Factors Influencing Outcomes for Indigenous Peoples Seeking Treatment for Addiction

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Abstract

This capstone project details the factors contributing to the disparities in both addiction prevalence and outcomes for Indigenous clients seeking and receiving addiction treatment. Research has identified factors both past (colonialism, intergenerational trauma) and present (systemic racism, lack of culturally-specific care) that contribute to this disparity. This capstone begins by exploring these factors in detail and presenting an overview of the current treatment options available to Indigenous clients and their effectiveness. There is also a discussion of the ethical implications of working with this population, the best practices indicated by research up to the present, and the gaps in care that currently face Indigenous clients seeking addiction care. Findings consistently point to the need for more opportunities for Indigenous peoples to develop and provide care within their communities autonomously, with governments and other stakeholders taking a supportive allyship role. Recommendations are offered for current and future counsellors working with this population to best serve these clients through culturally-competent care and collaboration.

Keywords: Indigenous*,* addiction, colonialism, intergenerational trauma, cultural competence

Factors Influencing Outcomes for Indigenous Peoples Seeking Treatment for Addiction

Current academic literature and government statistics provide several examples of the disparities in the rates of addiction between Indigenous and non-Indigenous populations. Kelly-Scott and Smith (2015) noted that 35% of First Nations people who do not live on reservations engage in heavy drinking, compared to 23% of non-Aboriginal people. In British Columbia, though the Indigenous population is only 5.9%, they account for 14% of documented overdoses (Lavalley et al., 2020). The overall health burden of Indigenous people is disproportionately high in Canada and other countries compared to non-Indigenous people, and this includes the harms associated with substance abuse (LaVallie & Sasakamoose, 2021; Leske et al., 2016; Urbanoski, 2017). Health conditions such as chronic liver disease, heart disease, and diabetes contribute to higher rates of illness and death in Indigenous populations worldwide compared to the general population. Substance abuse often contributes to these conditions and drastically lowers Indigenous people's life expectancy worldwide (Brady, 1995). A higher number of Indigenous people abstain from alcohol than the general population (Wilson et al., 2010). However, amongst Indigenous people who do drink alcohol, two-thirds are considered heavy drinkers and thereby at risk for associated harms (Marsh et al., 2016)

One reason for these disparities is the lasting effects of colonialism. *Colonialism* broadly refers to the process whereby settler populations exploit, marginalize, and use the labour and resources of the Indigenous people already living on these colonized lands to their benefit (Burns et al., 2016). Many of these acts of colonialism were in the form of laws and statutes developed by white European settlers to marginalize and occupy power from Indigenous peoples. The most notable of these statutes in Canada was the Indian Act of 1876, a consolidation of other laws and statutes dating back to the 18th century (Bartlett, 1977). One notable legacy of this era was the

beginning of the *Indian Residential School* (IRS) system. The IRS system, officially implemented in the 1880s, was a Canadian government campaign designed to forcefully assimilate Indigenous people into Canadian society. The Canadian government used the IRS system as a tool in this assimilation process. If Indigenous children were fully integrated into Canadian society, there would be a weakening of First Nation governments and, ultimately, a removal of the need for a working relationship between the Canadian government and First Nations communities (Burrage et al., 2022). This process involved children being taken from their families, disconnected from their culture, and often subjected to physical and sexual abuse. This system has led to higher rates of substance abuse for those who attended these schools, as well as their descendants (LaVallie & Sasakamoose, 2021; Pham et al., 2023).

Intergenerational trauma refers to the ripple effect of individual trauma affecting entire communities and the descendants of the survivors of that trauma (Wilk et al., 2017). While colonialism and the subsequent IRS system provide a historical pretext for the intergenerational trauma experienced by Indigenous peoples, it is also important to note how that translates into trauma rates for their descendants in the present day. As Spillane et al. (2023) noted, North American Indigenous populations are at an increased risk of multiple forms of trauma, including a 10-times higher rate of injury caused by assault, a 5-times increase in the risk of motor vehicle accidents, and a 400% higher risk of experiencing any traumatic event than non-Indigenous people. Because the final IRS school did not close until 1996, there are still many living residential school survivors, and it is estimated that around two-thirds of these survivors meet the diagnostic criteria for posttraumatic stress disorder (Czyzewski, 2011). Using the data available on the connection between trauma and addiction (Gill-Emerson, 2018; Spillane et al., 2023) and the data indicating the high levels of both past and present trauma in Indigenous populations, we

begin to get a clearer picture of the unique considerations involved when it comes to addiction treatment for Indigenous clients.

Addiction treatment in North America is often provided in settings that are provincially or federally funded. As Lavallie and Sasakamoose (2023) noted, these government-funded centres often employ a Western approach to addiction treatment, which primarily consists of the biomedical model of addiction. As noted by Jardine and Bourassa (2021), addiction treatment should recognize underlying factors that lead to addiction and that Indigenous peoples are more vulnerable to these factors due to the lasting effects of colonialization and subsequent intergenerational trauma. While more treatment programs are incorporating Indigenous-specific, culturally-appropriate practices, there is still a feeling of alienation and disconnection felt by many Indigenous clients who attend centers utilizing strictly Western models. In a qualitative study by Lavalley et al. (2020), Indigenous participants noted that treatment programs they had attended did not address culture-specific considerations and heavily favoured a Christian-focused approach. Pham et al. (2023) also noted that even in programs that integrate culturally-appropriate practices, there is still a strong tendency toward mandated, structured approaches, such as talk therapy and group therapy. This may be incompatible with certain Indigenous peoples still suffering the effects of government-mandated school attendance and living arrangements and create further alienation and distrust, as well as risk re-traumatization.

Given the considerations listed above, this paper will explore the following research question: what are the factors that influence outcomes for Indigenous peoples seeking addiction treatment?

This question will be addressed through several areas of research. First, I will provide background information on the systemic issues that have led to higher levels of addiction in

Indigenous populations, including colonialization and the residential school system, and the resulting intergenerational trauma. I will then provide data from studies utilizing both quantitative and qualitative research to help create a clearer picture of the difference in outcomes for the treatment of Indigenous peoples in addiction treatment. Lastly, I will discuss how culturally-appropriate addiction treatment affects clients' satisfaction and success and compare these to Western models that do not incorporate a culture-specific element.

Self-Positioning Statement

My own experience in this area of research has been marked by two distinct periods in my life: before and after working in the addiction field, beginning in 2016. Before this, my awareness of the struggles of Indigenous people in my country was minimal. I am a White male raised on the East coast of Canada in an area with a small Indigenous population. I had no Indigenous classmates, peers, or anyone else to give me a first-hand account of what went on in their communities. I grew up in a small rural town and had a very sheltered existence. While my parents were very tolerant people, and there was no overt racism in my household, I must acknowledge that I was utterly ignorant of the plight of people in First Nation reserves, some of which were only a short drive from my small community.

This ignorance continued unabated until I moved to Calgary in 2014. By this time, I had begun to get a better education in addiction. Still, I was unaware of why there seemed to be a disproportionate number of Indigenous people experiencing addiction relative to the general population. Were the stereotypes I had heard growing up about Indigenous people being more prone to addiction true? I had to face this question head-on when I took my first job in the field in 2016 and became a counsellor the following year. The Indigenous clients I met were respectful and friendly and had some of the most tragic stories I had ever heard. Aside from their

experiences of trauma being disproportionately higher than many others in the center where I worked, there was also another pernicious, heartbreaking pattern: I observed that these clients seemed to drop out of treatment at a rate much higher than other groups.

Despite beginning to develop a minimal cultural understanding of this population and learning about the connection between trauma and addiction, this phenomenon continued to puzzle me. This was until 2017 when the stories about the IRS system and the discovery of mass graves on the sites of these schools became an international news story. I had been entirely unaware of its existence and began to put the pieces together. The schools produced trauma; trauma is one of the precursors for addiction, and the final piece was that this information provided insight into the reasons why Indigenous people would be reluctant to participate in a government-funded, 12-step focused program. Our program was not designed by them, for them, or with any consideration to their unique needs. When the center where I worked implemented an Indigenous program in 2021, retention rates seemed to improve but still appeared to be far below other cultural groups in the program.

Myths and stereotypes that I had encountered in my younger years continued to stay with me even into the time I was working in the addiction field. One example is that there is a biological difference between the way Indigenous and non-Indigenous people process alcohol. I do not know where this idea originated, but it appears to have been part of the cultural zeitgeist when I was growing up. This is even though ongoing research continues to find no biological differences in how Indigenous people process alcohol or other drugs compared to other populations (Gonzalez & Skewes, 2021; Lavallie & Sasakamoose, 2023). Another myth I internalized at some point was that Indigenous people were more aggressive when under the

influence of alcohol, which has also been disproven through research (Lavallie & Sasakamoose, 2023).

Another consideration when approaching this area of research is my position as an outsider. As Shai (2020) noted, a person's insider or outsider worldview when researching a topic is arrived at through self-reflexivity. According to Nagata (2004), self-reflexivity refers to the conversation one has with oneself in the moment as one is experiencing it. For me, when I would be speaking to an Indigenous client about their experiences, while I could display empathy and compassion for them, I had no real-life context to base these feelings on. When it came to the Indigenous clients I worked with, I was an outsider in every sense of the word. While clients often came from homes broken by separation and addiction as the result of intergenerational trauma and its effect on parenting styles (Marsh et al., 2016), I had come from a home with two working, continuously married parents and wanted for little. No matter how many Indigenous clients I have or will work with in the future, I will always be an outsider in this regard.

Self-reflexivity, or reflective practice, is a valuable tool for non-Indigenous practitioners to critically reflect on their reactions to the Indigenous experience and lessen the often-present cultural differences and power imbalances between groups. Unlike taking a class or reading literature to improve cultural competency, reflexive practice involves continuous action to challenge underlying assumptions, attitudes, and beliefs based on previous experience (Rix et al., 2014). It also involves an understanding of how Indigenous culture intersects with other systemic inequalities, such as disparities in housing, employment, and education, to create an experience unique to Indigenous populations. As Dawson et al. (2022) noted, reflexive practice is important as all professionals' attitudes, biases, and worldviews can substantially influence how they

deliver care to clients. Additionally, failure to address these inner beliefs can result in, at best, negligent or dismissive behaviours and, at worst, outright overt racism.

While my cultural competency has improved in the intervening years, lingering biases remain. I am a strong proponent of the 12-step programs and feel they are an applicable option for anyone, regardless of culture or background. I did find myself having some disagreeing thoughts about some of the studies referenced for this paper surrounding 12-step being a "Christian" program potentially unsuitable for Indigenous clients, which is not a descriptor that I would personally use. Conversely, I am also a strong advocate for Indigenous communities, having their treatment programs entirely run on reserve or in their communities using their curriculum. I need to watch this bias as I have noted times in researching this project where I lean towards finding literature confirming this view. As noted in the Canadian Psychological Association's (CPA, 2017) *Canadian Code of Ethics for Psychologists*, striving towards an ideal of objectivity and challenging biases is crucial to client care. I recognize going into this project that my training in addiction and psychology leans in the direction of pathologizing conditions like substance abuse, as well as groupings of historically underprivileged populations such as Indigenous peoples.

To mitigate this, I plan to review articles that are critical of 12-step programs and reflect on why I have these reactions. I will also pay closer attention to the limitations sections in research related to Indigenous-led treatment programs to ensure I am getting the whole picture and not focusing solely on the positive aspects of these programs. Lastly, I intend to keep an open mind to treatment modalities and interventions that I am unfamiliar with, disagree with, or do not fully understand because of my cultural blind spots.

Literature Review

This literature review will begin with a further detailed description of terms used in the introduction, including colonialism, intergenerational trauma, and addiction. It will then outline a deeper exploration of the connection between addiction and trauma, followed by a more detailed description of the differences between Western and Indigenous approaches to addiction. It will end with a description of the efficacy of Indigenous culturally-focused treatment in addiction programs.

Colonialism

Background

On a global scale**,** colonialism dates back to antiquity. Modern descriptions of colonialism most commonly refer to the rapid expansion of European countries such as England, France, and Spain through appropriating other territories over several hundred years beginning in the 15th century (Veracini, 2014). This was achieved through warfare, coercion, and the conquering and ultimate control of the Indigenous peoples living in those areas. Initial European contact decimated Indigenous populations by way of diseases unfamiliar to them, such as smallpox, measles, and influenza (Spillane et al., 2023). As noted by Comaroff (2001), much of the subjugation was also done through what is described as “lawfare,” or the coercion of Indigenous peoples through European practices of law and justice they were unfamiliar with. Rand (2011) pointed out that colonialism has its roots in a sense of cultural superiority or the feeling that the colonizer's worldview, customs, and values are superior to those of Indigenous peoples. The difference between Indigenous communities before and after colonization is stark. Before colonialization, Indigenous peoples were self-governing and maintained healthy societies based on their philosophies concerning family, education, and other matters. In generations since

colonization, Indigenous peoples now experience higher rates of unemployment, neglect, and substance abuse, among other adverse life events, than the general population (Bombay et al., 2009).

In Canada specifically, while some statutes before the Indian Act of 1876 were presented under the pretense of cooperation and collaboration, it is clear what the government's true intentions were when it came to Indigenous populations. In 1845, a document titled *Report on the Affairs of Indians in Canada* was presented to the legislature. This document reflected the British colonialist attitude towards Indigenous peoples, specifically a stated interest in the welfare of these people framed as a description of their defects and deficiencies compared to Europeans and their need to be "managed" by colonizers (de Leeuw et al., 2010). The Civilization of Indian Tribes Act of 1857 further clarified the true purpose of these legal statutes: complete assimilation and "civilization" of the Indigenous peoples of Canada. These acts and future ones into the 20th century sought to control every aspect of the lives of Indigenous people, including schooling, practicing customary dances and ceremonies, land use, marriage, and many others (Bartlett, 1977). As demand for land by European settlers increased into the 1800s, government policies began to create more means of oppression, from the reserve system to the forced sterilization of Indigenous women (Nutton & Fast, 2015).

The IRS System

One sweeping reform that came shortly after the introduction of the Indian Act was the beginning of the IRS system. While church-run schools for Indigenous children had been in operation since the 1830s, the IRS system became official government policy in Canada in the 1880s (Pham et al., 2023). These schools were inspired by similar Indian boarding schools already established in the United States, which had a similar goal of isolating children and

forcing assimilation through several methods, including not only separation from their families but also from siblings and friends once they arrived at the school. This strategy also served to eschew Indigenous language and collectivist cultural practices, such as ceremonies (Rand, 2011).

If children were not sent voluntarily to these schools by their parents, they were taken by force. The Indian Act had given authority to the Canadian government to force Indigenous children to attend school and ensure compliance using truant officers. This role could be filled by Indian agents (government agents specifically tasked with the management of Indigenous people's affairs), Royal Canadian Mounted Police (RCMP) officers, or school employees (LeBeuf, 2011). If the parents reached out asking the children to return home, they were often ignored (Nutton & Fast, 2015). During the height of the IRS program in the 1930s-40s, an estimated 20% of Canada's Indigenous population attended these schools (Barker et al., 2019). These church-run schools saw more than 150,000 First Nations, Inuit, and Metis children attend from their opening to the closure of the final residential school in 1996 (Wilk et al., 2017). Attendees of IRS schools were regularly victimized by physical, sexual, emotional, and spiritual abuse (Burrage et al., 2022; Rand, 2011), and this abuse has been indicated as having a causal link to addiction and other issues in the attendees themselves (Burrage et al., 2022; Wilk et al., 2017) as well as their descendants (Walls & Whitbeck, 2012).

The level of abuse and trauma experienced by those who attended IRS schools cannot be understated. As MacDonald and Hudson (2012) pointed out, the experiences of colonized Indigenous peoples arguably meet the criteria for genocide under the United Nations Genocide Convention (UNGC), specifically, those sections that relate to the forced transfer of groups of people and intentionally causing harm to a group of people, among others. Sexual abuse within the IRS system was not condoned officially but was nonetheless widespread. Examples include

children being supervised while they washed their genitals, girls being forced to bind their breasts to prevent them from showing when they reached puberty (Robertson, 2006), forced sexual intercourse and oral sex between school authorities and boys and girls in their care, and forced abortions for Indigenous girls impregnated during these rapes (Sharpe, 2011).

Other physical abuses at IRS schools are also well documented, including but not limited to regular beatings for infractions such as speaking Indigenous languages (Robertson, 2006), being beaten, often to unconsciousness, with a wide range of instruments; restraining, burning, and electrically shocking children; and forcing children to eat their own vomit (Sharpe, 2011). The act of assimilation itself and the practices involved also created a variety of types of cultural or spiritual abuse in these schools. For example, Robertson (2006) provided the account of one survivor who noted that immediately upon admission to an IRS school, he had his hair cut off and had to switch from speaking his native Shuswap language to English overnight. Absolon (2010) noted that children were forbidden from engaging in spiritual practices, such as ceremonies, dancing, songs, and life teachings, among others. Additionally, Barker et al. (2019) noted that children were also forbidden from speaking their native language and often placed in schools far from their community as a means of isolation from their families.

Over 130 residential schools operated in Canada, with 1931 being the year when the number of simultaneously operational schools peaked at 80, declining gradually until the end of the 20th century (Miller, 2024). While the IRS schools slowly became less prevalent throughout the 20th century, another government-led initiative known as the 60s Scoop also created an environment of continuing marginalization and abuse for Indigenous peoples in Canada. This initiative saw the Canadian government forcefully remove children from Indigenous households and place them with White Canadian families as another means of forced assimilation (LaVallie

& Sasakamoose, 2023). Like the IRS system, this forced integration of as many as 20,000 Indigenous children into White foster and adoptive families in Canada and abroad, which created disconnection from their families and cultures of origin. It led to higher rates of mental health issues and substance abuse among those affected (Kodeeswaran et al., 2022).

Intergenerational Trauma

The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association [APA], 2022) uses the term posttraumatic stress disorder (PTSD) to describe the symptoms an individual experiences after a traumatic event. It is noted in the *DSM-5-TR* that the lifetime prevalence of PTSD in the general population is 8.7% (APA, 2022). While there are no concrete statistics on PTSD rates in Indigenous populations overall, some smaller samples provide insight into its increased prevalence in those populations. For example, one sample of 247 participants in an American Indian community found that the lifetime prevalence of PTSD in that group was 21.9% (Robin et al., 1997). In British Columbia, a sample of 127 residential school survivors found that 64.2% of them met the PTSD diagnostic criteria (Bellamy & Hardy, 2015). While Marsh et al. (2016) noted that PTSD is a good descriptor of cumulative trauma, it does not adequately convey trauma that has been transmitted intergenerationally. It is also important to acknowledge that terms such as trauma and PTSD are terms rooted in Western ideas of pathology and diagnosis.

One alternative descriptive term that has gained widespread acceptance in framing abuses specific to the lingering effects of colonialism is intergenerational trauma (IGT). IGT is defined as an individual's experience of psychological and emotional harm that, when left untreated, is passed on to subsequent generations (Marsh et al., 2016). While the term IGT was initially used to describe the experiences of Holocaust survivors, it is gaining more widespread use as a means

of describing the generational effect of colonialism (Barker et al., 2019). IGT initially caused by traumatic events such as residential school attendance or the '60s Scoop can be transmitted to subsequent generations through the parenting styles of the attendees affected by the trauma, as well as the effect that hearing the retelling of these traumas has on the survivors' family members (Bombay et al., 2009). IGT also does not have to necessarily be a result of historical events, as evidenced by the more recent discovery of mass graves on the former sites of IRS schools (Spillane et al., 2023), exposing a whole new generation of Indigenous people to the indignities experienced during colonization.

This legacy also continues to be perpetuated as an overrepresentation of Indigenous children in the child welfare system (Jardine & Bourassa, 2021). Barker et al. (2019) noted that despite Indigenous youth making up only 10% of this demographic in the population of British Columbia, they represent 63% of the total number of youth in care. Kodeeswaran et al. (2022) referred to the overrepresentation of Indigenous children from the 1980s to the present as the Millennial Scoop and pointed to this as an ongoing extension of IGT. Examples of this in the present day include the fact that Indigenous families are over four times more likely to be investigated for child maltreatment and twice as likely to have their children apprehended as a result of these investigations than non-Indigenous children (Barker et al., 2019)

Addiction and its Effects on Indigenous Populations

Addiction is defined by the National Institute on Drug Abuse (2020) as a disorder in which a person continues to use drugs and compulsively engages in behaviours despite adverse consequences. *Substance use disorder* (SUD), on the other hand, is a term used in clinical literature and detailed extensively in the *DSM-5-TR*. The *DSM-5-TR* gives several classifications regarding types of substances that can be abused and specific thresholds for what constitutes a

SUD, such as the duration and severity of symptoms. The *DSM-5-TR* also points out that the word addiction is mainly used outside of clinical settings in place of SUD (APA, 2022). The APA replaced the word addiction with the term drug abuse in 1972 to help move away from the colloquial, pejorative, and less scientific term addiction (Reinarman, 2005). The term addiction is still most commonly used when describing treatment centers, as well as government agencies that are responsible for these issues (often paired with mental health in many jurisdictions).

Both terms, addiction and SUD, are rooted in a Western view of problems related to intoxicants, and their definitions and explanations often do not provide any cultural or systemic context. The *DSM-5-TR* does not provide any culturally-specific insights into the cause of SUDs, aside from noting that the diagnostic criteria apply equally to all racial and ethnic groups (APA, 2022). Wesley-Esquimaux and Snowball (2010) pointed out that terms such as addiction provide labels and stigma to Indigenous people and downplay the agency of Indigenous people to address issues related to things like addiction, mental illness, and violence on their own. It is also notable that assessment tools used in addiction treatment programs administered on intake are often generalized, offering no culturally-specific criteria. For example, two commonly used assessments, the DAST (Drug Abuse Screening Test) and AUDIT (Alcohol Use Disorders Identification Test), do not include questions related to culture. Gentile et al. (2022) pointed out that these methods may not be suitable for Indigenous populations who have cultural objections to collecting data about them and using them for unknown purposes. Gone (2012) echoed this sentiment, adding that the power imbalance created by the favouring of a Western, scientific approach to assessment further diminishes Indigenous autonomy and is arguably a present-day extension of colonialist subjugation.

Regardless of the term used and its origin, the higher incidence of substance abuse in Indigenous populations is well-documented (Jardine & Bourassa, 2021; Walls et al., 2013; Weatherall et al., 2020). LaVallie and Sasakamoose (2023) pointed out that alcohol abuse is a relatively new phenomenon in Indigenous populations. While Europeans had used alcohol for centuries previously, Indigenous peoples did not know about its addictive properties or harmful effects, leading to the disintegration of their communities. Deaths attributed to alcohol, specifically in the United States, are estimated to be double the rate for Indigenous people compared to the general population (Walls et al., 2013). Also, in the United States, while the overall rate of substance abuse is 8.7%, it was found to be 21.8% in Indigenous populations (Nutton & Fast, 2015). Weatherall et al. (2020) noted that alcohol dependence rates are consistently higher in Indigenous peoples than in the general population in Canada, the United States, Australia, and New Zealand.

Aside from IGT, present-day policies and systemic issues are also acknowledged as being a factor in higher Indigenous addiction rates. For example, stress has been indicated as a contributing factor for developing addiction, with a positive correlation between stressful life events and the prevalence and severity of addiction being identified (Kuksis et al., 2017). Kodeeswaran et al. (2022) highlighted that survivors of the 60s Scoop have regularly turned to substance use as a means of coping with stress arising from the separation from their family and culture. Stress Indigenous peoples face both from the lasting effects of IGT as well as present-day institutional racism, discrimination, and unequal access to healthcare have been identified as precursors to addiction (Spillane et al., 2023). Monarrez et al. (2022) reminded us that the term colonialism does not refer to a single event and points to several examples of the ongoing exploitation of Indigenous people through the extraction of natural resources from Native lands.

This is in addition to an indifference by much of the general population to the plight of Indigenous peoples and ongoing discriminatory policies.

Connection Between Trauma and Addiction

The research connecting trauma to negative life outcomes, including addiction, is far from limited to Indigenous populations. The widely recognized Adverse Childhood Experiences (ACEs) study was conducted initially in 1998 by the Centre for Disease Control (CDC) and included nearly 17,000 participants from Southern California. This longitudinal study concluded that children exposed to more trauma experienced exponentially higher rates of addiction than those who experienced little to no traumatic events. For example, a child who experienced an event from six or more out of a possible ten traumatic categories had a 46-fold increase in the likelihood of intravenous (IV) drug use (Gill-Emerson, 2018). Men with a PTSD diagnosis have been found to have a 34.5% prevalence of SUD (Wolff et al., 2015). To put this in perspective, one population-based survey conducted across 18 countries found the median prevalence of SUD in participating countries to be 7% in the general population (Merikangas & McClair, 2012). Kuksis et al. (2017) also noted that PTSD in populations with SUD ranges from 25% to 50%, substantially higher than in the general population.

Research has also shown that the frequency and severity of trauma exposure is a factor in the severity of one's addiction. For example, Kuksis et al. (2017) noted that there is a strong correlation between the number of PTSD symptoms a person presents with and the severity of their addiction, as well as exposure to childhood physical, sexual, and emotional abuse. While a substantial decline in PTSD symptoms is typical in the first year after trauma, one-third of those with PTSD will continue to experience severe symptoms and go on to be diagnosed with another psychiatric disorder, such as substance abuse (Bellamy & Harding, 2015). This statistic would

also suggest that those experiencing ongoing or untreated trauma would continue to be at an elevated risk of developing SUD.

When looking at Indigenous populations specifically, there are considerations of not only the types of traumas experienced but also the conditions under which traumatic experiences are more likely to occur. For example, low socioeconomic status, low income, and being part of an ethnic minority have all been identified as risk factors for trauma exposure, and these are all conditions which are found to be more common in Indigenous communities (Bellamy & Harding, 2015). Using the data available on the connection between trauma and addiction and the data indicating the high levels of both past and present trauma in Indigenous populations, we begin to get a clearer picture of the unique considerations involved when it comes to addiction treatment for Indigenous clients.

Western Models of Addiction Treatment

While addiction historically has often been viewed as a moral failing, causing people living with addiction to be treated poorly, beginning in the 20th century, the "addiction as disease" model became more widely accepted. This was through several means, including the growing influence of Alcoholics Anonymous (AA), the establishment of the National Council of Alcoholism (NCA), which sought to develop scientific research to perpetuate the disease model, and more recently, the creation of drug court programs, which allow for people to enrol in diversion to treatment instead of prison for drug-related crimes (Reinarman, 2005). As these concepts became more widely accepted, the abstinence-based, 12-step model originating in AA began to spread into use with other types of addiction with the founding of sister fellowships such as Narcotics Anonymous and Cocaine Anonymous. In addition, as in-patient treatment programs became more widespread, many centers adopted 12-step facilitation (TSF) as their

curriculum (Kelly et al., 2020). Other treatment modalities used in these centers include cognitive behavioural therapy (CBT), motivational interviewing (MI), and contingency management, or CM (Olmstead et al., 2012).

These centers operate under a code of what is known as best practice or evidence-based practice. The best practice framework is built on incorporating treatment methods that are the most proven and effective for bringing about client recovery. They also originated from a Eurocentric idea of addiction and recovery (Wesley-Esquimaux & Snowball, 2010). At the root of Western approaches is the idea that recovery equates to the absence of disease and that treating addiction requires separation and individual treatment of the mind and body (Rowan et al., 2014). It is also most common for these centers to use the stated goal of treatment to be complete abstinence from drugs and alcohol, as well as include both pharmacological and behavioural methods to achieve this (Aria & McLellan, 2012). In a qualitative study by Wu et al. (2023), it was noted that psychiatrists, psychologists, and other clinical professionals in these treatment settings often lack first-hand understanding of the Indigenous experience. This means that the language used to describe their experiences can be paternalistic and pathologizing, which is an extension of pre-existing colonial power dynamics.

Indigenous-Specific and Integrative Models of Addiction Treatment

While the term best practice might be an adequate way of quantifying addiction treatment from a Western perspective, these methods are not necessarily replicable in other populations, including Indigenous peoples. As Wesley-Esquimaux and Snowball (2010) noted, the best practice approach does not consider Indigenous peoples' unique cultural and situational experiences. There is evidence that there are elements of a Western worldview influencing mental health care that are incompatible with the worldview of many Indigenous people

(Stewart, 2008). Generally, Western approaches often employ methods that create separation between treating the body and the mind. In contrast, Indigenous approaches are more holistic, emphasizing a balance between body, mind, spirit, and emotion (Rowan et al., 2014).

Several Indigenous-focused interventions have been provided and integrated into existing treatment delivery services. These include sweat lodge ceremonies, talking circles (Lavalley et al., 2020), and access to Elders (Rowan et al., 2014). As Wesley-Esquimaux and Snowball (2010) pointed out, Indigenous people need to have more culturally-appropriate means of dealing with addiction in their communities aside from the labelling and victim role assignment that occurs with Western methods. Pham et al. (2023) also pointed out that certain aspects of Western addiction treatment may run counter to Indigenous concepts. For example, Indigenous Elders, when sought for counsel by younger community members, will often give what is described as guidance rather than advice. They will often do this in the form of a story about something that happened to them when they were younger, and the expectation is that the young person seeking guidance will apply this to their own life as they see fit. This goes against the more directive nature of traditional Western counselling approaches.

Two-Eyed Seeing

One standard method of treatment delivery in recent years has been an integrative approach employing a combination of Western and Indigenous interventions. The *Two-Eyed Seeing* approach combines the biomedical Western approach to addiction treatment with Indigenous knowledge. The term comes from the Mi'kmaq word *Etuaptmumk,* which refers to the gift of having multiple perspectives (Roher et al., 2021). Two-Eyed Seeing has been recognized as a way to develop cultural respect between Western and Indigenous practices. Moreover, it has shown promise as a means of substance abuse treatment for Indigenous peoples,

although Marsh et al. (2016) stated that due to lack of research, more studies on its effectiveness are needed. This approach effectively moves away from pitting two differing approaches against each other and works towards identifying the strengths of both approaches and integrating them (Rowan et al., 2014). LaVallie and Sasakamoose (2023) also pointed out that Two-Eyed Seeing is a means of applying a more culturally-sensitive lens to Indigenous addiction treatment that is missing from Western models.

Factors for Professional Consideration

The Two-Eyed Seeing approach was not developed specifically to address addiction. It was conceptualized in 2004 by Mi'kmaq Elders in Cape Breton, Nova Scotia, to combine Indigenous and Western knowledge in scientific practice (Bartlett et al., 2012). While this framework is important for easing tensions between Western and Indigenous researchers and practitioners, it is not employed equally in every situation, nor a means of perfectly balancing each approach's perspectives. Instead, Two-Eyed Seeing allows for choosing which aspects of each lens are appropriate in each situation. The existing disparity, rooted in colonialism, is that Western models and research are most often provided attention and funding. As a means of decolonization, a Two-Eyed Seeing approach could mean funding provided to an Indigenous community to conduct their research (Hall, 2015; LaVallie & Sasakamoose, 2023).

As applied to addiction treatment, Wright et al. (2019) illustrated factors to consider for practitioners, including having non-Indigenous clinicians collaborate extensively with Elders and community members when delivering services to Indigenous clients. Clinicians should also be able to deliver trauma-informed services, employ a strengths-based approach, and be willing to spend a substantial amount of time building the therapeutic alliance and developing trusting

bonds with their clients (LaVallie & Sasakamoose, 2023) when engaging in Two-Eyed Seeing practice.

Effectiveness of Culturally-Focused Addiction Treatment for Indigenous Peoples

Types of Interventions Currently Employed

There is a great deal of variability when describing addiction treatment centers that are engaged in culturally-focused interventions. This spectrum can range anywhere from a 12-step center focused on providing access to Indigenous practices, such as a sweat lodge, to centers entirely Indigenous-led and utilizing primarily traditional interventions (Brady, 1995). Quantitative data is currently limited regarding the effectiveness and outcomes of people attending centers that have more culturally-focused interventions than those that do not. Rowan et al. (2014) described several challenges for attaining concrete data regarding the outcomes of Indigenous-focused treatment. These include the vast differences in service implementation between centers, the fact that some activities in these centers are voluntary and that many Indigenous interventions do not translate well into standard study models. However, several qualitative studies with Indigenous participants and service providers shed light on how current Western approaches to treatment can be improved, as well as the desire for more Indigenous-led programming.

The implementation of more Indigenous-focused interventions in addiction treatment centers takes many forms. These include having Indigenous staff deliver these services, inviting family and community members into the healing process, and the integration of Indigenous language and teachings (Leske et al., 2016). One study by Lavalley et al. (2020) noted several points of contention from its participants regarding existing addiction treatment programs. These include the overly regimented nature of the programs, Christian-focused approaches that risk re-

traumatizing clients who had a negative experience in sectarian-focused settings, and being given ultimatums to either attend treatment or risk child welfare involvement. In another study by Jardine and Bourassa (2021), participants pointed out systemic racism, discrimination, and a lack of trust in healthcare professionals due to previous negative experiences as being both disillusioning when accessing services and a reason for not accessing these services at all.

Approaches Proven Effective

In centers and programs that implement Indigenous practices, some consensus exists on approaches that work. These include Indigenous-led peer support (Lavalley et al., 2020), the importance of addressing clients' lived experiences with trauma (Jardine & Bourassa, 2021), and cultural competency by way of employing staff in these programs who have a strong understanding of issues affecting Indigenous populations, such as colonialism and IGT (LaVallie & Sasakamoose, 2023). Some existing mainstream models and Indigenous practices also converge in various ways. For example, the Western concept of group therapy and the Indigenous practice of talking circles can involve a group setting involving participants sharing to heal. Marsh et al. (2016) described a scenario where the Seeking Safety program, a mainstream group therapy curriculum specifically for individuals with PTSD, was employed in an Indigenous treatment setting and added culturally-specific elements, such as Two-Eyed Seeing, access to Elders, and participation in ceremonies, with positive results.

It is important to note that while Indigenous-led programs exist on reserves in Canada, known as healing lodges, there is an essential caveat to their service delivery: they are still government-funded and, as such, adhere to some mainstream models of service delivery. One such center in Manitoba was involved in a qualitative study involving clients and staff to determine the effectiveness of cultural interventions. While several positive outcomes were

noted, Pham et al. (2023) pointed out that there is a risk of tension when there is still a rigid adherence to certain Western treatment approaches. For example, in some Indigenous communities, such as the Plains Cree, there is a cultural norm that exists that strongly values silence and the nondisclosure in public of certain aspects of one's personal life. This could potentially go against the talk therapy model employed in these centers.

Despite these challenges, overall research suggests that outcomes are more favourable for Indigenous clients seeking help with substance abuse when they are engaged in programs that offer culturally-based interventions. In a scoping review of several studies of integrative Indigenous treatment, Rowan et al. (2014) found that all centers involved in the study reported improved outcomes in several areas of wellness, with 74% reporting a notable reduction in harms associated with substance abuse. Despite these promising figures, Brady (1995), Gone (2012), and Lavalley et al. (2020) all noted the limitations of current studies of Indigenous cultural interventions in treatment programs. These include poor methodology, the wide variation in Indigenous populations, and the lack of data involving subsets of Indigenous populations, such as transgender and Two-Spirited individuals in the research, among others.

See Appendix for a summary of the articles reviewed.

Implications for Counselling Psychology

As evidenced by the literature review, much has been written and researched regarding the disparities in addiction rates between Indigenous and non-Indigenous populations. The following section will focus on unique considerations for counsellors working with Indigenous clients seeking treatment for addiction or other concerns. This includes the importance of cultural competency, trauma-informed care, and gaining a deeper understanding of how Western models

of addiction treatment and counselling may not always be applicable or appropriate for Indigenous clients, as well as gaps in health care provision.

Gaps in Care

Access to Services

It has been widely documented that Indigenous peoples in Canada and elsewhere experience harmful disparities in accessing health care compared to the general population (Adelson, 2005; Paradies, 2016; Urbanoski, 2017). Hayward et al. (2020) identified several potential reasons for these disparities. First, the nature of Indigenous communities' remoteness provides a challenge for service delivery. There is also the issue of a lack of practitioners who utilize traditional medicines or other culturally-appropriate care methods. Additionally, there is an ongoing lack of trust on the part of Indigenous peoples on account of the historical effects of colonialism and ongoing systemic marginalization that can make healthcare access difficult. According to the United Nations Declaration of Human Rights of Indigenous Peoples, Indigenous people should have the right to equitable access to health and social services (Axelsson et al., 2016). Despite this declaration, this is not the reality in many Indigenous communities.

This problem, like many others experienced by Indigenous peoples, such as lower education levels, lower life expectancy (Czyzewski, 2011), addiction, and homelessness (Kim, 2019), has its roots in colonialism. It was the colonialist system that bred the Indian reservation, a move which, to this day, has left many Indigenous people without access to a primary care provider (Hayward et al., 2020). It is also colonialism that has played a significant role in the higher health burden experienced by Indigenous peoples through stressors such as family violence, grief, marital discord, and other traumas passed down through generations (Paradies,

2016). In the present day, Davy et al. (2016) pointed out several additional barriers, including ongoing racism and discrimination, high healthcare costs, and substandard communication between Indigenous patients and Western service providers.

Addiction treatment access is no exception to this phenomenon. The majority of remote Indigenous communities do not have inpatient residential treatment programs. Seeking treatment often necessitates the client to travel long distances to access these services. In a literature review on the development and effectiveness of community-based addiction treatment for Indigenous clients by Jiwa et al. (2008), it was noted that these clients travelling far distances for treatment invariably return to the same stressors present when they left, and relapse rates within 90 days range from 35% to as high as 85%.

Primary healthcare and addiction healthcare overlap when discussing opiate agonist therapy (OAT) or medication-assisted treatment for opiate use disorder (OUD). This is because OAT must be delivered by healthcare professionals in a controlled setting, and obtaining and retaining medical staff in these remote communities is a continuous challenge (Venner et al., 2018). Rates of OUD are higher in remote Indigenous communities, where there are serious gaps and barriers for clients receiving OAT. These include lack of physician access, lack of psychological services to be accessed in conjunction with OAT, and the distance many clients have to travel to the nearest healthcare facility or pharmacy (Franklyn et al., 2016; Pijl et al., 2022).

Provision of Care in Indigenous Communities

One important development in addiction treatment for Indigenous peoples in recent decades has been greater attempts to provide these services on or closer to reserves in Canada and elsewhere. An Australian study by Munro et al. (2018) found that increased provision of

Indigenous-specific interventions at centres catering to this population indicates improved well-being and lower relapse rates. The importance of community integration for the client struggling with addiction has also been explored. One example is The Sioux Lookout Program in Sioux Lookout, Ontario. This program highlights the importance of providing psychoeducation and medical treatment to help clients and including peers, Elders, and other community members in the healing process to reintegrate the client into the community (Pijl et al., 2022). This approach is rooted in a growing body of research suggesting the strong connection between community involvement and long-term positive outcomes for addiction recovery (Gone, 2009; Lavalley et al., 2020).

While there have been many improvements in the area of Indigenous-led service provision for addiction treatment, serious gaps remain. One example is northern, remote communities, which often send clients to urban or other First Nations centres elsewhere due to a lack of regional services. These remote communities are inhabited primarily by those of Inuit, First Nations, and Metis heritage, who often experience difficulties when travelling elsewhere for treatment due to differences in culture, language, and other factors that risk further perpetuating imbalances in care for these clients (Lauzière et al., 2021). The existing healthcare and addiction services framework was developed in urban settings, far away from the unique problems and considerations these remote communities face. As Cotton et al. (2013) noted, many of these communities lack the resources and infrastructure to properly care for those located there to access addiction treatment. In addition, the cultural differences between those living in these areas and the practitioners either travelling there to work or working in the distant locales these clients are sent to are likely stark. This presents concerns not just related to service delivery but also a lack of culturally-appropriate care when these clients travel elsewhere for treatment. The

challenges arising from this issue are notable in mainstream treatment settings that provide integrative services to Indigenous clients. Because most services are provided in these Western settings, much care and attention has been given to culturally-competent service delivery considerations.

Cultural Competence

Cultural competency refers to strategies that help improve equity for members of minority ethnic or racial groups receiving services. While the term and framework were initially developed to assist practitioners with delivering services to immigrant clients, they have been expanded to include Indigenous populations (Clifford et al., 2015). Wendt and Gone (2012) highlighted the differences between specific and general approaches to cultural competency. General competency refers to an overall comfortability to work with diverse groups. In contrast, specific competency consists of a strong knowledge base of culturally-specific considerations and a willingness and ability to confront any biases or racist beliefs related to specific populations.

When discussing Indigenous populations seeking care specifically, cultural competency is vitally important to consider due to the existing tension and reservations on the part of Indigenous people to engage in Western healthcare. Indigenous clients seeking care from non-Indigenous practitioners experience high levels of dismissiveness and disinterest (Wendt & Gone, 2012). Dropout rates for traditional psychotherapy for Indigenous clients are high; clients express a stronger desire to seek care from Elders and other community members than medical professionals and often prefer culturally-relevant services as opposed to those in mainstream healthcare settings (Pomerville et al., 2016). Clifford et al. (2015) noted that robust research suggests cultural competency training for professionals working with Indigenous clients has

positive results. Examples include practitioners' improved awareness and attitudes regarding working with this population and being more comfortable delivering interventions to Indigenous clients.

While cultural competency in Canadian healthcare settings has become more widespread and improved in recent years, Berg et al. (2019) pointed out several barriers reported by staff in emergency departments (ED) that are especially pertinent in Indigenous populations. This includes past experiences of racism when seeking care, a lack of resources such as social service staff in these settings, a distrust of the medical system, and poor continuity of care. For example, in urban centers, many socially disadvantaged people, including many Indigenous people, access the ED as their main source of health care as they lack a primary physician. This creates a higher probability that these individuals will not see the same practitioner each time they visit the ED, leading to poor continuity of care (Browne et al., 2011). Another consideration in addressing Indigenous clients seeking help with any presenting concern, including addiction, is the risk of re-traumatization due to previous negative experiences in the healthcare system.

Trauma-Informed Care

Trauma-informed care broadly refers to the idea that everyone in the caring professions should carry with them the understanding that a vast number of people seeking care will have a history of victimization and violence and subsequently use this understanding to help facilitate proper care (Butler et al., 2011). Bartholow and Huffman (2023) stressed the importance of trauma-informed care being a vital tool for minimizing the risk of re-traumatization. This is of great importance when considering the experience of Indigenous people in both primary healthcare and addiction treatment settings. In hospital emergency rooms, re-traumatization might look like racism and discrimination, affecting the quality of care received (Berg et al.,

2019). In some cases, these racist interactions are rooted in stereotyping, such as beliefs about Indigenous clients with addiction issues being accused of drug-seeking behaviours or Indigenous clients being noncompliant (Turpel-Lafond & Johnson, 2021). There is also a history of overinvolvement of police services when Indigenous clients present to EDs for care, particularly child welfare calls, based on assumptions that Indigenous children seeking medical attention are more likely to have been victims of abuse or neglect (McLane et al., 2022). In addiction treatment programs, racism may manifest as clients being exposed to Christian-based programs that represent reminders of the IRS system and other colonialist structures (Lavalley et al., 2020). Trauma-informed approaches are also notably important in addiction programs due to the overall high prevalence of trauma history in clients of all backgrounds seeking treatment (Kuksis et al., 2017).

There are two additional important subcategories of trauma-informed care related to addiction treatment. The first is *harm reduction,* which in the context of substance abuse treatment refers to any intervention designed to reduce drug-related harms to a person, including needle exchanges and certain pharmacotherapies (van Der Sterren et al., 2006). These strategies can reduce the barriers to entry to addiction treatment programs, many of which follow an abstinence-based model (Goldstein et al., 2022; Levine et al., 2021). The second *is patient-centred care*, which refers to practitioners tailoring interventions to suit client needs when possible (Bartholow & Huffman, 2023). LaVallie and Sasakamoose (2023) noted that when addressing Indigenous-specific trauma-informed care, practitioners must have a robust knowledge base regarding colonization, IGT, and the connection between trauma and addiction. In conjunction with this approach, those working in addiction services must also recognize the importance of not only working not to retraumatize their clients but also to create a safe

environment in which they can heal. This can be facilitated if these workers have enough knowledge of the Indigenous experience to offer support rooted in facts and methodologies with proven effectiveness for working with Indigenous clients.

Systemic Racism and Stigma

Systemic Racism

Systemic racism refers to the entrenched policies and practices that give the dominant culture a greater advantage over minority populations (Efimoff & Starzyk, 2023). This contrasts individual racism, which refers to people's unique views and beliefs surrounding other races. While systemic racism is a complicated issue whose resolution lies in major changes in many areas, individual racism, or improvements in individual cultural competency and sensitivity, can come through education and exposure. Because Indigenous peoples are a minority, both in population and representation in the medical and helping professions, researchers have noted the importance of creating cultural safety. Stigma and discrimination are both major considerations when dealing with Indigenous clients, making the urgency of cultural safety all the more pertinent (Jardine & Bourassa, 2021). The term systemic racism also must be viewed in the context of both historical events as well as the lived experiences of Indigenous people in the present day. The reality is that we are not in a "post-conflict" society in Canada, as pointed out by Siemens and Neufeld (2022); this means that education efforts for professionals in all fields working with Indigenous populations must focus on both historical considerations as well as the elimination of passive acceptance of these issues that is pervasive in current society

Education can be an effective strategy to mitigate these issues and improve care. In a longitudinal study, Efimoff and Starzyk (2023) measured the effects of Indigenous education programs for nearly 1,700 psychology students in Manitoba. The authors noted improvements in

participants' knowledge and attitudes about the Indigenous experience, including colonialism and systemic racism. One notable finding, however, highlights one of the issues facing organizations trying to implement cultural competency through education: backlash in the form of defensiveness. This was especially true when participants were educated on the concept of White privilege. Researchers found that this term often had the opposite desired effect, leading participants to show defensiveness through expressing their hardships. This issue is echoed by Phillips and Lowery (2015), who pointed to research suggesting that many White individuals identify individual hardship as a means of dismissing the overall greater negative experiences of other racial groups. These findings on individuals' feelings about their inherent biases strengthen the argument for people who intend to enter any helping profession, such as counselling, to improve their competency by engaging in education on historical elements of the Indigenous experience and subsequently challenging their biases and existing prejudices.

Stigma

Another consideration for Indigenous individuals seeking care is stigma. While addiction is less stigmatized and more widely accepted as a legitimate health concern in recent generations, stigma does persist. In Indigenous communities, this can be compounded by negative attitudes toward drug use, particularly in smaller communities. This can complicate the process of an individual reaching out for help and accessing harm-reduction services. For example, Levine et al. (2021) pointed out that a major Western-influenced concept, abstinence-based recovery, has permeated into Indigenous communities, making open conversations with community members struggling with substance abuse difficult. While peer support is a widely accepted means of countering this problem, it is a less available option in remote communities. Stigma also exists in many Indigenous communities regarding mental health issues more broadly. Historically, mental

health issues in Indigenous peoples were conceptualized as giftedness, spiritual possession, and an imbalance of harmonies within a person. For example, some American Indian tribes considered what is known in the Western world as psychosis to be the presence of some special ability (Grandbois, 2005). Examples of what is known as spiritual possession have been documented by anthropologists going back thousands of years among Indigenous groups in Africa, Asia, and the Americas (Bourguignon, 2005). This involves an individual becoming a conduit between their group and the spirit world, which in modern Western psychiatry could be interpreted as schizophrenia. In Australia, some Indigenous peoples believe mental illness can be seen as punishment for wrongdoing in one's past (Ypinazar et al., 2007). While these attitudes and traditions are not universal to all Indigenous groups, and many communities have strong connections to more Western models of treatment, they are still important considerations when assessing a client seeking care for addiction as part of culturally-competent care.

Indigenous Perspectives of Current Care Models

While there is a growing amount of literature examining the effectiveness of Indigenous interventions integrated into existing Western delivery models, there is a major gap in research examining the opinions and feelings of Indigenous peoples about the current state of healthcare delivery. It could be argued that Indigenous peoples are forced into treatment settings that are not compatible with their cultural background and experience. For example, Hill and Coady (2003) noted the differences between Western and Indigenous styles of healing related to talk therapy. While processing through speaking is a cornerstone of Western mental health treatment, in Indigenous communities, there is often a stronger focus on nonverbal communication, such as being together, sharing, and moving. Indigenous healing methods also often tend to be less directive and structured.

There also appears to be an incompatibility in the current mental health service delivery model and considerations that are unique to Indigenous populations and cultures. As Gone (2009) pointed out, there are no diagnostic criteria for IGT or historical trauma, no agreed-upon best practice for working with Indigenous populations, and a disagreement among many Indigenous clients and service providers on whether many of their presenting concerns are even pathologies at all. While assessing programs using a treatment-outcome approach is often necessary and useful in some scenarios, Gone noted that a true decolonization-based approach would benefit from moving away from Western ideas of diagnoses and evidence-based practices and towards granting more autonomy to Indigenous service providers.

Hill and Coady (2003) highlighted another barrier: many Indigenous healing methods are passed down through oral tradition. This means that an Elder or other knowledge keeper must deliver culturally-specific healing methods that might be better suited to Indigenous clients. This is an important consideration for Western counsellors, as it involves recognizing that while a non-Indigenous counsellor may address certain issues, there will often be other cultural interventions they may have to advocate for their Indigenous clients to access. In this way, the counsellor engages in cultural humility by acknowledging that they may not have the proper training or experience to deliver services to their client. This, in turn, can help lessen power imbalances between service providers and clients of different cultures, with an additional focus on lessening the often paternalistic nature of the helper-helpee relationship (Cox & Simpson, 2020).

Similar to traditional psychotherapy, one consistent finding in working with Indigenous clients is the importance of the relationship between the service provider and the client (Gone, 2009). Warmth, empathy, and a building of mutual trust are likely to prove more effective than

many interventions with Indigenous clients, particularly given the listed issues many Indigenous peoples have with existing treatment structures. As Wu et al. (2023) noted, all clients seeking treatment carry the influence of their experience and past relationships with them into every new admission into a program. The implication here is that any effective service delivery for Indigenous addiction clients will combine cultural competency, trauma-informed care, continuous self-reflective learning on the part of the practitioner, and a willingness on the part of the organizations that work with these populations to implement these strategies.

Fundamental Next Steps for Research

The research conducted on the connection between Indigenous populations and addiction, Indigenous populations and trauma, and the effects of IGT and colonialism on these populations in various parts of the world is robust and well-established. What is less clear is what are the most appropriate and proven strategies for addressing addiction in Indigenous populations and quantitative data on the interventions that have been implemented so far. Much of the current research in this area is collected through studies involving treatment centres that serve Indigenous clients and qualitative studies related to the overall experience of Indigenous peoples who access addiction and other health care services. The following section outlines possible improvements to existing research methods, the ethical considerations of such research, as well as potential new areas of research.

Research Conducted in Addiction Treatment Settings

As Rowan et al. (2014) pointed out, many of the studies conducted in addiction treatment centres use an integrative approach, which can create difficulties in separating the effectiveness of individual interventions in isolation. This highlights a need for developing methods to assess the effectiveness of interventions on their own. Researchers have outlined potential directions for

future research related to the effectiveness of addiction treatment centres serving Indigenous clients. Wu et al. (2023) suggested more collaboration between researchers and service providers and unique approaches to presenting the data outside a traditional report, such as art or oral storytelling.

These methods address an overarching goal of ensuring that reconciliation in all its forms, including those related to health and addiction care, aligns with the Truth and Reconciliation Commission's (TRC) *Calls to Action* (Government of Canada, 2015). This document was created as part of a reconciliation agreement between the Indigenous peoples of Canada and the Canadian government to educate Canadians about the reality of Indigenous issues, such as the experiences of the IRS system, and provide tangible goals for repairing disparities and improving equitable care. Many researchers (Efimoff & Starzyk, 2023; Jardine & Bourassa, 2021; Wu et al., 2023) cited these *Calls to Action* as an important guide to their research and highlighted the importance of working towards service delivery that acknowledges these recommendations adequately.

While the TRC's *Calls to Action* (Government of Canada, 2015) are too numerous to list here, reviewing those that mention the provision of care for addiction treatment specifically as benchmarks for future research is pertinent. The TRC suggests that annual progress reports on various aspects of the Indigenous experience, including addictions, be conducted to assess long-term trends. When addressing health gaps more broadly, the TRC recommends long-term, multi-year funding to help bridge health disparities (Government of Canada, 2015). It could be posited from these statements that some of this funding would be earmarked for both the establishment of more addiction treatment beds for Indigenous clients and to fund research in the form of longitudinal studies to track the progress of these initiatives over time. It may also be prudent to

develop flexibility in how outcomes are assessed. While many modern researchers in this field identify positive outcomes as lower relapse rates and substance use episodes, Henderson et al. (2023) also highlighted the importance of including other metrics, such as improved social support, improved cultural connectedness, and less involvement in the criminal justice system.

Ethical Considerations for Research

The challenges of conducting research with Indigenous populations are not just related to the influence and prominence of Western modalities. Another lasting legacy of colonialism is the broken trust Indigenous communities have towards Western scientific institutions, which has its roots not only in the IRS system and other historical events but also in previous unethical research practices conducted on these populations. As noted in the CPA's (2017) *Canadian Code of Ethics for Psychologists*, research conducted in communities deemed vulnerable through historical or economic disadvantage must be approached cautiously, with due care in ensuring the participant's rights are protected.

Unfortunately, this has not been practiced with due diligence. Research conducted in Indigenous communities often rarely provided benefits for those participating in the studies and, in some cases, caused harm (Kilian et al., 2019). For example, Indigenous peoples in Australia, who represent one of the most researched cultural groups on earth, have received little or no benefit to their overall health or circumstances as a result of these studies (Hawkes et al., 2017). In Canada, revelations have come out regarding the experiments conducted in IRS facilities during which children were given differing types of food and the effects of these differing diets were studied (White, 2013). Walters et al. (2009) also note medical experiments involving radiation exposure and organ removal in IRS schools. Unsurprisingly, the children did not

consent to these experiments and were subject to them without any attempt to correct or mitigate their harmful effects during or after the experiments were complete.

With this background information, it is understandable that prospective Indigenous participants in any study will have reservations. This shows great importance in emphasizing collaboration and developing studies that will benefit Indigenous communities. Offsetting the harm of the extensive history of unethical research practices among Indigenous communities must include strategies to accurately comprehend what the Indigenous community's needs are related to addiction treatment services and how a research study might meet those needs.

In 2018, the CPA responded to the TRC's report with a report outlining the psychology profession's desire to work with Indigenous peoples. This was a collaboration between service providers and Indigenous leaders to guide Canadian psychologists in fulfilling their role in the reconciliation process. In this report, the authors mention several considerations relevant to research conducted in Indigenous communities. These include an adequate effort to build trusting relationships, a desire by the researchers to enhance and strengthen the community by conducting the research, and a reflection on the community's own interventions, culture, and approach to science (CPA, 2018). These are all crucial steps in what Bull et al. (2020) described as the decolonization of research or the shifting of power imbalances by allowing communities to lead their research and ask questions they deem pertinent.

One example of this concept is collaborative and community-based research (CCBR), conducted by graduate students attending six universities in Brazil, the United States, and Canada. This project sees students engaging in research involving sustainability for key watersheds in these countries. It includes the direct involvement of the Indigenous peoples in the fishing communities where the research is being conducted (Wray et al., 2020). Another example

is the HONOR (Honor Our Nations, Our Relations) project, an initiative funded by the National Institute of Health in the United States to research the prevalence rates and risk factors for Indigenous peoples across the country living with HIV (Walters et al., 2009). These examples show the possibility of research that is collaborative, respectful to all stakeholders and focused on the improvement of the Indigenous peoples whose land, resources, and personal experience are being studied.

Recommendations for Practice

Any individual who currently works in addiction treatment serving Indigenous clients or wishes to in the future will have a multitude of considerations to keep in mind if they are determined to be effective at helping this population. Striving for self-education and self-reflection, additional training on cultural competency and trauma-informed care, and a continuous desire to grow these skills are invaluable tools for maximizing benefit and minimizing harm when working with these populations (Bull et al., 2020; Sinclair, 2021).

Standardization of Research and Practice

If research can successfully shift to being more autonomously conducted by Indigenous groups, it would stand to reason that this could lay the groundwork for programming that is more applicable to Indigenous addiction clients. Several issues have been identified as limitations in previous research, including small sample sizes (Marsh et al., 2016), fundamental differences in treatment approaches between Western and Indigenous parties (Gone, 2012), and a lack of generalizability of approaches and markers of success between Indigenous groups (Walls et al., 2013), among other challenges. Despite these seemingly overwhelming barriers, a few general guiding principles may be useful when conducting this work.

Education

One major development in recent years is the wide range of educational resources available to current or prospective therapists who work with Indigenous peoples. As Bartlett et al. (2012) noted, modern education practices have effectively extracted spiritual ways of knowing that existed in Indigenous and other cultures for countless generations. While this may be an effective strategy for keeping educational institutions free of cultural or religious biases, it has created an environment where students, or future therapists, are often not exposed to these cultures until they enter the field for the first time. While cultural competency is now a part of many curricula, this is usually a broad application. It may benefit professionals working with Indigenous clients to receive more culturally-specific training and education.

In postsecondary counselling programs, self-reflective student journals are a common practice for beginning to identify and challenge potentially problematic underlying beliefs about other cultures. With data collected from a systematic review of reflexive practice with Indigenous populations, Dawson et al. (2022) suggested that many educational institutions offer programs that teach reflexivity as a learning approach rather than a learning outcome. At an educational institution level, this could speak to the need for more immersive programs, in collaboration and with approval from Indigenous communities, for students to spend time with Elders or other community members to get a first-hand account of the issues facing Indigenous peoples. This could involve field trips to Indigenous communities, participation in ceremonies, or role-playing exercises utilizing Indigenous people as patient actors. This will give the counsellor-in-training exposure to methods and strategies specific to working with Indigenous populations prior to them entering the field. However, much of this exploration will likely come

from direct practice, meaning individual practitioners must figure out their methods and strategies for self-reflection when working with other cultures.

Trauma-Informed and Culturally-Competent Care

Education on the connection between trauma and addiction can be beneficial to both mental health professionals and as a psychoeducational tool for the clients they are serving. Levine et al. (2021) highlighted a curriculum for clients that includes the connection between addiction, trauma, and colonialism as crucial to healing. Henderson et al. (2023) also emphasized the importance of trauma-informed care training for practitioners to develop cultural humility and compassion. This is rooted in the understanding that many people who seek help for addiction from all cultures have more substantial trauma histories and that Indigenous peoples have experienced higher rates of trauma than the general population. As noted by Maté (2012), repeated studies have consistently found a connection between the severity of substance addiction and incidences of sexual, emotional, and physical abuse; in clinical practice, the rates of trauma in patients who use drugs intravenously are conservatively estimated at two-thirds, further solidifying the connection between trauma and substance abuse.

Taken together, this means that education for practitioners must combine both elements of connecting trauma and addiction, as well as information about the high rates of trauma and other special considerations present in Indigenous communities. This would ideally include rudimentary teachings about IGT, the IRS system, the 60s Scoop, and other policies that have created and perpetuated trauma. Here, we find the intersection of trauma-informed and culturally-competent care, as knowledge of the connection between trauma and addiction is culturally relevant to many Indigenous peoples. Kuksis et al. (2017) added that because of the high prevalence rates of trauma in those with addictions, all addiction treatment centres should

have trauma-informed care integrated into programming. Furthermore, early identification and treatment of comorbid PTSD and addiction will be beneficial to overall recovery.

Gainsbury (2017) notes that in nondominant cultures, the number of people seeking help for addiction and completing treatment programs is lower than the general population and that this disparity can be directly linked to a lack of culturally-competent care in these facilities. Cultural competency when working with Indigenous peoples starts with the recognition that many Indigenous people feel disconnected from modern psychotherapy. The next step is honouring Indigenous people's desire for self-determination when it comes to providing addiction treatment services. Wendt and Gone (2012) explained that while much focus has been put on training professionals to be more culturally competent, there may also be great value in assisting Indigenous populations in developing their own culturally-appropriate programs that align better with traditional values and healing methods. While this fact should not downplay the importance of or discourage professionals from engaging in educational programs, it is also essential to highlight advocacy for Indigenous communities' self-determination as a crucial additional component.

Ethical Considerations for Practice

Language

While cultural education is an important aspect of professional development for prospective counsellors, actual practice with Indigenous clients also requires several ethical considerations. For example, one challenge a non-Indigenous counsellor may face when working with Indigenous clients is language and communication differences. In the CPA response to the TRC report (CPA, 2018), it is noted that over 60 different languages are spoken among Indigenous peoples in Canada. The CPA (2017) *Canadian Code of Ethics for Psychologists* states

that consent must be delivered in language the individual understands, and a translator must be provided if necessary. This could prove difficult depending on the language spoken by the client, as many Indigenous languages have few, primarily elderly, speakers. The number of native speakers of these languages ranges in numbers from thousands to just a few hundred (Littell et al., 2018).

While it is unrealistic to assume that many counsellors will be fluent in Indigenous languages or have access to a roster of translators, it is still important to understand that communication with clients is not simply a matter of language but also of cultural understanding. A counsellor who is equipped with an understanding of IGT and its effects on Indigenous mental health will be in a much better position to communicate with clients than those lacking this knowledge. The CPA (2018) also identified assessments, training, and research conducted without a proper grounding in cultural collaboration as unethical and raising the risk of re-traumatization.

Gender and Sexuality

While the term stigma is often used in discourse related to addiction, additional stigmas exist for many clients seeking addiction treatment: gender identity and sexual orientation. A study of Indigenous transgender people in Ontario found that 71% of them were unable to access addiction treatment services (Lyon et al., 2015). Denial of service is common, as is violence and other forms of discrimination for transgender clients in these treatment centres. Sexually and gender-diverse people of all backgrounds face elevated levels of discrimination (Henrickson et al., 2020), and it can be assumed that additional stigma associated with addiction will make accessing recovery a more formidable challenge to these clients.

Counsellors working with Indigenous clients who are gender and sexually diverse will need to be equipped with additional knowledge related to the unique experience of these clients. Both adolescent (Chaiton et al., 2022) and adult (Ruppert et al., 2021) clients who are lesbian, gay, bisexual, transgender, and queer (LGBTQ) experience both elevated rates of addiction and more deleterious consequences. Another essential consideration surrounds the terminology sexually and gender-diverse Indigenous people use to describe themselves. Terms such as LGBTQ are Western constructions, and many Indigenous peoples use other terms, such as Two-Spirit, to describe gender fluidity in a way that eschews Western categorization (Henrickson et al., 2020). As noted in the CPA (2017) *Canadian Code of Ethics for Psychologists*, responsible caring includes continuous reflection on the part of the counsellor regarding their social context with their clients, including sexual orientation. Strategies to mitigate potential harms in this area could include personal reflection, utilizing supervision, and seeking education on current terminology on gender and sexuality.

Reflexive Self-Statement

I approached this project as someone who was by no means an expert on the topic but felt as though I might have a better understanding of the struggles faced by Indigenous peoples seeking treatment for addiction than the average clinician due to my experience in the field. One of the biggest lessons I learned as I progressed through this project was how surface-level my understanding was. While I had worked one-on-one with many Indigenous clients and gained insight from them through first-hand accounts of their experiences, I had never dug deep into the research on the history of colonialism, the connection between IGT and addiction, and the true horrors of the IRS system.

I was also humbled by my findings through the interviews with Indigenous people in qualitative studies surrounding their experiences in Western treatment programs. While my bias going into this capstone was that an abstinence-based, 12-step model was an appropriate approach for most people, I was somewhat ignorant to the possibility that the reluctance on the part of Indigenous people did not necessarily come from these programs themselves, but due to the very justified mistrust bred through generations of having Western ways of healing imposed on them against their will. A consistent finding by many researchers (Lavalley et al., 2020; LaVallie & Sasakamoose, 2023; Stewart, 2008) is that Indigenous people are not only reluctant to certain Western methods of addiction treatment, they often have many of their community-based approaches that are more culturally appropriate. If I were to work with this population again in the future, I would take great care to get a clear sense of the individual's cultural preferences before proceeding with any intervention. I would also hope that should I be in a position at a treatment center where I can make such decisions, I would use this to advocate for more culturally-appropriate and culture-specific interventions.

Another major revelation was how much a person's culture, regardless of background, influences their worldview and life course. Gainsbury (2017) noted that culture can refer to many aspects of a person, including race, religion, sexual orientation, disability status, and socioeconomic status, among many others. It was important to gain an understanding of the fact that it is not as simple as saying, Indigenous people are more prone to addiction. While there is statistical evidence to support this statement, it is a gross oversimplification that negates the factors that cause this disparity. Part of the culture of many present-day Indigenous peoples is their experiences of trauma, both first-hand and passed down through previous generations. The connection between trauma and addiction is well-documented (Kuksis et al., 2017; Spillane et

al., 2023), and it could be argued that the Indigenous addiction disparities are less about individual differences between racial or ethnic groups and more about marginalized, disenfranchised groups using substances as a means of coping from generations of abuse and mistreatment.

From this perspective, I began to feel a shift from observing the issues around addiction in Indigenous peoples as being less about substance use and more about healing from trauma. This solidified my assertion at the beginning of this project that Indigenous communities would best be served by more opportunities to develop more autonomous addiction care centres. Western addiction treatment practices will arguably never fully integrate the Indigenous experience into existing programming, no matter how well-intentioned efforts so far have been. As effective as Western psychotherapies and 12-step programs might be, these were not created and curated by Indigenous peoples and are, therefore, inherently problematic means of addiction treatment in and of themselves.

Overall, I believe this capstone project has made me a stronger therapist. Many of the concepts covered here, such as cultural safety, cultural humility, and cultural competency, are highly relevant and transferrable to all clients I will encounter from any culture. In the CPA (2017*) Canadian Code of Ethics for Psychologists*, Principle III states striving to be as objective as possible and monitoring and mitigating any biases in the counselling relationship. I understand this to be an ideal and not a goal that is ever fully accomplished, but one that can be constantly strived for through continuing curiosity, consultation, independent learning, and a willingness to learn as much as possible about the cultural perspectives of the people coming to us for help when they are most vulnerable.

Conclusion

Indigenous peoples in Canada and elsewhere who experienced colonialism have been subjected to countless harms in the generations since first contact with European settlers. These include the insult of disease and displacement by initial foreigner settlement (Barker et al., 2019), the use of Western law to clandestinely relegate Indigenous people to reserves and criminalize their customs (Comaroff, 2001), the horrors of the IRS system (Rand, 2011; Robertson, 2006; Sharpe, 2011), and more recently the 60s Scoop (Kodeeswaran et al., 2022) and disproportionately high involvement in the child welfare system (Jardine & Bourassa, 2021).

Substance abuse and addiction are an extension of these harms, a response to current and historical traumas (LaVallie & Sasakamoose, 2023; Marsh et al., 2016). In this way, substance abuse in Indigenous populations can be viewed as not a problem needing to be solved but rather a response to the original injury of colonialism. What is abundantly clear is that no intervention rooted in past government-mandated colonialist frameworks is going to be fully effective in deconstructing years of damage caused by colonialist policies. As long as Indigenous peoples face ongoing health disparities (Wilk et al., 2017), high unemployment, high incarceration (Shepherd et al., 2020), homelessness (Pottie et al., 2020), and other issues, many of them will continue to find solace and relief in substance use, just as many individuals facing chronic stress and trauma do (Gill-Emerson, 2018; Kuksis et al., 2017). As such, in our roles as both counsellors and allies, it is our responsibility to assist Indigenous peoples by not only offering culturally-competent care but also by doing our part to move forward towards a model of Indigenous addiction treatment that is rooted in autonomy and collaboration.

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Appendix

Methodology

Author(s) (Year)	Title	Sample size	Selection/ recruitment	Data collection process	Data analysis process	Type of study	Notes on findings
Marsh et al. (2016)	Impact of Indigenous Healing and Seeking Safety on Intergeneratio nal Trauma and Substance Use in an Aboriginal Sample	17	Participants were Indigenous volunteers recruited through a convenience sample. All were willing to participate in a Seeking Safety therapy group, an evidence-based, Western program specifically designed for the treatment of substance abuse and posttraumatic stress disorder (PTSD). Facilitators blended existing Seeking Safety curriculum with traditional practices, such as sweat ceremonies, smudging, and the presence of Elders.	Participants were first given a 90-minute briefing interview. The following assessments were taken at baseline and again at the end of the program: Trauma Symptom Checklist 40 (TSC-40), the Addiction Severity Index Lite (ASL-Lite), the Historical Loss Scale (HLS), and the Historical Loss Associated Symptom Scale (HLASS). Upon completion of the program, focus groups and semi-structured interviews were also conducted.	Baseline and postprogram assessments were analyzed using paired *t* tests. These scores were then pooled and charted to show differences between pre and posttreatment. Demographic information for all participants was also included. Data was also collected on participants considered "non-completers" (n = 7), those who left the program before completion but had completed initial assessments.	Mixed methods: assessment and semi-structured interviews	Results were provided for each of the main domains of the offered assessments. Trauma symptom severity and symptoms related to historical grief and trauma all showed a statistically significant positive (lowered) number at the end of treatment, while substance abuse assessments showed no statistically significant changes. Postprogram questionnaires showed unanimous positive responses to the Seeking Safety program combined with traditional interventions.
Pham et al. (2023)	Ideals of Counselling Practice: Therapeutic Insights From an Indigenous	32	Researchers used purposive sampling to select participants who were all involved with an Indigenous treatment	The senior researcher conducted in-person interviews with participants using a semi-structured approach and open-ended questions.	Researchers used thematic analysis to organize collected data into codes and themes. Rigorous analysis	Qualitative	Participant responses were collected to determine ideals for service delivery and the most effective means of care delivery at the

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	First Nations-Controlled Treatment Program		center (healing lodge) in Manitoba. Participants were a mixture of former clients, administration staff, counsellors, and non-staff community members who had strong connections to the center, such as board members and community volunteers.	The questions were related to the participants' history and experience with the therapeutic activities conducted at the center. Practitioners were also asked questions specific to service delivery, training, and therapeutic approaches.	was ensured through the use of Braun & Clarke's six-phase, 15-point checklist for thematic analysis. In addition, initial codes were generated using *NVivo,* a qualitative analysis software program.		center. Participants listed among the most important nonverbal expressions (crying, silence, visual representations), seeking counsel, sharing stories, and participation in ceremony.
Rowan et al. (2014)	Cultural Interventions to Treat Addictions in Indigenous Populations: Findings From a Scoping Study	19 studies involving 5,949 treatment clients	All studies included in the review involved programs that provide integrated services, offering both Western and Indigenous/traditional interventions. All studies focused on the use of cultural interventions used to treat addictions in Indigenous populations. All studies reviewed were from the United States and Canada.	Researchers utilized a librarian scientist to search databases for relevant articles (both scientific and grey literature) related to Indigenous addiction treatment and cultural interventions, both inpatient and outpatient. Of the 4,518 articles found in the search, 19 were selected (14 scientific and 5 grey literature).	Studies were categorized and charted based on the program's implementation of interventions in four key areas: Physical, Mental, Emotional, and Spiritual. Results on the most utilized cultural interventions were presented in a graph, and the most common were sweat lodge, ceremony, and social culture, respectively.	Scoping review	This review set out to find scientific and grey literature to determine the most widely used and effective interventions and subsequent outcomes for Indigenous addiction clients. Findings suggest that almost three-quarters of the studies found positive connections between cultural interventions and recovery outcomes. However, the authors also point out these studies were conducted on a wide variety of Indigenous communities and settings, making

Author(s) (Year)	Title	Sample size	Selection/ recruitment	Data collection process	Data analysis process	Type of study	Notes on findings
							generalizability and comparability difficult.
Walls & Whitbeck (2012)	The Intergenerational Effects of Relocation Policies on Indigenous Families	507	Data was collected from a longitudinal study of 507 adolescent Indigenous children and their biological mothers living on or near four reservations in Canada and the American Northern Midwest, which share similar cultures and languages. The study was conducted to examine the effects of Indigenous relocation on the descendants of those relocated.	Families who were part of the original longitudinal study met with an Indigenous interviewer who explained the process and offered a small incentive. Adolescent interview subjects were given questionnaires related to the following: delinquency, depressive symptoms, and family supportiveness. The mothers were asked questions related to depressive symptoms, alcohol and drug abuse, and their and their family of origin's experiences with relocation.	The authors utilized descriptive statistics, bivariate associations among variables, and a fully recursive path model using Mplus software. They tested several hypotheses related to the connections between G1 (ancestor), G2 (mother), and G3 (adolescent) and how outcomes such as substance abuse and depression are passed down through each generation as a result of G1 relocation.	Quantitative	This study produced statistically significant data to suggest that G1 relocation has a strong connection to G1 and G2 substance abuse, G2 depressive symptoms, and G3 delinquent behaviours. The authors note that these results represent only a small fraction of the Indigenous populations across the world and may not be generalizable to all Indigenous peoples. It is also notable that this study concerned primarily participants who lived in rural areas and on reservations and may not be generalizable to those in urban centers.
Wu et al. (2023)	Exploration of Existing Integrated Mental Health and Addictions Care Services	35	Researchers utilized purposive sampling methods for this study. To be included in the study, participants were required to be from	The key researcher conducted phone interviews with participants, who were primary representatives from each organization (Director of Care,	Researchers used inductive thematic analysis as a means of searching for patterns or themes in data. This	Qualitative	The overall theme of commitment to community involvement was found to be the most widely acknowledged for its importance, followed by

Author(s) (Year)	Title	Sample size	Selection/ recruitment	Data collection process	Data analysis process	Type of study	Notes on findings
	for Indigenous Peoples in Canada		an organization that worked with Indigenous populations aged 18+ and specifically offered addiction and mental health services using both Indigenous and Western methods of intervention.	Program Director, etc.). The researcher used narrative enquiry to ask open-ended questions in a semi-structured way to create an informal and conversational environment.	information was then used to inform questions asked in subsequent interviews. Researchers also utilized Indigenous collaborators who assisted in interpreting the data through equal Indigenous and Western lenses.		the subthemes of self-determination, continuity of care, program engagement, and the importance of evaluation. Ongoing prevalence of racism and the need for further self-reflection and cultural exposure for non-Indigenous practitioners working with Indigenous clients was also identified.