



HARM REDUCTION

FOR SPECIAL POPULATIONS IN CANADA

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Harm reduction policies and programs for persons of Aboriginal descent

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This document is intended to provide current, objective and empirically-based information to inform the implementation of policies and programs for promoting the reduction of harms associated with substance abuse in Canada.

This is one in a series of documents on harm reduction for special populations in Canada. The series comprises the following titles:

1. *Harm Reduction Policies and Programs for Persons Involved in the Criminal Justice System (May, 2005)*
2. *Harm Reduction Policies and Programs for Youth (August, 2006)*
3. *Harm Reduction Policies and Programs for Persons of Aboriginal Descent (June, 2007)*
4. *Harm Reduction Policies and Programs for Persons with Concurrent Disorders (to come)*

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Introduction

Harm reduction is a controversial term. This is evident in the range of social and political reactions to harm reduction policies and programs currently operating across Canada. It is also obvious in the intense and often moralistic responses that harm reduction elicits. However, there is no disputing the fact that harm reduction measures have an ever-increasing presence in the alcohol and drug abuse field. It is important to understand this as it relates specifically to persons of Aboriginal descent—First Nations, Inuit and Métis. Each has an individual and a collective history that contributes to their current position within Canadian society.

This publication is intended to help better define harm reduction and to identify Canadian examples of harm reduction policies and programs used by Aboriginal peoples. It is not designed to advocate a position on harm reduction, but rather,

to provide a comprehensive, up-to-date introduction to the issue.¹ The paper begins with a definition of harm reduction. It then briefly looks at the composition of persons of Aboriginal descent in Canada, the general health status and prevalence of problematic substance use within the population, and historical influences on the lives of Aboriginal peoples.

The paper then provides examples of 11 approaches to harm reduction policy and programming used by Aboriginal peoples, as well as seven key barriers to their implementation. For each barrier, a general solution or direction is proposed. Like the paper itself, these suggestions are intended to stimulate discussion and further reflection.

This paper draws on Canadian and select American and Australian peer-reviewed and grey² literature. In the absence of a sizable body of documented information, one of the authors, Tara Lyons, held conversations with approximately 25 organizations and individuals in Canada working in the area of substance use and Aboriginal peoples. The majority of the organizations were Aboriginal-specific. The authors are grateful to the individuals who shared their expertise and wisdom, and that of their organizations. Along with the literature, their collective voice has formed the foundation of this paper.

Reducing harms

The first of CCSA's series of documents on harm reduction for special populations in Canada—*Harm Reduction Policies and Programs for Persons Involved in the Criminal Justice System*—defined harm reduction as “a health-centred approach that seeks to reduce the health and social harms associated with alcohol and drug use, without necessarily requiring that users abstain. Harm reduction is a non-judgmental response that meets users ‘where they are’ with regard to their substance use...” (Thomas, 2005, p. 1). Harm reduction includes a broad continuum of responses, from safer substance use to abstinence. Essential to a harm reduction approach is that it offers users a choice of how they will minimize harms to themselves.

The following are features of harm reduction:

Pragmatism: Harm reduction accepts that some use of psychoactive substances is inevitable, and that some level of substance use is expected in a society.

Humane Values: No moralistic judgment is made, either to condemn or to support use of substances, regardless of level of use or mode of intake. The dignity and rights of the person who uses alcohol and other drugs are respected.

Focus on Harms: The extent of a person's substance use is of secondary importance to the harms resulting from that use.

Hierarchy of Goals: Most harm reduction programs have a hierarchy of goals; the most pressing needs are addressed first (Canadian Centre on Substance Abuse National Policy Working Group, 1996).

Fundamental features of harm reduction, specifically its focus on humane values, overlap with traditional Aboriginal values such as respect. The principles of harm reduction are not unknown to Aboriginal peoples and some observers have pointed to similarities between harm reduction and a holistic Aboriginal approach to substance abuse treatment, including the importance of links between the community and the individual (Peele, 2003).

To help understand the concept of harm reduction, consider the non-substance-specific example of seatbelts. In a car accident, seatbelts can help reduce the extent of physical injury suffered by the occupants of the car by, for example, keeping them from being thrown out of the vehicle. With substance abuse, the provision of sterile injection equipment to intravenous drug users can help reduce the spread of blood-borne diseases, and the distribution of controlled quantities of alcoholic beverages to alcohol-dependent individuals in homeless shelters can help to curtail the ingestion of non-beverage alcohol products.

¹ To assist with this, the paper is well referenced so that original sources can be easily accessed.

² Grey literature includes publications by a non-commercial source, such as a not-for-profit organization or government department.

One of the best ways to understand harm reduction is to hear about it in an individual's own words. A British Columbia woman conveys what harm reduction means to her life:

If you say that I can't come [to your program] because I am using, then you're telling me that I don't deserve to heal. Until you're clean you're not good enough. I already have a core belief that I am not good enough and that message just affirms that core belief (Poole, 2006).

The size and scope of needs and strengths specific to Aboriginal peoples and their communities must be acknowledged in any discussion of harm reduction. Not all harm reduction measures are applicable to all Aboriginal peoples and communities and so the range of such services is wide, as this paper will reveal. Any discussion of harm reduction measures among Aboriginal peoples should start by recognizing that developing effective policies and programs must be founded and directed by communities and their members. The work of Gray and Sputore (1998) supports the "open negotiation of realistic, achievable project goals, that are responsive to the needs of Aboriginal communities as they define them, instead of forcing them into the mould of uniform program objectives" (Gray & Sputore, 1998, p.46). The importance of this is illustrated in a 2004 study on the use of stop-smoking aids by First Nations. The study found that aids developed by Western society were rarely used among First Nations and concluded that "medication use, [such as the nicotine patch], may not be appropriate for [First Nations] smokers whose beliefs involve primarily behavioral modification" (Wardman & Khan, 2004, p. 691).

Also key to discussing any form of harm reduction among Aboriginal peoples is recognition that for some, Aboriginal traditions, customs and cultural ways are incompatible with the use of mood-altering substances. Individuals who use substances such as alcohol or methadone are viewed as being "out of balance". Once again, the applicability of harm reduction policies and programs must be determined by communities and their members.

Many Aboriginal communities and treatment programs today adhere to models of abstinence and prohibition (Chalmers, Cayen, Snowshoe & Collin, 2002; Daisy, Thomas & Worley, 1998; Korhonen, 2006; Landau, 1996; Lauzon, Gregoire, Glikzman & Douglas, 1998). There are a number of reasons for this, including the destructive impact of the introduction of alcohol on the lives of Aboriginal peoples, a desire by Aboriginal peoples to redefine themselves as distinct from the assimilative practices of mainstream society, and the devastating level of alcohol and drug abuse a number of communities face today (Canadian Aboriginal AIDS Network, 1998). The abstinence-based focus of many of the National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres stems in part from the fact that they were established at a time when disease-based theories and abstinence models were the norm.³

Models of abstinence and prohibition typically do not allow for moderate or reduced use—something that is implicit in most harm reduction policies and programs. Consequently, the emphasis on abstinence in Aboriginal communities has been identified as a barrier to offering and expanding harm reduction services (Canadian Aboriginal AIDS Network, 1998; Erickson, 1992; Wardman & Quantz, 2006).

Contrary to what many people believe, abstinence and harm reduction are not totally incompatible. Common to both is the goal of assisting individuals with the harms they are experiencing because of their problematic substance use. Some programs and policies offer clients a continuum of approaches. For example, All My Relations, a harm reduction program for Aboriginal injection drug users in Manitoba, offers abstinence as a potential goal, but does not make it a requirement (McLeod, 2001). Similarly, the Mamisarvik Healing Centre (www.ontarioinuit.ca/html/addictions.htm), one of only a few Inuit-specific residential substance abuse programs in Canada, offers its clients the choice of a harm reduction treatment program or a treatment program based on abstinence. As well, Canada's national Inuit organization, Inuit Tapiriit Kanatami, notes in its alcohol policies that there is a need to develop effective, community-based alcohol counselling programs based on both harm reduction and abstinence strategies that are appropriate to Inuit situation, culture, language and values (Inuit Tapiriit Kanatami, 2005a).

³ NNADAP is a network of 54 treatment centres located in First Nations and Inuit communities across Canada and represents approximately 700 inpatient treatment beds. There are also more than 500 NNADAP community-based prevention programs. NNADAP is largely controlled by First Nations communities and organizations and is the main source of treatment for Aboriginal peoples in Canada for all forms of substance abuse.

Some Aboriginal abstinence-based treatment programs have aligned themselves with harm-reduction initiatives such as offering clean needles to injection drug users. The Canadian Aboriginal AIDS Network (CAAN)⁴ offers the perspective that “[h]arm reduction does not necessarily mean you condone drug use but rather, [it] offers a pragmatic solution to stopping the spread of HIV” (Canadian Aboriginal AIDS Network, 1998, p. 38). CAAN’s work on developing an HIV/AIDS strategy in Canada for First Nations, Inuit and Métis describes harm reduction as one of nine strategic areas where the aim is educating and supporting individuals to make changes to reduce their risks for HIV or hepatitis C (Canadian Aboriginal AIDS Network, 2003).

Abstinence-based programs and policies that exclude harm reduction are not the focus of this paper, but these measures still share commonalities with harm reduction. Consider, for example, Alkali Lake, a Shuswap Indian Reserve near Williams Lake, B.C. that took action against problematic alcohol use through leadership, commitment, support and honouring spiritual and cultural foundations (Four Worlds International Institute, n.d.). Probably the best-known example of self-imposed alcohol prohibition by an Aboriginal community, Alkali Lake looks at first like a clear example of an abstinence-based approach, yet it used elements that are essential to harm reduction. It transformed its health conditions from within to suit its own self-defined needs. Among other measures, it issued vouchers for food and other necessities to its heaviest drinkers in place of social assistance funds. The community reduced its overall level of drinking over a period of several years and, in the spirit of harm reduction, rarely resorted to exiling users.

Setting the Context

Persons of Aboriginal Descent

Aboriginal peoples is a collective term for all of the original peoples of Canada and their descendants (National Aboriginal Health Organization, 2003). The Constitution Act of 1982 identifies three Aboriginal groups: Indians (First Nations), Inuit and Métis. First Nations generally applies to both Status Indians (recognized under the Indian Act by the Government of Canada and entitled to certain rights and benefits under the law), and Non-Status Indians (not recognized under the Indian Act for whatever reason, such as status cannot be proven or status rights have been lost). Inuit are the Aboriginal people of Arctic Canada. The Indian Act does not apply to Inuit; however, in 1939 the Supreme Court of Canada interpreted the federal government’s power to make laws affecting “Indians, and Lands reserved for the Indians” as extending to Inuit. Métis are people with mixed First Nations and European ancestry who identify themselves as Métis.

The majority of information available for this paper is specific to First Nations, in particular Status Indians living on-reserve⁵. Information on Inuit and Métis is included whenever possible. There is a general absence of information on the health status of all Aboriginal peoples in Canada (Adelson, 2005; Cardinal & Adin, 2005). Similarly, there is limited information pertaining specifically to women. When available, and applicable, it is presented. It is important when reading this paper, particularly for service providers and policy makers, to keep in mind the unique histories and vast differences between First Nations, Inuit and Métis, as well as the commonalities in their experiences.

⁴ In 2000, the Canadian Inuit HIV/AIDS Network was created under the auspices of the Pauktuutit Inuit Women’s Association.

⁵ Less information is available for Non-Status Indians and Status Indians living off-reserve.

According to the Canadian Census, in 2001, Indian, Inuit and Métis represented 3.3% of Canada's total population⁶. Of the nearly one million individuals, 62% identified as Indian, 30% as Métis⁷, and 5% as Inuit. The remaining 3% identified with more than one Aboriginal group or did not identify as Aboriginal, but were registered Indians or band members. Canada's proportion of Aboriginal people is second highest in the world (Statistics Canada, 2003).

Aboriginal peoples in Canada are a heterogeneous group, with diversity in ancestry, history and culture. There are approximately 630 First Nations (bands) in Canada, comprising an estimated 52 nations or cultural groups and more than 50 languages. The average on-reserve band population is 500 people, and there are more than 2,300 reserves⁸ (Fiss, 2003). The median age of the Indian population in 2001 was 23.5 years, with 35% of the population 14 or younger. Nearly half (47%) lived on a reserve. The Métis median age was 27 years, with 29% of Métis children 14 or younger. Sixty-eight percent lived in urban areas. Inuit had the youngest population of the Aboriginal groups, with a median age of 20.6 years. Children 14 and younger represented 39% of the total Inuit population. Half of the Inuit population lived in Nunavut territory (Statistics Canada, 2003).

Health Status

The overall health status of Aboriginal peoples is well below the national average (Health Council of Canada, 2005). According to the 2002-2003 First Nations Regional Longitudinal Health Survey⁹, First Nations rated their health status as lower compared with Canadians generally (National Aboriginal Health Organization, 2004a). There is a high rate of tuberculosis among First Nations and Inuit (Health Council of Canada, 2005), and Aboriginal peoples also have higher rates of diabetes, circulatory disease and death from suicide. Mental health¹⁰ has also been identified in recent reports as a key area of concern among First Nations, Métis and Inuit.

The erosion of a traditional way of life has had a negative impact on Aboriginal communities, families and individuals, including multi-generational losses of homeland, traditions, language and culture. This is rooted in government legislation (including the Indian Act), systemic racism and discrimination, the deliberate killing of wildlife and sled dogs, forced relocation, placement on reserves, and the historic impact of residential schooling¹¹. These experiences have affected the health and well-being of individuals, contributing to lower social and economic status, poorer nutrition, violence, crowded living conditions and high rates of substance abuse. Although most of the information available is specific to First Nations, census data indicate that Métis share a similar socio-economic and health profile (National Aboriginal Health Organization, 2004b). As well, a recent report on Inuit perspectives on circumpolar health similarly identified disparities between Inuit and the general Canadian population (Inuit Circumpolar Conference & Inuit Tapiirit Kanatami, 2005).

⁶The Canadian census derives this figure from a question that determines cultural origins or ancestry. The 2001 Aboriginal Peoples Survey (APS) focused on identification with Aboriginal ancestry, and the figure was 626,000. Indian and Northern Affairs Canada adjusted this figure to deal with under-coverage of the APS, and the compensated population is 720,000.

⁷The exact number is not known, but it is thought that a large number of Métis peoples in Canada do not identify themselves as such.

⁸"A reserve is the land that is set aside by the Crown for the use and benefit of a band in Canada. Many First Nations now prefer the term First Nation community and no longer use reserve." (Information Centre on Aboriginal Health).

⁹A total of 238 First Nations communities in 10 regions participated in the survey.

¹⁰Inuit commonly use the term "mental wellness". This includes mental health, mental illness, prevention of suicide and violence, and substance use/addictions.

¹¹Residential schools were a large part of the assimilative policies of the Canadian government toward Aboriginal peoples. The hearing of the Royal Commission on Aboriginal Peoples was the first large-scale telling of personal and painful stories of physical and sexual abuse at the schools.

Of particular concern is the health status of Aboriginal women in Canada. Many Aboriginal women's health issues are a function of gender-based social status and roles. Aboriginal women's lives are disproportionately affected by family violence, sexual harassment, inequality, discrimination, single parenting and poverty. The health effects have an impact on the lives of women's children, families and communities (Boyer, 2006; Canadian Aboriginal AIDS Network, 2002). To illustrate, the rate of diabetes among Aboriginal people is an approximate 2:1 ratio of women to men. As well, violence-related mortality is three times higher for Aboriginal women than for other women in Canada. A 2006 strategy on the prevention of abuse in Inuit communities has highlighted violence as a great concern for Inuit women (Pauktuutit Inuit Women of Canada, 2006).

Substance Abuse

Historical experiences influence the current health and well-being of First Nations, Métis and Inuit, and help explain present-day levels of alcohol and drug use. The introduction of alcohol had a devastating impact on the lives of Aboriginal peoples in Canada (Korhonen, 2006). As discussed earlier, this partially explains the strong reliance on abstinence-based approaches in some Aboriginal communities and the high rate of abstinence among Aboriginal peoples. Problematic substance use has been linked to high rates of poverty, family breakdown, unemployment, and poor social and economic structures among First Nations, Inuit and Métis. It is important to understand that for many, alcohol and other drug use offers a means of coping with traumatic life circumstances. It is equally important to recognize that protective factors such as culture can combat the problematic impact of substances.

Information on alcohol and other drug use among Aboriginal peoples is limited, as it is for information on general health indicators, as stated above. Recent data are highlighted here. Although substances are separated by category, they are often used in combination.

Alcohol: Although Aboriginal peoples have among the highest rates of abstinence from alcohol¹², and drink less often than the general population (17.8% vs. 44.0% reported drinking weekly), there are high levels of heavy use, such as binge drinking (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000). The 2002-2003 First Nations Regional Longitudinal Health Survey concluded that the proportion of heavy drinkers among First Nations adults is higher than in the general Canadian population (First Nations Centre, 2005).

Risk factors for heavy drinking for Aboriginals and non-Aboriginals alike include being young, male and having a low socio-economic status. According to the 2000 National Native Alcohol and Drug Abuse Program Renewal Framework, "alcohol abuse remains a major personal and social health problem of enormous magnitude" among Aboriginal peoples in Canada (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000, p. 5). Although the relationship is complex, alcohol has a documented role in violence, injury and suicide. The rate of death due to alcohol abuse among Aboriginal peoples is nearly twice that of the general Canadian population: 43.7 per 100,000 vs. 23.6 per 100,000. Rates for alcohol-related hospitalization among First Nations and Inuit are also well above national and regional rates for the general population (Single, Robson, & Scott, 1997).

Fetal Alcohol Syndrome (FAS) is estimated to occur at a rate of one or two for every 1,000 live births in Canada, while Fetal Alcohol Spectrum Disorder (FASD) rates are estimated to be higher (Roberts & Nanson, 2000). It is also estimated that the incidence of FAS/FASD in some Aboriginal communities in Canada is higher. It is important to note, however, that studies on drinking during pregnancy have focused disproportionately on Aboriginal women and the geographic areas in which they live, and this raises some methodological concerns (Tait, 2003).

¹² The 2002-2003 First Nations Regional Longitudinal Health Survey indicates that Aboriginal adults have a higher rate of abstinence from alcohol (65.5%) than the general Canadian population. Rates were lower among First Nations females (61.7%) than among males (69.3%), and increased with age (First Nations Centre [2005]. First Nations Regional Longitudinal Health Survey 2002-2003. Ottawa: Author).

Illicit drugs: Studies indicate that indigenous Canadians, as a group, also experience disproportionately high rates of non-medical drug abuse (Scott, 1997; Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000). According to the 2002–2003 First Nations Regional Longitudinal Health Survey, although the documented rate of illicit drug use in the past year is low (7.3%) among First Nations, it is still more than double the rate of the general Canadian population (3.0%) (First Nations Centre, 2005). The 1998 General Review Report of the National Native Alcohol and Drug Abuse Program identifies the use of illegal drugs as a concern at the Aboriginal community level (First Nations Inuit Health Branch, 2000?). Most recently attention has focused on methamphetamine (crystal meth). The overall morbidity rate from illicit drug use is almost three times higher for Aboriginal peoples than for the general population: 7.0 per 100,000 vs. 2.6 per 100,000 (Scott, 1997). There is also concern regarding the growing connection between drug use and illegal activity, including gang membership and drug trafficking.

Of particular concern with illicit drugs is injection drug use (IDU) as a key mode of transmission for human immunodeficiency virus (HIV) among Aboriginal peoples in Canada (Public Health Agency of Canada, 2004). In a 2003 study of the residents of the Downtown Eastside in Vancouver, HIV infection was found to be double the rate of non-Aboriginals (Craib et al., 2003). Of even greater concern is a 2006 Vancouver study in which the mortality rate for female IDUs, mainly from drug overdose, homicide and HIV/AIDS, was nearly 50 times that of the province's general female population (Spittal et al., 2006).

Prescription drugs: There is a general absence of data on prescription drug abuse in Canada, and particularly among Aboriginal peoples. Although dated, a 1995 study found that prescription drug abuse “is increasing among First Nations and Inuit people who are referred to NNADAP (National Native Alcohol and Drug Abuse Program) in-patient treatment programs” (Framework Sub-committee of the National Native Addictions Partnership Foundation & Thatcher, 2000, p. 7). A more recent study (2002) carried out in Calgary concluded that “[i]nappropriate prescription medication use was a significant problem among an Aboriginal population that sought addiction treatment, and many of these individuals accessed medication from a prescribing physician” (Wardman, Khan & el-Guebaly, 2002, p. 355). A recent Health Canada report on client safety improvements within First Nations and Inuit Health Branch (FNIHB) Non-Insured Health Benefits (NIHB) program recognizes that the vast majority of NIHB clients use prescription drugs in an appropriate way (Health Canada Non-Insured Health Benefits Program, 2007). There is a need for more understanding in this area.

Volatile solvents: Research and practice have uncovered high rates of volatile solvent abuse (VSA) among some First Nations and Inuit youth living in various rural and remote areas of the country. For example, a 2003 report from Pauingassi First Nation in Manitoba concluded that half the children under 18 living on reserve abused solvents (O'Brien, 2005, August 24). The current rate of VSA among Canada's Aboriginal youth as a whole is not known. Perceptions about the prevalence of this behaviour may be inflated due to the media. This may result partly from repeated showings of 1993 and 2004 media clips of Innu youth in Davis Inlet, Labrador getting high on gasoline.

Examples of Harm Reduction Measures Used by Aboriginal Peoples¹³

This section of the paper provides concrete examples of harm reduction programs and policies used by Aboriginal peoples in Canada. These include supply management, regulated consumption, managed alcohol consumption, safer spaces, injection drug use-related services (needle exchange programs, supervised injection facilities, methadone maintenance, anonymous HIV/AIDS testing), services for women, education and prevention programs, and product alteration. Canadian examples are provided except where information is lacking and in those cases, Australian experiences are used.

Although the non-traditional use of tobacco is not the focus of this paper, it is important to note that tobacco addiction is a significant health concern among Aboriginal peoples in Canada. For example, Inuit smoking rates are four times the Canadian average (Inuit Tapiriit Kanatami, 2005b). Examples of tobacco harm reduction strategies specific to First Nations, Métis and Inuit exist across Canada.

Supply Management

One approach to reducing alcohol-related harms is the management of alcohol sales—either extending or limiting access. In terms of extending access, the Royal Commission on Aboriginal Peoples recommended selling alcohol earlier in the day to reduce the use of more harmful alcohol substitutes such as mouthwash (Indian and Northern Affairs Canada, 1996). Limiting access can be achieved through the control of the hours of sale, product and volume (Brady, 2000; Gray & Sputore, 1998). Fort McPherson in the Northwest Territories is currently considering controls that could include a standard weekly per-capita allowance of alcohol. In 2000, Gray, Sagers, Sputore & Bourbon concluded that restrictions on access to alcohol showed promise in reducing alcohol-related harms among Aboriginal Australians. However, increasing or limiting access to alcohol alone is not sufficient to fully address alcohol-related harms over the long term. Similarly, prohibition alone is not a successful public health strategy (Elliott, Malkin & Gold, 2002).

Regulated Consumption

In some Aboriginal communities¹⁴ alcohol regulatory policies have been designed to support moderate drinking practices and reduce problems related to alcohol misuse (Drake, 2002; Landau, 1996; Lauzon, Gregoire, Glikzman & Douglas, 1998). For example, in 1993 the Mattagami First Nation in Ontario implemented a policy for serving alcohol that required a Special Occasion Permit and Band approval for the use of a designated building such as the community hall. It attempted to balance between a “wet” and “dry” approach by requiring that in addition to alcohol beverages, non-alcohol and low-alcohol drinks be available on the premise. Further, it required that all staff be trained and signs be posted in the facility to indicate that intoxicated people would be denied alcohol service, minors were not allowed (or only until a specified time), and there would be no “last call”. An evaluation of the policy showed it was effective in reducing alcohol service to youth and the number of fights at community events (Lauzon, Gregoire, Glikzman & Douglas, 1998).

A second evaluation by Glikzman, Rylett & Douglas (in press) of Mattagami First Nation and three other Aboriginal communities that implemented similar policies in Ontario (Moose Cree First Nation, Wikwemikong Unceded Indian Reserve, Aamjiwnaang First Nation) similarly found decreased reports of drinking and related problems. An evaluation of the policy at Wikwemikong Unceded Indian Reserve in the mid-1990s found a decrease in violence, vandalism, drinking in public areas and complaints. It was also reported that community attitudes towards the policy became increasingly positive over time (Narbonne-Fortin, Rylett, Manitowabi, Douglas & Glikzman, 2001).

¹³ Note that the majority of First Nations examples are specific to on-reserve Status Indians.

¹⁴ The term community is frequently referenced in the literature, but is seldom defined. For example, it can refer to a particular geographic location (for example, a reserve) or people living in separate locals but having a common tie through identity or history. In this paper the term community is variously referenced as it is used by the cited authors.

Managed Alcohol Consumption

Managed alcohol consumption is the provision of alcohol to alcohol-dependent people to prevent them from using more harmful substances when they cannot obtain beverage alcohol. The Western Aboriginal Harm Reduction Society, an all-Aboriginal organization associated with the Vancouver Area Network of Drug Users in the Downtown Eastside¹⁵, started an alcohol maintenance program where people are not forced to stop drinking immediately, but instead are offered beer to consume in managed doses. This harm reduction strategy is aimed at discouraging individuals from drinking more harmful substances such as rubbing alcohol (Vancouver Area Network of Drug Users, n.d.). It also reduces the harm to individuals and the community by preventing binge drinking and associated injuries as well as providing access to crisis services.

Safer Spaces

There are varying perspectives regarding what constitutes a safer space for alcohol and drug use. Some define it as a venue that is safer, compared with others, for consumption activities—that is, a place where individuals can use substances with reduced risk of physical violence and other harm-related incidents (Hunter, 1996). This can include no imminent threat of arrest by police, the ability to get assistance in the case of an overdose, and the option of consuming at a slower rate. An example is a supervised injection facility (discussed below).

Experienced and chronic users are also known to take it upon themselves to reduce potential harm from their own alcohol or drug use by not using in dangerous areas (near water or fire or in cold weather) (Landau, 1996) or by using in public spaces where they can get help if necessary (Sandover, Houghton & O’Donoghue, 1997). A study of volatile solvent use among Aboriginal peoples in Western Australia found that when presented with options, people tended to choose substances and ways of using (for example, sniffing glue in groups) that posed the least potential harm to themselves (Sandover, Houghton & O’Donoghue, 1997).

Sobering-up shelters are another approach to safer spaces. As an alternative to police detention in Australia, these shelters are offered as places where intoxicated individuals can go to reduce the risk of harming themselves and others (Loxley et al., 2004). The shelters also serve as a place where people can access or be referred to alcohol abuse services. Sobering-up shelters operate in both rural and urban regions in Australia and have been found to reduce injuries and arrests among Aboriginal peoples (Ministerial Council on Drug Strategy, 2003). A related example is night patrols, which transport intoxicated people to safe places such as sobering-up shelters. Night patrols are used by some Aborigines in Australia (Saggers & Gray, 1998; Loxley et al., 2004; Ministerial Council on Drug Strategy, 2003), and an Australian government document reports that they contribute to reduced violence and crime (Ministerial Council on Drug Strategy, 2003). In Canada, many homeless shelters have outreach services for people who are living on the street and using substances. This is particularly important in Canada’s winter climate.

Injection Drug Use-Related Services

Intravenous drug use is a prominent mode for HIV transmission among Aboriginal peoples in Canada. This is especially true for Aboriginal women. The Canadian Aboriginal AIDS Network suggests that harm reduction is a “pragmatic, non-judgmental way of dealing with HIV infection through intravenous drug use, and aims to address the issue of transmission rather than focus on the use of drugs which, in some instances, are inevitable” (Canadian Aboriginal AIDS Network, 1998, p. 16). Harm reduction strategies for injection drug use (IDU) include needle exchange programs, supervised injection facilities, methadone maintenance, and anonymous HIV/AIDS testing. At the provincial level, organizations such as the All Nations Hope AIDS Network in Saskatchewan (www.allnationshope.ca/News.htm)—a coalition of Aboriginal people, organizations and agencies focused on HIV/AIDS and hepatitis C among First Nations, Métis and Inuit—supports harm reduction services such as needle exchange and methadone maintenance.

¹⁵ The Downtown Eastside of Vancouver is noted for its high incidence of poverty, drug addiction and rates of HIV/AIDS. Persons of Aboriginal descent comprise a disproportionate percentage of the Downtown Eastside population.

Needle exchange programs: The Quesnel Tillicum Society Native Friendship Centre (www.quesnel-friendship.org/html/programs.htm#tillicum) in northern British Columbia provides a needle exchange program where needles, condoms and needle disposal containers are provided at no charge to community members. They also offer harm reduction education, including prevention information and awareness about HIV/AIDS and hepatitis C. There are also numerous examples of ad hoc exchange programs across Canada at Aboriginal AIDS service organizations.

Supervised injection facilities: Canada's only supervised injection facility is located in the Downtown Eastside of Vancouver. The Government of Canada recently announced a limited extension of an initial three-year exemption under Section 56 of the Controlled Drugs and Substances Act (CDSA) that will allow the site to remain open at least until the end of 2007. The facility opened in September, 2003, and is "a safe, health-focused place where people can go to inject drugs and connect with health care professionals and addiction services" (Vancouver Coastal Health Authority, n.d., para 2). A recent review of evaluations of the facility concluded that it has been associated with an array of community and public health benefits (Wood, Tyndall, Montaner & Kerr, 2006). Aboriginal peoples comprise 18% of the site's clientele (Vancouver Coastal Health Authority, n.d.). It is important that questions about the usefulness and cultural sensitivity of the site be addressed.

Methadone maintenance: Methadone "is an orally-administered, long-acting synthetic opioid that is prescribed to IDUs who are addicted to heroin and/or other opioids in order to block the euphoric effects of the drug and allow for gradual addiction withdrawal" (Canadian Aboriginal AIDS Network, 1998, p. 42). The report of the Canadian Aboriginal AIDS Network, *Joining the Circle*, documented misunderstanding surrounding methadone maintenance among Aboriginal treatment centres and noted that some did not accept clients who are taking methadone. There is a need to evaluate existing treatment centre policies that inherently will not support methadone maintenance (for example, not accepting clients who are using mind-altering substances). According to the 2005 National Native Alcohol and Drug Abuse Program treatment centre directory, nine NNADAP centres across Canada currently accept clients on methadone (First Nations and Inuit Health Branch, 2005).

An example of an Aboriginal organization that supports methadone maintenance is the Mi'kmaq Native Friendship Centre in Nova Scotia. The Centre offers Direction 180, described as an innovative, community-based, low-threshold methadone program based on a harm reduction, client-centred approach. Overall, the goal of the program is to reduce the dangers associated with injection drug use (IDU) by improving accessibility to methadone (Mi'kmaq Native Friendship Centre, 2005).

Anonymous HIV/AIDS testing: Some Aboriginal communities provide anonymous HIV testing as a harm reduction strategy. Anonymous HIV and STD testing and outreach are held twice a month in two Saskatchewan First Nations communities: Beardy's First Nation and Sandy Lake First Nation. Concerns surrounding confidentiality have been addressed by locating the clinics in places where people can enter without drawing much attention. Client confidentiality is further ensured by employing people from outside the community and storing client records outside of the clinic (Canadian Aboriginal AIDS Network, 1998).

The Aboriginal Strategy for HIV and AIDS in British Columbia outlines several additional harm-reduction initiatives for injection drug users, including "providing injection drug users with clean needles and syringes, bleach kits and instructions for disinfecting needles, education about HIV/AIDS and other diseases transmitted by needles...[and] non-judgmental medical care, including safe injection practices" (BC Aboriginal HIV/AIDS Task Force, 1999, p. 50).

Services for Women

Aboriginal women require harm reduction services that address their specific needs. Aboriginal women experience high rates of family violence, sexual harassment, inequality, single parenting and poverty in Canada. They are also leading in new HIV infections with injection drug use as the main mode of transmission (Public Health Agency of Canada, 2004). Stigma and discrimination are key factors preventing women from addressing their problematic issues with substances. In an attempt to address this, the Sisters in Spirit program being developed by the All Nations Hope AIDS Network plans to implement and disseminate an Aboriginal childbirth manual for front-line workers and professionals describing appropriate supports for women struggling with addiction during child-bearing years. A harm reduction approach is advocated.

Sheway is a harm reduction program currently operating in Vancouver's Downtown Eastside for pregnant and parenting women. Up to 80% of Sheway's clientele is Aboriginal (Burglehaus & Stokl, 2005). The program aims to provide education, referral and support to women to help them reduce risk behaviours and in particular to reduce or stop the use of alcohol and other drugs during pregnancy (Vancouver Native Health Society, n.d.). In a study of Aboriginal women accessing harm reduction services in Vancouver, it was reported that they were comfortable using the services at Sheway and most of the services they required were available; “[f]or these women, the program provides a safe, encouraging and supportive environment where women can learn problem-solving skills, gain valuable experience in interpersonal relationships, and enjoy role modelling and learning from other women.” (Benoit, Carroll & Chaudhry, 2003, p. 828). “Women [also] report that Sheway's model is akin to more traditional [Aboriginal] services in its fluid and informal method of service and the non-hierarchical relationship between the team and program participant” (Burglehaus & Stokl, 2005, p. 59).

Education and Prevention Programs

Some Aboriginal and non-Aboriginal organizations regard drug and alcohol education and prevention programs as harm reduction initiatives because they are seen to prevent future harms among existing and potential users. Some of these programs are general in scope and advocate an abstinence-based philosophy, while others are more oriented to reducing health and social harms among those who problematically use alcohol and other drugs. For example, NNADAP offers both education and prevention.

The Healthy Lifestyles Project offered by M'Chigeeng Health Services in Ontario provides community-based education and prevention programming. The project's vision is to “work towards a healthier community free of alcohol and drug abuse within a culture of safety. A proactive mix of holistic and healthy-living preventative strategies, including awareness, education, skill building and policy development, is based on strong involvement and connections in the community” (M'Chigeeng Health Services, 2005, p. 1). The project develops and implements harm reduction policies, and offers workshops on topics such as bar safety and server training.

Product Alteration

The private sector has also been involved in initiatives to reduce the harms of substance abuse among Aboriginal peoples. There are two innovative Australian examples. The communities of Wiluna and Fitzroy Crossing in Western Australia implemented a plan, in collaboration with the business sector, to help prevent injury resulting from glass alcohol containers. Liquor establishments in the community agreed to sell liquor in non-glass containers only (for example, aluminum cans) (Saggers & Gray, 1998). Another example is the use of Opal fuel in Australian communities where sniffing in groups is a problem. Opal fuel is a low-aromatic, unleaded alternative to regular fuel developed by British Petroleum in a gesture of corporate responsibility. The fuel contains fewer of the harmful solvents that produce the intoxication or “high” that inhalant users seek.

Barriers to the Development and Maintenance of Aboriginal Harm Reduction Policies and Programs

While some harm reduction policies and programs have been shown to be effective for responding to the health and social harms resulting from problematic substance use, there are several major barriers to implementing such measures. The development and implementation of Aboriginal-specific harm reduction policies and programs face additional challenges. Some of the main ones are discussed in this section: majority support for abstinence and prohibition, stigma, accessing care, availability of services, jurisdiction and funding, childcare, and cultural appropriateness. A suggestion for addressing each barrier is proposed.

While suggestions for addressing barriers are made in this paper, it is acknowledged that for some communities and individuals, harm reduction is incompatible with their cultural values. It is also acknowledged that the concept and practice of harm reduction, as understood in Western society today, has generally evolved outside of Aboriginal culture. This highlights the necessity of community consultation in any discussions of harm reduction policies and programs.

Majority Support for Abstinence and Prohibition

As discussed above, most Aboriginal treatment programs and a sizable number of First Nations, Inuit and Métis individuals and communities adhere to models of abstinence and prohibition. These models typically do not allow for moderate substance use or goals of reduced use, which are implicit in most harm reduction policies and programs. Consequently, the current high level of support for and adherence to a strict abstinence-based philosophy has been identified as a barrier to exploring options to offer harm reduction services.

It is suggested that... evidence-based approaches that offer communities and individuals a unique and important health care-centred and non-judgmental alternative should be considered when there is demonstrated need and general agreement on the applicability of harm reduction services. The

usefulness of this suggestion is substantiated in a report on the delivery of addictions services in the Northwest Territories. It concluded that “a harm reduction model ... will be a predominant force in the fight against addictions in the 21st Century. It is a modern day solution to modern day problems associated with substance use by attempting to reduce the criminality and social destruction caused by substance use” (Chalmers, Cayen, Snowshoe & Collin, 2002, p. 51).

Stigma

There is a range of understanding about harm reduction services within Aboriginal communities, including among service providers (Landau, 1996; Korhonen, 2004). Harm reduction programs are often inappropriately viewed as an indication of failure and “as the last stop after treatment options have failed” (Wardman & Quantz, 2006, p. 9). Consequently, the attachment of negative stigma to harm reduction programs and policies and the individuals accessing them has occurred (Canadian Aboriginal AIDS Network, 1998; Wardman & Quantz, 2006). The work of Jackson et al. (2006) with Aboriginal people living with HIV/AIDS concluded that individuals dealt with layers of stigma, including drug use, incarceration and their HIV/AIDS status. It has also been suggested that several reserves in Canada have engaged in a “war on drugs” designed to stigmatize and shame drug users in the community and particularly injection drug users.

It is suggested that... general, open discussions take place to define harm reduction and to examine the nature of its tensions and congruence with approaches that strictly promote abstinence. This is necessary for individuals to access care. There is also a specific need for increased education among addiction counsellors, health workers and community leaders on what harm reduction is. An example of an organization addressing stigma is Healing Our Spirit in British Columbia (www.healingourspirit.org/education.htm). Healing Our Spirit hosts province-wide, culturally appropriate HIV/AIDS education workshops that emphasize a harm reduction philosophy.

Accessing Care

Aboriginal peoples in Canada are generally hesitant to access health care for a number of reasons, including fear of harsh judgment and discrimination from health care providers. This reluctance is even greater among Aboriginal substance abusers. For example, a study by the Canadian Aboriginal AIDS Network found that injection drug users under-utilized hospital care and were not comfortable with it (Canadian Aboriginal AIDS Network, 1998). A study by Wardman, Clement & Quantz (2005) highlighted long-standing problems for Aboriginal peoples in rural areas accessing appropriate health services. In addition, because of cultural differences, Métis and Inuit are known to not access the sometimes more readily available services for First Nations.

It is suggested that... lessons be learned from organizations such as Anishnawbe Health Toronto (www.aht.ca/). The centre offers services to people using substances and living on the street. It adheres to a model of care in which individuals set their personal goals for healing and wellness in consultation with their health care providers. Key here is that people are given a choice of the best way for them to minimize potential harms related to their substance use. It is important that services be available specifically for First Nations, Inuit and Métis.

Availability of Services

There is an absence of funded harm reduction services in Aboriginal communities, and specifically on reserves and in rural areas where they are needed. The lack of local services means individuals are forced to travel long distances, often on a frequent basis. For example, many individuals who require methadone need to acquire it daily. Complications caused by travel can include transportation costs, family responsibilities, work commitments and childcare concerns (Currie, 2001; Wardman & Quantz, 2006; Women's Health Bureau, 2001). Concern has also been expressed that some physicians may not adhere to guidelines for prescribing methadone (for example, by providing urinalysis and counselling), and so some clients may sell it. As well, not having access to harm reduction services, such as a needle exchange, can be a potential health threat to a community at large.

It is suggested that... consideration be given to the option of offering mobile harm reduction services (for example, a needle exchange van) in rural and remote communities with demonstrated need (Daisy, Thomas & Worley, 1998; Women's Health Bureau, 2001). Remote (for example, fly-in) and smaller-sized communities may require additional methods for ensuring client anonymity and confidentiality.

Jurisdiction and Funding

Services to Aboriginal peoples are divided among federal, provincial and local governments. Only First Nations and Inuit qualify for funding under Health Canada's Non-Insured Health Benefits program. These arrangements can complicate the planning, coordination and funding of various substance abuse services, including harm reduction programs and policies (Landau, 1996; Poole, 2000). There is a need to provide adequate funding to develop and implement harm reduction policies and programs such as training for Aboriginal peoples and communities when it is requested.

It is suggested that... more amenable and flexible partnerships in the addictions field be formed between various levels of government. Adequate funding is required so that individuals can access the services they need. A possible example to look toward for leadership is the recently developed joint work plan by the Health Canada/Inuit Tapiriit Kanatami Task Group that aims to improve the health of Inuit.

Childcare

A major barrier preventing Aboriginal women from accessing harm reduction services is fear of social service authorities taking custody of their children¹⁶. This is true for most women accessing any addiction service in Canada, and particularly for pregnant women and Aboriginal women (Currie, 2001; Tait, 2000; Women's Health Bureau, 2001). Research shows that the likelihood of an Aboriginal woman's child being apprehended is much higher than for all other women in Canada (Kellington, 2001; British Columbia Human Rights Commission, 2001). For example, a study conducted by the First Nations Child & Family Caring Society of Canada found that "[i]n three sample provinces, one in 10 Status Indian children were in care as of May 2005 as compared to just under one in 200 for other children" (First Nations Child & Family Caring Society of Canada, 2005, p. 6). Fear of child apprehension among Aboriginal women is rooted in the historic actions of the Government of Canada. This includes Aboriginal children being adopted without the consent of their families and bands in the 1960s, residential schooling, and children being removed from their family homes without parental consent. A related barrier is a lack of childcare services for women while accessing harm reduction services.

It is suggested that... immediate attention be allotted to the persistent problem of women not accessing harm reduction and other addiction services because of childcare issues. Childcare options must be made available for women to access the services available to them. This may include allowing women to have their children accompany them in treatment.

Cultural Appropriateness

Given the substance abuse-related harms faced by First Nations, Inuit and Métis in Canada, existing and emerging harm reduction services need to be culturally appropriate so they will be accessed (Jackson, 2005). This includes incorporating Aboriginal culture, history and language into available and emerging services; culturally-specific programs and policies for First Nations, Métis and Inuit; and increased awareness and understanding about Aboriginal peoples among service providers. There is an overarching absence of Aboriginal-focused resources and programming in the substance abuse field, and in some cases this is a greater problem for Inuit and Métis as well as Non-Status Indians and Status Indians living off-reserve. A study of Aboriginal women who inject substances in Vancouver stressed the importance of having more service providers with "similar cultural backgrounds and life experiences" (Benoit, Carroll & Chaudhry, 2003, p. 826).

It is suggested that... Aboriginal culture, beliefs, traditions and practices be blended with current and emerging harm reduction services to make them as applicable and accessible as possible to all Aboriginal peoples. This must be done in collaboration with representatives of the relevant peoples.

¹⁶ Aboriginal women are the primary caretakers of children and represent the highest percentage of single-parent families in the country (Weber, 1998, p. v).

Conclusion

The absence of information on the general health status and rates of problematic substance use among First Nations, Inuit and Métis in Canada is of great concern. So too is the limited documentation on Aboriginal-specific harm reduction services. The aim of this paper has been to attempt to fill this gap. There remains a need for increased attention to these areas in Canada.

This paper has identified respect as the foundation of harm reduction policies and programs in the substance abuse field—respect for individuals, families and communities, and meeting users “where they are” in their health-care needs. The work of Ormond (2002) in Manitoba similarly identified that “[t]he central principle of respect and valuing the strengths of people should be the focal point of [harm reduction] initiatives undertaken” (p. 37). This calls for a very broad continuum of harm reduction responses to substance abuse, from services promoting safer substance use to those promoting abstinence.

It also means recognizing that the development of effective harm reduction policies and programs must take its direction from communities and their members. Harm reduction is about choice. This paper has not included abstinence-based approaches that do not respond to the specific needs of individual users. In fact, such approaches may harm people for whom abstinence is not practical at any given time. It is worth noting that respect is one of the nine principles of the National Framework for Action to Reduce the Harms Associated with Alcohol and Other Drugs and Substances in Canada (Government of Canada, 2005). Currently a complementary National Aboriginal Framework specific to First Nations, Métis and Inuit is in development.

The harm reduction measures reviewed in this paper are both encouraging and discouraging. Optimistically, there are numerous well-established harm reduction programs and policies specific to Aboriginal peoples in Canada, as well as new services starting up. For example, the Canadian Aboriginal AIDS Network recently received project funding to develop four harm reduction models for specific populations: two-spirited people¹⁷, women, prisoners and youth.

Less encouraging is that there are not enough culturally-appropriate harm reduction services available to Aboriginal peoples, including those that are specific to First Nations, Inuit and Métis. It is important to acknowledge the limited availability of Inuit- and Métis-specific harm reduction resources and programming. There are also many challenges to the development and maintenance of both Aboriginal- and non-Aboriginal-specific services that address the needs of Aboriginal peoples. For those harm reduction services that *are* available, there is a need for methodologically-sound and culturally-appropriate evaluations of their effectiveness.

This paper has reaffirmed that the problematic use of substances is not the “problem” but rather, the symptom of much broader social ills faced by First Nations, Inuit and Métis in Canada. For problematic substance use to be addressed in a comprehensive manner, fundamental inequalities faced by Aboriginal peoples must also be addressed. In Australia, for example, organizations are starting harm reduction programs that “aim to minimise the use of alcohol by improving the overall social, political and economic well-being of Aboriginal people” through job creation and recovering land rights (Gray & Sputore, 1998, p. 43). There are also many examples in Canada of tribal councils and bands adopting economic development, job creation and business entrepreneurship as part of a population health strategy. Such harm reduction models must be grounded in community choice, consultation, understanding and leadership. Societal factors, including the social determinants of health and their links to problematic substance use, also play a role in developing effective, long-term responses. In other words, harm reduction is “important, but not enough” (Sellman, Huriwai, Fua, Kahn, & Roche, 1997, p. 87).

¹⁷ The term two-spirited generally refers to Aboriginal people who identify themselves as gay or lesbian.

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With a legislated mandate to reduce alcohol- and other drug-related harms, the Canadian Centre on Substance Abuse provides leadership on national priorities, fosters knowledge-translation within the field, and creates sustainable partnerships that maximize collective efforts. CCSA is supported by Health Canada through Canada's Drug Strategy.

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