Developing Factors and Treatment of Substance Addiction in Indigenous Populations

Kristin L. Carpenter

City University of Seattle

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Abstract

Indigenous Peoples have experienced multiple forms of trauma for many generations that are still present today. The impact of colonizers' attempts to rid Indigenous peoples of their culture and identity led to experiences of colonial and historical trauma (Mitchell et al., 2019). Creation of residential schools, the Sixties Scoop, forced sterilization of women, and removal of Indigenous peoples from their lands are some of the many examples of colonial and historical trauma practices (Allan & Smylie, 2015; Nutton & Fast, 2015). Through the mistreatment of Indigenous peoples, coinciding consequences of trauma such as substance abuse, educational deficits, and parenting difficulties have provided the vessels for intergenerational trauma transmission (Bombay et al., 2009; O'Neill et al., 2018). Indigenous peoples today face aspects of racial trauma and marginalization (Bombay et al., 2009). Research shows that trauma is associated with an increased likelihood for Indigenous people to develop substance addiction, and they are less likelt to receive the necessary support (Firestone et al., 2015; Patterson-Silver Wolf et al., 2015). As such, this paper considers the necessary components of care for effective and accessible treatment and support for Indigenous people with substance addiction. For resources to adequately support and treat concerns of Indigenous peoples, necessary components of care need to be incorporated, such as providing trauma-informed care, culturally competent care, and equitably-oriented care. This paper is a literature review of those three components of care.

Developing Factors and Treatment of Substance Addiction in Indigenous Populations

Indigenous populations in North America and globally are accepted to be Indigenous to the land they inhabited before settler colonial forces subsequently overtook those lands. The imposition of land by colonialists was the beginning of Indigenous peoples losing their autonomy, heritage, language, religious and cultural connections, and independence (Lambert et al., 2014). Throughout history, Indigenous peoples have been exposed to numerous assimilation attempts by the European colonizers that remain prevalent in society today. Attempts to rid Indigenous peoples of their culture have contributed to the experience of colonial trauma, which continues to impact the well-being and experiences of Indigenous people in today's society. (Allan & Smylie, 2015).

Indigenous peoples are often categorized based on their geographic location and tribal connections (Stewart, 2018). For instance, Indigenous populations in Australia are referred to as Aboriginals and Torres Strait Islanders, while in Canada, the term "Indigenous" refers to Metis, Inuit, and First Nations people (C. Cunningham, 2003). Nonetheless, Indigenous peoples worldwide have faced similar experiences of colonialism and trauma (Allan & Smylie, 2015). For the purpose of this paper, the term Indigenous will be used as a collective term to encompass the first peoples to inhabit North American land long before colonization (C. Cunningham, 2003).

According to the First Nations Information Governance Centre (FNIGC; 2012), Indigenous peoples have a higher rate of adverse experiences related to cultural loss, structural violence, colonialization, and systemic racism than those of the general population. The inequitable treatment of Indigenous peoples in society, both in history and at present, and the cumulative trauma individuals experience has led many to encounter adverse effects such as

homelessness, criminal injustices, violence, and substance addiction (Fuller-Thomson et al., 2020). Systemic oppression, assimilation attempts, and racism all contribute to the decline in Indigenous peoples' mental health across generations and influence the treatment of such populations in society. Indigenous peoples have had to adapt to new lifestyles, standards, and cultural expectations due to the pressure to assimilate to non-Indigenous ways, which contributes to today's mental health challenges (Lambert et al., 2014).

Recent social and political movements show that today's society is taking steps towards the equitable treatment of different cultures and ethnicities and advocating for equal opportunity in terms of employment, justice procedures, and fundamental human rights. Movements such as the Coast Protectors Movement and Greenpeace aimed to protect Indigenous people in British Columbia against the harm to Indigenous land that was to be done by the Trans Mountain Pipeline (Gunster et al., 2021). People within both Indigenous and non-Indigenous populations also appear to be standing up against common challenges hrough social media, protests, and calls for government action in order to resist stereotypical norms and knock down systemic barriers in many societal processes (Ben et al., 2017).

Approximately 5% of the Canadian population and 1.6% of North America's population identifies as Indigenous (FNIGC, 2012). The percentage may appear small; however, as the first people of Canada, Indigenous peoples have made contributions to developing land, the supply of goods and services, and cultural identity (Paradies, 2016; Woolford & Benvenuto, 2015). Reseach often notes that Indigenous peoples are not included in the discussions of race and culture (Mullins & Khawaja, 2018). Omitting Indigenous voices from racial and cultural discourse highlights history's attempts to silence Indigenous peoples' experiences of

marginalization and racism and risks concealing systems that have historically provided inequitable treatment to Indigenous peoples (Mullins & Khawaja, 2018; Paradies, 2016).

The Indian Act, which was first introduced in 1876 and has been amended several times since, is a form of regulation that the federal government has for Indigenous peoples (Rahman et al., 2017). Under the Indian Act, the government was able to legally control many aspects of Indigenous life, such as their status, lands, ability to practice cultural forms of healing, and education."Kill the Indian in the man and child" (Starblanket, 2017) is a well known phrase from the original Inidian Act; this quote highlights the goal that Indian residential schools had to assimilate Indigenous children into Euro-Canadian cultural ideals. The Indian Act remains in use today although the amendments have aimed to provide attempts to reconcile and transfer power of self-governance back to Indigenous peoples.

In the process of reconciliation with Indigenous peoples through the Truth and Reconciliation Commission of Canada and support of their mental health, there is a need to implement culturally and contextually tailored care for treatment programs and services (Lavalley et al., 2018). As substance addiction rates are consistently rising amongst Indigenous peoples (FNIGC, 2012), the co-occurring adverse aspects such as homelessness, health problems, and structural violence are also increasing. Thus, it is necessary to identify the resources needed, and such inquiry allows for treatment and addiction programs to be assessed for their effectiveness with and accessibility to Indigenous peoples (Marsh et al., 2016).

This literature review aimed to discuss ways that different forms of trauma affect Indigenous peoples, focusing on the intersection of trauma and substance addiction while considering the components of care provided. First, a self-positioning statement describing personal influence and bias is presented alongside strategies to mitigate the writer's influence on

the research. Next, Indigenous trauma and other factors that may influence substance abuse rates are presented using literature that examines the association between attachment theory, substance use, and the role of intergenerational transmission of trauma. Lastly, a review of effective strategies for treatment resources and the implications of this research on the counselling field are provided.

Self-Positioning Statement

Growing up in a suburban, White, middle-class neighbourhood, I had little exposure to Indigenous peoples and little knowledge about their culture. In my personal experience, I thought that Canadian history was taught in great detail, and moderate amounts of information were provided about who Indigenous peoples are and what their rights were, such as what being a status Indian provides versus not being a status Indian according to the Canadian government. However, I believe there was a lack of discussion around the severity of residential schools' effects and the traumatic influence they had on Indigenous peoples. In my experience, I felt that there was also very little taught about the government's impact on Indigenous peoples, the systemic oppression they faced, or the assimilation methods used (Milne, 2017).

Educational institutions have played a significant role in downplaying the importance of Indigenous peoples as the original inhabitants of Canadian land by failing to include comprehensive discussions of Indigenous history in school curriculums. Lack of knowledge of Indigenous culture and history risks creating greater discriminatory attitudes among the general public. The lack of knowledge passed down creates a disadvantage for someone to adopt open-minded and anti-discriminatory beliefs about Indigenous people. As knowledge spreads in a trickle-down manner (McKenzie et al., 2016), it can be challenging for people to adapt to new views without the knowledge of oppression. I believe that the lack of in-depth knowledge I've

witnessed has sparked a movement to start educating people more so that the next generation has a better understanding of the respect and dignity that goes into the ethical treatment of humans. As an individual who did not experience open discussions about Indigenous peoples and their experiences with oppression and structural violence until my teenage years, I had a significant learning curve to understand the impact and harm of colonization on multiple generations. I was self-challenged by my biases and felt angry and guilty towards myself for the beliefs I had previously held, which led to negative and hurtful thoughts of Indigenous peoples. It was difficult and overwhelming to open my eyes to a new system of values and beliefs towards Indigenous individuals.

Stereotypical views influenced my idea of Indigenous peoples; they were harmful, they were trouble, and they wanted our land, rather than the other way around. These stereotypes, along with the influence of parental figures with less than kind perspectives on Indigenous peoples, led me to a place of fear and discomfort about Indigenous peoples. However, it would be unfair to place my ignorance around Indigenous social issues onto just that of parents and educational systems, as wider social structures also encouraged these beliefs by providing systemic barriers to the inclusion of Indigenous peoples in systems of healthcare, education, and politics (Allan & Smylie, 2015; Ben et al., 2017; Browne et al., 2016).

It was not until I was at an age where I had the mental capacity to do research that I began to comprehend the drastic and traumatic influence colonizers had on Indigenous peoples and learn how such traumas still greatly affected Indigenous peoples today. Indigenous peoples were no longer viewed in my mind as individuals who chose to live off of government money while spending it on substances rather than housing and education, as I was led to believe. Instead, I began to see Indigenous peoples as people no different than myself. I came to terms

with the biases that I held towards Indigenous peoples and substance users, which sparked the fire within me to dedicate myself to advocating for Indigenous peoples through work, education and research.

A story that has impacted me profoundly is that of Brian Sinclair. Brian Sinclair died at the hands of racism, judgment, and a flawed healthcare system (Geary, 2017). Brian Sinclair, a name that has remained engraved in my mind for years, was an Indigenous man and double amputee in a wheelchair. Due to intergenerational patterns of substance use, he was diagnosed with cognitive delay from fetal alcohol spectrum disorder and a substance addiction of his own. On September 19, 2008, Brian Sinclair was directed to the hospital by a family physician after complaining of stomach pain and catheter issues; after 34 hours, he died in the Health Sciences Centre waiting room in Manitoba, Canada (Geary, 2017). The Government of Manitoba's (2015) Provincial Implementation Team reported that the acute peritonitis that caused his death was avoidable. The lack of initial care he received contributed to his death and that lack of care was emphasized by racial and stereotypical beliefs held by the healthcare workers (Government of Manitoba, 2015). The team set out to add recommendations for further health care initiatives that would prevent the same instances from occurring again (Government of Manitoba, 2015).

The case of Brian Sinclair shook me to my core and made me think of all the times my father had been ill and led me to reflect on the idea that Brian Sinclair was someone's son and possibly someone's father; he was a significant part of someone's life, just as my dad is in mine. I thought of how that could have been my father dying alone in that waiting room, but then I realized that would likely never happen. My bias tells me that as a White, non-disabled male, my father would be treated with respect and with a desire to meet his needs only due to his skin colour and physical ability. From my viewpoint, Brian Sinclair's death was surrounded by

factors of systemic oppression and operational stigma towards Indigenous peoples and substance users.

The second impactful instance that replays in my mind is a quote that has led me to be a better advocate for Indigenous peoples and their addiction needs. I remember how the words hit a place in my heart while driving past a homeless shelter surrounded by Indigenous peoples who appeared to be under the influence. Although I cannot recall the speaker, they said, “you know, the only thing that sets you and I apart from the people sleeping on those mats each night is a handful of traumatic events and a lack of accessible resources to handle them.” I have allowed this awareness to reside in me as a constant reminder of why I want to be the person who continuously learns about the culture, traumas, and disparities of Indigenous peoples and who shows up to give Indigenous peoples a voice in areas where they have not been given one.

The biases I hold and have held do not only stem from my upbringing but also my work experience. While I remain working with Indigenous peoples who experience addiction, I recognize that I come with biases regarding what resources and care components are needed to help Indigenous peoples. I must also come to terms with the recognition that as a non-Indigenous person, no amount of education will allow me to fully understand Indigenous trauma or experiences despite having directly worked with Indigenous peoples. As I was born into a system that provided me with privilege, I must understand that regardless of the good I wish to do, aspects of my inherent privilege cannot be avoided but must be used for change. As someone on the outside looking in, it is essential for me to regularly make this fact noticeable to my conscious mind to take on a role that respects Indigenous culture and disparities.

Collective knowledge includes shared beliefs, values, languages, institutions, and symbols that play a significant role in developing worldviews (Jacob, 2013). I must understand

the way my differing beliefs of culture affect my position. Recognition of biases and differences is a way to mitigate prejudice and ensure it does not affect my research's external position. One of the most effective bracketing preconceptions I found to work well was to recognize when my biases came up during the literature review process and to place these biases in written format as they arose—an aspect known as journaling or thought response (Tufford & Newman, 2012). To bracket my biases, I created a thought response page where I would write down any immediate thoughts that came to mind for each piece of literature I read. Afterward, when I had completed the reading, I would look over the thoughts that I had and then identify which biases or positions I was taking during each thought. This strategy was immensely beneficial in identifying the preferences that I have held and sitting with my biases.

Literature Review

The literature review begins with a comprehensive overview of various forms of trauma experienced by Indigenous peoples. Next, the impact of colonial trauma and its longstanding effects on Indigenous peoples will be discussed with a particular focus on how colonial trauma intersects with and forms experiences of racial trauma. Finally, the role of trauma in the development of substance use issues in Indigenous peoples will be discussed through an attachment theory lens.

Terminology

Within the literature review, definitions referring to colonial and racial trauma are used. During the process of colonization in Canada, Indigenous peoples began to have their rights to their land removed in attempts for colonizers to gain financial and developmental control over such lands. *Colonial trauma* refers to the continuous and collective interaction of colonial policies that attempted to separate Indigenous peoples from their land, language, and cultural

practices (Gone et al., 2019; Mitchell et al., 2019). Within the topic of colonial trauma lies conversations about marginalization, which refers, in this case, to treating Indigenous peoples as insignificant or less than other European White populations (Woolford & Benvenuto, 2015). The marginalization of Indigenous peoples remains today in ways that affects the accessible treatment to services and equitable treatment (O'Neill et al., 2018).

Racial trauma refers to the ongoing experience of racism and racial biases towards people of colour, more typically people who are not White. This racial trauma includes Indigenous peoples' reactions to dangerous events and experiences of discrimination, including harm or injury, threats, and humiliating or shaming events (Comas-Díaz et al., 2019). Racial trauma holds similarities to that of colonial trauma in that they both involve invalidation of Indigenous peoples based on their cultural and ethnic identity. Still, it focuses on the specific interventions of colonialists in attempts to assimilate Indigenous peoples into the rest of society by ridding Indigenous populations of their identity (Hartmann et al., 2019).

Experiences of Trauma

Colonial Trauma

Indigenous peoples were the first inhabitants of the land when people from Britain and France arrived to take over the land, its resources, and governance. As the late 1800s continued, colonization took away Indigenous peoples' self-governance and autonomy over the use of the land they had inhabited for centuries. In doing so, colonizers began to recognize that the Indigenous peoples would not give up their land, so attempts were made to take it away and rid Indigenous peoples of their culture and heritage for personal gain.

One of the first accounts of European colonizers' impact on Indigenous peoples in North America was them bringing smallpox and measles and infecting Indigenous peoples while

simultaneously preventing them from accessing treatment. The lack of immunity to diseases led to 90% of Indigenous peoples being decimated (Hartmann et al., 2019). The decimation was followed by the displacement of Indigenous peoples from their land into bordered reserves, criminalization of cultural practices, termination of Indigenous languages, and sterilization of Indigenous women (Antonio & Chung-Do, 2015; Hartmann et al., 2019) through the Indian Act.

Colonial trauma reaches beyond that of European colonizers' impact on Indigenous peoples in North America and the similar impacts on Indigenous populations on other continents such as Australia (Gone et al., 2019; Mitchell et al., 2019; Nutton & Fast, 2015). The numerous attempts to rid Indigenous peoples and their culture contributed to the colonial trauma Indigenous peoples faced and continue to face. The attempts to separate Indigenous peoples from their cultural connections and traditional lifeways have resulted in social, cultural, spiritual, and emotional disruptions (Mitchell et al., 2019). The effects reach beyond mental and spiritual health and impact physical health aspects related to alienation, starvation, and lack of land leading to an inability to meet basic needs.

A significant instance of colonial trauma experienced by Indigenous populations was the creation of the Indian residential school system in an attempt to assimilate Indigenous peoples into European-White-culture. Indian residential schools involved forcibly removing children from their families to attend these schools where they were not permitted to use their cultural languages, practice cultural traditions, or act in any way that did not fit the governing body's Christian religious and cultural beliefs (Barnes & Josefowitz, 2019; Wilk et al., 2017). Those who did not obey were punished in unethical and inhumane manners. Children were exposed to sexual, emotional, verbal, physical, and spiritual abuse (Allan & Smylie, 2015). Residential schools were in existence for 154 years, and the last school closed in 1996 (FNIGC, 2012). In

these 154 years, it is known that at least 4200 of the 150,000 children in attendance died at the hands of harmful disciplinary tactics, leading to an even more significant impact on those families whose children never returned (FNIGC, 2012).

Following World War II in 1945, residential schools began to be dismantled as the federal government took over the administration of the schools and was able to end residential schools entirely in 1996, roughly 50 years later (McKenzie et al., 2016). During those times, numerous children remained exposed to the harm that occurred at residential schools and the associated trauma. However, the end of residential schools did not end the systemic racism and oppression of or violence towards Indigenous peoples, as discrimatory ideologies about Indigenous peoples was embedded within Canadian society by this time.

Another attempt at assimilation was an era called the Sixties Scoop where Indigenous children were taken away from their families and placed in White foster homes (Alston-O'Connor, 2010). It was a similar experience for those who had been previously pulled away from their families to be put into residential schools. Through the 1960s and 1970s, approximately 20,000 children were taken from their homes and fostered or adopted by mostly upper middle-class, White Catholic families (Hay et al., 2020; McKenzie et al., 2016). Such an approach aimed to further rid Indigenous peoples of their cultural values and "rid Canada of the Indian problem" (Patterson-Silver Wolf, 2015).

As Indigenous peoples are considered marginalized in many systems (Payne et al., 2018), it is important to note the difference between marginalized and colonized and how Indigenous peoples experience both. Indigenous peoples have been marginalized through stigma at the hands of society in healthcare systems, due to inaccessibility and judgment, and in government systems, due to misrepresentation (Ben et al., 2017; Gebhard, 2017). Indigenous peoples are

marginalized in society as they are often omitted from conversations of race and culture by political and social influences, provided with a lower standard of health care, and have inadequate access to culturally competent resources (Mitchell et al., 2019). However, Indigenous peoples are also affected by colonization as they are physically and culturally dispossessed from the rest of society, and they fall victim to termination of cultural identity (Payne et al., 2018).

The recognition of the effects of colonial and historical trauma on Indigenous peoples is essential to understand from a public and psychological health standpoint. Such recognition contributes extensively to providing well-rounded care for Indigenous peoples with respect to the complexity of trauma. The numerous impacts of colonial trauma have contributed to developing substance addiction aspects as substances are sought out as coping mechanisms for unresolved feelings (Firestone et al., 2015). Further, although not as evident or drastic as previous attempts to decimate Indigenous peoples, colonial trauma has not ended for Indigenous peoples, and contemporary colonization remains a significant injustice (Marsh et al., 2016).

Racial Trauma

The trauma that Indigenous peoples have experienced, along with its long-lasting effects, did not end with the closing of residential schools or Sixties Scoop practices. The systemic oppression of Indigenous peoples continues to be present in different social structures and societal processes. Indigenous peoples have demonstrated remarkable resilience in response to the oppression they have faced in terms of historical and colonial trauma, and they continue to demonstrate this resilience as they experience racial profiling, higher rates of violence, and health disparities (Figley & Burnette, 2017).

Although residential schools have been shut down and Indigenous peoples are beginning to have a voice, they are also being subjected to new forms of racial trauma. For instance, the

Indian Act placed restrictions on hunting and fishing and earning a living through those actions, which led to food scarcity and a loss of traditional food sourcing methods (Allan & Smylie, 2015). Not being able to rid society of Indigenous peoples, the government tried another tactic through forced sterilization of Indigenous women in which women were given hysterectomies without their knowledge or against their will so they could not further bring Indigenous children into the world (Cromer et al., 2018; Skewes & Blume, 2019).

The importance of recognizing racial trauma remains relevant as past racial injustices influence the present inequities. In North America alone, Indigenous peoples are victims of violent crime more often than any other racial group (Skewes & Blume, 2019). Although Indigenous peoples account for only 1.6% of the total North American population (FNIGC, 2012), Indigenous peoples are victims of 3% of all violent hate crimes (Skewes & Blume, 2019). In Canada alone, there were 30 police-reported accounts of hate crimes towards Indigenous peoples in 2019 (Armstrong, 2019). The notion that Indigenous peoples are still experiencing violence demonstrates the relevance and prevalence of racial trauma, which increases the likeliness of substance addiction (Paradies, 2016).

Substance Use

Experiences of trauma and the systemic barriers that have prevented Indigenous peoples from equitable and accessible mental and physical health care have led to adverse effects such as substance misuse and addiction. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed; *DSM-5*; American Psychiatric Association, 2013) encompasses ten different classes of substances, including but not limited to inhalants, opioids, alcohol, and stimulants. According to the *DSM-5*, there are two main categories of substance addiction: substance-related disorders and substance-induced disorders. The difference between the two categories lies in the physiological

and mental effects of substance abuse and its ability to disrupt daily life functioning (American Psychiatric Association, 2013).

It is important to note that the *DSM-5* definition of substance use disorders overlooks cultural influence in the experience of substance use, which risks leading to inaccurate or incorrect diagnoses (Dell et al., 2011; Ecks, 2016). Although some knowledge is provided on how to be culturally sensitive with diagnoses and what is or is not normal for a population, there is little to no information provided on using the *DSM-5* with Indigenous populations (Ecks, 2016). However, some researchers argue that in comparison with previous editions of the fifth version of the *DSM*, the current edition demonstrates an increase in cultural recognition (La Roche et al., 2015). The *DSM-5* makes efforts to acknowledge what is classified as typical or normal for certain cultural groups in regard to mental distress (Ecks, 2016).

Substance abuse is defined as a pattern leading to significant impairment in function, whereas substance dependence includes continuation and increased intolerance in addition to substance use (Dell et al., 2011). Although the *DSM-5* includes caffeine, nicotine, and cannabis dependence as substance use disorders, some argue that these diagnoses should be withdrawn to avoid understating more severe addictions such as alcohol and psychoactive or opioid drug addiction (Hasin et al., 2013). An argument for the omission of such addictions from the *DSM-5* shows that nicotine and caffeine addictions specifically have lower rates of the stigma associated with their use due to the general lack of negative behaviours produced by the addiction (J. A. Cunningham & Koski-Jännes, 2019). For the current review, caffeine, nicotine, and cannabis addiction is omitted in an attempt to narrow down the focus while still acknowledging that they may be counterparts of a different dependence.

Indigenous peoples in North America have higher substance addiction rates than non-Indigenous populations studied (Patterson–Silver Wolf et al., 2015). The rates of substance abuse or dependence were 8.7% for Caucasian populations and 21.8% within Indigenous populations (Nutton & Fast, 2015). Overall addiction rates and rates of specific substance use disorders can also differ between Indigenous peoples. For instance, proximity to liquor stores, family members or other authority figures experiencing addiction, and living on or off reserve can contribute to fluctuations in addiction rates (Bingham et al., 2019). Substance addiction is also often attributed to the experiences Indigenous peoples had when they were young and the relationship with their caregivers (Antonio & Chung-Do, 2015)

Attachment Theory

Attachment theory, initially founded by John Bowlby, believes that the earliest bonds formed between children and their caregivers significantly impact areas of behaviour, emotional regulation, and connection with others, and these bonds continue to affect individuals throughout their lives (Bowlby, 1982). Attachment and connection with others can be considered a fundamental human need that focuses less on seeking pleasure and more on seeking comfort (Fletcher et al., 2015). Due to the ability of substances to relieve psychological suffering through providing pleasure, comfort, pain relief, and distraction, substances can alleviate suffering by compensating for an alienated sense of self (J. A. Cunningham & Koski-Jännes, 2019; Firestone et al., 2015; Fletcher et al., 2015) or when that attachment bond is missing or has been harmed through neglect or abuse by caregivers.

Attachment theory recognizes that loss affects a child's attachment style by providing a lapse in their ability to connect to other authority figures or caregivers (Barnes & Josefowitz, 2019). Knowing that an attachment figure is near and available provides a strong sense of

security (Barnes & Josefowitz, 2019; Bowlby, 1982; O'Neill et al., 2018). Feeling secure contributes to an individual's personality development and their ability to have healthy relationships in their adult lives (Fletcher et al., 2015). From an attachment perspective, substance use disorders may be understood as a coping mechanism to relieve the psychological suffering that individuals experienced as a result of being separated from caregivers at a young age (Skewes & Blume, 2019). Attachment theory argues that a lack of parental warmth and involvement may lead to adverse outcomes such as greater difficulty self-regulating and a reliance on mind-altering or numbing substances to cope (Fletcher et al., 2015; La Roche et al., 2015).

Parents who have experienced trauma may be more likely to contend with educational deficits, insecure attachment styles, and addiction and consequently fail to meet children's needs (La Roche et al., 2015). Parental deficits can subsequently transfer and create trauma in their children and negatively impact attachment, which provides a basis for research on the channels of trauma transmission (Perry, 2009). Research is also needed, if not more importantly, to focus on healing the trauma as a way of stopping the cycle of intergenerational trauma (Fletcher et al., 2015; J. R. Schore & A. N. Schore, 2008; Skewes & Blume, 2019)

The Brain, Trauma, and Addiction

Following the development of Bowlby's attachment theory, researchers have argued that a comprehensive understanding of addiction also requires greater consideration of developmental and physiological influences (J. R. Schore & A. N. Schore, 2008). For instance, addiction has been conceptualized as a disease of the brain, but solely viewing addiction through a medical lens fails to capture the role of physiological development in addiction (Lewis, 2017; Perry, 2009). The development of the brain is considered highly experience-dependent (Lewis, 2017; J.

R. Schore & A. N. Schore, 2008). A person's experiences during brain development have the ability to change the brain's structure and influence future experiences, particularly those that involve self-perpetuation, emotional reactivity, and interpretation abilities (Lewis, 2017).

Attachment experiences significantly affect the early development of the brain, including its ability to self-organize and develop regulatory functions (J. R. Schore & A. N. Schore, 2008). The attachment relationship between children and their caregivers facilitates the development and maintenance of synaptic connections that help to institute long-lasting functional circuits (Allman et al., 2005; A. N. Schore, 2001; J. R. Schore & A. N. Schore, 2008). These functional circuits help with self-regulation in times of pain or crisis. Without these healthy connections, people may seek self-regulation through unhealthy means such as substance use and abuse.

The experience-dependent development of the brain's regulatory capacities, such as self and emotional regulation, can be disrupted by an unstable attachment to a caregiver (A. N. Schore, 2001). Indigenous populations may be more likely to exhibit insecure attachment styles due to parental loss, forced physical detachment from parental figures, parental deficits, and intergenerational trauma (Sinha, 2008). Thus, early childhood experiences of insecure attachment may have neurobiological consequences that impact Indigenous peoples' ability to self-regulate and maintain self-control (Garami et al., 2019).

Experiences of trauma, neglect, and maltreatment that impair early bonding and development have a strong influence on the brain and increase susceptibility to developing addictions (Garami et al., 2019; Perry, 2009). Adverse experiences during childhood as well as in adulthood create abnormal patterns of neural and neurohormonal activity (Perry, 2009). Abnormal patterns of neural activity affects an individual's capacity for change due to their impact.

From a developmental perspective, addiction is known as an outcome of learning and experiences (Garami et al., 2019; Lewis, 2017). Such experiences reduce executive self-control and allow for events that activate the brain's stress circuit to affect the brain's reward circuit—a common cycle associated with addiction (Garami et al., 2019; A. N. Schore, 2001). Trauma during early developmental stages affects the brain's ability to regulate, which promotes adverse emotional and self-regulation patterns (Lewis, 2017; Perry, 2009). Maladaptive regulation patterns then affect an individual's ability to develop self-control tendencies and enhance their susceptibility to reach for substances as an emotional coping mechanism (Garami et al., 2019; J. R. Schore & A. N. Schore, 2008; Perry, 2009).

Transmission of Trauma

Due to the rates of substance addiction and the impact of trauma on Indigenous peoples, it is necessary to consider the intergenerational patterns of addiction concerning the social and health determinants that have affected Indigenous peoples (Firestone et al., 2015). Research has highlighted that unresolved trauma may predispose future generations to trauma and other mental health concerns. Trauma experienced by Indigenous peoples contributes to the trauma presently experienced, which is how the implications of trauma are passed throughout generations (Cromer et al., 2018; O'Neill et al., 2018). According to a survey completed in 2018, 74.4% of Indigenous adults who did not attend residential schools reported being negatively affected by their family members' experience in residential schools (FNIGC, 2012). Their family members' reported adverse effects on their mental health resulted in the participants acknowledging a transmission of trauma (FNIGC, 2012). The residential school experience is connected to mental illness ramifications, including depression, suicide, addictive behaviours, and substance misuse. Such ramifications are often described as coping mechanisms used by Indigenous peoples to protect

themselves from the long-lasting pain and intergenerational transmission of abuse (Wilk et al., 2017).

The literature also describes two levels of trauma that are thought to contribute to the intergenerational transmission process: the personal level and the collective level (Bombay et al., 2009). The personal level includes those traumas occurring in isolation to the individual, such as sexual assault. Trauma at the collective level includes experiences touching several people, including war and cultural genocide (Bombay et al., 2009). The experience of collective trauma is more likely to be transmitted through generations (Gone, 2011). Those who experience trauma personally or collectively and in a colonial or systemic manner may be more susceptible to enacting poor parenting styles and demonstrating abuse or neglect (Bowen & Murshid, 2016). The abuse and neglect then transfers to the next generation as they develop poor appraisals and coping mechanisms, leading to increased reactivity to stressors and poor mental health that trickles down to the next generation (Bombay et al., 2009; Wilk et al., 2017).

The literature shows that exposure to trauma from caregivers who have also experienced trauma increases the likelihood of developing substance addiction (Meulewaeter et al., 2019). Indigenous children in the United States have the highest rate of trauma victimization—14.3 out of 1000 children (McKinley et al., 2021; Myhra, 2011). As discussed above, trauma may bring about attachment disruption and maladaptive coping strategies (e.g., substance misuse) that affects more than one generation; the cumulative effects of multiple traumas subsequently transmit through generations (O'Neill et al., 2018). At the core of intergenerational trauma lies the ripple effect of victimization (O'Neill et al., 2018). Trauma memories can be passed through several channels. For instance, in the biological channel, some individuals may be more predisposed to post traumatic stress disorder through cultural channels where traumatic

experiences are passed down through storytelling or social channels such as inadequate parenting and abuse actions (Marsh et al., 2016).

It is important to keep in mind that various terms can be used to conceptualize Indigenous peoples' experiences of intergenerational trauma. Intergenerational trauma is understood as resulting from external forces and elders who fell victim to external traumatizers. The transmission of trauma is considered unintentional and often done without awareness of the actual traumatic event (Gone, 2011; O'Neill et al., 2018). At the core of most of these terms is the idea that trauma is often connected to anxiety and depression, both of which are common factors associated with developing and maintaining substance addiction (McKinley et al., 2021). For instance, the term "soul wounds" was used initially to reference Holocaust survivors and the psychological and emotional scars left behind by those traumatic experiences that have been transmitted across generations. (Bombay et al., 2009; Cromer et al., 2018; Marsh et al., 2016) Trauma leaves behind more than physical reminders, and when not processed or treated fully, the psychological wounds of the soul may be passed down to other generations.

Another term commonly used by Indigenous peoples to conceptualize intergenerational trauma is seven generations (Nutton & Fast, 2015). Indigenous peoples believe that the damaging effects of colonialization including residential schools, the Sixties Scoop, forced sterilizations, and means of cultural loss are experienced by subsequent generations, and it will take seven generations to fully heal.

Implications for Counselling

The literature review provided insight into Indigenous peoples' experiences and the resulting trauma and mistreatment through colonizing forces, racial injustice, and marginalization in the past and present. The discussion surrounding such experiences shines a

light on the possible reasons for increased substance addiction rates in Indigenous peoples. The following sections will provide a more in-depth review of components of care that can have positive benefits and be effective in providing treatment for Indigenous peoples with substance addiction. The sections below will also examine resources already in place but that require the necessity for higher rates of accessibility for and inclusion of Indigenous peoples, their culture, and their experiences.

Evidence-based approaches such as cognitive behavioural therapy, motivational interviewing, contingency management, and mindfulness-based approaches have been researched and shown to be effective in the treatment of addictions with diverse populations, including Indigenous peoples (Amodeo et al., 2013). Although these approaches are not the primary focus of this research, interested readers can further their research through Glasner and Drazdowski (2019), Veach and Moro (2018), and Miller et al. (2019).

Components of Care

Trauma-Informed Care

In recent years, trauma-informed care has become a well-known and applicable service model across health and social service settings (Bowen & Murshid, 2016). One of the most significant aspects when incorporating trauma-informed care into any practice of substance addiction assistance, especially when working with Indigenous peoples, is the recognition that just like no two people are alike, no two experiences of trauma are either. Indigenous peoples struggling with substance use and co-occurring deficits such as homelessness often have shared experiences of trauma and marginalization stemming from colonialism, structural inequities, and the transmission of ancestral traumatic experiences (Bingham et al., 2019). The recognition that Indigenous individuals may have somewhat similar experiences of trauma and inequities allows

for the benefit of structuring care towards specific experiences and applying interventions to multiple individuals, thus enhancing the ability for more individuals to be reached. However, there is a tendency to overgeneralize the experiences of Indigenous peoples. Recognizing the deficit strengthens the notion that trauma-informed care cannot take a one-size-fits-all approach for treatment and providing service (Cloitre, 2015). For effective maintenance of an individual who experiences trauma, adaptation and innovation are essential aspects for resources to obtain.

The need for trauma-informed care stems from the complex trauma Indigenous peoples have experienced. This complexity is formed from collective, colonial, intergenerational, and personal trauma (Bingham et al., 2019; Bowen & Murshid, 2016). With respect to the vast complexity of the trauma experienced and in keeping with the need for resources to respect cultural differences to provide sufficient interventions and supply great supports, the question that emerges is if treating everyone the same an adequate way to respond to inequities? (Browne et al., 2012; Maritt et al., 2017). Research demonstrates that when asked about the quality-of-care Indigenous peoples experience in mental health services, providers are likely to answer that they do not treat Indigenous peoples any differently than how they treat a non-Indigenous person (Antonio & Chung-Do, 2015; Tang & Browne, 2008). The view of treating everyone the same is not wrong at a professional level as it adheres to standard codes of ethics and moral principles (Tang & Browne, 2008) and allows people to feel they have met the societal expectation for fairness and equal treatment. However, there is value in recognizing the difference between equality and equity.

Equal treatment implies that all individuals are given the same support; *equitable* treatment, on the other hand, recognizes that each individual comes with their own set of barriers and experiences showing the need for individualized supports (Browne et al., 2016). Research

demonstrates that it is more beneficial to work with Indigenous peoples with substance use problems in an equitable way (Lavalley et al., 2020). For example, a non-Indigenous individual with addiction may not have the same effects of colonial and intergenerational trauma that an Indigenous person may have that fosters barriers to overcoming obstacles and developing healthy coping patterns (Prangnell et al., 2016). Although the trauma experienced by Indigenous peoples may hold similarities to that of other cultural or ethnic groups, there is a need for mental health supports to not overlook or omit the cultural realities of Indigenous peoples and how that has affected the specific traumas they have experienced.

Trauma is described as experiences that produce emotional pain and distress that results in long-term consequences (Bowen & Murshid, 2016). The method of trauma-informed care aims to recognize the intersection of trauma with the need of health and social services to address their problems (Marsh et al., 2016). In working with Indigenous peoples, trauma-informed principles may include recognizing the intersection and overlap of experiences of trauma both at a personal and collective level. Social determinants of health that have the ability to lead to substance addiction (i.e., intergenerational trauma, parental deficits, and lack of access to education; Nutton & Fast, 2015) can benefit from trauma-informed practices. Adapting programs to hold a well-rounded view of Indigenous peoples' experiences of trauma can constitute a framework for analyzing social policy and guiding advocacy efforts to allow for characteristics of trustworthiness and collaboration (Bowen & Murshid, 2016).

Culturally Competent Care

Cultural Interventions. Healing is important. It refers to the mind, body, and spiritual connection and inter-connection that is a recognized component of how Indigenous peoples view their connection to their well-being and the world (Lewis et al., 2017 McKenzie et al., 2016).

When discussing the cultural interventions used in substance addiction, it is important to consider that strictly Western-based assessment, counselling, and treatment are not the most effective approaches than those that stem from Indigenous ideologies (Rowan et al., 2015). Indigenous peoples use different interventions for healing of the mind-body and spirit and substance use treatment, focusing on the traditional values of storytelling, sweat lodges, and smudging. These values consist of acts performed as a means of bonding with ancestors, getting in touch with one's heritage and cultural roots, understanding the importance of and respect for the land, and contacting one's spirit to gain knowledge about what one needs from their body and mind (Dell et al., 2011; Hall et al., 2015).

For a culturally competent program to work with Indigenous peoples, substance addiction programs must not force individuals to participate in Western-based methods and programs. These methods and program, however, can be an option. An aspect of being trauma-informed is giving power to the person seeking help through choices. Incorporating Indigenous beliefs of healing from addiction through methods such as sweat lodges, traditional teachings, and participation in cultural activities can be beneficial as well (Rowan et al., 2015). Resources should respect differing cultures, understand the different viewpoints of Indigenous peoples, and recognize the need to offer various healing methods (Rowan et al., 2015). In substance addiction treatment, the practice of cultural adaptation is often helpful in allowing for Indigenous people to be heard and included in their treatment (Hall et al., 2015). It can involve minor modifications to programs, such as changes in terms and accessibility, to more substantial changes that reflect the cultural phenomena intertwined with addiction services (Okamoto et al., 2014). Culturally grounded and thoughtful approaches to developing substance addiction interventions must utilize methods that place the targeted population's culture at the center of the intervention (Maritt et

al., 2017; Moullin et al., 2019). With Indigenous peoples, this approach could mean more involvement in the formation of mental health services and including Indigenous peoples in the changes and decisions that affect them.

Healing and wellness are highly valued within Indigenous and non-Indigenous populations (Gone & Calf Looking, 2015). Both healing and wellness contribute to overall happiness and emotional well-being, which coincides with the belief that efforts to improve wellness are critical for addiction services to use to be successful (Fiedeldey-Van Dijk et al., 2017). A significant factor in the treatment and rehabilitation of Indigenous peoples who misuse substances is a disconnection from their cultural identity.

Cultural identity refers to the desire to participate in and the overall involvement in cultural practices and the extent to which individuals feel connected to their culture (Fiedeldey-Van Dijk et al., 2017); Indigenous peoples have been denied their cultural identity due to colonialization practices mentioned above. Studies show that cultural identity and engagement in their traditional practices can act as protective factors against or healing factors for problematic substance use (Nutton & Fast, 2015). The significant value that Indigenous peoples place on community and ancestry coincide with cultural identity and the ability to allow their cultural connections to serve as protective forces.

Although there is no single method to slow or heal the impacts of trauma and its association with substance use with Indigenous peoples, there are strategies proven as useful for breaking down systemic barriers and patching wounds left by colonizers. One effective strategy is decolonization, which refers to undoing colonization and restructuring its effects (Antonio & Chung-Do, 2015).

Decolonizing involves methods such as self-determination and self-governance of Indigenous peoples (Wilk et al., 2017). Strategies such as identify formation, which involves participation in cultural activities and traditional teachings, and culturally adapted interventions to treat substance addiction, such as hiring culturally matched staff and incorporating training on cultural sensitivity and colonialism, enhance the cultural competency of treatment resources (Nutton & Fast, 2015). Further information regarding the process of decolonization will not be provided in this paper; however, resources such as *Unsettling Canada* by Arthur Manuel (2015) and by reviewing the Indigenization Guide provided by BCcampus learning.

Effective Strategies. There are many ways to create and maintain programs to ensure they are culturally competent and meet each individual's needs with respect for their cultural background and growth channels (Christensen, 2013). Effective interventions and programs recognize the importance of spiritual leaders and consider the level of biculturality alongside the role of trauma experienced by Indigenous populations (Payne et al., 2018). Advocating for clinicians' to be trained in cultural competency is essential to success in developing proficient services. Culturally competent and effective resources must recognize Indigenous peoples' alienation to understand and explore their place in society compared to others (Payne et al., 2018). Such a realization further validates the experiences of oppression and cultural loss experienced by Indigenous people. Alongside such recognitions comes the validity of respecting Indigenous people as susceptible to substance addiction due to colonial forces and trauma transmission (Bingham et al., 2019).

Much research shows the necessity of culturally tailored programs to increase effectiveness and acceptance (Fiedeldey-Van Dijk et al., 2017; Gone & Calf Looking, 2015; McKenzie et al., 2016). They include curricula and interventions derived organically by efforts

that place Indigenous populations' social and cultural contexts into view (Antonio & Chung-Do, 2015). With culturally tailored programs, it is essential to recognize a general lack of understanding of the depth in which culturally focused interventions reflect both the populations they intend to serve and the resources used to develop such interventions (Hall et al., 2015; Okamoto et al., 2014). For a program to be proficient in providing culturally competent care for Indigenous populations, the extent of incorporating cultural practices must be evaluated, and the facilitation of ideologies must be used and compared to that of the target populations (Okamoto et al., 2014).

The Two-Eyed Seeing Approach. Due to the political, systemic, and economic barriers that are in place, Indigenous peoples may find it difficult to gain the resources they need for mental health and well-being in a way that allows resources and agencies to provide appropriate care for substance use without the influences of Western populations (Ben et al., 2017). It is also difficult for Western practitioners to provide culturally competent care for Indigenous populations without the influence and input of individuals from that culture. In collaboration with Western ideology, Indigenous peoples created the Two-Eyed Seeing approach, which is now highly respected and used in many different agencies, health care programs, and addiction services (Bartlett et al., 2012).

The Two-Eyed Seeing approach was initially used in research settings to encourage Indigenous populations to participate in science and research and urged researchers to consider the strengths of both Indigenous and Western worldviews (Bartlett et al., 2012; Hall et al., 2015). Using a Two-Eyed Seeing approach honours and recognizes that no one worldview can exist without the other despite past attempts to eradicate Indigenous beliefs and viewpoints (Marsh et

al., 2016). The approach considers both cultural views and combines their lenses to provide the most rounded forms of care.

Just as both of one's eyes are equally important to sight, no two eyes see the same as their counterpart, just as those of the Indigenous and Western worldview do. The Two-Eyed Seeing approach recognizes this resemblance to sight (Hall et al., 2015). By incorporating the weaving of perspectives, the Two-Eyed Seeing approach emphasizes that both lenses have equal importance but acknowledges that in some instances, one view may be more applicable to understanding a specific concept or situation more than the other (Wright et al., 2019). The Two-Eyed Seeing approach's application can incorporate inclusion, respect, collaboration, and an acceptance that strengths can reside in both of Western and Indigenous worldviews (Marsh et al., 2016).

In the Blackfoot language, the term "I'taamohkanoohsin" translates in English to "everyone comes together" and was used as the basis and title of a program that was created for homeless Indigenous peoples with substance addiction (Victor et al., 2019). The I'taamohkanoohsin program incorporated the Two-Eyed Seeing approach by incorporating Niitsitapi's ways of knowing with Western-based ideologies. Niitsitapi's ways view spirit as the foundation for wellness and resilience; when incorporated with the Western views of addiction as a result of traumatic experiences, the program created a focus on supporting traditional Indigenous healing methods. I'taamohkanoohsin offered individuals a path out of spiritual homelessness by increasing opportunities for cultural connection and supported individuals in nurturing their spirit-self connection (Victor et al., 2019). Through the Westernized view of success as a scale, the program was deemed prosperous. Moments of hope experienced by participants accumulated stronger identities and self-worth (Victor et al., 2019). For some

participants, temporary sobriety or accessing health care was viewed as a success; for others, achieving long-term housing was viewed as a triumph (Victor et al., 2019).

Equitable Care

Primary Health Care. Indigenous peoples in North America have been treated with disparities both in the past and presently (Mitchell et al., 2019). Structural violence refers to the disadvantage and suffering that comes from the creation of structures and policies that are unjust (Browne et al., 2016). In North America, such policies and procedures are intertwined in mental health resources and provide a disadvantage for Indigenous populations by not allowing their care to be contextually tailored or equitably accessible. In attempts at reconciliation for the disparities that Indigenous peoples experience, government systems have made attempts at committing to principles of primary health care (PHC), such as social justice and health inequities (Hall et al., 2015; Lavalley et al., 2018). However, health inequities, inaccessible health care for Indigenous people, and individuals experiencing addiction remain a pressing concern (Lewis & Myhra, 2017).

To be effective, PHC requires trauma-informed care, culturally competent care, contextually tailored care, and equitable care (Browne et al., 2016). For PHC to work and be inclusive of Indigenous communities, reconciliation attempts must include investing in these communities, including investments in social and structural drivers of health inequalities (Lavalley et al., 2018). For PHC to be culturally competent, efforts must be made to rid the health care system of discrimination. One method to enhance cultural competency is to adjust policies and care practices to identify social justice goals as integral to health care. Adjusting policies allows for PHC practices to shift attention away from cultural safety and the sources of the problems to the culture of health care itself as a transformative force (Browne et al., 2018).

Within trauma-informed PHC, it is essential to not place an overly significant amount of value on the trauma itself. Resources should recognize that trauma exists and acknowledge that over-focusing on past traumas can allow for the ignorance of current structural violence (Browne et al., 2016). Instead, PHC services should ensure that re-traumatization is prevented (Lewis & Myhra, 2017). When involving contextually tailored care in a PHC setting, it is essential to recognize that it must go beyond patient-centred care and include services tailored explicitly to communities and populations (Browne et al., 2016).

Counselling is an essential piece of PHC as counselling respects the inclusion of physical and mental health. Counsellors can enhance the impact of therapy in PHC by responding more effectively to intersecting forms of trauma and violence, responding to the impacts of racism, and responding more adequately to the intersection of substance use and trauma (Browne et al., 2018). To strengthen the role of therapy in PHC, counsellors can complete further research, assure proper training resources for staff, and incorporate collaboration with Indigenous and homeless agencies. For PHC counselling to be culturally safe and trauma-informed, counsellors must know Indigenous history and the causes and consequences of inequity in healthcare (Purkey & MacKenzie, 2019).

Homelessness. In Canada, Indigenous people are 8 times more likely to suffer from homelessness than any other population (Prangnell et al., 2016) often due to a lack of accessibility to housing resources, the integration of poverty, lack of affordable housing, and social-economic inequities (Bingham et al., 2019). *Spiritual homelessness* refers to Indigenous people being displaced from their ancestorial lands, and their homes and camps being destroyed,which results in Indigenous people experiencing homelessness (Hodgetts et al., 2014). For some Indigenous peoples, homelessness refers to more than just being without a house but

being without a connection to their spiritual and ancestorial lands (Christensen, 2013). The immense connection that Indigenous people have with land translates the loss of land to the loss of a home. As the loss of home continued and adapted, the loss had the opportunity to increase the number of Indigenous peoples represented in the homeless population (Prangnell et al., 2016). A move by homeless Indigenous people towards places with more accessible resources such as food and shelter moved Indigenous populations from reservations and rural areas towards cities and towns (Christensen, 2013).

Being homeless in itself creates barriers to accessing resources as individuals must navigate a maze of systems to access essential supports such as substance use treatment, housing, and opportunities to meet their basic needs (Bingham et al., 2019). As being homeless in itself is a social determinant of health, adding in the colonial, racial, and intergenerational trauma of Indigenous people and the systemic oppression and social stigma surrounding them, Indigenous peoples are faced with significantly larger barriers towards accessing treatment (Hodgetts et al., 2014; Prangnell et al., 2016).

Experiencing homelessness has major psychological effects, the majority of which are influenced by the need to be in a mode of survival at all times and protect oneself from probable harm. Individuals who are homeless may be hesitant to reach out to counselling services due to the feeling that they will be met with stigma or judgment (Chaturvedi, 2016; Prangnell et al., 2016). For counsellors to adequately provide help for people experiencing homelessness, they must incorporate the idea that behavioural and psychological responses to being homeless are valid responses to an extreme personal crisis as opposed to maladaptive actions (Bentley, 1997). Individuals who encounter homelessness often develop mechanisms of helplessness due to the daily struggles to meet basic needs, which perpetuates the perception of the self as the agent of

change (Bentley, 1997; Chaturvedi, 2016). It is recommended that counsellors do not demonstrate fear towards individuals who are homeless to enhance approachability and that counsellors develop interventions that challenge feelings of personal helplessness (Chaturvedi, 2016).

Recommendations for Practice

Throughout the following section, recommendations are proposed for integrating knowledge of the traumatic experiences of Indigenous peoples, their cultural values and practices, and equitable care into the practice of counselling psychology. Within this section, strategies to foster the specific needs of Indigenous peoples attending substance addiction programs are suggested. By including strategies that incorporate the knowledge of trauma, culture, and social determinants of health into practice, the counselling field has the ability to strengthen its application with Indigenous populations.

Trauma-Informed Care

Harm Reduction Programs

To treat substance use disorders and addiction in Indigenous populations, it is important to assess all components necessary to provide competent care (Browne et al., 2018). It is also essential to define what treatment is often thought of in the traditional way of rehabilitation resources that focus on sobriety and not the inclusive nature of all forms of help for substance use. A recently developing perspective of substance use safety is that of harm reduction. Harm reduction interventions aim to reduce the negative effects of health behaviours without extinguishing the problematic behaviours (Hawk et al., 2017).

With the growing opioid crisis and the increased rates of substance addiction in Indigenous populations, now more than ever, harm reduction plays a role in survival. Harm

reduction methods and programs can be culturally competent by tailoring individual programs such as housing, food, and health services to Indigenous populations (Lavalley et al., 2018; Myhra, 2011). Critics of harm reduction programs often will advocate for sobriety-focused programs only to prevent enabling; the problem with having a sobriety focus is that abstinence-only programs do not have the broadness of capabilities to meet individualistic needs (Hawk et al., 2017). The value in harm reduction programs for Indigenous peoples correlates with the high rates of racism, cultural decimation, and homelessness due to inequitable social factors that they experience.

The process of harm reduction can be tailored for culturally competent care and is noticeable across programs. In housing first programs, for example, the goal is to get people off of the streets and into supportive housing programs so that their needs are met. Housing first programs are commonly based on the idea that someone cannot obtain health and have the capacity to heal if they are living in less than favourable conditions (Nutton & Fast, 2015). In housing first initiatives for Indigenous populations, supportive housing programs can bring in elders, have cultural ceremonies, and bring about a sense of community by including other Indigenous people (Hawk et al., 2017).

Trauma-Specific Practices

Trauma-specific practices hold similarities to those of *trauma-informed* practices; the difference lies in origin and the execution of fundamental principles. *Trauma-informed* care practices increase consumer safety with an effort to prevent traumatization; *trauma-specific* practices rather address individual experiences of trauma through treatment and intervention (Elliott et al., 2005; Maritt et al., 2017). With the inclusion of trauma-informed care and trauma-specific interventions into Indigenous people's treatment with substance addiction, practitioners

need to consider the complexity of the neurobiological response from prolonged adverse experiences (O'Neill et al., 2018). Indigenous populations have experienced complex and integrated forms of trauma beginning in early childhood that has affected their primary developmental years. As the brain develops, it learns to rewire itself to protect the mind and body from traumatic experiences' harms (Beckett et al., 2017). Significant cognitive differences are noted in those who have experienced substance addiction due to traumatic experiences (Stergiopoulos et al., 2015), resulting in the necessary consideration of understanding the effect of trauma on Indigenous people experiencing substance addiction.

Addressing different trauma experiences can allow Indigenous people to experience benefits associated with interventions specifically tailored to the forms of the trauma they have experienced. The development of trauma-specific practices helps to better meet the needs of individuals with intergenerational trauma, substance addiction, experiences of childhood trauma, marginalization, and victimization (Maritt et al., 2017). A combination of practitioner training on trauma and client involvement in the decision-making and development of interventions are two important ways to enhance trauma-specific practices' validity and benefits (Browne et al., 2012; Maritt et al., 2017).

Culturally Competent Care

Culturally Specific Interventions

Indigenous peoples experience a disproportionate number of burdens and harms associated with substance addiction than others, such as increased susceptibility to HIV and Hepatitis C and an overall lack of accessibility to beneficial addiction services (Maina et al., 2020). Multiple programs have been developed that are specifically tailored to treating Indigenous peoples with substance use disorders. However, a significant amount of treatment

programs focus on prevention as opposed to intervention. Substance use and addiction are more likely to develop in Indigenous youth than any other youth population due to the high rates of addiction they are exposed to and the many forms of trauma amongst Indigenous peoples (Bingham et al., 2019).

There is validity behind the idea that targeting the problem during youth can prevent it from occurring or provide the youth with strategies to avoid developing addictive behaviours and patterns. Research shows that Indigenous youth are exposed to alcohol by age 6, marijuana by age 7, and opioids by age 13 as compared to non-Indigenous populations whose average age of exposure to alcohol and opioids occur during late teen years (Maina et al., 2020; McKinley et al., 2021; Snijder et al., 2018). These findings confirm the need to develop interventions that prevent substance use or slow the rate of the onset of addictive behaviours. Focusing on school-based programs that involve social-emotional learning and cognitive behavioural interventions can help Indigenous youth develop alternative coping mechanisms and healthy emotional processing of trauma (Snijder et al., 2018)

An example of a culturally tailored method of care for Indigenous peoples is The Blackfeet Indian culture camp, which is a rehabilitation camp created to encourage Indigenous people with substance addiction to use cultural and spiritual methods and their connection to the land to heal from their addiction (Gone & Calf Looking, 2015). The camp used survival methods such as wood gathering and fire-making and individual and group therapy sessions. Western methods such as cognitive behavioural therapy and Indigenous methods such as sweat lodges and spiritual cleansing were combined (Gone & Calf Looking, 2015). The program, however, was shut down after several years due to a lack of funding. While running, the research

completed on the camp supports the effectiveness of its culturally inclusive methods in reducing the likelihood of relapse after leaving the camp (Gone & Calf Looking, 2015).

Equitable Care

Equity Oriented Care

As Indigenous individuals face obstacles with being able to access care due to stigmas and systems of oppression and racism, resources and services need to consider ways to practice equitable care and accessibility. Racial injustice forms a complex social system fueled by power relations (Ben et al., 2017), a struggle already known by Indigenous peoples. They have fought governing powers over control of their rights for centuries. The negative impacts from racism on mental and physical health can lead to further health damaging effects like substance use. Further lead to health-damaging effects such as substance abuse. In healthcare settings, access, utilization, and quality patterns are all affected by race directly putting barriers on Indigenous people's equitable treatment in healthcare settings.

A significant factor in providing equitable care is collaborating with patients about their preferences for treatment and welcoming Indigenous voices to speak about equitable care improvements (Lewis & Myhra, 2017). There are four dimensions for equity-oriented Indigenous care. First, partnerships must be developed, which involves the collaboration of Indigenous peoples in places where decisions about substance resources are being made. The second dimension involves taking action on intrapersonal levels (e.g., staff, interpersonal levels such as interactions, and contextual levels in which change is made within healthcare organizations; Browne et al., 2016). Regarding the need for collaboration within and promotion of equitable oriented care, it is essential for the individuals in charge of creating resources to be available for innovation and adaptation of such programs—the third and fourth dimension of fair

oriented care play into such visions. The third dimension is the need to attend to both local and global histories, which involves understanding the erosion of Indigenous peoples' power as purposeful in the service of historical and contemporary colonial conquest (Browne et al., 2016). Lastly, the fourth dimension involves attending to each strategy's unintended and harmful consequences (Browne et al., 2016). Together, the four dimensions of providing equitable care for Indigenous populations create a framework for integrating targeted forms of care for different populations. The dimensions allow Indigenous people's advocacy to voice the decisions and aspects of resources that their population will access.

Fundamental Next Steps for Research

There are multiple significant recommendations for research to enhance the treatment experience for Indigenous peoples with substance addiction and the components of care necessary for their benefit. Research surrounding Indigenous people lacks Indigenous people's inclusion in creating, applying, and interpreting the literature (Fuller-Thomson et al., 2020). Indigenous people have a unique set of beliefs and values associated with ancestorial forces, spirits, and connection to the land (Fiedeldey-Van Dijk et al., 2017; Lewis & Myhra, 2017). There is a significant amount of literature surrounding the experiences Indigenous people have had regarding colonization, trauma, and social determinants of health. However, most research does not include the Indigenous people themselves, leading to an overall lack of influence from Indigenous culture and viewpoints on health and wellness (Kwaymullina, 2016). There has been little research completed thus far that incorporates the application of the above-mentioned components of care to Indigenous populations, demonstrating a need for those components to be included in future research.

The notion of research on Indigenous peoples in the past is surrounded by a lengthy history of unethical treatment while being studied. Assimilation efforts by European colonizers were a primary reason for the dramatic population loss in Indigenous communities. Many of these attempts were conducted through methods involving a lack of consent and forced participation (Hodge, 2012; Lavalley et al., 2020). Some of the most notable infringements on Indigenous people's rights were through research in which smallpox infected blankets were distributed among Indigenous communities, INidgenous women were forced to be steralized without their knowledge and retrieval of blood samples by forced were used to be studied (Hodge, 2012). In addition, Indigenous people were subjected to more serious, experimental and harmful treatments for diseases. With the Institutional Review Board nonexistent at this time, there were few systems in place to protect Indigenous people (McKenzie et al., 2016). With the history of unethical research in mind, it is evident that researchers may hesitate to include Indigenous peoples due to a fear of re-traumatization. Indigenous people may be hesitant to participate due to their ancestors' experiences. The hesitation of both parties creates a gap in the representation of Indigenous populations in research.

Although governing systems have attempted reconciliation methods with Indigenous peoples, there remains an assumed superiority of Western ways of knowing, being, and doing (Kwaymullina, 2016). A significant limitation of the current research is the lack of cohesiveness and inclusion of Indigenous viewpoints, knowledge, and cultural healing ideals. Past research has ignored Indigenous health or viewed it without the Indigenous beliefs of resistance, resiliency, and healing (McKenzie et al., 2016). As long as there remains a dominant Westernized thinking pattern, there will be a deficit in research (Allan & Smylie, 2015). By enhancing Indigenous peoples and scholars' inclusion in the research surrounding Indigenous

experiences, there will be an increased knowledge of how to support Indigenous people in respective ways. Research must take on the role of creating equitable and innovative partnerships with Indigenous people and their knowledge (Kwaymullina, 2016).

Future research may benefit from stretching beyond simply exploring the higher prevalence rates of substance use among Indigenous peoples to assessing more culturally inclusive and appropriate ways of treating substance use concerns. Western science has thus far overlooked the potential of culture to impact healing (Hall et al., 2015). As such, future research should include both spiritual and cultural aspects of healing to better offer treatment options that accurately align with Indigenous values. Research needs to respect and include the role of spiritual and cultural methods of healing amongst Indigenous populations to offer treatment suggestions that accurately align with Indigenous values. One specific downfall in this area is the high representation of Christian and faith-based treatment approaches taken by treatment programs and facilities that work with substance addiction, placing a barrier to their effectiveness with Indigenous people (Lavalley et al., 2020). Using religion as a pillar for developing programs stems from the view that faith and powers above are the ultimate healers and the notion that individuals can find their strength heal through believing in that (Hall et al., 2015; Lavalley et al., 2020).

The crossing of Western science and evidence-based knowledge with Indigenous culture and ways of knowing advocated for the importance of the Two-Eyed Seeing approach to research, which looks at topics through the combined lens of Indigenous populations and Westernized ideals (Bartlett et al., 2012; Hall et al., 2015). Using the Two-Eyed Seeing approach, researchers can incorporate Indigenous knowledge into the research that affects Indigenous people, increasing the validity of the findings. The use of the Two-Eyed Seeing

approach increases Indigenous people's participation in research, encourages Indigenous scholars to have a voice, and provides practical support and evidence of the findings, all of which increase the ability to tailor resources and care to the specific needs of Indigenous people with substance addiction.

Lastly, there is a lack of cohesion between the titles given to first people and a high rate of generalization of words referring to Indigenous populations. Certain populations associate their preferred title with connection to the land and their ancestors (e.g., Alaska Natives) as it highlights pieces of their Indigenous heritage (Yuan et al., 2014). Research refers to people of Indigenous culture as Indian, Native, Aboriginal, Torres Islanders, and Indigenous. Indigenous populations are made up of different tribes and reservations; however, many share a similar baseline of values and ideals (Tang & Browne, 2008), which provides some support for grouping Indigenous peoples under one cultural title as opposed to specific tribe names. However, there is a lack of cohesiveness in research with Indigenous populations as many different names are used without identifying which is correct in the eyes of the populations being grouped. To solve this problem, scholars need to ensure that they collaborate with the population they are examining to ensure the correctness of terms and prevent "othering" (i.e., the phenomenon of labelling certain groups as not fitting into societal norms; Tang & Browne, 2008) from occurring. Not only does the diversity of group names disregard the notion that not all names are considered socially acceptable in today's culture, but many have racial underpinnings (Lewis & Myhra, 2017). The lack of cohesion leads to a gap in practitioners' ability to find research based on the ability to search under on particular group and expect the inclusion of all others.

Reflexive Self Statement

I inquired into the literature surrounding Indigenous peoples with substance addiction as someone who considers themself a strong social advocate for this population. This experience however, is not to say that I consider myself an expert in the issues at hand, nor am I able to confidently conclude what would be the most effective treatment for Indigenous peoples. I can say that going into this project, my mind automatically went to the need to formulate a discussion around the components of care beneficial in substance use treatment for Indigenous populations. Working on the frontlines with this population, I have had biases come up consistently surrounding the need for more resources to cater to the specific needs of Indigenous populations, and the research has further brought to light the lack of resources for healing.

I have witnessed the stigma and racism that Indigenous populations have experienced. I read the accounts of abuse at the hands of colonizers and residential schools, and I feel angry and astounded that a group of humans could do such inhumane things to others. I researched the processes of intergenerational trauma Indigenous peoples experience and the systemic barriers that prevent Indigenous peoples from navigating society in the same way that other populations can, and I wondered, what can I do to change this? The literature I have collected throughout this research has been eye-opening and enlightening to me as it has provided me with a deeper understanding of the traumatic experiences of Indigenous peoples. However, this research has also been heartbreaking and, at times, hopeless. I have questioned my role in the problem and my role in the solutions. Will society ever get to a place where marginalized populations can access essential resources without being met by oppression and discrimination? Will there ever be a time where substance use in Indigenous peoples is looked at as a trauma response and not a personal trait of the population?

I have heard first-hand accounts of individuals who have experienced the trauma and barriers associated with Indigenous experiences. I have gone through an educational system that stressed the importance of treating people as equals. But as this research has shown me, we are not all equals, and the idea that one group must remain superior to another is an oppressive and Westernized view that creates hierarchy and categorizes people's abilities based on their culture or beliefs. This hierarchy then forms a social structure that neglects the notion that social hierarchies based on race, culture, and mental health status further attempt to segregate populations from one another.

Individuals in the counselling profession are often known as helpers. We are the people who believe in the good and want to help as much as we can. However, we are not helping when we adopt the idea that individuals with substance addiction have to get sober to be helped. The same connotation goes for homelessness; as much as I do not want to see any person have to live on the street and appreciate all housing attempts made, not everyone wants to be or can be rehabilitated. Perhaps this lies in my personal view where I believe there are significant differences between living and surviving.

Throughout this research, the literature demonstrated the battle of substance addiction and the strong effect on an individual's mind, body, and life. Indigenous peoples with substance addictions primarily developed addictions as coping mechanisms for complex trauma. I imply then that substance use became a means of survival (Fiedeldey-Van Dijk et al., 2017; Marsh et al., 2016). The co-occurring effects, both related to and caused by the addiction, place Indigenous people in a lifelong battle of doing what they can to survive. With survival mode in play, I questioned the ability of some individuals who have spent the majority of their lives homeless or have used substances to adapt to a different lifestyle. The dangers of withdrawal alone can bring

someone to their death, and the lack of ordinary social rules while living on the streets may cause maladjustment in a housing or rehabilitation program (Rehm et al., 2017). I believe there to be a significant ignorance of this recognition and the incorporation of individualized treatment plans in research.

The beliefs I had before starting this research have further been strengthened throughout the research that has been discussed. My knowledge of Indigenous people's traumatic experiences, models of substance use and trauma, and the components of care shown to be effective and necessary in treatment protocols deepens as I continue to enhance my learning through research. I remain holding the knowledge that I was born with privilege and have been provided with opportunities that the populations I am researching have not. The privilege I was born with shows that I cannot relate to Indigenous populations' struggles and reinforces that I hold an inherent tendency to be more comfortable helping individuals similar to myself. I know that there is no way to rid myself of biases that come from my upbringing completely. However, as I continue my journey of advocating for culturally competent, trauma-informed, and equitable care for Indigenous people with substance addiction, I hope to further grow as a person and use the knowledge that privileges such as education have given me to foster humanity. I hope to advocate for a higher level of care and better resources to respect Indigenous populations' cultural significance and value. Through this research experience and looking to the future, I hold with me the notion that before making a judgment towards someone, I must remember that not everyone has had the same opportunities that I have.

Conclusion

Indigenous people in North America are considered the first people to have inhabited the land, yet they have been met with an uncountable attempt to terminate their culture, diminish

their presence, and assimilate into society. With the impact of European influences inhabiting North America and colonizing the lands as their own, Indigenous populations have experienced significant trauma due to their dismissal as human beings (Firestone et al., 2015; Marsh et al., 2016). Through harm induced methods of dissemination, Indigenous people have been subjected to methods of cultural genocide (Wilk et al., 2017), which included but were not limited to residential schools, forced sterilization, poisoning, and war (Hodge, 2012; Kwaymullina, 2016; Nutton & Fast, 2015). Attempts to displace Indigenous people from their ancestorial lands and rid their culture and identity (Allan & Smylie, 2015) have led to colonialism being considered a detrimental social determinant of health for Indigenous people (Payne et al., 2018). Social determinants of health have contributed to a higher prevalence of mental illness and substance use disorders among Indigenous people and social and systemic barriers to accessing mental health resources (Bingham et al., 2019). As Indigenous people encounter stigma associated with race and culture, they are often met with stereotypes when they are experiencing addiction leading to a reluctance to access resources due to fear of structural violence and social neglect (Medley et al., 2021).

Indigenous people have long-standing experiences of complex trauma (Allan & Smylie, 2015), which supports the need for trauma-informed care when treating those with substance addiction. Care for substance use problems cannot be seen as a generalized treatment with Indigenous people due to the complexity of the trauma they have experienced and the notion that it stems from colonial, historical, racial, and intergenerational forces (Firestone et al., 2015; Mitchell et al., 2019). Therefore, practitioners need to be well-informed and educated on the complex traumatic experiences of Indigenous peoples through streams of research, evidence-based practice, and contributions from Indigenous peoples.

As the systemic barriers of oppression and the co-occurring factors of substance addiction, such as homelessness, get in the way of Indigenous peoples accessing care and resources providing equitable care, there is an increased need for equity-oriented care approaches to take place (Ben et al., 2017). Resources aimed at providing substance addiction treatment must include attempts to recognize the diminished effectiveness that comes from grouping Indigenous populations with other substance users as they have their own set of unique and individual needs for rehabilitation and reduction of harm (Hall et al., 2015; Hodgetts et al., 2014). Incorporating Indigenous points of view and cultural practices enhances the benefits of substance addiction treatment resources (Bartlett et al., 2012). The inclusion of Indigenous cultural practices of healing and the benefit of their spiritual connection to the land as a means of healing are essential contributions and considerations for resources to consider when providing tailored treatment for Indigenous populations (Lavalley et al., 2020).

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