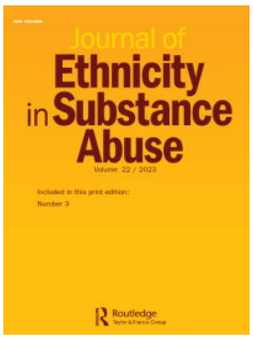

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REVIEW

Promoting indigenous cultural responsivity in addiction treatment work: the call for neurodecolonization policy and practice

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ABSTRACT

Addiction is a multidimensional issue affecting North American, Indigenous peoples. Most federal and provincial-funded treatment programs follow a Western model. We argue for more comprehensive culturally responsive training for workers, and the concept of neurodecolonization be covered. We also call for developing policy within education, licensing bodies, and front-line organizations for a working knowledge of the historical and racial contexts affecting Indigenous peoples. These policies must engage with the Kehte-ayak (Old Ones), while harmonizing Indigenous and Western knowledge systems that incorporate contemplative practices such as Indigenous ceremonies and neurodecolonzation approaches to healing.

KEYWORDS

Trauma; cultural responsivity; addiction; neurodecolonization

Introduction

First Nations peoples across Canada face a significantly higher risk of developing health issues than those of other populations due to the residual effects of historical and intergenerational trauma related to colonization and the residential schooling system (Aguiar & Halseth, 2015; Bombay et al., 2014; Brave Heart et al., 2011; Fiedeldey-Van Dijk et al., 2017; Ross et al., 2015; Wilk et al., 2017). In the area of addiction, biomedical models of health favor Western-based addiction treatment approaches. Examining addiction research using Indigenous Methodologies demonstrates that culture is a critical component of trauma and addiction recovery (Chong et al., 2009; Fiedeldey-Van Dijk et al., 2017; Government of Canada et al., 1996; Mental Health Commission of Canada, 2012; Mussel et al., 2004; Rowan et al., 2015). Cultural interventions address wellness from a wholistic perspective, unlike Western biomedical approaches that focus on the absence of disease and suggest treating the mind-body separately when

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treating illnesses such as addiction (Dell et al., 2011; Szlemko et al., 2006). The kind of change required to make a system culturally responsive will only occur with people educated and practiced in that system via attitudinal change and instruction. The sustainability of these culturally responsive systems will depend on individual organizations' establishing policies and regulations (Federation of Saskatchewan Indian Nations, 2013). Cultural responsiveness is an umbrella term that encompasses the concepts of developing health professionals' skill and knowledge (i.e., competencies) to recognize power imbalances within the health systems (e.g., safety) (Federation of Saskatchewan Indian Nations, 2012). The Indigenous Cultural Responsiveness Theory (Sasakamoose et al., 2017) is celebrated as a fundamental approach for healthcare professionals working with indigenous people. The Indigenous Cultural Responsiveness Theory, now known as the ICRF, provides a decolonized roadmap to reconcile the failure of conventional health systems that do not offer reliable Indigenous health care services. Decolonization through ICRF is a restorative justice approach that blends Western treatment understandings with culturally responsive services. Services providers collaborate with users to create clear service offerings that meet their unique cultural needs. Western approaches meet all service user needs is challenged, and Indigenous world views and customs are then welcomed.

The ICRF exemplifies a reconciliatory approach to health and wellbeing that is built on four protective factors: community-engagement strength-based, trauma-sensitive, and spiritually grounded (Federation of Saskatchewan Indian Nations, 2013; Sasakamoose, 2017; Snowshoe & Starblanket, 2016). Established through ceremonies, steeped in Indigenous ways of knowing, harmonized with evidence-based Western practices (LaVallie, 2019) and adaptable to local contexts, the ICRF approach is uniquely positioned to 1) promote the restoration of Indigenous community-based health and wellness systems; 2) create a middle ground for collaboration between Indigenous and Western structures to decolonize health research by upholding the commitment to reconciliation; and 3) to guide research that improves the health and wellbeing of Peoples in Saskatchewan and beyond (Federation of Saskatchewan Indian Nations, 2013; Sasakamoose et al., 2017; Truth and Reconciliation Commission of Canada (TRC), 2015).

FSIN Resolution #1979 mandates adopting and applying the ICRF where the inherent and defined right to health includes the right to access quality treatment that respectfully accommodates First Nations cultural traditions and values (Federation of Saskatchewan Indian Nations, 2013; Sasakamoose et al., 2017). The Knowledge Keepers and Elders of Saskatchewan developed the Cultural Responsiveness Framework of which the ICRT was formed. "Elders and others wanted clarification and assurances that what

was being done with the framework was not a 'giving away' of medicines, as they were all too familiar with examples where knowledge and medicines were shared and later plagiarized, stolen or used without permission." (FSIN, p. 16). Therefore, FSIN developed guidelines and protocols that include returning to Elders and reporting case studies of CRF uptake. This study's creation is based on the ICRF conceptual framework in collaboration with First Nations communities in Saskatchewan. This strategy reflects the ICRF's three strategic directions (Federation of Saskatchewan Indian Nations, 2013; Sasakamoose et al., 2017; TRC, 2015).

The ICRF theory emphasizes the concept of wellness, which is defined as a wholistic state of balance between one's spirit, heart, mind, and body (Elder Dumont as cited in National Native Addictions Partnership Foundation, 2014). The two-eyed seeing metaphor is a philosophy for employing cultural responsiveness, which allows for the harmonization (LaVallie, 2019) that emphasizes Indigenous health perspectives while implementing evidence-informed practices. Clinicians assist Indigenous peoples in exploring the consequences of compound loss through the technique of two-eyed seeing. Two-eyed seeing encourages professionals to look at both the Indigenous and Western worlds in order to comprehend the dynamic historical and cultural dimensions of addiction. Ermine's Ethical Space (2007) establishes a middle ground in which two different paradigmatic systems (Indigenous and Western) can engage in harmonizing knowledges for the benefit of all. The ICRF's endeavor to decolonize systems takes place in this middle ground. Snowshoe & Starblanket's reconciliatory approach to health and wellness that is grounded in four protective factors: community-engaged, strengths-based, trauma-sensitive, and spiritually grounded (Sasakamoose et al. , 2017; Snowshoe & Starblanket, 2016) are the ideas that addiction workers adhere to in order to improve cultural responsiveness and decolonize biomedical health approaches. This paper argues that Indigenous peoples with past or current addiction experiences require access to cultural supports. We posit that educational and licensing bodies that regulate addiction treatment providers should acknowledge the unique qualifications needed to deliver professional healing, health, and wellness services to Indigenous peoples. The addiction treatment workforce development plays a crucial role in the quality-of-care clients receive. The development plan includes the following critical components: cultural knowledge, skills, and humility; education and training; and personal wellness (Health Canada, 2011). To promote cultural responsivity, we call for neurodecolonization policy and practice in worker certification and regulation.

Specialized training, including cultural competency, is necessary to help inform the workforce of emerging addiction and mental health issues. In

addition, workers must acquire training within a strengths-based, trauma-informed understanding of colonization's historical effects, assimilation practices, and Reading's (2013) categories of racism, to work with Indigenous peoples healing from addiction. These considerations must naturally be taken into account by the care facilities and accreditation bodies that use the ICRF.

There is no biological difference between Indigenous and non-Indigenous addiction patterns; however, Western dominance has created conditions unique to Indigenous peoples that must be addressed in the healing process. Understanding diverse types of racism, acknowledging historical impact and trauma, honoring Indigenous knowledge and healing practices, and embracing cultural protection and reconciliation objectives are all part of the healing process. Indigenous peoples struggling with addiction must begin a decolonization process, questioning subjective characterizations and learned stereotypes, in addition to increasing worker knowledge. Following Yellow Bird (2012, 2013) call to put colonial legitimacy into question, Indigenous peoples can begin healing through neurodecolonizing exercises and supportive treatment programs. This paper provides a brief overview of the role colonization and assimilation techniques played in the manifestation of addiction and treatment choices is provided, as is the necessity for more comprehensive cultural safety training for workers and the concept of neurodecolonization. Finally, a challenge is made for policy development in education, licensing bodies, and front-line organizations to ensure that students have a working awareness of historical and racial contexts. These policies must harmonize Indigenous and Western knowledge systems, including Kehte-ayak (Old Ones), and incorporating neurodecolonization, contemplative practices, and local Indigenous approaches (LaVallie, 2019).

Addiction - a Western influence

Substance misuse is new to North American Indigenous populations (Vetulani, 2001). Alcohol, tobacco, and caffeine have detrimental effects when consumed and ingested in harmful non-ceremonial ways as introduced through European manufacturing and use. Alcohol is regarded as the "third great substance of abuse" and that "It was extensively used for entertainment, sometimes in religious ceremonies, in all cultures of the world, except certain islands of Oceania and North American Indian tribes" (Vetulani, p. 204). Along with forced negative assimilation practices, and the resulting trauma (Aguiar & Halseth, 2015), when alcohol was introduced in North America, Indigenous communities fragmented due to a lack of awareness of the substance's addictive characteristics and instruction

on safe consumption techniques. (Vetulani). Previously, tobacco was only smoked during ceremonies and in low concentrations. Tobacco was used as an offering or gift of thanks, and Inuit peoples did not use tobacco at all. Now, tobacco misuse is highest amongst Native American people (Centers for Disease Control & Prevention, 2019). The Centers for Disease Control and Prevention argues that commercials targeting Indigenous people influenced increased non-ceremonial usage.

Substances remained harmless when used in ceremony. For example, peyote used by members of a Native American Church precluded detrimental effects when used for ceremonial reasons (Vetulani). Hallucinogens (only mushrooms) were traditionally used by Indigenous peoples of South America, not North American. When ingested, these substances were consumed at low levels for entertainment, not patterned misuse (Vetulani). Drugs now come in higher concentrations, and some administration takes place directly into the bloodstream, creating quicker reactions (Vetulani). Inhalants, in solvents, gasoline, and aerosols are also a Western influence. Indigenous community members struggle to heal from fast-acting substances with minimal cultural tools offered through Western treatment systems.

Genetic predisposition

Many researchers question whether Indigenous peoples have a gene or enzyme that prevents alcohol metabolism (Ehlers, 2007; Ehlers & Gizer, 2013; Levey et al., 2014; NIAAA, 2007; Ting-Kai et al., 2006; Xingguang et al., 2007). The lack or presence of a gene that affects alcohol's metabolic rate would support the notion that Indigenous peoples cannot tolerate alcohol and are at higher risk for addiction (Ehlers & Gizer, 2013; Levey et al., 2014). Research suggests that the delay in metabolizing alcohol can be a protective factor or detrimental factor in that it keeps alcohol in the system longer. Ehlers's work stands out as referenced by many supporting the notion that a lack of the ALDH2 gene may increase North American Indigenous peoples' risk for higher alcohol consumption levels (Ehlers; Ehlers & Gizer). The AlDH2 gene and ALDH1 and ADH enzymes may be protective factors in that alcohol is metabolized faster, reducing the amount of alcohol ingested. Alternatively, the alcohol may last in the system longer, keeping the person intoxicated longer (Ehlers). However, no research has definitively linked specific genes or enzymes to alcoholism (Quintero, 2001; Cochrane review and general searches). Ehler & Gizer suggest that there is a common genetic substrate for alcohol dependence proposing genetic predisposition; however, it is absent in Native Americans. The authors found that there are substrates for other substances and report:

> The high rates of substance dependence seen… is likely a combination of a lack of genetic protective factors (metabolizing enzyme variants) combined with genetically mediated risk factors (externalizing traits, consumption drive, drug sensitivity/tolerance) that combine with key environmental factors (trauma exposure, early age of onset of use, environmental hardship/contingencies) to produce increased risk for the disorder. (p. 1)

Ting-Kai et al. (1998) attribute no gender or ethnic differences to body mass relative to liver mass. Thus, there appears to be no biological or genetic difference between Indigenous and non-Indigenous responses to alcohol; the difference appears to be a result of behavioral, social, or cultural influences. The concept of inability to handle alcohol is based on the propaganda that Indigenous peoples have a "weakness for" alcohol and are incapable of self-control once consumed (Ehlers & Gizer, 2013). This colonial perspective creates the Indigenous addict identity, which is then legitimized through Indigenous peoples manifesting the stereotypes.

Indigenous addict identity

Garcia-Andrade et al. (1997) contested the assumption that Indigenous peoples were hypersensitive to the effects of alcohol; this concept is most commonly referred to as the *Firewater Myth*. The myth holds that Indigenous peoples react differently to alcohol than White settlers, that they have a strong desire for alcohol, that they are very aggressive when inebriated, and that they cannot deal with addiction on their own, thus justifying the need to regulate the distribution of liquor to Indigenous peoples (Coyhis & White, 2002; Ehlers & Gizer, 2013; Fornssler et al., 2014; Garcia-Andrade et al., 1997). Garcia-Andrade et al. discovered that when Mission Indians were given a placebo, they subjectively experienced alcohol intoxication experiences without objective evidence to support. Numerous Indigenous peoples perpetuate the idea that they are incapable of tolerating alcohol (Quintero, 2001); nevertheless, there is no empirical evidence to substantiate an increased sensitivity or aggression. Garcia-Andrade et al. findings supported a reduced sensitivity, implying a proclivity for overconsumption. There is nothing that can be done to alleviate intolerance. What appears to occur is that the effects take longer to manifest; hence, more is consumed, resulting in increased intoxication. Additionally, increasing alcohol use does not indicate a genetic propensity to aggression, resulting in increased violent behavior. There have been no studies to support the assumption that Indigenous peoples become more aggressive or violent when under the influence of alcohol than non-Indigenous

peoples (Coyhis & White). Indigenous peoples, however, continue to be perceived in this manner.

According to Quintero (2001, p. 57), colonization has shaped Native American identity as an addict, and "what we know about Native American drinking is a type of colonial knowledge." Quintero observed a "disturbing tendency" in studies to carelessly "reinforce and perpetuate these existing colonial categories and views of Native Americans" (p. 57). During exchanges, settlers used alcohol to alter the perceptions of Indigenous peoples. Addiction theories about Indigenous peoples are founded on colonial assumption that proliferates "perceived biological, racial, cultural, and social oppositions between" settlers and Indigenous peoples (Quintero, p. 58). Statistics reinforce the colonized idea of pathology in Indigenous peoples by highlighting the stark disparity between White users and the supposed intrinsic genetic fault in Indigenous peoples. According to Reading (2013), research studies fail to explore the underlying reasons of disparities, such as history and health determinants. Many Indigenous peoples do not misuse alcohol and do not seek therapy based on Western norms. Stewart et al. (2011), submits that Indigenous persons who report heavy drinking are proportionally twice as likely as the broader Canadian population. The fact that Indigenous people abstain from alcohol at a higher rate than the Canadian average is omitted from the discussion (Stewart et al.). Additionally, Waldram et al. (2006, Alcohol and Substance Abuse section), see biological grounds for Indigenous people's alcohol problems as a "racist response to a major national problem," and we should look at the issue through a public health perspective. A public health lens or global strategy approaches the notion of addiction by addressing the numerous health determinants. Reading and Wein, (2013) classified health determinants into four categories: social, proximal, intermediate, and distal. Except for distal determinants of health (such as the environment, housing, education, and so on), Indigenous and non-Indigenous peoples are equally affected. Indigenous peoples face greater disparities as a result of government strategies and operations resulting from colonization and assimilation processes. Reading (2013) explains how colonial knowledge and assimilation strategies, as well as social exclusion, establish epistemic and structural racism. These inequities have also resulted in many Indigenous peoples exhibiting poor adaptive behaviors. Additionally, to these disparities, Reading and Wein, (2013) establish that Indigenous peoples face distal health factors. Colonialism, racism, social exclusion, and repression of self-determination are all distal determinants of health that "reflect political, economic, and social conditions that construct both intermediate and proximal determinants" (Reading & Wein, 2013, p. 22). Distal inequalities in the determinants of Indigenous peoples' health associated with

colonialism and assimilation programs have a clear correlation with their contemporary mental health issues and risk-taking behaviors.

Government acts and policies in the manifestation of addiction

Not all Indigenous peoples consume alcohol or other substances, or develop an addiction to them. As previously stated, there is no genetic distinction between white and Indigenous alcohol drinkers. Reading (2013) explains that racial divisions created by social rhetoric, rather than biological disparities, are utilized to create inequality based entirely on race, implying that the White race is superior and must intervene and rescue others. Quintero (2001) argues that colonial knowledge fosters pathological notions of Indigenous peoples, necessitating paternalistic intervention via legislation and public policy. Policies of assimilation were implemented in order to eradicate the Indigenous peoples' Indian-ness. Negative residential school experiences, as well as government actions and regulations, obliterated the healing and preventative capabilities inherent in an Indigenous way of life. The Assessment of the Royal Commission on Aboriginal Peoples was a seminal report on the impact of colonization and assimilation on Canada's Indigenous peoples ([RCAP], Government of Canada et al., 1996). For twenty years, RCAP made proposals and began numerous reports and projects based on its findings and recommendations (essentailly replaced by the Truth and Reconciliation Commission of Canada). Chansonneuve (2007) authored a study for the Aboriginal Healing Foundation's Research Series on addictive behaviors among Aboriginal peoples in Canada that addressed the history of Aboriginal peoples' experience with colonization and assimilation practices. They found that as a result of the initial assimilation policy, the Canadian Indian Act confined First Nations and Inuit peoples to a reserve system where they could be regulated by the government. The reserve system established a dependency on the government, compelling some natural competitors to come together in larger communities or bands. Indigenous peoples were confined to their communities, unable to leave, hunt, earn money, or seek medical care without the consent of an Indian Agent. Additionally, the Indian Act defined who was regarded an Indian. First Nations, Metis, and Inuit are the Indigenous populations in Canada. According to Chansonneuve (2007, p. 7), "Native women who married non-Native men lost their status rights, and their children were denied Indian Act rights; while non-Native women who married Native men, as well as their offspring, were granted status rights." Metis people were denied access to land and services, while Inuit people were "separated from the territories to which they had been culturally and spiritually connected for 6,000 years, social illnesses including as violence, suicide, and addictive behaviors began to rise in Inuit and Innu communities"

(Chansonneuve, p. 9). Indigenous peoples were denied autonomy and self-defense rights as a result of colonization.

According to Chansonneuve (p. 8), "From 1900 to 1927, the Canadian government made it unlawful to raise money or contribute finances to Indians for political purposes, including land claims." Not until 1960 were certain Indigenous peoples granted the right to vote. Because the government believed that adult Indigenous peoples were unchangeable, it focused on assimilating children. Canadian Residential Schools and the 60's scoop created traumatizing conditions for many Indigenous peoples. Shuttering residential schools forced the Canadian government to increase their cultural genocide efforts (Hanson). Starting in 1960, child protective services removed Indigenous children and placed them with Euro-Canadian families to accelerate assimilation practices (Hanson, 2009). Indigenous peoples experienced the following losses through the impact of residential school abuse: family and community life, parent-child bonds, love and connection, parenting skills, a sense of purpose and belonging, cultural pride, self-determination, and hope (Aboriginal Healing Foundation (AHF), 2006a, 2006b; Chansonneuve, 2007). The National Aboriginal Health Organization (NAHO, 2011) acknowledged that "Mental health problems faced by aboriginals arise from a long history of colonization, residential school trauma, discrimination and oppression, and losses of land, language and livelihood" (p. 1). Residential schools remained in effect until 1998 (AHF, 2006b).

Indigenous peoples experienced a loss of cultural continuity by losing language, parenting skills, and ceremonies, increasing the risk of addictive behaviors (AHF, 2006b; Chansonneuve, 2007; CSWG, 2013; Kielland & Simeone, 2014). In June, 2021, 215 child bodies, some as young as three-years old, were found in an unmarked burial site in British Columbia, Canada. The remains were identified as students of the residential school system. As shocking as the discovery was, many Indigenous peoples know that there are many more children who died and unceremoniously buried through the system. The emotional impact of colonization and assimilation remains one of the largest lingering issues of today. While the children were subjected to degradation, humiliation, physical and sexual abuse, Chansonneuve discovered that "their families and communities became flooded with people suffering from unhealed pain, grief, and rage" (p. 12). According to Chansonneuve, an increasing number of residential school survivors turned to addictive behaviors and other detrimental means of coping to numb their loss and pain (p. 12). The Truth and Reconciliation Commission of Canada (2015) provided survivors of Canada's residential school system a voice. Survivors shared their horrific experiences and advocated for greater services and education. Their results sparked 94 calls to action to

promote reconciliation and healing in the aftermath of Canada's unsuccessful assimilation efforts.

Potential explanations for why people use drugs include automated and self-soothing behavioral issues (Aguiar & Halseth, 2015; Canadian Centre on Substance Abuse, 2014). Healthy displays of fear and anxiety, accompanied by healthy reactions, lead to children who are well-balanced and well-adjusted. Survivors of residential schools have begun to speak out openly about their experiences (Truth & Reconciliation Commission of Canada, 2015). However, the lingering psychological repercussions of colonization, residential schools, and the 1960s scoop have encouraged health care professionals to start assigning diagnoses to pathological issues. Indigenous peoples' generational violence, losses, and trauma have recently been labeled as post-traumatic stress disorder. According to Chansonneuve (2007), "attachment disorder and complex post-traumatic stress disorder help explain how the trauma of residential school abuse has passed down through Aboriginal families from generation to generation" (p. 19). Haskell and Randall (2009) proposed a more comprehensive trauma framework for the DSM-V, dubbed disrupted attachment disorder (it was not adopted). According to Haskell and Randall, present classifications are "stigmatizing and pathologizing" (p. 52), and care providers must include the socioeconomic concerns that impact attachment and trauma, treating the issue at the community level rather than the individual level.

Assimilation policies caused more than just mental disruption, as their tactics were designed to remove the peoples' Indianness, seeking to make them more like European settlers. To that purpose, the Indigenous peoples' deeply ingrained spiritual and cultural customs were nearly eradicated. According to Chansonneuve (2007), "Traditional spiritual ceremonies were criminalized; anyone practicing them, as well as anyone who advocated such practices, was vulnerable to imprisonment" (p. 7). Cultural and spiritual traditions served as barriers to the development of addiction; however, colonial knowledge obliterated that concept and replaced it with the Indigenous addict identity.

Reading's layers of racism

Reading (2013) has spent a significant amount of time working on anti-racism activities; they find that "the concept of race as a category of identity did not develop until Europeans began to conquer other continents" (p. 1). Labeling distinctions in intelligence and morals based on race creates the impression that White is a superior race (Reading). Racist characterizations based on statistics, the government, the media, and academics foster ignorance and keep the dominant group from challenging their

privilege. Reading (2013) classifies racism into six types based on colonial and dominating knowledge systems: epistemological, structural, social exclusion, relational, symbolic, and embodied racism. Epistemic racism manifests itself in Western science and knowledge choices, which imply that Indigenous knowledge is inferior or primitive. Reports produced by Western institutions mention the health disparities that Indigenous peoples face; nevertheless, they disregard the disparity's historical and political significance (National Collaborating Centre for Aboriginal Health, 2013). When efforts adhere to Western-approved methods, funding and resources are provided without hesitation. Structural racism is visible through oppressive institutions; dominant structures construct laws and policies that perpetuate racial stereotypes, implying that their response is acceptable. Reading (2013, p. 4) gives the following example: the stereotype is that Indigenous peoples are alcoholics and irresponsible, which leads to the prejudice that every Indigenous person is a potential threat, leading to discrimination in that they must be treated differently, and then oppression, in which unequal treatment is justified. Numerous papers discuss Indigenous peoples' negative experiences with the Canadian healthcare system, including racism and intolerance (Allan & Smylie, 2015; Bourassa et al., 2004; Browne, 2005, 2007; Denison et al., 2014; Government of Canada et al., 1996; KPMG, 2009; Nestel, 2012; Turpel-Lafond, 2020). Indigenous peoples have lost trust in healthcare as a result of years of negative experiences. Reluctance to seek treatment due to possible experiences of intolerance, racism, and judgment prolongs the suffering of Indigenous peoples. When clients do decide to seek treatment, a lack of access to detoxification clinics, treatment services, racial stereotyping, and follow-up owing to remote location or long waiting lists has caused service gaps (CSWG, 2013; Health Canada, 2012; Kielland & Simeone, 2014; National Collaborating Centre for Aboriginal Health, 2011; Turpel-Lafond, 2020). The subcommittee of the Ontario Federation of Indian Friendship Centers (OFIFC, 2013) supports the "provision of Aboriginal-specific treatment and rehabilitation programs in all urban settings" (p. 21). Many experts and policymakers support for community-based cultural approaches to addiction treatment. Indigenous peoples struggle to relate to their traditions as a result of colonization and assimilation tactics thus, many avoid therapy altogether; additionally, government agencies determine the requirements for which therapies are permitted and how much money will be allocated to programs. Without the consent of government institutions, Indigenous communities are not free to establish programming that meets their needs. Quintero (2001) uses the Navajo culture as an example, stating that "colonial institutions play a crucial role in promulgating and upholding what is and is not traditional" (p. 63). White hegemony establishes

government entities in positions of authority over how Indigenous peoples should be treated. As a first step in addressing White privilege in healthcare, cultural protection training for health care employees has been identified.

Cultural protection training

The Royal College (2013) proposes that "Cultural safety liberates the truth and health inequities and points, without shame, to oppression as a main cause of health inequalities by harnessing critical thinking and self-reflection" (p. 5). Indigenous identity is protected "through the continual analysis of power relations and monitoring of practices" through critical self-reflection (OFIFC, 2013, p. 5). However, cultural sensitivity, cultural awareness, and cultural competence often become brief sessions on getting to know the "other" while keeping them as the "other." The First Nations, Métis and Inuit Advisory committee of the Cultural Safety committee for the CSWG (2013, p. 8) found that institutional barriers for Indigenous peoples were (a) lack of acknowledging the impact of colonization and assimilation policies; (b) lack of programs to meet the length of time required to address historical trauma reconciliation needs; and (c) lack of respect for Indigenous healing ways. Also, addiction workers are often unaware of the negative-energy Indigenous peoples hold through embodied racism (Reading, 2013). The following section explores each institutional barrier relating to addiction work.

Historical impact

Learning about smudging, drumming, and limited eye contact are generalizations taught by Western education institutions to health care workers to become sensitive to Indigenous peoples from Canada. Also, self-reflection is engaged by asking the worker to contemplate on biases about the "other"; however, there is limited success in identifying preferences when most healthcare workers are White, influenced by colonial propaganda, and a western knowledge bias. Reports such as Saskatchewan's Patient's First (KPMG, 2009) and Mental Health Commission of Canada's Strategic Plan (2012) encourage sensitivity training without identifying the need for workers to understand colonial and assimilation practices. The Mental Health Commission of Canada report spoke to the effects of colonization, residential school, and the 60's scoop. Yet, their strategy focused on culturally safe environments, not on the need to incorporate education for mental health workers and addiction counselors on the impact of colonization and assimilation policies. Without knowing about the historical

impact of colonization and assimilation policies on Indigenous peoples, self-reflection does not become critical. The Royal College (2013) summarizes that

> Self-reflection is a value that nourishes cultural safety; the provider is better able to understand the upstream barriers (e.g. structural racism, discriminatory laws, historical legacies, uneven distribution of economic opportunities, etc.) and their connection to the downstream effects (e.g., person-to-person mediated racism, classism, cycle of poverty, etc.) influencing the health and healing of those defined as under threat. (p. 5)

All addiction workers must receive training about the role the government played and continues to play in maintaining a colonial structure and the current health care system to more clearly reflect on barriers and negative stereotypes that may go unnoticed (TRC, 2015). Aguiar and Halseth (2015) argue that psychological effects of social, community, and/or personal trauma are similar to post-traumatic stress disorder. Trauma-impacted people may attempt to ease the symptoms of trauma through substances (Aguiar and Halseth). Indigenous Cultural ways of healing and social connection have been shown to support healing from addiction (LaVallie, 2019). Therefore, treatment options must employ culturally suitable approaches to be effective and addiction workers must be educated with options.

Historical trauma and reconciliation needs

Chansonneuve (2007, p. 13) proposes that "addictions workers are unaware of this tragic history, they are also unaware of the unresolved trauma underlying addictive behaviors; nor are the origins of other social problems facing the Aboriginal population fully understood, such as suicide and violence." To provide the client with insight into their grief and pain problems due to multiple losses, addiction workers must acquire a working knowledge of the history of their country's Indigenous Peoples. The AHF (2006a) offers,

> …for individuals who have been physically or sexually abused, who are attempting to work through other traumatic experiences or who are dealing with severe psychological pain and addictions, understanding the dynamics and impact of history can be a part of the therapeutic healing process. (p. 42)

In Canada, primary and secondary education students now receive some information about Canada's colonial legacy. However, the majority of students taking addiction worker programs are mature students and may not have received this information, may have received limited information, or may have received a colonial understanding of assimilation practices and

policies. A trauma-informed approach acknowledges the intergenerational impacts of colonization and its associated adverse addiction effects while seeing addiction as only part of a larger picture of historical trauma.

Indigenous peoples are expected to ignore pain and grief from unacknowledged multiple losses. Addiction workers must begin to explore these issues within their work with clients to start to heal. The AHF recommends that a survivor's healing journey begins with establishing safety, then remembrance, and once mourning starts, the survivor can reconcile with their past, reclamation of a new life way begins, and eventually a capacity to heal others (AHF). Indigenous addiction workers can also benefit from the validation and acknowledgement of their historical past, helping resolve their grief and pain issues.

The CSWG (2013) suggests that "To be effective, care providers need to understand how the burden of unresolved personal and historical losses carried by many recipients of care may shape present behavior" (p. 11). Addiction workers should have trauma knowledge and understand unresolved grief, both related to colonization and assimilation policies. The OFIFC (2012) calls for "Continued research to identify and develop skills to address impacts of residential schools on Aboriginal people" (p. 20). In addition to feeling shame, Indigenous people living with addiction often are made to feel guilty for who they are thus creating a spiral of unresolved emotions and believing that they are inherently not human and not worthy.

Addiction workers working with Indigenous peoples must keep in mind the client's hidden feelings of pain, loss, and grief related to colonization, assimilation practices, and racism levels. Not having these experiences, themselves, the addiction workers may not be aware of these considerations. Privileged groups are taught not to challenge their power or the status quo and therefore, addiction workers must be exposed to the colonial history and its effects (Native Women's Association of Canada, 2002). Sensitivity training alone will not work without acknowledging the role white privilege plays through epistemic, systemic, social exclusion, relational, symbolic, and embodied forms of racism.

Embodied racism

Cultural sensitivity training typically involves reading about "different" cultural traditions used by Indigenous peoples, reminding participants not to generalize across all peoples and that one should remain "colour-blind." Reading (2013) contests that the concept of "colour-blindness" is a way to maintain white privilege by seeing everyone as raceless or white; while ignoring the "social realities of racialized inequities experienced within

relationships, systems and structures, thereby maintaining the status quo" (p. 6). Without understanding and acknowledging that health inequalities are manifested by racism and oppression, health care professionals cannot overcome their own biases to provide positive based care (Royal College, 2013).

Allan and Smylie (2015) offer that racism is like battle fatigue. Indigenous peoples may be in a constant state of fear related to incoming threats of discrimination. The amygdala cannot process real or implied discrimination threats, causing the stress to increase cortisol levels produced by the fear response. Reading (2013) suggests Indigenous peoples experience a physiological reaction to the negative energy of the different forms of racism called embodied racism. Embodied racism may increase the chances for mental health issues and lifelong physical conditions (Reading). The AHF (2006b) advises that it takes on average ten years for healing to begin and a lifetime for complete recovery to occur depending on the level of safety, denial, and effort. Sobriety does not heal the trauma and losses from the past; it is but one layer of the onion (Maggie Hodgson as cited in AHF, 2006b). The addiction worker's role is to walk with the client in exploring the other layers of the onion.

Acknowledging indigenous knowledge

Canadian health organizations are calling for more comprehensive cultural safety training. More extensive training means acknowledging the past and including Indigenous peoples in developing educational and training curricula (AHF, 2006b; Health Canada, 2015; TRC, 2015). The CSWG (2013) advocates that Indigenous peoples need to be included in developing the programs and policies, not just involved but incorporating Indigenous ways of knowing. They propose that human connection methods are crucial to therapy because Indigenous peoples have been marginalized. Instead of "talk therapy," approaches should incorporate cultural activities or be based on nature, cooking, fishing, crafting, or hunting. There should be reciprocal relationships where the worker is as involved in self-care practices as the client. The Mental Health Commission of Canada (2012) recommends developing a mental health and substance use strategy in urban and rural centers; "More research is needed to deepen our understanding of First Nations, Inuit, and Métis mental health issues in urban and rural centers, and to inform the development of an urban and rural mental health and substance use strategy" (p. 105).

Incorporating Indigenous ways of knowing must be influenced by the Kehte-ayak's (the Old Ones') words in combining western and traditional approaches. The Mental Health Commission of Canada (2012) suggests

combining traditional and mainstream methods using Kehte-ayak or Knoweldge Keepers as service providers. What is needed is a balance between western approaches and traditional approaches (CSWG, 2013). This balance is not augmentation or complimentary; it is a reworking of what is currently available by co-constructing a new way. To address epistemic and structural racism, treatment programs can begin decolonizing treatment approaches. Reading (2014) suggests Indigenous peoples cannot combat racism alone and must collaborate with allies. For non-Indigenous people, the first step in decolonizing treatment means viewing Indigenous methods as credible. For Indigenous peoples it means questioning western practices and the validity of colonial knowledge and decolonizing begins with respecting knowledge produced by Indigenous peoples and understanding that colonial impact influenced the manifestation and perpetuation of the situation.

Neurodecolonization approach

Before we can begin to heal from addiction by entangling Indigenous and western knowledge, Yellow Bird (2012) submits that Indigenous peoples must decolonize their minds. Indigenous peoples can overcome negative feelings created by structural oppression maintained through colonialism by exercising a practice called neurodecolonization (Yellow Bird, 2012, 2013). Healing from addiction is more complex than merely relapse prevention – it involves neurodecolonization. Colonialism changes the brain's neural pathways, and neurodecolonization must occur within the colonized person to generate positive, empowering thoughts (Yellow Bird). Neurodecolonization is unsettling colonial tropes within cognitive thinking and replacing them with multiple ways of knowing. Yellow Bird (2013) argues that before any true work can take place, workers and clients must deprogram the colonial tropes established from Western knowledge dominance. It is described as a blend of meditation and traditional contemplative practices; mindfulness corrects cognitive biases and current western created mindlessness. Western perspectives describe a collective way of beliefs and values forced upon Indigenous peoples by European immigrants, enforcing a Christian influence. Yellow Bird is the leading theorist on neurodecolonization, with their work being integrated into mental health and addiction work, and University curricula.

Before colonization, North American Indigenous peoples practiced traditional contemplative rituals that supported positive, healthy neural networks (Yellow Bird, 2013). There are no distinct solutions through decolonization; instead, it is based upon inquiring on how things can look and then be done differently. Decolonization is creating change to forge a new-shared

path instead of post-colonial work that adjusts but does not change the current arrangement. Yellow Bird (2012) cautions that it is not a matter of recovering or reviving traditional roles but a *remaking*. Yellow Bird (2012, 2013) work utilizes Sharon Begley and Norman Doige's plasticity paradox, Rick Hanson and Richard Menduis's history of the brain, and his collective Indigenous knowledge and traditions. Blending Buddhist and Indigenous traditions, "… mindfulness practice can minimize the negative sequelae of trauma related to colonization and enhance psychological and community well-being in Indigenous communities" (Yellow Bird, 2013, p. 294). The process of wellbeing is accessing, acknowledging, and then releasing unresolved or interfering feelings and judgements; "Its aim is self-awareness so we might better serve others, consistent with Indigenous Peoples' collective values and deep connection to the natural environment" (Yellow Bird, 2013, p. 295). Earth's human collective is on the verge of a mental change; Yellow Bird (2013) advises that we are moving away from the old, primitive brain toward more compassionate, less aggressive emotional thinking. Through neurodecolonization, Indigenous peoples can harness positive thinking and challenge oppression through creative, strategic approaches (Yellow Bird, 2013). Decolonizing is not about self-improvement but about envisioning futures, "for which we currently have no language" (Smith, 2013, p. 16).

Recommendations

Historical trauma is the consequence of disruptive events taking place and then lingering with the person and the generations that follow. Forced negative assimilation practices, colonial stereotyping, and racism must be understood as root causes for some addiction impacted Indigenous peoples. Institutions begin decolonizing by changing Western knowledge structures to include unique and locally understood cultural responses. Culturally responsive Addiction workers incorporate Indigenous Cultural Responsiveness Frameworks into their policies and practices to reconcile failed health systems. We recommend institutions incorporate policies and practices that include an Indigenous Cultural Responsiveness Framework, Neurodecolonization, and education on the negative impact of the colonial legacy. Addiction worker education and service must include policies that benefit Indigenous peoples through their healing practices.

Practicing neurodecolonization begins with settling the amygdala through neuro-modulation (reawakening pathways in the brain) (Yellow Bird, 2012); mindfulness practice is one example. Kaplan and Berman (2010) looked at the effects of "attention" on healing from addiction. They suggest that low levels of attention influence the ability to stave off cravings and compromise making healthy choices. Attention is restored through three

avenues, sleep, meditation, and increased use of involuntary attention (Kaplan & Berman, 2010). People impacted by trauma and/or addiction struggle to achieve adequate sleep. Meditation takes time to develop and Kass (2015) argues that cognitive reshaping is required to produce an effect. Kass (2015) suggests that mindfulness incorporates neuro-modulation and impacts decision making. Mindfulness practice is being with your thoughts for short periods and working your way up to at least 10 mins of cognitive contemplation and restructuring. Thoughts are invited into your awareness, acknowledge, and then moved out. Thoughts are recognized but not remunerated upon. Negative thinking reduces; and pathways for alternate options awaken. Mindfulness practice enhances when involuntary attention is replenished. Restoring involuntary attention includes activities of brain curiosity about what is happening, compatible environment, and time for reflection (Kaplan & Berman). Involuntary attention is easily restored through North American Indigenous land-based and cultural practices. Indigenous Cultural Responsiveness Framework creates a middle-ground for Western institutions and Indigenous knowledge to create a new way forward. Addiction workers can engage with Kehte-ayak to harmonize ways of knowing and develop culturally suitable healing approaches that are locally known.

Conclusion

Introduced through colonization and manifested through assimilation policies and white supremacy, addiction is a multidimensional issue affecting North American, Indigenous peoples. Most federal and provincial funded treatment programs follow a western model. Treatment options are controlled and monitored by western knowledge structures, perpetuating an Indigenous addict identity and poor outcomes. Cultural responsivity allows western dominant treatment programs and funding organizations to legitimize colonial stereotyping and pathologize Indigenous behavior. Indigenous peoples living with addiction require comprehensive healing approaches, including understanding the historical impact of colonization on Indigenous peoples for themselves and Addiction workers. Also needed is an understanding of Reading's (2013) arenas of racism.

To assist in evolving the primitive brain toward a controlled, humbled brain, neurodecolonization is employed to release and heal trauma's adverse effects. Educational institutions, licensing bodies, and front-line institutions must incorporate policy that demands a working knowledge of the historical and racial context of the manifestation of addiction amongst Northern American Indigenous peoples. This understanding will help begin decolonizing western treatment methods and strengthen reconciliation

efforts. Future research should explore how neurodecolonization may assist in addressing addiction areas in equalizing colonial and Indigenous knowledge through the voices of the Kehte-ayak.

"For American Indians, the voice of the drum, the heartbeat of Earth Mother, in harmony with Sky Father, is a voice of our being, a voice of knowing our place among all our relations." Waters (2004, p. 158).

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