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PL

ONTARIO COURT OF JUSTICE
(Northeast Region)

B E T W E E N:

HER MAJESTY THE QUEEN

Respondent

- and -

DANE BEBAMASH

Applicant

AFFIDAVIT OF DR. DARREL MANITOWABI

I, Dr. Darrel Manitowabi, of the Village of Birch Island, in the Province of Ontario, MAKE OATH AND SAY/AFFIRM:

1. I acknowledge that it is my duty to provide evidence in relation to this proceeding as follows:

   (a) to provide opinion evidence that is fair, objective and non-partisan;
   (b) to provide opinion evidence that is related only to matters that are within my area of expertise; and
   (c) to provide such additional assistance as the court may reasonably require, to determine a matter in issue.

2. I acknowledge that the duty referred to above prevails over any obligation which I may owe to any party by whom or on whose behalf I am engaged.

3. I propose that I be qualified as an expert in indigenous health-related matters and indigenous traditional medicine.

4. I am an Associate Professor at the Northern Ontario School of Medicine University where I am the inaugural Associated Medical Sciences Hannah Research Chair in the History of Indigenous Health and Indigenous Traditional Medicine.

5. I am a citizen of Wiikwemkoong Unceded Territory and currently reside in the Whitefish River First Nation in Birch Island, Ontario.

6. I have a PhD in anthropology from the University of Toronto (2007) and research specialization in Indigenous Knowledge, Indigenous Peoples, Indigenous Health, De/Colonization, Indigenous-State Relations, Indigenous Studies, Anishinaabe Studies and Anishinaabe Bimaadiziwin, all taking place within an interdisciplinary framework situated in the disciplines of anthropology, Indigenous studies and the anthropological subdisciplines of medical anthropology and applied medical anthropology.

7. I have a lifelong immersion in Indigenous (Anishinaabe) communities, and carries Indigenous Knowledge through oral history teachings, immersion in land-centred activities which are balanced with formal Western education credentials. My work weaves Indigenous Knowledge paradigms (Indigenous pedagogy and Indigenous knowledge) in the application of Western knowledge (teaching, curriculum development, administration, research and publishing).

8. I have held academic appointments in Native/Indigenous Studies at the University of Sudbury (2004-2012), Native Human Services/Indigenous Social Work (2012-2014) and Anthropology (2014-2020) at Laurentian University.

9. I am currently a tenured Associate Professor in the Human Sciences Division of NOSMU and I am a faculty member of graduate programs at Laurentian University (Indigenous Relations, Rural and Northern Health and Human Studies and Interdisciplinarity).

10. I have over eight years' experience in University Administration (Indigenous Studies Chair [3 years], Director of Native Human Services [1 year], Director of the School of Northern and Community Studies [3 years], Interim Director of Indigenous Affairs [8 months], and Assistant Dean of Graduate Studies [one year]).

11. My research is collaborative, and research grants total over $5 million. I am an active researcher and have published academic articles, primarily in Indigenous social determinants of health and have conducted research and published on the topics of Indigenous diabetes, traditional medicine, socioeconomic interventions, urban issues, gambling, recovery from opioid addictions, occupational health and safety and Indigenous education.

12. All of my research is undertaken in holistic perspective that centers Indigenous Knowledge and oral history, and most of my research integrates Indigenous history in health research. My expertise in Indigenous oral history was recognized when I served as an expert witness and wrote a report on Indigenous oral history in Alderville et al vs the Queen. In response to First Nations litigation, the Governments of Ontario and Canada reached a settlement out of court returning lost land and reinstating Indigenous hunting, fishing, and rights to the Beausoleil, Rama, Georgina, Scugog, Hiawatha, Curve Lake and Alderville Chippewa and Mississauga Anishinaabeg First Nations in south-central Ontario. Lead legal counsel for the First Nations expressed a personal appreciation for the significance of the Indigenous perspective legal argument.

13. At present, I am working with Elders and traditional healers in the areas of capacity development, recognition, and policy work.

14. Attached hereto and marked as Exhibit A is a true copy of my CV.

Have colonialism, residential schools, COVID-19, undocumented residential school burial sites, and systemic discrimination impacted the health outcomes of Canadian indigenous people, and what are those health outcomes?

15. Colonialism, residential schools, trauma, and COVID-19 have impacted Indigenous peoples. There are structural (e.g. fundamental) features of colonialism that have affected Indigenous Peoples globally and Canada in the following ways:

16. Cultural loss: Missionaries introduced new religions with the support of government officials. This action led to the creation of Residential Schools that threatened cultural practices such as spirituality and ceremonies, language, traditional healing, and cultural continuation by eliminating exposure to Elders, knowledge holders and parents who would naturally transmit Indigenous cultural

knowledge (Alfred 2009; Cunningham 2009; Czyzewski 2011; Gracey & King 2009; King, Smith & Gracey 2009; Manitowabi & Maar 2018; Truth & Reconciliation Commission of Canada 2015; Waldram, Herring & Young 2006).

17. Loss of Land: Treaties in Canada ceded control of Indigenous land to colonial authorities and settler peoples in exchange for rights such as hunting, fishing, and harvesting (Alfred 2009; Czyzewski 2011; Manitowabi & Maar 2018; Truth & Reconciliation Commission of Canada 2015; Waldram, Herring & Young 2006). For instance, on Manitoulin Island, a Treaty in 1836 initially recognized the entire Island as Indigenous territory. However, the government's motive was to encourage other Indigenous groups to move to the Island to congregate for assimilatory purposes. Agitation by settlers over land led to a second Treaty in 1862, ceding most of the Island except the modern-day Wiikwemkoong Unceded Territory on the eastern portion, which did not sign the 1862 Treaty. Gradual settlement encroached on Indigenous lands, restricting resources such as hunting and fishing, and settler fisheries competed with Indigenous fisheries (Wightman 1982; Pearen 1992).

18. Economic and Political Marginalization: Treaties set Reserves on economically marginalized lands, and in the case of Manitoulin, settlers received preferred lands. There are instances where settler economic stakeholders and government officials deliberately constrained and limited Indigenous economic initiatives. For example, on Manitoulin Island, in the now Town of Little Current, Indigenous businessman George Abotossaway was driven from this ideal economic location for settler economic expansion (Pearen 1992). The Indian Act of Canada (1876-present) furthermore imposed a municipal-style government (replacing Indigenous clan governance structures), made Residential School attendance mandatory, and set social controls through Indian Agents (Alfred 2009; Czyzewski 2011; Manitowabi & Maar 2018; Truth & Reconciliation Commission of Canada 2015; Waldram, Herring & Young 2006).

19. Compromised health and COVID: Residential Schools generated ill health and death. Underfunded and overcrowded, attendees were malnourished and faced compromised mental health by being punished for continuing cultural practices (Truth and Reconciliation Commission of Canada 2015). Overcrowding led to high mortality, for instance, with TB and unmarked graves now being uncovered, revealing unknown fatalities. The total experience of Residential Schools has led

to trauma to this day and endangered languages. In turn, intergenerational trauma has led to substance abuse and social problems. Economic marginalization leads to poverty and poor overall health, e.g. malnutrition, dependency. Political marginalization through the Indian Act restricts Indigenous sovereignty in dealing with these issues (Truth & Reconciliation Commission of Canada 2015). The onset of COVID-19 in 2020 exacerbated Indigenous health by increasing stress and associated substance abuse (Maar, Ominika & Manitowabi 2022; Spence & Sekercioglu 2023).

What is cultural safety, and is it important? How does it factor into the healthcare for Indigenous Peoples?

20. Cultural safety has its roots in the application of mitigating the harmful effects of discriminatory and racist healthcare for Indigenous Peoples in New Zealand (Māori peoples). It has now widely adapted in the healthcare literature involving Indigenous Peoples and their experiences in the healthcare system. The concept refers to patient safety and addressing the legacy of discrimination and racism that Indigenous Peoples experience in healthcare. It posits that it is harmful for Indigenous patients to experience discrimination and not feel safe disclosing their cultural background or practices, such as the use of traditional medicine and ceremony as part of a healing method (FNHA no date).

21. Cultural safety is common to the explanatory models in the healthcare framework. The explanatory model framework emphasizes that there are cultural views in place from the perspective of the patient and the medical practitioner (Kleinman 1981). Specific to Canada, colonialism must factor into this equation given there is a legacy of epistemic, systemic, and ongoing discrimination facing Indigenous Peoples in institutions such as hospitals and clinics since the time of Residential Schools, and the current health care system is a continuation of the Residential Schools as a structural effect of harm on Indigenous Peoples (Jacklin & Warry 2012; Matthews 2017). Healthcare practitioners are now encouraged to offer culturally safe care for Indigenous Peoples by recognizing the impact and ongoing colonialism and how colonialism has impacted the socialization and enculturation of non-Indigenous Peoples in Canada (FNHA no date). Cultural safety is standard in medical school curricula like the Northern Ontario School of Medicine University (Maar et al. 2020). The unfortunate deaths due to racist medical mistreatment of Brian Sinclair in Manitoba and Joyce Echaquan in

Quebec raised the importance of cultural safety and demonstrates the reality of epistemic racism in the Canadian health care system (Browne et al. 2022).

Does local and Indigenous community involvement in matters related to healthcare help address the legacy of colonialism and improve health outcomes for Indigenous people?

22. Before the onset of colonialism in Canada, Indigenous Peoples had their healthcare systems. This healthcare involved notions of disease causation (disease resulting in imbalance in human-spirit beings), medical specialists (herbalists, ceremonialists) and concepts of preventive medicine (balanced relations with others and spirit beings) (Waldram, Herrin & Young 2006).

23. The colonialist Indian Act banned ceremonies until 1951, introduced Residential Schools that outlawed cultural practices such as traditional healing and imposed new religions that suppressed Indigenous healing. State support of biomedicine (Western medicine) in Canada gradually displaced and, in some cases, replaced Indigenous healing systems. The legacy of this process is a rejection of traditional healing for some due to conflicts with Christianity and active objection by the government and Christian clergy. Shame or secrecy are furthermore outcomes around the continued practice of traditional healing given the oppression faced in the present and past. Both Indigenous and non-Indigenous Peoples in Canada have been subjected to this relationship over generations, and this is the outcome of non-Indigenous Peoples unknowingly or uncritically continuing this systemic and epistemic relationship. Thus, Indigenous Peoples deliberately avoid disclosing traditional healing practices to health care providers and other non-indigenous people (Waldram, Herring & Young 2006; Manitowabi 2009).

24. In the 1960s-1970s, Indigenous social movements confronting the legacy of colonialism challenged the oppressive effects to heal and recover from the effects of assimilation, oppression, and racism of Indigenous Peoples. In the 1980s-1990s, health transfer agreements between the federal government and Indigenous communities led to community control of healthcare delivery (Manitowabi & Maar 2018). For instance, First Nations took over healthcare on Manitoulin Island by opening local clinics and administering local delivery. In the 1990s, the province of Ontario initiated the Aboriginal Healing and Wellness Strategy, incorporating Indigenous culture and healing in health care settings. For

example, this takes place on Manitoulin Island at the Noojmowin Teg Health Access Centre, offering specialized health services to Indigenous Peoples, complementing First Nations federally funded local services. Noojmowin Teg provides access to traditional healers and incorporates ceremony and Indigenous healing concepts in program delivery (Manitowabi 2013).

25. The outcome of the health transfer and Aboriginal Healing and Wellness Strategy is culturally relevant care services through recognition of Indigenous health models such as: holism and traditional healing; local control; cultural safety through the recruitment of Indigenous and culturally safe health care providers; culturally and locally relevant health practices such as Indigenous diabetes prevention models (and treatment with traditional medicine); and youth-targeted programming. Furthermore, there are medicine-picking offered to First Nations in the catchment of Noojmowin Teg Health Centre to empower and reconnect lost knowledge due to colonialism (Manitowabi 2009; Manitowabi 2013).

For the Anishinaabe and the Canadian Indigenous people, is the approach to traditional healing and plant medicine holistic, localized, spiritual and social?

26. Indigenous traditional healing practices vary across the world and Canada. A standard global definition offered by the United Nations is a "harmonious coexistence of human beings with nature, with themselves, and with others, aimed at integral well-being, ritual, and social wholeness and tranquillity" (Cunningham 2009, p. 157). It generally incorporates the person's physical, mental, spiritual, and emotional components concerning the community, including politics, economics, society, and culture. Furthermore, it recognizes the impact of history, worldview, and community behavioural norms. Disease prevention involves the maintenance of harmony between persons in the community and with those of the world, including spiritual beings (Cunningham 2009; King, Smith, Gracey 2009).

27. The First Nations Health Authority of British Columbia (2021) defines Indigenous traditional healing as "the health practices, approaches, knowledge and beliefs that incorporate First Nations healing and wellness. These practices include using ceremonies, plant, animal or mineral-based medicines, energetic therapies and physical or hands-on techniques."

28. For the Anishinaabe People, oral tradition states the Anishinaabe were once faced with disharmony and ill health. A mythic being emerged and provided teachings on the healing quality of the plants with instructions. Some of these instructions were further offered by animals who predate the Anishinaabe. In practice, the Anishinaabe had herbalists, ceremonialists and spiritual leaders providing health care services and community leadership (Manitowabi 2012). The word for plant medicine is "mshkiki," meaning "strength from the earth." Belief factors into traditional healing, with adherents insisting one needs to believe in it to work. There are ritual aspects to plant medicine harvesting and processing, including offering tobacco and ensuring no overharvesting for sustainability (Manitowabi 2012; Redvers & Blondin 2020).

29. Common ceremonies involve the sweat lodge comprising of heating rocks in a dome structure with water added to generate steam causing one to sweat. The dome is believed to symbolize the womb of Mother Earth, and it represents the Anishinaabe's connection to and reliance on Mother Earth. Spirit beings participate in the ceremony, which involves prayer, song, and engagement with participants (Waldram, Herring & Young 2006; Redvers & Blondin 2020).

30. Traditional healing practices remain active on Manitoulin Island through First Nations health clinics and Noojmowin Teg. Non-institutionally affiliated healers also remain active, who continue healing practices in the community and are known in social networks. Indigenous Peoples travel long distances to see healers (Manitowabi 2012; Manitowabi 2013).

31. For the Anishinaabe who still practice traditional healing, healing is understood to be holistic and it is a spiritual, physical, emotional, and mental experience (Waldram, Herring & Young 2012). It is understood there are limits to both Western biomedicine and Indigenous healing. When one modality does not sufficiently meet one's needs, the other is sought out (Manitowabi 2013). For example, surgery may be accessed in Western biomedicine, while spiritual healing and some plant medicines are accessed in Anishinaabe healing.

For Anishinaabe peoples using cannabis as a medicine, does it matter how it is dispensed and received? For example, is it appropriate to receive it in the mail?

32. Assuming that medical cannabis is a medicine, within this context there is life and spirit in the plant medicine, and it is thus treated with respect. The healing

power of plants takes place within this belief system since healing is derived from both the properties of the plant and the spiritual recognition of it. This relationship is person and socially centered through the relationship with the healer in community, and the relationship with the plant medicines, the provider of the plant medicine and the community (Redvers & Blondin 2020). It is thus more appropriate and therapeutic to request and receive plant medicines in person, within the community and from an Indigenous provider because the community is aware of the above description of the classification and recognition of the meaning of plants in healing and the vital role of community knowledge in this, in that individuals share the cultural values of plant medicines. It also more culturally appropriate and therapeutic to request and receive plant medicines in person, from a known and trusted healer (or knowledgeable trusted plant provider), and within the community and from an Indigenous provider because culture and community connections are essential to healing. Indigenous methods and practices for helping and healing are more culturally appropriate and therapeutic when they involve local community control. Traditional medicine and knowledge are not to be isolated from a way of life which is all encompassing of diet, physical, spiritual, and emotional thoughts and actions (Hill 2009).

33. There are protocols when medicine is harvested and accessed. Medicine must be harvested in areas uncontaminated by pollution (e.g. be far from roads). It furthermore must be offered through relationships with trusted healers or knowledgeable trusted plant providers since personal relationships ensure protocols and procedures are followed. The healer is respectful of the medicine and takes appropriate care in storing and administering the medicine to the client. Furthermore, instructions are given on the appropriate dose or other preparatory instructions (Redvers & Blondin 2020). Therefore, it is vital that the personal connection is in place to receive traditional medicines and not to be receiving medicines without face-to-face contact and a trust relationship, it is not appropriate for medicines to be sent in the mail.

Assuming that medical cannabis is a plant medicine that can provide holistic benefits, would such a medicine lend itself to and would it work well with the Indigenous traditional healing approach much more than to a western biomedicine approach?

34. Indigenous healing practices are not frozen in time. Indigenous peoples have modified and changed their cultural and healing traditions in the past and present

(Waldram, Herring and Young 2006). For this reason, it is possible Anishinaabe peoples can recognize and use cannabis as a medicine in the expression of their self-determination, and this traditional healing self-determination is supported by the UNDRIP. In this context, the use of cannabis as a plant medicine can be recognized as having spirit and healing qualities that are incompatible with the Western biomedical approach which is reductionist and focused on biology and is devoid of spirituality, its connection to community, and the land (Waldram, Herring and Young 2006).

35. By virtue of its holistic nature and the fact that it is a plant medicine, medical cannabis can be compatible with traditional healing medicines.

For Anishinaabe peoples using cannabis as medicine, is it appropriate to be prohibited by the federal government from receiving it in-person, within their community from an Indigenous provider?

36. The involvement of the federal government in traditional healing is inappropriate and is consistent with the colonial model rooted in power, control, and assimilation of Indigenous Peoples. Since time immemorial, Indigenous Peoples have had healing tradition and systems that involve oversight and regulation. This involves socially recognizing healers and the knowledge of medicines from both the healer and patient. There is no evidence the federal government possesses the competency of oversight and regulation of traditional healing. It is an Indigenous right to access and provide oversight of traditional healing by Indigenous Peoples in community.

37. Within an Anishinaabe perspective, autonomy, respect, and non-controlling and non-confrontational relationships with healing practices are paramount (Hallowell, Gray & Browne 2010). In the healing encounter, it is believed the patient and spirit are the mechanisms of the healing outcome. The healer is a helper or offers a conduit to this outcome, and the patient and spirit beings are credited for the result rather than the healer (Redvers & Blondin 2020). When one is ill, it is understood that healing is only possible when one is ready for it, and it is one's responsibility to initiate it. Any outside control or intrusion is counter to an Indigenous worldview that places autonomy at the core of one's relationship with others, including First Nations or other governments (Manitowabi 2009).

38. The Truth and Reconciliation Commission of Canada's (2015) Call to Action 22 calls "upon those who can effect change within the Canadian healthcare system to value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients." Furthermore, the following United Nations Declaration on the Rights of Indigenous Peoples (2007) Articles demonstrate the need for Anishinaabe local control of cultural and healing practices:

39. Article. 4. "Indigenous peoples, in exercising their right to self-determination, have the right to autonomy or self-government in matter relating to their internal and local affairs, as well as ways and means for financing their autonomous functions" (p. 8).

40. Article. 24 1. states, "Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals…" (p. 18).

41. Article 31 1, states, "Indigenous peoples have the right to maintain, control, protect, and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including human and genetic resources, seeds, medicines, knowledge of the properties of fauna and flora, oral traditions, literatures, designs, sports and traditional games and visual and performing arts. They also have the right to maintain, control, protect and develop their intellectual property over such cultural heritage, traditional knowledge, and traditional cultural expressions. 2. In conjunction with indigenous peoples, States shall take effective measures to recognize and protect the exercise of these rights." (UNDRIP p. 22-23)

42. On 21 June 2021, the UNDRIP Act received royal assent by the Government of Canada with a commitment to implement the Declaration to address "lasting reconciliation, healing and cooperative relations" (Government of Canada 2021).

43. In line with UNDRIP and the TRC it is appropriate for Indigenous Peoples to access traditional medicines in the manner consistent to traditional healing systems. If for instance, cannabis is used as a medicine, it is customary to access the medicine in-person in the Indigenous community from a trusted provider. Trust and community access ensure that the medicines have been harvested

properly from a community member following protocols, e.g. offering of tobacco to the plant, and harvesting sustainably. Communities are tight-knit, and all members know of one another, and this knowledge informs access since the person providing the medicine can be trusted.

44. Community access differs in how traditional medicine is classified outside communities. Due to the legacy of colonialism already described, community members are not comfortable discussing traditional healing with non-indigenous people due to the history of marginalization and stereotypes (Manitowabi 2013).

45. Attached hereto and marked as Exhibit B are copies of the studies by Maar, 2010, Hill, 2009, Maracle, 2021, and Maar and Manitowabi 2022 that I accept and adopt as accurate statements about Indigenous health matters.

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Sworn remotely via video conference)

by Darrel Manitowabi in the Village of)

Island DM

Birch ~~Park~~, ON and the commissioner)

PL

Paul Lewin in the City of Toronto, ON)

this 14th day of January 2024.)

Darrel Manitowabi

Commissioner for taking affidavits

Paul Lewin

This is Exhibit ....A..... referred to in the
affidavit of ...Darrel Manitowabi.....
sworn before me, this ...14th.....
day of ....January..... 2024....

.....
A COMMISSIONER, ETC

PAUL LEWIN

Island DM

Sworn remotely by Darrel Manitowabi in the Village of Birch ~~Park~~, ON
with commissioner Paul Lewin in the City of Toronto, ON.

DM

CURRICULUM VITAE

DATE: May 15, 2023

1. PERSONAL BACKGROUND

NAME:	Darrel J. B. Manitowabi
DEPARTMENT:	Human Sciences Division, Northern Ontario School of Medicine University, Sudbury Campus
PRINCIPAL SUBJECT TAUGHT:	Indigenous Health & Social Determinants of Health
HOME ADDRESS:	1248 Old Village Road South Box 58 Birch Island, ON POP 1A0

2. ACADEMIC HISTORY

Northern Ontario School of Medicine University, Human Sciences Division

Date of Appointment:	July 1, 2020
Rank when Appointed:	Tenured Associate Professor

Laurentian University, School of Northern and Community Studies, Anthropology Program

Date of Appointment:	July 1, 2014
Rank when Appointed:	Assistant Professor (Tenure-Track)
Date of Tenure:	July 1, 2015

Laurentian University, School of Indigenous Relations

Date of Appointment:	August 1, 2012
Rank when Appointed:	Assistant Professor (Tenure-Track)

University of Sudbury (federated with Laurentian University), Department of Indigenous Studies

Date of Appointment:	July 1, 2004
Date of Tenure:	October 30, 2008

Date of Promotions:	Year

Northern Ontario School of Medicine University

To Cross-Appointment, Human Sciences:	2011
To Interim Director of Indigenous Affairs:	2018
To Assistant Dean of Graduate Studies:	2019
To Associate Professor, Human Sciences:	2020

Laurentian University

To Assistant Professor:	2012
To Director School of Indigenous Relations:	2013
To MIR Program Coordinator:	2013
To Anthropology Program Coordinator:	2014
To Associate Professor:	2015
To Director School of Northern and Community Studies	2016

University of Sudbury

To Lecturer:	2004
To Assistant Professor:	2007
To Chair:	2009

3. ACADEMIC BACKGROUND:

Degree granted	Discipline	Year	Institution
Ph.D.	Anthropology	2007	University of Toronto
M.A.	Anthropology	2001	McMaster University
Hons. B.A.	Anthropology	1999	Laurentian University

Ph. D. Thesis Title: From Fish Weirs to Casino: Negotiating Neoliberalism at Mnjikaning

4. FELLOWSHIPS, AWARDS AND HONOURS:

Greater Sudbury Chamber of Commerce Student Awards Fund Honour, 2012
University of Toronto Fellowship, University of Toronto, 2004
Lorna Marshall Doctoral Fellowship in Social and Cultural Anthropology, 2003
University of Toronto Fellowship, University of Toronto, 2003
Ontario Problem Gambling Research Doctoral Fellowship, 2002
University of Toronto Fellowship, University of Toronto, 2001
Graduate Scholarship, McMaster University, 1999

5. TEACHING EXPERIENCE:

a) University teaching experience:

2020-Present	Northern Ontario School of Medicine U.	Full-time
2014-2020	Laurentian University (Anthropology)	Full-time
2012-2015	Laurentian University (Indigenous Relations)	Full-time
2011-2020	Northern Ontario School of Medicine	Part-time
2006-2007	Laurentian University (Anthropology)	Part-time
2004-2012	University of Sudbury (Indigenous Studies)	Full-time

Courses Taught (2004-Present):

Anthropology:
-ANTR 1007 Introduction to Sociocultural Anthropology (3cr)
-ANTR 2016 Human Biological Variation, Adaptations and Health (3 cr)
-ANTR 2036 Ethnology of North American Native Peoples (3 cr)
-ANTR 2126 Anthropology and the World Today (3 cr)
-ANTR 3086 Medical Anthropology: Medicine, Culture and Society (3 cr)
-ANTR 3087 Ethnomedicine: Cross-Cultural Healing (3 cr)
-ANTR 4006 Food and Disease Prevention (3 cr)
-ANTR 4056 Advanced Topics in Social/Cultural Anthropology: Canadian Anthropology from the Past to Present (3 cr)
-ANTR 4095 Research Essay (6 cr)
-ANTR 4905 Independent Studies: Indigenous Health (6 cr)
-ANTR 4116 Critical Perspectives in Medical Anthropology (3 cr)
-ANTR 4136 Ethnopsychiatry and Cross-Cultural Mental Health (3 cr)

Rural and Northern Health Graduate Program:
-IRNH 6134 Perspectives on Indigenous Health and Wellness (3 cr)

Master of Indigenous Relations Graduate Program:
-MIRE 5006 Indigenous Relations and Worldviews: Theory and Practice (3 cr)
-MIRE 5106 Special Topics in Indigenous Relations: Advanced Research in Indigenous Communities (3 cr)

Human Studies and Interdisciplinarity Graduate Program:
-HUST 6226 Critical Issues in Indigenous Studies

-Indigenous Social Work:
-NWLF 1006 Introduction to Social Welfare
-NWLF 1007 Introduction to Native Social Welfare and Social Work Practice
-NSWK 3305 Native Theories and Perspectives in Social Work Practice I
-NSWK 4517 Management and Administration in Native Social Work

Indigenous Studies:
-NATI 1105 Original People of North America (6 cr)
-NATI 2105 Culture, Behaviour and Identity of the Native Person (6 cr)
-NATI/RLST 2285 North American Native People: Tradition and Culture (6 cr)
-NATI 3256 Aboriginal Health and Wellness (3 cr)
-NATI 3315 Economic Management and Aboriginal Self-Determination (6 cr)
-NATI 4655 Honours Essay (6 cr)
-NATI 4955 Independent Reading and Research (6 cr)

Northern Ontario School of Medicine University:
-NOSM CBM 103 Facilitator
-NOSM CBM 106 Facilitator
-NOSM Indigenous Peoples' Health and Wellness Complementary Studies

b) Research experience

07/2020-05/2023	Manitoulin & Lake Huron Northshore First Nations, Part-time
07/2017-05/2019	Wiikwemkoong, Whitefish River First Nations, Part-time
07/2017-08/2018	Algoma, Sudbury & Manitoulin District First Nations, Part-time
05/2014-10/2015	South-Central Ontario First Nations, Part-time
01/2012-06/2014	Manitoulin & Lake HuronNorth Shore First Nations, Part-time
02/2011-07/2011	Sagamok First Nation, Ontario, Part-time
09/2009-05/2010	Wikwemikong First Nation, Ontario, Part-time
07/2007-09/2010	Manitoulin Island First Nations, Ontario, Part-time
06/2003-06/2004	Rama First Nation, Ontario, Full-time
08/2002-12/2004	Sheguiandah First Nation, Ontario, Full-time
07/1998-08/1998	Attawapiskat First Nation, Ontario, Full-time

6. ADMINISTRATIVE CONTRIBUTIONS:

Centre for Addictions and Mental Health

2020-23	Shkaabe Makwa Leadership Circle

Northern Ontario School of Medicine University

2020-23	Graduate Studies Council
2020-23	Academic Indigenous Health Education Committee
2020-23	Northern Ontario History of Health and Medicine Lecture Series Co-Chair
2019-22	Academic Council
2023	Present Senate

Laurentian University

2015-18	Human Studies PhD Program Committee
2015-17	Academic Planning Committee
2015- 17	Faculty Personnel Committee
2014-19	Anthropology Program Coordinator
2013-14	Master of Indigenous Relations Coordinator
2013-22	Master of Indigenous Relations Program Committee
2013-22	Master of Indigenous Relations Admissions Committee
2013-14	Director, School of Indigenous Relations
2013-2015	Graduate Studies Council
2012-17	Laurentian University Native Education Council Indigenous Languages Sub-Committee Chair (2012-2014), Member (2014-2017)

University of Sudbury

2009-12	Native Studies Chair (Sabbatical leave 2010-11)
2010-11	Sabbatical Leave
2009-12	University of Sudbury Senate
2009-12	Humanities Council, Laurentian University
2006-07	Department of Anthropology Ethics Committee, Laurentian University
2005-2014	Laurentian University Native Education Council, Laurentian University
2005-2015	Northern Ontario Scientific Training Program Grant Committee, Laurentian University
2004-09	Ethics Project, University of Sudbury

7. SCHOLARLY ACTIVITY/ACADEMIC PUBLICATIONS:

a) Academic Books

Belanger, Yale, **Darrel Manitowabi** & Robert W. Williams. N.D. Indigenous Gaming in Canada: Past, Present, and Future. McGill Queen's University Press. (In progress).

Abbott, M; Binde, P; Clark, L; Hodgins, D; Johnson, M.; **Manitowabi, D**; Quilty, L.; Spangberg, J; Volberg, R.; Walker, D.; Williams, R. **2018**. Conceptual Framework of Harmful Gambling: An International Collaboration, Third Edition.Guelph, ON: Gambling Research Exchange Ontario (GREO). https://doi.or/10.33684/CFHG3.en

b) Chapters in Academic Books

Hudson, Geoffrey & **Darrel Manitowabi**. N.D. Accidental History and Manitoulin Island, c. 1830-1960. Chapter under review in Accidental History of Canada edited by Megan Davies & Geoffrey Hudson, McGill-Queen's University Press (in press).

Manitowabi, Darrel and Marion Maar. **2018**. Applying Indigenous Health Community-Based Participatory Research. In, Indigenous Research: Theories, Practices, and Relationships, ed. Deborah McGregor, Rochelle Johnston and JeanPaul Restoule, pp. 238-260. Toronto: Canadian Scholars Press.

Manitowabi, Darrel. **2017**. Masking Anishinaabe Bimaadiziwin: Uncovering Cultural Representations at Casino Rama. In, Gambling on Authenticity: Gaming, the Noble Savage, and the Not-So-New Indian, ed. Becca Gercken and Julie Pelletier, pp. 135-158. East Lansing, MI: Michigan State University Press.

Manitowabi, Darrel and Marion Maar. **2013**. Coping with Colonization: Aboriginal Diabetes on Manitoulin Island. In, Indigenous Bodies: Reviewing, Relocating, Reclaiming, ed. Jacqueline Fear-Segal and Rebecca Tillett, pp. 161175. Albany, NY: State University of New York Press.

Manitowabi, Darrel and Alan Corbiere. **2011**. Anishinabek and Mushkegowuk: The Indigenous Peoples of Northeastern Ontario. In Come on Over! Northeastern Ontario A to Z, ed. Dieter Buse and Graeme Mount, pp. 16-19. Sudbury, ON: Your Scrivener Press.

Manitowabi, Darrel. **2011**. Casino Rama: First Nations Self-Determination,

Neoliberal Solution or Partial Middle Ground? In First Nations Gaming in Canada: Perspectives, ed. Yale Belanger, pp. 294-318. Winnipeg, ON: University of Manitoba Press.

Manitowabi, Darrel. 2011. Neoliberalism and the Urban Aboriginal Experience: A Casino Rama Case Study. In Aboriginal Peoples in Canadian Cities: Transformations and Continuities, ed. Heather Howard and Craig Proulx, pp. 109122. Waterloo, ON: Wilfred University Press.

c) Published Journal Articles

Wabie, Joey-Lynn, Jennifer Walker, H. Neil Monague, Mary Elliot, Paulette Stevens, Elizabeth Carlson, **Darrel Manitowabi** & Robin Rowe. N.D. Niigaaniiwin: Vision and Spirit of our Journey. Turtle Island Journal of Indigenous Health (Accepted, In press).

Manitowabi, Darrel. 2023. The Healing Path: reconciling the attempt to eliminate Indigenous healing in Canada. CMAJ 2023 27 March; 195:E455-6. DOI: 10.1503/cmaj.221002.

Maar, Marion, Tim Ominika and **Darrel Manitowabi**. **2022**. Community-led Recovery from the Opioid Crisis through Culturally-based Programs and Community-based Data Governance. International Indigenous Policy Journal 13(2): 1-28. DOI:10.18584/iipj.2022.13.2.13792.

Lightfoot, Nancy, **Darrel Manitowabi**, Victoria Arrandale, Nathaniel Barnett, Carmen Nootchtai, Mary Lyn Odjig, Jeff Moulton, Julie Fongemy, Michel Lariviere, Zusanna Kerekes, Linn Holness, Leigh MacEwan, Tammy Eger & Wayne Warry. N.D. Workers' Compensation Experience in Some Indigenous Northern Ontario Communities. Work: A Journal of Prevention, Assessment & Rehabilitation. Work. **2022**;73(2):707-717. doi: 10.3233/WOR-210895. PMID: 35938275.

Manitowabi, Darrel. **2022**. Weweni Ezhichegewin: Wise Practices in Urban Indigenous Education in Northern Ontario. AlterNative: International Journal of Indigenous Peoples 18(1): 114-121. doi:10.1177/11771801221088863

Manitowabi, D. and Fiona Nicoll. **2021**. Editorial: The Problem with Representation in Indigenous Gambling. Critical Gambling Studies 2(2), i-iii. https://doi.org/10.29173/cgs123

Manitowabi, Darrel. **2021**. Gambling with the Windigo: Theorizing Indigenous Casinos and Gambling in Canada. Critical Gambling Studies 2(2), 113-122. https://doi.org/10.29173/cgs82

Manitowabi, Darrel and Sheila Wahsquonaikezhik. **2021**. "This is not about gambling, it's about our lives": An Interview with Sheila Wahsquonaikezhik. Critical Gambling Studies 2(2), 159-165. https://doi.org/10.29173/cgs84

Cornect-Benoit, A, Pitawanakwat, K. Wiikwemkoong Unceded Territory Collaborating First Nation Community, Walker, J., **Manitowabi, D**. & Jacklin, K. **2020**. Nurturing Meaningful Intergenerational Social Engagements to Support Healthy Brain Aging for Anishinaabe Older Adults: Nakaazang Wenjishing naagdawendiwin nji gechipiitzijig Anishnaabek. 2020. Canadian Journal on Aging 39(2): 263-283. DOI : 10.1017/S0714980819000527.

Hilbrecht, M, Baxter, D, Abbott, M, Binde, P, Clark, L, Hodgins, **D, Manitowabi**, D, Quilty, L, Spangberg, Volberg, R, Walker D, & Williams, R. **2020**. The Conceptual Framework of Harmful Gambling: A revised framework for understanding gambling harm. Journal of Behavioral Addictions. Journal of Behavioral Addictions Advance online publication. doi:10.1556/2006.2020.00024

Bennett, Beaudin; Maar, Marion; **Manitowabi D**; Moeke-Pickering, Taima; Trudeau-Peltier, Doreen; and Trudeau Sheila. **2019**. The Gaataa'aabing Visual Research Method : A Culturally Safe Anishinaabek Adaptation of Photovoice. International Journal of Qualitative Methods 18:1-12.

Manitowabi, Darrel and Marion Maar. **2018**. "We stopped sharing when we became civilized": A Model of Colonialism as a Determinant of Indigenous Health in Canada. Journal of Indigenous Social Development 7(1): 1-19. http://umanitoba.ca/faculties/social_work/media/V7i1-01_manitowabi__maar.pdf

Manitowabi, Darrel and Kathryn T. Molohon. **2013**. In Memoriam: Dr. Krystyna Z. Sieciechowicz. Anthropologica Fall 55: 471-473.

Manitowabi, Darrel and Marjory Shawande. **2013**. Negotiating the Clinical Integration of Traditional Aboriginal Medicine. Canadian Journal of Native Studies 33(1): 97-124.

Manitowabi, Darrel and Marjory Shawande. **2012**. The Meaning of Anishinabe Healing and Wellbeing on Manitoulin Island. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 9(2): 441-458.

http://www.pimatisiwin.com/uploads/jan_20112/10ManitowabiShawande.pdf

Maar, Marion, **Darrel Manitowabi**, Danusia Gzik, Lorrilee McGregor and Cherie Corbiere. **2011**. Serious Complications for Patients, Care Providers, and Policy Makers: Tackling the Structural Violence of First Nations People Living with Diabetes in Canada. The International Indigenous Policy Journal 2(1), http://ir.lib.uwo.ca/iipj (ejournal).

d) Published Conference Proceedings:

Manitowabi, Darrel and Marion Maar. **2013**. The Impact of Socioeconomic Interventions on Anishinaabe Health and Wellbeing. In, Anishinaabewin Niiwin: Four Rising Winds, ed. Alan Corbiere, Mary Ann Naokwegijig-Corbiere, Deborah McGregor and Crystal Migwans, pp. 115-130. M'Chigeeng, ON: Ojibwe Cultural Foundation.

Manitowabi, Darrel. **2012**. The Meaning of Bear-Walking. In, Anishinaabewin Niizh: Culture Movements, Critical Moments, ed. Alan Corbiere, Deborah McGregor and Crystal Migwans, pp. 49-65. M'Chigeeng, ON: Ojibwe Cultural Foundation.

Manitowabi, Darrel. **2010**. Barriers to an Indigenous Participation in Archaeology. In, Freedom and Expression: Culture and Religion, ed. Melchior Mbonimpa and Gerry Copeman, pp. 31-42. Sudbury, ON: University of Sudbury Press.

Manitowabi, Darrel. **2008**. Sinmedwe'ek: The other-than-human grandfathers of North-Central Ontario. In, Papers of the Thirty-Ninth Algonquian Conference, ed. Karl S. Hele and Regna Darnell, pp. 444-458. London, ON: University of Western Ontario.

e) Book Reviews:

Manitowabi, Darrel. **2014**. Review of Living with Animals: Ojibwe Spirit Powers (Michael Pomedli, 2014). Canadian Journal of Native Studies 34(2): 260261.

Manitowabi, Darrel. **2010**. Review of The Archaeology of Native-Lived Colonialism: Challenging History in the Great Lakes (Neal Ferris, 2009). Ontario Archaeology 89 (90): 130-133.

f) Referred Reports:

Manitowabi, Darrel. **2015**. An Anishinaabeg Oral Narrative of the Williams Treaties Based on 174 Interviews with Members of the Williams Treaties First

Nations Collected by the Late Dr. Krystyna Sieciechowicz in the Years 20012002, And Related Materials. Report Submitted to Hutchins Legal, Inc. Montreal, Quebec.

g) Non-Referred Reports:

First Nations Information Governance Centre, First Nations Perspectives on Poverty: "It's not in our culture to be poor", (Ottawa: **2021**). 42 Pages. Published in May 2021. Ottawa, Ontario. URL: https://fnigc.ca/wpcontent/uploads/2021/05/FNIGC-Research-Series-Perspectives-onPoverty_21.04.28.pdf Researcher & writer: **D. Manitowabi**.

Finnie, Ross, **Darrel Manitowabi**, Ashley Pullman, Michael Dubois and Andrew Niles. **2019**. Wise Practices: A Qualitative and Quantitative Analysis of the Experiences of Indigenous Youth in Sudbury High Schools. Report for the City of Greater Sudbury, Rainbow District School Board, Sudbury District Catholic School Board and Indigenous Services Canada.

Manitowabi, Darrel and Marion Maar. **2014**. The Impact of Socioeconomic Interventions on Mnnamodzawin: Improving Chronic Disease Care Through Community-Based Participatory Research in Ontario First Nations Communities. Report for Atikameksheng Anishnawbek.

Manitowabi, Darrel and Marion Maar. **2014**. The Impact of Socioeconomic Interventions on Mnnamodzawin: Improving Chronic Disease Care Through Community-Based Participatory Research in Ontario First Nations Communities. Report for M'Chigeeng First Nation.

Manitowabi, Darrel and Marion Maar. **2014**. The Impact of Socioeconomic Interventions on Mnnamodzawin: Improving Chronic Disease Care Through Community-Based Participatory Research in Ontario First Nations Communities. Report for Sagamok Anishnawbek.

Manitowabi, Darrel and Marion Maar. **2014**. The Impact of Socioeconomic Interventions on Mnnamodzawin: Improving Chronic Disease Care Through Community-Based Participatory Research in Ontario First Nations Communities. Report for Whitefish River First Nation.

Manitowabi, Darrel and Marion Maar. **2014**. The Impact of Socioeconomic Interventions on Mnnamodzawin : Improving Chronic Disease Care Through Community-Based Participatory Research in Ontario First Nations Communities. Report for Wikwemikong Unceded Indian Reserve.

Dantouze, Tara, Brenda Pangowish, **Darrel Manitowabi** and Kevin Fitzmaurice. **2014**. A Discussion Paper on Integrating Anishinaabemowin in Laurentian University's Tricultural Mandate. Report for Laurentian University Native Education Council.

Manitowabi, Darrel. **2009**. Assessing the Institutionalization of Traditional Aboriginal Medicine. Report for Noojmowin Teg Health Centre and the Indigenous Health Research Development Program.

Manitowabi, Darrel. **2007**. An Annotated Bibliography of Recent Research on Canadian Aboriginal Type 2 Diabetes. Report for Northern Ontario School of Medicine, Human Sciences Division.

Manitowabi, Darrel. **1999**. The N'Swakamok Native Friendship Centre: An Urban Aboriginal Learning Environment. Report for New Approaches to Life Long Learning Project, University of Toronto and Kenjgewin Teg Educational Institute and N'Swakamok Native Friendship Native Friendship Centre.

h) Referred Papers read at academic/professional conferences, societies:

Manitowabi, Darrel. **2023**. The Social Practice of Indigenous Gambling in Ontario in the Past and Present. Alberta Gambling Research Institute 22nd Annual Conference: Contemporary Issues in Gambling Research. Banff Centre, Banff, Alberta. 31 March 2023.

Manitowabi, Darrel. 2023. Seers of Life Spirits: Theorizing Indigenous and Allied Educator Competency. Hawaii International Conference on Education. Hilton, Honolulu, Hawaii. 5 January 2023.

Manitowabi, Darrel, Matthew Bombardier, Meschaquin Neekan, Jessica Meekis, and Cait Salmon. **2022**. The Gamification of Indigenous Digital Futures: A Youth Perspective. Indigenous Education Sovereignty: Our Voices...Our Future. World Indigenous Peoples' Conference on Education. Panel presentation. Adelaide Conference Centre, Adelaide, South Australia. September 29, 2022.

Hudson, Geoffrey and **Darrel Manitowabi**. **2022**. Accidental History and Manitoulin Island, circa 1830-1960: Indigenous and Settler Experience. MOMS Conference, University of Saskatchewan, Saskatoon. October 22, 2022.

Belanger, Yale and **Darrel Manitowabi**. **2022**. Casinos in the Wild: Settler Colonialism, Provincial Hegemony, and the Indigenous Challenge of Pursuing Economic Sovereignty. Alberta Gambling Research Institute 22nd Annual Conference: Back to the Future of Gambling Research. Banff Centre, Banff, Alberta. June 24, 2022.

Manitowabi, Darrel. **2022**. Mino-Bimaadiziwin: Indigenous Preventive Medicine and Public Health. Turtle Island Indigenous Science Research Conference. University of Manitoba, Winnipeg, Manitoba. June 14, 2022.

Manitowabi, Darrel. **2021**. Confronting the Windigo in Indigenous Casinos: Theory & Practice. Paper presented at the Alberta Gambling Research Institute Conference (virtual conference) University of Calgary, Calgary, Alberta, 29 April 2021.

Manitowabi, Darrel. **2021**. Mino-Bimaadiziwin: The Historical & Cultural Roots of Indigenous Health. Paper Presented at the Canadian Association for Health Humanities Creating Space 11 (virtual conference). St. John's, Newfoundland, 16 April 2021.

Manitowabi, Darrel. **2020**. Mino-Bimaadizwin: A Theory of Indigenous Health. Paper presented at the Northern Health Research Conference (virtual conference). 2 October, 2020.

Manitowabi, Darrel. **2020.** Wise Practices in Indigenous Secondary Student Success. Paper Presentation at 18th Annual Hawaii International Conference on Education 3-7 January 2020, Hilton Hawaiian Village, Honolulu, Hawaii (5 January 2020).

Maar, Marion, Ominika, Tim, & **Darrel Manitowabi**. **2019**. First Nations culture and community as foundation for OAT: The Naandwe Miikaan approach to opioid disorder treatment. Paper presented at the Northern Health Research Conference, Manitoulin Conference Centre, Little Current, Ontario 20-21 September 2019 (20 September 2019).

Manitowabi, Darrel, Maar, Marion & Trudeau, Randy. **2019**. "There's nothing traditional about government": The Emergence of Two-Tiered Traditional Healing in Addiction Treatment. Paper presented at the Northern Health Research Conference, Manitoulin Conference Centre, Little Current, Ontario 20-21 September 2019 (20 September 2019).

Lightfoot, Nancy, Barnett, Nathaniel, & **Darrel Manitowabi**. **2019**. Mino-Nokiiwin : Indigenous Occupational Health, Safety, and Compensation

Experience in Some Northeastern Ontario Communities. Paper presented at the Northern Health Research Conference, Manitoulin Conference Centre, Little Current, Ontario 20-21 September 2019 (21 September 2019).

Manitowabi, Darrel. **2019**. Indigenous Casinos are a Medicine for Colonialism. Paper Presentation at the Philosophy of Gambling Conference, University of Macau, Macau, China 18-19, 2019 (18 October 2019).

Manitowabi, Darrel. **2019**. Weweni Ezhichegewin: Good (or Wise) Pathways in Collaborative Indigenous Education Research. Paper presentation at Hawaii International Conference on Education. Honolulu, Hawaii: Hilton Hawaiin Village (6 January 2019).

Manitowabi, Darrel; and Naponse, Vivian. **2018**. Moving Beyond Research : Collaborating in Indigenous Capacity Building in Culture, Education and Training. Paper Presentation at Maamwizing Research Conference. Sudbury, ON : Laurentian University (16 November 2018).

Manitowabi, Darrel. **2018**. A Pathway to an Education of Indigenous Healing in Medical School Curriculum: A Northern Ontario Case Study. Paper Presentation at The Global Community Engaged Medical Education MUSTER Conference. Mount Gambier, SA : Australia, Main Corner Complex (15 October 2018).

Manitowabi, Darrel. **2018**. Wise Practices in Collaborative Indigenous Education Research. Invited Paper Presentation at Symposium of Sustainable Development Goals. Taitung City, Taiwan : Formosan Naruwan Hotel (6 October, 2018).

Manitowabi, Darrel; Ominika, Tim; and Maar, Marion. **2018**. Naandwe Miikan : Indigenous Community Participation in Addressing Opioid Addictions and Recovery. Paper Presented at the Indigenous Health Conference. Mississauga, ON : Hilton Meadowvale (25 May 2018).

Maar, Marion, Ominika, Tim and **Darrel Manitowabi**. **2018**. Naandwe Miikan (Healing Path) : Patient and Provider Experiences with a First Nations Operated Methadone Clinic. Paper Presented at the Indigenous Health Conference. Mississauga, ON : Hilton Meadowvale (25 May 2018).

Frid, Breanne; Maar, Marion; Ominika, Tim; **Manitowabi, Darrel**; and Sutherland, Mariette. **2018**. First Nation Community Service Provider Collaborations as a

Response to the Opioid Crisis: Naandwe Miikan. Poster Presentation at the Indigenous Health Conference. Mississauga, ON: Hilton Meadowvale (25 May 2018).

Ominika, Tim; Maar Marion; and **Manitowabi, Darrel. 2018**. An Anishinabe Approach to Recovery from the Opioid Crisis. Paper Presented at the Indigenous Health Conference. Mississauga, ON : Hilton Meadowvale (24 May 2018).

Manitowabi, Darrel, Marion Maar and Tim Ominika. **2018**. Naandwe Miikan (The Curing Path): An Indigenous Holistic Model Addressing Opioid Addictions and Recovery. Society for Applied Anthropology 78th Annual Meeting. Philadelphia, PA : Loews Philadelphia Hotel. (4 April 2018).

Manitowabi, Darrel. **2018**. Integrating Culture-Based Education for Indigenous Elementary School Students: An Anishinaabe First Nation Case Study. 16th Hawaiian Conference on Education, Honolulu, Hawaii : Hilton. (6 January 2018).

Manitowabi, Darrel. **2017**. The Commensurability of Indian and Casino. 8th International Conference on the Image. Venice, Italy: Venice International University. (1 Nov. 2017).

Manitowabi, Darrel. **2016**. Colonialism as a Determinant in Indigenous Casino Gambling Research. Paper Presentation. National Association of Gambling Studies, 26th Annual Conference : Many Pathways : The Diversity of Gamblers and Gambling Behaviour. Cairns, Australia: Hilton. (24 November 2016).

Manitowabi, Darrel. **2016**. Indigenous Anthropology: Centring Anishinaabe Kendaaswin in the Social Sciences. Paper Presentation. Maamwizing : Indigeneity in the Academy Conference. Laurentian University. (19 November 2016).

Manitowabi, Darrel. **2016**. The Ethical Space of Indigenous Casino Research: A Step into the Future. Society for Applied Anthropology Conference. Vancouver, British Columbia: Weston Bayshore (31 March 2016).

Walsh, Andrea and **Darrel Manitowabi**. **2016**. The Making of Reconciliation: Two Stories. Society for Applied Anthropology Conference. Vancouver, British Columbia: Weston Bayshore (29 March 2016).

Manitowabi, Darrel. **2016**. The Meaning of Indigenous Casinos: An Anishinaabe Perspective (Keynote Address). International Gambling Conference. Auckland, New Zealand: Auckland University of Technology (10 February 2016).

Manitowabi, Darrel. **2015**. Integrating Indigenous Knowledge in Traditional Medicine Program Policy. Fifth International Conference on Health, Wellness & Society. Madrid, Spain: Universidad de Alcala (4 September 2015).

Manitowabi, Darrel, Andrea Walsh and Mary Pheasant. **2015**. Decolonizing the Archive: Revisiting the 1960s Anishinaabek First Nations Children's Art Camps. Second International Individual Self-Esteem and Transition to Adolescence with Respect Conference. Sudbury, Ontario: Laurentian University (19 June 2015).

Manitowabi, Darrel, Andrea Walsh and Mary Pheasant. **2014**. Anishinaabe Binoojiinyag Gaa Mmiznibiimawaat: The Anishinaabek First Nations Children's Art Camps (circa 1967). Great Lakes Research Alliance for the Study of Aboriginal Arts and Cultures Second GRASAC Research Conference. Brantford Ontario: Woodland Cultural Centre (14 June 2014).

Manitowabi, Darrel. **2014**. Anishinaabe Language and Cultural Revitalization: An Indigenous Framework. World Indigenous Peoples Conference on Education. Honolulu, Hawaii: Kapi'olani Community College (22 May 2014).

Manitowabi, Darrel. **2013**. Casino Culture vs. Anishinaabe Bimaadiziwin: Uncovering Noble Chippewa Imagery at Casino Rama. Native American and Indigenous Studies Association Conference. Saskatoon, SK: University of Saskatchewan (15 June 2013).

Manitowabi, Darrel. **2013.** Reflections on Being and Becoming an Indigenous Anthropologist. In, Contesting the Production of Indigeneity: A Roundtable in Memory of Dr. Krystyna Sieciechowicz (Referred roundtable, organized and chaired by Darrel Manitowabi). The Canadian Anthropology Society Conference. Victoria, British Columbia: University of Victoria (10 May 2013).

Manitowabi, Darrel. **2013.** From Degradation to Acceptance: The Implications of Institutionalized Traditional Aboriginal Medicine. Third International Conference on Health, Wellness & Society. Sao Paulo, Brazil: Universidade Federal De Sao Paulo (16 March 2013).

Manitowabi, Darrel and Marjory Shawande. **2012**. Integrating Traditional Aboriginal Medicine: A Two-Tiered Bi-Cultural Approach. Native American Indigenous Studies Association. Uncasville, Connecticut: Mohegan Sun Casino and Conference Centre (6 June 2012)

Manitowabi, Darrel. **2011**. Bear-walking as a Narrative of Colonialism. The 43rd Algonquian Conference. Ann Arbor, Michigan: University of Michigan (22 October 2011).

Manitowabi, Darrel. **2011**. Masking Bimaadiziwin: Anishinabe Casino Imagery and Cultural Renewal. Native Studies Research Network, Fourth International Conference. Canterbery, Kent, UK: University of Kent (6 July 2011).

Manitowabi, Darrel and Marion Maar. **2011**. Wini Ezhichiget (Doing it Right): Anishinaabe Perspectives on Ethical Diabetes Research. The 23rd Annual Native Health Research Conference. Niagara Falls, New York: Niagara Conference Center (28 June 2011).

Julig, Patrick and **Darrel Manitowabi**. **2011**. Walking the Tightrope of Preserving and Interpreting the Sheguiandah Archaeological Site. Great Lakes Research Alliance for the Study of Aboriginal Arts and Cultures Conference. M'Chigeeng, Ontario: Ojibwe Cultural Foundation (11 June 2011).

Manitowabi, Darrel. **2010**. From Devil to Healer: The Bear-Walker as a Symbol of Anishinabe Decolonization. American Society for Ethnohistory Conference. Ottawa, Ontario: Lord Elgin Hotel (16 October 2010).

Manitowabi, Darrel and Marjory Shawande. **2010**. Anishinabe Ethics and Traditional Medicine Research: A Noojmowin Teg Case Study. First Annual Decolonizing Indigenous Health Conference. Niagara Falls, Ontario: Crowne Plaza Fallsview (7 September 2010).

Manitowabi, Darrel and Marion Maar. **2010**. The Conflict of Material and Non- Material Indigenous Knowledge in the Context of Diabetes Research. Third National University of Sudbury Ethics Centre Symposium. Sudbury, Ontario: University of Sudbury (26 February 2010

Manitowabi, Darrel and Marion Maar. **2009**. Aboriginal Diabetes and Spiritual, Emotional and Social Wellness: Insights from Manitoulin Island. Native Studies Research Network Second International Conference. Norwich, UK: University of East Anglia (10 July 2009).

Manitowabi, Darrel. **2009**. Casino Culture vs. Anishinaabe Bimaadiziwin. Native American and Indigenous Studies Association Conference. Minneapolis-St.Paul, Minnesota: University of Minnesota-Twin Cities (23 May 2009).

Manitowabi, Darrel and Marjory Shawande. **2009**. The Light in the Shadow of Darkness: Institutionalized Anishinaabe Medicine. Canadian Anthropology Society Conference. Vancouver, British Columbia: University of British Columbia (15 May 2009).

Manitowabi, Darrel and Marion Maar. **2009.** The Complexity of Anishinaabe Traditional Knowledge and Diabetes Research. Canadian Anthropology Society Conference. Vancouver, British Columbia: University of British Columbia (13 May 2009).

Manitowabi, Darrel and Marjory Shawande. **2009**. Nurturing Indigenous Knowledge: Noojmowin Teg's Traditional Medicine Program. Indigenous Earth Issues Summit. Marquette, Michigan: Northern Michigan University (6 April 2009).

Manitowabi, Darrel. **2008**. Ontario's Aboriginal Casino: Neoliberal Solution or Aboriginal Empowerment? American Anthropological Association 107th Annual Meeting. San Francisco, California: Hilton (22 November 2008).

Manitowabi, Darrel and Marjory Shawande. **2008.** Anishinaabe Perspectives on the Biomedical Integration of Traditional Medicine. The 40th Algonquian Conference. Minneapolis-St. Paul, Minnesota: Radisson University Hotel (24 October 2008).

Manitowabi, Darrel. **2007.** Barriers to an Indigenous Participation in Archaeology. University of Sudbury Ethics Colloquium. Sudbury, Ontario: University of Sudbury (9 November 2007).

Manitowabi, Darrel. **2007**. Sinmedwe'ek: Other-Than-Human Grandfathers of North-Central Ontario. The 39th Algonquian Conference. Toronto, Ontario: York University (19 October 2007).

Manitowabi, Darrel. 2007. From Political to Local: The Economic Impact of Casino Rama. Canadian Anthropology Society Conference. Toronto, Ontario: University of Toronto (10 May 2007).

Manitowabi, Darrel. 2006. Bimaadiziwin in Practice: A Mnjikaning Case Study. The 38th Algonquian Conference. Vancouver, British Columbia: University of British Columbia (28 October 2006).

Manitowabi, Darrel. 2006. Moving to the City to Work on the "Reserve": The Experiences of Casino Rama's Native Migrants. Canadian Anthropology Society Conference. Montreal, Quebec: Concordia University (16 May 2006).

Manitowabi, Darrel. 2005. From Coldwater and the Narrows Reserve to Casino Rama: Negotiating Re-Colonization at Mnjikaning. The 37th Algonquian Conference. Hull, Quebec: Museum of Civilization (October 2005).

Manitowabi, Darrel. 2005. Ojibwa Anishinaabe Bimaadiziwn, "Real Ojibwa Culture"? Canadian Anthropology Society Conference. Merida, Mexico: Universidad Autonoma de Yucatan (May 2005).

Manitowabi, Darrel. 2003. "Shogusbidun" The Sugar Disease (film). Canadian Anthropology Society Conference. Halifax, Nova Scotia: Dalhousie University (May 2005).

Manitowabi, Darrel. 2002. Sustainable Tourism Development on a Canadian First Nation. Canadian Anthropology Society Conference, Windsor, Ontario: University of Windsor (May 2002).

h) Non-Referred/Invited Workshops, Presentations and Lectures:

Manitowabi, Darrel. 2022. Wisdom Keepers of Healing. Presentation at Second Gathering Date: October 24, 2022, Casino Rama Hotel and Conference Centre, Rama, Ontario.

Manitowabi, Darrel. 2022. Mino-Bimaadiziwin: Indigenous Preventive Medicine and Public Health. Turtle Island Indigenous Science Research Conference. University of Manitoba, Winnipeg, Manitoba. June 14, 2022.

Manitowabi, Darrel. 2022. Wisdom Keepers of Healing. Presentation at First Gathering Date: May 28, 2022, Manitoulin Hotel and Conference Centre, Little Current, Ontario.

McGregor, L, **D. Manitowabi** & M. Maar. **2022**. The Indigenous Peoples' Health and Wellness Collaborative Specialization Hallway Conversation. Northern Constellations 2022 Annual Faculty Development Conference. 7 May 2022.

Manitowabi, Darrel. 2021. Foundations of Indigenous Health: A Framework for Reconciliation. Georgian College. Invited Lecture via Zoom (2 February 2021).

Manitowabi, Darrel. 2020. Behind the Paradise of Cottage Country: Treaties, Indigenous Wellness and Applying Anthropology. Public Anthropology Forum York University Invited Lecture via Zoom (13 November 2020).

Manitowabi, Darrel. 2020. The Problem with Placebo and Nocebo in Traditional Medicine. Indigenous Education Week Laurentian University Invited Lecture via Zoom (12 November 2020).

Manitowabi, Darrel. 2019. Nishnaabe Bi Maadan Miikana Circa 1850. Invited Presentation at Robinson Huron Treaty Gathering: Honouring & Remembering our 1850 Treaty. Nimkii Beneshii Kaaning, Kaboni Road, Wiikwemkoon Unceded Territory September 13-15, 2019 (13 September 2019).

Manitowabi, Darrel. 2019. Navigating the Whiteman's Casino Indian: Tracing Indigenous Agency in Casino Formation. Invited Presentation at Alberta Gambling Research Institute Research Day. Edmonton, AB: University of Alberta (2 April 2019).

Manitowabi, Darrel. 2019. Wise Practices: Reorienting Education and Training Systems to Improve the Lives of Indigenous Youth. Paper Presentation at Indigenous Education for Sustainable Development Symposium. Sudbury, ON: Laurentian University (22 March 2019).

Manitowabi, Darrel. 2019. The Thunderbird and Great Lynx: Anishinabe Gambling and Wellbeing in the Past and Present. Keynote Address at 4th Anishinabek Nation Health Conference. Sault Ste. Marie, ON: Quattro Hotel (22 January 2019).

Manitowabi, Darrel. 2018. Indigenous Capacity Building in Sustainable

Development: A Northeastern Ontario Case Study. India-Canada Research Summit. Pollachi, Tamil Nadu, India: Dr. Mallingham College of Engineering and Technology (26 April 2018)

Wahsquonaikezhik, Sheila, **Darrel Manitowabi** and Fiona Nicoll. **2018**. Panel Discussion on Indigenous Gambling Policy. Alberta Gambling Research Institute's 17th Annual Conference: Current Issues in Gambling Resarch : The Banff Centre, Banff, AB (13 April 2018).

Manitowabi, Darrel, Patricia Cook, Sheila Wahsquonaikezhik and Angela Voght. **2018**. The Impact of Gambling on Indigenous Communities. Discovery 2018: Responsible Gambling Council: Putting Knowledge to Work. Toronto, ON: Marriott Downtown Eaton Centre (11 April 2018).

Manitowabi, Darrel. **2016**. Celebrating Diversity, Acknowledging Diversity: Indigenous and Western Approaches to Gambling Research. International Gambling Conference. Auckland, New Zealand: Auckland University of Technology (9 February 2016).

Manitowabi, Darrel. **2015**. Indigenous Issues Related to Casinos and Gambling. International Think Tank on Gambling Research, Policy and Prevention. Gambling Research Exchange Ontario. Toronto, Ontario: Delta Hotel (20 April 2015).

Manitowabi, Darrel, Pierrot Ross-Tremblay, Deb McGregor and Mary Ann Naokwegijig-Corbiere. **2015**. Linking the Academy with the Community. Anishinaaabewin 6 Conference. Sudbury, Ontario: Holiday Inn (14 March 2015).

Manitowabi, Darrel. **2015**. Redefining Aboriginal Student Success Workshop. North Bay, Ontario: Nipissing University (5 March 2015).

Manitowabi, Darrel. **2015**. Anishinabe Perspectives on Culture and Values in Exploration. Creating Shared Value : Progress on Partnerships in Mineral Development Symposium. Ontario Ministry of Northern Development and Mines. Prospectors and Developers Association of Canada Convention. Toronto, Ontario: Metro Toronto Convention Centre (4 March 2015).

Manitowabi, Darrel. **2014.** Mineral Resource Extraction and Development from the Aboriginal Community Perspective. Aboriginal Awareness Workshops. Ministry of

Northern Development and Mines. Sudbury, Ontario: Willet Green Auditorium (5 November 2014 and 16 December 2014).

Manitowabi, Darrel. **2014**. Wenesh na edming 'culture'?. Wikwemikong Board of Education Conference 2014 : First Nation Student Success. Wikwemikong, Ontario: Wikwemikong High School (10 October 2014).

Manitowabi, Darrel. **2014**. My Academic Journey. 2Nd Annual Growing Together Youth Gathering. Kapuskasing, Ontario: Centre de Loisirs (25 September 2014).

Manitowabi, Darrel. **2014**. On Being Aboriginal: Culture, Communication and Indigeneity in Northern Ontario. Summer Student Aboriginal Awareness Day. Ministry of Northern Development and Mines. Sudbury, Ontario: Willet Green Auditorium (7 August 2014).

Manitowabi, Darrel, Andrea Walsh and Mary Pheasant. **2014**. Anishinabewin Naanan: Vistas of Knowledge, Voices of Change Conference, Sudbury, Ontario: Odawagaming Binoojiinyag Gaa Mmniznibiimawaat: The Lake Huron Anishinaabek First Nations Children's Art Camps (circa 1967). Sudbury, Ontario: Holiday Inn (28 February 2014).

Manitowabi, Darrel, Susan Manitowabi, Cheryle Partridge, Lissa Lavallee and Shelly Moore Frappier**. 2014**. "25 years of Indigenous Social Work Education." Anishinabewin Naanan: Vistas of Knowledge, Voices of Change Conference. Sudbury, Ontario: Holiday Inn (28 February 2014).

Manitowabi, Darrel. **2013**. Coldwater-Narrows Experiment and First Nations Casino: Uncovering Indigenous and State Narratives of Wellbeing. Aboriginal Speakers Series. Orillia, Ontario: Lakehead University (7 November 2013).

Manitowabi, Darrel. **2013**. Mineral Resource Extraction and Development from the Aboriginal Community Perspective. Ontario Ministry of Northern Development and Mines, Mineral Development and Lands Branch Meeting. Sudbury, Ontario: Helenic Centre (9 October 2013).

Manitowabi, Darrel. **2013**. Being a Good Guest...Working in the Traditional Territory of First Nations Communities. Communications and Engagement

Workshop. NSERC Canadian Network for Aquatic Ecosystem Services First Annual Meeting. Sudbury, Ontario: Laurentian University (30 April 2013).

Manitowabi, Darrel. 2013. "We stopped sharing when we became civilized": The impact of socioeconomic interventions on Anishinaabek Wellbeing.
Anishinabewin Niiwin: Four Rising Winds Conference. Sudbury, Ontario: Holiday Inn (9 March 2013).

Manitowabi, Darrel. 2012. Indigeneity and Education. Faculty Forum on Diversity and Retention. Sudbury, Ontario: Laurentian University (7 December 2012).

Manitowabi, Darrel. 2012. My Academic Journey Part Two. SAGE Supporting Aboriginal Graduate Enhancement. Sudbury, Ontario: Laurentian University (23 November 2012).

Manitowabi, Darrel. 2012. Native Spirituality. Henvey Inlet First Nation Career Fair. Pickerel, Ontario: Community Centre (22 August 2012).

Manitowabi, Darrel. 2012. Whitefish River First Nation: The Changing Anishinabe Family. Birch Island, Ontario: Health Centre (28 June 2012).

Manitowabi, Darrel. 2012. Whitefish River First Nation: Decolonizing Anishinabe Identity. Birch Island, Ontario: Health Centre (25 May 2012).

Manitowabi, Darrel. 2012. Who Owns the Research? What Must be Done with the Research? Alberta Gaming Research Initiative. Banff, Alberta: Banff Centre (12 April 2012).

Manitowabi, Darrel. 2012. My Academic Journey. SAGE Supporting Aboriginal Graduate Enhancement. Sudbury, Ontario: Laurentian University (28 March 2012).

Manitowabi, Darrel. 2011. Manitoulin Island and Northshore Aboriginal Health Working Group: A Social History of Manitoulin Island A(/)nishinabek: A Narrative Account. Sudbury, Ontario: Northern Ontario School of Medicine (21 July 2011).

Manitowabi, Darrel. **2011**. School of Rural and Northern Health PhD Program Guest Lecture: The Ethical Space of Aboriginal Health Research. Sudbury, Ontario: Laurentian University (29 March 2011).

Manitowabi, Darrel. **2011**. Bad Medicine and the Colonial Encounter: An Examination of the Origin of Bear-Walking. Anishinabewin Niizh: Culture Movements, Critical Movements Conference. Sudbury, Ontario: Radisson Hotel (25 February 2011).

Manitowabi, Darrel. **2010**. From Underwater Spirit to Powwow: An Illustrative History of Wikwemikong. Misery Park Reserve Speaker Series. Manitoulin Island, Ontario: Misery Park Centre (3 August 2010).

Manitowabi, Darrel. 2010. (A)nish(i)naabe Wellbeing Through Time: Insights from Nishnaabe Oral Histories. Great Lakes History Symposium. Wikwemikong Ontario: Pontiac School (30 July 2010).

Manitowabi, Darrel. **2010**. Is Ethical Aboriginal Research Possible? School of Rural and Northern Health PhD Program. Sudbury, Ontario: Laurentian University (10 March 2010).

Manitowabi, Darrel and Velma Pheasant. **2010**. Traditional Medicines and Intellectual Property. Anishinaabewin Modes of Knowledge, Ways of Knowing Conference. Sudbury, Ontario: Holiday Inn (26 February 2010).

Manitowabi, Darrel, Herb Nabigon and Marion Maar. **2009**. First Nations Diabetes Research. Ziisbaakdaapnet Diabetes Symposium, Canadian Diabetes Association. Sudbury, Ontario: University of Sudbury (13 November 2009).

Manitowabi, Darrel. **2006**. Anishinaabe Ontology: Implications for Medical Research. Sudbury, Ontario: Northern Ontario School of Medicine.

Manitowabi, Darrel. **2001**. Applied Research in an Aboriginal Community. Aboriginal Research Conference. M'Chigeeng, Ontario: Abby's Catering Hall.

i) Graduate Student Committees and Examinations:

External Reviewer:

-Doctoral Thesis: Clint Rickard, PhD Indigenous Studies, Te Whare Wananga O Awanuiarangi (New Zealand), Thesis Title: The Influence of Public Servants on Treaty Settlements. February 28, 2023.

-Doctoral Thesis, Alexander Stevens II, PhD Faculty of Health and Environmental Sciences, Auckland University of Technology, Thesis Title: StandingTALLNZ: An Indigenous Psychology Approach to Develop an E-Health Website to Support Māori and Pacific Men, Their Support People and Community Groups Affected by Male Childhood Sexual Violence. 2 March 2022.

-Doctoral Thesis, Joshua Kaplan, PhD Indigenous Studies, Te Whare Wananga O Awanuiarangi (New Zealand), Thesis Title: Mā Te Ture, Te Ture anō e Āki: Culturally Inspired Remedies to Legislative Harm 25 March 2022.

-Doctoral Thesis, Peta Ruha, The Kawerau Story is a Case Study of a Kaupapa Māori Suicide Prevention and Postvention pathway mobilized by whānau for whanau, School of Indigenous Graduate Studies, Te Whare Wānanga o Awanuiārangi New Zealand.

-Professional Doctoral Thesis, Monique Gemmell, Who Holds the Power and What Counts as Knowledge: Maori Women, School of Indigenous Graduate Studies, Te Whare Wānanga o Awanuiārangi New Zealand.

-PhD Thesis, Pawan Chugh, A Holistic Approach to Accountability: Measuring Outcomes of Economic Funding in Northern Canadian Aboriginal Communities, Faculty of Arts, Business, Informatics and Education, CQ University Australia

PhD Human Studies and Interdisciplinarity, Laurentian University:

-Supervisor: Thomas Radder, Thesis title TBD.

-Supervisor: Dominic Beaudry, Thesis title TBD.

-Supervisor: Judy Binda, Thesis title TBD.

-Committee Member: Julie Burtt, PhD Human Studies and Interdisciplinarity, Laurentian University, Thesis title TBD.

-Internal Review of Yasser Ghoreishi Thesis, September 2019

-Co-Supervisor (with Dr. Jan Buley): Sharla Peltier, Thesis title: Demonstrating Anishinaabe Storywork Circle Pedagogy: Creating Conceptual Space for Ecological Relational Knowledge in the Classroom (PhD 2016)

-Committee Member: Michael Hankard, Thesis Title: The Health Work Off-Reserve First Nations People Do Accessing Traditional Healing Services Through the Medical Transportation Policy Framework of Non-Insured Health Benefits (PhD 2012)

PhD Rural and Northern Health, Laurentian University:

-Internal Review of Kristen Morin PhD Thesis January 2019, Thesis Title: Evaluating mental disorders and physician-based mental health services for patients enrolled in opioid agonists treatment across Ontario, Canada

-Committee Member: Roger Pilon, Thesis Title: Promoting a decolonized model of type II diabetes care for Aboriginal peoples living along the North Shore of Lake Huron (PhD 2015)

-Committee Member: Joey-Lynn Wabie, Thesis Title: Kijiikwewin aji: sweetgrass stories (PhD 2017)

-Committee Member: Zoe Higgins (2018-Present)

-Comprehensive External Oral Examiner: Teresa Marsh (2013); Lorrilee McGregor (2012); Stephen Ritchie (2009)

Master of Indigenous Relations, Laurentian University:

-Supervision: Amy Shawanda, Thesis Title: An examination of the integration processes of Anishinaabe smudging ceremonies in Northeastern Ontario health care facilities (MIR 2017)

-Co-Supervisor (with Cheryle Partridge): Natalie Lacasse, Thesis Title: Indigenous culture as a strategy to defer Mushkegowuk youth from criminal behaviour in Moose Cree First Nation (MIR 2017)

-Supervisor: Carinna Pellett, Thesis Title: Reconciliation of Indigenous and Non-Indigenous Youth Through Leadership Programs (MIR 2023)

-Committee Member: Nicole Nicholas-Bayer, Thesis Title: Smudge and mirrors: representations of First Nations knowledge in the Sudbury Catholic District School Board (MIR 2019)

-Committee Member: Toni Valenti, Thesis Title: Flip it Around! To being a good reminder on how you're supposed to live: understanding the role of storytelling as a means of encouraging compassionate listening in Type 2 Diabetes healthcare settings (MIR 2018)

-Committee Member: Beaudin Bennett, Thesis Title: The Noojamadaa Project: using visual research methods to elicit Indigenous women's perspectives on healthy relationships and support reconciliation in Canada (MIR 2018)

-Supervisor: Joseph Burke, Thesis Title: Including Indigenous perspectives in policy-making processes: natural resource development in Northern Ontario (MIR 2020)

-Supervisor: Kathleen Manitowabi (2020-Present)

-Supervisor: Peggy Simon (2020-Present)

-Committee Member: Mandy Herbert (2017-Present)

-Committee Member: Rachel Arsenault, Thesis Title: Mitigating the impacts of the First Nation water crisis in Ontario using Indigenous approaches (MIR 2021)

-Committee Member: Simon Leslie (2021-Present)

Master's in Interdisciplinary Health, Laurentian University:

-Supervision: Brigham, Cloey. 2022-Present

-Supervision: Skrinar, Hannah. 2022-Present

-Committee Member: Zachary Innes. 2022-Present

-Co-Supervision (with Sheldon Tobe): Andrew Niles, Thesis Title: Using provider perspectives to understand what makes obesity and diabetes prevention programs for children living in a First Nations Community in Northern Ontario effective (MSc 2018)

-Committee Member: Ashley Cornect-Benoit, Thesis Title: Exploring traditional roles of first nation older adults to promote the quality of life for those experiencing alzheimer's disease and related dementia's (MSc 2017)

-Second Reader: Kian Madjedi (2016-2017, MA conferred June 2017)

-Committee Member: Nathaniel Barnett (2017-Present)

-Committee Member: Matthew Leblanc (2017-Present)

Administration:

-Chair, M.A. Thesis Defence 2017; M.Sc. Thesis Defence 2013

j) Academic and University Service:

Peer Reviews:

-Saskatchewan Health Research Foundation (2022)
-Critical Gambling Studies, Associate Editor (2019-2021)
-Canadian Institutes of Health Research (2021-2022)
-Social Sciences and Humanities Research Council (2020)
-AlterNative (2020)
-University of Toronto Press (2020)
-Genealogy (2019)
-Anthropologica (2019)
-International Journal of Environmental Research and Public Health (2019)
-International Journal of Water Resources Development (2019)
-International Gambling Studies (2016, 2014, 2011)
-Centre for Addictions and Mental Health Press (2013)
-BioMed Central, BMC Public Health Journal (2012)

-Native Social Work Journal (2011)
-Papers of the Algonquian Conference (2011)
-Alterities Revue d'anthropologie du contemporain (2010)
-Indigenous Studies Undergraduate Journal (2009-Present) -Canadian Foundation for Dietetic Research (April 2009)

k) University Service:

-Review of Master of Indigenous Development Practice, University of Winnipeg 2022
-Curriculum Coordinator for CBM 103 & 106 NOSM
-Indigenous Health & Wellness Stream Proposal Co-writer, NOSM
-Anthropology Program Curriculum Committee: Coordinated revision of Anthropology Minor, Major, Concentration and Revision (2014, 2015, 2016); and created three new courses: ANTR 2126 EL Anthropology and the World Today (3 cr.); ANTR 4116 EL Critical Perspectives in Medical Anthropology (3 cr.); and
ANTR 4136 EL Ethnopsychiatry and Cross-cultural Mental Health (3 cr.)
-Master of Northern Development Planning Committee (2014-Present)
-Northern Ontario School of Medicine Admissions Assessor (2013)
-Laurentian University Master of Indigenous Relations Planning Committee (2009-2013)
-Creation of new elearning course: INDG 3256 EL-10 Aboriginal Health and Wellness for Desire2Learn Platform, Indigenous Studies, University of Sudbury (2012, revision 2020)
-Creation of new program in Native Studies with Dr. Kevin Fitzmaurice: Certificate of Native Studies (2011)
-External Faculty Examiner, Native Human Services Program Review, Laurentian University (May, 2008)

l) Community Service and Contributions:

2022. Canadian Society for the History of Medicine Programme Conference Chair. 4-5 June 2022 Virtual Conference.

2022. Thunder Bay Medical Society Virtual Summer School 11 September 2021 Speaker.

2020. College of Medicine Research Award: Research Resumption Adjudication Panel Member. University of Saskatchewan College of Medicine

2019-2020 Alberta Gambling Research Institute Conference Co-Organizer

2015 Expert Testimony (6 days) Alderville First Nation et al. v. Her Majesty the Queen in Right of Canada et al., Federal Court, Toronto, Ontario (December 2015).

2013, 2015-2016. Anishinaabewin Conference Planning Committee Member.

2012. A New Road: Ontario's Pathway to Social and Economic Development of the Far North Symposium with Centre of Excellence in Mining Innovation and the Institute for Northern Ontario Research and Development (Co-organizer, panel session organizer and moderator, Willet Green Centre, 9 February 2012, Laurentian University, Sudbury, Ontario).

2010. 37th Annual Symposium of the Ontario Archaeological Society, Killarney, Ontario: Friend or Foe? A Dialogue on the Aboriginal-Archaeological Relationship I, II (Two-part session organizer and chair, 25 September 2011, Killarney Bay Inn).

2009-2013. First Nation Issues and Exploration: Two sides of the coin, Mineral Exploration Research Centre and Centre for Excellence in Mining Innovation, Laurentian University (Co-Organizer, Co-Chair with Harold Gibson, Presenter Workshop on Aboriginal Culture and Communication Mining).

2008-15. Giigdowin: "Giving a Talk" Brown-bag Lunch Series, Founding CoOrganizer with J. Buley and colleagues (six monthly guest speakers per academic year).

2012. City of Greater Sudbury Chamber of Commerce Breakfast of Champions: Bridging Urban Aboriginal and Business Communities (Co-organizer, presenter, 8 February 2012, Howard Johnson, Sudbury, Ontario).

2011. Wikwemikong Community Development Consultation: Wiikwemikoong Shkonganing Noongo-maadiziwin (Invited Presentation, 5 October 2011, Wikwemikong Recreational Centre).

2010-11. Sheguiandah Archaeological Site Initiative Working Group.

2010. Rainbow District School Board Native Studies Professional Development Presentation at the School of Education, Sudbury Ontario (Event co-organizer and presenter, 28 April 2010).

2009. Native Studies Presentation at St. Benedict Catholic Secondary School Sudbury, Ontario (9 November 2009).

2009. Ziisbaakdaapnet: Diabetes Symposium, Canadian Diabetes Association, University of Sudbury College, Sudbury, Ontario (Symposium co-organizer and Master of Ceremonies, 13 November 2009)

2009. Confronting the Challenge of Aboriginal Diabetes, Canadian Institutes for Health Research Café Scientifique featuring Dr. Dawn Martin-Hill and Marion Maar, Grand Ciel Bleu, Sudbury, Ontario (Co-organizer and moderator, 12 November 2009)

2009. Science for a Changing North Conference, Fresh Water Ecology Unit, Laurentian University, Sudbury, Ontario: "Science and Indigenous Knowledge" (Lead session organizer with M. Corbiere and K Fitzmaurice, session co-chair with Dr. K. Fitzmaurice, 29 October 2009).

2009. "A Networking Approach...Achieving Student Success!" Kenjgewin Teg Educational Institute Principals and Educators Conference, Sudbury, Ontario: The Need for Aboriginal Self-Determination in Education (Invited keynote address).

2009. "Diabetes and Anishinaabe Spirituality": Giigdowin Brown-Bag Lunch (Presentation with Marion Maar, 2 March 2009, Laurentian University).

2008. "Striving for Education Excellence in First Nations Communities" Conference, Wikwemikong, Ontario: The Role of Culture in Self-Determination and Education (Invited keynote address).

2008. Zhiimaachtaan Conference: Economic Awareness Days, Wikwemikong, Ontario: The Meaning of History in Tourism and Gaming on First Nations (Invited keynote address).

2008. Wikwemikong Plaque Project, Wikwemikong, Ontario (Volunteered content consultant for historical and cultural plaques).

2008. Ojibwe Cultural Foundation, M'Chigeeng First Nation, Ontario: The Bell Rocks Speak (Invited public lecture with Elder Arthur McGregor).

2008. Second Aboriginal Cultural Sharing Session at the City of Greater Sudbury, Sudbury, Ontario: Cultural Sensitivity and Identity (Invited workshop).

2007. Aboriginal Cultural Sharing Session at the City of Greater Sudbury, Sudbury, Ontario: Cultural Sensitivity and Identity (Invited workshop).

2007. Interpretive Facilitator, University of Sudbury Trip to Manitoulin Island (Invitation).

2007. Ojibwe Cultural Foundation, M'Chigeeng First Nation, Ontario: Bridging Archaeology and Oral History at Manitoulin: A Case Study of Corn and the Flood (Invited public lecture).

2006. Speak Your Piece, University of Sudbury, Ontario: First Nations: The Persistent Spirit (Invited presentation).

2005. Sudbury Sustainability Conference and Film Festival, Sudbury, Ontario: Anishinaabe Ontology as Sustainability: Perspectives of the Past and Present (Invited presentation).

2004. Act Now Youth Conference, Wikwemikong, Ontario: First Nations History: Western and Indigenous Perspectives (Invited workshop).

8. RESEARCH PROJECTS:

2022-2023. A Conceptual Framework for Training and Mentorship of Indigenous Traditional Healers

2021-2024. Maamwizing community driven research

2021-2022. Indigenous Data Sovereignty

2021-2023. Indigenous Knowledge in Gambling through Videogaming

2020-2024. Culture and Land-based Approaches to Opioid Addictions

2019-2022. First Nations National Gambling Research Project

2019-2021. Repatriating Anishinabe and Algonquin Children's Art Research

2018-2020. Starting on a Healing Path Opioid Addictions Research

2017-2019. Mino-Nokiiwin: Advancing an Understanding of Indigenous Occupational Health and Safety in Northeastern Ontario.

2017-2018. Mino-bimaadiziwin : Enhancing Wellness in Anishinabek Communities in Northern Ontario through Indigenous Ways of Knowing.

2014-15. The Impact of Socioeconomic Interventions on Mnnamodzawin: Knowledge Translation and Research Program Community/University Partnership Development.

2009-11. The Impact of Socioeconomic Interventions on Mnnamodzawin: Improving chronic disease care through community-based participatory research in Ontario First Nations Communities.

2009-10. The Impact of Casino Rama on the Wikwemikong First Nation.

2008-09. Assessing the Institutionalization of Traditional Aboriginal Medicine.

2007-09. Bridging Aboriginal and medical epistemologies: An exploration of the impact of spiritual, emotional and social wellness on the development of diabetes and secondary complications in Aboriginal people.

9. MEMBERSHIP AND CONTRIBUTION IN PROFESSIONAL ORGANIZATIONS:

Algonquian Conference
American Anthropological Association
American Society for Ethnohistory
Anishnaabewin
Canadian Anthropology Society/La Societe Canadienne d'Anthropologie
Canadian Association of Health Humanities
Canadian Society for the History of Medicine
Native American and Indigenous Studies Association
Society for Applied Anthropology

10. RESEARCH GRANTS:

2022-2023. A Conceptual Framework for Training and Mentorship of Indigenous Traditional Healers. Principle Investigator: **Darrel Manitowabi**; Co-applicants: Esstin McLeod (Mississauga First Nation); Danielle Wilson (Noojmowin Teg Health Centre [NTHC]); Germaine Elliot (Mamaway Wiidokdaadwin Primary Care Team); Hannah Roberts (NOSM); Debbie Francis (NTHC). Northern Ontario School of Medicine Research Development Grant: $7,125; Other Contributions: Noojmowin Teg Health Centre: $10,000; Mamaway Wiidokdaadwin: $9,000, Esstin McLeod: $2000, Total: **$28,125**.

2021-2024. Wabie, Joey-Lynn et al. (with **Darrel Manitowabi**, Co-applicant). Maamwizing: a hub for Indigenous community driven research. Social Sciences and Humanities Research Council. Amount: **$430,832**.

2021-2023. Jull, Janet et al. (with **Darrel Manitowabi**, Co-applicant). Indigenous community research partnerships: A community-centred research approach to develop and conduct Indigenous evaluation of an open access training resource. Canadian Institutes of Health Research. One year Project Grant, extended one more year due to COVID. Amount; **$100,000**.

2021-2023. Nicol, Fiona et al. (with **Darrel Manitowabi**). Giwii-nisidopanmin odaminowin: Gambling with Videogames in the lives of Indigenous Youth in Northwestern Ontario. Principle Investigator: Fiona Nicol, Co-Principle Investigator: Darrel Manitowabi et al. Alberta Gambling Research Institute**: $159,975**.

2021-2022. Zelek, Barb, Brianne Wood & **Darrel Manitowabi**. Indigenous Data Sovereignty: Informing the Northern Ontario School of Medicine Research Toward Health Hub (NORTHH) Practice-based Research Network (PBRN). Principal Investigator: Barb Zelek, Co-Principle Investigators: Brianne Wood & Darrel Manitowabi. Northern Ontario Academic Medicine Association. Amount: **$50,000**.

2020-2024. Maar, Marion et al. (with **Darrel Manitowabi**). A First Nations Community Response to Support Recovery from Opioids: Integrating Cultural and Land-based Practices with Clinical Approaches. Principle Investigator: Marion Maar, Co-Principle Investigator: Darrel Manitowabi et al. Canadian Institutes of Health Research. Amount: **$466,651**.

2019-2022. Williams, Robert et al. Gambling and Problem Gambling in Canada: A National Study. Alberta Gambling Research Institute, Canadian Consortium for Gambling Research, Canadian Centre on Substance Use and Addiction and Gambling Research Exchange Ontario.

Principal Investigator: Robert Williams (University of Lethbridge) Co-applicants Dr. Carrie Leonard et al. (with **Darrel Manitowabi**) Amount: **$1,273,687**.

2019-2021. azhen giinawaa mazinibii'iganan: Repatriating Indigenous Children's Artwork in Anishinabe & Algonquin Territory. New Frontiers in Research Fund— Exploration Canada. Principal Investigator: Dr. Celeste Pedri-Spade (Laurentian). CoInvestigators: Laura Hall (Laurentian), **Darrel Manitowabi**, Andrea Walsh (U. Victoria), Demetra Christakos (Art Gallery of Sudbury), Mary Pheasant (Wiiwemkoong Unceded Territory), Pamela Toulouse (Laurentian), Joey-Lynn Wabie (Laurentian), Anong Beam (Ojibwe Cultural Foundation), Lewis Debassige (M'Chigeeng First Nation). Amount: **$248,682.**

2018-2020. Starting on a healing path rooted in First Nation cultural and clinical approaches to Opioid Replacement Therapy: Minobimaadiziwin after Addiction. **Darrel Manitowabi** Co-Investigator with Dr. Marion Maar (Northern Ontario School of Medicine). Amount: **$150,000.**

2018-2020. Reorienting Education and Training Systems to Improve the Lives of Indigenous and Margionalized Youth. Catherine Matheson (City of Greater Sudbury, United Nations University) and **Darrel Manitowabi**. Indigenous and Northern Affairs Canada: Amount: **$250,000.**

2017-2019. Developing Indigenous Knowledge Keepers Program. Skills Development Fund, Aboriginal Skills and Employment Strategy Canada. Atikameksheng Anishnawbek, Wahnipatae First Nation and Gezhtoojig Employment and Training (with **Darrel Manitowabi**): Amount: **$2,600,000.**

2017-2019. Mino-Nokiiwin: Advancing an Understanding of Indigenous Occupational Health and Safety in Northeastern Ontario. Ontario Ministry of Labour. **Darrel Manitowabi** Co-Investigator with Dr. Nancy Lightfoot. Amount: **$68,418.50.**

2017-2018. Mino-bimaadiziwin : Enhancing Wellness in Anishinabek Communities in Northern Ontario through Indigenous Ways of Knowing. Canadian Institutes of Health Research. **Darrel Manitowabi** Co-Investigator with Dr. Marion Maar (Northern Ontario School of Medicine). Amount: **$149, 945.**

2012-2017. Urban Aboriginal Knowledge Network Research for a Better Life. Principal Investigator: Prof. David Newhouse (Trent University). Co-Applicant: Ann Sherman (University of New Brunswick) et al. (with **Darrel Manitowabi**). Granting Agency: Social Sciences and Humanities Research Council Canada, Amount: **$2,500,000.**

2014-2015. The Impact of Socioeconomic Conditions on Mnamodzawin: Knowledge Translation and Research Program Community/University Partnership Development.
Principal Investigator: Marion Maar (Northern Ontario School of Medicine), Co-Investigator: **Darrel Manitowabi**. Granting Agency: Indigenous Health Research Development Knowledge Translation and Exchange and Networking Grant, Amount: **$10,000**.

2009-11. The Impact of Socioeconomic Interventions on Mnnamodzawin: Improving chronic disease care through community-based participatory research in Ontario First Nations Communities. Principal Investigator (academic): Marion Maar (Northern Ontario School of Medicine), Principal Investigator (community): Dawn Madahbee (Waubetek Business Development Corporation), Co-Investigator: **Darrel Manitowabi**. Granting Agency: Indigenous Health Research Development Program/Canadian Institutes for Health Research/Canadian Institutes of Health Research, Amount: **$25,000.**

2008-09. Assessing the Institutionalization of Traditional Aboriginal Medicine. Principal Investigator (academic): **Darrel Manitowabi**, Principal Investigator (community): Pamela Williamson (Noojmowin Teg Health Centre), Co-Investigator: Marjory Shawande (Noojmowin Teg Health Centre). Granting Agency: Indigenous Health Research Development Program/Canadian Institutes of Health Research, Amount: **$25,000.**

2007-09. Bridging Aboriginal and medical epistemologies: An exploration of the impact of spiritual, emotional and social wellness on the development of diabetes and secondary complications in Aboriginal people. Principal Investigator: Marion Maar (Northern Ontario School of Medicine), Co-Investigator: **Darrel Manitowabi** (University of Sudbury). Granting Agency: Social Sciences and Humanities Research Council, Amount: **$25,000.**

1998. Northern Scientific Training Program, Department of Indian and Northern Affairs Canada, **Darrel Manitowabi**, Recipient, Grant Number: 20-61732. Amount: **$2,500.**

This is Exhibit ....B..... referred to in the
affidavit of ....Darrel Manitowabi.....
sworn before me, this ....14th.....
day of ....January..... 2024....

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A COMMISSIONER, ETC

PAUL LEWIN

Island D M

Sworn remotely by Darrel Manitowabi in the Village of Birch ~~Park~~, ON
with commissioner Paul Lewin in the City of Toronto, ON.

Traditional Anishinabe Healing in a Clinical Setting:

The Development of an Aboriginal Interdisciplinary Approach to Community-based Aboriginal Mental Health Care

Marion A. Maar, Ph.D., Assistant Professor, Northern Ontario School of Medicine, Laurentian University

Marjory Shawande, Traditional Coordinator, Noojmowin Teg Health Access Centre, Aundek Omni Kaning, ON

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, & AI-SUPERPFP 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 fogotten*, 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 fogotten*, 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.[2] During these interviews we posed open-ended questions to gather information on participants' experience with the integration of traditional healing in the clinical setting. This part of the research was guided by the university-based researcher, Marion Maar, in collaboration with community representatives selected by local health boards. The community-based researcher, Marjory Shawande, has been the traditional healing services coordinator at the health centre since its inception and therefore did not conduct interviews in order to avoid unintentionally influencing the participants. She brought a historical and cultural perspective to this research as well as first hand knowledge of the extensive community consultations that guided the early development of traditional healing services at the health centre. The local Aboriginal health boards and the Manitoulin Anishinabek Research Review Committee reviewed and approved this research.[3]

RESULTS AND DISCUSSION

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

Core elements of integration

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

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

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

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

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

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

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

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

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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, Mnaamdozawin 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 wholisitc 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

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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 *Mnaamodzawin 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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1. For example see: Public Health Agency of Canada. (2008). Retrieved on August 29, 2008 from http://www.phac-aspc.gc.ca/ph-sp/determinants/index-eng.php#determinants.

2. The research project involved several health organizations and was initiated by Mnaamodzawin Health Services in partnership with Noojmowin Teg health centre. See: Maar, M. , Erskine, B. , McGregor, L. Sutherland, M., Graham, D., Larose, T., Shawande, M., & Gordon, T. (2009). Innovations on a shoestring: A Study of a Collaborative Community-based Aboriginal Mental Health Service Model in Rural Canada. *International Journal of Mental Health Systems*. (in press). Accessible at http://www.ijmhs.com/.

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Traditional Medicine and Restoration of Wellness Strategies

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ABSTRACT

The overview of literature provides emergent themes on the topic of Aboriginal health, culturally oriented interventions and prevention strategies. Recommendations are also provided on how to apply indigenous knowledge and traditional medicine approaches in the intervention for at risk Aboriginal populations or communities in crisis. Through a literature review of indigenous knowledge, it is proposed by several Indigenous scholars that the wellness of an Aboriginal community can only be adequately measured from within an indigenous knowledge framework which is a holistic and inclusive approach that seeks balance between the spiritual, emotional, physical, and social spheres of life. Their findings indicate that high rates of social problems, demoralization, depression, substance abuse, and suicide are prevalent in many Aboriginal communities and must be contextualized within a decolonization or self-determination model. The evidence of linkages between the poor mental health of Aboriginal peoples and the history of colonialism is key to improving the wellness in communities. Conversely, there is sufficient evidence that strengthening cultural identity, community integration, and political empowerment contributes to improvement of mental health in Aboriginal populations including at risk youth and women. The interconnection of land, language and culture are the foundations of wellness strategies. The overview clearly suggests adopting new strategies for intervention and prevention, and learning from historical wrongs to ensure future policies support of the restoration of traditional practices, language and knowledge as a means of developing strategies for this generation's healing and wellness.

KEYWORDS

Traditional medicine and healing, Indigenous knowledge, intervention and prevention, historical trauma, holistic and inclusive approaches, partnerships of empowerment in restoration of culture and wellness strategies

INTRODUCTION

This paper will review literature on the topic of traditional medicine and indigenous knowledge as protective factors for at risk Aboriginal populations and communities. Aboriginal peoples will be used to define First Nations, Métis and Inuit peoples of Canada. According to the National Aboriginal Health Organization, Aboriginal peoples in Canada are identified in the following ways:

ABORIGINAL PEOPLES: Is a collective name for all of the original peoples of Canada and their descendants. Section 35 of the Constitution Act of 1982 specifies that the Aboriginal Peoples in Canada consist of three groups – Indian (First Nations), Inuit and Métis. It should not be used to describe only one or two of the groups.

ABORIGINAL PEOPLE: When referring to Aboriginal people with a lower case people, you are simply referring to more than one Aboriginal person rather than the collective group of Aboriginal Peoples. (NAHO, 2007, p. 32).

The following discussion will outline the basic tenants of

indigenous knowledge, traditional knowledge, medicine, and healing as preventative factors for Aboriginal communities. The overview provides emergent themes of literature on the topic of Aboriginal health, culturally oriented interventions and prevention strategies. Recommendations are also provided on how to apply indigenous knowledge and traditional medicine approaches in the intervention for at risk Aboriginal populations or communities in crisis.

DEFINING TRADITIONAL MEDICINE

Traditional medicine and healing are difficult concepts to define, as many Aboriginal peoples describe the medicine and practices within the localized geographical context of their community or nation. However, working definitions are provided by the World Health Organization (WHO) and the Royal Commission on Aboriginal Peoples (RCAP). The term "traditional medicine," as defined by WHO:

> Is the sum total of knowledge, skills, and practices based on the theories, beliefs, and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness (WHO, 2001).

The *Report of the Royal Commission on Aboriginal Peoples* (1996) defines *traditional healing as*:

> Practices designed to promote mental, physical and spiritual well-being that are based on beliefs which go back to the time before the spread of western 'scientific' bio-medicine. When Aboriginal Peoples in Canada talk about traditional healing, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counseling and the accumulated wisdom of elders (RCAP, 1996, Vol.3, p. 348).

The terms *Elder* and *healer* are used interchangeably since traditional teachings are considered "healing for the mind." "Elder" is another term attached to traditional healing that is discussed in the Gathering Strength Volume of the *Report of the Royal Commission on Aboriginal Peoples*. The report states that Elders are "Keepers of tradition, guardians of culture, the wise people, the teachers. While most of those who are wise in traditional ways are old, not all old people are Elders, and not all Elders are old" (ibid).

Through a literature review of indigenous knowledge, it is proposed by several Indigenous scholars that the wellness of an Aboriginal community can only be adequately measured from within an indigenous knowledge framework which is a holistic and inclusive approach that seeks balance between the spiritual, emotional, physical, and social spheres of life (Stewart, 2007; Martin-Hill, 2003; Kelm, 1998; Duran & Duran, 1995). Martin-Hill (2003) suggests Elders and healers frequently frame western concepts as disconnected from culture, families and community. Several Elders interviewed in Martin-Hill's (2003) research found that traditional medicine and knowledge are not to be isolated from a way of life; it's all encompassing of diet, physical, spiritual, and emotional thoughts and actions. Healing is one aspect, and as stated, "a smile or words of encouragement" can be good medicine (workshop interviews, 2002; ibid). As such, the Elders address intervention and prevention with an emphasis on lifestyle not curative ceremony. Data gathered by the First Nations and Inuit Regional Health Survey (RHS) in 2002 presented progress amongst Aboriginal communities in the areas of community well-being by integrating traditional activities including those used to enhance self-esteem. It is the position of this analysis that only through an integrated approach to community health services that supporting traditional medicine and practices within culturally sensitive environments will the current state of crisis within Aboriginal communities find remedy. This includes promoting culture and self-esteem among Aboriginal peoples and their communities (RHS, 2002).

The assumptions presented by Aboriginal traditional world-views have been articulated by several scholars as fundamental for framing a system of knowledge that is valid and based on sound science. Currently, there are emerging discourses that explain and define traditional thought as a part of indigenous knowledge.

INDIGENOUS KNOWLEDGE

Dr. Daes (1993), *Report on the Protection of Heritage of Indigenous People* (as cited in Battiste & Henderson, 2000) states:

> Indigenous knowledge is a complete knowledge system with its own concepts of epistemology, philosophy, and scientific and logical validity...which can only be understood by means of pedagogy traditionally employed by these people themselves (p. 44).

According to Marlene Brant-Castellano's article in Dei, Hall and Rosenburg's (2000) *Indigenous Knowledge's in Global Contexts*, indigenous knowledge has a multiplicity of sources including:

> *Traditional* - passed on through generations through oral stories, histories and inter-action with the environment.
>
> *Empirical* – observations made over time and incorporated into ecological knowledge.
>
> *Spiritual* – revelation understood through dreams, visions or even as divine messengers.

Vandana Shiva (2000) states that indigenous knowledge is a pluralistic system that has been delegitimized by western science. She writes:

> Indigenous Knowledge's have been systematically usurped and then destroyed in their own cultures. Diversity and pluralism are characteristic of non-western societies. We have a rich biodiversity of plants for food and medicine. Agricultural diversity and the diversity of medicinal plants have in turn given rich plurality of knowledge systems in agriculture and medicine.
>
> However, under the colonial influence the biological and intellectual heritage of non-western societies was devalued...transformed the plurality of knowledge systems into a hierarchy of knowledge systems. When knowledge plurality mutated into knowledge hierarchy, the horizontal ordering of diverse but equally valid systems....(p. vii).

The displacing of indigenous knowledge will be addressed in the literature overview of numerous authors examining traditional knowledge (also identified as indigenous knowledge). Before over viewing the literature on the topic of traditional knowledge and communities in crisis, a discussion of statistics and Aboriginal demography will provide insights to population trends and identify target groups providing a context for a population in crisis.

STATISTICS & DEMOGRAPHY

An Overview

Cloutier et al., (2008) write in the Statistics Canada analysis of 2006 Aboriginal census data, that according to information collected, the current socio-economic status of First Nations children is bleak. Nearly half (49 per cent) of off-reserve First Nations children under the age of six live in low-income families, compared to 18 per cent of non-Aboriginal children. While 57 per cent of young off-reserve First Nations children living in large urban cities are living in low-income families. Registered Indian status First Nations children are more likely to live in low-income families than non-status Indian children, 55 per cent and 38 per cent respectively (Statistics Canada, 2008). There has also been a growing movement of First Nations children living in urban areas, 78 per cent compared to a remaining 22 per cent living in rural areas and Aboriginal communities (Cloutier et al., 2008, p. 12).

Statistics Canada reports that in 2006 census data, the majority of Aboriginal children aged 14 and under (58 per cent) lived with both parents, while 29 per cent lived with a lone mother and 6 per cent, with a lone father, 3 per cent of Aboriginal children lived with a grandparent (with no parent present) and 4 per cent lived with another relative (Cloutier, 2008; Statistics Canada, 2008). In other words, almost half of Aboriginal children are being raised with one or less parent.

Furthermore, the current age demographics of Aboriginal Peoples in Canada illustrates an urgent need to address the despair experienced among many in Aboriginal populations and communities. The majority of the Aboriginal population is young with the median age of 27 as compared to the non-Aboriginal population which median age is 40 (Cloutier, 2008, p. 7). Among all Aboriginal people, almost one-half (48 per cent) are children and youth aged 24 and under, compared to only 31 per cent of the non-Aboriginal population. Similarly, 10 per cent of the Aboriginal population is aged five to nine, compared with only 6 per cent of the non-Aboriginal population. Based on this data, Statistics Canada reports the population projection for Aboriginal people in the next decade could account for an escalating share of the young adult population of Canada. In fact it is anticipated that by 2017 Aboriginal people in their 20's could make up approximately 30 per cent of the whole population in a similar age categories in provinces across Canada (Statistics Canada, 2008).

Literature Overview

The proceeding literature overview provides a number of articles and books that address issues facing Aboriginal populations and communities in crisis and/or address the topic of traditional knowledge, medicine and culturally relevant intervention and prevention strategies. Youth, women and mental health were frequent themes discussed in the literature. The historical colonialism, oppression, displacement, and assimilation of Aboriginal peoples and communities arises as a central factor influencing the array of social, environmental, political, and health issues impacting Aboriginal communities. A discussion of the current state of Aboriginal health and well-being cannot be complete without first examining the historic legacy of colonialism that has shaped Aboriginal life. Colonialism is identified by several authors as the source of historical oppression and the cause of the current health status of Aboriginal people.

What is colonialism and how is it directly linked to historical and current influences that determine such conditions as poverty, educational non-achievement and socio-economic status? According to sociologist James Frideres (2008), colonialism is best understood in seven parts. He outlines the key processes as synthesized into the following points:

- The incursion of the colonizing group into a geographical area.
- Colonization's destructive effect on the social and cultural structures of the indigenous group. Colonizers destroyed the people's political, economic, kinship, and in most cases religious systems.
- Interrelated processes of external political control and Aboriginal dependence, (Department of Indian and Northern Affairs Canada, 1999) is the "representative ruler" in this model of Aboriginal economic dependence.
- Colonization is the provision of low quality social services for the colonized Aboriginal people in education and health.
- Related to the social interactions between Aboriginal people and white people referred to as the color-line or racism. Racism is the belief in the genetic or cultural superiority of the colonizing and the inferiority of the colonized.
- Prevention from entering into the economy – creating a "culture of poverty" - creating two economies; one for Canadians who have the skills required and one for Natives who do not.

An example of an ill informed social policy is the Children's Aid policy of adopting out Aboriginal children during the sixties. The policy known as the 60's scoop, removed over 1500 children from their homes based on Eurocentric assessments of Aboriginal families. The impact of colonialism on Aboriginal people's lives is beyond measure and has exacted a significantly terrible toll on Aboriginal families and children specifically. *A National Crime* by John Milloy (1999) reported further that the conditions Aboriginal children faced in government child care and the residential school system were deplorable due to poor nutrition, hard labour and unsanitary conditions. Furthermore, the sexual, emotional, physical, and cultural abuse in the system was widespread and severe, serving to erode the traditional knowledge, practices, identity, pride of heritage, and language of Aboriginal peoples (Milloy, 1999).

Healing Traditions: Culture, Community and Mental Health Promotion with Canadian Aboriginal Populations by Laurence Kirmayer, Carl Simpson and Margaret Cargo (2003) reviews literature examining links between the history of colonialism, government interventions and the mental health of Aboriginal Canadians. Their findings indicate that high rates of social problems, demoralization, depression, substance abuse, and suicide are prevalent in many Aboriginal communities. They suggest evidence of linkages between the poor mental health of Aboriginal peoples and the history of colonialism. Conversely, there is sufficient evidence that strengthening cultural identity, community integration, and political empowerment contributes to improvement of mental health in Aboriginal populations (Kirmayer, 2003).

Walking in a Sacred Manner, Healers, Dreamers, and Pipe Carriers- Medicine Women of the Plains Indians by Mark St. Pierre and Tilda Long Soldier (1995) explores the interconnectedness of the spiritual with the everyday life of Plains Indian culture. The Plains culture observed spiritual laws as a way of life that promoted core values of cherishing children, women and the elderly. The creation stories and spiritual laws were interrupted by missionizing and massacres which left the Plains culture in a state of grief and loss. The central thesis is that women have always played a critical role as spiritual leaders and healers and were the backbone of their societies. Throughout the colonial era, the Plains culture adopted western views of women and children

which led to a state of social disarray. Mark St. Pierre and Tilda Long Soldier (1995) suggest the need to re-instate the traditional laws to improve the quality of life for Plains people, families and communities.

In her publication entitled *Colonizing Bodies, Aboriginal Health and Healing in British Columbia* 1900-50, Mary-Ellen Kelm (1998) examines the impact of colonization on the health of Aboriginal people in British Columbia. Kelm's analysis of Aboriginal health statistical data demonstrates critical factors such as how colonization impacted traditional diets and nutrition that led to severe erosion of Aboriginal peoples' health. The under-serviced health care compounded by loss of traditional subsistence and healing practices led to the current poor health of Aboriginal people. Her linking the loss of traditional knowledge in preventative health practices to that of colonial policies that outlawed 'a way of life' is detailed with both quantitative and qualitative data. Much of the literature suggests there is a linkage between colonialism and ill-health of Aboriginal people and Kelm's in-depth analysis is evidence to the commonly held view. She also suggests that loss of autonomy over one's body is similar to the continued government practice of controlling Aboriginal peoples. Restoring traditional healing practices and knowledge is a pathway to both empowerment and healthy communities.

Aboriginal Suicidal Behavior Research; from Risk Factors to Culturally-Sensitive Interventions by Laurence Katz et al., (2006) state that: "There is a significant amount of research demonstrating the rate of completed suicide among Aboriginal populations is exceedingly higher than the general populations" (p.159). They suggest there is a shortage of research on evidence based interventions for suicidal behaviour. The results of their study suggest developing a research program that tracks intervention is a solid evidence based process to study risk factors and interventions. They conclude that identifying risk factors for Aboriginal suicidal behaviour is required to develop appropriate interventions. The multi-faceted problem of suicide requires increased knowledge of the types of culturally sensitive suicide prevention strategies identified (Katz et al., 2006, p. 165).

In his book *Fighting Firewater Fictions, Moving beyond the Disease Model of Alcoholism in First Nations* Richard Thatcher (2004) describes that traditional knowledge needs to be restored as an intervention to the addictions facing Aboriginal communities. Thatcher (2004) describes the role colonialism played in missionizing that led to spiritual bankruptcy in Aboriginal peoples and is seen as a precursor to poor coping skills with alcohol and other substances. He explains that recovery must provide Aboriginal people with the skills to heal from historical trauma.

Walters, Simoni and Evans-Campbell's (2002), *Substance use among American Indians and Alaska natives: incorporating culture in an "indigenist" stress-coping paradigm* proposes a new stress-coping model that manifests a paradigm shift in the conceptualization of health. They conclude cultural identity is part of traditional medicine and healing paradigms. Through decades of assimilation policies in Canada and the residential school suppression of Aboriginal language, drumming, singing, or spiritual practices, many have lost connection to their cultural belief systems and knowledge. Cultural identity was identified as an issue for traditional healing as many Aboriginal people have never been exposed to traditional practices and do not identify with the belief system embedded in traditional healing practices such as sweat lodges, false face healing rituals or other indigenous healing methods. These ceremonial practices would be as foreign to highly acculturated Aboriginal people as it would be to non-Aboriginals who have no context in which to decipher what is transpiring in the ceremony. However, many Aboriginal people are attempting to recover and revitalize their heritage and ceremonies as a means of healing.

Access to Traditional Medicine in a Western Canadian City, by James Waldram (1990) examined research in Saskatoon with 147 Aboriginal people and found that there were a number of factors that influenced the individuals' choice and usage of traditional medicine. Waldram identified at least six distinct Aboriginal cultural groups in Saskatoon. One group in the study had concerns over the use of "bad" medicine. One of the major differentiating characteristics between traditional medicine and biomedicine is the duality that many indigenous groups believe there is "good" and "bad" Aboriginal medicine. Respondents to the questionnaire clearly indicated that they would use a traditional healer, but the issue of "bad medicine" is a complex belief that clearly demarcates traditional medicine from western biomedicine. Also, people who have adopted a variety of spiritual beliefs, such as Pentecostalism, Catholicism and other organized religious beliefs, would not support traditional healing approaches from a spiritual/ritual perspective. Religious affiliation, however, may not be a barrier for Aboriginal people when choosing a specialized Aboriginal health service outside of the spiritual, ceremonial realm, for example, herbalism and midwifery (Waldram, 1990, pp. 325-348).

Language is also identified as an important factor in traditional knowledge and or the practice of medicine. The expert paper written for the United Nations Permanent Forum on Indigenous Issues, *Indigenous Children's Education and Indigenous Languages*, identifies language as the key success factor for educational achievement in indigenous communities. The panel concluded that:

> Present-day indigenous and minority education shows the length of the mother tongue medium education is more important than any other factor (including socio-economic status) in predicating the educational success of bilingual students (UN, 2008, p. 2).

The report explains that the dominant language is often from a colonizing framework which subtracts and displaces indigenous languages rather than approaching education as a bi-lingual enterprise providing an additional language in educational repertoire. The subtractive model of education, taught to Aboriginal children, implies an inferiority of their language and culture which inhibits pride, self-esteem and empowerment (ibid).

In his book *Unfinished Dreams: Community Healing and the Reality of Unfinished Dreams*, Wayne Warry (2000) suggests that communities in crisis require a degree of self-governance and empowerment to meet their unique needs. He suggests that for communities to be successful in crisis intervention there must be a concerted effort to train them and provide them with the tools for skill enhancement. Warry (2000) also emphasizes the need for community members to develop skills that would assist them in identifying suicidal behaviour, communications and facilitation of traditional healing practices, and western specialized approaches. His analysis of services in Aboriginal communities concludes that Aboriginal self determination and the improvement of mental health services would serve to repair the current status of northern communities in crisis (ibid).

In Maria Brave Heart's (1998), *The Return to the Sacred Path: Healing the Historical Trauma and Historical Unresolved Grief Response Among the Lakota Through A Psycho Educational Group Intervention*, she integrates the concept of Post-Traumatic Stress Disorder (PTSD) and psychic trauma with traditional healing methods. Her seminal work includes acknowledging the behaviours associated with this diagnosis of historical trauma as effecting Indigenous populations. She explains historical trauma is unresolved grief and the behavioural responses are: 1) withdrawal and psychic numbing; 2) anxiety and hyper vigilance; 3) guilt; 4) identification with ancestral pain and death, and 5) chronic sadness and depression. Brave Heart's research conducted with Lakota human service providers concluded that the Lakota suffer from impaired grief of an enduring and pervasive quality.

The root cause of communities in crisis is driven by collective impaired grief that results from massive cumulative trauma associated with "such cataclysmic events as the assassination of Sitting Bull, the Wounded Knee Massacre, and the forced removal of Lakota children to boarding schools" (Brave Heart, 1998, p. 50). Brave Heart also encourages the enhancement of training for service providers and intervention strategies that incorporate traditional healing methods to help facilitate the recovery of historical trauma. Brave Heart's (1998) work is in the same conceptual framework as mental health profiles found in the *Aboriginal Healing Foundation Research Series: Mental health profiles. British Columbia's Aboriginal survivors of the Canadian residential school system* states that:

> Three-quarters of the case files (74.8 per cent) provide information about the current mental health of the subjects. Of these case files, only two indicate that the subject did not suffer a mental disorder. As expected, based on the mental health literature on residential school Survivors, the most commonly diagnosed disorder is post-traumatic stress disorder (64.2 per cent), followed by substance abuse disorder (26.3 per cent), major depression (21.1 per cent) and dysthymic disorder (20 per cent) (Corrado & Cohen, 2003, p. 68).

Mitchell and Maracle's (2005) publication *Healing the generations: Post traumatic stress and the health Status of Aboriginal populations in Canada* confirms the role of historical trauma and the need to develop a model for mental health services to Aboriginal populations. They suggest that the following criteria are necessary to develop an efficient model:

1. An acknowledgment of a socio/historical context.
2. A reframing of stress responses.
3. A focus on holistic health and cultural renewal.
4. A proven psycho-educational and therapeutic approach.
5. A communal and cultural model of grieving and healing (p. 18).

They further suggest that there are four phases for community healing which include getting a core group together to address healing needs, increasing healing activity, recognition of root causes of addictions or abuse, building capacity by providing training, and lastly, shift from fixing problems to transforming systems (Mitchell & Maracle, 2005, p. 20).

Aboriginal children and youth mental health literature entitled, *Mental Health and Well-being of Aboriginal children and Youth: Guidance for New Approaches and Services* summarize the state of Aboriginal children and youth's mental health as a consequence of the following historical and contemporary issues:

- Profound impacts of residential school experience on family functioning.
- Multi-generational losses among First Nations people.
- Emphasis on collectivist rather than individualistic perspectives education and health.
- Relevance of community-based healing initiatives (Mussell, Cardiff & White, 2004, p. 4).

Their findings offer several recommendations for long term commitment to building capacity in Aboriginal communities. The action items should:

- Recognize the role that culture plays in determining health.
- Focus on implementing ecological, community level interventions.
- Promote local leadership and develop high quality training.
- Provide mentoring and support.
- Foster links between communities.
- Support on going capacity building.

They also suggest large scale interventions are needed with regards to First Nations families, which encompass the entire ecological nature of the issue. They state that:

> It is not expected that individually focused models of treatment strategies must understand that the problems facing First Nations communities are complex and involve multiple factors including individuals, families, peers, schools, community's culture, society and environmental factors. Children and youth safety, health and well-being are linked to quality interaction not only within family but across these other sectors of influence. The development of effective approaches must involve input from a wide array of sectors, organizations and individuals (Ibid, 2004, p. 19).

Furthermore, Suzanne Stewart (2007) writes that despite elevated rates of mental health issues among Aboriginal populations that contribute to overwhelming rates of suicide in Aboriginal youth, mental health services are underused by Aboriginal peoples. Lee and Armstrong (1990) explain that throughout history cultures have found methods for dealing with psychological distress and behavioural deviance. They further state that in the interest of developing awareness, knowledge and skills to promote cultural responsiveness, counseling professionals need to appreciate traditional healers. Likewise, Stewart (2007) asserts that incorporating indigenous approaches to helping and healing are essential methods for addressing the mental health crisis in Aboriginal communities and populations. She describes indigenous models and practices of helping and healing as:

- Storytelling.
- Advise from Elders.
- Interconnectedness with family and community.
- Healing circles.
- Ceremony.

Stewart (2007) further explains that these indigenous methods and practices for helping and healing need to include the involvement of local communities, Elders and traditional helpers.

Duran and Duran's (1995) *Native American Postcolonial Psychology* observed the ways in which western constructions of mental health have had serious consequences for Native Americans. They explain:

> A good example of how some of the ideology of biological determinism affects people is seen in the field of psychometric assessment. The relevant literature is filled with studies showing cultural bias and outright racist practices, yet researchers continue to use the same racist tools to evaluate the psyche of Native American peoples (p. 19).

They suggest the current tools to evaluate Aboriginal mental health do not take into consideration the colonial context or the Euro-culture based assessment methods which have not worked well for improving the mental health of Native Americans. The lesson learned is the critical need to develop culturally sensitive assessment tools and intervention strategies.

These studies exemplify the significance of culture, and community in intervention programming and community services. Their analysis also demonstrates the need to employ a multiplicity of services and for Aboriginal families and services to work together to address collective mental health needs. Another target group, Aboriginal women, has been identified as marginalized within its own community.

Lisa Udel's (2001) *Revision and Resistance, The Politics of Native Women's Motherwork* concludes that, Native women require men's social and cultural participation in tribal life in order to ensure survival of specific collective experiences and to perpetuate their traditions in their communities (p. 61). The cultural networks, both mothers and fathers enjoyed, have been diminished due

to colonialism and have resulted in Aboriginal children suffering. This is why it is urgent to move swiftly to find new ways to improve their quality of life which would include recovery of traditional practices in contemporary settings.

Traditionally, Aboriginal women were highly regarded as the mothers of our nations as they were seen as "*givers of life*" through their ability to bear children, and foster the healthy development of the future generations (Benoit & Carrol, 2001, p. 1). Similarly, Long and Curry (1998) suggests that women were the primary transmitters of wisdom and culture through oral traditions. The authority and the esteemed positions that Aboriginal women held in their societies have been severely eroded through federal policies that have disrupted women's roles (Long & Curry, 1998).

The objective of the *Aboriginal Women's Health Research Synthesis Project Report* states:

> Our agenda is to illustrate traditional Indigenous knowledge and practices concerning traditional parenting as essential methods to improving the health and wellness of Aboriginal families. Namely by supporting First Nations in restoring women's traditional knowledge and roles within the family, clan and community is an essential cultural healing tool (Stout, Kipling & Stout, 2001, p.12).

In the article, *Identity, Recovery, and Religious Imperialism: Native American Women in the New Age*, Cynthia Kasee (1995) asserts Aboriginal women often lack the economic means to access traditional medicine. Thus the ill health of many Aboriginal women within Aboriginal communities is often a direct result of poverty and low cultural identity, demonstrating the unequal power-relations found in communities. It is a battle for Indigenous women to access traditional healing even though their lack of wellness is greater than men's. Aboriginal women have been both formally and informally marginalized through legal, social and economic impositions into the family and community (Kasee, 1995, p. 85).

In *A Recognition of Being* Kim Anderson (2000) states that Aboriginal women's societal positioning and authority were undermined by missionaries and the government, influences severely impacting their economic and social autonomy. Anderson explains that the diversity in socio-cultural arrangements allowed, in both matrilineal and patrilineal cultures, gender autonomy through a women's voice. She outlines the specific impacts of colonialism in displacing Aboriginal women from their rightful positions within their own societies. The main issues Indigenous women identify are power and domination, cultural constructs of Aboriginal women's identity, and knowledge which assumed the inferiority of Indigenous women. Women have taken up the issue of Indigenous women's resistance to dominant hegemony and their constructions "of them." The western literature had been primarily concerned with responding to legal-social policies implemented through colonialism.

In *Black eyes all of the Time; intimate Violence, Aboriginal Women, and the Justice System*, McGillivray and Comeskey (1999), suggest that the normative socialization through years of colonialism within Aboriginal communities has the effect that violence against women is no longer viewed as deviant behaviour. McGillivray and Comeskey (1999) state the rate of intimate violence against women is consistently higher than violence against women. Eight in 10 Aboriginal women witnessed or experience intimate violence in childhood, and the same number have been child or adult victims of sexual assault. Between 75 and 90 per cent of northern Ontario's Aboriginal women are assaulted in an adult relationship. Aboriginal women typically endure 30 to 40 beatings before calling police, and physical injury is the leading cause of death of Aboriginal women on reserve. Statistical relationships between intimate violence and the death of women in geographically culturally remote populations require further investigation (McGillivray & Comaskey, 1999).

In *Aboriginal Single Mothers in Canada: An Invisible Minority*, Jeremy Hull (1996) explores the challenges facing Aboriginal mothers in Canada today. Hull overviews the statistical data of single mother's housing and income, exposing the challenges Aboriginal women face in achieving the most basic quality of life. The ability to raise consciousness and empowerment for Aboriginal women however, is contingent on several variables including poverty, suicide and violence, which plague Aboriginal women and youth.

In *Identity Formation and Cultural Resilience in Aboriginal Communities*, Christopher Lalonde (2005) describes resilience as the ability of whole cultural groups to foster the healthy development of children and youth. In examining high suicide rates among Aboriginal communities, he found that the rates are unevenly distributed with communities that have enhanced "cultural continuity" having the lowest suicide rates. Lalonde (2005) suggests that what is needed to find solutions for improving well-being for Aboriginal youth lies with the communities, lateral knowledge exchange efforts, and cross-community sharing of indigenous knowledge. Furthermore, Lalonde (2005) asserts that success in improving the status of First Nations communities lies in efforts to restore cultural sovereignty to expand the indigenous knowledge that has allowed First Nations peoples to overcome historical and present adversities.

DISCUSSION

The Impact of Colonialism on Communities & Emerging Factors

Inter-generational trauma is exacerbated by the ongoing colonial framework Aboriginal people have to struggle with. The Royal Commission on Aboriginal Peoples (1996) emphasizes the need to contextualize Aboriginal health within a historical framework of colonialism. Research by Kirmayer, Simpson and Cargo (2003) found that high rates of social problems, demoralization, depression, substance abuse, and suicide are prevalent in most Aboriginal communities. They suggest there is evidence of linkages between the poor mental health of Aboriginal peoples with the history of colonialism and oppression. Mary-Ellen Kelm's (1998) Aboriginal health statistical data analysis demonstrates how colonization impacted traditional Aboriginal people's health. Kelm links the loss of traditional knowledge of health practices to colonial policies that outlawed 'a way of life' and suggests there is a linkage between colonialism and ill-health of Aboriginal people. Richard Thatcher (2004) explains that colonialism played a significant role in destroying this knowledge through colonialism, and that missionizing has lead to spiritual bankruptcy, leading in turn to alcohol and other substance addictions among Aboriginal populations and communities. Likewise, Voyle and Simmons (1999) write that the "... alienation and marginalization within their own countries have had deleterious consequences for [Aboriginal] cultural traditions and identity, social cohesion and self-esteem" (p. 1035).

Authors Mark St. Pierre and Tilda Long Soldier (1995) write that the creation stories and spiritual laws of Aboriginal peoples were interrupted by missionizing and massacres which left Aboriginal culture in a state of grief and loss. The authors state that Aboriginal women have always played a critical role as spiritual leaders and healers and were the backbone of their societies. However, through the colonial era, Aboriginal culture adopted western views of women and children which led to a state of social disarray (St. Pierre & Long Soldier, 1995). There is no doubt colonialism has had both direct and indirect negative consequences for Indigenous people's health.

According to Fournier and Crey (1997), "[A]boriginal children were taken away in hugely disproportionate numbers less for reasons of poverty, family dysfunction or rapid social change than to effect a continuation of the colonial argument" (p. 85). They further state that in the East side of Vancouver, social workers had noted that most Aboriginal people living in the depths of addictions, sex trade and extreme poverty are graduates of residential schools and the sixties scoop. There are Aboriginal communities in crisis that do not the have access to their traditional practices, knowledge and culture, leaving the sense that assimilation policy has achieved its goal (ibid). The historical policies that attempted to assist Aboriginal people have failed miserably, creating social chaos and alienation of Aboriginal people from dominant society and their own heritage. The overview clearly suggests adopting new strategies for intervention and prevention, and learning from historical wrongs to ensure future policies support of the restoration of traditional practices, language and knowledge as a means of developing strategies for this generation's healing and wellness.

Factor: Colonialism as the Root Cause of Communities in Crisis:

Literature on the state of Aboriginal communities' health and health care services confirm the need for Aboriginal community control over health care, which must include access to traditional medicine as a critical aspect to community well-being and health. The recognition of the validity and importance of traditional medicine within the mainstream health care system is also a key component to improving the status of Aboriginal health. There was a general consensus that throughout history, Eurocentric education curriculums and residential schools regarded indigenous knowledge as unscientific and superstitious. Further, the consensus among anthropologists is that indigenous knowledge of medicine has suffered even greater stigmatization through missionaries, through assimilation policies that successfully outlawed ceremonies from being practiced, and even jailed many political and spiritual leaders up until the mid-1900s (Cummins & Steckley, 2000).

Factor: Education as a Tool for Assimilation:

The legacy of education within Aboriginal communities is not a positive one. In light of this historical context it is easy to understand why education was and is still viewed as a place where one is disempowered, not liberated. Education is not viewed as a tool for liberation and success which may explain the poor retention rates of Aboriginal people in the education systems. According to a world panel for the U.N., *Indigenous Children's Education and Indigenous Languages* expert paper written for the United Nations Permanent Forum on Indigenous Issues:

> They learn a dominant language at the cost of their mother tongue which is displaced, and later often replaced by the dominant language. Subtractive

> teaching subtracts from the child's linguistic repertoire, instead of adding to it. Research conclusion about the results of present-day indigenous and minority education show the length of the mother tongue medium education is more important than any other factor (including socio-economic status) in predicating the educational success of bilingual students (UN, 2008, pp. 2-3).

Factor: The Loss of Value and Support for Woman:

Women were impacted by the dominant society's historical views of women's place in society. The erosion of their traditional positions of value was significant and unique to their gender. Few people have the experience of having their children removed to attend residential schools and later to experience the sixties scoop. It was stated that the sixties scoop, the removal of children en-mass from their families, was due to 'poor living conditions'. Children were removed by the Children's Aid Society because their assessments were based on western constructs of child care and welfare. The 15,000 children removed were taken out of state and country and the families had no recourse to have their children returned (Steckly & Cummins, 2000; Fournier & Crey, 1997).

The continued assault on Aboriginal people's culture and heritage had inter-generational impacts on societal mores and ethos. People were demoralized in childhood by the education system and further harmed through authority figures and the dominant society. The outcomes of such experiences are embedded in current statistics showing a number of social ills. The state of Aboriginal women in Canada is another indictor of families in crisis. Current statistics reveal Aboriginal women have a higher chance of incarceration. RCAP's (1996) report states:

> The imposition of the Indian Act over the last 120 years, for example, is viewed by many First Nations women as immensely destructive. Residential schools and relocations subjected Aboriginal communities to such drastic changes in their way of life that their culture suffered immeasurable damage…Our re-education will serve to bring more people home, to encourage our youth and lost ones to safely reconnect with their past communities (pp. 18-19).

A century of persecuting Indigenous Peoples' spiritual practices has left many communities traumatized and fearful of traditional beliefs, practices and medicines. Many Elders consistently underscored the current reality that they are no longer authority voices in their communities. While Elders were the lead advisors and decision makers in Aboriginal communities, historically Indian Agents, Priests and their appointed Aboriginal "Chiefs" undermined their roles because they represented tradition, culture and spiritual leadership. The loss of Elders and diminishment of their roles and relationships with the broader community is one more fracture that leads communities into crisis.

Anderson (1999) argues that many urban Aboriginal people know they are Native but have no idea what it means which leads to poor self-esteem and feelings of alienation. She also concludes that not knowing what it means to be "Indian" is this generation's common experience tie as "Indians." She concludes finding ones cultural roots and heritage is deeply meaningful and has healing value. To have a sense of self, belonging and dignity is essential. The inter-generational impact of colonization resulted in a generation of children that were raised unaware of their heritage, roles and responsibilities (Pierre & Long Soldier, 1995). She argues that the historical authority many Aboriginal women once enjoyed was diminished through adoption of European ideals, displacing women from decision making. The recovery of traditional knowledge would improve the status of Aboriginal women and their families' overall well-being (Anderson, 1999).

Factor: Youth Suicide Prevalence in Communities in Crisis:

Nancy Miller's (1995) *Suicide Among Aboriginal People*, a report prepared for the Royal Commission on Aboriginal Peoples, provides the following:

> The Commission report identified four groups of major risk factors generally associated with suicide; these were psycho-biological, situational, socio-economic, or caused by culture stress. Culture stress was deemed to be particularly significant for Aboriginal people. Situational factors were considered to be more relevant. The disruptions of family life experienced as a result of enforced attendance at boarding schools, adoption, and fly-out hospitalizations, often for long-term illnesses like tuberculosis, were seen as contributing to suicide. Socio-economic factors, such as high rates of poverty, low levels of education, limited employment opportunities, inadequate housing, and deficiencies in sanitation and water quality, affect a disproportionately high number of Aboriginal people. It is obvious that in conditions such as these, people are more likely to develop feelings of helplessness and hopelessness

> that can lead to suicide and high risk behaviors such as alcoholism and drug abuse. Miller (1995) further describes 'culture stress' as a term used to explain the loss of confidence in the traditional ways of understanding life and living that have been learned within a culture (1996, p. Mr-13IE).

She recommends that the Royal Commission develop a strategy of action and a national campaign to address the incidence of suicide in Aboriginal communities, one that is developed and driven by the community. These services need to include provisions for building capacity for self determination, self-sufficiency, healing, and reconciliation. She reports, that "this approach is to be based on seven elements: cultural and spiritual revitalization; strengthened family and community bonds, children and youth; holism; whole-community involvement; partnership; and community control" (p. 7).

The documentary '*Place of the Boss*' chronicles the experiences of the Innu of Labrador. Elders recall the Catholic Priest insisting to them that they do not drum, sing or conduct ceremonies claiming that it was a sin. Several Innu elders featured in the documentary felt the loss of their traditional activities was directly related to their peoples addictions and high suicide rates. Davis Inlet and Sheshesit are examples of Aboriginal communities in crisis suffering devastatingly high suicide rates (Survival International, 2008). *A Way of Life that Does not Exist: Canada and the Extinguishment of the Innu*, explains that the Innu of Eastern Canada have extremely high suicide rates, ranking among the highest in the world (Survival International, 2008). This illustrated report describes their way of life, religion and society, and investigates their current situation. It explains how their forced transformation from a nomadic hunting people into a settled and dependent population has brought terrible social problems, and details the communities own suggestions for regaining control of their land and their future (Survival International, 2008).

The Innu elders had identified the need for the Innu youth to know traditional ways. This knowledge was critical for suicide intervention and would help them heal, have self-esteem and assist in empowerment. This goes hand in hand with economic growth, educational success and Innu strategies for self-help and intervention. While there are no established indicators that conclusively define what constitutes a 'community in crisis,' there are communities that are fully aware their people are in need of significant support and assistance. The Elders voiced their concerns at the International Indigenous Elders Summit, 2004, suggesting they have answers but their views fall on deaf ears (International Indigenous Elders Summit:2004, Six Nations).

Recommendations: Traditional Knowledge and Medicine as Protective Factors:

Indigenous knowledge enhances an inter-connected, inter-related holistic approach to addressing and analyzing social phenomena. This theoretical framework is drawn from a body of research that critiques western science from an indigenous viewpoint. It contributes to the emergent articulation of indigenous experiences with colonialism and oppression. The literature overview of indigenous scholarship demonstrates that the basis of indigenous knowledge is related to an indigenous understanding of identity, self-worth and self-determination.

The spiritual, emotional and physical well-being is dependant upon a number of variables including the political, social and economic positioning of Aboriginal peoples and communities. However, a community that is doing well, economically, does not mean they will automatically have lower suicide rates than a community that is considered impoverished. There are several factors determining the well-being of Aboriginal communities and this section will demonstrate how indigenous knowledge and traditional medicine can facilitate health and well-being by acting as preventative factors to many of the crises facing Aboriginal communities. Recommendations include identifying the leading factors that sustain communities in crisis and need to be addressed by intervention and prevention strategies as follows:

1. Colonialism as the root cause of communities in crisis.
2. Education as a tool for assimilation.
3. The loss of value and support for women.
4. Youth suicide prevalence in communities in crisis.

Restoring traditional healing practices and knowledge is a pathway to both empowerment and health for communities. The traditional knowledge once practiced in historical Aboriginal societies needs to be restored as an intervention to addictions and the epidemics facing Aboriginal peoples (Thatcher, 2004). There is also sufficient evidence that strengthening ethno cultural identity, community integration and political empowerment contributes to improving mental health in Aboriginal populations (Kirmayer, 2003). The Gathering Strength Volume underscores the need for Aboriginal people to restore healthy communities by restoring traditional preventative practices in health services as determined by

the community. Overall, RCAP (1996) provided over 500 recommendations for Aboriginal people in all spheres of their lives. Only a handful has been implemented thus far.

Lesley Malloch (1989) writes that through teachings from Elders, there is a strong belief that traditional principles of health based on the balance between the physical, emotional, mental, and spiritual elements, hand in hand with a traditional healthy lifestyle prevents sickness. Malloch writes that the Elders she spoke with were understanding of the need for western medicine but also expressed that it is vital that Aboriginal peoples return to core cultural values and traditional medicine. The Elders state: "This is the only way the people will become strong again" (Malloch, 1989, p. 10). Colomeda and Wenzel (2000), write that "[f]or Indigenous peoples good health includes practicing cultural ceremonies, speaking the language, applying the wisdom of the elders, learning the songs, beliefs, healing practices, and values that have been handed down in the community from generation to generation" (p. 245). The authors note that in indigenous health and healing, Elders have always played a crucial role in maintaining the health of the people. The Elders are the key players as they are considered to be wise and responsible for educating the people (Colomeda & Wenzel, 2000).

Indigenous literature on the topic of traditional approaches to enhancing well-being emphasizes ties to the land, language and culture. The land and physical environment shapes the cultural knowledge in achieving community well-being as practiced historically by Indigenous people. Definitions and measures of well-being include everything from diet, lifestyle, identity, knowledge of language and culture, positive verbal reinforcement, herbal and ritual knowledge, and traditional knowledge (heritage). In short, community wellness is connected to all areas of human activity; good medicine is a lifestyle that encourages a good state of being. It is a common Aboriginal belief that traditional culture and knowledge are important for promoting community health and well-being.

Furthermore, Svenson and Lafontaine (1999) report in their research that over 80 per cent of Aboriginal respondents answered 'yes' to the question, "Do you think a return to traditional ways is a good idea for promoting community wellness?" According to Nancy Zukewich's (2008) article, *First Nations Children Six Years Old Living off Reserve: Statistics Canada*, 46 per cent of young off-reserve children had engaged in "traditional First Nations, Métis, or Inuit activities such as singing, drum dancing, fiddling, gatherings or ceremonies" (p. 2). Also, 45 per cent of off-reserve children had someone teach them, had someone who helped them understand First Nations history and culture. Most of these children were being taught by their parents (60 per cent) and grandparents (40 per cent). She also states those with status were more likely to have access to traditional knowledge (Zukewich, 2008, p. 1).

Recommendations: Traditional Medicine as a Protective Strategy:

Given the previously illustrated young demographic of Aboriginal peoples in Canada, it remains crucial to focus on the health and well-being of Aboriginal children and youth. Furthermore, because mental health is one of the most extreme issues facing Aboriginal communities, it requires significant attention including the promotion of intervention and prevention strategies that encompass traditional medicine and healing approaches. The demography also indicates that the young Aboriginal population is increasingly expanding which speaks to the current needs of young families. Therefore, the need for policies and practices supporting solutions for communities in crisis is critically urgent as was pointed out by RCAP (1996), approaches in preventing crisis and providing intervention strategies for Aboriginal communities. Integrating traditional practices was also identified by the RCAP (1996). It states that cultural and spiritual revitalization would strengthen family bonds since the activities of drumming, dancing and singing are collective and social by nature. Furthermore, Struthers et al., (2004) conclude that traditional medicine is still in widespread use and it is critical for health care professionals to have an understanding of the basic ideologies of holistic health which underscores an indigenous approach to health.

The host site of healing for Aboriginal peoples is within the ceremonial context. There, ideas and beliefs emerge and are reinforced through the physical, mental and spiritual experiences. The above literature reviewed and outlines ways to restore balance in all areas of life, including education, raising self-esteem, claiming their identity, asserting their dignity, learning their traditions, customs and spiritual teachings, and letting go of pain – all approaches have many facets. The healing is holistic, inclusive of improving mental, emotional, psychological, and spiritual states. The improvements of economic, political and social standings are interlocked with holistic aspirations of traditional healing practices.

The traditional knowledge Aboriginal societies possessed concerning the emotional and mental health, reproduction, nutrition, prevention and intervention, and physical care had been suppressed through the missionary and colonial era of the eighteenth century. The objective

of the literature review is to gain an understanding how traditional healing traditions from across Canada share their experiences, and how thoughts and aspiration are constructed in healing strategies. Aboriginal voices have been silenced in their struggle to heal Aboriginal communities which have often been recipients of ill informed government policies that privilege western approaches over indigenous approaches.

Aboriginal people would better assess the cause and treatment of Aboriginal mental health. Also, this work importantly serves to validate Aboriginal experiences which have often been denied by mainstream institutions and methods. Culturally sensitive assessment tools have the greatest relevance in 'treatment.' The authors argue that the role of colonialism in diminishing Aboriginal identity as a root cause to a myriad of mental health problems. The wounds of the past continue to fester and it is often in silence. The path to healing is voicing the abuse and receiving validation from culture. The high suicide rates indicate a crisis in mental health and maybe due to under servicing of First Nations communities' health systems. Aboriginal mental health strategies should be a priority in any current mental health initiatives within Canada (Warry, 2000). Aboriginal mental health issues are best understood in the context of colonialism.

The overarching themes suggest restoring cultural practices of Elders, transmitting knowledge and teachings to youth. The only barrier to this practice is youth not having access to them so they can inherit the knowledge. Elders have in the past been role models to community members guiding moral and spiritual teachings and providing emotional support. This has been disrupted by a variety of colonial influences. The traditional ways are viewed as an essential solution to community wellness (Soucy & Martin-Hill, 2005).

The works of several Indigenous scholars presented expose the direct link between historical events and contemporary circumstances for Aboriginal communities. Within an indigenous knowledge framework, identified as having excessively high incidence of addictions and or youth suicide.

The leading factors that sustain communities in crisis and need to be addressed by intervention and prevention strategies are as follows:

1. Colonialism as the root cause of communities in crisis.
2. Education as a tool for assimilation.
3. The loss of value and support for women.
4. Youth suicide prevalence in communities in crisis.

Health is viewed as a state of well-being not the absence of illness. An indigenous knowledge framework also places emphasis on collective forms of preventions and intervention at the family and community levels. The bio-medical model poses a one dimensional view of mental health and therefore justifying an Aboriginal specific strategy within an indigenous knowledge framework or paradigm. Key characteristics in indigenous knowledge systems are the inter-relatedness and interconnection between social, political, economic, and spiritual life intersecting with emotional and physical well-being. The variables of poverty, low-self worth and powerlessness are predicating factors to problems such as addictions. Overall, the summary of literature on mental health and youth brought out several themes and recommendations.

Indigenous Knowledge and Traditional Healing as key to Empowerment and Prevention

Synthesizing Warry's (2000) work, the following practices are fundamental components to ensuring a culturally strategic approach to addressing Aboriginal communities in crisis, utilizing traditional medicine and healing in an indigenous knowledge framework:

- Prevention over intervention.
- Cultural care including traditional practices.
- Collective care on a holistic scale.
- Long term care for children and youth, including prenatal care.
- Develop programs that include family support versus individual support.
- Culturally informed diagnosis and tools of assessment.
- Interagency collaborative strategies.
- Education of institutions and communities.
- Capacity building, recruitment and retention of Aboriginal health care professionals.

Warry (2000) suggest the community workers in the mental health sector are under-funded and have few community services at a historical time when they are critically needed. He underscores that the thematic areas listed are consistent in Aboriginal health literature but there does not seem to be policy changes to implement identified solutions to communities at risk or in crisis. Traditional medicine and healing are a substantial consideration for at risk or high risk communities experiencing high levels of addictions, suicide or violence (Warry, 2000). Again, traditional revitalization is underscored as a way to altering

behaviours that are destructive or pathological. Traditional ways require personal responsibility and accountability for one's well-being (ibid).

Mussell, Cardiff and White (2004) suggest the state of Aboriginal children and youth's mental health is a consequence of the following historical and contemporary issues:

- Profound impacts of residential school experience on family functioning.
- Multi-generational losses among First Nations people.
- Emphasis on collectivist rather than individualistic perspectives.
- Relevance of community-based healing initiatives. (p. 4)

Duran and Duran (1995) suggest that development of assessment tools that are culture-based are needed for improving the mental health status of Native Americans. The authors explain that the lessons learned from history need to be acknowledged and it is critical to develop culturally sensitive assessment tools and intervention strategies (Duran & Duran, 1995, p. 19).

A recommendation identified in the literature includes finding ways to restore balance in all areas of life for Aboriginal people, by incorporating traditional knowledge, bilingual education as a means of increasing self-esteem, reclaiming identity and asserting dignity, learning traditions, customs and spiritual teachings, and letting go of the pain. All the approaches have many facets and include multi-dimensional culture-based approaches. The emphasis of intervention and prevention strategies through the application of traditional practices requires communities, Elders and healers to develop these strategies in collaboration with community health service providers. Most important is to ensure the leadership, education and health institutions work together to move their communities out of crisis (Duran & Duran, 1995; Mussell, Cardiff & White, 2004; RCAP, 1996; Warry, 2000).

Stewart's (2007) work provides a description of the tools or methods that could be developed as indigenous models and practices of helping and healing. These tools are described as:

- Storytelling.
- Advice from Elders.
- Facilitating interconnectedness with family and community.
- Healing circles led by professionals and Elders.
- Ceremonies.

These tools are examples of approaches to developing culturally significant intervention and prevention strategies that can be incorporated into health services for Aboriginal communities. Stewart (2007) further explains that these indigenous methods and practices for helping and healing need to include the involvement of local communities, Elders and traditional helpers.

The overarching themes in the literature are congruent with self-determination and enhancement of restoring traditional knowledge, medicine and healing which are rapidly becoming vulnerable due to lack of transmission and training. Currently few communities have the resources to recover and revitalize their language and culture. Policy should acknowledge traditional knowledge as a critical component to success of preventative and intervention strategies for Aboriginal communities. Indigenous knowledge is a key to resolving communities in crisis however, it must be noted that it is a rare resource due to the age demography, loss of identity, cultural knowledge, and healers; therefore incorporating traditional knowledge should take priority. Furthermore, efforts should be made to retain this knowledge as a community resource for helping and healing in the future. The most important recommendation is to develop resources for the continuance of traditional healing, language and knowledge with vigor.

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Connections and Processes: Indigenous Community and Identity's Place in the Healing Journey

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Abstract

This article focuses on the role of Indigenous identity and community connection in the healing journey. Healing from trauma and colonization are critical components to the lived experience of Indigenous people. This article outlines how Indigenous people in Turtle Island experience colonization and trauma. It will also discuss how the connection to our communities and our own identities are essential to addressing the spectre of trauma and colonization. This paper is rooted in the understanding that all of these concepts are not static but active processes. By actively engaging in our communities and our identities, we can gather strength and heal. By engaging with Indigenous communities, urban and reserve, our Indigenous identity is strengthened, which can help in healing from trauma and colonization.

Keywords

Colonization, community, Indigenous identity, healing journey, health, relationship, trauma

Introduction

Community and being connected to a community is an integral part of being Indigenous. Indigenous identity does not exist in a vacuum; connections to peoples, places or languages all contribute to what it means to be Indigenous. Our identities are active processes that are affirmed, supported and enhanced through communities and relations. These connections from the individual to the community also help people who are on a healing journey towards recovery. In this paper, I want to explain how Indigenous identity and Indigenous communities help people on their healing journey. It is essential to discuss these community connections. The current global pandemic has shown how vital links are among people and how the loss of these connections affects people.

The critical thing to understand going into this work is that all of these concepts, communities, identities, trauma, healing and colonization, are processes. They are dynamic and change depending on the individuals and their environment. I want to emphasize this because, for many Indigenous people, there are very few static and unchanging things. Framing how we understand ourselves and our relations as active processes is crucial to understanding healing. At the same time, looking at trauma and colonization themselves as dynamic processes also helps us understand, in the best way any of us can, what these experiences are like, and the best way to move forward to assist people on their healing jour-

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Even though our peoples, cultures, traditions, and perspectives have been under assault for centuries, there is still an immeasurable amount of strength in our Indigenous identity. By no means perfect, nor is it prescriptive, it is still vital to stress that we should do everything to cultivate healthy relationships with our own identities and communities. Doing so gives us strength and strengthens a support system for those on their healing journeys.

Indigenous Identity

To start, I want to briefly discuss some of the key ideas around what is 'Indigenous identity.' I intend to sketch out some elements of what Indigenous identity is, how it is conceptualized *by* Indigenous people, which enforces the need for connection to communities, and how it helps people on the healing journey. Jeff Corntassel (2012), a Tsalagi scholar, argues that relationships, languages, and communities are fundamental to Indigenous life:

> If one thinks of peoplehood as the interlocking features of language, homeland, ceremonial cycles, and sacred living histories, a disruption to any one of these practices threatens all aspects of everyday life. The complex spiritual, political, and social relationships that hold peoplehood together are continuously renewed. These daily acts of renewal, whether through prayer, speaking your language, honouring your ancestors, etc., are the foundations of resurgence. (89)

It is an active process that underpins how we understand ourselves and our relationships with one another and the land. Corntassel suggests that being Indigenous is anchoring oneself to a community, history, language, and people. He stresses that it is an active process rooted in a community that extends to ceremonies, institutions, and kinship networks. In his discussion of the definition of an Indigenous person, he centres the description on a shared culture, history, and institutions grounded in communities (Corntassel, 2003, p. 92).

It is an identity collective in its scope and an active process that needs to be continually renewed. Scott Richard Lyons (2010), an Ojibway/Dakota scholar, likewise suggests that being Indigenous is rooted in what actions we take and what relationships we cultivate:

> Indian identities are constructed...they do not come from biology, soil, or the whims of a Great Spirit, but from discourse, action and history...this thing is not so much a thing at all, but rather a social process. Indian identity is something that people do, not what they are (p. 40).

This identity is expressed and supported through the institutions and relationships we cultivate in our life journeys. Bill Lee (1992), a non-Indigenous social work scholar, suggests that our communities encompass our relations, languages and cultures, but also the institutions that compose Indigenous life: "For us, culture, identity and values are expressed in the mass institutions, government, education and media that are both countless and subtle. Native identity, culture and values tend to be transactive with life within a community context" (p. 212). Indigenous identity and community are deeply connected. The community provides an anchor for our sense of self and a continual opportunity to renew our sense of connection to our friends, families, and lands. It exists as a part of ourselves and an extension of an extensive network of relations that need to be continually renewed.

Communal connectivity helps renew our sense of self and assists in our well-being. Taylor and de La Sablonnière (2014) state that collective and cultural identities are essential facets of a person's identity and well-being. Echoing Corntassel and Lyons, Taylor and de La Sablonnière (2014), suggests that within cultural groups, it is not just a matter of who we are but the relationships we carry (p. 101). They stress that there is a potent connection between Indigenous well-being and community connection: "our own research (Usborne & Taylor 2010) indicates that for real cultural groups, including one First Nation group, a clearly defined cultural identity is associated with a clear personal identity, which is then linked to self-esteem and well-being" (p. 98). Social

settings in Indigenous communities are foundational to how we conceptualize ourselves and our relation to one another. The presence, or absence, of a sense of community and identity can have a wide-ranging impact on an Indigenous person.[1] A person's identity, and community connection, regardless of what that community looks like, are robust support systems.

Urban Communities

When I am speaking of the relationship between community, identity, and healing, keep in mind that this is not exclusive to reserve communities. Throughout my research, there is a misconception about urban Indigenous communities by Indigenous people across Canada. Generally, there is a tendency to view urban communities as somehow less authentic than their reserve counterparts (Peters, 1992, p, 52). All the while, Indigenous people across Canada are becoming predominantly urban people. The 2016 census attributes 51.8% of Indigenous people living in cities of 30,000 or more, and the urban population growth is at 59.7% (Government of Canada, 2017, p. 10). Urban Indigenous people have created their own institutions and services, like Friendship Centres, which have been part of urban communities since the 1950s. When discussing communities in relation to healing and identity, it is essential to include urban communities in the discussions because they have their own perspectives, values, and experiences.

There is a tendency to equate Indigenous communities with *just* reserve communities. There is a longstanding perspective that reserve communities are the only *proper* type of Indigenous community. This bias is seen as early as the 1970s by the Union of B.C. Indian Chiefs (1970) when advocating for self-government:

> Our programs are based upon self-determination and involvement of Indians at a local level. They are self-help programs that will require the use of all available government programs and the involvement of the private sector of the economy. *Our problems will be solved within the communities rather than to relocate our people in urban areas* [Emphasis Added] (p. 8).

Urban Indigenous people are often viewed as abandoning their communities. This is a perspective that is a consistent theme throughout the 20th and into the 21st century (Harding, 1992, p. 366). Some Indigenous reserve communities did not look kindly on urban populations and would view them as either less than or as something that threatens reserve communities political will: "For some land-based Aboriginal communities, the situation of urban Aboriginal people may be perceived as both anomalous and potentially threatening." (Groves, 1999, p. 9) There are different components to urban communities that make them unique, but that is not a basis for looking at urban communities as less than.

The reality is that urban Indigenous communities are diverse, interconnected, and older than most people think. David Newhouse points out that Friendship Centres, since the 1950s, are essential to providing 'invisible infrastructure' for urban Indigenous communities to build and grow (Newhouse, 2003, pp. 246–247) The infrastructure supports the complex ecosystem in which urban Indigenous communities exist and thrive. Urban Indigenous communities are different from reserve communities; there still exists a sense of community and means to maintain the network of relationships in that community. Likewise, Kevin FitzMaurice (2012) points to how Friendship Centres are instrumental in providing community infrastructure and networks (p. 11). He further suggests that Friendship Centres and other service and program providers are critical because they are rooted in Indigenous perspectives and values (p. 12). Institutions based on Indigenous values and perspectives are crucial to maintaining connections between peoples. Institutions and community connections are vital in cities. Urban institutions serve as dedicated spaces for urban Indigenous people to gather, meet, and connect.

All of this is to say that communities, whether

[1]**While cultural practices and community supports are important to identity formation and the development of healthy habits and decisions, I am not suggesting that these are the only determinants of well being health, nor does the presence or absence of particular community or individual supports determine a person's life trajectory.**

it be urban or reserve communities, offer a basis of support for Indigenous people. Susan Lobo (2011), in her work on the urban Indigenous community in the San Francisco Bay Area, notes that: "the Indian community is not a geographic location with clustered residency or neighbourhoods, but rather it is fundamentally a widely scattered and frequently shifting network of relationships with locational nodes found in organizations and activity sites of special significance" (pp. 74–75). Urban Indigenous communities are different from reserve communities, but that does not mean that urban Indigenous people have not generated communities and community connections.

It is essential to understand that urban Indigenous communities are still Indigenous communities. There are fundamental differences in demographics and exposure to 'mainstream' Canadian culture and institutions to reserve communities. It does not mean that urban Indigenous communities should be viewed as a pale imitation of the real Indigenous communities. It is crucial to frame the discussions around finding healing within a community as something that occurs in urban and reserve communities.

As this paper reinforces, healing is an active process, and each person's healing will be unique. As such, communities of support will look different for everyone. A sweat lodge that helps one person does not mean that it will help another person. In the same sense that finding a sense of community on a reserve does not mean that there will be the same sense of community for someone else. Indigenous identities are processes, as is healing; they both require action and support. What is shared is that community, wherever it is found, can be crucial in supporting Indigenous people recovering from colonization and their own trauma.

Colonization and Trauma

The importance of Indigenous communities for our well-being is one reason why colonialism is so focused on disrupting our connections. One of the critical components of the colonial state is to disrupt, destroy or assimilate original peoples into the colonial system. Doing this while our kinship and connections are still intact is difficult. It is easier to erase cultures, peoples, and traditions if the systems of relations and connections are fractured. This process manifests itself in trauma in ourselves and our communities. This section aims not to showcase a parade of misery but to understand and unpack what this trauma looks like and how it affects us. By better understanding colonization and trauma, we can better address and heal from these processes.

The manifestation of trauma due to the ongoing process of colonization and assimilation can begin at a very early age. Lisa Monchalin (2012) notes that child welfare and the development of children into healthy adults are connected. The destabilization of families and communities traumatize Indigenous children to develop unhealthy and dysfunctional coping mechanisms (p. 166). Trauma can profoundly affect people at an individual level, but trauma is not isolated to just the individual; it can affect people adjacent to the individuals. As Addie Rolnick (2016) notes in her work on the Indigenous youth experience with incarceration: "Present-day trauma compounds the impact of historical traumas that Native communities have experienced" (p. 58). Indigenous communities experience longstanding effects colonization which carries their own sets of trauma; these traumas manifest in actions, behaviours and perspectives, which can cause trauma to ourselves, families and communities.

It is an insidious system that Indigenous people have been dealing with and navigating for centuries. Kirmayer, Brass, and Tait (2000) point out that stress, dysfunction and abuse create a feedback loop between communities and individuals:

> The high rates of suicide, alcoholism, and violence, and the pervasive demoralization seen in Aboriginal communities, can be readily understood as the direct consequences of a history of dislocations and the disruption of traditional subsistence patterns and connection to the land (p. 609).

Being Indigenous in Canada means that our communities are sources of strength and connection and subject to a perpetual onslaught of colonization, which continues to try destabilizing and alienating us

from our lands, peoples, and cultures. Understanding the nuances of trauma and how it manifests in Indigenous communities is also essential to better understand how a sense of community is crucial to Indigenous identity and healing.

Communities are a part of an Indigenous identity; when the community is affected and destabilized due to colonization, identities are also affected. This creates a feedback loop; Indigenous communities are impacted by colonization, which affects people and their sense of self, translating into dysfunctional relations, which are funnelled back into the community. Sam McKegney (2012) observed that a lack of Indigenous identity is a crisis affecting all Indigenous Peoples, stating that "[t]he systematic decimation of traditional Indigenous social systems and the suppression of traditional roles and responsibilities has indeed created significant crises of identity for many Indigenous people" (p. 255). Janice Hill (2014) points to the lack of positive male identities in her home community of Tyendinaga because of the effects of colonialism: "Most recently, men aren't learning those roles [how to be a good man] themselves because there's nobody to teach them, or very few people to teach them, which goes back to the residential school era" (p. 17). Her observations speak to how the community shapes Indigenous identities and how deeply colonization has injured our communities and our identities. With that said, this is not to suggest that it is hopeless. However, it is crucial to understand how colonization is still an active and immediate presence in our lives as Indigenous people.

It is also crucial to understand that trauma is not isolated to a single source or incident. Like colonization, it is an active process with long-term effects and is not relegated to the past. Elizabeth Comack (2018) notes that trauma and Post-Traumatic Stress Disorder are not just responses to colonization, but a deeper-rooted system that influences all aspects of the Indigenous lived experience:

> we need to understand trauma not as a "response" but as "lived experience," We need to see it as being located with the particular historical and social conditions in which individuals live their lives. In doing so, we can come to appreciate that trauma is not strictly a psychological phenomenon; it has distinctly social determinants (p. 33)

Colonization is rooted in a particular historical context, but at the same time, it manifests in the daily lived experience of Indigenous people across Turtle Island.

Comack's (2018) framework, when looking at trauma and colonization, point to colonization as an ongoing process: "[academia] conceives of colonization as a historical process "in the past" that created unresolved trauma for Indigenous peoples "in the present" – as opposed to being an *ongoing* process that continues to generate trauma for Indigenous individuals, their families, and their communities" (p. 45). Her description of trauma as an ongoing process reflects how colonialism is a process, not as a discreet category or historical period.

Many scholars note that existing in a colonial system has explicit and implicit stress that takes its toll on Indigenous people. Stein & Stein (2011) suggest colonization is something that is navigated by Indigenous people in real-time, all the time:

> Increasing exposure to the dominant society and the increasing influx of new traits, many of which cannot be easily integrated into the existing culture, increasing amount of stress on the individuals. Means of livelihood may be restricted, and new economic patterns may emerge that are not consistent with the ideas of the culture (p. 236).

This fundamental shift brought on by colonialization has an impact best understood holistically; it goes beyond economic impacts or social impacts. It can continually impact Indigenous people and how we know ourselves and how we navigate the post-contact world. The capacity for Indigenous people to navigate spaces that are alienating to our cultures, perspectives and values can be profoundly difficult, which is why it is vital to cultivate a community that reflects our values, ideas and knowledges.

The damage and trauma done to Indigenous Peoples and our identity can have profound consequences which are replicated over generations. Cultivating an identity rooted in values, cultures, and

perspectives that promote relationships with oneself, one's family, one's community, and the land are powerful motivators in the healing process. Given the far-reaching impact of alienation through colonization on Indigenous Peoples and communities, a framework that promotes reorienting oneself can be a massive step on the healing journey. James Frideres (2018), a sociologist focusing on Indigenous peoples, suggests that culture helps maintain identity and community in the face of colonialism: "it is clear that the dominant society has not been able to destroy their culture and identity completely and Aboriginal people are using their fragmented culture and identity to re-assert their Aboriginal identity" (p. 319). Fridere's work speaks to how resilient Indigenous people are; we can navigate any number of spaces: urban, rural, reserve, off-reserve, and still create a sense of community and cohesion that helps us navigate the various forces that are actively and passively trying to assimilate us.

Colonization and the ensuing trauma from colonization are a lived experience for all Indigenous people across Turtle Island. It can manifest in the cycles of violence and dysfunctions in our families and communities or the sense of loss when we cannot speak the languages of our ancestors. As much as trauma is a lived experience and is present in our lives as Indigenous people, it is also something that we have endured, survived and flourished under. No matter how small, any act of resilience is still an act of defiance against a system that has tried to destroy us since contact. This is why cultivating a sense of community and belonging is essential for Indigenous people across Turtle Island. It offers a space of understanding and support as we navigate being Indigenous in a system that was not meant for us.

Healing in Community

Having a sense of community is an integral part of healing. It generates a support network for the bad days and gives a sense of connection to people who may have experienced similar experiences. It is important to stress that communities are flexible; they can be found in different places and with other people. Rupert Ross (2014), in his analysis of the Hallow Water's Community Holistic Circle Healing program, stresses that the communal component is essential to Indigenous understandings of healing (p. 198). Ross (2014) notes that an individual's experiences with traumas, women who have experienced sexual abuse and violence in his study, can be isolated and insular (p. 198). Ross (2014) speaks to the power that Indigenous-led programming, which focuses on communal experiences, can have:

> As I have since realized, a host of important healing steps were just beginning to occur to her, and all of them came from the fact that she was in a group of healing people, not sitting alone on a couch with a single therapist nearby (p. 198).

The development of community and belonging is why Indigenous-led programming is critical to the healing journey. Indigenous-led services and programming rely on creating a space for honest reflection and healing and supports the idea that people do not heal on their own. (Ross, 2014, p. 198) Isolation and disconnection are antithetical to our understanding of what it means to be Indigenous and what it means to heal from the effects of trauma and colonization.

In whatever form that takes, the community is an integral part of the healing journey. Rod McCormick (2005), in his discussion of the healing path, stresses the need for a community's involvement in a person's healing:

> Connection can mean the process of dealing with problems with the assistance of others and not by oneself. Assistance can be obtained from friends, from family, the community, and in the context of group counselling or on a social basis (p. 300).

Community and the connection to something, whether it is friends, family or group counselling, facilitates healing. The critical component is that the work of healing involves (re)connections to something larger than oneself:

> [T]he goal of traditional Aboriginal healing was not to strengthen the client's ego, as in

> non-Aboriginal counselling, but to encourage the client to transcend the ego by considering himself or herself as embedded in and expressive of the community. Like family therapy, systems therapy, and community psychiatry, Aboriginal healing promotes the idea of bringing together many forces to utilize best the powers that promote health (McCormick, 2005, p. 301).

McCormick suggests that the healing journey (or healing path in his text) comprises four stages. The first stage is separating oneself from the unhealthy behaviours and lifestyles that influence their life (McCormick, 2005, p. 302). The second stage is the individual seeking out "help and support from others and establishes social connections with others... The individual feels socially connected when he or she is able to get beyond his or her own world through social interaction" (p. 302). The third stage is experiencing this healthy living while continuing to embed oneself in a healthy community, and the fourth is about maintaining progress (pp. 302–303) Reorienting oneself towards a community, and being connected to said community, can be an excellent way to continue on the healing journey, especially when someone needs an anchor during trying or stressful times.

Healing is an important process and an essential tool to Indigenous Peoples and communities due to the longstanding effects of colonialism that continue to affect our peoples. Healing systems have been a part of Indigenous well-being since before contact. While there were concerted efforts to annihilate these Indigenous systems, they survived the process of colonization. These systems have been adapted into our institutions and programs. They emerged through community programming and Friendship Centres from the 1960s onward and have flourished into different institutions over the past 20 years. The advantage to Indigenous healing practices is that they can become self-sustaining and affect more people as more people go through healing processes. Morgan and Freeman (2009) note that healing does not stop at an individual, and as an individual continues their journey, they can help other people in this process:

> In most Native nations, it is understood that the power of healing comes from a spiritual source and is given to the people. In this sense, it is a renewable resource; i.e., the more the healing is received, the more there is to give...Traditional healing seeks to make things whole—the people, the culture, and the community (p. 90).

The programing and services may be staffed by people who themselves have gone through their own healing journey, and as such, drawing on their personal experiences can be a powerful way to support others on this journey. In this context, the more well-versed a person is in their healing, the more strength they can draw on and help other people going through similar experiences.

Drawing strength from community is an incredible source of power for individuals. It offers a network of relations that can help support people travelling through their healing journey. It also provides opportunities for individuals to interact with people who have gone through similar experiences. Eduardo and Bonnie Duran (1995) note that Indigenous communities and Indigenous services are the most effective way to address issues that stem from colonialization and colonial society. "Things will not get better by themselves, and ultimately it will be up to the community of Native American people to undertake and solve some of the problems" (p. 200). Duran and Duran also point to the work of Paolo Freire's who stresses that the oppressor, or the colonizer in this framework, is not the one that will liberate those who are oppressed; it will be the work of the oppressed who liberate and heal themselves (Duran & Duran, 1995, p. 198). Indigenous communities are sources of strength, resilience, and healing and have the capacity to provide a support network for the healing of Indigenous people.

Healing in Identity

Renewal of Indigenous identities is a part of Indigenous resurgence and health. Overcoming ongoing colonialism and the trauma that manifests itself in our selves and our communities is more than just a matter of succeeding in colonial society. The resto-

ration of our sense of pride, histories, and cultures is crucial to undoing the colonial process. It does not mean that we need to return to some imagined glorious past, nor does it mean dissociating ourselves from the society that has since grown on the back of Turtle Island. One of the most crucial steps to that is how we, as diverse groups of Indigenous Peoples and people belonging to various nations, understand ourselves and our identities and draw strength from them.

One element of Indigenous healing that comes up repeatedly is the role that traditional teachings and practices have in facilitating this process. Teresa Howell (2016), in her work on Indigenous offenders, notes that cultural and traditional practices and experiences are powerful tools in healing former and present incarcerated Indigenous people: "Cultural and traditional experiences can be seen as catalysts for change and contribute to an underlying foundation of the transformation category, with literature supporting this view" (p. 114). The healing process can be a powerful experience and provide opportunities for reflection and growth. Naomi Adelson (2009), focusing on spirituality in the healing process, notes that this process has two components:

> Many Aboriginal people speak about this recuperative process in terms of healing, and for many part and parcel of that process is a (re)awakening or renewal of indigenous spirituality (Harper 1995). Both healing and spirituality are potent and multilayered concepts, textured as much by what people are healing *from* as what they are healing *towards* (p. 274).

Framing healing as a process reflects how Indigenous scholars think of colonization and trauma. None of these concepts are static; they ebb, flow, and change depending on time and circumstances. Adelson's approach of healing *from* something and healing *toward* something highlights this and that people who are healing are active agents in their journeys. Her work also stresses the importance of Indigenous spirituality, and by extension, Indigenous Knowledge.

Numerous scholars have pointed out that orienting healing programming and supports with specific Indigenous cultural practices is crucial to healing. Chris Cunneen and Juan Tauri (2016) suggest three pillars to Indigenous healing: reclaiming history, cultural interventions and therapeutic healing (p. 129). Reclaiming history is understanding the ongoing effects of colonialism. Cultural interventions focus on the recovery of language, culture and ceremonies, but that "culture isn't limited to traditions and the past, it is a living breathing thing. These programs foster identity... [By providing] a different understanding... they are actively creating a new culture of pride and possibility" (Cunneen & Tauri, 2016, p. 129). Therapeutic healing can involve counselling, support groups, traditional ceremonies and healing circles. "They may involve traditional Indigenous counsellors, healers and medicine people, as well as modified or adapted Western approaches" (Cunneen & Tauri, 2016, p. 130). In Cunneen and Tauri's (2016) framework, healing is multifaceted, requiring time, context and cultural and traditional practices. With that said, they also stress that cultural practices and identities are not frozen in time. This approach opens the healing processes to other forms of healing and support, like Alcoholics Anonymous or Western psychiatric traditions.

Rooting healing in traditional Indigenous perspectives allows for cultivating a healthy understanding of what it means to be Indigenous. It undoes the effects of colonialism. It restores lost or damaged practices and gives people the opportunity to address their own traumas in a culturally sensitive manner. It also helps re-enforce the idea that expressing our Indigenous identities is healthy and that our identities are something to be proud of. Another advantage to Indigenous healing practices is that they can become self-sustaining and affect more people as more people go through healing processes. Morgan and Freeman (2009) note that healing does not stop at an individual, and as an individual continues on their journey, they can help other people in this process:

> In most Native nations, it is understood that the power of healing comes from a spiritual source and is given to the people. In this sense, it is a renewable resource; i.e., the more the healing is received, the more there is to give...Traditional healing seeks to make

things whole—the people, the culture, and the community (p. 90).

The (re)construction of Indigenous identities through cultural practices, Traditional Knowledges and community connections are essential components to healing. It is a way to reconnect oneself to histories and cultures that are continually attacked by colonialism. In expressing our identities as Indigenous people, we are active in honouring our histories and highlighting that we are not something relegated to some tragic past. Expressing our identities is crucial in keeping our communities, our relations and ourselves healthy.

Conclusion

The healing journey is about healing from trauma and healing towards a good life. Each path will be unique, and what works for one person may not be helpful for another. Each person has a unique history and culture, and likewise, their experiences are fundamentally different. There is a strength drawn from being a part of a community. Engaging with a community is a critical part of expressing our Indigenous identity. Being Indigenous means navigating the ongoing effects of colonialism in our families, communities, nations, and ourselves. While colonization and trauma continue to affect us and disrupt our relationship, these networks still offer an incredible source of strength and support for our resiliency.

In some cases, communities and families are dysfunctional, or they do not offer adequate support on our journeys. Still, a community can be whatever you need it to be, whether it is a complex system of kinship ties found on reserve or in the city, or it can be a small gathering of people coming together to conduct a sweat lodge once a month. Our identities as Indigenous people are not static; they are active processes that need to be maintained and cultivated. Doing this allows us to be a part of a larger system than ourselves and helps us navigate our lands impacted by colonization. Continuing to support our communities and community initiatives is essential to our resurgence as the proud original peoples of Turtle Island.

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Community-led Recovery from the Opioid Crisis through Culturally-based Programs and Community-based Data Governance

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Community-led Recovery from the Opioid Crisis through Culturally-based Programs and Community-based Data Governance

Abstract

The opioid crisis is disproportionately impacting Indigenous communities in Canada. There is a need to evaluate practical approaches to recovery that include community-based opioid agonist treatment (OAT) and integration of cultural treatment models. Naandwe Miikan, translated as The Healing Path, is an OAT program that blends clinical and Indigenous healing concepts and providers in a community-based setting. Aside from OAT pharmaceutical treatment, clients work with Indigenous counsellors that integrate culture with treatment, such as land-based activities, that reconnect the community to Indigenous teachings and harvesting. In this paper, we present a case study showcasing community advocacy in creating innovative funding models and engaging with clinicians to provide a shared care OAT model with traditional Indigenous counselling, cultural programs, and data sovereignty. Policy needs are identified.

Keywords

addictions, opioids, Indigenous, culture-based treatment, data sovereignty, First Nations Mental Wellness Continuum Framework

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> Honestly, like maybe over a year ago, I was really bad. Like just over a year, I was really, really bad. I didn't care about if I lived or died. I must have OD'ed three times in one week. I still kept going when I got up. I got up after just OD'ing, and I'd just do some more. I was bad. I'm trying to get over that life, and this program has helped me lots. Not only the methadone but the counselling . . . Every day when I started smudging, that really helped too. . . . I think that's when I really started opening my eyes.
>
> —Naandwe Miikan OAT Client

Since Health Canada approved the opioid pain medication OxyContin in 2000, communities in Canada have been affected by rapidly increasing trends in problematic prescription and illicit opioid use leading to growing opioid-related poisoning, first responder calls, emergency department visits, and deaths (Belzak & Halverson, 2018; Jones et al., 2020). All of Canada is affected by the opioid crisis, but there are regional inequities, including access to treatment services and rates of overdose deaths (Belzak & Halverson, 2018). Many First Nations communities are among those disproportionately affected, and some have experienced dramatic increases in opioid use disorder (OUD) rates, opioid-related crimes, negative social consequences, and overdoses (Carriere et al., 2018).

The opioid crisis has sharply escalated during the COVID-19 pandemic as COVID-19 containment measures have increased opioid-related poisonings (The Ontario Drug Policy Research Network et al., 2020). Innovative, Indigenous led, culturally safe treatment approaches are urgently required to support the health, well-being, and recovery of Indigenous people living with OUD.

Using a multi-year case study approach, we examine the phenomenon and complexities of the development of a culturally-based Opioid Agonist Therapy (OAT) clinic in a First Nations community in Canada. We provide insights into why effective First Nations community-based OAT clinics are needed and how they can be established. In the study of the dynamics of complex health systems, "the world moves quickly" (Greenhalgh & Papoutsi, 2018, p. 2) and health services are moving targets (Cohn et al., 2013). This is particularly true at the time of writing, as health services rapidly transform in response to the COVID-19 pandemic.

Background and Literature Review

It is important to discuss our work within the literature of the epidemiology of OUD and culturally-based OAT in Indigenous communities in Canada. We also situate our research within the emergent literature of the intersection of pressing current events and their policy implications: the COVID-19 pandemic and the locating of unmarked children's graves at former Indian Residential School (IRS) sites.

Opioid Misuse, OUD and Treatment

Provincial statistics have consistently shown higher rates of opioid-related harms among First Nations people and the "higher rates of substance use in Indigenous communities have been associated with the effects of colonization, racism, intergenerational trauma, and reduced access to mental health services" (Carriere et al., 2018, pp. 25–26). The Nishnawbe Aski Nation in Northern Ontario declared a state of emergency in 2010 due to widespread prescription opioid misuse (i.e.: use of prescription opioids in other ways than prescribed) (CRISM Ontario, 2016). In 2015, the highest opioid-related deaths per capita in the world were reported in Manitoulin Island, Northern Ontario, where our research is situated (Erskine, 2017). First Nations in British Columbia and Alberta had five times the rate of opioid-related overdoses compared with non-First Nations counterparts (Belzak & Halverson, 2018). Rates of hospitalizations for on-reserve First Nations populations were 5.6 times higher compared with the general population (Carriere et al., 2018).

OAT is a harm reduction treatment for people living with OUD that includes a prescribed daily dose of a long-acting opioid (such as methadone or buprenorphine) to reduce withdrawal symptoms and cravings without a "high." By eliminating withdrawal symptoms, OAT can assist individuals to address areas of their lives that have been negatively affected by addiction (Centre for Addiction and Mental Health, 2016). In Canada, OAT has been used since 1959 in the form of methadone treatment for opioid dependence (Eibl et al., 2017). Each province in Canada maintains oversight of methadone programming, and physicians require an exemption from Section 56 of the Controlled Drugs and Substances Act to administer it (Eibl et al., 2017). Buprenorphine (marketed as Suboxone) has been available since 2008. It is considered a safer alternative to methadone indicated for most clients except those with high-intensity OUD, including high tolerance and frequent use of opioids (Bruneau et al., 2018). In Ontario, both physicians and pharmacists require training in addiction medicine before prescribing or dispensing these medications (Kalvik et al., 2014).

OAT patients receive a daily dose of liquid methadone or sublingual buprenorphine-naloxone (Suboxone) under observation at a physician's office or pharmacy. There are three settings where OAT is provided: 1) in a specialized clinic with staff that may include physicians, counsellors, pharmacists, social workers, and case managers; 2) in a doctor's office; or 3) in federal or provincial correctional facilities (Eibl et al., 2017).

In Canada, registered First Nations and recognized Inuit people receive coverage for a range of select health benefits. First Nations people accessing OAT receive financial coverage of methadone and Suboxone included in their benefit plan (Government of Canada, 2021).

Indigenous Culturally-based OAT in Canada

There is emerging research on Indigenous culture-based OAT interventions. In 2011, the Cedar Project examined variables in methadone maintenance treatment (MMT) of 605 Indigenous participants in Vancouver and Prince George, British Columbia. Results revealed that less than half of those reporting daily injection of opioids were ever on MMT, and those who had used MMT were more likely to be older adults, female, and had hepatitis C antibody positivity (Yang et al., 2011). In 2014, Rowan et al.

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reviewed 4,518 research articles that integrated Western and culture-based treatments, 42% based in Canada. In total, 17 types of cultural interventions were identified, with Sweat Lodge Ceremonies being the most frequent (68%), followed by smudging with sage, cedar, and sweetgrass (63%), and social, cultural, and family-based activities (58%) (Rowan et al., 2014). The authors found that 74% of the studies showed a benefit in reducing or eliminating substance abuse through these programs.

Community members of Eabametoong (Fort Hope) in northern Ontario explained their reasons for starting a community OAT program was the growing sense of loss in family and community life and a particular concern over the effect of addictions on children. Those seeking treatment often did so to bring families back together. The physician researcher believed that "the success is rooted in the community's ownership of the program" and "in Eabametoong, there is an understanding that the addiction epidemic is undermining the physical, mental, spiritual, and emotional well-being of the people and that [therefore] the healing must also be physical, mental, spiritual, and emotional" (Uddin, 2013, p. 392). However, information needed to create similar holistic healing services elsewhere, such as a description of services and explanation of how they are structured, financed, and supported by policy locally and nationally, was not reported.

Currie et al. (2013) examined "Aboriginal enculturation" defined as how Aboriginal[1] peoples identify with their culture and engage in cultural behaviours and found it to be a protective factor against illicit drug problems. Kanate et al. (2015) examined a community-developed opioid dependence treatment program inclusive of First Nations healing, addiction treatment, and substitution therapy in remote northwestern Ontario First Nations communities. The study measured changes in the number of criminal charges, addiction-related evacuations, child protection, school attendance, and attendance at community events. One year after the development of the program, changes in the community included: overall criminal charges dropped by 61.1%, child protection cases decreased by 58.3%, school attendance increased by 33.3%, and attendance at community events increased by 20% (Kanate et al., 2015). Though it is a promising study supporting the effectiveness of culture-based treatments, there was no information about the traditional healing and land-based activity components and their integration or funding.

Mamakwa et al. (2017) conducted a retrospective study of six northwestern Ontario First Nations with 526 participants in opioid dependence programs, buprenorphine-naloxone substitution therapy, and First Nations healing programming. Each community designed its own program with staff and consultants with oversight by political and community leaders and health directors. Furthermore, "a 'Land' aftercare program has been developed in some communities, with organized days of fishing, hunting, traditional walks for memorial events, and community gardening programs. Elders and experienced First Nations counselors provide individual and group healing sessions where possible" (Mamakwa et al., 2017, p. 140). Results indicated a high retention rate with negative drug screening, and the authors conclude, "First Nations communities in other provinces should establish their own buprenorphine-naloxone programs, using local primary care physicians as prescribers. Sustainable core

[1] The term "Aboriginal peoples of Canada" is defined in Section 35 of the Constitution Act of Canada, 1982 as including Indian, Inuit and Métis peoples of Canada. The term "Indigenous" is used internationally to describe original people of an area and is increasingly replacing the term Aboriginal in Canada.

funding is needed for programming, long-term aftercare, and trauma recovery for such initiatives" (Mamakwa et al., 2017, p. 137). The authors recommend that medical providers and provincial and federal governments support cultural, community-based programs.

Impact of the COVID-19 Pandemic on People Living with OUD

Opioid-related deaths increased by 38% in Ontario within just the first three months of the declaration of emergency measures to slow the spread of COVID-19 on March 16, 2020 (Gomes, Murray, et al., 2021). Morin and colleagues (2021) reported a 108% increase in fentanyl use among Ontario OAT clients and attribute this to the increased stress and reduced monitoring and support for OAT clients. More recently, drug supply chains have been disrupted, resulting in the street drug supply being increasingly contaminated by newly created extremely potent synthetic opioids (Cribb, 2021; Gomes, Murray, et al., 2021). Gomes, Murray et al. (2021) stated that by December 2020, "the absolute number of opioid-related deaths increased considerably across geographic regions of all population densities, with numbers nearly doubling in rural areas" (p. 20). A geographical analysis revealed that the top five largest increases in opioid-related death rates per public health region were located in Northern Ontario, with the highest in Sudbury and Districts (Gomes, Murray, et al., 2021), the region that includes our study location of Manitoulin. COVID-19 containment measures introduced additional hardships for people who use drugs, including reduced access to pharmacies and outpatient clinics as well as harm reduction services such as OAT clinics and supervised consumption sites (Gomes, Kitchen, & Murray, 2021). The authors also noted increases in death rates of younger people and increased presence of fentanyl and stimulants in those who overdose. They emphasize an "urgent need for low-barrier access to evidence-based harm reduction services and treatment for OUD in all jurisdictions grappling with the overdose–COVID-19 syndemic" (Gomes, Kitchen, & Murray, 2021, p. 3). Clearly, it is critical to situate policy implications related to OAT within the COVID-19 pandemic as the impact on health and health services will linger for years to come.

An Intersection of Multiple Crises in Indigenous Communities: Opioid Misuse, COVID-19, and Undocumented IRS Burial Sites

Many Indigenous leaders have leveraged self-determination for community lockdowns and monitoring infection rates in the community to respond very successfully to the pandemic (Richardson & Crawford, 2020). However, distancing measures have resulted in isolation and reduction in access to cultural, spiritual, and land-based activities (Mashford-Pringle et al., 2021). Further, Wendt and colleagues (2021) state that COVID-19 containment measures have "exacerbated opioid use problems among Indigenous communities [in Canada and the USA], especially for individuals with acute distress or comorbid mental illness, or who are in need of withdrawal management or residential services" (p. 2). Further increases in acute stress, depression, and anxiety in many Indigenous clients were also observed by mental health service providers when the first Indian Residential School unmarked gravesite of Indigenous children was found in May 2021 (Taylor & Neustaeter, 2021). The revelation of the gravesites has caused deep grief and re-traumatization for many Indigenous and non-Indigenous people, but especially for IRS Survivors and the families of missing children (Sound & Jones, 2021). Indigenous service agencies have been overwhelmed with requests for trauma support services. In an interview, Jason Mercredi, of Prairie Harm Reduction in Saskatoon, explained the discoveries are triggering

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"troublesome memories" for IRS Survivors and have resulted in more visits to the local supervised (drug) consumption sites, where clients are seeking mental-health support. "We can't really keep up, and it's tough because some of these folks have been successfully coping for a number of years" (Hobson, 2021, para. 5). Front line workers are also noting that individuals who have been in long-term recovery are being triggered and are struggling with their recovery. The Indigenous health system is simply insufficiently resourced to meet the need for support. Adequate resourcing commitments informed by research on effective Indigenous community-based OUD treatment models are needed.

Methodology and Setting

Our case study methodology follows a community-based participatory approach that invites citizens of Wiikwemkoong[2] Unceded Territory to collaborate as partners with the academic team (Holkup et al., 2004; Manitowabi & Maar, 2018). Specifically, community leadership collaborated on setting the research objectives, and a community advisory committee (CAC) with representation from community members and organizations guides all aspects of the research process and ensures that the work meets the needs of the community.

A case study involves qualitative research in which "the investigator explores a real-life, contemporary bounded system (a case) . . . over time, through detailed, in-depth data collection involving multiple sources of information (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a case description and case themes" (Creswell, 2013, p. 97). In this case study, we explore the development of culturally-based OAT services congruent with the restoration of mino-bimaadiziwin (Anishinabe holistic health) among people with addictions and more broadly within the First Nation of Wiikwemkoong Unceded Territory. We chose this methodology because it is useful when little is known about a phenomenon, and case studies can "generate an in-depth, multi-faceted understanding of a complex issue in its real-life context" (Crowe et al., 2011, p. 1).

Data Collection and Analysis

In line with the case study tradition (Creswell, 2013; Cronin, 2014), our methodology included multiple methods, including intensive field research, review of program documents and electronic records systems, deep observational research (see Flyvbjerg, 2006), informal group discussions with advisory committees and service providers, as well as formal interviews with OAT clients and service providers (see Brogan et al., 2019). The questions we ask were focused on why a community-based OAT clinic was needed, the community development required to establish it, and the participants' current experiences. The interviews with direct service providers and clients at the Naandwe Miikan clinic explored these topics in an open-ended format (see Table 1). Participants were recruited through fliers posted in the clinic. Those who were interested were provided with more information by the community researcher and case manager (TO), who scheduled the interview with one of the academic researchers (MM). Participants often recounted traumatic events, and support was offered during and after each interview by a traditional healer. All interviews were recorded, transcribed, and thematically analyzed

[2] The people of Wiikwemkoong self-identify as Anishinabe (variously translated as "original person" or "good person") of the Three Fires Confederacy (Ojibwa, Odawa and Pottawatomi tribal groups).

using NVivo 12 qualitative research software. All authors reviewed the themes individually, shared their findings, and came to consensus though discussion.

Table 1. Method and Number of Participants

Method	Date	Number
Client Interviews	Nov. 2017	16
Service Provider Interviews	Nov. 2017	5
Community Agency Interview	July 2018	1
Land-based Activities (7 in total)	May 2019–Nov. 2022	104
Total		126

We also engaged in participant observation to experience the land-based experiences *in situ*, to observe community participation, and better understand the significance of land-based healing. We purposely offered research specific land-based activities in addition to those regularly scheduled, and we advertised our sessions as being part of the research project. For example, Naandwe Miikan generally holds 2–3 hunts, and we sponsored an additional one to avoid interfering with the customarily scheduled community hunts. We furthermore collected audiovisual footage for a forthcoming video ethnography (Maar & Msheekehn Trudeau, 2019). Participation was voluntary, and at the start of each activity, we explained the purpose of our research and received consent from participants.

Finally, we observed administrative practices, including community access to clients' electronic medical records (EMR) and aggregated electronic data for reporting on the effectiveness of the Naandwe Miikan approach for quality improvement purposes. We reviewed access to aggregated EMR data coded as intake data, dosing data, access/referral to supportive services, and traditional Indigenous support services and how these indicators might be related to clients' recovery based on the community goal of holistic health and well-being.

Iterative Design

Yin (2013) reminds us that "to arrive at a sound understanding of the case, a case study should not be limited to the case in isolation but should examine the likely interaction between the case and its context" (p. 321). Therefore, case studies use a flexible and iterative approach that allows for continuous data collation and analysis (Cronin, 2014). This feature of our methodology allowed us to integrate emergent evidence of the impact of COVID-19 on OAT and its policy implications based on our ongoing co-research and member checking with the CAC into 2022.

The Laurentian University Research Ethics Board and the Manitoulin Anishinaabek Research Review Committee granted ethics approval for this research project, and the Wiikwemkoong Chief and Council provided approval through a Band Council Resolution.

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Results

Description and History of the Naandwe Miikan OAT Services

Naandwe Miikan OAT clinic is situated in Wiikwemkoong Unceded Territory on Manitoulin Island, Ontario, Canada. Its goal is to offer OAT with a culturally safe, community-based integrated approach designed to connect clients to Indigenous culture and inspire hope, belonging, and connections. The Naandwe Miikan approach is focused on cultural and community safety by incorporating the holistic health and well-being concept of mino-bimaadiziwin; the program strives to build collaboration across community sectors including health, social services, justice, policing, and employment. Staff create safe policies, such as rigorous criteria for take-home doses that go beyond OAT clinical practice guidelines.

In 2014, when the Naandwe Miikan services began, many members of this tight-knit community had been directly or indirectly touched by social consequences of the rising rates of opioid addictions. Deterioration of community relationships, increases in family violence, break-ins, and human trafficking were significantly affecting community life. Many people with opioid addictions had long burned bridges with families and friends. Interviews revealed that the notion of using scarce community resources to create OAT and supportive services for "drug users" [sic] was contentious and frustrated many community members who were not familiar with harm reduction approaches (see also Narbonne-Fortin et al., 2001). The community hosts a well-known abstinence-based treatment program with cultural components of healing through a medicine wheel framework and Seven Grandfather Teachings combined with positive psychology (Downton et al., 2019; Manitowabi, 2017). This abstinence-based approach was seen by many as preferable over OAT because the community lacked confidence in relying on drugs for the treatment of an addiction. One provider explained:

> Harm reduction is totally different from an abstinence-based program. Our community members are accustomed to abstinence-based programs . . . [but at Naandwe Miikan] success is not abstinence, instead success is when the clients walk through the door. (Service Provider)

Some considered the OAT approach as incompatible with living a good life or mino- bimaadiziwin, the Anishinabe worldview of health and healing. From this perspective, to return to an ideal living state, people focus on healing from a physical, mental, emotional, and spiritual perspective and become free from depending on substances. In contrast, OAT focuses only on the physical aspects of recovery. For OAT to become accepted in this community, the model needed to focus on a holistic approach to recovery, integrating cultural approaches, educating the community on harm reduction, and maintaining a long-term recovery goal of eliminating drug therapy when this can be done safely.

Thematic Analysis

From 2017 to 2018, we conducted 22 interviews with Naandwe Miikan clients (16), service providers (5) and community agency staff (1). During the year 2018–2022, we attended seven land-based Naandwe Miikan activities that included trapping, fishing, traditional medicine harvesting, and deer and goose hunts with 9–20 participants (see Table 1).

The thematic analysis of the transcripts revealed several themes related to the development of OAT in the community: recognizing an urgent need for community-based services, focusing on the specific needs of clients and the community, and anchoring Anishinabe Knowledge and culture in recovery. We expand on these themes and their subthemes and showcase selected quotes from this qualitative analysis.

Recognizing an Urgent Need for Community-based Services

This theme explores the reasons why a community-based OAT clinic needed to be established in Wiikwemkoong.

Social Effects of the Opioid Crisis

Naandwe Miikan arose from the inescapable effects of opioid addiction and its devastating community-wide impact.

> There was a huge opiate problem here before this clinic was here. And I do think that maybe there's some people that wouldn't be here today. (C7)

> I think people aren't realizing the impact . . . this little place, it reverberates throughout the entire community. We are cousins, uncles, aunts to all these other people in the community. We're entrenched in a community and we need more help. (C14)

For example, before Naandwe Miikan, OUD often translated into criminal behaviour to obtain opioids. In one poignant incident in the community's reckoning with the opioid crisis, a home invasion theft of prescription opioids led to homicide.

> [T]here [are] a lot of individuals affected by our criminal justice system. Either it was through whichever trouble they've gotten into, that is decreased because they don't have to go and do home invasions as what was occurring in our community before. Robbing people, stealing off their parents or their grandparents for their medication. So that's discontinued now. So that's how the program works also. It eliminates – it decreases the amount of criminal activity in our community. (S1)

> At that time, there were a lot of home invasions, there was a murder based on opiates, there were people—parents getting their medication stolen. All of this stuff was happening without this clinic being in the community. (S1)

Inaccessibility of OAT Services located "in Town"

Originally, methadone treatment was not available in the community and patients were required to travel 45 minutes one-way to a clinic to a nearby town off-reserve, an all-consuming daily experience factoring in return transportation and wait times at the clinic. The community health services provided transportation offering several trips back-and-forth daily, however, due to public pressure in opposition to the clinic's location in the town's central business section and its perceived negative impact on

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businesses, the town council re-zoned the location. This led to the closure of the clinic. The prescribing physician invited Wiikwemkoong clients to an OAT clinic in a more distant town, thus increasing travel time to over 2 hours. This created the impetus for Wiikwemkoong to take control and offer localized OAT (Manitoulin Expositor, 2013). This development was well received by clients:

> [W]hen I heard about [this program], I was happy. I was like that's good, then people won't have to leave their kids everyday. It was really bad though when the methadone office in Little Current closed and then everybody had to travel to Espanola. And then, when that didn't work out, we all had to go to Sudbury. So, we were gone all day away from our kids, you know. (C7)

> You can do a lot more with your day. You feel more productive and all that. It's a lot better. Like more people can access it, that are struggling and all that. It makes it a lot easier [than] to have everything in town where some of us can't even access stuff like that. (C9)

Focusing on the Specific Needs of Clients and the Community

This theme explores the community, organizational, and policy development required to establish community-based OAT in Wiikwemkoong.

Community-based OAT Policy Development

Initially, OAT in Wiikwemkoong was based on a mainstream model with little accountability by the visiting providers to the community or collaborative practice with First Nations services. Ultimately, the community terminated its relationship with those service providers and recruited another physician, with the understanding of increased local control over the clinic and collaborative program development, the integration of traditional healing approaches, active involvement of local staff in the treatment, and more robust reporting and communication with political leadership. This led to the creation of the Naandwe Miikan clinic. The ultimate goal was to support clients' healing from an Anishinabe perspective, with the ultimate goal of safely reducing reliance on medication when possible.

> The clinic was brand new and what I did was develop policies in which we wanted to make the program successful and to assist individual wellness to slowly get off of this medication or decrease their doses. So, what I did was create policies where I would advocate for the client; if they feel that they have to get their doses lowered, we would make sure that the worker sits with them, with the physician, and requests for that dose to get lowered. And if the doctor said no, that worker would advocate for them to decrease that dose. (S1)

Take-home doses (carries) were provided to clients after initial stabilization had occurred. Take home doses could threaten the community if given to clients who are not yet well enough to use them as prescribed. Stringent guidelines with oversight were developed to ensure that clients met community-identified indicators of participation in community life and demonstrated being stable in their healing journey.

> Carry agreement contracts that we developed [are] nowhere in any other treatment facility in Ontario. . . . Our policy from the community, states you have to be abstinent [from illicit drugs] for two months. You have to be doing two urine screening deposits a week. You have to do one toxicology test a month because that's more accurate than the urine screening. And you also have to be taking part in counselling, be employed in the community, [or] volunteering. . . . So those are the criteria which have to be followed in order to get a carry. . . . [So] making it very structured [so that clients] have to earn those carries and not just [be] given this medication that could be sold on the street. (S1)

Increasing Interprofessional Collaboration for Effective Case Management

The opportunity for local and integrated community service involvement in OAT presented challenges. It required advocacy for improved care and sufficient resources. Initially, this posed a challenge of heavy caseloads for the community clinic manager with no additional resources. It further required collaboration with other social service providers since clients needed access to these support services. OAT clients require coordinated access to social services such as employment and training and child and family services to facilitate positive treatment outcomes. During our research, additional investments in Naandwe Miikan addressed the issue of human resource needs:

> Not enough case managers is the biggest thing because what I'm encountering here is I can't do all of that. I'm supposed to be doing the case management for clients for 132 people which is kind of impossible. But I'm still trying to reach out to the [community] programs to tell them this is how this has to go. This is how we have to make this run smoothly. If you want our clients to be successful, and you know, to stay out of the justice system or get their children back, we all have to work together and we all have to sit down together. Not leave one organization out when you're having these case conferences. (S1)

Offering a Holistic Approach to Care

From the perspective of the Indigenous knowledge of mino-bimaadiziwin, clients require more than pharmacological substances to be well supported in their healing journey; instead, the whole person requires attention. This approach is the core of Naandwe Miikan and significantly different from mainstream OAT programs.

> Whenever we give any medication; we always say take this medication along with other things. . . .So along with other things is his emotional situation, how he's feeling, financial problems, actual problems whether he's depressed or not, whether the person has limitations, how the children are doing. . . . I mean if you don't do the other things then medicine will not work. So those are the things that are the social things, financial things, your emotional things, spiritual things. So, these are important, and these cannot be given by doctors, they cannot be given by pharmacists; it can be given only with the teamwork. (S2)

> [W]hen we dispense our medicine, this is a routine, we always say "along with." If I give a pill, I say take this medicine along with other things, meaning that this medication will be effective if

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> you will take it with other things. What other things means that you have to take care of your education, you have to take care of exercise, you have to—if somebody doesn't do anything, then taking simply a medicine is not an effective thing. . . . the personal care is very important. Somebody should feel that somebody is there to take care of them. [S2]

Anchoring Anishinabe Knowledge and Culture in Recovery

This theme explores the programs and experiences that Naandwe Miikan offers by integrating Indigenous knowledge and recovery.

Integrating OAT with Mental Health and Traditional Indigenous Counselling

A unique component of the Naandwe Miikan program is the integration of OAT with mental health and traditional Indigenous counselling. Clients are encouraged to seek mental health services in the community as well as to speak with traditional counsellors. Natural Helpers[3] are also part of the program. Community leadership advocated successfully for funding of Natural Helpers as legitimate Indigenous healing providers in addiction treatment with government funders (First Nations and Inuit Health Branch).

> I've learned these teachings about having that flame inside of us. So a lot of individuals we are assisting, dealing with this substance use, that flame is very low in them. So when they come in, we're just helping them, give them tools and motivating them and encouraging them to how to stoke that little fire inside of them. And as they start to stoke it and we start to give them some tools, not showing them how to do it but giving them those tools, how to do it themselves and they rebuild that fire inside them themselves, and they start to feel more empowerment within the individual and start to regain their motivation again and purpose. (S1)

Natural helpers are also integrated in land-based activities, and this encourages clients to socialize with community members.

> Land-based activities, I guess would be close to normalizing them, grounding them with Mother Earth. A lot of times, [clients]—they don't go out except among with other friends that have addictions. They don't have that time to find out—you could associate in public normally without having that addiction. So, when we have these land-based activities, either we're harvesting medicine, or we're going for fish, or we're hunting. (S4)

Applying a Family-based Approach to Land-based Activities

The Naandwe Miikan approach recognizes clients are not isolated individuals but instead they need to be part of a family and belong in the community, connected to a network of social relations. Thus,

[3] "Natural helpers are Indigenous peoples who already live in the community and are already well known as a reliable support person for anyone to reach out to during a time of crisis" (Dudgeon et al., 2018, p. 13).

activities that are land-based incorporate a significant social element to rebuild relationships with family members and rectify the hurt caused by past addictive behaviours.

> And it's grounding the clients individually, and their families. So, in order to take their families out, it's just as important they're going out. Because they're the witness to their mother, to their father, in their addictions. So, it's starting that rippling effect. So, these children actually view that. They're viewing what their parents are doing. (S4)

Exploring Land-based Healing

In land-based activities such as community hunts or medicine harvesting sponsored by Naandwe Miikan, community members come together with OAT clients. Experienced hunters, trappers, and harvesters guide community participation in these events. We observed participants having the opportunity to learn and engage in traditional activities that they had not learned due to the cultural disruption of colonialism.

> Everyone here has a different story . . . [but] they're here for one reason. It's to find that healing journey. So, this is really important for these people to attend these medicine harvesting. And we showed them the protocols and what to do and how to prepare it, what it helps. And teaching those kids that, they teach their friends, they'll teach their family, they'll teach their kids. And now these kids are coming along and they're going "Wow, we've never done this before, this is cool!" Then they're seeing mom or dad all of a sudden, like wow. There is another side of life besides being in addictions or being an alcoholic. (S4)

We observed young children learning how to skin a harvested beaver, taking part in cleaning fish, and accompanying hunters on the land. The land-based activities functioned similar to a family outing, bringing clients together to cook and eat together, sharing stories and local land-based histories of traditional use of the land. Experienced hunters mentor community members in this Indigenous knowledge while teaching fishing, hunting, and trapping skills. A strong sense of acceptance and belonging was evident among participants.

Self Determination and Data Sovereignty

This theme provides insights into how much self-determination the community has to access quality data to monitor the effectiveness of Naandwe Miikan Services and make informed decisions about ongoing service development needs. We found that clients typically had many separate electronic medical records, including an OAT record, a local health clinic record, family physician health record, a mental health services record, and perhaps other records with off-reserve providers. Exactly how many different health records each client had is unknown. At the time of the research, there was no capacity to link client records to determine health service use patterns, such as the level of support clients received from primary care or mental health services. Only one case manager had access to individual health records with clinical information such as intake data, doses, and toxicology screens. However, clients' participation at cultural events and traditional or mental health counselling were missing in this record system. Furthermore, the manager did not have access to the EMR system's query section and,

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therefore, could not run aggregate data for individuals or statistics for the whole clinic. The ability to explore summary statistics and trends over time was not made accessible to community staff, which indicates a poor usability of the vast electronic data to support informed decision making. Accordingly, there was minimal capacity to track the program's effectiveness using quantitative evidence within the OAT health records system or other community health or mental health records. The records of a single client at different service agencies were not linked, and that precluded a bird's eye view (let alone analysis) of care pathways or value of cultural supports for OAT clients. The Principles for Indigenous Data Governance such as collective benefit, authority to control, and responsibility to support community data capabilities are therefore not well realized in the OAT program. It limits the community's ability to analyze services, conduct evaluations, and base program decisions on documented treatment outcomes.

Discussion

This case study was designed to shed light on why a community-based OAT clinic was needed, the community development required to establish it, the client and staff experiences, and related policy implications. The original access to OAT services for community members of Wiikwemkoong was off-reserve, providing an "out of sight, out of mind" approach. However, several health and political leaders were adamantly advocating that addictions *must* be addressed by the community, and the approach *must* be community-driven and incorporate a community vision for healing. In this section, we discuss the policy development needed to support Indigenous self-determination to facilitate mino-bimaadiziwin in OAT with the backdrop of current events.

Implications for First Nations-led OAT

Working Towards Restoring of Mino-bimaadiziwin

In line with findings in the literature (Kanate et al., 2015; Mamakwa et al., 2017; Rowan et al., 2014; Uddin, 2013), our case study shows that a community-led approach to OAT can lead to more culturally safe experiences in clients' recovery; however, there are complex barriers that have to be overcome. A core requirement for the implementation of this model to succeed was the ability of community staff to advocate for clients with the prescribing physician and dispensing pharmacist to integrate OAT services within the community service and cultural context. While there is cooperation between providers, power structures in the health system provide a challenge for true service collaboration. Funding models for physicians and pharmacists do not incentivise the high level of interprofessional and cultural integration that the community is seeking, and collaborative care with community providers is not a requirement of their professions. Conceptual barriers to a First Nations community-based collaborative model had to be overcome, and this required significant advocacy and commitment by community leaders. In fact, prior to the First Nations leaders' advocacy work, the precursor to Naandwe Miikan, the Wiikwemkoong OAT clinic's operational structure focused exclusively on drug prescribing and dispensing. Based on community perception, clients would enter the clinic, acquire their medication, and leave, arguably without any healing taking place.

That model was incompatible with the concept of mino-bimaadiziwin because it only addressed the physical aspects of addiction. Ultimately, this model was opposed by the community leadership and the clinic was terminated. Then, after comprehensive community consultation with social services, police, political leadership, health, education, and Elders, Naandwe Miikan was born. This engagement of relevant community agencies was critical in Naandwe Miikan becoming a community OAT clinic and is symbolized by its Anishinabe name and increased community oversight. From the perspective of Wiikwemkoong clients, OAT prescribing physicians and dispensing pharmacists come and go, but Naandwe Miikan is in the community to stay. Hence, the clinic's spirit and intent will remain in the community to support clients' recovery in a culturally congruent model as long as there are opioid addictions to address (Ominika, 2018).

Despite their often-tenuous relationship with the community, physicians and pharmacists have tremendous power and influence in providing health care, and current health policy ensures that most of the financial resources that cover OAT are allocated to their services. This authority is exercised within a biomedical framework that does not create space for the concept of mino-bimaadiziwin or other Indigenous community-based holistic healing models. We have not found this problematized in the literature thus far; however, it was not acceptable at Naandwe Miikan. Another core component of the community-led approach was to allocate resources for culturally informed counselling, treatment, and support for reintegration into community life. To achieve this, the community required that the pharmacy provide suitable clinic space that included several office rooms for counselling and case conferencing. To improve equity, the private medical clinic is required to apply some of its profits to cost share traditional Indigenous counsellors and cultural and land-based activities with the existing community programs.

The Naandwe Miikan staff supports clients in their healing journeys by reuniting families in land-based activities; this integrates Anishinabe knowledge in the recovery process. Advocacy for families also takes place with child protective services or assisting with housing, employment and job training, and staff providing personalized support for each client's unique healing journey. This is a crucial element for clients to recover and requires policies for interagency collaboration. Clients become hopeful for the future when they experience caring support and a renewed sense of belonging in the community. Physicians and pharmacists simply cannot fulfil this time-consuming, stabilizing, supportive role that is often the cornerstone of clients' recovery journey; nor do they understand the Indigenous client sufficiently to identify their cultural needs and their position in the community to provide personalized support. The collaborative care model involving community staff in clinical discussions on dosing, tapering, and take-home doses is, therefore, essential for clients to achieve their wellness goals.

Policy Environment of Indigenous Data Sovereignty

Culturally-based innovations in OUD require accurate personal health records to support informed decision-making in treatment plans. Therefore, Indigenous sovereignty in access to usable electronic health data is central to Indigenous self-determination to develop effective culturally-based services (Loutfi, et al., 2018; Maar, 2006; McBride, n.d.; McRae-Williams et al., 2018; Schultz & Rainie, 2014; Trevethan, 2019; Walker et al., 2017). From a policy perspective, most of this literature focuses on large-

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scale, global, national, or provincial approaches to Indigenous data sovereignty. There are significant global calls for Indigenous data sovereignty as well. Data sovereignty is embedded in the United Nations Declaration for the Rights of Indigenous Peoples (UNDRIP), which stipulates Indigenous Peoples have the right to improvements over "their economic and social conditions, including . . . health and social security" (United Nations, 2007, p. 17). In Canada there are further linkages with the Truth and Reconciliation Commission's (TRC) Calls to Action, specifically call 53.iii, to, "develop and implement a multi-year National Action Plan for Reconciliation, which includes research and policy development, public education programs, and resources" (TRC, 2015, p. 6).

On a national level, there have been formal positions on Indigenous data sovereignty for several decades. These include the Royal Commission on Aboriginal Peoples (RCAP, 1996) and the First Nations Information Governance Centre (FNIGC, 2021). The RCAP recommended:

> First Nations, Inuit and Métis leaders establish a working group, funded by the federal government, with a two-year mandate to plan a statistical clearinghouse controlled by Aboriginal people to (a) work in collaboration with Aboriginal governments and organizations to establish and update statistical databases; and (b) promote common strategies across nations and communities for collecting and analyzing data relevant to Aboriginal development goals. (1996, p. 218)

However, in the same year (1996), Canada's federal government excluded on-reserve First Nations from three major Canadian population surveys. The Assembly of First Nations responded by forming a National Steering Committee to undertake a First Nations health survey (FNIGC, 2021). This action resulted in the creation of the First Nations and Inuit Regional Longitudinal Health Survey (1997), the first Indigenous-governed national health survey (FNIGC, 2021). A year later, the steering group released a position paper on data sovereignty known by the acronym OCAP, referring to First Nations ownership, control, access, and possession of their collective data. In 2000, the committee transitioned to the First Nations Information Governance Committee. Ten years later, it incorporated into an independent non-profit entity, the First Nations Information Governance Centre (FNIGC, 2021).

The FNIGC continues to advocate for data sovereignty, given that it concerns a resource used in policy development, decision making, and to leverage funding. In this context, it is data holders, most often non-Indigenous researchers, who acquire and hold prestige rooted in the control of Indigenous data (FNIGC, 2016). According to the FNIGC, "First Nations themselves are the only ones who have the knowledge and authority to balance the potential benefits and harms associated with the collection and use of their information" (2016, p. 141). Given this circumstance, there is a need to establish Indigenous jurisdiction over data by enacting privacy and access to information laws, to define relationships, and if applicable, repatriate data back to First Nations or engage in sharing agreements (FNIGC, 2016).

Researchers are also responding to the global declaration of Indigenous self-determination and the TRC Calls to Action. For instance, a consortium of international researchers is advancing the CARE Principles for Indigenous Data Governance for research to be of collective benefit to Indigenous Peoples, to extend authority to control data, to exercise responsibility, and to engage in ethical research (Carroll et al., 2020). Certainly, Indigenous Peoples' data are diverse. They comprise knowledge of the

land and non-human beings, administrative data about Indigenous persons, oral histories, and Indigenous knowledge (Carroll et al., 2020), and thus the implications of CARE are complex:

> When working with Indigenous data, there is a responsibility to nurture respectful relationships with Indigenous Peoples from whom the data originate. Aspects of the relationship include investing in capacity development, increasing community data capabilities, and embedding data within Indigenous languages and cultures. Pursuing these goals fulfills the ultimate responsibility of supporting Indigenous data that advances Indigenous Peoples' self-determination and collective benefit. (Carroll et al., 2020, p. 6)

In Canada, several Indigenous data sovereignty frameworks have been implemented. The Institute for Clinical Evaluative Sciences (ICES) is a provincial research institute home to researchers who have access to the province's administrative health services records (ICES, 2021a, 2021b). ICES recognizes that Indigenous Peoples' have a right to access data about their communities and to determine the use of these data (Pyper et al., 2018). ICES has partnered with the Chiefs of Ontario, an Indigenous political advocacy organization, with a framework to advance ethical relationships, engage in data governance and collaborative methodologies and approaches, and seek evidence to build policies and programs (Pyper et al., 2018). However, there is also a need for community-specific access and analysis of local data to support decision making. Walker and colleagues (2017) stated:

> Indigenous peoples have long claimed sovereignty over their culture and lands and are now making this claim over health data, believing this will empower communities and guide them in advocating for better health and health care . . . Greater efforts are needed to track the health of Indigenous peoples, and address concerns about the ways in which data are gathered and the political ends to which they might be used. (p. 2022)

Based on our case study, we argue there is an urgent need for policy development to support community-based sovereignty over usable health and social service data related to opioid recovery. This will empower communities to integrate Indigenous healing approaches and to evaluate the effectiveness of these services based on Indigenous criteria such as the restoration of mino-bimaadiziwin.

Policy Requirements for Indigenous Community Data Sovereignty

If a core element of a successful community-led OAT approach is community oversight of the effectiveness of culturally-based programs, then health services data must be accessible for analysis at the community level. First, comprehensive individual client health information, including their OAT records linked to other health and mental health records and cultural program participation, must be accessible to a case manager to support informed decisions with the client concerning their recovery journey. Second, the community requires the capacity to de-identify and aggregate health services data, to track statistical trends in treatment outcomes, and to analyze how these outcomes coincide and relate to cultural and clinical supports. Ultimately, this should include the ability to track community-identified, culturally-based indictors of wellness. However, in our case, access to individual OAT health records was restricted to one community staff member, and the many different client chart data could not be linked to understand clients' recovery from the holistic perspective of living a good life. Data

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sovereignty policies urgently require further development so that data can become accessible to the community to track what cultural approaches work best to support clients at Naandwe Miikan. Data usability is an important aspect to consider for all community-led OAT services.

The Convergence of the COVID-19 Pandemic and the Opioid Crisis

Prior to the COVID-19 pandemic, there was already an urgent need to improve access to opioid treatment in First Nations communities. Barriers to treatment included structural disparities such as geographic isolation, jurisdictional divides, and lack of evidence-informed, culturally-based or culturally congruent services (Eibl et al., 2017). With the onset of the COVID-19 pandemic, some First Nations experienced a doubling of already elevated opioid and particularly fentanyl-related overdose-deaths (Mashford-Pringle et al., 2021). As a COVID-19 containment measure, many First Nations restricted community access, which reduced transmission of COVID-19. For now, the unintended consequences of physical distancing policies have resulted in reduced access to monitoring of OAT, naloxone kits to counteract overdoses, clinical and traditional Indigenous counselling, and support for land-based healing activities (Mashford-Pringle et al., 2021). Further, and perhaps less predictably, there has been an interruption of supply chains of street drugs, as well as a subsequent increasing trend of mixing illicit drugs with fentanyl and other even more potent synthetic drugs, that trigger increased rates of overdosing (Sutherland & Maar, 2019).

Our local observations during COVID-19 suggest that opioid-related overdoses, resulting in deaths of people with concurrent disorders, have increased since the start of the COVID-19 pandemic (Maar et al., 2020), a finding that is also supported by other research (Wendt et al. 2021). Specifically, in a survey completed in June 2020, community leaders and primary care providers identified people living with mental health and substance use issues as being disproportionately affected by consequences of COVID-19, including physical distancing and self-isolation. Those who are on opioid replacement therapies have had decreased access to virtual and remote care options. During the pandemic, care providers were often unable to properly integrate Anishinabe cultural and land-based practices, traditional medicine, Anishinabe language, and worldview into care (Maar et al., 2020).

The Impact of COVID-19 Containment Measures on Indigenous Healing Practices

Social distancing has limited the size of gatherings and physical proximity between people. Access to traditional Indigenous cultural and healing practices and ceremonies that might support addiction recovery has therefore been greatly reduced (First Nations Health Authority, 2020). In some cases, conducting ceremonies during times of government applied distancing measures has become highly politicized in the colonial state. In May 2020, RCMP arrived in cruisers to interrupt sun dance ceremonies in Beardy's and Okemasis Cree Nation in Saskatchewan, despite Indigenous organizers' insistence that "they limited the number of people at the event, [and] practised physical distancing" (Shield & Martell, 2020, para. 1). The conductor of the Ceremony, Sun Dance chief Clay Sutherland emphasized that the pandemic exposed existing structural racism: "This took us back to 150 years ago when all of our people had to go underground. They had to hide. They had to hide who they were" (Shield & Martell, 2020, para. 13). Prime Minster Trudeau later responded that the decision for

ceremonies would be at the discretion of Indigenous leadership (Bridges, 2020a), although the Sask. Premier continued to disagree with that position (Bridges, 2020b).

The Intersection of the COVID-19 Pandemic with the Trauma of the Uncovering of the Unmarked Graves at Residential Schools

In May 2021, just over a year after the onset of the COVID-19 pandemic, unmarked children's graves were first officially discovered at IRS sites. These tragic revelations are currently reverberating in Indigenous communities and likely contributing to the negative effects of the COVID-19 pandemic on people who live with OUD and their families. These triggers highlight the need for culturally and family-based healing approaches that respond to the complex trauma that people with OUD may have experienced as the multi-generational consequences of colonial policies (Brave Heart et al., 2011; Fiedeldey-Van Dijk et al., 2017; Pomerville & Gone, 2019; Restoule et al., 2015; Ritland et al., 2020; Rowan et al., 2014). Colonial policies have facilitated multi-generational mental, physical, and sexual abuse in residential and day schools, which are the root causes of high addictions rates today (Dell et al., 2011; Health Canada, 2015; Marsh et al., 2015).

Clearly, an affirmation of traditional, cultural, and clinical support for the escalating needs of Indigenous people living with OUD are urgently needed at this time. According to the First Nations Mental Wellness Continuum Framework, "culture as a foundation means starting from the point of Indigenous knowledge and culture and then integrating current policies, strategies, and frameworks" (Health Canada, 2015, p. 6). The implementation of an Indigenous framework for recovery, undisturbed by colonial polices, and the creation of a continuum of mental health and social services based on culture is the next step in that direction (Dumont, 2005; Heilbron & Guttman, 2000; McCormick, 2000).

The development of effective, culturally safe, community-led models for OAT are needed more than ever (CRISM Ontario, 2016; Mamakwa et al., 2017). However, to facilitate sustainable, culturally safe, community-designed Indigenous practice models, the legitimacy of Indigenous knowledge and science alongside Western approaches to recovery needs to be acknowledged. First Nations should be able to access and monitor the data pertained from integrated approaches, so that the communities can decide if their visions for healing and wellness are being met. Therefore, a focus on data usability and data sovereignty should not be lost despite the need for front line services. We provide several policy recommendations to help move towards knowledge translation of our findings.

Recommendations

1. Recommendations to Improve Community-Based Data Sovereignty

Mainstream indicators of OAT programs, such as retention and reduced criminal activity, while useful, are not sufficient to determine culturally-based effectiveness. Instead, Indigenous perspectives of wellness such as mino-bimaadiziwin may guide a community's vision of success. This requires data that describes the whole person, their family, their community, and their reconnection with Indigenous knowledge, culture and the land. Therefore, OAT and health records need to be available for analysis and linked with other relevant service data so that communities have the evidence for informed

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decisions. Privacy and confidentially issues in small communities should be considered and addressed to facilitate safe use of health information data. Specific steps of implementation that apply to this case study include:

1.1 Increase data usability by identifying community staff to become meaningful operators of the electronic records system and to run regular queries on individual client and aggregated clinic outcomes, such as:

1.1.1 Monitor tapering trends and its relationship to clients' history with drugs, past trauma, and comorbidities.

1.1.2 Track buprenorphine (Sublocade and Suboxone) versus methadone use for OAT to determine safety profiles and overdose risk in the community.

1.1.3 Monitor take-home dose data closely during crises, including the COVID-19 pandemic, to keep the clients safe from unintended uses, as well as keeping the community safe from diversion of methadone to the streets; take home dose data should be linked and cross referenced with toxicology screens as well as indicators of integration into community and culture, such as accessing counselling and/or cultural programs, education programs, community programs, and volunteering.

1.2 Develop data sharing agreements within the community health and social services network, which might include:

1.2.1 Data linking agreements with health, mental health, and social services sector in order to facilitate multi-community agency wrap-around and case management support for clients.

1.2.2 Create privacy policies that provide safeguards for linking of health data in small communities.

1.3 Develop holistic indictors of success that can be tracked, such as uptake of mental health and traditional counselling: Many clients are affected by intergenerational trauma where painkillers assist in escaping from unresolved grief and pain of traumatic experiences. Tracking the level of success of various services for different clients will allow clinics to offer the most reliable services for recovery.

1.4 Track cultural activities and indicators of connectedness to better understand the role of Indigenous culture and knowledge in recovery.

1.5 Track community-identified indicators of success that may include OAT clients enrolling in education, volunteering, gaining employment, reducing the level of involvement of child protective services, and participation in traditional activities. Qualitative approaches and

Indigenous research methods to evaluation should be explored.

1.5.1. Track aggregated data on prescribed opioids in the community in collaboration with the primary care teams.

1.5.2. Track police statistics such as changes in drug-related calls and crime rates.

2. Recommendations for Health Transformation to Improve Equity in the Funding Model for OAT

Currently, funding of OAT strongly privileges compensation for the prescribing physician and pharmacist. However, case management, wrap around services, and especially trauma-informed counselling and cultural support are urgently needed for clients to recover from opioid addictions. Yet, funding models almost exclusively recognize drug therapy, while clinical therapy, traditional Indigenous counseling, healing, comprehensive case management, and cultural support services are nearly completely neglected. Health transformation requires "expanding health systems to include practices that meet the unique needs of First Nations" (Government of Canada 2021). We recommend the following policy improvements to support health transformation:

2.1 Position recovery from opioids as part of health transformation as a "health system or model that responds to the needs of the Anishinabek, that is holistic and culturally relevant" (Anishinabek Nation, 2020, para 1).

2.2 Funding models for OAT should support community self-determination and Indigenous recovery models, such as the Mental Wellness Continuum Framework (Health Canada, 2015).

2.3 Funding models for OAT must include culturally-based mental health and addictions and case management services. Given the high rate of complex trauma experienced by First Nations community members, the disproportionate impact of the COVID-19 pandemic on Indigenous people living with OUD, and the current re-traumatization related to the uncovering of unmarked graves of children at IRS, a continuum of culturally based services from prevention to aftercare must be developed.

2.4 Respectful collaborative practice rooted in culture and involving prescribing or dispensing professionals, community-based health care providers and traditional Indigenous providers should be considered an essential component of truth and reconciliation and health transformation (Maar et al., 2022).

Conclusion

Naandwe Miikan's success in developing community-led and culturally-based OAT services was predicated on the community leaders' persistence to advocate for their community. At this point, equitable funding models for culturally-based OAT services in First Nations do not exist. Yet, without

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community access to useable OAT health information, it is difficult to demonstrate the positive outcomes of culturally-based services that could inform the development of a community-based business case. Data sharing polices for OAT services and new funding models that empower First Nations in creating strengths-based services are needed to support First Nations people with OUD in their recovery journey towards restoring mino-bimaadiziwin.

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