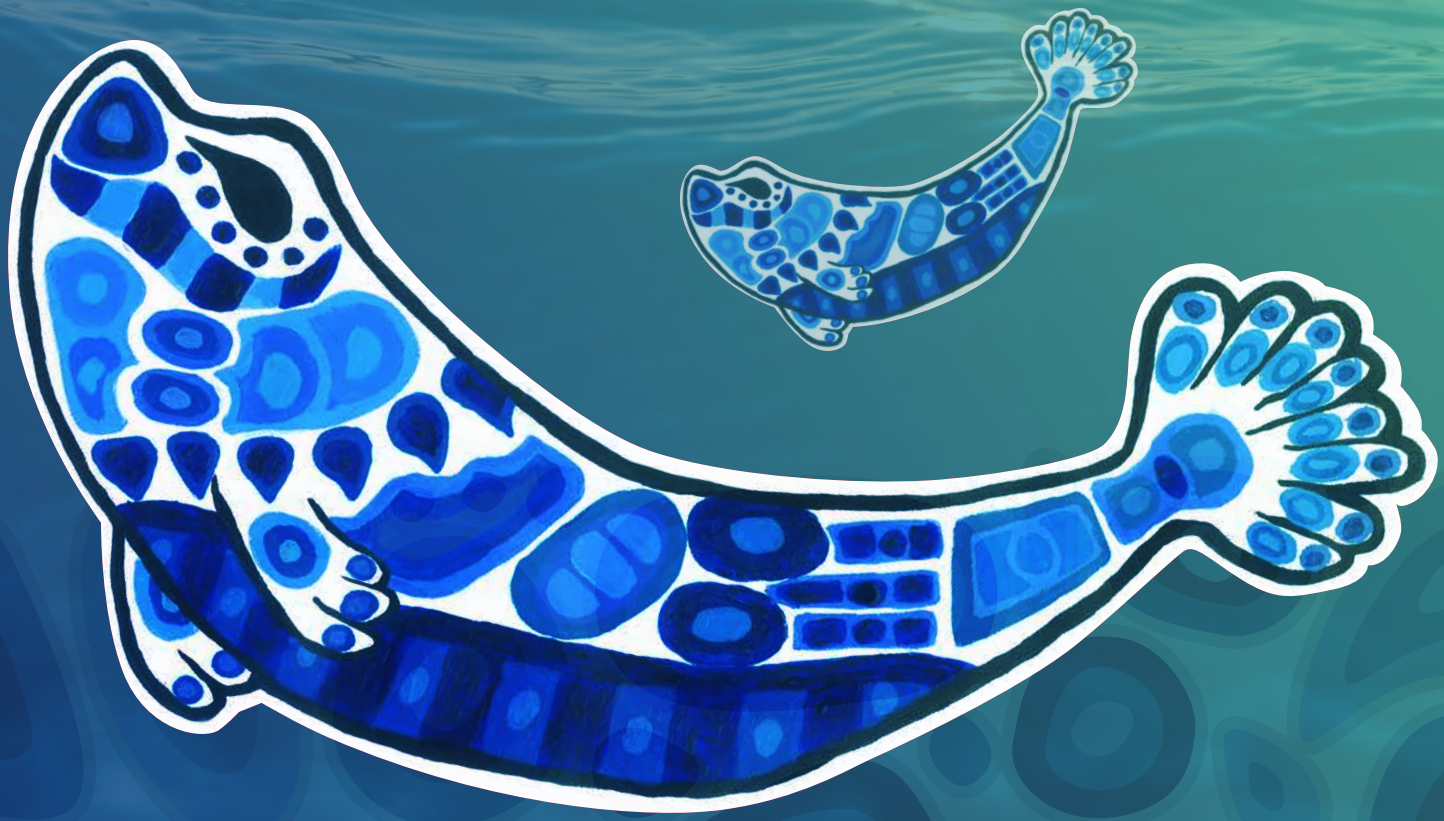
POLICY BRIEF

INDIGENOUS HARM REDUCTION = REDUCING THE HARMS OF COLONIALISM



UPDATED: MARCH 19, 2019

Indigenous harm reduction is love.

- Traditional Knowledge Carrier, Wanda Whitebird

Canadian Aboriginal AIDS Network

Interagency Coalition on AIDS and Development

Coalition interagence sida et développement

ACKNOWLEDGMENTS

We would like to acknowledge: the **Indigenous Harm Reduction Advisory Committee** for their guidance and feedback in developing this document: Rene Boucher, Dr. Alexandra King, Dawn Lavand, Valerie Nicholson, Chaneesa Ryan, Raye St. Denys, Julie Thomas, Wanda Whitebird and Project Coordinators Patrick Brownlee and Kate Alexander; all those who generously shared their knowledge and wisdom with us in focus groups, telephone interviews, online surveys or in panel discussions; and the Elders and Knowledge Carriers who shared their knowledge with us or helped us hold space during focus groups, including Linda Barkman, Marjorie Beaucage, Sandy Laframboise, Ross Saunders, Leslie Spillett, and Wanda Whitebird. We would also like to acknowledge First Nations, Métis and Inuit Elders and Knowledge Carriers, for keeping Indigenous cultures, ceremonies, traditions, and languages alive, and for transmitting these knowledges through the generations, even when it was not safe to do so.

Thank you to the research and writing team at **Stronger Circles** (Tracey Prentice, Sharp Dopler, and Krista Shore). Your commitment, energy, sensitivity and thoughtfulness throughout the entire process are incredibly appreciated.

We would like extend our sincerest thank you to **Gabrièle Paradis** for contributing her beautiful artwork for the resource. Gabrièle is a 15 year old Woodland Cree artist from Treaty 6, Montreal Lake, SK. Born in Edmonton, raised in Calgary and Kingston, Gabriele has called Ottawa home for the past 11 years. Gabrièle's inspiration comes from deep inside herself and her Indigenous teachings. She can be reached at gabriele_paradis@yahoo.ca; or www.facebook.com/GabrieleTheFabulous/

Lastly, thank you to **Design de Plume Inc.** for bringing the work to life through the design of this resource. Design de Plume Inc. is an Indigenously-owned company that uses their experience and cultural background to create effective communication pieces for First Nation, Métis, and Inuit organizations across Canada. Design de Plume Inc. operates in the traditional territory of the Atikameksheng Anishnaabeg.

Funding for this project was provided by the Public Health Agency of Canada.

CONTENTS

Executive Summary 4

Introduction 5

Background 6

Harm Reduction 8

Indigenous Harm Reduction 10

Challenges To Indigenous Harm Reduction 15

Recommendations For Indigenous Harm Reduction Policy And Practice 18

Conclusion 20

Promising Practices In Indigenous Harm Reduction 21

Methodology 23

Suggested Readings 24

References 25

EXECUTIVE SUMMARY

Indigenous peoples, communities, and cultures are strong. While the experiences of First Nations, Métis and Inuit in Canada are unique, they have all experienced hundreds of years of colonization, persecution and on-going structural violence that was intended to push them to the margins of society. In the face of such oppression, however, with the guidance of Elders, ceremonies, and local Indigenous knowledges that have been passed down through generations, Indigenous peoples, languages, cultures, and traditions have not only survived, they have been revived, reclaimed, and revitalized. This can be no more important than now, amid Canada's on-going opioid and overdose crisis, in which Indigenous peoples are over-represented.

Mainstream harm reduction practices, such as naloxone distribution and opioid substitution therapies, have been proven to save lives; however, they are narrowly focused on substance using behaviours and do not address the broader social and system-wide issues that contribute to and intersect with substance use for Indigenous peoples in the first place. For Indigenous communities, harm reduction = reducing the harms of colonization. This means that Indigenous harm reduction is not tethered to the use of substances. Instead, Indigenous harm reduction is a way of life, embedded within traditional knowledge systems that see the spiritual world, the natural world, and humanity as inter-related. Given that these knowledge systems and the way of life they give rise to have been disrupted by the historic and on-going impacts of colonialism, decolonizing policy and program environments to support the restoration of these relationships is critical to restoring the health and wellness of Indigenous communities.



To this end, Indigenous harm reduction policies, programs, and practices are: **Decolonizing**. They must go beyond addressing substance use and substance using behaviours and interrogate the neo-colonial systems and structures that shape and constrain the lives of First Nations, Inuit and Métis people by *centering power and control* in places where it has been systematically removed. This means supporting policies, programs and practices that are: *community-based and peer-led, trauma-informed, distinctions-based and culturally-safe*, and have a built-in *reflexive* component to ensure that colonial systems are not re-inscribed. **Indigenizing**. Supporting policies, programs and practices that are grounded in local Indigenous knowledges, traditions, teachings, ceremonies, land, and languages where appropriate. **Holistic and Wholistic**. Creating the conditions in which Indigenous peoples can be mentally, physically, emotionally and spiritually well. This means ensuring Indigenous peoples have equitable access to all social determinants of health, including access to education, housing, language, land, and cultural and political self-determination. **Inclusive**. In addition to incorporating and respecting diverse and local cultural knowledges and practices, programs must also respect age, gender, sexual orientation, literacy levels, socio-economic status, criminal backgrounds, spiritual belief or disbelief and substance use of clients. **Innovative and Evidence Based**. Combining the best of Indigenous and mainstream approaches to ensure that First Nations, Inuit and Métis peoples have access to the most competent, professional and culturally grounded assistance possible with full recognition that evidence comes in many forms.

Recommendations for successful Indigenous harm reduction policies and practices include: *Indigenous community-based leadership; peer leadership, engagement and support; a multi-level and multi-sectoral approach; diverse and inclusive programming; evidence-based programs and practice that include strong evaluation components*.

INTRODUCTION

Indigenous communities from coast to coast to coast have repeatedly called on all levels of government to recognize and address the egregious health and social inequities among First Nations, Inuit and Métis peoples that are a direct result of colonial policies, practices and institutions of previous and current governments. From the Royal Commission on Aboriginal Peoples,[1] to the Truth and Reconciliation Commission,[2] Indigenous communities have consistently identified self-governance, decolonization, adequate and sustainable funding, and community-informed, community-led and distinctions-based initiatives at multiple levels and across multiple sectors as key ingredients in restoring Indigenous communities to thriving levels of health and wellness.[3] These can be no more important than now, amid Canada's on-going opioid and overdose crisis, in which Indigenous peoples are over-represented.[4, 5]

In 2016, in response to this crisis, Canada's then Minister of Health announced a new Canadian Drugs and Substances Strategy that reinstated harm reduction as a core pillar of Canada's federal drug policy. The strategy is supported by an investment of $110 million over five years (2017-2022).[6] $30 million is committed to the Harm Reduction Fund that is intended to support community-based projects that reduce the harms associated with using injecting drugs, and expands supports for First Nations and Inuit communities, such as increasing access to naloxone kits and suboxone programs.[7] Governments must recognize, however, that using injecting drugs or other substances, is only one manifestation of centuries of devastating government policies that continue to shape and constrain First Nations, Inuit and Métis health in similar but different ways. Therefore, technical solutions and targeted behavioural interventions alone, the hallmark of mainstream harm reduction approaches, while necessary, will fall far short of addressing the complex health and social inequities within which harmful substance use is embedded.

As noted by Anderson and Champagne, "the drugs alone are not the crisis, and as long as we continue to focus just on the drugs, we will see one [crisis] fall and another rise up in its place. The real crises [in First Nations, Inuit and Métis communities] are the historic and current factors [of colonization] that place some populations at higher risk of harmful drug use than others."[8] It is only in addressing these factors in a wholistic, comprehensive, culturally-informed, trauma-informed, and community-driven way that we can make progress in reducing the health gap between Indigenous and mainstream Canadians, and thereby create the conditions in which First Nations, Inuit and Métis peoples can be truly self-determining.

The purpose of this policy brief is to outline Indigenous approaches to harm reduction. We also recommend ways in which governments and organizations can incorporate Indigenous approaches to harm reduction into their on-going and future efforts to support the self-defined, self-determined, and distinctions-based health and wellness of First Nations, Inuit and Métis.

> "The drugs alone are not the crisis and as long as we continue to focus just on the drugs, we will see one fall and another one rise up in its place. The real crises are the historic and current factors that place some populations at higher risk of harmful drug use than others."
>
> *– Anderson and Champagne, 2018*

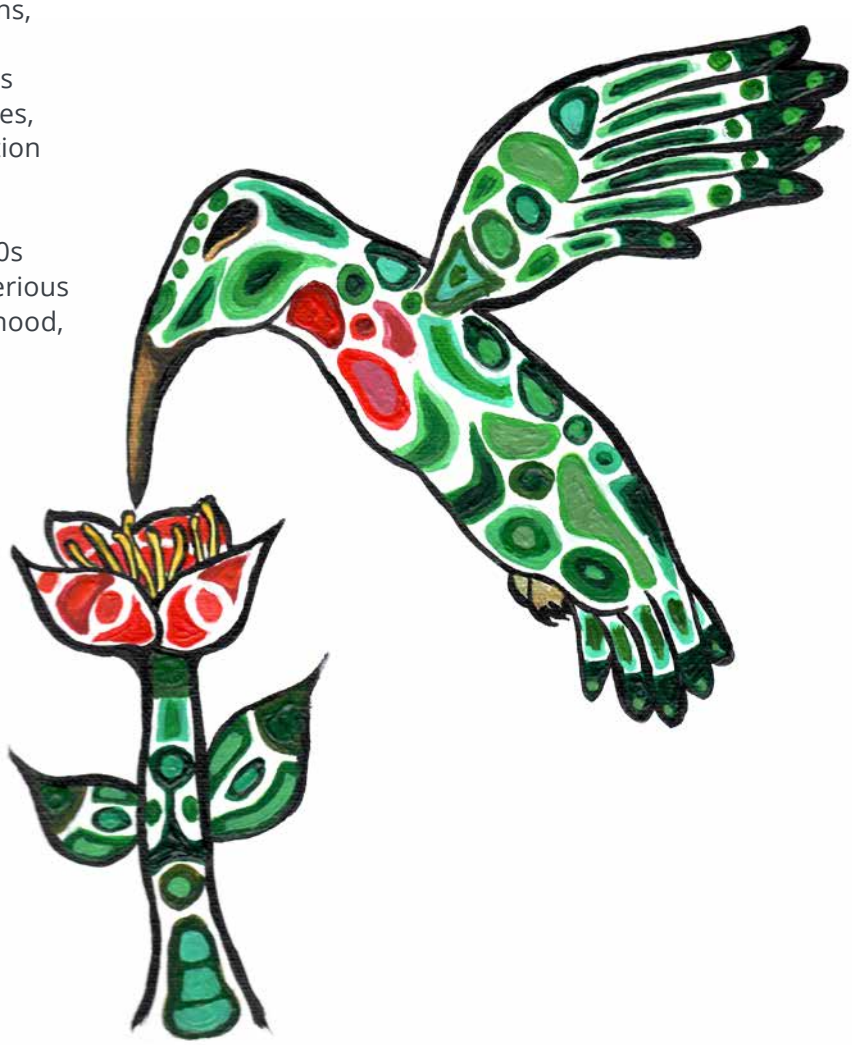
BACKGROUND

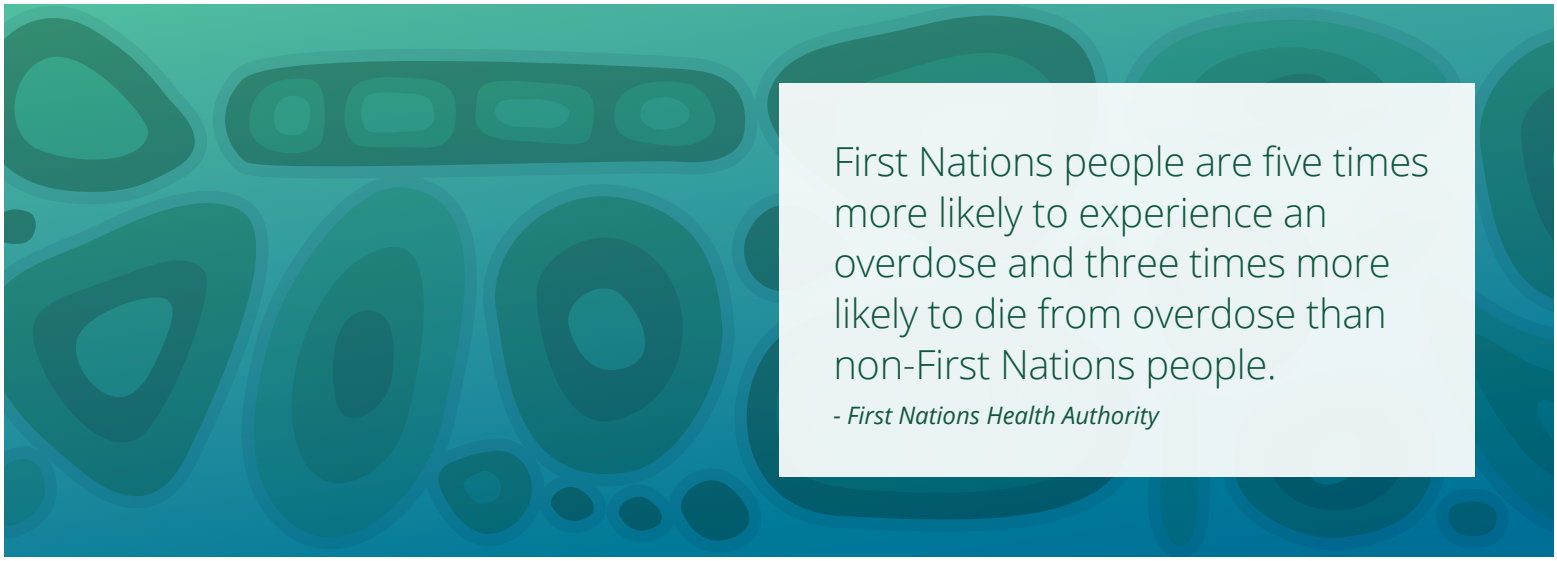
Indigenous peoples, communities, and cultures are strong. While the experiences of First Nations, Métis and Inuit in Canada are unique, they have all endured and pushed back against hundreds of years of colonization, persecution and on-going structural violence that was intended to push them to the margins of society.[9] In the face of such oppression, however, with the guidance of Elders, ceremonies and local Indigenous knowledges that have been passed down through generations, Indigenous peoples, languages, cultures, and traditions have not only survived, they have been revived, reclaimed, and revitalized. With the strength of their ancestors pushing them forward, First Nations, Inuit and Métis peoples today are working towards a future in which their children, their children's children, and their children after that, i.e., seven generations, can thrive.

Neo-colonial structures, however, such as a draconian child welfare system that has placed grossly disproportionate numbers of First Nations, Inuit, and Métis children in foster care, coupled with the historical and intergenerational traumas that have resulted from colonial policies, practices, and institutions such as the Indian Act, the creation of a reserve system, the forced relocation of communities, including the deliberate killing of wildlife and sled-dogs, residential schools, the 60s scoop, and violation of treaty rights, have had serious implications for many Indigenous peoples' livelihood, health and wellness.[10, 11]

At a population level, Indigenous peoples continue to have considerably less access to determinants of good health such as income, education, food security, and adequate housing than non-Indigenous Canadians.[12, 13]

These are inextricably linked to their over-representation among youth who are street involved, people who use alcohol or injecting drugs, those with experience of sex work, and those with experience of incarceration.[14] They are also linked to Indigenous peoples' experience of inequities across most health outcomes.[15]





> First Nations people are five times more likely to experience an overdose and three times more likely to die from overdose than non-First Nations people.
>
> *- First Nations Health Authority*

While differences between First Nations, Inuit, and Métis peoples are pronounced, Indigenous people experience shorter life spans, higher infant mortality, higher rates of unintentional injury, and higher suicide rates than non-Indigenous Canadians.[16] These are particularly true for Inuit and First Nations. Inuit can expect to live 10 years less than their non-Indigenous counterparts and suicide rates for Inuit are five to 25 times higher than all Canadians.[17] Indigenous people are also five times more likely to contract HCV[18] and 2.7 times more likely to be diagnosed with HIV.[19] Non-sterile injecting drug use is a primary risk factor in both. In 2017, one in five (20%) HIV diagnoses in Canada were among those who self-identified as Indigenous. The majority of these were First Nations (86.5%).[20] Younger females who use injecting drugs are disproportionately impacted.[21]

In the context of Canada's on-going opioid and overdose crisis that has taken over 9,000 lives between January 2016 and June 2018,[22] Indigenous people are significantly over-represented. Recent data from Alberta and British Columbia, the provinces most heavily impacted by the crisis, indicates that First Nations people are five times more likely to experience an overdose and three times more likely to die from overdose than non-First Nations people.[23, 24] Older First Nations women appear to be disproportionately affected. In BC, contrary to a province wide trend of men being more likely to die from overdose, fatalities among First Nations are evenly split between men and women. Alberta First Nations women who die from overdose are, on average, 15-20 years older than their male counterparts.[25] Recent data also suggests that hospitalizations due to opioid or other substance use is higher among Alberta Métis than non-Métis, as is accidental death from opioid toxicity.[26] In British Columbia, Indigenous youth between the ages of 14 and 30 who use injecting drugs are thirteen times more likely to die from multiple causes, including overdose, than their non-Indigenous counterparts.[27]

Data on Inuit, two-spirit, gender non-binary and gender diverse people in the context of the overdose crisis is not available. Substance use in many Inuit communities, however, is linked to high levels of suicide and violent crime. In Nunavut, for example, 23% of all premature deaths involved excessive drinking, and 30% of all homicides were linked to drugs and/or alcohol.[28] Across Inuit Nunangat, 82% of those accused of homicide had used alcohol.[29] Multiple studies suggest that two-spirit, non-binary and gender diverse Indigenous people experience high rates of substance use resulting from historical and on-going trauma, as well as significant barriers to services and care.[30, 31]

Western harm reduction approaches such as managed alcohol programs, safe consumption sites, the distribution of clean needles and drug use equipment, naloxone, and opioid substitution therapy, can be effective tools for reducing the harms associated with substance use. For Indigenous peoples, however, harm reduction is not tethered to the use of substances. Instead, Indigenous harm reduction is a way of life, embedded within traditional knowledge systems that see the spiritual world, the natural world, and humanity as inter-related. Given that these knowledge systems and the way of life they give rise to have been disrupted by the historic and on-going impacts of colonialism, decolonizing policy and program environments to support the restoration of these relationships is critical to restoring the health and wellness of Indigenous communities.

HARM REDUCTION

Harm reduction is a complex and value-laden phrase, most often associated with public health approaches that are designed to minimize negative consequences related to using psychoactive substances, including alcohol and other drugs. Rooted in the Western principles of pragmatism, humane values, focus on harms, balancing costs and benefits, and priority of immediate goals,[32] previously disparate practices such as needle exchanges and methadone maintenance programs emerged in Canada and internationally as 'harm reduction' or 'harm minimization' practices in the late-80s and early-90s in response to an increase in HIV and AIDS diagnoses among people who used injecting drugs.[33] While many of these early initiatives were peer-led, harm reduction has come to encompass a range of policies, practices, and programs proven to reduce the harms that may be associated with substance use. These include safe consumption sites, needle exchanges, opioid substitution programs, managed alcohol programs, wet shelters, education and outreach, and naloxone distribution. The philosophy of harm reduction has also been applied to sexual activity and includes condom distribution, safer sex education, and outreach.

Harm reduction has been criticized, however, for being too narrowly focused on technological or behavioural interventions that disregard the broader context in which those behaviours occur.[34] This is sometimes referred to as operating within 'silos' that artificially separate one aspect of human experience from another, while ignoring intersecting and interlocking experiences. Focusing on substance use, for example, without also addressing racism, trauma, poverty, homelessness, or other determinants of ill health, will do little to change a person's circumstances long term.[35]

This is also true when the focus of harm reduction is on individual change while ignoring the systems and structures within which the individual must operate. In the context of Indigenous harm reduction, for example, increasing access for Indigenous peoples to the mainstream harm reduction services noted above belies the greater need to disrupt the colonial systems and structures that put some people at greater risk of increased substance use in the first place. As noted by Community Grandmother, Leslie Spillett,

Mainstream harm reduction is about individual 'choices' and not about systemic change. [It] does not interrogate those bigger pictures. If we don't deal with larger issues all the needle exchanges in the world aren't going to change [anything]. People will continue to reach for the medicines to feel better.

This is especially true if Indigenous people experience racism or discrimination while accessing these services. This causes further harm and keeps Indigenous people from accessing much needed services in the future.[36]

"I think the reality is if mainstream harm reduction models are working for Indigenous people they wouldn't be like 5x more likely to die of an overdose. It's not working, mainstream harm reduction. The numbers wouldn't be where they are."

- Focus Group Participant

A third kind of siloing occurs when harm reduction policies, programs or practices address only one aspect of health, such as physical health, while disregarding mental, emotional, and spiritual aspects. This artificial separation fragments the human experience and inappropriately prioritizes one aspect over others. As two-spirit Métis Elder, Marjorie Beaucage, suggested, "Indigenous people don't think of themselves as a body, or one thing…[we need to treat] the whole person not just one behavior".[37] Prioritizing physical health over other aspects of wholistic health has the effect of making those other aspects invisible or unimportant.

Mainstream harm reduction has been criticized for being too focused on the individual and excluding family, friends, community, and other relationships. For Indigenous peoples, individuals are inextricably connected to all other elements of creation, including family, community, land and Spirit, and as such, an individual's health is connected to all these elements.[38] Individuals are mothers, brothers, aunties, uncles, sisters, sons and cousins. They are embedded in networks of relationships that impact their daily lives, and therefore, to exclude them from harm reduction programs is to exclude part of themselves. As noted by Maori activist, Marama Pala,

[governments] need to stop looking at silos. Maori services try to have that communication and work in a wholistic way. Family must be there, must be staying in the hospital, etc. It makes us stronger and different from mainstream.[39]

Focusing on numbers instead of people is another criticism leveled at mainstream harm reduction programs. The bio-medical and scientific bias towards quantitative measurement as a higher standard of evidence than qualitative measures sometimes leads to a focus on the number of people reached by a harm reduction program, rather than the quality of the client's experience. As one focus group participant suggested,

"health unfortunately is separated into boxes and that's a Western colonial way of doing things, and even this [policy brief] is going to go to the colonial system, so they don't think of community, they don't think of the individual, they think, 'we give you $10 million, you have to have 100,000 people clean.' That's the way they think."[40]

This focus on quantitative over qualitative measurement, on numbers instead of people and relationships, undermines the value of Indigenous Knowledges and denies Indigenous communities the opportunity to develop and implement harm reduction policies and programs that are grounded in Indigenous realities and Indigenous ways of knowing and being.

"Indigenous harm reduction is reducing the harms of colonization."

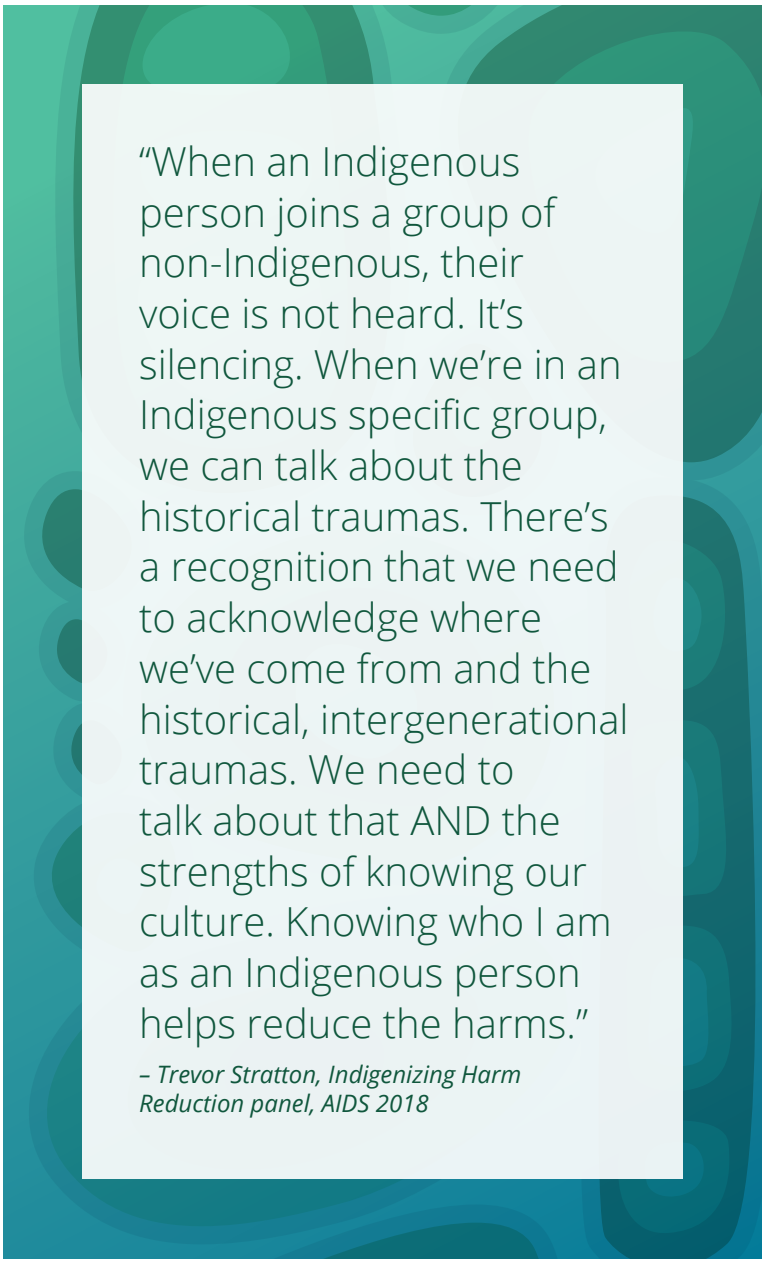
– Rawiri Evans, Maori Educator

INDIGENOUS HARM REDUCTION

Among Indigenous peoples, harm reduction can be contentious and contested. Individuals and communities who narrowly associate harm reduction with drugs, alcohol, or sex, rebuff the very idea of harm reduction, despite the opioid and alcohol-related devastation they may have experienced. This is largely on moralistic grounds that are thought to be a result of centuries of colonization and Christianization. Many Indigenous communities, however, see not only the humane, health, and social benefits of harm reduction but also its broader historical and philosophical perspective that corresponds with Indigenous Knowledges, cultures and traditions.[41, 42] For these individuals, harm reduction is inclusive of, but much broader than, a focus on using substances or safer sex. Instead, "harm reduction is a way of life".[43] It is love, non-judgement, and non-interference. It is rooted in Indigenous Knowledges and worldviews, combined with the best of what the Western world can offer, and focused on mitigating the egregious harms of colonization and all that colonization has wrought. For these Indigenous peoples, Indigenous harm reduction may include:

1. **Decolonizing**. Indigenous harm reduction recognizes that many of the health and social inequities experienced by First Nations, Inuit and Métis peoples today are a result of and response to their historic and on-going experience of colonization. High rates of substance use, commonly seen as a way of coping with extreme or multiple traumas, are among these inequities. As such, mainstream interventions that narrowly address substance use, such as expanding naloxone or suboxone programs, are necessary to saving lives but they are insufficient to adequately address the intersecting harms of colonization, including racism, harmful alcohol or drug use, harmful sex work and sex trade, poverty, homelessness, and violence, to name a few. To address this broader context, Indigenous harm reduction must go beyond addressing individual behaviours and "interrogate those bigger issues",[44] the systemic and structural issues that have shaped and constrained the lives of First Nations, Inuit and Métis peoples.

   Centering Power and Control. A central feature of decolonizing harm reduction is helping individuals recognize and begin to reverse the impact of colonization in their lives by consciously and deliberately creating environments, systems and infrastructures that "center power and control in places where it's been systematically removed…Colonization is about taking power and control so the way you begin to reverse that is by honoring the adult", [45] by honoring the agency and self-determination of individuals and communities, and trusting that they know what they need. The principles of non-judgement and non-interference, or meeting people where they are at, are foundational.



In practical terms, at the individual level of those accessing services, this means putting the needs of the individual first. It means no or low barrier services, safe spaces where people can be themselves, with trained and compassionate staff who can ask people what they need and then work towards meeting that need in the moment. As two-spirit Métis Elder, Marjorie Beaucage suggests,

"just having people feel welcome and safe in any situation is harm reduction for me… Don't kick people out of spaces. No barriers. If people are disruptive, [we] have to be kind and ask them what they need. People will tell you and go from there. If they're hungry feed them. If they need a bus ticket find a bus ticket. Meet [their] needs in the moment. Ask them. People need to belong and be seen as human beings. There are too many limitations [in services] so that people can't get their needs met, too many hierarchies of needs. No measuring sticks, just be in the moment."[46]

Community-Based and Peer-Led. At the program development and delivery level, centering power and control means Indigenous communities, organizations, and people with lived or living experience must be leading or involved at every step of the way,[47] and this involvement must be local. Imposing or importing programs or service delivery models without local community and peer leadership, regardless of their success in other jurisdictions, denies communities agency, self-determination, and reinforces unequal power relations. It also leads to unsuccessful and unsustainable programs.[48] Centering the experience and leadership of peers, people with lived or living experience of substance use or any other issue that is central to the initiative is crucial, as they are experts in their own health and harm reduction needs, and those of their peers. This is the principle of 'nothing about us, without us'.

Trauma-Informed. Decolonizing harm reduction means recognizing that Indigenous clients have likely experienced multiple traumas, sometimes known as complex trauma, that have contributed to their needing services in the first place. This means that organizations, systems and service providers must be trauma-informed, i.e., i) realize the widespread impact of trauma and understand potential paths for recovery; ii) recognize the signs and symptoms of trauma in clients, families, staff, and others involved with the system; iii) respond by fully integrating knowledge about trauma into policies, procedures, and practices; and, iv) actively resist re-traumatization.[49] This means that all staff, Indigenous and non-Indigenous, must be trained in trauma-informed practice.

Distinctions-Based and Culturally-Safe. Decolonizing harm reduction means creating culturally safe spaces that acknowledge, accept and affirm the identities of all First Nations, Inuit and Métis service users, including two-spirit, non-binary, and gender non-conforming individuals. This means acknowledging the power differences that exist between service provider and client and allowing for and creating spaces for a diversity of Indigenous peoples to feel physically, mentally, emotionally, spiritually and culturally safe when receiving care. It means acknowledging

"You need to have people from those neighborhoods working in those neighborhoods. Happy people coming out of university working down there, no. Most of them don't get it. They've never had any sort of struggles so they don't get it."

- Focus Group Participant

the unique histories of First Nations, Inuit and Métis nations, as well as the similarities and the differences between and within them, and providing relevant and appropriate cultural representation, cultural guidance and connections. First Nations teachings, for example, are not appropriate for Inuit clients, just as Inuit teachings are not appropriate for those who identify as Métis. It means acknowledging that not all Indigenous peoples are interested in Indigenous spirituality and creating safe spaces for people to connect with Spirit in whatever ways are meaningful for them. This may include Christianity, Islam, or other forms of spirituality.[50] It also means respectfully working with and gently challenging programs and perspectives that cite 'traditional values' as a reason for not allowing people who are using substances, or who challenge gender binaries, to access ceremony or traditional medicines.[51]

> "We must understand how Christianity has impacted on our culture. We have all been colonized so all of us are still working through that, even in ceremony. Sometimes we do things unconsciously and have no idea how much that has been impacted by colonization."
>
> *– Community Grandmother, Leslie Spillett*

Reflexive. To achieve these things, harm reduction programs must have a built-in mechanism for self-reflection to allow and encourage the individuals who run them to understand and assess their own biases. As noted by Community Grandmother, Leslie Spillett, "the colonial project is on-going and we need to examine ourselves and the impact it's had on us. We [all] need to be aware of our own biases", and to understand the ways in which we impose them on others. For example, the unspoken but tangible hierarchy of socially acceptable substances, from coffee to prescription drugs such as heart or diabetes medications, from alcohol through medical marijuana to heroin or other opioids, beliefs about which substances are acceptable to consume and which are not must be examined and made conscious before those beliefs can be challenged.[52] In addition, many Indigenous ceremonies and traditions reinforce gender binaries that exclude and cause harm to two-spirit, non-binary and gender diverse Indigenous people, including stigma, discrimination, and social isolation. These gender binaries must be interrogated through a process of self and collective reflection to ensure that the harms of colonialism are not re-inscribed.

2. **Indigenizing**. Indigenous harm reduction is "harm reduction that is shaped by Indigenous cultural wisdom and practices."[53] It is policies, programs and practices that are grounded in local Indigenous knowledges, traditions, teachings, ceremonies, land, and languages where appropriate. Indigenizing harm reduction is similar but different from decolonizing harm reduction. Decolonizing policies or programs is an attempt to deconstruct or dismantle existing policies and programs that are rooted in colonial thinking, while Indigenizing policies and programs is about building something new that is grounded in Indigenous ways of knowing. We can think of decolonizing and Indigenizing on a continuum, with decolonizing as a necessary but insufficient first step in reorienting existing policies, programs and practices to better meet the needs of First Nations, Inuit and Métis peoples. Non-Indigenous allies and organizations, for example, can and must take responsibility for decolonizing their policies, programs and practices, but Indigenizing the same must be done in meaningful partnership with Indigenous people and communities. Indigenizing harm reduction then, must be:

Culturally-grounded. Indigenous harm reduction that reflects local Indigenous knowledges and worldviews are more easily accepted by Indigenous peoples and have greater chances of long term positive impact.[54, 55] This means designing, integrating and implementing programs and practices that "privilege interrelationships among the spiritual, the natural and the self: reflect a sacred orientation to place and space; encompass a fluidity of knowledge exchanged between past, present and future, thereby allowing for constant and dynamic knowledge growth and change; and honor language and orality as an important means of knowledge transmission."[56] Often, however, trauma, impacts of colonization, disconnection from the land, community, family and self, results in the loss of interest in and access to spiritual practices.[57] Indigenizing harm reduction then, means designing programs and practices that value and support interrelationships between individuals, families and communities, and finding ways to connect or reconnect them with land and Spirit in whatever manner works best for them. Engaging Elders or Traditional Knowledge Carriers in designing and delivering Indigenous harm reduction is key. As noted above, however, being open to and supportive of Spirit in all its forms both recognizes the impact of colonization and works to repair it.

Strengths-Based. Indigenous harm reduction is focused on wellness instead of illness, strengths instead of weaknesses, and attributes instead of deficits. It is future-oriented, with a healthy respect and reverence for the individual and collective life experiences that brought us to today. Mainstream harm reduction is rooted in the biomedical model that typically defines health as the absence of illness. It is pathogenic (origins of disease) in orientation and works first to identify an illness and then respond to it through an array of primarily technical interventions. In contrast, Indigenous approaches to harm reduction are salutogenic (origins of health) in orientation and work first to understand what health and wellness look like in a particular context, and then build on the inherent strengths of the individual, the family, the community, and the culture towards that vision.

Indigenous-Led. Whether a program is delivered by an Indigenous or non-Indigenous organization, Indigenous harm reduction programs must be designed, developed, and carried out by, for and with First Nations, Inuit and Métis people in meaningful and appropriate leadership roles. As noted above, Indigenous leadership should be local and should include people with lived or living experience of substance use. This is more than having a First Nations, Métis or Inuit representative at the table and it is more than a consultation after decisions have been made. The decision to develop or implement a harm reduction program in a community must come from within that community. This is not to say that there is no role for non-Indigenous peoples. On the contrary, there is a great need to train non-Indigenous allies to work alongside Indigenous people, but the leadership and development of these programs must be Indigenous.

"[We have to] take harm reduction into ceremony all the time. So many people think that harm reduction is just about the drugs, and the problems, and they don't see that the problem is that so many of our people don't get to access those ceremonies and traditions that they are drawn to."

– Community Grandmother, Leslie Spillet

3. **Holistic and Wholistic.** Indigenous harm reduction recognizes and acts on the knowledge that harmful substance use among First Nations, Inuit and Métis peoples is one small part of the unnecessary and unjust health and social inequities that have their roots in the historical and on-going experience of colonization. It is inclusive of, but much broader than, mitigating the harmful consequences of substance use. Indigenous harm reduction is about creating the conditions in which First Nations, Inuit and Métis peoples can be mentally, physically, emotionally and spiritually well. It is also about ensuring Indigenous peoples have equitable access to all determinants of health, including education, adequate housing, adequate income and employment, language, land, and cultural and political self-determination. As noted by one focus group participant:

"[We] have to also address poverty in harm reduction and homelessness in harm reduction. It's not just, we stopped using drugs it's not just we diminished a harm in one area. We have to look at the whole, it's a whole being, a whole process."[58]

Indigenous harm reduction, therefore, must be multi-sectoral, multi-jurisdictional, and multi-leveled. Responsibility for reducing the harms of colonization must be shared across political, governmental, and service provider portfolios. Positioning harm reduction as a healthcare issue, and limiting its scope to substance use, allows governments and funders to treat harm reduction as an isolated issue, and to divert much needed funds from other areas of need, such as housing, instead of coordinating a meaningful response across all sectors.

4. **Inclusive.** In addition to incorporating and respecting diverse and local cultural knowledges and practices, programs must also respect age, gender, sexual orientation, literacy levels, socio-economic status, criminal backgrounds, spiritual belief or disbelief and substance use of clients.[59] One of the impacts of colonization has been the replication of colonial structures within Indigenous communities and organizations that create hierarchies of 'worthiness' to engage in community at any level, resulting in feelings of exclusion, further disconnection, and shame. These hierarchies create barriers to services and to community for individuals who do not feel, or are not seen to be 'enough', whether that is Indigenous enough, sober enough, good enough or straight enough. As noted by one individual:

"If you say that I can't come (to your program) because I am using, then you're telling me I don't deserve to heal. Until you're clean you're not good enough. I already have a core belief that I am not good enough and that message just affirms that core belief."[60]

This exclusion from services and community has a devastating impact on individuals whose response to the unremitting trauma, grief, loss and colonization includes the use of substances. For two-spirit, non-binary and gender diverse individuals, the loss of Indigenous understandings of gender because of colonization and residential schools means that they must fight to be accepted by community due to ignorance, fear, stigma and homo/trans aggression. Therefore, Indigenizing harm reduction must include efforts to break down barriers of all kinds; to restore two-spirit, non-binary and gender diverse people to their places of honour in their communities and Nations; and to create inclusive programs, policies and practices in which all Indigenous peoples can feel welcome and respected.



5. **Innovative and Evidence-Based.** Indigenous harm reduction combines the best of Indigenous and mainstream approaches to ensure that First Nations, Inuit and Métis peoples have access to the most competent, professional and culturally grounded assistance possible. This means using the best available evidence to design and implement policies and practices, with full recognition that evidence comes in many forms. Mainstream programs, such as needle exchanges, safe injection sites or naloxone distribution can be lifesaving and life giving in the short term. To be effective at reducing the harms of colonization, however, they must be combined in innovative ways with Indigenous approaches that have stood the test of time, such as connecting with other Indigenous people, including Elders, building relationships, storytelling, participating in ceremonies and traditional land-based activities, making traditional and contemporary Indigenous arts and crafts, language revitalization, and reclaiming Indigenous identity. Indigenous harm reduction programs must also include robust evaluation and assessment that is respectful of Western and Indigenous knowledges to ensure Indigenous people have access to the best that both worlds can offer.

> "A recent review of Indigenous community studies published between 1990 and 2015 has shown that despite much rhetoric about the importance of community development interventions designed, implemented and evaluated in partnership with Indigenous communities, only 31 such evaluations were published in this 25 year period and they were of low methodological quality."
>
> *- Clifford and Shakeshaft, 2017* [61]

CHALLENGES TO INDIGENOUS HARM REDUCTION

Indigenous harm reduction, however, is not without its challenges. Despite a significant and growing base of support for the principles outlined above, barriers to implementation exist at all levels and these must be considered and addressed when designing, developing and implementing programs, policies or practices.

1. **Abstinence versus Harm Reduction.** Despite a strong evidence-base for harm reduction, not everyone, including Indigenous peoples - First Nations, Inuit, or Métis, or communities and individuals within each of these groups - agree that harm reduction is a valid or viable approach to treating harmful use of substances. An on-going debate in many Indigenous communities is centred on the perceived dichotomy of abstinence versus harm reduction, and in some First Nations, Inuit or Métis communities, particularly those in northern, rural or remote areas, even the phrase 'harm reduction' is contentious. If Indigenous approaches to harm reduction are to be successful, communities and community leaders, such as elected Chiefs and Councils, Elders and Traditional Knowledge Carriers, and others in leadership positions, must find a way to facilitate or engage in conversations on the pros and cons of each approach, as well as common grounds. The First Nations Health Authority Indigenous Wellness Team has trained 180 people across British Columbia on how to facilitate these conversations in their Not Just Naloxone: Talking About Substance Use in Indigenous Communities Train-the-Trainer program. These conversations have the potential to save lives.[62]

> Talking about the approach of coming from a place of care and compassion and being really mindful of that foreign language of harm reduction and it's not this big scary thing that someone from the outside is coming to do. Looking at the languages between culture and tradition and the practices of harm reduction like patience, education, mindful judgment, meeting people where they're at and looking at those linkages and using the language that we have as Indigenous people around supporting each other. I think that, from our perspective, is how we talk about Indigenous harm reduction. Harm reduction is love.
>
> *– Focus Group Participant*

2. **Stigma.** The single largest barrier to Indigenous harm reduction is stigma, its causes, and its consequences. As noted above, in some Indigenous communities, the belief in abstinence is so strong that even the language of harm reduction is stigmatized. This can lead to a prohibition of harm reduction services in some communities, despite the numbers of people who are in obvious need of support. It can also lead those who need services to avoid them due to fear of being stigmatized or discriminated against. In some cases, the stigma surrounding substance use and the conditions that sometimes accompany it, such as poverty, homelessness, experience of incarceration, and disruptive behaviours, is so strong that people encounter barriers not only to harm reduction services – both mainstream and Indigenous - but also to community, cultural activities, and other health and social services. This can lead to further isolation and likely further use of substances to manage the pain of exclusion. An insistence on 'clean' time, for example, before accessing services or ceremonies, is a barrier that many people who use substances find untenable. It can also be life-threatening. The language of 'clean time', of being clean, staying clean, and recovery, is also stigmatizing. Grounded in deficits rather than strengths, this language suggests that a person who is not 'clean' is dirty and therefore less than, and a person who is recovering is being restored to a 'normal' state of health and therefore has been living in an abnormal or deviant state. The values and judgement inherent in these words presents further obstacles of exclusion for those who use substances. The intersection of stigma and racism is particularly egregious. This sometimes-lethal combination is well documented.[63] Adopting Indigenous approaches to harm reduction can counter stigma and discrimination in all its forms, and not only save lives, but give life to individuals and to communities who struggle daily to decolonize and Indigenize their futures.

3. **Barriers to Services.** First Nations, Inuit and Métis experience many barriers to harm reduction and related services, including fear of stigma and discrimination by predominantly non-Indigenous health and social service providers. These fears are exacerbated for those who use substances, and particularly for those who are involved in other parts of the social system in which substance use is seen as a character flaw, breach of parole, or reason for eviction or apprehension of one's children.

For those who wish to access services, availability is often an issue, with uneven and inadequate coverage from coast to coast to coast. While those in urban centres have the most reliable access to services, these may not be culturally-relevant or appropriate and are likely limited in scope. They may also not be accessible to non-status Indigenous people due to jurisdictional funding requirements. For those in rural, remote, on-reserve or northern communities, where services, or awareness of services, are limited or non-existent, "travelling to harm reduction and other health services requires overcoming significant barriers such as transportation costs, family responsibilities, work commitments, lack of child care, and stigma around drug use and treatment."[64] Concerns around privacy and confidentiality may be particularly pronounced for those seeking services in small communities.

First Nations, Inuit and Métis who are incarcerated face additional barriers to harm reduction. Most will have no access to clean needles, and access to opioid replacement therapies are uneven and unreliable at best. Opioid replacements and other supports may be especially important upon release when overdoses are 30 to 140 times higher than that of the general population due to decreased tolerance.[65]

4. **Lack of Adequate and Sustainable Funding.** Despite recent federal investments to address the on-going opioid crisis, harm reduction services, including Indigenous harm reduction, are woefully underfunded across all jurisdictions. Even basic, long-standing services such as needle exchange programs have far from adequate coverage.[66] Indigenous community-based initiatives, where they exist, continue to struggle to make ends meet, on and off-reserve, in rural, remote, and northern communities.[67] Even successful initiatives such as Mamisarvik Inuit Healing Centre, the only Inuit-specific treatment centre in Canada, with a proven record of success, has faced funding shortfalls that forced their closure for a period of time.[68] This ad hoc and often temporary funding of Indigenous harm reduction and healing initiatives threatens programs and threatens lives.

It also threatens the long-term viability of peer-led or peer-engaged initiatives. Peer-led programs rarely receive adequate funding to support full-time peer positions. Nor do they receive adequate funding for workplace wellness programs for peers who are on the front lines of the opioid or related crises, many of whom are managing their own life challenges as well as that of their 'clients'. [69]

"We need more funding for indigenous programs, groups, peer coordinators with experience. If you're going to indigenize harm reduction you gotta have a healing circle available every day of the week. There's gotta be these outlets and safe spaces for all of us. We're fighting over scraps and it takes away from the work."

- Focus Group Participant

RECOMMENDATIONS FOR INDIGENOUS HARM REDUCTION POLICY AND PRACTICE

1. **Indigenous Community-Based Leadership.** Indigenous harm reduction policies and programs must be conceptualized, led and implemented by Indigenous people and communities, and be inclusive of those with lived or living experience of substance use. History has shown the imposition of outside practices has been ineffective and often harmful. Indigenous peoples are the experts on what they need to return the balance of wholistic health to individuals, families and the greater community, which is the essence of Indigenous harm reduction. Therefore, supporting Indigenous, community-based leadership and development of harm reduction policies and practices that are decolonizing and grounded in Indigenous knowledges and worldviews is imperative.

2. **Peer-Leadership, Engagement and Support.** Engaging peers in leadership roles is a core principle of Indigenous harm reduction and supporting peers to do the work is crucial to its success. Those with lived or living experience are experts in their own health and harm reduction needs, and those of their peers. They are often the first to recognize and respond to emerging crises and the last to be emotionally or financially supported to do so. When there are gaps in services, or programs are de-funded, peers are the ones who fill the gaps because they, better than anyone, understand that all our lives are interdependent, that every life has value, and that we all need assistance from time to time. Peer engagement is the foundation of Indigenous harm reduction and leads us one step closer to de-colonizing, to self-determination, to centering power and control in the hands of those who have been most marginalized. To be successful, however, peers must be adequately compensated for their efforts. They must also have access to traditional Indigenous or mainstream counselling or other forms of emotional support that will allow them to process their own grief and trauma as well as the vicarious traumas of those with whom they work.

> I am proud working with peers. I mean I must be doing something right because I get to see them thriving. They've made their choice. We can give them a life line and let them know that they have choices and they can get out of where they're at and feel safe, loved and secure. That's the whole approach and letting them tell us what they need.
>
> - *Focus Group Participant*

3. **Multi-Level and Multi-Sectoral Approach.** In keeping with the Truth and Reconciliation Commission Call to Action #18, governments and service providers must recognize harmful substance use is embedded in a much larger network of health and social inequities that are grounded in the on-going legacy of colonization. Using behavioural or technological interventions alone, such as safe injection sites, needle exchanges, or managed alcohol programs, to help mitigate negative consequences associated with substance use, is a necessary but insufficient response. These life-saving interventions, while vital to the well-being of individuals, families and communities, must be part of a wholistic and intersectoral package of policies and programs that treat the whole person in the context of their families, communities and Nations. Addressing only one aspect of the issues that contribute to harmful substance use is counterproductive.

> "Harm reduction isn't all about substances, it doesn't even start there. That's just what gets you in the door."
>
> *- Focus Group Participant*

4. **Diverse and Inclusive.** Indigenous harm reduction is not a one-size-fits-all approach. Policy, funding, and practice must recognize and support the unique needs of each individual, community, and Nation, including diversity between and among First Nations, Inuit and Métis peoples; urban, rural and on-reserve; cis-gender, two-spirit, non-binary and gender diverse people; youth, and socio-economic and incarceration backgrounds. Each of these groups will have unique needs that can be addressed in local contexts, but all must be welcomed into spaces that some have been left out of.

5. **Evidence and Evaluation.** To ensure First Nations, Inuit and Métis peoples have access to the best available harm reduction programs and practices, there is a need for more Indigenous harm reduction programs with strong evaluation components. To date, the evidence is scarce but consistent in its support for culturally grounded programs that address substance use for First Nations, Inuit and Métis. However, "there is a need for well-designed studies to address the question of best relational and contextual fit of cultural practices given a particular place, time, and population group."[70] Program evaluations, therefore, must consider different kinds of evidence and must honor and acknowledge that Indigenous communities know what is best for Indigenous communities. To this end, governments must direct funds to community-driven and community-led initiatives.

6. **Adequate and sustained funding with long-term vision.** Despite the federal government's commitment of $30 million for harm reduction in 2017, and recent funding decisions that saw 1/3 (7 of 28) of funded projects committed to reducing harms for Indigenous peoples, Indigenous harm reduction programs remain seriously underfunded across all jurisdictions. Even basic and long-standing interventions such as needle exchange programs have far from adequate funding and community-based initiatives perpetually operate on shoe-string budgets. Support for peers and grassroots organizers are often the first to be cut when funds run short. Federal, provincial and territorial governments must provide adequate and sustained funding for Indigenous harm reduction that is mid- to long-term in vision, and wholistic or multi-sectoral in scope. Support for community-based initiatives should include explicit funding for peer-led and culturally-grounded initiatives.

CONCLUSION

The opioid and overdose crisis, as well as the disproportionate burden of HCV and HIV in Indigenous communities, has focused our attention on reducing the harms associated with the use of injecting drugs. Expanding and developing evidence-based policies and programs that combine mainstream and Indigenous approaches to mitigate these harms is crucial to saving lives. For Indigenous communities, however, harm reduction is about more than reducing the harms associated with substance use. Indigenous harm reduction is about reducing the harms associated with colonialism, the traumatic legacies of colonialism, and the neo-colonial structures that continue to oppress and repress Indigenous peoples and communities. Indigenous harm reduction is about meeting people where they are at; practicing non-judgement and non-interference; promoting sovereignty and self-determination; building relationships with people not behaviors; helping people re-connect to their cultures, traditions, ceremonies, languages and land; including families and communities in on-going care; and facilitating access to the health and social services they need. Governments and service providers must recognize that Indigenous harm reduction is a way of life based on mutual respect and relationality, not a time-limited behavioural intervention. They must broaden their scope and their vision to include policies and programs that decolonize institutions and shift the balance of power and control to Indigenous communities in ways that support First Nations, Métis and Inuit self-determination. Finally, governments must provide adequate and sustained funding for these community-identified and community-controlled initiatives.



PROMISING PRACTICES IN INDIGENOUS HARM REDUCTION

1. **AIDS Saskatoon: Using First Nations and Métis Languages to Educate Northern and Remote Communities on HIV and Hepatitis C Transmission**

   In 2018, in an effort to provide northern, rural and remote communities in Saskatchewan with the tools they need to help stop the transmission of HIV and Hepatitis C, AIDS Saskatoon, with leadership from Indigenous CEO, Jason Mercredi, released HIV and Hepatitis C pamphlets in Dene and Cree.[71] They also launched an award-winning condom campaign called #wrapitupSK, in which Indigenous youth from northern communities chose humorous slogans for condom covers that were distributed in four languages; Cree, Dene, Michif and English. In October 2016, right after the campaign was launched, condom distribution increased by 20 percent. A campaign website lists all 35 condom pick-up locations, as well as testing sites. It also provides information about STIs and HIV, birth control, fun facts about condoms and a demo video on how to use condoms effectively.[72, 73]

2. **TORO (Tenant Overdose Response Organizer): Engaging Peers in Reducing Intersecting Harms of Housing and Opioid Overdose Crises Among Socially Isolated Individuals**

   The Tenant Overdose Response Organizers (TORO) program in Vancouver's Downtown Eastside is an innovative and effective harm reduction response to the high rate of opioid overdose and accidental deaths in Vancouver, 88% of which occurred in private residences. Developed by the SRO (single room occupancy) Collaborative and funded by the City of Vancouver, TORO is a promising example of a community-based, peer-led, harm reduction program in which tenants of SROs are trained as TOROs and supported to do in-reach with other tenants of their SRO, organize naloxone training for tenants, and distribute naloxone and other harm reduction supplies where needed. TORO's innovative combination of mainstream and Indigenous approaches to harm reduction enables Indigenous TOROs to do in-reach with their Indigenous and non-Indigenous neighbors, and to provide cultural and spiritual support to fellow tenants around grief and loss. TORO is an effective overdose intervention that saves lives, builds capacity in the community, and reduces stigma. The program was hindered, however, by structural barriers including a lack of emotional support, including grief and bereavement support for TOROs who responded to dozens of overdoses, and in some cases lost friends or family members to overdose. Future TORO programs would benefit from stronger and more integrated structural supports, including support for TOROs, and adequate and sustained funding.[74, 75]

> TORO started because we were seeing our friends, families and community members dying in large numbers. We live in hotels, we know what we need to take care of each other. SRO tenants need training, equipment and continual wrap around support from their peers, in order to build up networks of care. We do this with non-judgement. TOROs help people stand up and have a voice, reduce stigma, and draw people together to make an inter building bond. We build each other up and empower each other. We are a family and our family network is growing.
>
> *- Samantha Paranteau, Indigenous TORO*[76]

3. **Spruce Wood Sundance Family: Decolonizing Indigenous Ceremony**
In response to the stigma associated with HIV and other blood borne infections such as Hepatitis C, the leaders of the Spruce Wood Sundance, in Spruce Wood, MB, developed a 'Routine Practices at Indigenous Healing Ceremonies' brochure to educate the "healers, helpers, dancers and those who participate in ceremony" about routine practices, or universal precautions, when there is the potential to encounter human blood. Indigenous people living with HIV and Hepatitis C have long reported feeling excluded from ceremony due to stigma and lack of understanding around modes of transmission. By treating every person's blood in the same way, insisting that there is no need to disclose one's HIV or Hepatitis C status, and educating readers about HIV and Hepatitis C transmission, the brochure mitigates potential harms to people living with blood borne illnesses by reducing the associated stigma and creating safe and welcoming ceremonial spaces.[77]

4. **13 Moons Harm Reduction Initiative: A Peer-Led, Strengths-Based, Culturally-Grounded Project for Indigenous Youth Who Use Drugs**
Developed in response to the death of a young community member, the 13 Moons Harm Reduction Initiative is a peer-led, strengths-based, culturally-grounded harm reduction initiative aimed at reducing harms for Indigenous youth who currently use drugs in Winnipeg, MB. Based on the Native Youth Sexual Health Network's Four Fires Model of Indigenizing Harm Reduction,[78] 13 Moons is a 13-week program on healthy sexuality and harm reduction that includes training youth who currently or formerly use drugs to provide peer outreach to other Indigenous youth who use drugs. The project operates in North End and downtown Winnipeg in areas of high drug use coinciding with high rates of infectious disease transmission and offers community events to promote culturally safe spaces to engage youth in harm reduction practices and broader health care services. The project is led by Aboriginal Youth Opportunities (AYO!), an Indigenous youth-led organization, by and for Indigenous youth, in partnership with Ka Ni Kanichihk. Funded in 2018, 13 Moons is a promising practice for reducing harms to Indigenous youth.[79]

5. **Mamisarvik Inuit Healing Centre: Trauma-Informed and Culturally-Grounded Healing**
Mamisarvik is an Inuit-specific treatment program focused on trauma-informed recovery from substance use and sexual and domestic violence through cultural healing and wellness. Located in Ottawa, ON and serving Inuit clients from the north and south, the program is offered in English and Inuktitut. Clients attend day-time programming focused on trauma, addiction, Inuit history, anger management, gender-group discussions, assertiveness and continuing care. Inuit Elders offer traditional healing knowledge and incorporate on-the-land activities. Predominantly Inuit staff support clients with evening recreational activities including art therapy, Inuit crafts, life skills, visits to community centres and recovery support groups. Country food, such as caribou, seal and arctic char are prepared by a full time Inuk chef. Mamisarvik was a highly successful program from 2003 to 2016 when it closed due to funding shortfalls. It is scheduled to re-open a 10-bed facility in 2019 with planned expansions to follow. It is the only Inuit-specific program in Canada.[80]

"This place transforms people. You see a life change. You see a life begin to dream, begin to love themselves. Begin to forgive themselves. Begin to forgive others. These are major things that happen to a person here."

- Mamisarvik Program Coordinator[81]

6. First Nations Health Authority: Not Just Naloxone Train-the-Trainer Program, Talking about Substance Use in Indigenous Communities

The First Nations Health Authority's Not Just Naloxone three-day train-the-trainer workshop was developed in response to an understanding that the opioid crisis, and the impacts of addiction in First Nations communities is rooted in the long-term and on-going impacts of colonialism, residential schools, the 60's scoop, racism, and land theft. Grounded in Indigenous knowledge and strengths, and built on the foundation that reducing harm is not a new concept to Indigenous communities, the workshop addresses the fear and stigma that exists in some communities around substance use and harm reduction, and gives attendees the tools they need to facilitate and reframe these discussions within their own communities. Participants are trained as trainers on responding to overdoses with Naloxone, Decolonizing Addiction, and Indigenous Harm Reduction. The workshop supports participants to address problematic substance use and accidental poisonings with trainings that are based on culture, connection and relationship-building, including the need to engage people who use substances in the work. The Indigenous Wellness Team has traveled across British Columbia in the past two years delivering this NJN training to 180 people, who have in turn, delivered the training to members of their own communities. A Gathering of these participants in December 2018 has shown how successful these trainings have been.[82]

METHODOLOGY

We used academic and public search engines and referrals from key stakeholders to identify peer-reviewed and grey literature between 2000 and 2018 related to: 1) substance use or harm reduction, and 2) First Nations, Inuit, Métis, Aboriginal or Indigenous, in 3) Canada or internationally. We also conducted four in-person consultations (Vancouver, Regina, Ottawa and Thunder Bay), four telephone interviews, hosted one international panel discussion, and received five responses to our targeted online survey. In total, we heard from 41 stakeholders. Fifty-eight percent (24/41) of all stakeholders had lived or living experience of injecting drug use, 22% (9/41) were Elders or Indigenous Knowledge Carriers, and 34% (14/41) were health or social service providers. Ninety-five percent (39/41) of all stakeholders self-identified as Indigenous. The vast majority were First Nations. Twenty-four percent (10/41) were two-spirit, trans-identified, or LGBTQ. In addition, 92 people from 38 countries completed the sentence, "Indigenous harm reduction is..." at an international conference on HIV.

"The Indigenous Harm Reduction training is so awesome going back to community, because it's our approach as opposed to the Western approach. It's really important that we continue to do this work."

- Not Just Naloxone Train-the Trainer workshop participant[83]

SUGGESTED READINGS

Pauktuutit Inuit Women of Canada. (2017). Tavva: National Inuit Sexual Health Strategy. Available at: https://www.pauktuutit.ca/wp-content/uploads/Tavva_SexualHealth_English.pdf

Native Youth Sexual Health Network (2016). Indigenous Harm Reduction: The Four Fires Model. Retrieved from: http://www.heretohelp.bc.ca/visions/indigenous-people-vol11/indigenizing-harm-reduction.

Whakapapa/How Te Ara Whakamana: The Mana Enhancement Model. (2017). http://www.akosolutionz.com/mana-enhancement/mana-enhancement-overview.

First Nations Health Authority. (nd). Indigenous Harm Reduction Principles and Practices. [Fact Sheet] Available at: http://www.fnha.ca/wellnessContent/Wellness/FNHA-Indigenous-Harm-Reduction-Principles-and-Practices-Fact-Sheet.pdf.

Native Women's Association of Canada. (2018). Transforming Our Response to Sexual and Reproductive Health: Trauma-Informed Care. https://www.nwac.ca/wp-content/uploads/2018/08/Appendix-II-trauma-informed-care-screen.pdf.

Canadian Aboriginal AIDS Network. (nd). Harm Reduction Implementation Guide. Available at: http://librarypdf.catie.ca/PDF/ATI-30000s/30001.pdf.

REFERENCES

[1] Canada. (1996). Royal Commission on Aboriginal Peoples. People to people, nation to nation: *Highlights from the report of the Royal Commission on Aboriginal Peoples. Retrieved from:* https://www.aadnc-aandc.gc.ca/eng/spirit1100100014597/1100100014637.

[2] Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada. Retrieved from: http://nctr.ca/assets/reports/Final%20Reports/Executive_Summary_English_Web.pdf.

[3] National Collaborating Centre for Aboriginal Health. (2012) The State of Knowledge of Aboriginal Health: A Review of Aboriginal Public Health in Canada. Prince George, BC.

[4] First Nations Health Authority. (2017). Overdose Data and First Nations in BC. Preliminary Data. Available at: http://www.fnha.ca/newsContent/Documents/FNHA_OverdoseDataAndFirstNationsInBC_PreliminaryFindings_FinalWeb_July2017.pdf.

[5] Métis Nation of Alberta. (2018, May 2). Métis Nation of Alberta Releases Opioid Data and Action Plan. Retrieved from: http://albertametis.com/2018/05/metis-nation-alberta-releases-opioid-data-action-plan-2/.

[6] Government of Canada. (2017). Chapter 3: A Strong Canada at Home and in the World. In Budget 2017: Building a Strong Middle Class. Available at: https://www.budget.gc.ca/2017/docs/plan/chap-03-en.html

[7] Health Canada. (2017, April 10). Budget 2017 Brings Additional Federal Funding to Fight the Opioid Crisis. Retrieved from: https://www.canada.ca/en/health-canada/news/2017/04/budget_2017_bringsadditionalfederalfundingtofighttheopioidcrisis.html?wbdisable=true.

[8] Anderson, M., and Champagne, M. (2018, April 29). "Crystal Meth is a colonial crisis and its root causes must be addressed." CBC News. Retrieved from: https://www.cbc.ca/news/canada/manitoba/crystal-meth-colonial-crisis-opinion-1.4639133.

[9] Truth and Reconciliation Commission of Canada. (2015). Honouring the truth, reconciling for the future: summary of the final report of the Truth and Reconciliation Commission of Canada. Retrieved from: http://nctr.ca/assets/reports/Final%20Reports/Executive_Summary_English_Web.pdf.

[10] Dell, C., Lyon, T., Cayer, K. (2010). The Role of 'Kijigabandan' in Understanding Harm Reduction Policies and Programs for Aboriginal Peoples. Native Social Work Journal, Vol 7, pp. 109-137.

[11] Dell, C., Lyons, T. (2007). Harm reduction policies and programs for persons of Indigenous descent. Harm Reduction for Special Populations in Canada, Canadian Centre on Substance Abuse. Retrieved from: https://www.addictionresearchchair/wp-content/uploads/Harm-Reduction-Policies-and-Programs-for-People-of-Aboriginal-Descent.pdf.

[12] Inuit Tapirit Kanatami. (2018). Inuit Statistical Profile. Retrieved from: https://www.itk.ca/wp-content/uploads/2018/08/Inuit-Statistical-Profile.pdf.

[13] Reading, C., Wien, D. (2009). Health Inequalities and Social Determinants of Aboriginal Peoples' Health. National Collaborating Centre for Aboriginal Health. Retrieved from: https://www.ccnsa-nccah.ca/docs/determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf.

[14] King, A. (2015, February). First Nations, Inuit and Métis people and Hep C. CATIE's National Deliberative Dialogue on Integrated Hepatitis C (HCV) Programming and Services. Toronto, ON. Retrieved from: https://www.catie.ca/en/first-nations-inuit-and-metis-peoples-and-hep-c.

[15] Public Health Agency of Canada. (2018). Key Health Inequalities in Canada: A National Portrait. Ottawa: Minister of Health.

[16] Public Health Agency of Canada. (2018). Chief Public Health Officer's Report on State of Public Health in Canada 2018. Ottawa: Ministry of Health. Available at: https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/2018-preventing-problematic-substance-use-youth/2018-preventing-problematic-substance-use-youth.pdf

[17] Inuit Tapirit Kanatami. (2018). Inuit Statistical Profile. Retrieved from: https://www.itk.ca/wp-content/uploads/2018/08/Inuit-Statistical-Profile.pdf.

[18] Fayeed, King, et al (2018). In the eyes of Indigenous people in Canada: exposing the underlying colonial etiology of hepatitis C and the imperative for trauma-informed care. Canadian Liver Journal 1.3. doi: 10.3138/canlivj.2018-0009.

[19] King, A. (2015, February). First Nations, Inuit and Métis people and Hep C. CATIE's National Deliberative Dialogue on Integrated Hepatitis C (HCV) Programming and Services. Toronto, ON. Retrieved from: https://www.catie.ca/en/first-nations-inuit-and-metis-peoples-and-hep-c.

[20] Haddad N, Li JS, Totten S, McGuire M (2018). HIV in Canada–Surveillance Report, 2017. Can Commun Dis Rep 2018;44(12):324-32. https://doi.org/10.14745/ccdr.v44i12a03.

[21] Jongbloed, K., Pearce, M., Pooyak, S., Zamar, D., Thomas, V., Demerais, L., Christian, W., Henderson, E., Sharma, R., Blair, A., Yoshida, E., Schechter, M., and Spittal, P., the Cedar Project Partnership. (2017). The Cedar Project: mortality among young Indigenous people who use drugs in British Columbia. CMAJ November 06, 2017 189 (44) E1352-E1359; DOI: https://doi.org/10.1503/cmaj.160778.

[22] Government of Canada. (2018, December 12). Overview of national data on opioid-related harms and deaths. Retrieved from: https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/data-surveillance-research/harms-deaths.html.

[23] Jongbloed, K., Pearce, M., Pooyak, S., Zamar, D., Thomas, V., Demerais, L., Christian, W., Henderson, E., Sharma, R., Blair, A., Yoshida, E., Schechter, M., and Spittal, P., the Cedar Project Partnership. (2017). The Cedar Project: mortality among young Indigenous people who use drugs in British Columbia. CMAJ November 06, 2017 189 (44) E1352-E1359; DOI: https://doi.org/10.1503/cmaj.160778.

[24] Alberta First Nations Information Governance Centre. (2017). Opioids and Substances of Misuse among First Nations People in Alberta. Alberta Government. Retrieved from: https://open.alberta.ca/dataset/cb00bdd1-5d55-485a-9953-724832f373c3/resource/31c4f309-26d4-46cf-b8b2-3a990510077c/download/opioids-substances-misuse-report-firstnations-2017.pdf.

[25] Belzak, L., Halverson, J. (2018). Evidence synthesis – The opioid crisis in Canada: a national perspective. Health Promotion and Chronic Disease Prevention in Canada, Jun 38(6): 224-233. Retrieved from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6034966/.

[26] Métis Nation of Alberta. (2018, May 2). Métis Nation of Alberta Releases Opioid Data and Action Plan. Retrieved from: http://albertametis.com/2018/05/metis-nation-alberta-releases-opioid-data-action-plan-2/.

[27] Bains, C. (2017, November 6). Study finds 'appalling' death rate among young Indigenous drug users in B.C. The Globe and Mail British Columbia. Available at: https://www.theglobeandmail.com/news/british-columbia/study-finds-appalling-rate-of-death-among-young-indigenous-drug-users-in-bc/article36841253/.

[28] Government of Nunavut. (2016). Taking Steps to Reduce Alcohol-Related Harm. Retrieved from: https://www.gov.nu.ca/sites/default/files/files/Finance/Nunavut%20Liquor%20Annual%20Reports/alcohol_harm_reduction_action_plan_29_sep_eng.pdf.

[29] Pauktuutit Inuit Women of Canada. (2017). Tavva: National Inuit Sexual Health Strategy. Ottawa: Pauktuutit.

[30] Hunt, S. (2016). An Introduction to the Health of Two-Spirit People: Historical, contemporary and emergent issues. National Collaborating Centre on Indigenous Health. Retrieved from: https://www.ccnsa-nccah.ca/docs/emerging/RPT-HealthTwoSpirit-Hunt-EN.pdf.

[31] Laing, M. (2016). Two-Spirit and LGBTQ Indigenous Health. Rainbow Health Ontario. Retrieved from: https://www.rainbowhealthontario.ca/wp-content/uploads/2016/07/2SLGBTQINDIGENOUSHEALTHFactHeet.pdf.

[32] Riley, D., O'Hare. P. (2002). Harm Reduction: Policy and Practice. Retrieved from: https://canadianharmreduction.com/node/889.

[33] Cavalieri, W., Riley, D. (2012). Harm Reduction in Canada: The Many Faces of Regression. Retrieved from: http://www.canadianharmreduction.com/sites/default/files/Harm%20Reduction%20in%20Canada.pdf.

[34] Dell, C., Lyons, T., Cayer, K. (2010). The Role of 'Kijigabandan' and 'Manadjitowin' in Understanding Harm Reduction Policies and Programs for Aboriginal Peoples. Native Social Work Journal, Vol 7, pp. 109-137.

[35] Smye, V., Browne, A., Varcoe, C., Josewski, V. (2011). Harm reduction, methadone maintenance treatment and the root causes of health and social inequities: An intersectional lens in the Canadian context. Harm Reduction Journal, 8:17.

[36] Allan, B. & Smylie, J. (2015). First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, ON: the Wellesley Institute. Available at: http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf.

[37] Interview with two-spirit Métis Elder, Marjorie Beaucage, August 4, 2018.

[38] First Nations Health Authority. (2019). First Nations Perspective on Health and Wellness. Available at: http://www.fnha.ca/wellness/wellness-and-the-first-nations-health-authority/first-nations-perspective-on-wellness.

[39] Marama Pala, Indigenizing Harm Reduction panel participant, Indigenous People's Networking Zone, AIDS2018, July 25, 2018.

[40] Vancouver focus group participant, April 26, 2018.

[41] Dell, C., Lyons, T., Cayer, K. (2010). The Role of 'Kijigabandan' and 'Manadjitowin' in Understanding Harm Reduction Policies and Programs for Aboriginal Peoples. Native Social Work Journal, Vol 7, pp. 109-137.

[42] First Nations Health Authority. (nd). Indigenous Harm Reduction Principles and Practices. [Fact Sheet]. Available at: http://www.fnha.ca/wellnessContent/Wellness/FNHA-Indigenous-Harm-Reduction-Principles-and-Practices-Fact-Sheet.pdf.

[43] Vancouver focus group participant, April 26, 2018.

[44] Interview with Community Grandmother, Leslie Spillett, August 2, 2018.

[45] Interview with Community Grandmother, Leslie Spillett, August 2, 2018.

[46] Interview with two-spirit Métis Elder, Marjorie Beaucage, August 4, 2018

[47] Dell, C., Lyons, T. (2007). Harm reduction policies and programs for persons of Indigenous descent. Harm Reduction for Special Populations in Canada, Canadian Centre on Substance Abuse. Retrieved from: https://www.addictionresearchchair/wp-content/uploads/Harm-Reduction-Policies-and-Programs-for-People-of-Aboriginal-Descent.pdf.

[48] Jiwa, A., Kelly, L., Pierre-Hansen, N. (2008). Healing the community to heal the individual. Canadian Family Physician, Vol 54, July, e5

[49] Substance Abuse and Mental Health Services Administration. (2018). Trauma-Informed Approach and Trauma-Specific Interventions. Available at: https://www.samhsa.gov/nctic/trauma-interventions.

[50] Trevor Stratton, Indigenizing Harm Reduction panel participant, Indigenous People's Networking Zone, AIDS2018,

[51] Native Youth Sexual Health Network. (2015). Indigenizing Harm Reduction. Available at: http://www.nativeyouthsexualhealth.com/indigenizingharmreduction.html.

[52] Interview with Traditional Knowledge Carrier, Wanda Whitebird, June 30, 2018.

[53] Survey participant.

[54] First Nations Health Authority. (nd). Indigenous Harm Reduction Principles and Practices. [Fact Sheet]. Available at: http://www.fnha.ca/wellnessContent/Wellness/FNHA-Indigenous-Harm-Reduction-Principles-and-Practices-Fact-Sheet.pdf.

[55] Rowan, M., Poole, N., Shea, B., Gone, J., Mykota, D., Farag, M., Hopkins, C., Hall. L., Mushquash, C., Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. Substance Abuse Treatment, Prevention and Policy, 9:34. Retrieved from: https://www.substanceabusepolicy.com/content/9/1/34.

[56] Greenwood, M. (2005). Children as citizens of First Nations: Linking Indigenous health to early childhood development. Perdiatric Child Health, 10(9), 535-555.

[57] d'Abbs, P., Chenhall, R. (2013). Spirituality and religion in response to substance misuse among Indigenous Australians. Substance Use and Misuse, Vol 48 (12): 114-29.

[58] Vancouver focus group participant, April 26, 2018.

[59] Wardman, D., Quantz, D. (2006). Harm reduction services for British Colombia's First Nation population; a qualitative inquiry into opportunities and barriers for injection drug users. Harm Reduction Journal, 3: 30, p 3.

[60] Dell, C., Lyons, T. (2007). Harm reduction policies and programs for persons of Indigenous descent. Harm Reduction for Special Populations in Canada, Canadian Centre on Substance Abuse. Retrieved from: https://www.addictionresearchchair/wp-content/uploads/Harm-Reduction-Policies-and-Programs-for-People-of-Aboriginal-Descent.pdf.

61 Clifford, A., Shakeshaft, A. (2017). A bibliometric review of drug and alcohol research focused on Indigenous peoples of Australia, New Zealand, Canada and the United States. Drug and Alcohol Review, 36: 520.

[62] Personal communication, Andrea Medley, March 17, 2019.

[63] Allan, B. & Smylie, J. (2015). First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, ON: the Wellesley Institute. Available at: http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf.

[64] Canadian HIV/AIDS Legal Network & Canadian Aboriginal AIDS Network. (2017). Harm Reduction Services for Indigenous People Who Use Drugs. Ottawa: Canadian HIV/AIDS Legal Network.

[65] Bigham, B. (2018, April 4). 'A human rights issue': Lack of treatment for drug users means deaths behind bars. CBC News. Available at: https://www.cbc.ca/news/health/inmates-harm-reduction-1.4600615.

[66] Canadian HIV/AIDS Legal Network. (nd). Harm Reduction in Canada: What governments need to do now. Available at: http://drugpolicy.ca/wp-content/uploads/2017/05/Harm-Reduction-in-Canada-EN.pdf.

[67] Kanate D, Folk D, Cirone S, Gordon J, Kirlew M, Veale T, Bocking N, Rea S, Kelly L. (2015). Community-wide measures of wellness in a remote First Nations Community experiencing opiod dependence: evaluating outpatient buprenophine-naloxone substitution therapy in the context of a First Nations Healing Program. Can Fam Physician 2015 Feb 61(2):160-5.

[68] CBC News. (2016, February 10). Tungasuvvingat Inuit to suspend Mamisarvik Healing Centre. Available at: https://www.cbc.ca/news/canada/north/ti-mamisarvik-healing-centre-1.3442166.

[69] Vancouver focus group participant, April 26, 2018.

[70] Rowan, M., Poole, N., Shea, B., Gone, J., Mykota, D., Farag, M., Hopkins, C., Hall. L., Mushquash, C., Dell, C. (2014). Cultural interventions to treat addictions in Indigenous populations: findings from a scoping study. Substance Abuse Treatment, Prevention and Policy, 9:34. Retrieved from: https://www.substanceabusepolicy.com/content/9/1/34.

[71] Charlton, Jonathon. (2017, August 16). AIDS Saskatoon makes pamphlets on HIV and Hep C in Cree and Dene Languages. Saskatoon Star Phoenix. Available at: https://thestarphoenix.com/health/sexual-health/aids-saskatoon-makes-pamphlets-on-hiv-and-hep-c-in-cree-and-dene-languages

[72] Saskatoon Sexual Health. (nd). Wrap It Up. Available at: https://wrapitupSK.com.

[73] Monkman, Lenard. (2017, October 11). Saskatchewan group launches cheeky condom wrappers in Indigenous languages. CBC News. Available at: https://www.cbc.ca/news/indigenous/saskatchewan-condom-indigenous-languages-1.4349557.

[74] Grauer, Peter. (2018, August 2). Peer-led overdose response program highlights need for better housing supports, says report. Vancouver Star. Available at: https://www.thestar.com/vancouver/2018/08/02/peer-led-overdose-response-program-highlights-need-for-better-housing-supports-says-report.html.

[75] British Columbia Centre on Substance Use. (2018, August). Tenant-led overdose response in Vancouver SROs proves to be effective at reaching socially isolated. Available at: https://www.bccsu.ca/news-release/tenant-led-overdose-response-in-vancouver-sros-proves-to-be-effective-at-reaching-socially-isolated

[76] BC Centre on Substance Use. (2018, August). Tenant-led overdose response in Vancouver SROs proves to be effective at reaching socially isolated. Available at: https://www.bccsu.ca/news-release/tenant-led-overdose-response-in-vancouver-sros-proves-to-be-effective-at-reaching-socially-isolated/

[77] Spruce Wood Sundance Family. (nd). Routine Practices at Indigenous Healing Ceremonies. Available at: https://static1.squarespace.com/static/561d5888e4b0830a0f1ed08b/t/5c363f3b0ebbe8ad1177a9b0/1547059007303/SWS-ROUTINEPRACTICE-FIN-REV2-WEB.pdf.

[78] Native Youth Sexual Health Network. (2016). Indigenizing Harm Reduction: Moving beyond the four-pillar model. Retrieved from: https://www.heretohelp.bc.ca/visions/indigenous-people-vol11/indigenizing-harm-reduction.

[79] 13 Moons Harm Reduction Initiative. (2018). Aboriginal Youth Opportunities! (AYO!). Retrieved from: https://www.ayomovement.com/13moonswpg.html.

[80] Tungasuuvingat Inuit. (nd). About the Mamisarvik Healing Centre. [website]. Available at: http://tungasuvvingatinuit.ca/programs/

[81] CBC News. (2016, Feb 10). Tungasuvvingat Inuit to suspend Mamisarvik Healing Centre. Available at: https://www.cbc.ca/news/canada/north/ti-mamisarvik-healing-centre-1.3442166

[82] First Nations Health Authority. (2018, June 27). Not Just Naloxone Training: A three-day train-the-trainer workshop. [webpage] Available at: http://www.fnha.ca/about/news-and-events/news/not-just-naloxone-training-a-three-day-train-the-trainer-workshop

[83] First Nations Health Authority. (2019, Jan 14). Not Just Naloxone Gathering: Celebrating Champions in Indigenous Communities During the Overdose Emergency. Available at: http://www.fnha. ca/about/news-and-events/news/not-just-naloxone-gathering-celebrating-champions-in-indigenous-communities-during-the-overdose-emergency