Healing the Whole Human Being

Realist Review of Best Practices and Contextual Factors for Preventing & Treating Opioid Misuse in Indigenous Contexts in Alberta

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Target Audiences:
We believe that this report will be of interest to groups and sectors involved in Indigenous health research and service, as well as others who work in addictions-related research, policy, and practice. We hope that Indigenous leaders, program planners, and community members may find insights or confirm their knowledge and practices within the findings presented here.

Within health systems, insights contained here are relevant for funders, decision-makers, and front-line providers where Indigenous clientele may access resources and supports for the prevention and treatment of opioid misuse.

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No conflicts of interest to declare by any of the authors or affiliated organizations.

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Abstract

Opioid Crisis Knowledge Synthesis

Healing the Whole Human Being: Best Practices & Contextual Factors for Preventing and Treating Opioid Misuse in Indigenous Contexts in Alberta

WHAT IS THE ISSUE?

- Opioid dispensation rates are significantly higher for First Nations (FN) than non-FN Albertans
- Rates of opioid-related emergency department visits and hospitalizations, and apparent accidental opioid drug toxicity deaths are significantly higher for FN than non-FN people in Alberta
- The opioid crisis is more than an issue of physical addiction, but especially in Indigenous contexts a consequence of social disconnection & systemic harm
- Opioid misuse is one among several substances of misuse in Indigenous contexts, communities currently report equal concern for alcohol & crystal meth

WHAT WAS THE AIM OF THE STUDY?

1. Synthesize peer-reviewed literature on best practices and contextual factors for preventing and treating opioid misuse in Indigenous contexts
2. Build collaborative networks between Indigenous communities, health and other service providers, and decision-makers to contextualize & address knowledge gaps in Alberta

HOW WAS THE STUDY CONDUCTED?

A provincial knowledge-holders gathering was convened in May 2018, bringing together 28 Elders from primarily FN contexts in Treaty 6, Treaty 7, and Treaty 8 territories to contextualize community experiences of opioids and guide the literature review's. Knowledge holders directed analysis to identify mechanisms and outcomes of efforts to *heal the whole human being* within contexts affected by colonization.

A realist review of literatures based on a systematic search of key peer-reviewed sources internationally; the realist approach explored how healing the whole human being may play out in Indigenous contexts.

Five consensus-building gatherings in August and September further contextualized literature findings to the realities of Indigenous people and service providers in Alberta.

WHAT DID THE STUDY FIND?

- 276 peer-reviewed sources within Canada, the USA, Australia, and Aotearoa/NZ describe interventions for opioid misuse prevention or treatment either alone or in the context of broader substance use or holistic health programs.
- Upwards of 90 Indigenous community members and providers who work directly with these communities in Alberta highlighted how the healing process requires attention to related issues such as social disconnection, widespread trauma, life adversities, and unresolved or ongoing grief.
- Resource disparities and underfunding of service innovations to enhance transitions within and between health, criminal justice, education, and child welfare systems perpetuate ineffective treatment and a revolving door effect of existing treatment models.

Key Messages

- Colonization and resulting traumas directly impact addictions & mental health among Indigenous people, perpetuating stigma, misinformation & mistrust around accessing addictions services
- Improving coordination between all levels of healthcare (e.g., primary/tertiary) and service domains (e.g., residential treatment, incarceration to community & vice versa) is key to sustained treatment outcomes

Implications

- Opioids first entered Indigenous communities as prescription painkillers; medical, health, criminal justice, education, and child welfare systems have a responsibility to mitigate burden by identifying and preventing common pathways into prescription misuse
- Healing the whole human being requires community-oriented and accountable resources to break cycles of trauma

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Executive Summary

This knowledge synthesis focuses on understanding what makes interventions for the prevention or treatment of opioid dependency work in Indigenous contexts. Of particular interest are non-pharmacochemical wrap-around models, including programs integrated with an individual's everyday life (e.g., social programs, holistic or spiritual programs, counselling, therapy). Oriented to Indigenous contexts in Alberta, we ask:

1. What are best practices for prevention, treatment, and harm reduction-related to opioid misuse?
2. What are contextual factors that shape opioid misuse and community-based responses?
3. What wrap-around support models indicate promise for initiating and maintaining opioid use disorder patients?

Four key principles guide this work. These emerged from advice and guidance from Elders throughout Alberta, who gathered in May 2018 to launch this work. Aligned with legislation, principles, and findings from the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Truth and Reconciliation Commission of Canada (TRC), we affirm that:

1. **Colonization and its resulting traumas directly impact wellness** among Indigenous people, including addictions and mental health
2. **The opioid crisis is more than an issue of physical addiction,** but also one of social disconnection and systemic harm against certain people
3. **Health and other service providers have much to learn from Indigenous people** whose communities have extensive experience and wisdom with healing from addiction
4. Opioids are a relatively new drug that first entered Indigenous communities as prescription painkillers, meaning that **medical and health systems have a responsibility** in helping communities to heal from opioids.

Research methods

Activities and approaches included:

- A collaborative, consensus-building approach to ensure alignment with Indigenous principles of respect for and inclusion of diverse perspectives
- Systematic literature search and synthesis to identify evidence is relevant and generalizable for policy/decision-makers and healthcare/service providers
- Realist review methodology to contextualize knowledge generated largely from literature, focusing on intervention mechanisms that contribute to desired outcomes
- A knowledge contextualization process that centers community relevance of evidence as a decolonizing research strategy, involving a knowledge holders gathering (n=28 Elders) and five consensus-building gatherings (n=90) with representation from community members and across service sectors to provide insight into community-based supports for healing from opioid dependency.

Findings

Context of Opioid Misuse & Overdose Crisis

- Resource disparities and underfunding of prevention & transitions within/between systems perpetuate a revolving door of existing treatment models (e.g., detox without aftercare or transitional housing; ER stabilization with inconsistent primary care follow-up).
- Recognizing pathways into opioid misuse and dependency, as well as other substances of misuse, highlights opportunities to optimize transitions within and between systems.

Mechanisms for Healing the Whole Human Being

- Coordinated community and wrap-around supports for appropriate, accessible, and high-quality care.
- Interventions that focus on keeping individuals connected to family & community, restoring cultural knowledge, and healing from trauma.

Outcomes of Efforts to Heal the Whole Human Being

- Evaluation of intervention success varied, often measured by: retention in programs; urine samples to detect drug use; decline in suicides, criminal charges, child protection cases; increased school attendance
- Impacts of cultural resources & individual/spiritual growth beyond physical addiction were seldom tracked in existing studies.

Conclusion and Recommendations

1. Contextual factors shaping opioid misuse and community-based responses

- Patient and family mistrust in healthcare is common due to the colonial legacy of health systems
- A desire for cultural reconnection may prioritize abstinence-based approaches, but does not have to as communities have modeled bridging of harm reduction with cultural approaches
- Bridging of clinical and Indigenous knowledge around healing from addictions promotes mutual respect, collaboration, and community ownership in innovating models of care
- Community-based responses to the overdose crisis require cross-sector partnerships located within or in close-proximity to affected communities
- Engagement of leadership and community-based providers at the outset of interventions strengthens the impact
- The role of the health professions remains a significant systems driver of prescription drug misuse
- Pathways into substance misuse for Indigenous people are significantly shaped by gaps and inequities that persist in education, child welfare, and criminal justice systems

2. Best practices for prevention, treatment, and harm reduction in Indigenous contexts

- Prioritize community-based access to appropriate therapies/treatment to heal from substance misuse and multi-generational trauma
- Broaden investments in prevention prior to crisis onset (e.g., promote social connectedness, reconnection to land, peer outreach, interrupting childhood adversities)
- Enhance primary health care capacity for alternative pain management, appropriate pain diagnosis, and rehabilitation services (e.g., provider training; telehealth care for specialist access/diagnoses)
- Expand health professional education in anti-racism related to Indigenous health and healthcare
- Grow multi-sector collaborations to address systems pathways into substance misuse

3. Wrap-around support models indicating promise for Indigenous opioid-dependent patients

- Cohort/peer-based approaches to in-patient, detox, and recovery services
- Flexible and integrated access to traditional, medical, and social supports for care
- Accessible and safe housing that is responsive to and supportive of patient, peer group, and family needs (e.g., for withdrawal, aftercare following discharge from rehabilitation)
- The cross-sector interchange of knowledge around harm reduction within a community (e.g., health, education, policing, social services, leadership) promotes the application of new and adapted approaches.

List of Acronyms

AFNIGC	Alberta First Nations Information Governance Centre
FNIHB	First Nations and Inuit Health Branch
OCAP	First Nations' Ownership, Control, Access and Possession principles
OAT	Opioid Agonist Therapy (e.g., methadone, buprenorphine/naloxone, Suboxone®)
OUD	Opioid Use Disorder
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta Analyses
SDoH	Social Determinants of Health
SUD	Substance Use Disorder
TRC	Truth and Reconciliation Commission of Canada
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples

Introduction

What follows is a knowledge synthesis of best practices and contextual factors for enhancing the prevention and treatment of opioid misuse in Indigenous contexts in Alberta. The work was completed in partnership between University of Calgary researchers and the Alberta First Nations Governance Centre (AFNIGC). All affirm that First Nations (FN) research initiatives align with Indigenous ethical protocols, including FN Ownership, Control, Access and Possession (OCAP®) principles. In the Spring of 2018, our team of university and First Nations researchers initiated this work by convening 28 traditional knowledge holders from throughout Alberta to guide us. We gathered for two days at the Banff Centre in Alberta to discuss experiences of wellness and drug use in communities, with particular interest in an overdose crisis connected to opioids.

Common threads of knowledge held by Indigenous Peoples about health and wellbeing include the circle, inherent connections to land, ceremony, and cultures of each distinct group. While vast and diverse across cultures, teaching such as from the Medicine Wheel on the plains are shared across many Indigenous nations (Lavallee & Poole, 2010). The shared teachings reflect that everything is connected and bring together a balance between the interconnected physical, mental, emotional, and spiritual realms for holistically attaining health (Graham & Martin, 2016). Within this understanding, contextual factors that influence health include self-determination, social exclusion, racism, and colonialism; wellness requires culturally appropriate means to reduce inequities caused by these factors (Greenwood, de Leeuw, Lindsay, & Reading, 2015). Following centuries of healthy traditions, the "soul wound" of colonization now persists across generations, necessitating approaches to healing that draw on cultural resilience (Duran, Duran, Brave Heart M, & Yellow Horse-Davis, 1998). Based on discussions from a wide range of First Nations communities across Canada, the First Nations Mental Wellness Continuum notes that culturally appropriate healing includes connections to land, ceremony, and culture (Health Canada, 2015). Connection to an individual's unique culture is foundational to achieving hope, belonging, meaning and purpose, outcomes that promote wellness and healing from substance use issues (Health Canada, 2015). These common threads of knowledge and wellness support a concept of ***healing the whole human being*** presented in this work.

Providing one description of ***healing the whole human being***, we begin here with a concept shared by Blackfoot Elders at our knowledge holders meeting as key to contextualizing addiction in their communities today: kimaa'pii'pitsin. In doing so, we aim to offer a window into how traditional knowledge systems encounter people who struggle with opioids and other substances of misuse. This concept is not meant to eclipse the cultural and geographic diversity of First Nations, Métis, and other Indigenous peoples residing in Alberta, or the specific knowledge systems that guide each. Rather, we draw on the Blackfoot language here as a reminder of the expertise that Indigenous people have about themselves and their worlds.

Kimaa'pii'pitsin

Kimaa'pii'pitsin is a Blackfoot conception of compassion that involves a psychological and spiritual approach to the world in which an individual operates with kindness, consideration, and love for all of creation. It is not limited to compassion for another person or circumstance alone but involves a total embodiment of one's being. This embodiment includes a connection to the land and life-giving forces all around, as well as accountability to ancestors and future generations.

Kimaa'pii'pitsin guides the work here to address how the current opioid and overdose crisis affects Indigenous people, focusing on the prevention and treatment of opioid dependency on ***healing the whole human being***. The concept derives from a people and culture that have thrived for thousands of years in the Northwestern plains of Turtle Island. In this region of what is today North America, strength and survival have long depended on unity and spiritual connection between all living things. In pre-colonial times, for peoples of the Blackfoot Confederacy for whom the concept is important, connection to the land and life-giving forces involved communal practices for hunting, as well as proficient arrangements for the processing and distribution of resources. Traditional societies and clan systems organized age and gender groups to fulfill different responsibilities for the greater common good (e.g., learning, nurturing, policing). Together, these ensured a sustainable order with which to withstand natural adversities. This order reached well beyond economic and social organization, as the knowledge accumulated and transmitted within such systems could promote a place and purpose for each individual—nested within families, wider communities, and Nations—throughout the life course.

Colonial Roots of the Overdose Crisis

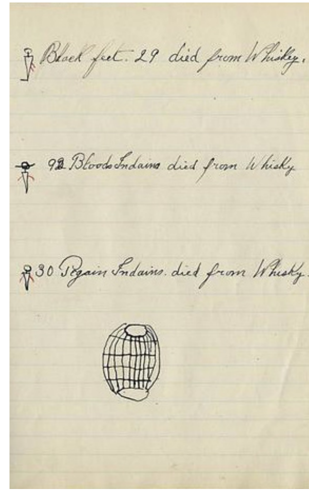
Colonization has historical and ongoing effects on substance use in Indigenous communities. Throughout the 19th century, whiskey traders followed Indigenous camps in Southern Alberta to persuade members to trade buffalo hides for alcohol laced with gunpowder. A Blackfoot winter count of that era indicates multiple years with dozens of deaths within the Piikani Nation arising from increased trade with outsiders. Whiskey, along with other early and ongoing colonial policies and practices, resulted in widespread trauma, social disconnection, and loss in communities.

Bull Plume's winter count, Item, Glenbow Archives, GLEN glen-145-iw-glen-22

By the time of the signing of Treaty 6 (1876), Treaty 7 (1877), and Treaty 8 (1899), First Nations had endured repeated and devastating assaults on their existence. In the southern reaches of the province, Niitsitapi (Blackfoot of Siksika, Kainai, and Piikani), Îyârhe Nakoda (Stoney Nakoda), and Tsuut'ina Nations had experienced waves of infectious diseases that killed as many as 80-90% of communities in the region, sometimes wiping out whole camps (D. Thompson, 1968). Similar assaults occurred against Néhiyaw (Cree), Nakoda, and Dene peoples in what would become Treaty 6 and Treaty 8 territories in Alberta's central and northern reaches.

The treaties promised land and resource-sharing between First Nations and the British Crown, later the Canadian government, including annual payments and provisions for members of Nations entering into the agreements,

as well as protection of traditional hunting and trapping rights. First Nations leaders who signed those treaties did not anticipate that their people would effectively become prisoners on reservation lands for decades, with their mobility severely curtailed until the 1960s by government-appointed 'Indian Agents' who administered all aspects of local affairs on reservation lands. For decades, those living on reserve lands were disenfranchised and unable to engage in commerce, electoral processes, higher education, or traditional spirituality without the sanction of government agents. Some forfeited access to community resources and recognition of their Indigenous status by the Canadian state when they sought higher education, joined the military, or moved to urban centres. For nearly a century, Indigenous children were also forced from an early age into residential schools, described by the Truth and Reconciliation Commission of Canada (TRC, 2015a)(TRC, 2015a) as sites of 'cultural genocide,' which aimed to destroy First Peoples' political and social institutions.



Bull Plume's winter count, Item, Glenbow Archives, GLEN glen-145-iw-glen-22

Indigenous people falling outside of the Treaty agreements faced colonial harm as well, with Métis settlements rising up throughout the prairies in the 1880s. The Métis people trace descent to First Peoples and early European settlers in the region as part of the eighteenth and nineteenth-century fur trade. Over several generations, they developed unique cultural communities; excluded from Treaties, the Métis people were significantly displaced when what is today Western Canada was opened up for railways and agricultural settlement, with their children also sent to residential schools. Though this report focuses primarily on First Nation experiences, we acknowledge that similar processes have disrupted Métis communities as well.

It is not an understatement to note that the traditional organization and knowledge systems of Indigenous peoples in Alberta have endured several generations of persistent attacks by colonial forces. Today, Indigenous knowledge holders and leaders identify current crises of substance use within their communities as a result of historical alienation and ongoing trauma resulting from colonialism. Therefore, the opioids and overdose crisis are experienced as an enduring legacy of colonization.

Profile of the Overdose Crisis in Indigenous Context in Alberta

Today, a range of substances disrupt community cohesion and the capacity to heal from multigenerational trauma arising from colonization. Our focus here on opioids is not because these are the most common in communities, like alcohol and stimulants (e.g., methamphetamine) are also disruptive and dangerous to health; opioids are just the most immediately lethal. In high doses, opioids slow breathing, making it shallow to the point that a person can overdose (e.g., be unresponsive, require emergency medical assistance) and die. They can also be mixed into other substances, meaning that drugs bought from unknown or unregulated sources may unknowingly contain opioids, increasing the risk for overdose and death among people who may not even know they are consuming one.

Limited evidence exists for how this crisis plays out in Indigenous contexts, but the increased burden for First Nations and Métis populations is evident in what data does exist. For instance, while Indigenous peoples represent 6.5% of the Alberta population, 18% of people who died from opioid poisoning in Alberta in 2017 were Indigenous (69% of these First Nations; 27% Métis; 10% unspecified) (Alberta Health, 2019). Between January 2016 and March 2017, the rates of apparent accidental opioid drug toxicity deaths were three times higher for First Nations people than Non-First Nations People in Alberta. In Canada, those who most frequently die from opioid overdoses are male, between 30-39 years in of age, and use other non-opioid substances (Belzak & Halverson, 2018); by contrast, First Nations males and females have similar risks of death from overdoses, indicating unique factors driving overdoses within Indigenous contexts. Opioid dispensation, opioid-related emergency department visits, and associated hospitalizations in Alberta are significantly higher for First Nations people than among the non-FN population (AFNIGC & Alberta Goverenment, 2017, 2019; Alberta Government & AFNIGC, 2016b, 2016a).

- In October 2017, this overdose crisis was declared a public health emergency in the United States based on urgency for collective action (Haffajee & Frank, 2018)
- Across all populations, since 2016 more than 14,700 people have died in Canada due to an opioid overdose, with nearly 20,000 opioid-related hospitalizations (Special Advisory Committee on the Epidemic of Opioid Overdoses, 2020)
- In Canada, illegal and prescription opioids drive the crisis, which has been most concentrated in British Columbia, Alberta, the Yukon and Northwest Territories (Belzak & Halverson, 2018)

Understanding the burden of opioid misuse and dependency among Indigenous communities is complicated by the task of identifying not only physiological, but also social, material, and political pathways to health inequities. For primary health care providers working mainly with medically under-served and stigmatized populations, supports to mobilize appropriate care plans for patients with complex social determinants of health are limited (Metzl & Hansen, 2014). In addition, high levels of opioid prescribing for pain management, inequitable access to safe and appropriate healthcare, and prevalence of adverse opioid-related events among Indigenous people establish a strong rationale for strengthening community capacity to guide models of care to reduce harms. In June 2017, an Alberta Indigenous Opioids Advisory Sub-Committee defined recommendations for growing a research and policy agenda in this area (see Appendix A).

Healing the Whole Human Being

In the Spring of 2018, our team of university and community-based researchers initiated this project by convening 28 traditional knowledge holders from throughout Alberta to guide the work, which began with a pipe ceremony led by Kainai Elders Roger Prairie Chicken and joined with a pipe kept by Îyârhe Nakoda Elder Jackson Wesley. We gathered for two days at the Banff Centre in Alberta to discuss experiences of wellness and the opioid crisis in their communities (see Appendix B: Witness Statement). Knowledge holders highlighted that the rupture of traditional systems by colonial forces is the key context driving all health disparities affecting Indigenous peoples today.

Colonization has exposed Indigenous peoples to previously unfamiliar addictive substances, including prescription opioids by the medical community. Colonial policies have diminished social networks and cultural resources capable of protecting Indigenous peoples, while also perpetuating inaction on the part of settler society—through ignorance, stigma, and indifference—to address root causes of repeated health crises. In light of these forces, the Elders advised us to orient our work to healing the whole human being, and not just to treating a physical body disconnected from place or community. Their advisement and guidance set us on the path for this knowledge synthesis of best practices and contextual factors for healing the whole human being, which we explore here in the international literature about preventing and treating opioid dependency in Indigenous contexts.

Keywords

OPIOIDS

Opioids are a class of substances commonly used in medicine for pain relief. “Opiate” is a term sometimes used synonymously and refers to drugs derived from the opium poppy (e.g., morphine). By contrast, “opioids” are synthetic or semi-synthetic, which means they are in some way manufactured. “Narcotics” is another term often used; this refers to drugs that cause sleepiness or numbness, which opioids do, and is often used in reference to legally controlled substances.

With the growth of pain research in recent decades, opioids have become common in medical practice and among people who use drugs. Opioids are known by dozens of medical names (e.g., hydromorphone, hydrocodone, oxycodone, tramadol, buprenorphine) and street names (e.g., Oxy 80s). Another common group of opioids have been developed to help reduce the lethal effects of physical dependence that can develop; opioid agonists (i.e., methadone; buprenorphine/naloxone, also known as Suboxone®) and slow release oral morphine have been used for several decades around the world to reduce the harm of opioid dependence.

OPIOID MISUSE & DEPENDENCE

As a highly addictive substance, anyone who uses an opioid may become dependent. This means that people having never used illicit drugs or who have no experience with addiction may develop a dependence, even if their initial exposure was through a prescription for pain relief. Exposure to violence, toxic stress, and trauma, including intergenerational trauma, has been shown to increase the risk for a wide variety of poor health outcomes, including substance misuse disorders (Blanch, Shern, & Steverman, 2016). Research suggests that the emotional numbness triggered by opioids may increase the risk of opioid use disorder (OUD) for people who have been exposed to significant trauma (Fareed et al., 2013).

In the body, a first exposure often involves good feelings, as opioids increase the release of endorphins in the brain, a hormone that can produce pleasure while reducing the perception of pain[1]. Over time and repeated use of opioids, the body’s production of endorphins slows down, meaning that good feelings associated with opioids eventually stop. As the body becomes more tolerant to opioids, a person might increase the amount they take in order to keep having the same good feelings. Misuse happens when someone consumes opioids against prescription guidelines (e.g., increasing one’s dose, accessing the drug from unregulated sources) and is a common risk factor for addiction, which is experienced as a powerful, even out-of-control or compulsive craving. The terms substance use disorder (SUD) or opioid use disorder (OUD) are often used in place of terms like addiction, to be specific and avoid potentially stigmatizing language.

[1] *https://www.mayoclinic.org/diseases-conditions/prescription-drug-abuse/in-depth/how-opioid-addiction-occurs/art-20360372*

OPIOID AGONIST THERAPY (OAT)

Opioid agonist therapy (OAT) is a treatment for addiction to opioids that involves taking opioid agonists (i.e., methadone; buprenorphine/naloxone, also known as Suboxone®) and/or slow-release oral morphine. OAT prevents withdrawal and helps eliminate cravings without causing a person to feel high. For people who are addicted to opioid drugs, taking OAT can help to reduce harms related to drug use. A person who is stabilized on OAT should be able to focus on their health and wellbeing beyond this medication.

THE OVERDOSE CRISIS

Some people who develop opioid addiction struggle hard to reduce their use of opioids on their own, which can increase willingness to consume forms of the drug obtained illicitly (i.e., on the street, via non-medical sources) and in more risky ways (e.g., injecting its liquid directly into the bloodstream instead of swallowing it in pill form, which can slow absorption through digestion). When opioids are secured illicitly, their potency and purity are not guaranteed, often leading to overdoses when unpredictable concentrations of powerful opioids are mixed into non-opioid drugs. Additionally, when illicit opioids are injected, usually to experience a quicker effect, the use of unsterilized needles may increase the spread of blood-borne illnesses like Hepatitis C and HIV (Secretariat of the Safe Injection Global Network, 2000). This further undermines one's own health and others health who come into contact with supplies that are not safely disposed. Other harms that can come from uncontrolled opioid use come by way of the risks that a person may be willing to take in order to satisfy an out-of-control craving. In the past decade, growing numbers of overdoses and deaths caused by opioids have created a public health emergency, sometimes referred to as the overdose crisis in Alberta. These overdoses and deaths are partly linked to prescription opioids, but also to an increasingly toxic supply of illicit drugs (e.g., fentanyl) that are as much as "50-100 times more potent than morphine" [2].

COLONIZATION AS A DETERMINANT OF HEALTH

The World Health Organization characterizes social determinants of health (SDoH) as the main cause of health inequities, these being unfair or avoidable disparities in the health status of whole populations. SDoH are "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" [3]. Conventionally, in order to demonstrate the strong association between social factors and health status, SDoH research has focused on environmental factors such as social exclusion (e.g., poverty, gender), socioeconomic status (e.g., education, unemployment), and infrastructure (e.g., sanitation, housing, service availability). In recent decades, much like the Elders guiding this study, Indigenous health scholars and practitioners have emphasized the role of colonization as a significant determinant of health (Czyzewski, 2011; Greenwood et al., 2015). Colonization refers to the traumatic relationships between Indigenous Peoples in Canada and the Canadian government both historically and through inequitable policies and treatment today. Colonization is considered a broad or "distal" (as in distant from the individual, but no less important) determinant of health because it works at multiple social and systems levels—restricting, for instance, funding for on-reserve education, housing, sanitation, and social services (Blackstock, 2011). The effect of these forces is to render very diverse First Peoples located in widely different contexts more susceptible to illness.

[2] https://www.canada.ca/en/health-canada/services/substance-use/problematic-prescription-drug-use/opioids/federal-actions.html
[3] http://www.who.int/social_determinants/sdh_definition/en/

For addictions, a SDoH lens is essential, particularly one that centers colonization as the pre-eminent driver of illness and disease among Indigenous peoples. Understanding behavioural and mental health requires a bio-psycho-social model to explain illness, and this should be sophisticated enough to recognize the interplay between environment, life experiences, and genetic factors (Canadian Foundation for Healthcare Improvement, 2012). Arguably, any understanding must also account for how cultural resources and Indigenous knowledge are enmeshed with these. A SDoH lens invites attention here to how the colonial legacy of healthcare—an institution that extends from the Canadian state itself—undermines the accessibility, safety, and effectiveness of appropriate models of care.

COMMUNITY RUPTURE

This term is applied frequently throughout this document, primarily to describe the forceful severing of Indigenous people from their cultures, communities, and families by colonial policies and practices. We use it to highlight a sense of disturbance produced in Indigenous communities by colonial forces, signalling breaking, bursting, or breaching of harmonious relationships. We have also opted to use this term instead of limiting the focus to trauma and loss alone in order to direct attention to systems that harm. Importantly, the term highlights that despite the colonial disruption of community cohesiveness—and the losses that this entails—many communities resist disruption, retaining and reclaiming connections and knowledge key to their wellness.

TRUTH, RECONCILIATION, AND THE UN DECLARATION

The 2015 Truth and Reconciliation Commission (TRC) of Canada's final report argues for the need to recognize and address the adverse and multigenerational impacts of residential schools on Indigenous peoples in Canada (TRC, 2015a, 2015b). Calling for reconciliation, the report was supplemented with 94 Calls to Action to redress the impacts of residential schools (Calls 18-24 pertain to the health legacy of that system) (TRC, 2015b). In response to these calls, this report details the impacts of previous government policies aimed at producing social disconnection. Specifically, it is an effort to address Call to Action 18, which emphasizes the need: "to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties". This report details the impacts of previous Canadian government policies aimed at social disconnection and highlights the relationships between substance misuse and these policies arising from colonization. As well, this report aligns with the United Nations Declaration on the Rights of Indigenous Peoples' (UNDRIP) resolutions that Indigenous Peoples have the rights to enjoy "the highest attainable standard of physical and mental health" (p. 9) and to be actively involved in the development of health programs that affect them (UN General Assembly, 2008).

Methods

The research team collaborated to gather, synthesize, analyze, and share findings. The University of Calgary's Conjoint Health Research Ethics Board approved components involving research with human participants (#REB18-052). The AFNIGC ensured alignment with Indigenous ethical protocols, such as around OCAP® principles relating to the Ownership, Control, Access, and Possession of First Nations data. Activities focused on two broad areas: conducting an international literature search of prevention and treatment of opioid dependency in Indigenous contexts, and a knowledge-contextualization process to Alberta realities.

The team determined that a realist review guided by community partners was most appropriate, since this approach centers community contexts in which knowledge may be used over academic standards alone for assessing health evidence. Realist reviews are increasingly relevant in cases where positivist approaches have led to an overreliance on empirical evidence without considering contextual factors and assumptions, risking inadequate understanding of underlying theory (Smylie et al., 2016). In this case, an abundance of research documents the opioid crisis, however, reviews of this research often do not adequately reveal how complex social determinants influence health outcomes, what interventions should include and how to best address health outcomes (Kirst & O'Campo, 2011). A realist review allows for a synthesis of findings from quantitative and qualitative research to identify how and why certain interventions are successful (see (Pawson, 2005) for a detailed description of realist methodology). As such, approaching the knowledge synthesis with a realist review methodology allowed for a review of literature sources that may not conform to conventional medical standards for evidence rigour (e.g., randomized control trials). Beginning with an Elder gathering to guide the literature search and holding consensus-building gatherings following the literature search allowed us to contextualize evidence to Alberta communities systematically. After conducting the literature search, consensus-building gatherings allowed us to contextualize the evidence during our analysis to Alberta contexts systematically.

Elder Gathering

A two-day provincial knowledge holder gathering including primarily Elders was convened in May 2018 to initiate the opioid knowledge synthesis. Directed by the AFNIGC and guided by OCAP Principles, knowledge holders were invited from all 48 First Nations in Alberta to participate in Talking Circles. The gathering was attended by 28 Elders providing perspectives from: (1) the three main treaty regions in the province (6, 7, 8); (2) Cree, Metis, Blackfoot, Dene, and Stoney Nakoda groups; and (3) urban Indigenous people who may originate from other regions. Others present included researchers from the University of Calgary and the University of Alberta, representatives from the Indigenous Services Canada's First Nations and Inuit Health Branch (FNIHB) leadership, and the Alberta Health Services Strategic Clinical Networks leadership, including the Emergency Strategic Clinical Network and Population, Public and Indigenous Health Strategic Clinical Network, however their perspectives are not included in this report (see Appendix B for witness statement) as the gathering was held to ensure the broader research project was guided by community leadership and integrative of cultural wisdom.

Two questions were posed for consideration in the Talking Circles:

1. What is your community's experience of opioids?
2. What practices indicate promise for addressing opioid misuse in Indigenous contexts?

Systematic Literature Search and Synthesis

Book-ended by the Elder gathering and consensus-building meetings, our literature search focused on the following questions:

1. What are best practices for prevention, treatment, and harm reduction-related to opioid dependency in Indigenous contexts?
2. What are contextual factors framing opioid dependency and Indigenous community-based responses in Alberta?
3. What non-pharmacological wrap-around support models indicate promise for initiating and maintaining opioid-dependent patients in Indigenous contexts?

Research team members searched 13 electronic health and social sciences databases in June 2018 to locate peer-reviewed articles that included concepts related both to Indigenous people internationally and to opioid use and harm reduction (see Table 1).

Table 1. Search Strategy

DATABASES	SEARCH TERMS	
	CONCEPTS RELATING TO INDIGENOUS PEOPLE INTERNATIONALLY	CONCEPTS RELATING TO OPIOID USE AND HARM REDUCTION
Medline, EMBASE, Scopus, Cochrane Central Register of Controlled Trials, PubMed, PsycINFO, iPortal (Indigenous Studies Portal), CINAHL Plus, Bibliography of Native North Americans, SocIndex, Web of Science, Healthstar, and Academic Search Complete	Indigenous, First Nations, Aboriginal, American Indian, Metis, Inuit, Pacific Islander, Aborigine, Polynesian, Alaska Native, Oceanic Ancestry Group, American Native Continental Ancestry Group, Native, Samoan and/or Tribe	opioids, opiates, fentanyl, street drugs, substance abuse, treatment, prevention, wrap-around supports, harm reduction, harm minimization, models of care, naloxone and/or suboxone

The team identified 27 articles. A PRISMA (Preferred Reporting Items for Systematic Reviews and Meta Analyses) diagram outlines the inclusion and exclusion process of the peer-reviewed records (See Appendix C for detailed flow chart of search strategies, inclusion, screening, and extraction). Adhering to the guiding principles, articles were screened to ensure that only those that maintained a non-oppressive, affirming voice were included. Additional considerations focused on whether the article contained sufficient detail to conduct a realist review (see Text Box 1 for full inclusion criteria).

Text box 1. Inclusion criteria

1. Describes an intervention for opioid misuse, prevention or treatment, or includes information on treating opioid misuse in the broader context of substance abuse or holistic health programs
2. Includes information on elements of intervention success, either through qualitative methods or through quantitative methods with sufficient in-depth description of the intervention combined with quantitative methods
3. Focuses exclusively on Indigenous populations
4. Maintains a non-oppressive, affirming voice
5. Research article (excludes commentaries)
6. Focuses on Indigenous communities in countries with similar healthcare systems and settler-colonial histories framing health inequities (Canada, USA, Australia, New Zealand)
7. English
8. Full text available

Three researchers reviewed 27 studies to ensure relevance to the study. The researchers discussed findings and resolved discrepancies until all were comfortable that each of the 27 studies met all inclusion criteria. At this point, the full text of each article was reviewed for information relevant to the study, including contextual factors driving opioid misuse, program descriptions, and evidence and conclusions relevant to healing in Indigenous communities.

Results

Guided by a realist review methodology, findings from these activities are structured here to describe the **context** of opioid dependency in Indigenous contexts in Alberta and internationally, the **mechanisms** at play to heal the whole human being within these, and the **outcomes** of Indigenous-focused approaches. The context section derives primarily from the Elder gathering and consensus-building meetings with supporting evidence from the literature, whereas the mechanism and outcomes sections focus on findings from the literature review.

Context

Findings from the Elder gathering that informed the literature review methods are presented here. Elders shared stories of loss, resilience, and healing through community and culture. Stories shared of community support, love and reconnection were considered central to healing. Lessons from the talking circles held at this gathering revealed guiding principles for policymakers, healthcare, and other service providers working on the overdose crisis in Indigenous communities, namely that:

1. **Colonization and its resulting traumas directly impact wellness** among Indigenous people, including addictions and mental health
2. **The opioid crisis is more than an issue of physical addiction**, but also one of social disconnection and systemic harm against certain people
3. **Health and other service providers have much to learn from Indigenous people** whose communities have extensive experience and wisdom with healing from addiction
4. Opioids are a relatively new drug that first entered Indigenous communities as prescription painkillers, meaning that **medical and health systems have a *responsibility*** in helping communities to heal from opioids

Additionally, across the Elder gathering, literature, and consensus-building meetings, we identified three areas that contextualize substance use in Indigenous contexts: a) Colonization and Trauma; b) Systems and Services; and c) Community Centrality.

A. COLONIZATION AND TRAUMA

Trauma (Kilpatrick et al., 2000) and social disconnection (Heilig, Epstein, Nader, & Shaham, 2016) are known drivers of substance misuse and addiction. Elders highlighted that unresolved grief from colonization and oppression influences mental health even when a person may not have direct personal experiences of such adversities. Scholars note that the effects of intergenerational trauma may be transmitted socially, via, for instance, learned behaviours, the loss of parenting strategies, or coping mechanisms (S. Thompson, Kopperud, & Mehl-Madrona, 2010). In this context, substance use emerges as one symptom of disruption in the social, cultural, political, material, and spiritual order of Indigenous societies (N. Gray, 1998; Marquina-Márquez, Virchez, & Ruiz-Callado, 2016; Rieckmann et al., 2012; Yang et al., 2011). Chronic health problems are known to emerge with greater frequency from persistently stressful environments, in which people enduring breakdown of family and community ties often live (Adelson, 2005; Blanch et al., 2016; Greenwood et al., 2015; King, Smith, & Gracey, 2009).

B. SYSTEMS & SERVICES

The ongoing legacy of colonization through existing systems and services has resulted in an overdose crisis in Indigenous communities today. The experiences of our Elder and consensus-building participants (aka "advisors") illuminated that the overdose crisis for Indigenous people in Alberta is the result of systems-based drivers and is perpetuated by gaps and barriers in health systems and services.

As advisors recounted experiences to us, four pathways to substance misuse became clear via: 1) education systems, 2) child welfare systems, 3) the criminal justice system, and 4) health systems.

1. ***Education Systems Pathway:*** Advisors frequently discussed the residential school system, with community members describing Indian agents during much of the early and mid-twentieth century taking children away from their families and being forced to speak English from a young age, leading to significant social and cultural losses. Residential school syndrome is a suggested mental illness in the literature, in which individuals who were in residential schools or who are closely related to someone who attended a residential school experience symptomology similar to post-traumatic stress disorder (Brasfield, 2001; Chansonneuve, 2007; Partridge, 2010). To deal with the stress, individuals with residential school syndrome may use drugs or alcohol as a coping mechanism to chaos and persistent adversities in their lives (Brasfield, 2001; Chansonneuve, 2007; Partridge, 2010). The advisors' experiences showed that the unresolved grief from this trauma is compacted today by western educational approaches such as pass/fail and grading systems that damage self-confidence, increase self-doubt and lead to poor school attendance. In turn, this was seen to lower school completion rates and reduce employment opportunities that might allow a person to feel a place and purpose in the world. One youth advisor described being prescribed stimulants for attention or behavioral issues, relating that this early exposure to prescription medication affected his own psychological and social adjustment, and sense of comfort in schools.

2. ***Child Welfare Systems Pathway:*** Advisors described a direct link between losing their children to child welfare systems and using substances to cope with the pain from this loss. Further, removing children from families and wider communities was described as a force that perpetuates the loss of Indigenous languages and ruptures in community ties. Several consensus-building meetings described First Nations that knew of youth apprehended by child welfare systems, but whom community members were barred from locating or reconnecting with. Not only are Indigenous children two times more likely to be placed in foster care than non-Indigenous children, but they also experience greater adversities within that system, such as in disproportionate victimization identified in rates of homicide, suicide, and accidental deaths within child welfare in Alberta (Kleiss, 2014). When children age out these systems, some find it difficult to return to home communities (Navia, Henderson, & First Charger, 2018). As social connections are key protective factors for wellness, rupture of community ties by this system can perpetuate isolation and increase vulnerability later in life.

3. ***Criminal Justice System Pathway:*** Today, the justice system sees a disproportionate representation of Indigenous people in courts and prisons, particularly for youth (Statistics Canada [Internet], 2018), suggesting systemic racism. Advisors widely reported racial profiling and bias on this work, as well as excessive force for minor offences (e.g., serving jail time for inability to pay traffic fines). Advisors explained that fear of mistreatment within prison led some to their first prescription of anti-anxiety medications; when released early for good behavior, one described not having adequate medical support to taper from this new dependency, which lead him to instead turn to an illicit supply of opioids to calm nerves on release. Advisors also emphasized that despite their attempts to engage the justice system to protect Indigenous populations from drugs and illicit dealers, the justice system demonstrated a lack of concern.

4. ***Health Systems Pathway:*** Opioids first entered Indigenous communities as prescription painkillers. An additional pathway to misuse outlined by our advisors emerged in descriptions of healthcare relationships. Advisors described their relationships with physicians as often difficult, physicians and dentists were overprescribing opioids for pain. Patient-provider relationships displayed neglect with regards to providing sufficient information on alternative pain management or risk information such as the addictive potential of the prescribed drugs, as well other health risks. Alternatives for chronic pain management were not well understood, though advisors felt more could be done to help their communities identify nutritional changes, physiotherapy or rehabilitation care, or exercise that could help. Advisors also reported feeling that healthcare providers unfairly judged alternatives for pain management they might access among traditional medicines, leaving many disinclined to share these possibilities with their providers. Further, given federal drug insurance coverage for First Nations people, some felt that the system is biased towards pharmacological options for pain management, such as opioids, rather than non-pharmacological options that patients may not otherwise be able to afford. Advisors expressed concern about the selling of First Nations prescription dispensation data to pharmaceutical companies, which was suspected of increasing the marketing of opioids to physicians providing care to Indigenous people. Finally, the federal insurance coverage of opioids above other pain management options was feared to fuel the diversion of prescription medications within First Nations, particularly, where people living in poverty may sell prescription opioids for profit.

Other systems-based issues raised by the advisors focused on systemic gaps, for instance in transitions between primary and tertiary care in the health system. Advisors identified a lack of healing spaces for Indigenous people, both in hospitals and on reserves. Underfunding and a lack of beds for patients with opioid dependency specifically was seen to result in patients seeking care for their substance use disorder being turned away from hospitals.

Gaps were also noted in wrap-around services. Some concerns highlighted the need for men to also benefit from services that conventionally focus on helping Indigenous women and children heal from trauma. Though noting the importance of existing services, advisors were concerned about the lack of transitions in care for those coming out of detox and rehabilitation services or incarceration. Research on individuals who are incarcerated while receiving opioid agonist therapies to treat their use disorder shows that, in the US, individuals are often forced to abruptly discontinue their treatment as they move within a system, causing discomfort and reducing the likelihood that individuals will return to this important care once released (Rich et al., 2015). Individuals may experience high rates of relapse and overdose without an accessible follow-up system in place after detox or rehabilitation. Advisors frequently identified this lack of 'aftercare' or supportive transitional housing as a reason why those desiring to heal often return to substance use.

Additional Service Barriers

Everyday experiences of racism, discrimination, and anti-Indigenous bias also undermined healing. Some advisors described family members who disappeared from hospitals or were given treatment and labeled as 'John Doe' without any attempts by the hospital to find out the patient's name or engage support systems. This was felt to perpetuate social disconnection that often drives substance use in the first place, as well as fear and anxiety for Indigenous patients with limited support networks outside of their home communities. Several advisors described having been turned away from hospitals, sometimes due to underfunding and a lack of beds for opioid misuse specifically (where detox services were seen to more consistently target alcohol use). Some also attributed this to doctors being unwilling or unable to treat complex healthcare needs. This stirred a lack of trust among our advisors in physicians and hospitals and was acutely experienced in emergency department bias.

Pregnant and postpartum women faced particularly adverse barriers to addressing opioid misuse and addiction. They expressed difficulty accessing treatments like opioid agonist therapies due to lack of childcare, increased stigma, risk of child welfare apprehensions of their children or refusal to return children, and pressure to detox before medically-advised, which is contrary to evidence that opioid agonist therapy is appropriate for pregnant and breastfeeding women (Saia et al., 2016).

C. COMMUNITY CENTRALITY

Community was described as central for healing through culture, ceremony, and bringing families together. Advisors described past experiences overcoming substance misuse, with healing rooted in culture and community. Even for those who grew up disconnected from their traditional cultures, some felt that reconnecting and participating in traditional activities was a crucial part of their healing. Finding a purpose within the community was described as an important motivator, such as for pregnant women driven to healing through inspiration to recover custody of their children currently in child welfare systems. Within these experiences, advisors described key moments when community members reached out to them to provide support. Finding a sense of belonging was highlighted as fundamental, and advisors advocated for healing centres to support this. Advisors explained that when individuals must overcome adverse life experiences without healing centres in the community, they often grieve alone, where isolation puts them at greater risk for substance use.

Trauma and the social disconnection policies, including residential schools and the Sixties Scoop create barriers to the healing opportunities offered by communities (Navia et al., 2018). Advisors reported a lack of connection between generations, contributing to cultural and community disconnection, resulting in a the loss of a sense of purpose for youth but also in housing insecurity and poverty for many individuals. In some cases, hoping to reduce stress on their family, an individual who is struggling with substance use may leave their home entirely to avoid exposure to negative influences or negatively influencing others also struggling with substance use. In the case of intergenerational disconnection, shame was described as especially difficult. Individuals who feel shame about their substance use were reported as avoiding asking for help and feeling particularly hesitant to approach Elders to reconnect culturally. At the same time, families were identified as important units to support, as many families described struggling with helping individuals without enabling further substance use. This struggle is rooted in part in some advisors' experience and extensive knowledge about abstinence-based approaches to healing from substance use, an experience that they described arising following the lifting of prohibition in First Nations in the 1960s.

While many advisors agreed that opioid agonist therapies (OAT) are the best practice for healing from opioid use disorder, many felt that this alone is not sufficient. They argued that systems could support community-based healing through investment in communities rather than individuals alone, particularly support for healing spaces on reserves and in areas of urban centres where Indigenous people often live. The discussions on healing from trauma, systems and service-based drivers, gaps and barriers to care, and the community centrality indicated a need for broader systems of care for opioid misuse, beyond simply bringing more opioid agonist therapies to Indigenous communities.

Mechanism

Here we outline how Indigenous-focused approaches to addressing the overdose crisis work to heal the whole human being. This highlights the importance of collaborative community and wrap-around supports, in addition to appropriate and accessible medical care. Healing the whole human being is therefore evident in programs focused on keeping individuals connected to family and community, restoring cultural knowledge and healing from trauma. In the context outlined above, this mechanism includes addressing the colonial legacy of healthcare, centering community in the face of divisive child welfare and criminal justice systems, and restoring hope, belonging, meaning, and purpose.

A. COLONIAL LEGACY OF HEALTH—SPECIFIC POPULATION NEEDS

Healing the whole human being must consider the colonial legacy of healthcare and the resulting specific population needs of Indigenous patients. Advisors noted that the colonial legacy of healthcare in Alberta affected them through mistrust and fear regarding the medical system; scholarship has also documented these experiences, along with stigma and discriminatory treatment (Campbell et al., 2015; Landry et al., 2016). In some cases, stigma in healthcare settings may manifest as overprescribing of opioids. Research has shown that prescription drugs are the primary source of opioids in some communities, either directly through prescriptions or from elderly or disabled community members who were overprescribed and sold some medication to help make ends meet (Momper, Delva, & Reed, 2011). Overprescribing may perpetuate physicians' community mistrust and indicate a need for further physician training on prescribing practices and a responsibility on behalf of the healthcare system to address the opioid crisis.

Healthcare providers reported inadequate cultural training for working in Indigenous contexts (Teasdale et al., 2008b). To reduce health inequities due in part to the provider-patient relationship, scholars suggest improved education on trauma-informed care (Jumah et al., 2017), and building patient relationships to establish trust (Benoit, Carroll, & Chaudhry, 2003). This includes spending more time talking with Indigenous patients and working to understand their social, geographical, and cultural contexts (Kiepek et al., 2012). Understanding the individual's context supports provider compassion. Through non-judgmental care, trauma-informed care, and provider education on the social determinants of health, providers can illustrate respect for their patients and provide care specific to their needs, integral to the success of healing the whole human being (N. Gray, 1998; Jumah et al., 2017).

Culturally or contextually appropriate interventions for substance use programs that engage with traditional, cultural, or spiritual aspects of Indigenous healing and frameworks was a strong theme within the literature (Marquina-Márquez et al., 2016; Radin et al., 2015; Russell, Firestone, Kelly, Mushquash, & Fischer, 2016; Venner et al., 2018). In some communities, this may include a preference for abstinence models, though support for medication-assisted treatment is growing and can be enhanced with the involvement of community leaders (Mamakwa et al., 2017; Venner et al., 2018). For instance, one program that is attracting and maintaining more Indigenous clients than any previous program in the region built support for OAT by engaging a champion of abstinence programs well-known in the community (Williams, Nasir, Smither, & Troon, 2006). In communities with similar spiritual beliefs, working with the patient to safely and efficiently taper OAT may be particularly important in motivating patients by providing hope they may live medication-free in the future (Mamakwa et al., 2017).

SPECIFIC POPULATION PRIORITIES & NEEDS	PROGRAMMING SOLUTIONS
Though abstinence approaches are valued across many Indigenous communities, support for medication-assisted treatment is growing (Venner et al., 2018) Some spiritual practices not aligned with medication-assisted treatments, requiring contextualization of harm reduction (Landry et al., 2016) Fully involving & educating community leaders about the value of medication-assisted treatments important to success (Mamakwa et al., 2017)	Evidence of pharmacy-based programs that enhance education around pain management considered effective when involving community coalitions for healing, collaboration & sovereignty (Duvivier et al., 2017a) Community-based opioid tapering approaches blended off-site addiction treatment with on-site care providers (Campbell et al., 2015) Culturally-adapted interventions & culture-based programming improves clinical responses to safe injection sites (Leske et al., 2016) Training of clinicians in working with pain among Indigenous communities (Katzman et al., 2016)

B. COMMUNITY CENTRALITY—COMMUNITY DEVELOPMENT, OWNERSHIP AND CAPACITY BUILDING

Collaborative partnerships that meaningfully engage community leadership early on (Black et al., 2007; Jumah et al., 2018; Radin et al., 2015) and incorporate traditional healing practices (Kiepek et al., 2012; Russell et al., 2016; Saylors, 2003) are central to healing the whole human being. Community-based tapering could also facilitate healing the whole human being. One program found success (95% program completion rate) with a collaboration between off-site addiction treatment specialists and on-site care providers (Katt et al., 2012). Supporting healing spaces for Indigenous populations on reserve and building capacity around traditional and spiritual community activities are also integral to healing the whole human being. One example of a community-developed protocol for opioid withdrawal and symptom management included traditional menus, Elders in residence, traditional healers, ceremony, traditional medicines, and Indigenous transitional care (Kiepek et al., 2012). In this initiative, successful program outcomes were also locally developed and included patients referring their friends and family to the program, making healing a community venture (Kiepek et al., 2012). A responsibility for raising awareness or community events aimed at peer outreach and sharing information about the program (Black et al., 2007; Williams et al., 2006) were common community-based actions in the literature.

Additional community-based actions outlined in the literature include volunteering in the program (Benoit et al., 2003) and leadership in harm reduction educational programs (Black et al., 2007). In one buprenorphine-naloxone treatment program in NW Ontario, the community initiated land-based aftercare programs (e.g. fishing, traditional walks, gardening) and integrated healing circles and traditional activities into the buprenorphine-naloxone treatment program, with treatment facilities used as meeting places for healing circles (Mamakwa et al., 2017). In addition, inductions into treatment are a community-wide celebration and being initiated into a program is viewed as a "welcoming back" of the patient to their family and roles (Mamakwa et al., 2017). One article outlined that subarctic Ontario First Nations communities engage in a pan-Indigenous Healing Movement for spiritual revitalization (Marquina-Márquez et al., 2016). The Healing Movement is partly in response to high rates of prescription opioid misuse and other social inequities resulting from the trauma and loss of culture due to colonization (Marquina-Márquez et al., 2016).

COMMUNITY CAPACITY BUILDING AND OWNERSHIP	PROGRAMMING SOLUTIONS
Community ownership & control over programming requires early inclusion of leadership in decision-making & hiring of local staff (Radin et al., 2015; Uddin, 2013) Addressing mistrust through community involvement & outreach is important to addressing structural inequalities driving addiction (Benoit et al., 2003) Disseminate program opportunities via word of mouth to build from local networks (Black et al., 2007)	Clinicians can develop protocols for local withdrawal symptom management to include traditional menus, Elders in residence, traditional healers, ceremony, medicines, and transitional care (Kiepek et al., 2012) Counselling & land-based after-care programs to support transitions back to community, connected to longitudinal clinical treatment plans (Mamakwa et al., 2017) Address opioid-related stigma in communities through a family-friendly, holistic model for drug treatment & counselling that includes free lunches (Williams et al., 2006) Overcome difficulty of accessing harm reduction sites among women for childcare or mobility issues (Tetstall, Liu, An, Canalese, & Nanan, 2009)

C. RESTORING HOPE, BELONGING, MEANING, AND PURPOSE

By enhancing social supports, either through maintaining existing supports, including keeping families intact, or building social supports in a group setting, healing the whole human being can address substance misuse drivers such as social isolation. To enhance social connection, one weekly trauma treatment group integrated culture and spirituality with notions of 'internal strength,' peer support, and building interpersonal trust (N. Gray, 1998). Addressing ruptures in family dynamics also requires addressing the roots of trauma such as loss, structural barriers, institutional racism, and poverty (N. Gray, 1998). Restoring hope, belonging, meaning and purpose also includes building self-esteem and a sense of purpose, and may include relaxation, socialization, and identity workshops, recreation, art, and education (N. Gray, 1998; Lee, Dawson, & Conigrave, 2013). Programs that combine outpatient substitution therapy with traditional healing approaches have positive impacts (Beckstead, Lambert, DuBose, & Linehan, 2015; Dooley, Ryan, Gerber-Finn, et al., 2018; Dinah Kanate et al., 2015; Saylors, 2003).

Scholarship indicates a need for aftercare, including relapse prevention and gaining support after treatment, including a family program to integrate the individual's family into their care plan (N. Gray, 1998). Additional supports needed include support groups in outpatient care that include childcare to reduce barriers to ongoing participation (Lee et al., 2013). Scholarship also indicates the need to intergrate healthcare for the individual, the community, and the family (Teasdale et al., 2008a). One source described the need for a national strategy to address opioid misuse in pregnancy this can be accomplished through education and improved OAT access in the community (Jumah et al., 2017). One program maintained strong links with correctional services, ensuring seamless transitions between services while on an OAT program (Williams et al., 2006).

RUPTURED INTERPERSONAL INTIMACY AND CONNECTIONS	PROGRAMMING SOLUTIONS
Racism/discrimination Losing children to social services Poverty Lack of childcare Unemployment Overcrowded/insecure housing Polluted drinking water Unresolved grief & trauma Limited access to healthcare in rural settings Food insecurity Education barriers	Call for national strategy for opioid misuse in pregnancy to encompass education, appropriate medication access, community-based treatment & strong cross-sector links to ensure transitions (Jumah et al., 2017) Therapy talking circles (Momper et al., 2011) Combined substitution therapy with intensive counselling (e.g., DBT) & traditional healing support (Beckstead et al., 2015; Dooley et al., 2018; Dinah Kanate et al., 2015; Saylors, 2003) Gendered approaches to support women in outpatient care & connect to childminding, relaxation, socialization & self-esteem work (Lee et al., 2013; Teasdale et al., 2008b)

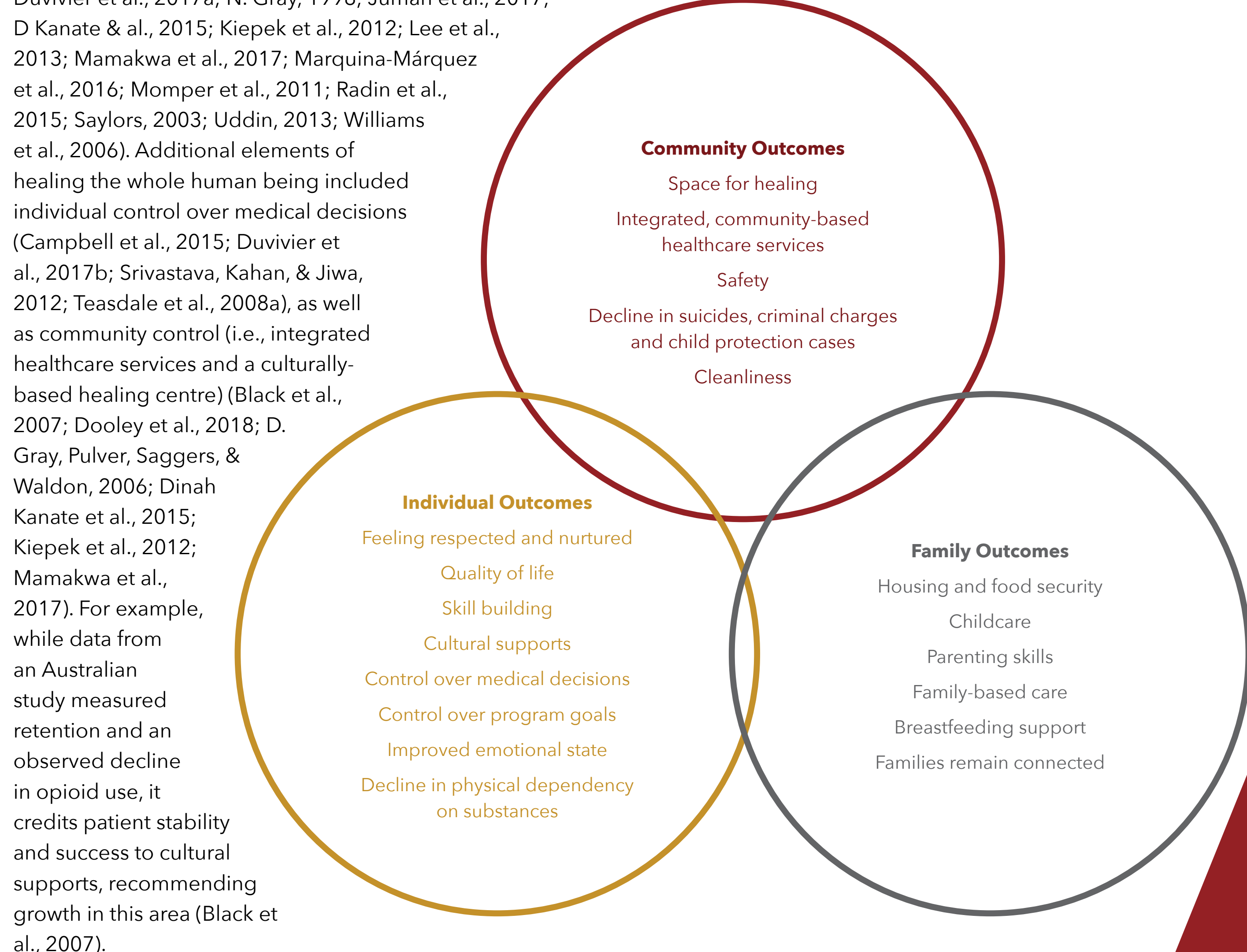
Outcomes

The treatments that measured outcomes tracked their success through program retention, urine samples to detect drug use, or the increase of treatment facilities (Beckstead et al., 2015; Black et al., 2007; Katt et al., 2012; Mamakwa et al., 2017; Russell, Firestone, Kelly, Mushquash, & Fischer, 2016b; Williams et al., 2006).

Impacts of cultural resources and individual growth beyond physical dependency were difficult to capture in current studies.

However one study measured success through the decline in suicides within a community, reduced criminal charges and child protection cases, and an increase in school attendance, in addition to the typical outcome measures of treatment retention rates and urine drug screening (Mamakwa et al., 2017). Other studies used outcome measures such as patients reporting that a program made a positive difference in their life (Uddin, 2013) or positive community-level impacts like cleanliness and increased safety (Landry et al., 2016).

Where outcomes did not encompass a holistic focus, research indicated a need to focus on elements of healing the whole human being in treatment programs, without naming it as such. Some studies advocated for respect for patients, a nurturing atmosphere, or consideration of individual needs, including quality of life, skill-building, and space for reflection (Beckstead et al., 2015; Benoit et al., 2003; Duvivier et al., 2017a; N. Gray, 1998; Jumah et al., 2017; D Kanate & al., 2015; Kiepek et al., 2012; Lee et al., 2013; Mamakwa et al., 2017; Marquina-Márquez et al., 2016; Momper et al., 2011; Radin et al., 2015; Saylors, 2003; Uddin, 2013; Williams et al., 2006). Additional elements of healing the whole human being included individual control over medical decisions (Campbell et al., 2015; Duvivier et al., 2017b; Srivastava, Kahan, & Jiwa, 2012; Teasdale et al., 2008a), as well as community control (i.e., integrated healthcare services and a culturally-based healing centre) (Black et al., 2007; Dooley et al., 2018; D. Gray, Pulver, Saggers, & Waldon, 2006; Dinah Kanate et al., 2015; Kiepek et al., 2012; Mamakwa et al., 2017). For example, while data from an Australian study measured retention and an observed decline in opioid use, it credits patient stability and success to cultural supports, recommending growth in this area (Black et al., 2007).



Conclusion

The theory-driven, interpretative approach to this evidence synthesis based on community perspectives supports contextualization to Indigenous communities. The knowledge contextualization process employed here has been vital to identifying evidence around causes of opioid dependency, and how these causes must be addressed to reduce harm. Closer connections and more open communication between community members, healthcare providers, policymakers, and researchers are essential for effective policy and healthcare programming.

The summary report of the Truth and Reconciliation Commission of Canada (TRC) states that a lack of knowledge about historical and contemporary conflicts between Indigenous peoples and the federal government has significant consequences, resulting in poor public policy (TRC, 2015a). In particular, Call to Action #18 from the TRC emphasizes the role of past government policies in significantly determining Indigenous peoples' health today. This report's knowledge contextualization process engages community perspectives on historical and ongoing disruptions in Indigenous communities in Alberta to promote recommendations contextualized to those most closely affected by the overdose crisis and their providers.

This report outlines trauma and social disconnection caused by colonization, consequences of disruption that drive health inequities across First Nations, Metis, and Inuit peoples in Canada. We now work to advance research and policy development aligned with the guiding principles outlined by Elder advisors to enhance opportunities for relevant and appropriate addictions care with Indigenous communities. Namely, we affirm that: 1) colonization impacts wellness; 2) that the opioid/overdose crisis is more than an issue of physical addiction; 3) that health service providers have much to learn from Indigenous people about healing from addictions; and 4) medical and health systems are responsible for helping communities heal from opioids. From these principles, we grounded this knowledge synthesis in intentions to **heal the whole human being** as a means of identifying models of care congruent with community and cultural values, the restoration of family and community-connectedness, and reclamation of cultural knowledge to resist the overdose crisis.

Recommendations

Systemic drivers of opioid misuse and dependency in Indigenous contexts in Alberta emphasize:

- Priority for **community-based access** to appropriate supports to healing from substance use disorders and multi-generational trauma, with approaches suited to the particular needs for treating opioid use disorder
- Broadened **attention for prevention** prior to crisis onset
- Desire for enhanced primary health care capacity for **alternative pain management, appropriate pain diagnosis,** and rehabilitation services
- Need for critical **health professional education in anti-racism** for engaging with Indigenous patients & families
- Multi-sector collaborations to address **systems pathways into opioids** & other substances of misuse

Community priorities and strategies for addressing opioid use disorder highlight desires for health systems and providers to:

- Recognize **sources of Indigenous community mistrust** in healthcare and aspirations for cultural reconnection that often frame priorities for abstinence-based approaches affirmed by many in Indigenous contexts; engage leadership & communities at the outset in programming
- Bridge **clinical and Indigenous knowledge around healing** from addictions by promoting mutual respect, collaboration, and community ownership in innovating models of care
- Centre responses to the opioid crisis in **cross-sector partnerships** located within or in close proximity to affected communities
- **Strengthen community-based knowledge around opioids** and other substances of misuse by promoting an exchange of expert insights & local experiences from diverse contexts
- **Address the role of health professions in prescription drug misuse** by working with health professional bodies

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Appendix A

Recommendations for Action—Alberta Indigenous Opioids Advisory Sub-Committee (June 16, 2017; shared with team by Dr. Esther Tailfeathers)

1. Distribution of and training for the use of naloxone by indigenous peoples.
2. Mobilization of information and engagement of community members in discussions on opioid use/ addiction, treatment options, and presentation in a culturally sensitive manner.
3. Develop specific initiatives for children and youth who use with a focus on prevention and awareness.
4. Share evidence-based and best practices to support the development of targeted, integrated (holistic), and culturally appropriate programs and services.
5. Provide training for frontline service providers in social, health, and justice service delivery roles.
6. Support the development of accurate information on the nature of the opioid issue within the Indigenous population.
7. Address prescription practices related to opioids and other substances and current limitations of the non-insured health benefits formulary for First Nations.
8. Urge all levels of government – federal, provincial, territorial and local Indigenous – to work together to change policies and programs in a concerted effort to repair harm – move forward with reconciliation
9. Develop supports and service responses for the most vulnerable within the Indigenous population to ensure fair and effective treatment.
10. Stop the supply of illicit opioids and other substances.

PARAMETERS FOR DEVELOPING RECOMMENDATIONS FOR ACTION:

The Indigenous Opioids Advisory Sub-Committee's work was guided by the following parameters:

1. First Nations and Métis communities are unique, requiring a range of flexible and community-based approaches. The Sub-Committee's recommendations for action are designed to support First Nations living on-reserve, Métis living on Settlements, and/or Indigenous peoples living across the province. Off-reserve and off-Settlement (including urban Indigenous peoples) are an important target audience for action.
2. All the Sub-Committee's recommendations for action are designed to build upon and complement action underway in Alberta to address the opioid/fentanyl crisis. Actions will complement the work of both the Chief Medical Officer of Health and the Deputy Minister's Committee on Valuing Mental Health.
3. The Sub-Committee's role is one of need/action identification and advocacy.
4. The Sub-Committee wishes to go beyond generalities and identify action with as much detail as possible to ensure that clear next steps and accountability can be identified.
5. Identified actions will be client-centered. Jurisdiction and funding issues will not restrict actions considered by the Sub-Committee.
6. The initial focus of the Sub-Committee will be upon immediate action/short-term action, The initial focus of the Sub-Committee will be upon immediate action/short-term action, but the Sub-Committee will identify longer-term issues and actions. It is recognized that some of these longer-term issues are outside of the scope of the Sub-Committee's mandate.
7. Respect for culture, governance, and protocol is important. The Sub-Committee assumes that this respect will be embedded into the implementation of its recommendations for action.
8. Collaborative partnerships are needed for the effective design and implementation of actions. Success requires connections and building relationships between and within communities and organizations.
9. There are different cultures and traditional ways of knowing within Indigenous populations. Local strategies for engagement and respect/acknowledgement of culture and traditional ways of knowing are needed. Local input is essential.

Appendix B

Witness statement form Elders' gathering in Banff, Alberta from May 16-17, 2018

Witness Statement–Elders' Gathering: Exploring the Impacts of
Social & Natural Environments on Health
Banff, AB May 16-17, 2018

Purpose

This statement was written by a group of researchers and health service providers committed to supporting First Nations achieve their data sovereignty goals, and explore and affirm their health rights, including rights concerning data collection, management, and utilization. This group of researchers and health service providers attended and were witness to a two-day Elders' gathering convened around the idea of "Exploring the Impacts of Social & Natural Environments on Health" by the Alberta First Nations Information Governance Centre (AFNIGC) at the Banff Centre in Banff, AB on May 16-17, 2018. This preparatory gathering was planned to summarize Elder priorities before the June 11-12, 2018 I-HeLTI (Indigenous-Healthy Life Trajectories Initiative) workshop in Ottawa, aimed at identifying priorities for creating and sustaining Indigenous developmental origins of health and disease (DOHaD) cohort research.

Gathering Overview

Some 28 Elders attended the May 2018 gathering, with an even distribution of male and female Elders. All consenting participants self-identified as Indigenous. Witnesses in attendance represented the University of Calgary, the University of Alberta, as well as Indigenous Services Canada's First Nations and Inuit Health Branch (FNIHB) leadership, the Alberta Health Services Strategic Clinical Networks (SCNTM) leadership, including the Emergency SCN and Population, Public and Indigenous Health SCN (See Appendix B: Witness Statement). Funding was provided by an I-HeLTI Development Grant to convene two Spring 2018 meetings on high-level priorities around which diverse Alberta First Nations partners envision the I-HeLTI initiative to direct attention. Due to the shortened timeline and the quickly approaching I-HeLTI June meeting in Ottawa, the two meetings scheduled for May and June 2018 were combined. Outlined below are reflections and themes that emerged from the Elder discussions as observed by the group of witnesses. Themes and this witness statement have been reviewed and approved by the Alberta First Nations Information Governance Centre (AFNIGC).

AFNIGC I-HeLTI Elder Engagement

Elders are individuals recognized in distinct ways by their communities as having accumulated knowledge and skills with which they mentor and/or lead others for the benefit of their culture and communities (Stiegelbauer, 1996). Their perspectives on the I-HeLTI initiative were gathered at the May 2018 gathering with their insights informing themes listed below. The AFNIGC reports having undertaken more than a year-long process to engage Elders in shaping health and social policy agendas, and prioritizing health research in the process of achieving these. Outputs from the year of work include an upcoming Elders' Declaration, as well as a deep investigation into appropriate indicators for developing community profiles, informed by the six language groups in Alberta (i.e., Blackfoot, Cree, Chipewyan, Dene, Tsuut'ina, and Stoney (Nakoda Sioux)). Exploring this body of work for the I-HeLTI opportunity [Day 1] was the basis for the May 2018 gathering, in addition to learning from Elders about their insights for another Canadian Institutes of Health Research (CIHR)-funded initiative around Indigenous approaches to the prevention and treatment of opioid misuse [Day 2].

Sharing Circles

The gathering began with a pipe ceremony, followed by an overview of the event and an explanation of objectives. After the Elders were well oriented with the I-HeLTI project, Iskotoahka (William) Wadsworth from the AFNIGC facilitated discussions on how the Elder Declaration may inform the I-HeLTI process, how communities can be involved with establishing community indicators, and how Elders wish to communicate their perspectives at the June 2018 meeting in Ottawa. The second day focused on opioid misuse, on experiences of opioids in First Nations communities across the province, and possible solutions and supports needed. Both days concluded with a collective debrief on lessons learned and opportunities for moving forward. The Elder discussions were held as sharing circles, which are similar to qualitative focus groups, but incorporate strategies to honor values that are common in Indigenous contexts (i.e., non-interference, non-competition, reciprocity) (Brant, 1990). Sharing circles promote the sense of safe spaces to discuss experiences and knowledge that impact spiritual, mental, emotional, and physical life (Nabigon, Hagey, Webster, & MacKay, 1999).

Results

The following themes are those that were emphasized as important by the Elders and sparked discussion. The witnesses undersigned confirm having heard the Elders share these messages and affirm that these perspectives should inform future research for healthy communities.

Theme 1: Elder Organization

The Elders discussed the need for First Nations Elders to be organized at an inter-community level. Without inter-community collaboration, they are divided by colonial structures, where paternalistic service and leadership structures imposed by government departments have created mistrust between communities. Current forms of racism and discrimination (i.e., from dominant Canadian society towards Indigenous peoples, and when communities are positioned to compete with one another) also perpetuate barriers to knowledge transfer around wellness. Witnesses saw Elders mutually supporting one another at the meeting through challenges, including translating their own languages to Elders from other language groups. In this, witnesses sensed comradery and a desire for cooperation. The Elders saw value in creating a senate-like organization to bring them together with a purpose that could work in an inter-community fashion and include unifying ceremonial structures such as a song, flag, and tipi. The Elders saw such collaboration as an opportunity to work from a position of love and care for their families and communities. They expressed the importance of the senate organization being consulted and involved in leading projects that impact Indigenous health.

Envisioning a sort of Elder senate, the Elders indicated that they need to be supported by the research and health services communities to engage at an inter-community level, to build clarity about what they share in terms of resilience and barriers to wellbeing, and to build knowledge and inter-cultural leadership skills to more effectively connect their wisdom to meaningful change. The witnesses heard the Elders' concerns about the lasting impacts of colonization and the stress associated with it, and the repetition of some colonial dynamics within current healthcare, legal, child welfare, and other systems.

While the First Nations Elders who were present were Alberta-based, they also expressed a sense that their concerns were not unique to Alberta communities, but that the commonalities they face compel them to work in an inter-community fashion to overcome the divisions that colonization has thrust upon them. The Elders discussed that ongoing problems of colonization must be addressed within research in order to create lasting change. Research that is ignorant to the lasting effects of colonization and its impacts on wellness cannot transform the lives of people in First Nations communities.

Theme 2: Community Health Indicators

The Elders have a vision for research around a Developmental Origins of Health and Disease (DOHaD) cohort study that addresses environmental and socio-political factors as key determinants of wellness in their communities. They spoke to many types of indicators that are important to their communities relating to natural resource security, community connection, and self-determination.

They also spoke at great length about the need to foster a return to Indigenous culture and spirituality where it may be lost. They discussed socio-political attacks on Indigenous culture and spirituality, which have led to disconnect with their heritage and suppression of Indigenous cultures. The Elders viewed a return to their original practices, language, intergenerational connections, and teaching to build identity, spirituality, and drawing on the strengths of their knowledge systems and stories as creating resilience and benefitting wellness holistically. They also saw a need to restore the family unit, clans, and societies for building resiliency. The resurgence of culture as a healing factor in the lives and communities of First Nations gives a strong rationale for the need to focus on appropriate indicators across time in projects such as the I-HeLTI initiative. While the Elders' perspectives do not negate other approaches (e.g., epigenetic testing), the witnesses recognize that socio-politically oriented research can strengthen a nuanced understanding of appropriate indicators (e.g., ecosystem health, presence of animals, water sources, changes in the land, food sources, opioid prescribing, etc.).

Conclusion

Witnesses to the "Exploring the Impacts of Social and Natural Environments on Health" gathering heard the Elders communicate the importance of an inter-community organization to address lasting effects of colonization and community prioritizations of indicators for health research. The witnesses do not wish to speak on behalf of the Elders, but rather we aim to communicate the themes heard and commit to carrying these messages in our diverse work moving forward. The tasks to carry forward from these discussions should not fall on the shoulders of Indigenous people alone; everyone involved in addressing the health and wellness needs and priorities of First Nations are also compelled to incorporate such priorities in their leadership.

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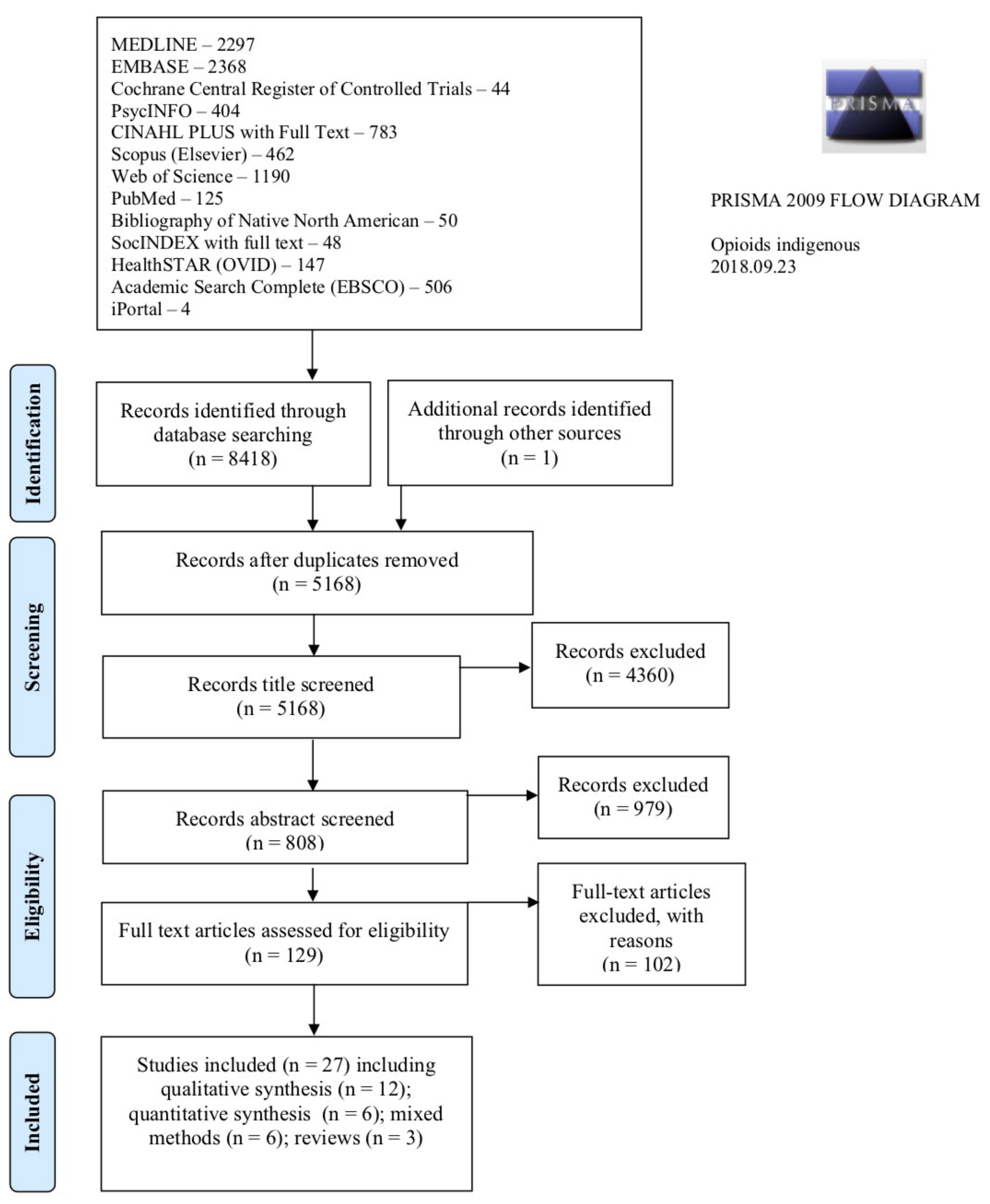
Appendix C

Process Summary of Peer-Reviewed Literature Search



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(7): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisma-statement.org.

Appendix D

Agendas differed only by target population for community consensus-building events, held on:
(1) May 16-17, 2018 in Banff, Alberta;
(2) August 23, 2018 at the Grey Eagle Resort and Casino;
(3) August 29, 2018 at the Grey Eagle Resort and Casino;
(4) September 5, 2018 at an urban Indigenous primary care clinic called the Elbow River Healing Lodge;
(5) September 24, 2018 in Edmonton, AB.

Sample Agenda:

Opioid Knowledge Synthesis

Consensus-Building for Community-Based Opioid Agonist Treatment

Treaty 8 Offices

18178 102 Ave NW, Edmonton, AB T5S 1S7

Monday, September 24, 2018

8:30am-4:00pm

Research Team:

Drs. Rita Henderson and Lindsay Crowshoe, University of Calgary

Ms. Bonnie Healy and Mr. William Wadsworth, AFNIGC

Background

Our team is working on the following 3 activities:

1. A literature review of best practices, contextual factors, and wrap-around supports for enhancing prevention and treatment of opioid misuse among Indigenous people (May-August 2018)
2. An Elders and Knowledge-Holders gathering that shared community experiences of opioids (May 2018)
3. A series of **consensus-building working groups** for providers, patients and their families to work together to inform policy and future models of care (August-September 2018)

Agenda

Introductions

Background of Consensus-Building Work & Future Initiatives

#1 In your community, what is the experience of people accessing opioid agonist therapies (OAT; i.e., Methadone, Suboxone)?

#2 What are contextual factors & needs to address in order to maximize OAT effectiveness?

#3 What partnerships, protocols, processes, and spaces are needed to realize effective OAT to address opioid misuse within your community?

Closing prayer

Ethics ID#: REB18-0582
Study Title: Best Practices and Contextual Factors Enhancing Prevention & Treatment of Opioid Disorders in Indigenous Contexts in Alberta
Principal Investigator: Dr. Rita Henderson (rihender@ucalgary.ca)

Conflict of Interest

No conflicts of interest to declare.

Target Audiences

We believe that this report will be of interest to groups and sectors involved in Indigenous health research and service, as well as others who work in addictions-related research, policy, and practice. We hope that Indigenous leaders, program planners, and community members may find insights or confirm their knowledge and practices within the findings presented here.

Within health systems, insights contained here are relevant for funders, decision-makers, and front-line providers where Indigenous clientele may access resources and supports to prevent and treat opioid misuse.

Notes

Notes

Healing the Whole
Human Being
January 2021