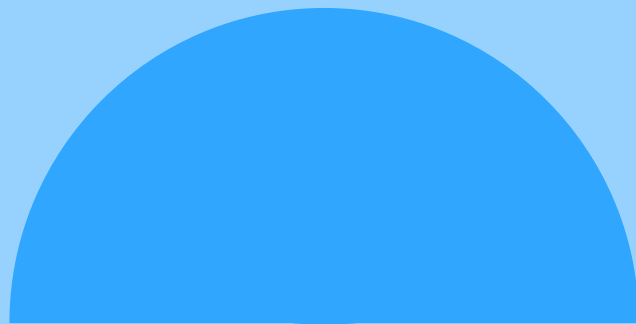
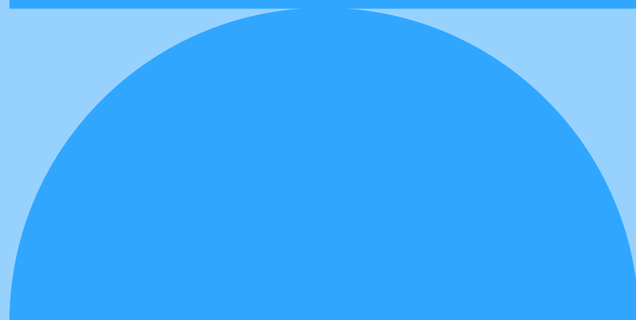
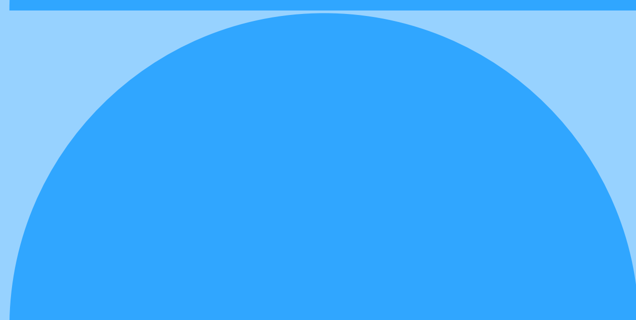
THEMATIC CHAPTER: INDIGENOUS PEOPLE



THE GLOBAL STATE
OF HARM REDUCTION 2024

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INDIGENOUS PEOPLE

In response to the *Global State of Harm Reduction 2024* thematic survey, 95% of Indigenous respondents indicated that drug use had been identified as a problem among Indigenous people in their countries. Methamphetamine, cannabis, tobacco and opioids were identified as the most commonly used drugs. The majority of respondents (77%) said drug-related harm was higher for Indigenous people than for non-Indigenous people.[1]

A 2017 evidence review by Anton Clifford-Motopi (Mosotho)[a] and Anthony Shakeshaft confirmed Indigenous people in Canada, the USA, Australia and Aotearoa New Zealand experience disproportionately high burdens of harm from substance use.[2] Among Indigenous contexts considered in this chapter, opioid toxicity deaths were seven times higher for Kainai people in Alberta, Canada than for the general population,[3] while in Minnesota, USA, opioid toxicity deaths were six times higher for Native Americans than for non-Hispanic whites.[4]

a Throughout this chapter, where source contributors are Indigenous people, the name of their community is given.

Note on our use of the term 'Indigenous'

The United Nations Declaration on the Rights of Indigenous Peoples purposefully does not include a formal definition of Indigenous peoples, noting that self-identification as Indigenous is considered a fundamental criterion of indigeneity, and that Indigenous peoples hold the right to determine their own identity or membership in accordance with their customs and traditions.[5]

The United Nations does, however, describe the following experiences and characteristics as commonly shared among Indigenous peoples: "Indigenous peoples have in common a historical continuity with a given region prior to colonization and a strong link to their lands. They maintain, at least in part, distinct social, economic and political systems. They have distinct languages, cultures, beliefs and knowledge systems. They are determined to maintain and develop their identity and distinct institutions and they form a non-dominant sector of society."[6]

Most survey respondents identified trauma from colonisation as a primary catalyst for drug-related harms experienced by Indigenous people.[7] This trauma is exacerbated by ongoing structural racism,

defined by Keith Lawrence and Terry Keleher as 'an array of dynamics – historical, cultural, institutional and interpersonal – that routinely advantage whites while producing cumulative and chronic adverse outcomes for people of color'.[8] Structural racism might be manifested in ease of access to alcohol and drugs,[9] overprescription of opiate medications,[10] underfunding of Indigenous healthcare,[11] lack of recognition for Indigenous healthcare models (including at the level of multilateral organisations such as the World Health Organization),[12] policies that are unfavourable to the complexity, scale and urgency of drug-related harms experienced by Indigenous people,[13] intersectional stigma and discrimination (including in healthcare settings) and over-policing.

Intergenerational poverty directly relates to colonisation and structural racism, and it is another significant catalyst for drug use among Indigenous people. Poverty is compounded by unemployment, a lack of social services such as housing and limited access to ancestral land for traditional economic activities.[14] Josien Tokoe (Kari'na) describes the situation in Suriname as follows: 'Some communities are surrounded by third-party concessions, which prohibit them from entering the forest to hunt or fish for their daily family support. Young people and many [marginalised people] are on drugs, alcohol, etc., which means there are no development prospects for the future.'[15]

Increasingly, Indigenous harm reduction is turning away from mainstream Western frameworks towards self-determined approaches imbued with Indigenous identity, values and knowledge.

These responses vary in scale and relative complexity. The case studies presented below are selected to convey the range of harm reduction responses deployed within Indigenous settings, from urgent intervention via extrajudicial use of naloxone to longer term healing through the reintegration of Indigenous worldviews, languages and ways of life.

Work is currently being undertaken by Indigenous people around the world, including the Aboriginal Drug & Alcohol Council (South Australia), Drug Free World Fiji, Federación por la Autodeterminación de los Pueblos Indígenas (Paraguay), First Nations Health Authority (Canada), Indigenous Health Australia, Papa Ola Lokahi (Hawai'i), Te Hiku Hauora (Aotearoa New Zealand), Thunderbird Partnership Foundation (Canada) and many others.[b]

b For more on these organisations see: Aboriginal Drug & Alcohol Council: https://adac.org.au; Federación por la Autodeterminación de los Pueblos Indígenas: https://fapi.org.py; Indigenous Health Australia: https://iaha.com.au; Papa Ola Lokahi: www.papaolalokahi.org; Te Hiku Hauora: www.tehikuhauora.nz; Thunderbird Partnership Foundation: https://thunderbirdpf.org/.

ALBERTA, CANADA

Esther Tailfeathers (Kainai Nation), Medical Lead of the Indigenous Wellness Core at Alberta Health Services, has led the Kainai response to the fentanyl crisis, initiating a harm reduction response that is underpinned by 'kímmapiiyipitssini', a Blackfoot term meaning 'to give kindness to each other'.[16]

Tailfeathers identifies several social determinants that made the Kainai Nation vulnerable to fentanyl, including intergenerational poverty, unemployment and inadequate housing. The historic trauma of the Canadian Indian residential schooling system, and the adverse childhood events associated with it, is the number one cause.[c]

A more recent factor has been overprescription of opioids to First Nations people. Data from the Alberta First Nations Information Governance Centre shows opiates being prescribed to Indigenous people at twice the rate of non-Indigenous people.[17]

Tailfeathers' work follows a 'continuum of care' model, which moves from prevention to harm reduction, clinics, detoxification, treatment and aftercare to supportive housing, community care and, finally, to addressing the social determinants of challenges around drug use. A major part of her work to date has involved bringing naloxone kits onto the Kainai reserve and educating people about their use.

This work was initially outside the law, as naloxone could only be provided in metropolitan clinical settings. However, Dr. Hakique Virani, a public health physician and substance use specialist in Alberta, worked with Health Canada's Drug Distribution Centre to procure as much naloxone as possible to be sent to the Blood Tribe in overdose reversal kits for local physicians to dispense to people who could benefit from them. The naloxone distribution approach on-reserve, in fact, was the impetus for a province-wide program later advanced by Dr. Jim Talbot (then the provincial Chief Medical Officer of Health). In March 2016 Health Canada approved naloxone's availability without a prescription, and naloxone became more widely available in First Nations community settings and throughout the country as a result.

A further challenge for Tailfeathers' work was resistance from Kainai elders, who thought naloxone would enable drug use on the reserve. Tailfeathers' team provided information to community members which enabled them to see that the use of naloxone was about celebrating the lives of people without judgment. As Tailfeathers bluntly states in a speech given in 2023: "our [position] was you cannot enable a dead body to continue to use drugs".[18] The last two fentanyl overdose deaths on the Blood Reserve occurred on 20 March 2015, directly contrasting to the steady increase in overdose deaths across Alberta following the provincial government's cutbacks to harm reduction services.[d]

Carol Hopkins (Lenape Nation), CEO of Thunderbird Partnership Foundation, notes that First Nations harm reduction remains uneven: 'There are some programs, like national distribution of naloxone [and] some communities have access to resources that support mobile outreach and distribution of sterile drug use equipment. But this is not standard across all First Nations because of inequitable funding.'[19]

MINNESOTA, USA

Minnesotan Native American communities have similarly had to pursue their own responses to the opioid overdose epidemic into a headwind of federal underfunding and inadequate policy. Thaius Boyd (Ohkay Owingeh and San Felipe Pueblo) et al. note this has happened despite the USA government's obligation, rooted in Native American treaties, to provide healthcare services to Native Americans in exchange for land and resources.[20]

c From the 1880s until 1996, Indigenous children (some as young as four) were compulsorily removed from their homes and placed in residential schools, where many experienced physical, emotional and sexual abuse.

d Tailfeathers cites Alberta First Nations Information Governance Centre data which shows the rate of apparent accidental opioid poisoning deaths among Alberta First Nations people rising from 44.1 per 100,000 people in 2016 to 142.8 per 100,000 people in 2020.

Government attempts to improve Native American access to health services and Native American health outcomes have been negatively affected by consistent underfunding. In 2019, for example, the Indian Health Service per capita expenditure for healthcare services was USD 4,078, compared with a national average of USD 9,726 per person.[21]

These federal policy failures have been exacerbated by opioid prescribing and dispensing practices which include a lack of oversight of opioid prescription within the Indian Health Service.[22]

Opioid agonist therapy (OAT) is a critical public health tool for addressing increase in opioid use and related harms, including overdoses.[23] But the lack of culturally appropriate options, which explicitly integrate spirituality, holistic healing and wellness care into OAT, may exacerbate and prolong opioid-related harm within Native American communities. In 2017, only 22% of substance use treatment facilities offered OAT for Native Americans and Alaskan Natives, rising to only 40% in 2018.[24]

This low uptake of OAT among Native Americans is also due to an absence of specialised expertise and training, stigma towards substance use and treatment and misperceptions about treatment therapy.[25] This echoes Tailfeathers' observation about the cool reception to naloxone from Kainai elders.

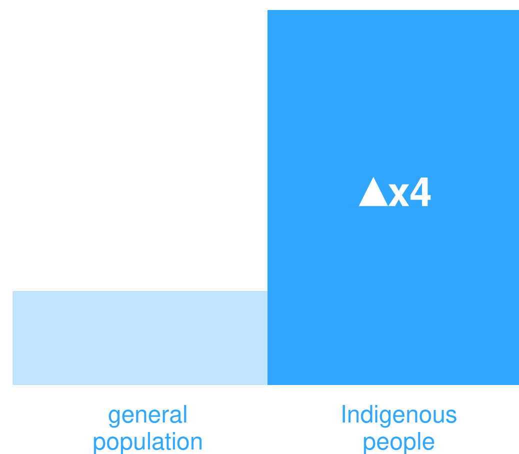
OAT with culturally-specific implementation approaches, integrated care, a focus on family and community wellness and accompanying psychosocial counselling would facilitate greater acceptance among Native Americans and better treatment outcomes.[26]

WISCONSIN, USA

While uptake of OAT has been uneven in Native American tribes and settings in the USA, there have been notable successes, including among the Bad River band of Lake Superior Chippewa, Wisconsin.

The 2022 rate of overdose deaths among Indigenous people in Wisconsin was four times that of the general population (97.8 per 100,000 people, against a statewide average of 24.8).[27] To counter this, and to avoid the potential stigma posed by in-clinic treatment, the Bad River band established a statewide mail-order service offering free naloxone in late 2022. Since then, the tribe, in partnership with the NEXT Distro online and mail-based harm reduction service,[28] has made 1,900 deliveries to people in at least 63 counties. Tribe members have also provided more than 2,000 in-person deliveries. Overall, around 14,800 doses of naloxone and 165,000 syringes have been distributed.[29]

Overdose deaths in Wisconsin



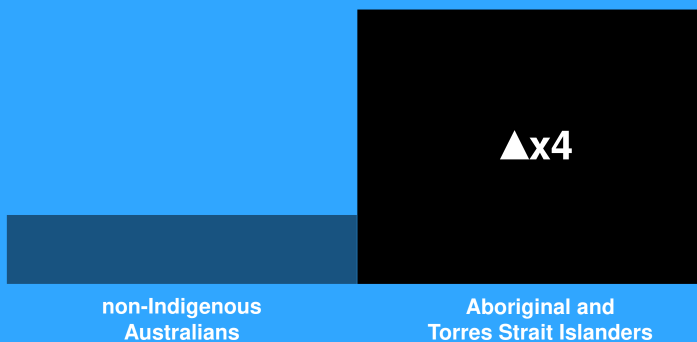
SYDNEY, AUSTRALIA

The Penington Institute's *Australia's Annual Overdose Report 2023* states there were 1,675 unintentional drug-induced deaths in Australia in 2021.[30] The report notes that Aboriginal and Torres Strait Islanders had a higher rate of unintentional drug-induced deaths (20 per 100,000 people) than non-Indigenous Australians (5.9 per 100,000 people).[e,31] While this number is significantly lower than the rates identified for Alberta First Nations people (142.8 per 100,000 people in 2020 – see footnote c) and Wisconsin Native Americans (97.8 per 100,000 people in 2022, as above), the disproportionality between Indigenous and non-Indigenous Australians is alarming.[f]
In 2023, Marguerite Tracy and Bradley Freeman (Bundjalung) et al. reviewed treatments for drug harm among Aboriginal and Torres Strait Islander people in Australia.[32] Cannabis is identified as the most common recently-used drug reported by Aboriginal and Torres Strait Islanders (16%), followed by strong pain relievers (not purchased over the counter) and opioids (5.9%).[33] The authors note the central, ongoing role of colonisation in placing Aboriginal and Torres Strait Islanders at increased risk of harms from drug use.[34] They endorse tailored holistic treatments which combine mainstream clinical practice with culturally secure care that promotes social and emotional wellbeing. This is a dual approach that is common among Australia's 140 Aboriginal and Torres Strait Islander Community Controlled Health Services.[35]

e The Pennington Institute's *Australia's Annual Overdose* Report 2023, p.45 clarifies that data on Indigenous status is only reported for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory (i.e., Victoria, Australian Capital Territory and Tasmania are absent) as these are the only states with an appropriate level of Indigenous identification and sufficient number of Indigenous deaths for the Australian Bureau of Statistics to include the data in its causes of death analysis

f Scott Wilson, board member of the Penington Institute and director of the Aboriginal Drug and Alcohol Council (South Australia), believes that the difference between the Indigenous Australian and Indigenous North American rates of unintentional drug-induced deaths is due to fentanyl not having taken as strong a hold in Australia as it has in North America.

Aboriginal and Torres Strait Islanders are four times more likely to die of an unintentional drug overdose as compared to non-Indigenous Australians



The Aboriginal Medical Service Cooperative (AMS) is a longstanding example of an Indigenous community-controlled health service. It was established in Redfern, a suburb of Sydney, in 1971 to counter the racism Aboriginal people experienced in mainstream health services and provide comprehensive and culturally secure primary healthcare for local Aboriginal people.[36]

The AMS founded a Drug and Alcohol Unit in 1999, following record numbers of people dying from heroin overdoses in Sydney and New South Wales.[37] The unit combines mainstream relapse prevention approaches with culturally-centred care led by Indigenous staff. Cultural aspects of care include connection to country through yarning, incorporation of family and observance of local cultural protocols.[38] The unit's coordinator (a Bundalung man) provides onsite counselling, aided by an Aboriginal drug and alcohol worker (of any gender, as required).[39]

The unit's mainstream medical care follows standard practice. When first established, the unit provided methadone prescribing and counselling. From 2001, it started prescribing and dispensing buprenorphine tablets. Later on, it began providing a branded medication called Suboxone (buprenorphine plus naloxone). At the outset of the COVID-19 pandemic, the unit offered slow-release injectable buprenorphine (Buvidal), meaning clients would not need daily or near-daily visits to the unit. The unit currently prescribes for around 150 clients, including onsite dispensing of Suboxone or Buvidal.[40] The unit's doctors also provide home detoxes, relapse prevention medicines and treatment for hepatitis C.[41]

AOTEAROA NEW ZEALAND

Andre McLachlan (Ngāti Apa /Ngāti Kauae, Muaūpoko/Ngāti Pāriri) and Waikareomoana Waitoki (Ngāti Hako, Ngāti Hako, Ngāti Māhanga, Ngāti Māhanga) describe similar combined approaches within Aotearoa New Zealand, where Western clinical practices have been reframed within an Indigenous understanding of harm reduction.[42]

McLachlan and Waitoki note that Māori, as with other Indigenous people, are disproportionately affected by mental health and challenges with substance use.[43] The authors see a tendency within Western approaches to drug-related harm to use reductionist models that focus on the individual outside of their relationship with family or community. Such top-down approaches utilise principles held by the practitioner and their organisation, rather than by the individual or their collective, and lack consideration of the needs, preferences and voices of those affected and their communities. This can lead to unintended consequences like criminalisation, inequitable law enforcement experiences, withdrawal-related harms and disconnection from treatment agencies and support services.[44]

Strategies focussed upon isolated health behaviours have limited efficacy if they do not also address the impact of systemic issues related to colonisation, interpersonal and structural racism, intergenerational trauma, poverty, homelessness or other determinants of ill health.[45]

Harm reduction responses developed by and from Indigenous perspectives can identify and articulate how colonisation and racism have created the systemic, biological and interpersonal factors leading to challenges with substance use. Extending beyond narrow clinical interventions, Indigenous responses to trauma can focus on cultural revitalisation and regeneration, providing space for language and the cultural dimensions of wellbeing to be centred.[46]

Indigenous harm reduction strategies have been successfully employed within Aotearoa New Zealand healthcare, including *Te Whare Tapa Whā* and *Pae Tata Pae Tawhiti: An Indigenous Framework for Brief and Early Intervention*.[47,48] The New Zealand Ministry of Health has funded and developed training based on these Indigenous strategies for Māori and non-Māori practitioners working within primary mental healthcare and harm reduction.[49]

There are four components viewed as critical for effective Indigenous harm reduction approaches:

1 **Whakapapa:** Harm reduction must consider the history and relationships between culture and community-specific harms, particularly colonisation and intergenerational trauma.

2 **Huanui oranga:** The strengths, preferences and strategies of Indigenous communities must be included to accurately and effectively respond to drug-related harms.

3 **Mauri ora, Whānau ora and Wai ora:** Harm reduction efforts must seek to increase quality of life as defined by Indigenous communities.

4 **Ngā take pū o te tangata:** Harm reduction must be guided by the values and principles of Indigenous peoples.[50]

Te Kāika (the village) in Otago, Aotearoa New Zealand is an example of this harm reduction approach.[g] Te Kāika was founded by Ōtākou Health Limited, a Ngāi Tahu[h] charity, with the vision of providing integrated health, social and educational services to Māori and other guests. Te Kāika prioritises affordability and takes a holistic, Māori-centred approach to improving and maintaining whānau (family) wellbeing; this reduces cultural and financial barriers to accessing health services.

Its services include the Te Kāika Community-Based Alcohol and Other Drug Addictions Service, which provides inclusive harm reduction within Māori-centred models of relational care for people with moderate to severe drug challenges and their families. The service incorporates a range of approaches, including safer use, managed use and abstinence, meeting people who use drugs 'where they're at', and addressing the conditions of substance use along with the use itself.

Te Kāika's operations parallel the dual approach recommended by the AMS unit in Redfern, Sydney and other Indigenous settings in Australia. Its clinical practice (delivered by Indigenous and non-Indigenous practitioners) is underpinned by the Te Whare Tapa Whā framework (outlined in the left hand column) and uses Indigenous delivery models, such as Ngāi Tahu's *Whānau as First Navigators*,[51] which champions the roles of family self-agency and received ancestral wisdom in achieving and maintaining wellbeing.

Despite the recent positive developments in reducing drug-related harm among Māori in Aotearoa New Zealand, a change of government in 2023 has seen nuanced Māori health policy abandoned in favour of a one-size-fits-all approach. This may stall some of the momentum that was building within Māori harm reduction. A respondent to the *Global State of Harm Reduction* survey observes: '[The] NZ government very recently dismantled the Māori health support organisation [authority], choosing instead to reduce its impact by cutting jobs and pushing it back into the mainstream health system, which instantly reduces services, increases waiting times and by design, de-prioritises Māori health.'[52] This policy shift, with its expected reduction in services, mirrors changes described by Tailfeathers and Boyd within First Nations and Native American contexts (above).

g For more on this, see www.tekaika.nz.
h Ngāi Tahu (people of Tahu) is the collective tribal name for a conglomerate of interrelated sub-tribes in Te Waipounamu (the South Island of Aotearoa New Zealand).

Increasingly, Indigenous people are taking the lead in their own healthcare relating to drugs, establishing harm reduction interventions and care programmes that are designed and implemented by and for themselves, with some notable successes. As described by Indigenous scholars, optimal Indigenous harm reduction will require approaches that merge leading clinical practice with Indigenous worldviews (identity, values and knowledge) and Indigenous leadership and agency, supported by stable policy and equitable funding. Achieving and maintaining this balance in the current volatile global political environment will require skill, resilience and tireless advocacy.

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