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Miýo-pimātisiwin Developing Indigenous Cultural Responsiveness Theory (ICRT): Improving Indigenous Health and Well-Being

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Miýo-pimātisiwin Developing Indigenous Cultural Responsiveness Theory (ICRT): Improving Indigenous Health and Well-Being

Abstract
The Truth and Reconciliation Commission of Canada calls upon those who can effect change within Canadian systems to recognize the value of Indigenous healing practices and to collaborate with Indigenous healers, Elders, and knowledge keepers where requested by Indigenous Peoples. This article presents the Indigenous Cultural Responsiveness Theory (ICRT) as a decolonized pathway designed to guide research that continuously improves the health, education, governance, and policies of Indigenous Peoples in Saskatchewan. Decolonizing practices include privileging and engaging in Indigenous philosophies, beliefs, practices, and values that counter colonialism and restore well-being. The ICRT supports the development of collaborative relationships between Indigenous Peoples and non-Indigenous allies who seek to improve the status of First Nations health and wellness.

Keywords
Indigenous health, Indigenous methodologies, Indigenous theory, health and well-being

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Miýo-Pimātisiwin[1]
Developing Indigenous Cultural Responsiveness Theory (ICRT): Improving Indigenous Health and Well-Being

Situating Our Work

This article describes the theoretical development of the Indigenous Cultural Responsiveness Theory (ICRT). Indigenous Peoples and communities are leading the way by melding science with tradition, laying new ground for evaluating culture-as-intervention (Fiedeldey-Van Dijk et al., 2016). In 2016, The Muskowekwan First Nation (MFN) engaged Indigenous scholars JoLee Sasakamoose (Ojibwe) and Shauneen Pete (Cree), as well as Indigenous therapist Dr. Kim McKay-McNabb (Cree), to work with the MFN community to develop a First Nations community-based family healing and wellness centre. Federation of Sovereign Indigenous Nations (FSIN, previously known as the Federation of Saskatchewan Indian Nations) partners Terrina Bellegarde (Nakota-Cree) and Wilson Sutherland (Cree) joined Sasakamoose, Pete, and McKay-McNabb to transform the Culturally Responsive Framework (CRF; FSIN, 2013) into a theoretical model that continuously improves the well-being of Indigenous Peoples in Saskatchewan. This partnership draws from the collective wisdom of First Nations Elders, knowledge keepers, and leaders at the community level alongside provincial First Nations leadership, scholars, and health practitioners. Together we are working to challenge the assumptions and privileging of Western researchers' intellectual practices (Blaut, 1993). This community-based partnership answers Whitbeck's (2006) call for new generations of Indigenous researchers who can do the work from within. While ICRT is a model created and owned by First Nations peoples living within Saskatchewan's borders, the fundamental principles can be locally adapted and applied.

Terminology and Context

We use the terminology First Nations, Aboriginal, Indigenous, Native, and Métis throughout the manuscript as we have adopted the terms used by authors of studies cited. Although for the purpose of applying this theoretical model, we address the First Nations people of Saskatchewan to whom this framework belongs, as expressed by principles of Ownership, Control, Access, and Possession (OCAP®; First Nations Information Governance Centre, 2017).[2] First Nations people in Saskatchewan developed this framework and, for the purposes of this article, First Nations refers to: Those people in Saskatchewan who are . . .

> Reserve or urban-based, rural, remote, or northern dwellers, Status or non-Status members, treaty and non-treaty nations, traditional or non-traditional peoples. It is inclusive of all kinship patterns and all tribes and linguistic groups, whether they be of the Nehiyawak (Cree, Plains, Swampy, and Woodland), Nakawe (Saulteaux/Anishnaabe), Deesuline, or Lakota, Dakota, and Nakota decent. In other words this is a framework that speaks to and is for all First Nations in the province. (FSIN, 2013, p. 9)

[1] Cree for "In a good way."

[2] First Nations Principles of OCAP® are a set of standards that establish how First Nations data should be collected, protected, used, or shared. They are the *de facto* standard for how to conduct research with First Nations.

This framework was also intended for non-Indigenous peoples interested in providing culturally responsive service that continuously improves the health, education, governance, and policies of Indigenous Peoples in Saskatchewan.

A Synopsis of the Indigenous Cultural Responsiveness Theory (ICRT) Development

Theories are systematic sets of interrelated statements and constructs intended to explain some aspect of social life (Gay & Weaver, 2011). The development of a theory is a complex and philosophical experience and all research requires a sound theoretical basis and strong methodology (Udo-Akang, 2012). From a First Nations perspective, everything relates to the spiritual realm. As developers of this theory, we understand this to be of key importance. We created this model as an overt act of resistance countering settler narratives that seek to hold power and privilege, justifying and reinforcing aggressive assimilative policies aimed at the destruction of First Nation well-being (Snowshoe & Starblanket, 2016). This decolonizing model validates and supports Indigenous histories and inherent rights. Such a theory will generate research and the research generated will refine the theory (Gelso, 2006). We are using this model to reframe, rename, reclaim, and restore our own methodological approaches.

Our team carried out an Indigenous-centred research process supported by local Traditional Knowledge Keepers. This allowed us to develop a decolonizing theory that prioritizes Indigenous methodologies and ways of knowing alongside evidence-based Western practices to harmonize with localized Indigenous knowledges. In August 2016, a draft of the paper was taken into the Sundance lodge. A message from one of the Elders indicated that our team "must continue to talk to the old people about the framework and keep asking for guidance" (Sundance Elder, personal communication, August 2016). By engaging in ceremony, the ICRT establishes a middle ground that allows parties to come together, ask for guidance from the ancestors, and move forward together in reconciliation.

This article presents the Indigenous Cultural Responsiveness Theory (ICRT), a decolonizing model that aims to improve First Nations well-being in the province of Saskatchewan. This framework emerged from ceremonial and community engagement processes that identified three strategic directions:

a. Restore First Nations community-based health and wellness systems;

b. Establish a "middle ground" for engagement between mainstream and First Nations systems and worldviews by instituting a mutually beneficial co-existence as the foundational stage for reconciliation and respectful engagement; and

c. Transform mainstream service delivery to become culturally responsive by guiding research that continuously improves the health, education, governance, and policies of Indigenous Peoples in Saskatchewan.

Each of these strategic directions clearly identifies objectives that can be found in more detail in the FSIN (2013) *Cultural Responsiveness Framework* (CRF) document. As we further develop the model, we will translate the knowledge back to First Nations community members through engagement processes as well as academic channels to allow this theory to be expressed through practical applications.

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The key to developing a much-needed culturally adaptable framework for First Nations peoples may not lie in decolonizing the approach but utilizing culture as the very tool to engage wellness. Snowshoe and Starblanket (2016) identify four healing protective factors that are effective when applied as principles decolonized approaches to well-being:

a. Trauma-informed,

b. Strengths-based,

c. Community engaged, and

d. Spiritually grounded.

These principles are appropriate for the ICRT because they fit with an Indigenous worldview and are already a component of the establishing a middle ground. Therefore, according to definitions of theoretical practice, ICRT is a working theoretical model that is grounded in the nuances of life that give meaning and significance to the various stakeholders (Gay & Weaver, 2011).

Setting the Context: We Are Grounded in the Treaty

The historical context when one is working with Indigenous Peoples of Canada is crucial. The legacies of colonialism are ubiquitous and tenacious. The trauma of colonization and the residential school system remains embedded in the lives of Indigenous Peoples through direct experience and intergenerational transmission. Without reparation and healing, such trauma is compounded by racism and inequity in health, education, governance, and policy systems. For Indigenous Peoples, endemic poverty and attitudes toward health further compound these barriers from the earliest age. However, evidence reveals that recovery from colonization is grounded in cultural healing practices (for example, sweat lodges, traditional teachings; Fiedeldey-Van Dijk et al., 2016; Yellow Bird, 2012, 2013, 2015). These culturally based healing practices are usually regionally specific and are commonly led by respected community members who are able to facilitate such experiences (Rowan et al., 2014). Culturally based healing addresses wellness in a holistic manner, unlike Western biomedical approaches that focus on the absence of disease (Shea et al., 2013). Culturally based healing practices have been shown to improve functioning in all areas of wellness for Indigenous Peoples on the road to recovery from Canada's colonial policies and practices (Fiedeldey-Van Dijk et al., 2016).

First Nations assert that the treaties are a sacred covenant in which sovereign nations exchanged solemn promises—*kihci-asotamatowin*, meaning "sacred promises to one another, the treaty sovereigns' sacred undertakings"—that were formalized by the pipe ceremony. Treaty 6 signatories agreed to share land in exchange for relief and medical services; these are most commonly known as the "medicine chest" and "pestilence" clauses of Treaty 6. In signing the treaties, First Nations *did not surrender their traditional healing practices or medicines*. Instead, they stood to protect their health system and *supplement* this section with Western medical care and medicines (Boyer, 2003). According to the Office of the Treaty Commissioner (1998):

> Both the modern Western medical practices and traditional First Nations healing systems have important contributions to make to the well-being of Treaty First Nations people. The FSIN

> wishes to explore how Treaty First Nations governance in the area of health might help Treaty First Nations optimize the benefits of both the Western and traditional medical systems. One possibility suggested by First Nations is to establish institutions that integrate both systems. (p. 51)

Between 1871 and 1921, the Crown and First Nations across Canada signed 11 numbered treaties. Saskatchewan is covered by the "sacred blanket" of Treaties 2, 4, 5, 6, 8, and 10, and the First Nations signatories range from Saulteaux, Dene, Cree, Dakota, and Lakota to Nakota or Assiniboine descent. When the Crown and First Nations entered into a treaty for purposes of mutual respect and benefit, the treaties were to secure a positive future for the children of the signatories and future generations (Cardinal & Hildebrandt cited in Boyer, 2003). Treaty rights are constitutionally protected under Section 35(1) of the Constitution Act (1982) and they have also been recognized by the Canadian courts.

The fact that First Nations peoples did not surrender their systems and meant to supplement with Western health services should mean that Indigenous Peoples are among the healthiest in Canada. To the contrary, First Nations peoples face many health challenges in contemporary Canadian society. Decades of colonization, oppression, and government assimilation policies have eroded First Nations languages and cultures. First Nations languages and cultural practices (such as sweat lodge, sun dance, rites of passage, traditional medicines) embedded community specific protective factors to help people deal with individual, family, and community well-being. The loss of cultural and healing practices caused Indigenous Peoples to experience a variety of social and health challenges. Current issues in the Canadian context include a high rate of disengagement from education (Crooks et al., 2015), ongoing health challenges, high suicide rates, physical inactivity, obesity, substance abuse (Sasakamoose, Scerbe, Wenaus, & Scandrett, 2016), and overrepresentation in corrections facilities and poverty (Brokenleg, 2012). First Nations' experiences of many historical and current events have exerted a lasting effect on the health of Indigenous Peoples. These determinants include the creation of the reserve system, forced relocations, forced placement of children in residential schools, inadequate services for those living on reserves, systemic racism, and a lack of comprehension of the effects of these experiences in the mainstream society (Association of Faculties of Medicine of Canada, 2017).

By imposing Western cultural values and laws, Canada has profoundly influenced every social determinant of health for Indigenous Peoples living within colonized lands. This colonization has been described as a "process of encroachment and subsequent subjugation of Indigenous Peoples since the arrival of the Europeans. From the Indigenous perspective, it refers to the loss of lands, resources, and self-direction and to the severe disturbance of cultural ways and values" (Association of Faculties of Medicine of Canada, 2017, p. 84). Although there is no lack of First Nations input into the future of First Nations health, education, policy, and governance, this perspective has clearly not been honoured or implemented. Further, our community engagement processes acknowledged that the type of change needed to make a system culturally responsive will only occur through the people who are trained and practise within those same systems. It will be through attitudinal change and education, and each of these will be dependent upon individual organizations and the policies and regulations through which we can affect change (FSIN, 2013).

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Indigenous Epistemologies: A Community-Driven Methodology

In the summer of 2008, the Federation of Saskatchewan Indians (FSIN), Health Canada's First Nations and Inuit Health Branch, and the Saskatchewan Ministry of Health signed the *Memorandum of Understanding on First Nations Health and Well-Being in Saskatchewan* (FSIN, Government of Canada, & Government of Saskatchewan, 2008). A main aim of the partnership was to improve First Nations health status and eliminate the health disparities between First Nations and non-First Nations people in the province. The Truth and Reconciliation Commission (TRC) of Canada released 94 calls to action (2015), in order to redress the legacy of residential schools and advance the process of Canadian reconciliation. Therefore, we have all been charged to take steps to reconcile the historic wrongs to which Indigenous Peoples were subjected through colonization and the residential school system. Practitioners operating within the ICRT framework will directly engage many of these TRC calls to action. The Truth and Reconciliation Commission of Canada (TRC, 2015) calls upon those who can effect change within Canadian systems to recognize the value of Indigenous healing practices and to collaborate with Indigenous healers, elders, and knowledge keepers where requested by Indigenous Peoples.

After the signing of the MOU in 2008, the FSIN engaged in a community-based research strategy to develop a First Nations health and wellness plan. The FSIN used Indigenous methodologies to engage First Nations peoples in developing a health and wellness plan that addressed culturally appropriate, responsive, patient-oriented care as a foundational priority. Programs that reflect the social and cultural realties of the group for which they are intended are anticipated to be more accessible, congruent, and effective than programs that do not (Whitbeck, Adams, Hoyt, & Chen, 2004). Because Indigenous methodologies are relatively new to academia, it is useful to illustrate the ways in which Indigenous theory and worldview influenced aspects of the research design (Kovach, Carriere, Montgomery, Barrett, & Giles, 2015). The FSIN conducted in-depth Indigenous qualitative consultations (Kovach, 2012; Sasakamoose et al., 2016). Community participants included men, women, and youth from a broad array of First Nations communities. The FSIN held community engagement consultations during cultural camps, conferences, ceremonies, and other community events. The FSIN team considered it particularly important to seek permission from and involve the cultural "experts"—the *mitew* or *kehte-ayak* (Elders),[3] *otisapahcikewiyiniw* (ceremonialists), *maskihkiwiyiniw* (medicine people or herbalists), and *oskapewis* (helpers)—from the various tribes and linguistic groups. In accordance with traditional practices and protocols of the hosting communities. The team approached the *kehte-ayak* with tobacco and invited them to contribute as advisors and leaders of this sensitive process. The *kehte-ayak* made it clear from the outset of the project that "whenever life is spoken about, ceremony leads the discussion and gathering" (FSIN, 2013, p. 11). In keeping with these words, pipe ceremonies and other cultural protocols became essential to the framework development process.

The document, the Cultural Responsiveness Framework (CRF) emerged as a 31-page living guide designed to address several key principles and objectives to ensure that Saskatchewan's health care system respects the cultures of First Nations peoples and assists in the restoration of First Nations own health systems. As FSIN (2013) stated as part of the CRF:

[3] We recognize that there are several languages represented in this document. We use Cree predominately among the other languages throughout this article.

> While it is important to make reforms to mainstream health policies, services and programs that recognize and respect First Nations cultures, it is equally important to keep in mind *nuhec'alanie* (Dene: *our way of life),* that it is the fact that distinct First Nations systems (e.g., *mitewiwin*, grand medicine society) still exist, systems which are guided and shaped by their own protocols, *e nacinehiket* (Cree), languages, healing approaches, medicines and practitioners, and which continue to be accessed and utilized by many First Nations peoples for their health and well-being. (p. 7)

Culture-as-Intervention to Affect Colonial Residue

A profound assertion derived from the First Nations community members was that culture is "critical to both understanding and remedying the issue, and that culture is key to health and healing" (FSIN, 2013, p. 11). First Nations peoples in Saskatchewan recognized that change is needed in the systems that affect the social determinants of health (for example, income, education, health, research, governance) and that health disparities will not be addressed unless those who practise within these systems embrace an Indigenous cultural responsiveness paradigm. This paradigm recognizes that colonial policies and practices will continue to be a detriment to Indigenous health and well-being. Health, education, research, governance, and policies that practitioners bring to the forefront must engage the land, language, and cultural practices specific to the people for whom they are meant to work. In other words, any attempts to improve First Nations mental, emotional, spiritual, or physical well-being must involve co-participation in protocols specific to the community for whom they are being designed (National Aboriginal Health Organization [NAHO], 2007; Snowshoe & Starblanket, 2016; Whitbeck, 2006).

When the duty to consult[4] with First Nations communities is respected and an Indigenous model of cultural responsiveness is implemented, educators, researchers, health and wellness practitioners, and governance leaders may influence change in the social determinants of health that affect Indigenous Peoples (FSIN, 2013; Reading & Wein, 2009; Snowshoe & Starblanket, 2016).

The FSIN team's community-engaged research findings also indicated that Indigenous medical thinking emphasizes healing, which is achieved by restoring balance in the four realms of spiritual, emotional, mental, and physical health, whereas Western medicine focuses on treating illness. Indigenous healing relationships recognize more routes to healing than biomedical science, and the contrast highlights the dilemma facing modern clinicians who aspire to provide health care when often they only have time to treat disease (Hunter, Logan, Goulet, & Barton, 2006). First Nations community members agreed that Western biomedical frameworks that revolve around diagnoses tend to be limited and do not consider the collective and cumulative intergenerational and historic trauma that Indigenous Peoples experience (Brooks, Daschuk, Poudrier, & Almond, 2015; Yellow Horse Brave Heart, 1998, 1999, 2000). Those frameworks also tend to focus on negative outcomes rather than on ways in which people can maintain wellness after trauma (Smith, 2006). Therefore, the ICRT embeds a strengths-based approach within the framework as it shifts the perceived deficits away from the individual and places them within the appropriate context (i.e., residential schools, colonization; Snowshoe & Starblanket, 2016).

[4] Article 19 of the *Declaration on the Rights of Indigenous Peoples* (United Nations General Assembly, 2007) indicates that First Nations have the right to be consulted in good faith before the adoption and implementation of legislative or administrative measures that may affect First Nations.

The Model: Weaving Indigenous Scholarship with Community Need

Operational Definitions and Indigenous Wellness

We acknowledge that Indigenous nations have distinct sacred knowledge, beliefs, and traditions and that each individual community will locally develop this framework to their own ways of knowing. However, unified concepts of culture have been identified (Dumont, 2014) and we use this as a basis for building the theory. As an Indigenous construct, wellness is an inclusive state or position of balance, wherein spirit–heart–mind–body work together through the primary unified concepts of culture, thus rendering culture, in and by itself, as an intervention toward wellness (Fiedeldey-Van Dijk et al., 2016). McConnery and Dumont's (2010) concept of Native wellness is defined as the whole and healthy person expressed through a balance of spirit, heart, mind, and body. Researchers theorized and empirically demonstrated that Indigenous culture expressed through Cultural Intervention Practices (CIP) are an underpinning for wellness with Indigenous Peoples (Fiedeldey-Van Dijk et al., 2016). The foundation of ICRT is that Indigenous health, wellness, and education can be improved by utilizing CIP. Therefore, the mere participation in Indigenous cultural healing practices is an intervention for wellness for all people (Lavallie & Sasakamoose, 2016) and is particularly effective for First Nations, Métis, and Inuit peoples.

Concept 1. Middle Ground: Ermine's Ethical Space

The concept of middle ground emerged as a place where the two systems (First Nations and Western) could come together as "equals to work together in a way that would be to the benefit of all" (FSIN, 2013, p. 6), and it was in this conceptual space that the ICRT was formed.

Ermine (2007) described ethical space as being formed when two societies with disparate worldviews are poised to engage each other:

> The ethical space of engagement proposes a framework as a way of examining the diversity and positioning of Indigenous Peoples and Western society in the pursuit of a relevant discussion on Indigenous legal issues and particularly to the fragile intersection of Indigenous ways of knowing and Canadian legal systems. Ethical standards and the emergence of new rules of engagement through recent Supreme Court rulings call for new approaches to Indigenous–Western dealings. The new partnership model of the ethical space, in a cooperative spirit between Indigenous Peoples and Western institutions, will create new currents of thought that flow in different directions of legal discourse and overrun the archaic ways of interaction. (pp. 193–194)

Throughout history, Indigenous Peoples have refused to surrender to a fear-based worldview that purports to have answers to everything yet has answers to very few problems. We are living in a time when our technological power has so vastly outdistanced our spiritual progress that we are threatened by the prospect of a global catastrophe. The human mind can create medicine to keep us alive, but it cannot create the will to live; it can manufacture an engine of war, but it cannot create deep peace (Williamson, 2010). In the ethical space, we atone for our human arrogance. One of the major features of Indigenous spiritualty is the belief in the spirit world and the consciousness that resides there. It is recognized that spirit beings are real and that it is possible to develop relationships with them and that they can provide guidance in crucial areas such as health and healing (Stonechild, 2016).

> Ceremonies are the way we deal with good health. We do these things to seek "health, happiness, help and understanding." Spiritual growth "comes from the inside out" and spiritual learning and strength "comes from the heart." Long ago our people lived a simple life that encompassed total spirituality. Everything that was done was with the traditional teachings. Today, our people are facing hardships because they have forgotten the old ways. There is a need to bring this back if one wants to survive and to have a healthy community. (*Kehte-ayak* (Elder) cited in Federation of Saskatchewan Indian Nations, 2013, p. 11)

Within the ICRT, the ethical space is a sacred space. Anyone agreeing to enter it should be committed to working toward the improvement of Indigenous well-being and be prepared to follow the metaphysical guidance that emanates from the spiritual interactions. Prayer is to take spiritual action. From an Indigenous perspective, the spiritual is the gateway to the mental, physical, and emotional planes. It is said that seeking balance between the emotional, spiritual, mental, and physical domains is where the healing process occurs (Sasakamoose et al., 2016). On a spiritual level, with every problem we have, our role is to find the place of hurt and transform it. It is in the negative emotions that we need healing; this is the chance to transform the past and move into healing or, for some, reconciliation (personal communication, Noel Starblanket, July 12, 2016).

While there is an assumption that ICRT practitioners begin in the ethical space of engagement, we acknowledge that, before entering the middle ground, non-Indigenous partners and allies must engage in critical reflection and move beyond the awareness of differences to examine the significance of these differences for themselves and society (Peters, 2010). In the ethical space, differences are not only acknowledged, but also negotiated in culturally sensitive ways. Seldom do non-Indigenous participants have all the values, attitudes, skills, and knowledge they require for genuine dialogue with Indigenous Peoples (Peters, 2010). Therefore, it is an assumption of this theory that non-Indigenous partners will do their own work and reconciliation within prior to engaging in this model of action.

Concept 2. Two-Eyed Seeing

Etuaptmumk is the Mi'kmaw word for "two-eyed seeing." This concept originated through the work of Mi'kmaq Elders Murdena and Albert Marshall from Eskasoni First Nation. It means to see from one eye with the strengths of Indigenous knowledges and ways of knowing and from the other eye with the strengths of Western knowledges and ways of knowing and to use both of these eyes together (Bartlett, Marshall, & Marshall, 2012; Ermine, Sinclair, & Jeffery, 2004). It is within this area of ethical space that the strengths of Indigenous ways and the strengths of evidence-informed Western approaches are considered. The work of grappling with each other's cognitive universes and learning to see through the minds of others is the work of generations to come (Newhouse, 2004). The Canadian Institutes of Health Research (CIHR) Institute of Aboriginal Peoples' Health has adopted the two-eyed seeing concept with the goal of transforming Indigenous health and it figures prominently in its vision for the future (CIHR Institute of Aboriginal Peoples' Health, 2011; Hall, Dell, Fornssler, Hopkins, & Mushquash, 2015).

One Indigenous practice that takes place in any ceremony is the act of offering gratitude and seeking kindness, humility, and guidance from the ancestors. Within the middle ground, the two-eyed seeing approach honours the spirits of place and the knowledge of the participants, and it recognizes the

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colonial power relations and collective power differences. Two-eyed seeing allows for making conscious decisions to activate whichever lens is more appropriate to use or a harmonization of both. This re-centering debases enshrined modes of colonial power and governance mechanisms and brings into question the fundamental role of the outcomes (Hall et al., 2015).

Concept 3. Neurodecolonization

Neurodecolonization is based on the evidence of brain neuroplasticity, meaning the brain can change neurologically and adapt and/or compensate (Adlaf et al., 2017). With neurodecolonization, people are using mindfulness techniques to create new and healthy neuropathways while changing negative harmful pathways associated with colonization. Yellow Bird (2013) provided a scientific rationale:

> Neurodecolonization is a conceptual framework, which uses mindfulness research to facilitate an examination of ways in which the human brain is affected by the colonial situation and an exploration of mind–brain activities that change neural networks and enable individuals to overcome the myriad effects of trauma and oppression inherent in colonialism. (p. 294)

In other words, colonialism changes the brain's neural pathways and neurodecolonization takes place within the colonized person to generate positive, empowering thoughts. Neurodecolonization uses traditional ceremonies (cultural intervention practices) as training to change the mind and brain, allowing healing to occur from the trauma of colonialism (Yellow Bird, 2012, 2013, 2015). Described as a blend of meditation and traditional contemplative practices, mindfulness corrects cognitive biases and current Eurocentrically created mindlessness. Through the creative strategic approaches of neurodecolonization, Indigenous Peoples can harness positive thinking and challenge oppression (Yellow Bird, 2013). Using neurodecolonization (ceremonial) approaches within the ethical space, both Indigenous Peoples and non-Indigenous allies are able to work in solidarity to build a collaborative future in the areas of Indigenous health, wellness, and education. Current research identifies the strong mind–body connection that occurs during neurodecolonizing activities. Malchiodi (2003a) noted that neuroscience is beginning to identify the benefits of approaches that support and develop mind–body connections. Neuroscience also shows that trauma affects cognition and interferes with an individual's ability to understand, make sense of, and verbally express what they are thinking and feeling (Kuban, 2015).

Concept 4. Snowshoe and Starblanket's Protective Factors of Culture-Based Healing

Snowshoe and Starblanket (2016) have identified four protective factors of a culturally responsive healing model that are effective when applied to decolonized healing approaches with First Nations clients. We liken these four factors to the *maskihkiy* or medicines that should be picked up and placed in the intervention bundle. The factors are spiritually grounded [seeing]; community-based [teaching]; trauma-informed [storytelling]; and strengths-based nurturing [healing]. The reference to Snowshoe and Starblanket's protective factors as *maskihkiy* (medicine) transforms the evidence and trauma-informed, strengths-based approaches into culturally based healing practices (Snowshoe, 2016).

The spiritually grounded seeing maskihkiy. The ICRT as a model begins with seeking guidance from Indigenous knowledges within ethical space, reflecting Snowshoe and Starblanket's (2016) spiritually grounded seeing factor. The seeing factor is protective, as it makes use of Indigenous

ways of *knowing* and *being*. It is the study of knowledge and the justified belief that we seek guidance from the culture through Elders and ceremony. We position this within the ethical space of engagement. In this place, one should consider engaging with Elders and enacting appropriate community-specific ceremonial protocols (for example, smudge, prayer, pipe, sweat lodge) to guide the efforts of the two-eyed seeing.

The community-specific teaching maskihkiy. It is expected that in ethical space the community-specific aspect of Snowshoe and Starblanket's (2016) protective factors be engaged. It is through the community-specific teaching *maskihkiy* that one can ensure the needs of the community are met. It is important to support wellness for Indigenous Peoples through initiatives that reflect the community's unique lived experiences and that highlight culturally appropriate modes of enhancing wellness (Fiedeldey-Van Dijk et al., 2016). In this ethical space, the two-eyed seeing approach is used to determine the best Indigenous and evidence-based Western approaches to be engaged.

The trauma-informed story maskihkiy. A trauma-informed perspective in any programming tailored for First Nations is required to take into account the intergenerational impact of colonization and its associated negative health impacts, and this perspective must be integrated into all aspects of programming (Snowshoe & Starblanket, 2016). The trauma-informed story factor is the recognition that through colonization and residential schools, trauma is entrenched in the lives of Indigenous Peoples through both the lived experience and intergenerational knowledge. Through the story factor, we enliven the human story of Indigenous Peoples and enact the "truth" telling of truth and reconciliation efforts. Trauma-informed practice acknowledges how the mind and body respond to traumatic events rather than seeing symptoms as pathology; it uses a strengths-based approach and sees symptoms as adaptive coping mechanisms (Malchiodi, 2003b). Trauma-informed practice is also sensitive to culture, values, and perspectives on illness and treatment; it views individuals as "thrivers" and focuses on fostering resilience (Garrett et. al, 2014; Malchiodi, 2015).

The strengths-based nurturing maskihkiy. Hammond (2010) stated that traditional Western approaches in the helping professions focus on deficits, or "what is wrong," which leads to reliance on the "experts." Individuals who are dealing with issues are not given the opportunity to take control of their lives, and their ability to conquer life's challenges is inhibited. A strengths-based approach does not minimize or ignore problems. Instead, it attempts to identify what resources an individual has to positively address problems. It is a model that focuses not on pathology, but rather on developing assets (Smith, 2006). The strengths-based model focuses on now and the future, and it situates actions in these times as being far more important than those in the past could ever be (Smith, 2006). It is a perspective that holds that people have untapped reservoirs of mental, physical, spiritual, social, and emotional abilities that can be mobilized. As people develop greater awareness of their own strengths, they will be able to take control of their lives and make appropriate decisions to empower themselves (Smith, 2006). Although trauma, illness, and abuse are painful experiences, they can also be used as an opportunity for growth. Strengths-based approaches can be particularly relevant for marginalized or oppressed peoples who often have problem-infused narratives about their lives (Blodgett et al., 2013). In the past, research with Aboriginal peoples tended to emphasize their problems and deficiencies rather than their strengths and capacities (Blodgett et al., 2013).

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Conclusion

The ICRT provides a pathway for changing the short-term and long-term outcomes of Indigenous health, wellness, and education in Saskatchewan. Indigenous scholars used groundbreaking research to create a model with culture-as-intervention at the apex and woven through an operationally defined construct of Native Wellness (Dumont, 2014; Fiedeldey-Van Dijk et al., 2016) that incorporates Snowshoe and Starblanket's (2016) protective factors of culture-based healing (culture-as-intervention) and adaptations of Ermine's (2007) ethical space of engagement, two-eyed seeing from Bartlett et al. (2012), and Yellow Bird's (2012) concepts of neurodecolonization. The ICRT weaves the concepts from multiple theories of cultural responsiveness, safety, and competency with theories of resiliency grounded within Indigenous knowledges (for example, ceremony, protocols, language) and ways of knowing to substantiate each of the concepts and generate this new theory.

The ICRT is based on the assumption that new theories initiated and developed by Indigenous communities and scholars are needed to guide changes in Indigenous health, wellness, and education. The ICRT asserts that health behaviour and educational experiences can be enhanced by fostering comprehensive, multi-level education; strengthening community-based systems; changing existing health and education services and programs; and creating new avenues by melding together two worldviews (FSIN, 2013). With these guiding principles as the cornerstone, we created this theory out of various ceremonies and engagement sessions, with an emphasis on treaty and the treaty relationship. The ICRT was designed for flexibility, for use by organizations, institutions, education centres, health and wellness programs, or individuals, and for those implementing strategies to understand the assumptions and expectations that guide the development of programs for the well-being of First Nations. The ICRT has been an effective way of empowering; communicating; fostering self-awareness, resilience, and identity; addressing trauma; and connecting with culture. The possibilities for making use of the ICRT are endless.

Future direction of the ICRT will include engaging an Indigenous artist to create a visual representation of the model to be shared. At each phase of the theory development, ceremony is engaged to ensure that the ancestors guide the developers in an appropriate spiritual way. Indigenous scholars working alongside First Nations communities have generated much excitement in the province regarding this theoretical model. Because of the unique community-engaged design, it can be easily adapted locally. We offer this model to all Indigenous Peoples and our non-Indigenous allies to move forward the agenda of recovering First Nations health and education systems, establishing a culturally responsive community of care, and fostering a middle ground for reciprocity where two systems can support one another in the common efforts to enhance the health and wellness of First Nations peoples.

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