and integrate their services. Indigenous methods for healing are often stigmatized and viewed as illegitimate forms of treatment by many Western professionals [3]. At the same time, the Royal Commission on Aboriginal Peoples [39] illustrated that Indigenous Healers are entrusted with the task of healing in their communities, and for some Healers and Elders, it is Western medicine that has become suspect. As is noted in the RCAP [39] report, Healers and Elders "have seen people become addicted to Western medicines or be subjected to uncomfortable or painful treatments with little or no positive results" (p. 13).

Suspicions and mistrust may therefore impede both groups of helpers in collaborating and integrating their services. Part of this suspicion may stem from a lack of understanding and awareness of the work and approach that each helper takes. Becoming educated about each helper's healing paradigm, approaches, and practices has been identified as a critical task for collaboration and integration. However, practitioners and Healers must be open to developing their own cultural awareness and understanding of each approach, and be willing and interested in integrating their own services.

While developing cultural awareness and providing education about Indigenous practices is important, a key element in the formation of collaborative working relationships is respect. At its core, epistemological hybridism is founded upon the notion that acceptance and respect for diverse realities and ways of knowing and being are paramount. Principal among Indigenous helpers' grievances with the Western health-care system, and its professionals, is a lack of respect for Indigenous

Knowledges and healing practices, and for Indigenous Healers themselves. As was reported to Beaulieu by an Elder who was a participant in her cultural research study, "We're available, our Healers are available, but they have to come to us and ask us in the right way. They have to respect us. They can't just expect something to happen without there being some kind of respectful protocol of how we're going to work together" (2011, p. 165). Practitioners must also be mindful of respecting cultural protocols related to the disclosure of sacred rituals, ceremonies, and teachings. As a result of colonial legislation which outlawed the practice of many Indigenous healing traditions and increased surveillance of Indigenous peoples and communities, much cultural knowledge and tradition was forced underground [40]. Great strides have been taken to protect this knowledge throughout the decades and to also avoid persecution, punishment, or exploitation—both historically and in the present day. We believe the onus falls on Western practitioners and health systems to create the safety needed for practitioners of Indigenous medicine to come forward and collaborate.

Despite the various challenges that exist with respect to culturally integrated care, it is important to not lose sight of the potential significant benefit that may result from the harmonization of these approaches to healing in mental health care. We are encouraged by the success stories from AHT and ABS at CAMH. However, again, the integration of worldviews, knowledge systems, and practices must be founded on values of respect, equality, and reconciliation. In the era of "truth and reconciliation" in Canada, it is important to approach and understand the mental health care of Indigenous peoples within a reconciliatory framework. It is essential to acknowledge these truths: that Indigenous peoples have experienced, and continue to experience, significant health disparities as a result of colonization [1]; that Indigenous peoples have been chronically under-served in mental health care and often receive a poorer quality of care [11]; and that Indigenous clients have been the recipients of imperialistic clinical interventions rooted in Western worldviews, values, and ways of knowing [41]. In order to reconcile these truths and injustices, it is imperative that mainstream health-care professionals not only ensure their practices are culturally safe but are also committed to adapting their services so that cultural integration with Indigenous Knowledge and healing systems is possible. At the core of this practice is the establishment of trusting, mutually respectful, and authentic relationships between Western trained clinicians and Indigenous clinicians and clients. As articulated in the Truth and Reconciliation Commission's final report [36],

> Together, Canadians must do more than just *talk* about reconciliation; we must learn how to *practice* reconciliation in our everyday lives—within ourselves and our families, and in our communities, governments, places of worship, schools, and workplaces. To do so constructively, Canadians must remain committed to the ongoing work of establishing and maintaining respectful relationships. For many Survivors and their families, this commitment is foremost about healing themselves, their communities, and nations, in ways that revitalize individuals as well as Indigenous cultures, languages, spirituality, laws, and governance systems. (p. 20)

The pathway toward enhancing mental health service delivery for Indigenous peoples requires clinicians to embrace a position of flexibility, humility, openness, and a genuine interest in transformative innovation.

Upon release of the Truth and Reconciliation final report in 2015, the Liberal government stated that Canada was committed to a full implementation of the 94 Calls to Action outlined in the final report. This included Canada's adoption and implementation of the *United Nations Declaration on the Rights of Indigenous Peoples* (UNDRIP), and the use of UNDRIP as the framework for reconciliation. The UNDRIP Declaration is made up of 46 articles which pertain to the inherent rights of Indigenous peoples globally. The articles address individual and collective rights related to culture, identity, education, health, employment, language, economic sustainability, Indigenous lands and resources, and self-determination, among other rights. Canada was only one of four nations that initially voted against the UNDRIP when it was first introduced in 2007, in comparison to the 144 states that voted in support of the Declaration. This was due to the refusal of the government of the time to accept a provision related to land rights. It took 9 years for Canada to reverse its standing, and in 2016, Canada declared its adoption and intention to fully implement UNDRIP. As of May 2018, Bill C-262, an act to ensure that the laws of Canada are in harmony with the *United Nations Declaration on the Rights of Indigenous People*, had passed its third reading before the House of Commons. Canada's commitment to the implementation of the TRC Calls to Action and UNDRIP has implications for mental health service design and delivery, and clinicians' individual practice.

Two of the UNDRIP Articles that speak directly to Indigenous peoples' rights to culture, health care, and the use of cultural practices as a means for healing include Article 12 and Article 23:

> *Article 12:* 1. Indigenous peoples have the right to manifest, practice, develop and teach their spiritual and religious traditions, customs and ceremonies; the right to maintain, protect, and have access in privacy to their religious and cultural sites; the right to the use and control of their ceremonial objects; and the right to the repatriation of their human remains.
>
> *Article 23.* Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

The principles of UNDRIP clearly delineate Indigenous peoples' rights to culture and spiritual practices, as well as their self-determination in developing health and other social programs. In addition, TRC Call to Action 22 stipulates that: "We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients."

Taken together, the design and delivery of mental health-care services for First Nations, Inuit, and Métis peoples in Canada are on the precipice of significant and long-lasting change. In order to move forward in allyship, we recommend that

Western mental health services begin with the following recommendations for change at the systemic (national) level, at the health agency level, and at the individual practitioner level:

Systemic Level

- Educate mental health professionals in accredited counseling and psychology programs across Canada in Indigenous mental health and cultural safety.
- Train all mental health practitioners and administrators across mental health delivery programs in Canada in Indigenous mental health and cultural safety.
- Support Indigenous communities to have autonomy in determining their own health priorities and needs and to procure helping services from Western and Indigenous healing services, as communities deem necessary.

Health Agency Level

- Build relationships and collaborate with Indigenous mental health professionals in clinical practice issues, teaching, and research initiatives.
- Engage in consultation with Indigenous community members and Healers to determine if integrated services (Indigenous and Western) would be appropriate in a health organization that serves Indigenous clients.

Practitioner Level

- Complete coursework and specialized training on Indigenous cultural safety and cultural humility, including education on the history of Indigenous peoples, current health needs, and healing approaches of First Nations, Inuit, and Métis peoples.
- Cultural safety training also involves personal reflection of one's social location, as well as personal assumptions and biases related to health services, Indigenous peoples, and culture-based approaches to health and healing.
- Cultural safety training involves intellectual, emotional, spiritual, and relational learning related to allyship.
- Obtain clinical supervision from an Indigenous or culturally safe clinician in order to deepen your practice of cultural humility and cultural safety.
- Be a respectful health-care consultant if your services are requested by the community; engage in sincere relationship building with Indigenous community members, health professionals, and associations.
- Collaborate on treatment and healing plans with Indigenous helpers involved with a shared client's care.
- Where appropriate, engage in a deepening of your own understanding of Indigenous cultural knowledges. This may come in many forms and can be understood as an ongoing learning journey that is personal for each of us. Some examples might include attendance at cultural teaching sessions in the workplace or community, or attending personal teaching sessions with Indigenous helpers.

It is our hope that all clinicians can work toward offering collaborative, harmonized care to Indigenous clients in a manner that promotes optimal healing. To do so, Western mental health systems and practitioners must embody the spirit of allyship and reconciliation in their work, by embracing epistemological understandings

of health and well-being from more than one perspective. If mental health care is to be aligned with the needs of Indigenous peoples in Canada, health-care professionals and organizations must understand their ethical and legal obligations to ensure that First Nations, Inuit, and Métis peoples have access to their cultural and spiritual traditions as part of their healing work and journeys. Ultimately, First Nations, Inuit, and Métis peoples must be supported and enabled to exercise self-determination in the development and provision of health and healing services for their people and communities.

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