Traditional Anishinabe Healing in a Clinical Setting:
The Development of an Aboriginal Interdisciplinary Approach to Community-based Aboriginal Mental Health Care

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ABSTRACT
Traditional medicine has been practiced by Aboriginal people for thousands of years at the community level. It is still practiced today outside of the mainstream health system by many Aboriginal people. However, providing this type of care in a clinical, health centre setting and in co-operation with western treatment methods is new, and requires a merging of traditional Aboriginal and western medical world views in order to develop protocols for service delivery that ensure the integrity of both systems. The groundwork required to ensure the safety of clients, providers, and organizations within the new integrated system is still largely undocumented. To address this gap, we studied factors that support the successful integration of traditional Aboriginal healing and western mental health care approaches, and document the experiences of clients and providers. To accomplish this we contextualize 10 years of experience of traditional healing services development with in-depth interviews and focus groups with 17 community service providers and 23 clients. We found that the development of traditional healing protocols, inter-professional education for providers and community members and a focus on client access to traditional Anishinabe health services provide the basis for the integration of western and traditional healing practices in the model under study. Our findings show integrated care resulted in positive experiences for clients and providers. We conclude that traditional healing approaches can be successfully integrated with clinical mental health services. Further research is necessary to improve our understanding of client experiences with this integrated approach and the impact on wholistic health and well-being.

KEYWORDS
Traditional Medicine, Traditional Healing, Aboriginal mental health, integrated services, interdisciplinary care
INTRODUCTION

I remember once sitting down with [a clan leader], and he was telling me that all the people were going down to the nursing station…because they were sick with either chest pains or colds. But while they were walking down there, they were stepping over all the medicine from the land. They were walking over the medicine that they needed! …When we go to the doctor and the nurse, we give them our power to heal us when we should have the power within ourselves to heal us (Royal Commission on Aboriginal Peoples [RCAP], 1996).

Healing traditions are a vibrant and vital aspect of Aboriginal cultures. Oral histories told by Aboriginal Elders paint a picture of a past where an understanding of healing and herbalism was an integral part of Aboriginal community life (Remembering what we have forgotten, 1998). There are many accounts of Aboriginal people sharing medicines and allowing early Europeans to observe traditional doctoring (Waldram, Herring & Young, 2007). However, with centuries of governmental attempts to suppress Aboriginal cultures, traditions and spirituality, traditional healing went underground. Furthermore, assimilation practices such as the residential schools system made it difficult to pass traditional knowledge on to subsequent generations and disruptions in the education of traditional practitioners occurred in many communities. As a result, the knowledge of traditional healing was eroded or became dormant in many communities. However, some traditions were kept alive by concealing them from the outside; at times, traditional healing practices actually evolved in response to the changing health needs of Aboriginal people. Today, traditional healing remains an important aspect of health and healing for many Aboriginal people, and is commonly practiced in Aboriginal communities outside of the official healthcare system (Remembering what we have forgotten, 1998; National Aboriginal Health Organization [NAHO], 2008). Many Aboriginal people know how to find and access traditional healing in local or distant communities through an informal network. In recent decades, there has even been a resurgence of traditional healing practices, coupled with an increasing desire to bring these practices out into the open again and to incorporate traditional healing practices in formal settings such as correctional institutions (Waldram, 1990) and the primary health care system (Maar, 2004). However, in order to protect traditional healing and spirituality from further erosion, traditional knowledge keepers often remain guarded about sharing traditional knowledge with western professionals.

Research on traditional healing

The body of literature on community-based or institutional-based practice of traditional medicine in North America today is in its infancy. Much of the research to date has focused on describing the traditional healing encounter, or how Aboriginal people navigate between traditional and western health systems. For example, research has documented utilization patterns of how Aboriginal people of various cultures use traditional and western medicine (Cook, 2005; Kim & Kwok, 1998; Buehler, 1992; Gurley, Novins, Jones, Beals, Shore, & Manson, 2001; Marbella, Harris, Diehr, Ignace, & Ignace, 1998; Novins, Beals, Moore, Spicer, Manson, & AL-SUPERFPP Team, 2004; Van Sickle, Morgan & Wright, 2003). Other researchers have focused on how traditional healers conduct their work (Schneider & DeHaven, 2003; Struthers, 2000, 2003), or described traditional practices or cures (Carroll, 2002; Cohen, 1998, 2003; Hopkins, Kwachka, Lardon, & Mohatt, 2007; Morse, Young & Swartz, 1991; Nauman, 2007). Researchers have also studied patient experiences (Struthers, Eschiti & Patchell, 2004; Struthers & Eschiti, 2005), and examined the effectiveness of traditional medicine (Mehl-Madrona, 1999; Waldram, 2000) and its role in culturally appropriate care (McCormick, 1995; Walters & Simoni, 2002).

Generally, the research shows that traditional medicine continues to be an important aspect of well-being for many Aboriginal people. However there is little information on if, or how traditional medicine can be integrated with western medicine in a clinical setting. A better understanding of this process is needed to advance collaborative practice. We need to learn more about how bridges are built between these two systems; how practitioners of these distinct healing traditions can collaborate while maintaining the integrity of each health system, and how integrated approaches impact on the health of Aboriginal people, families and communities from a broad and wholistic perspective.

However, there are significant obstacles to conducting this kind of research. Most significantly, traditional medicine addresses health from a wholistic perspective, including physical, mental, emotional, and spiritual aspects - realms that are clearly beyond western scientific paradigms and their applications. While mainstream theoretical frameworks for health are expanding and researchers and
policy makers are increasingly acknowledging the complex impacts of social and economic determinants on health,¹ western-based knowledge frameworks are still generally inadequate to engage with and make sense of the wholistic aspects of traditional healing. In addition, western-trained researchers often have difficulties collaborating across different knowledge systems such as traditional Aboriginal healing.

**Policy perspectives on traditional healing in a clinical setting**

Policy makers have been increasingly supportive of traditional healing practices in primary care for several reasons. First, in the 1980’s it became increasingly clear to researchers and governments that the poor state of Aboriginal health could not be improved by increasing western health services alone (Young, 1984). Second, the World Health Organization began to advocate for traditional healers and their recognition by the primary care system world wide (World Health Organization, 2002a, b; World Health Organization Regional Office for Europe, 2006). In Canada, this has resulted in some, albeit tentative, policy support by the First Nations and Inuit Health Branch (FNIHB) of Health Canada to provide travel support for First Nations people seeking traditional healing services; however, no funds are provided for actual traditional healing services or associated costs such as ceremonial expenses, traditional medicines or honoraria for healers (First Nations and Inuit Health Branch [FNIHB], 2005).

The province of Ontario has made further policy improvements to promote traditional healing practices. Ontario’s Aboriginal Health Policy affirms that “Traditional approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system.” (Ontario Ministry of Health and Long-Term Care, 1994). Subsequent to the release of this policy, a strategy was created which funds various Aboriginal programs, including traditional healing services (Aboriginal Healing and Wellness Strategy, 2007). In addition, Ontario’s Regulated Health Professions Act has acknowledged and exempted Aboriginal healers from regulation by government bodies (Canadian Legal Information Institute, 1991).

This exemption signifies an affirmation that mainstream biomedical bodies must not impose regulation on traditional Aboriginal healing practices – rather it is up to Aboriginal people to decide how traditional medicine is practiced and regulated. While this provides some protection of Aboriginal autonomy over traditional healing practices, it does not exempt traditional practitioners from malpractice or criminal charges, which, although rare, have occurred (Waldram, Herring & Young, 2007). Since it is not in the interest of Aboriginal people to determine the future practice of traditional healing within the judicial system, the debate on whether or how traditional providers might be regulated continues, particularly when practicing in clinical primary care settings.

Oral traditions indicate that in the past, healers were nurtured by their community. Communities identified healers and informally monitored their work. Those who had the necessary skills were sought out by community members, and those who had questionable skills were avoided. Although this informal process may still be at work in some communities, many Aboriginal people and health professionals do not have the traditional knowledge necessary to distinguish a traditional healer from a charlatan (Remembering what we have forgotten, 1998; Waldram, Herring & Young, 2007).

Still, traditionalists are often quoted as opposing any form of regulation, based on very valid concerns over past colonial policies that suppressed Aboriginal cultures (Indian and Northern Affairs Canada, n.d.; Martin Hill, 2003). In response, the Royal Commission on Aboriginal Peoples (RCAP) report advocates for traditional practitioners to self-regulate similar to western health professionals (Indian and Northern Affairs Canada, n.d.), essentially replicating the peer review model of western medicine. However, this self-regulatory model would be at odds with the cultural norm firmly anchored in many Aboriginal healing traditions, that traditional healers are validated by the community and do not necessarily even self-identify as healers (Remember what we have forgotten, 1998).

In 1998, Aboriginal health professionals and Elders on Manitoulin Island were tasked with resolving these complex issues when they decided to integrate western and traditional healing approaches at their regional health centre. Finding appropriate answers to questions related to policies and regulations would be critical for the successful integration in the clinical setting, where it is the health board’s and staff’s responsibility to protect clients, healers, helpers, and the organization from avoidable risks.

In this paper, we document the process of integrating traditional Anishinabe healing practices and mainstream clinical services in a health centre setting, based on 10 years of experience developing traditional healing services on Manitoulin Island, combined with qualitative research on the experiences of clients and providers. We describe factors that have supported the successful integration of traditional
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. 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.

**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 Anishinabe 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 Noojomowin 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 michidaumowin.

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.

Michidaumowin is the Anishinabe concept of the breach of debweyendaa, the sacred trust. It is seen as a grave transgression. Michidaumowin 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.
The maturation of integrated services

I called them…regarding a medicine man for my child... Oh they came to our house actually, so it would be more comfortable for the children and it was really good. It’s been a while since we’ve seen the medicine man, and it was just great (relative at Mnaamodzwain Noojmowin Teg, 2007).

Today, a decade after traditional healing services were first offered at Noojmowin Teg Health Centre, the services have grown much beyond providing clients with access to healers. The demand for traditional healing services is continually increasing and outweighs the current level of services provided by healers. Therefore, follow up services are provided by the traditional coordinator and coordinated with other health care workers. This model of sharing the responsibility ensures that healers are not working in crisis mode in response to their clients’ needs. It requires an integrated interdisciplinary approach to care. The traditional coordinator is working particularly close with the long-term care and the mental health program staff, and several processes have been established to strengthen interdisciplinary integration. During interviews with the local mental health team, participants were overwhelmingly supportive of this approach and discussed many benefits.

Integration of traditional and mental health services

The interdisciplinary mental health team includes a case manager, a psychologist, a mental health nurse, two social workers, a program assistant, and the traditional coordinator. The mental health team members review new referrals at weekly intake meetings where clients are assigned to the most suitable provider, or to several providers. Services may include mental health counseling, chronic illness care, psychiatry services, and/or traditional healing services. Other needs such as long-term care or nursing requirements may also be identified, and clients are referred to other service providers in the organizations. During these meetings all team members are encouraged to exchange relevant information on treatment approaches, and provide interdisciplinary support. This team approach facilitates a high level of continuity of care for mental health clients, as well as a fast response to urgent cases. The weekly intake meeting process has further benefits. It creates an environment for new staff members to learn more about local Aboriginal communities, culture and the integration of traditional approaches. Other factors that support integrated practice were also identified, including the fact that all providers share a main office location and maintain an open door policy. Informal case consultation and case reviews of clients/relatives between members of this team also act as catalysts for integration. Within the individual First Nations clinics, similar capacity building for interdisciplinary care has taken place. At the community level, community workers such as mental health workers or community health representatives are mentored to assist the traditional healer and provide follow up services to the clients in their community. Interviews with providers showed that traditional healing approaches are accepted and respected within this team.

Impact on mental health services

It enhances the quality of care just because… I have more access to input from different professions, from different people who are from different backgrounds…A real richness of resources to choose from and to get information and support from. So, it can only help me, understand my clients better and broaden my own skills so that I’m able to meet their needs (Mental health service provider, Mnaamodzawin Noojmowin Teg, 2007).

The Noojmowin Teg approach to traditional healing services in a clinical setting has led to significant overall advancements in the integration of clinical and traditional approaches to mental health. During the interviews almost all clients expressed the belief that their workers are supportive of Aboriginal healing approaches, and that these services are accessible to clients. Service statistics show that community interest in traditional approaches to health is steadily increasing. This is an indication that more and more clients are comfortable accessing traditional services and sharing that information with clinical providers. Several clinical providers regularly inquire with each client about a referral to the traditional healing services. This development is particularly significant since a recent Canadian study showed that 92 per cent of Aboriginal people who use traditional medicine do not share this information with their primary care provider (Cook, 2005). In contrast, workers report that information about Aboriginal herbal medicines is openly shared in this service environment. For example an estimated 30 per cent to 40 per cent of those clients who receive care for geriatric or chronic mental health issues are also receiving traditional healing services.
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 holistic 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 Mäori 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, Mnaamdozawin 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
expect a separation of traditional and clinical approaches to health. Clients we spoke to who reported accessing the traditional healing services were generally self-referred. Provider-initiated referrals do occur, however our interview results show that cultural and communication barriers still exist. Ongoing education and promotion regarding integrated care for clients and providers is therefore essential. In contrast, clients who were admitted through the traditional healing services were freely and frequently referred to the clinical mental health services.

CONCLUSION

People think [traditional and clinical healing perspectives] are so far apart but I never see it that way. I always think there are so many possible meeting points, when I listen to the healer speak it’s like: okay, I’m with you on this and this is… You know, to me, there is some sort of partner concept, [something] I can sort of see [Mental health service provider, Mnaamdozawin Noojmowin Teg, 2007].

While some challenges certainly remain, the Mnaamdozawin Noojmowin Teg mental health team has made significant progress over the past decade in the development of an interdisciplinary team approach that includes both clinical and traditional Aboriginal approaches, with a particular focus on client choice related to services.

The development of local guidelines, rooted in local culture, was an essential element for the successful integration of traditional and western services, because this protocol has alleviated uncertainties for clients and the interdisciplinary team of providers. Ongoing education for providers, as well as communities has resulted in improved understanding of traditional healing. Aboriginal and non-Aboriginal mental health team members alike expressed observing positive results in clients who accessed traditional healing. Many expressed a desire to increase the level of interdisciplinary collaboration, and believed this would be beneficial for their clients/relatives. Many also believed that increasing formal opportunities for collaboration would allow providers to further explore the congruence between the two healing approaches, and therefore improve treatment and healing approaches to the most prevalent mental health disorders.

Further research is necessary to help us better understand factors that facilitate the integration process. Research is also necessary to improve our understanding of the healing experience of Aboriginal individuals and their families who use this integrated approach to care. We are interested in how the traditional healing services have helped to support families from a wholistic perspective, such as decreasing violence in the home and encouraging healthy parenting, and how clinical services can best complement traditional approaches. At this point, there is just anecdotal evidence of this. However, research on outcomes of the integrated services should not attempt to force traditional healing practices into clinical mental health evaluation models, because clinically established outcome measures or efficacy research are likely inappropriate. The interdisciplinary approach can only be researched using a collaborative and empowering approach that employs a merging of traditional and clinical health indicators, and a focus on wholistic impacts on community, health, families, and individuals.

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END NOTES


3. Information on this ethics committee is available at http://www.noojmowin-teg.ca/default5.aspx?l=,1,613