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Combining Western Evidence-Based Psychological Counselling Practice and Theory with Indigenous Cultural Wellness Practices

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Abstract

Indigenous populations in Canada have statistically worse mental health outcomes than non-Indigenous people. This racialized gap is often attributed to historical and ongoing colonization. Western health practices often fail in addressing this gap due to paradigmatic differences between the two worldviews. This research seeks to address the integration of Indigenous wellness and Western counselling practices. The literature review highlights the gaps as a lack of distinction between urban and rural Indigenous communities and a danger of adopting a pan-Indigenous approach. The methodology of this research followed two paths: a jurisdictional scan and community engagement. The jurisdictional scan utilized snowball sampling. The Indigenous Children and Youth Mental Health (ICYMH) North Fraser team identified organizations that were then contacted by the research team resulting in nine interviews, seven of which had participants that self-identified as Indigenous. Community engagement sought two sharing circles where participants would have been recruited through further snowball sampling. The findings uncovered five main themes: Indigenous leadership, culture, relationships, education, and organizational regulations. The themes discovered in the research were congruent with existing literature and add to the ongoing conversation surrounding Indigenous mental health. Specifically, this project added to understandings of: epistemic racism as an individual and systemic barrier, the need to incorporate spiritual and cultural practices, practitioner responsiveness to the Canadian colonial context, Indigenous leadership, and Two-Eyed Seeing as an approach to practice. The collected data point to five recommendations: (1) Organizations must integrate Indigenous cultural practices into Western approaches to accommodate clients who want it. (2) Clinicians should engage with Indigenous communities to better connect to their clientele and to educate themselves on local culture. (3) Clinicians ought to engage in self-reflection and educate themselves on colonization and its impacts. (4) Work with Indigenous communities needs to be Indigenous led to optimize the most authentic practices. (5) Organizations should review and adjust their regulations to effectively promote these recommendations within a formalized setting.

Keywords: Indigenous Wellness, Western Counselling Practices, Children and Youth Mental Health (CYMH)

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Introduction

The mental health of Indigenous peoples in Canada is a critical point of examination for research, as they have disproportionately worse mental health outcomes than non-Indigenous people (Bhattacharjee & Maltby, 2017; Stewart & Marshall, 2017; Smylie et al., 2009; Taylor & Burgess, 2020). This racialized mental health gap is directly linked to the trauma of historical and ongoing colonization (Bhattacharjee & Maltby, 2017; Boksa et al., 2015; Iwama et al., 2009; Smylie et al., 2009; Stewart & Marshall, 2017). Typical Western mental health approaches to Indigenous populations often fail because the two populations exist in different paradigms which can create ideological and systemic barriers in accessibility for Indigenous clients (Gone, 2011; Rogers et al., 2019; Smylie et al., 2009; Stewart & Marshall, 2017; Taylor & Burgess, 2020). The evidence that governs Western practices often does not include Indigenous people in its sampling, so the results that are produced are not generalizable (Rogers et al., 2019).

The North Fraser ICYMH team received recommendations from the 2006-2008 Aboriginal Child & Youth Mental Health Plan to make mental health services for Indigenous communities more culturally-informed. This research is being done in collaboration with the ICYMH team to understand how mental health practices that are often based in a Western paradigm can integrate Indigenous cultural programming, and to inform a unified framework to address the gap in mental health outcomes for Indigenous people.

Literature Review

When addressing how Western counselling practices and theory can be combined with Indigenous cultural wellness, there are many factors which must be considered to build a culturally-informed framework. These are: important cultural factors for integration, suggested approaches in existing literature, and evidenced-based approaches to integration.

Aspects of Indigenous Culture to Consider for Integration

Indigenous Métissage & Two-Eyed Seeing. Existing literature describes two similar approaches to integrating Indigenous and Western approaches, Indigenous Métissage and Two-Eyed Seeing. These are primarily described as research approaches; however, there is growing support for the use of these approaches in other contexts.

Métissage is an approach which is used to explore mixed or oppositional identities, perspectives, and ideas in a way that acknowledges both perspectives (Burke & Robinson, 2019; Donald, 2012). This approach is congruent with Indigenous experiences as many Indigenous peoples must continually interweave contradictory elements of their identities (Burke & Robinson, 2019). Additionally, it is an approach that allows professionals to strategically choose both Indigenous and non-Indigenous methods as appropriate to their projects (Burke & Robinson, 2019), instead of providing an exact framework or set of best practices.

Two-Eyed Seeing was coined by Albert Marshall, a Mi'kmaw Elder in Nova Scotia (Iwama et al., 2009; Peltier, 2018; Reid, 2020; Wright et al., 2019). Although it is rooted in Mi'kmaw culture, it is not an exclusive concept (Wright et al., 2019). The central metaphor for this approach is that research projects should be considered from the 'two eyes' of both Western and Indigenous perspectives (Colbourne et al., 2019; Hovey et al., 2017; Peltier, 2018; Reid, 2020). Two-Eyed Seeing is distinct in that it requires partnership with Indigenous professionals and participants, while Métissage is a more philosophical approach that anyone can practice (Hovey et al., 2017). Proponents of this approach claim that it allows Indigenous and non- Indigenous professionals to conduct anti-oppressive practice with an Indigenous community (Colbourne et al., 2019; Hovey et al., 2017; Peltier, 2018; Reid, 2020).

There are some limitations with both of these approaches. Both Métissage and Two-Eyed seeing are developing approaches primarily used in research contexts, meaning they may not be applicable to a mental health setting. Métissage is not originally developed by Indigenous people, and its universality may be inappropriate in this setting. Also, there is some debate as to whether Métissage should constitute the blurring of the perspective it employs,

or if it incorporates them while keeping them distinct (Burke & Robinson, 2019). Additionally, some suggest that integration of Indigenous and Western approaches in this way may lead to the fetishization or tokenization of Indigenous cultures (Donald, 2012).

Suggestions for Integration. The integration of Indigenous perspectives into Western practices also requires a revaluation of relationships with community, land, and sovereignty. A strong relationship system within a client's community is crucial (Bhattacharjee & Maltby, 2017; Marsh et al., 2015; Oulanova & Moodley, 2017; Smylie et al., 2009). Many Indigenous cultures value kinship (Marsh et al., 2015), and this can be respected with the inclusion of family and Elders in the healing process (Bhattacharjee & Maltby, 2017; Marsh et al., 2015). This approach exists in direct contrast to Western individualism. Healing is encouraged to take place outdoors where connection to the environment can occur (Oulanova & Moodley, 2017). Self-government, when emphasized as a part of Indigenous identity, is another important healing tool (Auger et al., 2016; Bhattacharjee & Maltby, 2017; Chandler and Lalonde, 2008), and can create feelings of ownership and responsibility over the healing process (Auger et al., 2016).

The Plains Indigenous medicine wheel is another useful tool in integration (Bhattacharjee & Maltby, 2017; Gone, 2011; Oulanova & Moodley, 2017; Rowan et al., 2015; Stewart & Marshall, 2017; Taylor & Burgess, 2020). The medicine wheel balances the physical, mental, emotional, and spiritual aspects of a person, while Western approaches silo their care through doctors, psychiatrists, counsellors, and priests (Oulanova & Moodley, 2017; Taylor & Burgess, 2020). Western approaches often fail with Indigenous communities due in part to the priority placed on physical and mental health, at the exclusion of emotional and spiritual health (Stewart & Marshall, 2017).

The most important aspect of integration is the connection between spiritual identity and culture (Auger et al., 2016; Bhattacharjee & Maltby, 2017; Gone, 2011; Marsh et al., 2015; Oulanova & Moodley, 2017; Rogers et al., 2019; Rowan et al., 2015). The literature provides many practical guides. Sessions can involve prayer or connection to the Seven Grandfather Teachings (Marsh et al., 2015; Rogers et al., 2019; Rowan et al., 2015). Healing can include traditional ceremonies such as a smudging ceremony, a pipe ceremony, powwow dances, and drumming circles (Gone, 2011; Marsh et al., 2015; Oulanova & Moodley, 2017; Rowan et al., 2015).

Evidenced-Based Approaches to Integration

The Effective use of Storytelling. The practice of storytelling is a longstanding Indigenous healing and cultural practice. This practice has been found to be an effective method of integrating Western and Indigenous approaches. Similarly, many Western therapeutic modalities such as Cognitive Behavioural Therapy and Narrative Therapy use stories and reframing as a part of therapeutic work. In substance use treatment, storytelling was found to be an important part of the healing discourse (Gone, 2011). Additionally, Western practitioners may encourage incorporation of other Indigenous cultural practices such as traditional dance, songs, or drumming to accompany the storytelling process (Bigfoot & Schmidt, 2010).

Acknowledging the Impact of Colonization on the Indigenous Community. Historical oppression of Indigenous populations, including the residential school system, forced assimilation, and discriminatory policies have huge implications for one's healing journey. It is crucial for practitioners who provide services to Indigenous clients to always be aware of the impact of colonialism, as well as their own social location in regards to colonization (Oulanova, 2008). To ensure best practice, frameworks aimed at providing integrated services to Indigenous populations must have the goal of de-colonization of services.

In a qualitative study that measured the impact of Indigenous healing on mental health services for Indigenous survivors of sexual trauma, talking circle participants identified loss and grief due to colonization as a main source of disconnectedness (Reeves & Stewart, 2015). The participants cited colonialism as interrupting the intergenerational knowledge sharing of healthy sexual behaviours resulting in their involvement

in abusive or unhealthy relationships (Reeves & Stewart, 2015). Through education and acknowledgement of the influence of colonialism, practitioners can help clients process their grief and recognize their shared experience.

Integrated Trauma-Informed Care Approaches. Culturally safe practice should be grounded in trauma-informed care. The trauma of colonialism can interact with other traumatic life events and cause compounding complex trauma. Practitioners engaging with Indigenous survivors of sexual trauma reported this Western model as being effective in the healing journey; the most important factor in implementing Trauma-Informed Care was building trust and rapport in the therapeutic relationship (Reeves & Stewart, 2015). Trauma-Informed practice is integral in building non-oppressive therapeutic relationships and in the decolonization of services.

Barriers for Integration

Interpersonal relationships are a potential barrier to Two-Eyed Seeing practice within an organization (Auger et al., 2016; Marsh et al., 2015; Rogers et al., 2019; Rowan et al., 2015; Whiting et al., 2018). Epistemic racism, where Western ways of knowing are considered superior, can be detrimental to this process (Auger et al., 2016; Rogers et al., 2019; Whiting et al., 2018). This can emerge as those who are mistrustful of or disrespectful to the process, or those who have been educated differently on Canadian colonial history (Rowan et al., 2015; Whiting et al., 2018). Another barrier is ideological. Iwama et al. (2009) identifies a materialism within Western perspectives that might hinder a more spiritual Indigenous approach. This could potentially lead to the commodification of traditional knowledge, ultimately leading to cultural appropriation and further oppression (Marsh et al., 2015; Rogers et al., 2019).

Epistemic racism can also be built into the structure of mental health services (Auger et al., 2016; Gone, 2011; Taylor & Burgess, 2020; Whiting et al., 2018). This can manifest as a lack of funding for sustained interventions (Boksa et al., 2015; Marsh et al., 2015), a high turnover rate of non-Indigenous workers in Indigenous organizations which leads to a lack of continuity in services (Boksa et al., 2015), a focus on short term change rather than systemic overhauls, and a lack of access to local Elders and traditional knowledge (Rogers et al., 2019). Tokenism, when perfunctory implementation of Indigenous measures is utilized as the entire strategy, is also a risk (Whiting et al., 2018). These barriers would depend on the institutional and interpersonal context of the organization in which integration is being applied, and are thus not universal.

Research Gaps

Although the existing research provides a basis for integrative therapeutic frameworks, there are many areas for consideration. One such consideration is the implementation of services for urban versus rural Indigenous populations. Many existing articles focus on rural Indigenous communities. However, there is also a need for additional research to focus on the unique needs of diasporic, urban Indigenous populations. Practitioners must be cognizant of how to tailor the interventions to best fit the local Indigenous population rather than using a broad approach, as Indigenous groups are unique and do not exist under a pan-Indigenous identity (Rogers et al., 2019; Smylie et al., 2009). This research project seeks to add to the ongoing conversation on integrating Indigenous and Western practices by understanding the diversity of Indigenous perspectives.

Methodology

This exploratory research project included two phases. The first was a sharing circle. This was intended to be a gathering of the local Indigenous population where they would identify successes and areas needing improvement in the mental health care being received in their community. The second phase was a jurisdictional scan that explored the successes and challenges in combining Western and Indigenous approaches from a professional perspective. Respondents were professionals from organizations in BC and Alberta that have integrated Indigenous and Western practices into their mental health programming.

Sharing Circle

Participants. Potential sharing circle participants were recruited with a snowball sampling process. The research team prepared a recruitment poster which

provided information and invited interested participants to contact the research team. The ICYMH team reached out to Katzie First Nation, local social service organizations, and other contacts to inform potential participants. Participants were offered a $15 honorarium in the form of a gift card for their participation. Participants in the sharing circle would have been adult members of the Katzie First nationscommunity and adults in the Ridge Meadows and Tri-Cities areas who self-identify as Indigenous. Community members who did not meet this criteria could still participate based on the recommendation of the Elders supporting this project.

Three potential participants reached out to the team to express their interest in the research project. They were provided with more detailed information and asked to complete a brief online survey to provide consent, demographic information, and scheduling information. However, none opted to continue participating, and thus, a sharing circle was not held.

Jurisdictional Scan

Participants. Recruitment for the jurisdictional scan was conducted through direct contact and snowball sampling. The ICYMH team identified organizations which state that they provide culturally integrated mental health services. The research team then searched the organization's websites for publicly available contact information for individual practitioners. Researchers contacted potential participants to inform them about the study and invited them to participate. When direct contact information was unavailable, researchers sent information to general organization contact information. In some cases, the researchers also conducted follow-up phone calls to recruit participants. Upon expressing their interest, potential participants were invited to complete an online survey to provide their consent, demographic information, and scheduling information for an interview. Two participants provided verbal consent during the interview.

The research team reached out to 24 individuals from 14 different organizations and had a response rate of 37.5%. A total of nine participants completed an interview (n=9). Seven out of nine participants self-identified as Indigenous. All participants reported having professional experience in Indigenous mental health and represented a range of experience levels: three participants had 0-5 years, two had 6-10 years, and four had more than 10 years of professional experience. Five participants had managerial or supervisory experience.

Data Collection

Semi-structured, individual interviews were used to explore the challenges, barriers and successes in integrating Indigenous and Western practices. To improve reliability, the research team established some guiding questions (Appendix A) to ensure consistency across the interviews, but participants were allowed to answer in whatever way they chose. Indigenous participants were invited to indicate whether they preferred to be interviewed by an Indigenous team member. Interviews were up to 90 minutes and held remotely through Zoom. The interviews were recorded, and recordings were kept secure on the interviewer's device or on the secure UBC OneDrive platform. Additionally, participants were invited to provide feedback through a member-checking process: after establishing initial themes, the research team consulted interested participants to ensure their contributions were accurately summarized.

Data Analysis

Thematic analysis was used to understand the data provided through the interviews. More specifically, the research team used inductive coding, which ensures that the themes are derived from the data itself rather than from the existing assumptions of the researchers (Chandra & Shang, 2019). The team followed the steps outlined by Nowell et al. (2017): familiarizing themselves with the data, generating initial codes, debriefing on the validity and accuracy of the code system as it develops, identifying key themes, reviewing the themes, defining and naming the themes, and producing the report. The process of this research project also included member- checking during interviews and after the development of initial themes. This was done to empower the participants to have control over the interpretation of the information that they provided.

Findings

The research findings revealed a set of distinct yet interrelated themes and subthemes, which provide insight into the ways in which Indigenous and Western practices can be best integrated in mental health settings. The five main themes are presented in this paper in the order of most to least referenced by the participants across all nine interviews: Indigenous leadership; culture; relationships; education; and organizational regulations. Exact numbers can be found in Appendix B.

Indigenous Leadership

The need for Indigenous led practice was discussed and emphasized by all participants. A non-Indigenous participant reflected upon their allyship and expressed their deference to those who have been more deeply involved in Indigenous communities and culture. Participants discussed the importance of viewing oneself in a "support role" to be led by elders and knowledge keepers. The importance of including the effective participation of Indigenous elders and leaders throughout the development and implementation of services was also expressed. One participant described how their organization follows protocols that were passed down by generations of elders to ensure they are following the teachings of the ancestors. Another participant linked success to Indigenous leadership:

> So when I think about successes, you know, I think this- this particular program was very much a land-based program and led by Indigenous leaders, Indigenous medicine people, Indigenous knowledge keepers and elders, it was very much grounded in Indigenous culture.

There is also a need for the legitimization of Indigenous cultural practitioners and knowledge keepers, and clinicians should support the self-determination of Indigenous communities. Within the broad theme of Indigenous leadership, there are sub-themes of client directed practice, commitment to practice, and the value of elders

Client Directed Practice. Client directed practice is an approach that attends to the unique needs of communities and individuals by allowing them to guide the practitioner. One participant described this practice as "a guest deferring to a host." As a part of this approach, clinicians should be respectful of the client's pace and position in their healing journey. This prioritizes and empowers the client's definition of success and health. Participants stressed the importance of recognizing the similarities and differences which exist between Indigenous communities to avoid stereotyping a pan-Indigenous identity. Services must be tailored to the specific community with whom organizations are partnering. The inclusion or exclusion of culture in care should also be client directed. There are individuals who may not want to be connected to Indigenous culture or identity or would prefer to receive cultural support from their own community. Participants encouraged clinicians to engage in respectful question-asking to guide client directed practice; "Some people don't have any idea of what their identity is even, right? Because of those histories of displacement and stuff. So always just asking that person, you know, like, where they're from, and- and just getting to know them and building that rapport, and then we'll find out what we need to know."

Commitment to Practice. A need for commitment from both clinicians and organizations to follow Indigenous leadership was also identified. Work of culturally-integrated practice must be "personal" to the clinician. There is a need for a foundation of love, and the clinicians must approach the work as "heart people" rather than "head people." One participant spoke to the success of their team due to members' passion and commitment to building relationships within the Indigenous community, and their willingness to learn about cultural safety. Clinicians who work alongside Indigenous communities must understand the mistrust that still exists surrounding Western mental health services and approach this work with sensitivity.

Several barriers in commitment to practice were also expressed by participants, including the lack of unity among staff in backing cultural approaches. It was noted that non-Indigenous staff sometimes have a lack of understanding of the depth of need for culturally-safe practice, and demonstrate a reluctance to participate in culturally inclusive approaches. This

results in inconsistent service delivery within the organization. The superficiality of cultural safety programming, addressing calls to action, and addressing community requests is also a challenge. One participant described this superficiality:

> I'll be talking to a non-Indigenous clinician or leader who says, 'Well, I want to follow cultural safety practices and trauma informed consent and all this stuff.' And I'm going - but you have no frame of reference, even though you're talking the same language, I can tell. It's just, it's just a blank stare.

Organizations who are only invested in addressing these calls to action on a superficial level are not seen to be committed to creating real change.

Value of Elders. Elders hold the knowledge, language, and spiritual ways of Indigenous peoples, and participants emphasized the need for their involvement in the delivery and implementation of culturally-integrated practice. Elders hold authority within their community, especially when working with children and youth. Losing an elder was described as a major barrier to practice, and the COVID-19 pandemic has created a lack of access to elders; one organization purchased and distributed iPads to elders in an effort to reconnect them to their community. It is important to recognize the lifelong skills and practice of elders to perform ceremonies; one participant stated:

> Elders… in leadership are crying for legitimacy for cultural practitioners … medicine people, or cultural teachers or language carriers, etc, [need] to be given the same jurisdictional power as clinicians have with [their organization]. And basically, that goes back to the topic about Indigenous sovereignty, and the healing of our own people.

Along with institutional recognition, participants expressed a need for increased pay to commemorate elders' specialized skills.

A participant described the elder's role on their team as the "cultural compass," continuing to bring the cultural and spiritual aspect of care to the forefront of the team's priorities. Many clinicians expressed that including elders in their work is an effective way to hold their practice culturally accountable. The inclusion of elders in service provision was also cited as the sign of a successful program. Participants also expressed the influence that inclusion of elders has on both Indigenous and non-Indigenous staff members. Several participants described ceremonies which elders have conducted with their staff that had a profound effect.

Culture

Culture was described as a crucial aspect of the healing process when working with Indigenous people. Culture was defined as the externally visible cultural practices, such as the usage of the medicine wheel, smudging ceremonies, canoe journeys, drumming, song and dance, storytelling, traditional foods and teas, blanketing ceremonies, the burning of sweet grass and candles, sweat ceremonies, swims, beadwork, brushing ceremonies, powwows, Welcome Home ceremonies, and healing circles. It also includes the more internal aspects such as the understanding of land and nature, the following of laws and protocols, the learning of the Seven Sacred Teachings, and the embracing of traditional value systems. Using these practices in clinical interventions was described as being useful in treating or preventing physical or mental health conditions, and contributing to general wellness, self-esteem, and self-worth. Culture was deemed a determinant of health not often considered when analyzed with a Western lens.

In addition to culture being utilized as a treatment method, it was also imbued into the fabric of some of the organizations. In one particular organization, departments were renamed in the traditional language of the region to reinvigorate and normalize Indigenous identity. Opening team meetings with a song, drumming, or a prayer was described as an effective way to normalize culture within the organization. One participant described imbuing culture into their organizational life:

> Normally when we have a meeting or do anything like that we, we open up with a song, and we- we do our best to follow the Snowoyelh and follow, the Snowoyelh, the s'í:wes, the teachings that are passed down to us from generation to generation. And the Snowoyelh is the natural law that Creator provided – provides for us, and it-it's the law of everything.

A need was emphasized for a spiritual way of decision making. Colonialism attempted to remove it, but some participants saw its renaissance as the way forward. This undertaking is not something to be taken lightly, and accountability toward cultural authenticity was demanded as a preventative measure against the corruption of sacred practice.

Two-Eyed Seeing. Two-Eyed Seeing is already in practice, and many participants highlighted the value of de-centering dominant cultural narratives to allow space for marginalized narratives to obtain greater equality. The gifts of all people are recognized to be valid and weaving all the strengths together is advocated for the betterment of all. This approach requires research and consultation with community and local knowledge holders to fully develop.

The practical applications of Two-Eyed Seeing are described as being fairly straightforward. Traditional Western techniques, such as Cognitive Behavioural Therapy, Dialectical Behavioural Therapy, Acceptance and Commitment Therapy, and so on, can be used in conjunction with Indigenous culture, either by taking place in sacred spaces on the land or by taking place in tandem with cultural practices like a sweat ceremony. Creativity is asked for by looking for ways existing cultural practices can confirm or be woven together with Western approaches. Two-Eyed Seeing could also be implemented by having Western practices co-facilitated by those who can authentically relate the practice back to Indigenous culture.

Balance is mentioned as key to making this interdependent approach work. Respect needs to be given to marginalized perspectives, and open-mindedness is key to maintain equality among approaches. One participant described the dangers of having Western practices as the default:

> The challenges that- in a way, staff are all trained, you know, you have to have a Master's degree in a clinical area; you have to have training as a counselor and those foundational skills. So that Western way of looking at mental health is typically the background of the staff that … we hire, and it's so easy without being intentional around how you're going to really bring in more Indigenous cultural considerations to help guide your work.

Progress was described by another participant who acknowledged the Fraser Partnership Accord which has a vision of weaving together Indigenous and non-Indigenous perspectives in a healthcare setting.

Relationships

Many participants discussed the importance of a relational approach to work with Indigenous people and communities. For example, a participant shared, "I've learned [this teaching] not only from my family, but from people in the communities I work with… recognising that… strengthening relationships, maintaining relationships, and repairing broken relationships is so valuable." They shared some general considerations for engaging in these relationships such as being mindful of ethics and safety in engagement. Participants also highlighted the need for different skills, tools or values at different stages of the relationship such as the initial engagement, building the relationship, and maintaining the relationship. Participants also shared insights on relationships with the community, with the environment, and with other organizations.

Relationship to Community. Participants discussed the importance of ensuring that mental health practice is informed by relationships with the local Indigenous communities. This is a way to counteract pan-Indigeneity. Respect for the sovereignty and strengths of these communities was also described as an important part of these relationships.

Community relationship was described as a benefit to clients to improve their sense of belonging, and it was emphasized that the practitioner and organization develop community relationships as well. When establishing and maintaining a community relationship, it is important to engage with kindness, love, respect, and equality. One ought to be physically present and visible in the community by attending community events and ceremonies. The genuineness of the relationship was also repeatedly mentioned by participants who challenged practitioners to engage on a human-to-human level rather than as a professional. For example, one participant said,:

> You're not going to give your heart away to the organizations, but you can certainly give your heart away to the communities. Because eventually you'll

> belong there, not at your work…. [it's] just about being seen as… an authentic human being.

Participants also discussed how seeking permission from the communities where the work is conducted is critically important to being accepted or trusted. Once trust is gained, practitioners and organizations have to be accountable to communities, including adapting to fit community needs, and ensuring the longevity of those relationships. One of the significant barriers identified was the lack of time or funding to support practitioners to engage with communities in this immersive way.

Relationship to Nature, Land, and Place. Many participants also discussed the importance of connecting mental health practices to nature, or the specific land on which the work is being conducted. Specific nature-based practices were mentioned, and they were recommended as ways to strengthen the cultural and spiritual identities of clients and ways for the practitioner to develop rapport. For example, one participant explained, "Your therapy is sitting by the river; therapy is going for a hike; therapy is getting on the land…" Participants also discussed the importance of nature because of how it informs the values and teachings of Indigenous culture. Some specific examples included understanding ceremonies as attached to specific times of day or seasons, and the understanding that "everything has a spirit" which creates accountability to land, nature, animals and other people. Finally, participants highlighted it was important to understand how changes to the environment and the land as a result of colonialism has impacted Indigenous people.

Relationship to Other Organizations. Participants discussed the need for collaboration between organizations. Some participants praised specific existing partnerships between Indigenous and non-Indigenous governments and organizations that were creating positive change. These relationships were also important to supporting individuals with their holistic health by having established guidelines for cultural consultation and the sharing of client information. For example, one participant stated they had ongoing contact with other organizations to "know how to work together, and [know] who's doing what, and how we can support individuals… [with] their physical, emotional, mental and spiritual selves." Another important role that organizational relationships play is the provision of funding. Participants acknowledge the ways that outside funding can improve services at their organization. However, they also acknowledge that existing funding structures disadvantage smaller Indigenous nations and that being funded by certain organizations or arms of the government may impact the perception of the services in the community. For example, one participant discussed how receiving funding from the same ministry that is responsible for child protection investigations may make some Indigenous clients avoid seeking mental health services.

Education

The importance of on-going learning and self-reflection was also detailed. This learning was suggested in a formal manner via direct training programs like a monthly Lunch and Learn to develop an understanding of local culture, stories, worldviews, history, and stories. Safe spaces for dialogue were recommended as a means to develop practitioner education, as well as to facilitate cross-cultural communication. One participant posited that when practitioners have this kind of education, it would allow them to understand the way that racism has fostered a distrust of the system in Indigenous communities. While ongoing education is recommended on a professional level, some degree of education prior to employment is also necessary. Some organizations were taking direct action:

> If anybody is going to come and work for [our Coast Salish Nation], they need to get to know our ways… Some of our Elders are in process of developing some cultural modules… that's all related to [our Coast Salish Nation],… and people that come work for [our Coast Salish Nation] have to complete those [modules].

Colonialism. Colonialism was characterized by participants as an integral component of education. Practitioners are encouraged to explore how colonialism has become infused within the

organizations and institutions of society. Practitioners need to familiarize themselves with residential schools, intergenerational trauma, and the loss of identity as well as how that history continues to place barriers and inequities on Indigenous people. Knowledge of colonialism was asked to be acquired in tandem with knowledge about how an oppressive environment can impact a client physiologically:

> You can learn about the history until hell freezes over, but if you don't somehow understand the impact of that on the children, how that's passed down [through processes like epigenetics]… [Colonialism changed] their environment… so much that they lost who they were.

The holistic impacts of colonialism were highlighted as contributing factors to addiction, fear and anger, and the loss of identity and culture; the understanding of these impacts were emphasized as important factors when making practice decisions.

Self-Reflection. Self-reflection was referred to as the inner learning that practitioners were encouraged to develop within their practice. This can involve reflecting on one's personal privilege regardless of identity, analyzing personal biases, acknowledging the power and position of one's organization, and contemplating one's own social location. One participant used their relationship to colonialism to direct their practice, "I'm very much a guest on these territories, and I've always lived on stolen territories. And, you know, when I think about my work that I do, it's very much identifying myself as a guest." This work is done to elevate responsibility in advocacy, provide authenticity in cultural procedures, and to encourage best practice. It can be fostered by training programs, consultation and dialogue, and individual curiosity. Humility was endorsed to normalize not having all the answers, ultimately leading to an openness to new ideas and practices.

Organizational Regulation

Policies and practices set forth by organizations can impede the work of integrating wellness practices. There are many challenges within organizations, including a lack of funding and time, understaffing, and high rates of staff turnover. Participants also emphasised the discrepancies between Western and Indigenous concepts of health, safety, wellness, success, and time. Organizations' focus on short term and measurable successes, rather than long-term growth and development is also a major barrier. Government-based mental health organizations must also meet provincial standards related to accreditation when hiring clinicians for their programs. The differences between accreditation and Indigenous ways of healing also creates barriers; this interferes with Indigenous sovereignty over healing. Accreditation and credential requirements also limit the ability of of Indigenous Healers and Medicine People to provide formal mental health care.

As a result of the regulations created by organizations, there is a need for clinicians to "work around" the existing boundaries of the agencies. One participant summarized this mentality:

> A lot of it is… massaging the rules and kind of having to work things in your favor, if that makes sense… It sounds kind of deceitful, but it's not like it's- I mean, you do what you have to do, right?

For example, there are difficulties in the use of language surrounding culture and spirituality when working in conjunction with government-accredited services; participants described their need to carefully select the terms used to describe their programming.

Although participants brought many barriers to the attention of researchers, they also cited successful endeavours by organizations. A participant cited the way their organization successfully adjusted their service delivery after incorporating feedback from the local Indigenous community: the services shifted from office-based to outreach and community-based, and two additional clinicians were hired in order to supplement mental health care. Other participants mentioned the hiring of clinicians who are focused on spirituality and culture. A creative way that one organization has integrated Indigenous culture into practice is the renaming of departments in the local Indigenous dialect described above.

Several solutions were offered by participants when discussing organizational regulations. They expressed a need to follow the recommendations from the In Plain Sight report, the Fraser Health Accord, the Truth and Reconciliation Commission, the United Nations

Declaration on the Rights of Indigenous People (UNDRIP), and the Murdered Missing Indigenous Women and Girls report. One participant suggested the development of standards which must be met by caregivers, in order to equip youth with life skills prior to their release from the foster care system.

Epistemic Racism. The sub-theme of epistemic racism emerged from the broader theme of organizational regulation. Participants acknowledged the existence of epistemic racism within society and organizations, and how this interferes with providing effective culturally-integrated services. The concept of cognitive imperialism was brought forth by several participants. Cognitive imperialism views the dominant epistemology as absolute, thereby delegitimizing the epistemologies of oppressed groups, including Indigenous communities. Cognitive imperialism was also cited as negatively impacting the Indigenous communities' sense of self. One participant reflected this sentiment, expressing that many Indigenous people have been "brainwashed" into believing Caucasian people know best. This has silenced the voices of many Indigenous people. Cognitive Imperialism can also define values; this can guide goals of care toward turning Indigenous people into "cookie-cutter colonial people." This mindset is pervasive within society, and can inform the structure and services of organizations. There is a lasting legacy of laws and policies, such as the potlatch and other ceremonial bans, which forbid Indigenous communities from engaging in their traditional culture. This also creates a burden on Indigenous staff members to fight for their worldview and practice to be seen as legitimate.

Participants discussed that there is an overall view of Indigenous people being broken which requires a shift to a strengths-based approach. A participant also brought forth the danger that can come with sharing the stories of Indigenous people, as they may be appropriated or commodified. A participant described the hurt and mistrust caused by epistemic racism:

> I know our people don't trust you, you understand why, our people have a hard time trusting, you know, the way they're treated for the colour of their skin, for being native, for being Indian… we face a lot of racism. And… we're treated differently, and there's no trust, out there, for a lot of our people, … we're tired of being hurt.

Discussion

The findings of this research project add to the existing literature on the topic of integrating Indigenous and western approaches to mental health care. Participants discussed the critical importance of Indigenous leadership in any efforts to blend Indigenous and western practice for mental health. More specifically, participants spoke to the necessary inclusion of Indigenous practitioners and Elders in front-line and supervisory roles. They also spoke about how important it was to practice from a client directed approach which is inclusive of clients who may not have knowledge of or desire to connect with Indigenous culture. The importance of Indigenous leadership and sovereignty is similar to existing research which calls on the inclusion of Indigenous Elders in the healing process (Bhattacharjee & Maltby, 2017; Marsh et al., 2015).

Participants in this study identified several specific cultural practices that were useful to mental health practice. These practices included: sweat lodges, smudging, cedar brushing, etc.. Existing research on this topic highlights many of these same practices (Bhattacharjee & Maltby, 2017; Bigfoot & Schmidt, 2010; Gone, 2011; Marsh et al., 2015; Oulanova & Moodley, 2017; Rowan et al., 2015; Stewart & Marshall, 2017; Taylor & Burgess, 2020). Besides the specific cultural practices, participants also highlighted the importance of incorporating specific cultural values such as communal wellbeing, respect, kindness, compassion, sovereignty, and many more. Some participants also specifically mentioned the Seven Grandfather Teachings; wisdom, love, respect, bravery, honesty, humility and truth, which have also been captured in existing literature (Marsh et al., 2015; Rogers et al. 2019).

Participants also discussed the importance of relationships in mental health care for Indigenous peoples. They specifically spoke to the importance of relationships to Indigenous communities and the land. These relationships were described as important to informing the practice of mental health professionals.

Existing research also confirms the importance of establishing and maintaining respectful and collaborative relationships with Indigenous communities (Bhattacharjee & Maltby, 2017; Marsh et al., 2015; Oulanova & Moodley, 2017; Smylie et al., 2009). The importance of nature for Indigenous mental health care was also highlighted in existing research (Oulanova & Moodley, 2017).

Participants also discussed how important it was for mental health practitioners who are providing services to Indigenous people to have the necessary education. Specifically it is important that practitioners are aware of and responsive to the context of historical and ongoing colonialism and reflect on their privileges. The need for this kind of education, as well as reflective practice to identify personal privileges and biases, is also confirmed by earlier research into the topic (Oulanova, 2008).

Participants in this research also highlighted how epistemic racism is still affecting the regulations of organizations in ways that make it difficult to integrate Indigenous and Western approaches to mental health care. Specific ongoing issues that were discussed included funding, low administrative support for new initiatives, and the limitations and boundaries of professionalism when engaging in relationships with Indigenous people and communities. These are very similar to the concerns to the ones identified in other recent research which include professional distrust of Indigenous methods (Rowan et al., 2015; Whiting et al., 2018), lack of funding (Boska et al., 2015; Marsh et al., 2015) and a lack of access to Elders or traditional knowledge (Rogers et al., 2019).

Present findings further explore the issue of integrating Indigenous and Western perspectives in mental health care for Indigenous peoples. The professionals who were interviewed identified some best practices and ongoing challenges based on their experiences of integrating these two approaches in practice. Highlighting these insights, based on the practical experiences of professionals who work in the field, is a key contribution of this study.

Limitations

The COVID-19 pandemic was a great barrier when conducting this research. Researchers were not able to collaborate in person, nor connect to the ICYMH team outside of a digital format. This necessitated individual analysis to avoid long bouts of digital meetings that result in fatigue and eye strain. While the pandemic did not create noticeable limits on the jurisdictional scan, it did prevent the sharing circle from taking place in person. Sharing circles traditionally have food, ceremony, and camaraderie, but the pandemic forced this process online. This put technical barriers in front of potential participants, and added extra formalities to the recruitment process. In a physical space, participants could arrive and sign consent forms immediately prior to the sharing circle, but online, this process required back and forth emails between the researchers and the participants. This increased the chance of participants dropping out, and of the contacts that were made during the recruitment process, none made it to the actual event.

The lack of a sharing circle reduced the richness of the research overall. Much of the literature, as well as data gathered from the jurisdictional scan, advocated against a pan-Indigenous approach. Local knowledge is highlighted as being necessary when working with local communities, and the method that would have provided that perspective did not happen.

The reasons for the failure of the sharing circle are difficult to pinpoint concretely. Of the two sharing circles that were planned, one was declined by the one of the local Indigenous nation's band council Chief during the consultation phase. Initially, the request was denied due to a misunderstanding of this research representing a repetition of what was already taking place in the community, but after further dialogue, the Chief did consent to the circle. Unfortunately, this consent was not given in time to organize an additional gathering. Another factor could be that the research team itself is majority Caucasian, and is new in its experience with research in Indigenous communities. The literature review highlights the importance of community involvement and collaboration during every aspect of the research process when working with Indigenous populations, and that approach was not emphasized in this research due to its origin in a student group, and the

COVID-19 pandemic, which prevented in-person excursions into community. There is also a historical distrust of Western research in Indigenous communities that necessitates these additional measures, and that could have contributed to the loss of a sharing circle.

Time constraints were another factor that limited this research. Due to the deadlines associated with this project, there was an inability to organize another sharing circle to seek out local knowledge. Additional time might have allowed for reflection on the challenges of the first attempts which could have led to greater turnout in future sharing circles. Additionally, the aim of pursuing Indigenous methodologies required extended time: consulting local leaders, acquiring Elders to facilitate ceremonies, and the member-checking process are necessities that demanded further commitments from the team and participants. While deadlines were able to be met, the rushed process may have been a further factor in the unrealized outcome of the sharing circle.

Implications for Policy and Practice

There are five implications for policy and practice which researchers recommend for organizations and clinicians to improve culturally-integrated practice. The ICYMH team has committed to further research with local Indigenous communities by holding future sharing circles to inform these recommendations with local knowledge.

First, given the belief that culture is medicine, organizations must integrate specific Indigenous cultural wellness practices in Western mental health theory and practice. In order to provide holistic and culturally-informed mental health services, cultural wellness practices must be integrated into Western mental health approaches. These cultural practices must be specific to the community with whom organizations are providing services. This recommendation is founded in a client directed approach with an acknowledgement of differences and similarities that exist within Indigenous communities.

Second, beyond the expectations outlined by their organizations, mental health clinicians should make an effort to connect with the Indigenous community with whom they are partnering. Attending ceremonies or events within the community can be crucial in building trust and rapport. This will also deepen the clinician's understanding of the community to better tailor their culturally-integrated approach. Organizations providing mental health services should encourage staff in further community engagement, and create policies that enable such freedom within clinician's roles.

Third, organizations should review and adjust their regulations to better include the integration of Indigenous Wellness practices and culture. By creating more culturally-inclusive policies, organizations will decrease bureaucratic obstacles around providing care, and diminish the need for their clinicians to "massage the rules" in order to provide the best care to Indigenous clients.

Fourth, clinicians working with Indigenous communities must engage in self-reflective practice, study the impact of Colonization on Indigenous peoples, and integrate trauma-informed care into their practice. Clinicians must reflect upon and recognize their privilege. They must engage with Indigenous communities from a self-reflexive and anti-oppressive position. They must understand the impact of colonization and intergenerational trauma on Indigenous people. Organizations must encourage reflective practice, invest in training on culturally-safe practice, and create policies which reflect the decolonization of services.

Fifth, work with Indigenous communities must be client-directed and Indigenous-led. Organizations and clinicians alike must reject the concept of a pan-Indigenous identity and tailor services toward the specific indigenous communities, with whom they are partnering. Organizations must include Indigenous leaders, Elders, Knowledge Keepers, and Medicine People in the development and implementation of services. Organizations and clinicians should support Indigenous sovereignty, and advocate for the legitimacy and equal recognition of Indigenous cultural practitioners.

Conclusion

This research adds to the established literature on Two-Eyed Seeing approaches to mental health. It highlights Indigenous leadership and sovereignty, the use of specific cultural practices in mental health care, and the importance of relationships in providing culturally-integrated services. This study utilized the insights of mental health professionals and their experiences in blending Western counselling and Indigenous cultural practices into care. It was intended to benefit the ICYMH team and influence their interactions with their Indigenous clientele. The Jurisdictional Scan and thematic analysis provided several findings, including themes of Indigenous leadership, culture, relationships, education, and organizational regulation. From these findings, five implications for policy and practice emerged which will provide a framework for integrating Indigenous and Western practices. There is a need for further research to address the limitations of this study; predominantly, the need for local Indigenous perspectives which will be pursued by the ongoing efforts of the ICYMH team.

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Appendix A.

Jurisdictional Scan Interview Questions

Individual:

- How would you describe your approach to practice with Indigenous peoples?
- How do you integrate Indigenous culture or practices into your work?
    - What does that look like?
        - What are some of the barriers to doing that?
            - What is needed to overcome those barriers?
        - What are some of the successes?
            - What enabled those successes?
- What would you need to [better] integrate Indigenous culture or practices into your work?
    - Ex: organizational supports, funding, knowledge etc.

Organizational:

- How does your organization integrate Indigenous culture/practices or encourage the integration of Indigenous culture/practices by its staff?
    - What does that look like?
        - What are some of the barriers?
            - What is needed to overcome those barriers?
        - What are some of the successes?
            - What enabled those successes?
- What does your organization need to [better] integrate Indigenous culture in its practices or approach?
    - Ex: funding, knowledge, staff etc.

Further Questions:

- What skills, qualities/values, or knowledge should a mental health practitioner who is working with Indigenous people have?
- What values or qualities should a mental health organization that works with Indigenous people have?
- What advice do you have for other practitioners or organizations who want to provide better mental health services to Indigenous peoples?

Appendix B

Theme Prevalence

Theme	# of References
Indigenpus Leadership	**139**
• Sub Theme: Client Directed	41
• Sub Theme: Indigenous Leadership	39
• Sub Theme: Commitment to Practice	32
• Sub Theme: Value of Elders	27
Culture	**133**
• Sub Theme: Culture	94
• Sub Theme: Two-Eyed Seeing	39
Relationships	**132**
• Sub Theme: Relationship to Community	77
• Sub Theme: Relationship to Nature, Land and Place	29
• Sub Theme: Relationships	14
• Sub Theme: Relationship to Other Organizations	12
Education	**106**
• Sub Theme: Colonialism	46
• Sub Theme: Reflective Practice	42
• Sub Theme: Education	18
Organizational Regulation	**82**
• Sub Theme: Organizational Regulation	51
• Sub Theme: Epistemic Racism	31