

Aboriginal and western health care approaches, as well as ongoing challenges.

METHODOLOGY

We conducted a case study focusing on the development of the traditional healing services at *Noojmowin Teg Health Access Centre* over a 10-year span from 1998 to 2008. To inform our research, we conducted an organizational document review, concentrating on program descriptions, policies and annual reports. We also conducted in-depth ethnographic interviews with 17 service providers and 23 clients at the *Manaamodzawin Noojmowin Teg Mental Health Services* in 2007.² During these interviews we posed open-ended questions to gather information on participants' experience with the integration of traditional healing in the clinical setting. This part of the research was guided by the university-based researcher, Marion Maar, in collaboration with community representatives selected by local health boards. The community-based researcher, Marjory Shawande, has been the traditional healing services coordinator at the health centre since its inception and therefore did not conduct interviews in order to avoid unintentionally influencing the participants. She brought a historical and cultural perspective to this research as well as first hand knowledge of the extensive community consultations that guided the early development of traditional healing services at the health centre. The local Aboriginal health boards and the Manitoulin Anishinabek Research Review Committee reviewed and approved this research.³

RESULTS AND DISCUSSION

Commitment to full self-determination and self-government requires the federal and provincial governments to allow for — indeed to encourage — institutional development in Aboriginal nations and communities that differs from mainstream practice. Thus, Aboriginal governments and health agencies must have the authority to decide what place traditional health and healing will have in their care services (Indian and Northern Affairs Canada, n.d.).

Core elements of integration

Oral traditions tell us that in the Manitoulin area, traditional healing practices were, in the past, monitored within the community, and healers were recognized and

identified by their community. Building on this tradition, a community-driven approach was taken to develop guidelines for traditional healing practices in a clinical setting, which would be compatible with traditional teachings of the Anishinabek of the Manitoulin area. During the interviews many service providers emphasized that the development of these traditional healing guidelines was an essential element for the successful integration of traditional and western health services at this centre.

The guidelines were developed at the inception of the program, using Aboriginal research methods to consult with Elders, people with traditional knowledge and practitioners of traditional healing in the seven local First Nations to determine how traditional healing in a clinical setting should occur in the region. Similar to consultations on this issue held elsewhere, there was not always immediate consensus (Martin Hill, 2003). The process took several years to complete and was supported by a traditional advisory working group of Elders who provided ongoing guidance and direction on contentious issues.

While the consulted community members were decidedly against formal regulations for traditional healing practices in general, there was consensus that formal guidelines were required when practicing traditional healing in a health centre setting to protect clients from inappropriate practices and to safeguard healers, helpers and health organizations from legal risks such as malpractice law suits. Foremost, Elders stressed that the guidelines they developed are rooted in local culture, and are not intended to be imposed on other Aboriginal cultures nor on healers who practice in the community outside of the clinical setting. There was also consensus that as part of the erosion of traditional culture, many community members did not have the traditional knowledge to identify Aboriginal healers. Therefore, a screening process was developed and healers are screened by the traditional coordinator and a traditional advisory group before they begin their work at the centre.

Consensus emerged also on important Anishinabe concepts that were thought to be essential to preserve in the clinical setting. These were incorporated into the traditional healing protocols for the centre (*Noojmowin Teg Health Centre, 2007*). Anishinabe values are often anchored in words and expressions whose meaning may be lost in translation. For example, in clinical settings a person seeking health services is thought of as a client (a consumer) or a patient (a passive receiver). This is at odds with Anishinabe values of healing, where the person is thought of as an equal partner who is engaging in a healing relationship and is therefore referred to as a *relative*. To reinforce this



concept, the term “relative” is used to refer to people who receive traditional healing services at *Noojmowin Teg*. Other Anishinabe concepts were identified as vital during the consultations, and were also incorporated into the policies. They include the Anishinabe concepts of *bgidniged*, *debweyendaa* and *michidoumowin*.

Bgidniged is the Anishinabe concept of a *gift* that should be given to a healer by the *relative* or their advocate. Clients are encouraged to take responsibility for their healing by providing a practical gift to the healer based on their means. The traditional coordinator also arranges for a monetary gift to the healer to cover travel and accommodation expenses. There is an important conceptual difference between payment and the gift or *bgidniged*. In the Anishinabe understanding, it is impossible to put a price on traditional healing services. The traditional healer is not paid on a fee for service arrangement, but rather provided with a *bgidniged* reflecting the number of days that they are working with clients at the health centre. The *bgidniged* from the health centre is in monetary form for practical reasons. While in the past Anishinabe healers may have been gifted with food, hide, horses, or other utilitarian implements to support themselves, today it is difficult to get by without the use of money (*Remembering what we have forgotten*, 1998). The *relative* however is encouraged to provide the healer with a practical gift.

Debweyendaa is the Anishinabe concept of the sacred trust between people and the Creator. It is invoked to convey the expectation of ethical conduct by the healer, creating an appropriate healing relationship with the *relative* and maintaining confidentiality of services.

Michidoumowin is the Anishinabe concept for the breach of *debweyendaa*, the sacred trust. It is seen as a grave transgression. *Michidoumowin* is used to convey violations of ethical conduct of traditional healers while providing traditional health services. At the health centre, such a breach would lead to termination of the services provided by the healer.

These important Anishinabe traditional concepts of the provision of a gift to a healer, the ethical integrity and sacred trust between healer and client, and a course of action in the event of a breaking of the sacred trust, are outlined in the traditional healing policies and have important implications for integrated practice. These Anishinabe concepts address issues that are also essential for the provision of western medical services, such as patient safety and confidentiality, and provider accountability for misconduct. Incorporating these concepts into the traditional policies has therefore also fulfilled the administrative need for risk management

and provides the foundation for collaboration with clinical providers.

Health record keeping is a clinical practice that was also seen as important for the traditional services. Record keeping facilitates interdisciplinary practice and long-term follow up care for clients, as well as monitoring of herbal medicines and potential drug interactions. There was consensus that the traditional healers should not be charged with the task of recording in health records. The established protocol therefore includes the provision of an assistant for the healer to record relevant information, such as the traditional diagnosis and the prescribed treatment for the *relative*, a role filled by the traditional coordinator, a trained helper or another community health worker. This practice also ensures, for the protection of healers and *relatives*, that a third person is witnessing the visit. After the visit with the healer, the traditional coordinator is responsible to provide or arrange follow-up care to the client and the records are essential for this process. Providers, however, found that many *relatives* were guarded about their traditional health record, and often request that this information only be shared within a specific circle of care, such as the mental health team or the long-term care team. To respect confidentiality, traditional health records are kept physically separate, and information can only be accessed by those agreed upon by the client.

The role of teaching and education

A second focus of the groundwork was to build the readiness of community members and health professionals for traditional healing services through ongoing educational opportunities. Traditional teachings encourage life long learning. Communities, families and individuals vary in their comfort level and understanding of traditional healing. It is therefore also seen as important to offer a variety of ongoing learning opportunities, geared towards community members as well as Aboriginal and non-Aboriginal health care providers. One care provider stressed the importance of education for integrated care as follows: “Fortunately I was provided with a fair amount of training, and opportunities to go to gatherings and participate in ceremonies through the [traditional healing services] program...that was enormously helpful!” Continuing education opportunities are also essential for new staff members and contract providers. Learning opportunities at the centre have included Anishinabe life cycle teachings, language classes, story telling, workshops, and participating in Aboriginal ceremonies, dancing workshops and helping with traditional healing sessions.



Enhancing cultural safety

Providers explained to us that the education and interaction with traditional providers has deepened their understanding of their clients and ultimately enhanced a wholistic approach and client care. One clinician explained the importance of learning about traditional culture for clinical practice as follows:

We understand something about the culture, appreciate it. You know, when clients talk about ceremonies, we have an idea what they're talking about. When they talk about spirituality, when they talk about spirits, when they talk about dreams, when they talk about different concepts that are really important in their culture, we do understand what they're communicating to us and what that experience might mean for them.

Care is thus becoming more culturally appropriate and clinicians are becoming aware of the danger of medicalizing Aboriginal spirituality.

Clients and providers agreed, however, that culturally competent care must go beyond offering and appreciating traditional healing services. In fact, some Aboriginal clients preferred clinical mental health services because traditional practices are not part of their way of life. Many clients told us that an important aspect of culturally competent services is that they can present themselves without fear of judgment and receive services that are right for them and their beliefs, religions and personal background. The notion that providers need to be "respectful of whatever the client is comfortable with" is in line with the concept of cultural safety developed by Māori researchers (Ramsden, 1990). During the interviews, clients repeatedly expressed the belief that their workers facilitated cultural safety. Many saw this as a feature of the *Mnaamodzawin Noojmowin Teg* services, which was clearly different from mainstream approaches. One client explained this in these words:

Living on the reserve is a different way of life... a different way of thinking. Maybe some needs are different. A lot of people I talked to in the past who were counselors that hadn't worked for *Mnaamodzawin* or *Noojmowin* – they didn't understand certain things that seem like it's a part of your life when you're on the rez. It's a different way of thinking. A different way the whole community deals with things. These two counselors [at this centre] understand that; it's not even an issue.

Ongoing Challenges for Integration

We really don't have the opportunity to sit down and have long meetings with healers, to tell you the truth! (Mental health service provider, *Mnaamodzawin Noojmowin Teg*, 2007).

There are many accomplishments related to integration of clinical and traditional services. However, many challenges still remain. For example, the chronic underfunding of Aboriginal mental health services creates a service environment where client case reviews and interdisciplinary collaboration take a back seat compared to the high demand for direct client services. Staff members discussed that greater collaboration between all mental health team members and the traditional healer, as well as a psychiatrist, is desirable. However, this is not possible at this time because the need for direct services is very high and resources are limited. More time with healers is also required for direct services. Staff turn over is an ongoing challenge for integration because new clinical providers often face a considerable learning curve.

We also discovered that requests for referrals for traditional healing services are not necessarily forthcoming from clients once they receive clinical services. Our client interviews showed that although clients believe their workers to be culturally competent and supportive of traditional healing, some Aboriginal clients are not comfortable discussing traditional healing options with non-Aboriginal providers. For example, one client commented "I didn't request any traditional approaches, I just went along with what the worker said." Another participant questioned if the clinicians actually "believed fully" in traditional healing. This is evidence of the subtleties of the clinical encounter that can discourage Aboriginal clients from requesting traditional medicine even if the clinician is perceived as being open to traditional approaches. Another client explained his barriers even more bluntly, saying "I would be uncomfortable talking about Indian spiritual needs with my worker."

Other clients mentioned that they did not ask their clinical provider about traditional approaches because they were unsure how this interdisciplinary approach would work. For example, one client stated, "What could you incorporate [in terms of Traditional Medicine]? Unless you want someone to smudge you or pray with you before you speak to your worker – I don't need that to sit down and talk to somebody." Clearly, based on their previous experience with the mainstream health care system, many Aboriginal people



