Characteristics of Culturally Grounded Harm Reduction Approaches for Indigenous Canadians: A Critical Review

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Abstract

Background: Indigenous Canadians experience a disproportionate burden of substance-related harms compared to their non-Indigenous counterparts. Public health data indicates that First Nation, Métis, and Inuit people are overrepresented in the number of overdose deaths and experience markedly higher rates of HCV and HIV infection. Mainstream harm reduction initiatives have been insufficient at reducing health inequities despite efforts to bolster the accessibility of services in Indigenous communities. Closing the gap between Indigenous and non-Indigenous health outcomes requires an indigenized approach to harm reduction that interrogates and redresses the socio-cultural, economic, and political realities of First Nation, Métis, and Inuit people that drive intergenerational problematic substance use.

Purpose: The purpose of this critical literature review is to identify and describe the key characteristics of Indigenous harm reduction in Canada. The findings will contribute to a growing body of literature on the topic, which is essential for informing future best-practice Indigenous harm reduction models. This review also aims to clarify key concepts in extant academic literature and identify and analyze persistent knowledge gaps.

Methods: A single author scoping review was conducted to inform this critical literature synthesis. A search strategy was developed to explore two online databases, Medline® (Ovid) and APA PsycINFO (Ovid), for relevant extant literature on Indigenous harm reduction methodologies in Canada.

Results: Six articles met the inclusion criteria and were included in this review. Thematic analysis of the articles identified five key characteristics of Indigenous harm reduction: culture, trauma-informed, cultural safety, Indigenous led, and integrative.

Conclusion: Indigenous harm reduction is a culturally integrative, decolonizing approach to harm reduction that holds immense promise for redressing inequities in the distribution and severity of substance-related harms experienced by Indigenous Canadians. Indigenous harm reduction characteristics should not be siloed, but rather broadly adopted across harm reduction initiatives in Canada to close the gap in health outcomes between Indigenous and non-Indigenous Canadians.

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1.0 Introduction

Canada's modern harm reduction movement gained footing in the 1980s in response to the sudden emergence of Human Immunodeficiency Virus (HIV) infection and Acquired Immune Deficiency Syndrome (AIDS) among people who inject drugs (Des Jarlais, 2017). Harm reduction refers to both the goal of harm minimization as well as the implementation of evidence-based strategies and policies shown to reduce adverse health, social and legal consequences associated with various highly stigmatized behaviors, most prominently, drug and alcohol use (Des Jarlais, 2017; Boucher et al., 2017; SAMHSA, 2023; Janku et al., 2023). Harm reduction emerged as part of a larger movement towards equity and reparative justice for people who use drugs (PWUD). The philosophy of harm reduction is rooted in radical resistance to a highly moralized and politicized culture of intolerance towards drugs and the people who use them (Des Jarlais, 2017; Tammi & Hurme, 2007). This emancipatory approach to substance use is a necessary alternative to historically punitive responses to drug and alcohol use, which disproportionately target minority racial and ethnic groups (Des Jarlais, 2017).

In 2016, the Canadian government introduced a new federal drug policy that employs a public health approach to overdoses and other drug-related harms (Government of Canada, 2023). The new federal drug policy, the Canadian Drugs and Substances Strategy (CDSS), replaced the National Anti-Drug Strategy which had been in place since 2007. The CDSS reestablished harm reduction as a core pillar of the government's drug policy, allowing Canada to embed harm reduction policies into its national drug strategy (Government of Canada, 2023).

Since the introduction of the CDSS, the Canadian government has taken actionable steps to minimize substance-related harms for individuals and communities. Federal funds continue to

support community-based prevention and education initiatives throughout the country. This includes investing in social services and mental health support to address risk factors for substance use disorders (Government of Canada, 2023). The new federal drug strategy has also bolstered health education and promotion initiatives. This includes public education on drugs and alcohol so that Canadians can make informed decisions about their substance use. Another education initiative, the Drug Stigma Awareness Program, offers Canadian law enforcement an anti-stigma curriculum so that officers can appropriately and compassionately navigate interactions with people who use drugs (Government of Canada, 2023).

Under the new federal drug strategy, the government has assembled the Canadian Pain Task Force to identify priority areas and make recommendations for better preventing and managing chronic pain. The Canadian Pain Task Force recognizes that people who live with chronic pain experience stigma and often struggle to access safe, evidence-based pain management practices (Government of Canada, 2023). Other federal strategies to promote safer use include increasing access to Naloxone and drug-checking services as well as streamlining the authorization process for organizations that wish to run a supervised consumption site (Government of Canada, 2023).

Canada's harm reduction-focused strategies hold promise for reducing substance-related harms. Yet, the benefits of new and expanded harm reduction programs and policies remain unrealized for many Indigenous Canadians (Hyshka et al., 2017). Similar to other public health interventions, harm reduction strategies are more likely to have a sustained benefit to the individual when they are created or carefully adapted to reflect the values, principles, and cultural norms shared by the individual's community (Betancourt et al., 2003). The lack of culturally congruent harm reduction services is acutely felt by Canada's three Indigenous groups - First Nations, Inuit,

and Métis (Government of Canada, 2024). These three groups continue to bear a disproportionate burden of substance-related harms compared to their non-Indigenous counterparts despite substantial federal investment in harm reduction over the past 8 years (CAAN, 2019). This suggests that non-Indigenized, or "mainstream," harm reduction does not take into consideration the intersection of substance use stigma and racism, nor does it adequately minimize harms for Indigenous people who use drugs due to the failure to incorporate Indigenous knowledge and values into service delivery.

In the pursuit of health justice for First Nations, Inuit, and Métis peoples, it is imperative that Indigenous people assume leadership roles in the development, implementation, and evaluation processes of harm reduction interventions. Harm reduction resources and services are most meaningful and useful when they are created with or by the community they are intended to serve. For First Nations, Inuit, and Métis communities, this entails incorporating Indigenous ways of knowing and being into behavioral interventions as well as dismantling oppressive colonial structures that perpetuate inequities. Using a scoping review methodology, this essay aims to identify and describe the key characteristics of Indigenous harm reduction strategies and practices in Canada. This review also aims to clarify key concepts in extant academic literature and identify and analyze persistent knowledge gaps.

2.0 Background

Harm reduction is often conceptualized only by structural interventions such as syringe services programs, Naloxone distribution, medications for opioid use disorder, and safer consumptions sites (Frankeberger et al., 2023). These initiatives offer lowest barrier, non-coercive alternatives to abstinence-based approaches to care, which is central to promoting safety while honoring bodily autonomy and personal choice. However, the heart of the movement, reflective of its social justice roots, lies in the relational component, which seeks to humanize and dignify people who use drugs (PWUD) by normalizing substance use and acknowledging and redressing stigma (Frankeberger et al., 2023).

Principles of relational harm reduction continue to shape the movement as it transitions from a small, grass-roots initiative to a widely adopted public health approach. Hawk and colleagues (2017) identify six core principles of mainstream relational harm reduction. The first principle, humanism, emphasizes values such as dignity and respect and acknowledges the inherent value of all individuals (Hawk et al., 2017; National Harm Reduction Coalition, n.d.; Amadi, 2023). The humanist nature of harm reduction centers lived experiences and respects individuals' choices while withholding moral judgements and other personal biases.

Pragmatism is the second tenet of harm reduction. A pragmatic approach discards the aspiration to perfection within the context of health behaviors (Hawk et al., 2017; National Harm Reduction Coalition, n.d.). When taking a pragmatic approach, providers and on-the-ground harm reductionists recognize that abstinence or safer use every time is unrealistic (Hawk et al., 2017; Gallagher, 2017). Additionally, providers understand that a patient's ability to modify their health

behaviors is influenced proximally and distally by familial, peer and community norms and socio-structural determinants of health (Hawk et al., 2017).

The third principle of harm reduction is individualism. Hawk and colleagues (2017) aptly note that individualism "reflects the idea that every person presents with their own needs and strengths as well as with a spectrum of health behaviors and receptivity for intervention." Harm reduction is person-centered to accommodate the diversity of individuals' needs and goals. Taking this pragmatic and individualistic approach to care, harm reduction rejects the one-size-fits-all model, instead allowing PWUD to pursue strategies to minimize alcohol- and drug-related harms that work best for them (Hawk et al., 2017; National Harm Reduction Coalition, n.d.).

Autonomy is the fourth principle of harm reduction and a core theme woven throughout the other principles. Including autonomy as a principle of harm reduction underscores the right of individuals to make their own decisions about treatment and to determine what role substances will or will not continue to play in their life (Hawk et al., 2017; Gallagher, 2017; National Harm Reduction Coalition, n.d.; Amadi, 2023). Gallagher (2017) poignantly states that "this approach is built from an understanding that addictive behaviors are not done in a vacuum…They are meaningful activities that have a purpose in the person's life." Thus, for many people who use drugs, abstinence is not the end goal.

Another key tenet of harm reduction is incrementalism, which posits that any positive change is a step in the right direction (Hawk et al., 2017). By celebrating small triumphs, individuals are positively reinforced to continue their healthy behaviors. Positive reinforcement in a clinical setting is particularly important for PWUD, who are often met with harsh judgement and even intolerance due to their substance use. Celebrating incremental positive change not only

improves the patient's self-esteem and the patient-provider relationship, but also helps maintain one's engagement in their own progress (Hawk et al., 2017).

Accountability without termination is the sixth principle of harm reduction. This principle sets forth the expectation for both patients and providers alike that PWUD are responsible for their actions and should take accountability for their return to use. However, it is expected of providers that they do not punish patients nor terminate their care (Hawk et al., 2017). This ties back to the tenet of pragmatism, recognizing that "perfect" health behaviors are unrealistic and terminating care only reinforces the stigmatization of people who use drugs.

The abovementioned principles provide a conceptual framework for harm reduction. These principles illustrate that harm reduction is not just a set of interventions and tangible resources, but also a philosophy (Hawk et al., 2017; Drug Policy Alliance, n.d.). The philosophy of harm reduction sets guidelines for practice and conduct in the field, which can be continually referenced to ensure that structural interventions are grounded in social justice and a deep commitment to community capacity building. Together, the structural and relational arms of mainstream harm reduction work synergistically to reduce potential harms associated with substance use. Carried out through various public health initiatives, harm reduction is proven to prevent and reverse drug-related overdoses and reduce the transmission of HIV and viral hepatitis (Harm Reduction International, n.d.). Engagement with harm reduction services is also positively associated with coordinated connections to other health and social services for PWUD that could benefit from additional support across the continuum of care (Harm Reduction International, n.d.; National Harm Reduction Coalition, n.d.). To date, over one hundred countries have adopted harm reduction policies and/or practices, which serves as a testament to the efficacy and feasibility of mainstream harm reduction (Harm Reduction International, n.d.).

2.1 Indigenous Harm Reduction

Mainstream harm reduction initiatives continue to crop up across the globe, suggesting that it is a valuable public health strategy for minimizing harm and improving population health outcomes (Harm Reduction International, n.d.). However, mainstream harm reduction has been criticized for its strict alignment with Western values, beliefs, and concepts of health and well-being (CAAN, 2019). A westernized approach to care can result services that are unresponsive to the unique considerations of Indigenous patients (CAAN, 2019). Grounded in the Western values of individualism, autonomy, and pragmatism, mainstream harm reduction centers its focus on individual behavior change. Critics assert that when harm reduction's scope is limited to the individual it fails to address the broader systemic and structural contexts that create the conditions in which problematic substance use arises (CAAN, 2019). For First Nations, Métis and Inuit populations in Canada, mainstream harm reduction tools and services are insufficient at reducing substance-related harms because they do not target the intersecting impacts of colonialism and racism that put them at a higher risk for problematic substance use (CAAN, 2019).

Indigenous harm reduction emerges as a salient and urgently needed alternative to mainstream harm reduction. Indigenous harm reduction diverges fundamentally from mainstream harm reduction in that it is not bound to any health behavior, including the use of substances (CAAN, 2019). The First Nations Health Authority (FNHA, 2024) states that "Indigenous harm reduction means undoing the harms of colonialism." The colonization of Canada was disruptive to traditional First Nation, Métis, and Inuit ways of life including familial and social structures, subsistence patterns, land ownership, and engagement with cultural and spiritual traditions (Allan & Smylie, 2015). Colonizers also introduced distilled alcohol to Indigenous communities. Goldstein and colleagues (2022) note that the introduction of alcohol was not only a "cultural

disturbance," but also a "genocidal act" used to destabilize Indigenous communities. In addition to alcohol, colonizers sought to impede Native peoples' ability to be self-determining through assimilationist policies and practices. These policies and practices include institutionalized education, land dispossession, forced relocation, and the imposition of Christianity and Western norms and values (Allan & Smylie, 2015; CAAN, 2019). In 1876, the Canadian government introduced the Indian Act, which enabled the federal government to determine the Indigenous status of their constituents. Those deemed to be "Indian" by the government were subject to increased legal restrictions intended to deprive them of civil rights (Allan & Smylie, 2015).

The discrimination and forced acculturation of First Nations, Métis, and Inuit groups both figuratively and literally uprooted Indigenous peoples, leaving them stripped of spiritually and culturally grounded coping mechanisms (Goldstein et al., 2022). Consequently, alcohol, and later, illicit drugs, became a predominant coping mechanism for Indigenous people. Today, many Indigenous Canadians experience intergenerational problematic substance use and face disproportionately high rates of alcohol- and drug-related harms compared to their non-Native counterparts (Goldstein et al., 2022; Swaim et al., 2018; Spillane et al., 2015; Cunningham et al., 2016).

Situated in this historical context, "undoing the harms of colonialism" entails revitalizing and nurturing Indigenous culture and knowledge systems, which emphasize healing through cultural affiliation in community settings (FNHA, 2024); Jiwa et al., 2008; Wu, 2023). Connection is the cornerstone of the Indigenous worldview, in which the human, natural, and spiritual worlds are profoundly interrelated (FNHA, 2024). An indigenizing and de-colonizing approach to harm reduction is imperative for restoring Indigenous sovereignty and self-determination. Both rights

are necessary for First Nations, Métis, and Inuit peoples to not only reduce substance-related harms, but also be physically, mentally, emotionally, and spiritually well (CAAN, 2019).

2.2 Public Health Significance

First Nation, Métis, and Inuit people experience pronounced health inequities compared to non-Indigenous Canadians (CAAN, 2019; Public Health Agency of Canada, 2018). Public health surveillance data reveals that Canada's Indigenous populations score poorer on a wide array of indicators for health and well-being across the lifespan (Public Health Agency of Canada, 2018). This includes infant mortality, childhood development milestones, and the prevalence of chronic conditions in adulthood (Public Health Agency of Canada, 2018). Health inequities experienced by Indigenous groups are exacerbated by geographic, financial, and cultural barriers to services and care. As a result of inaccessible and often inadequate care, First Nation, Métis, and Inuit populations experience devastating rates of premature, preventable deaths which is reflected in a markedly shorter life span for Indigenous people (CAAN, 2019). The discrepancy is most severe for Inuit people, whose life expectancy at birth is 10 years shorter than the general Canadian population (CAAN, 2019).

Indigenous Canadians also experience health inequities related specifically to substance use. Indigenous communities face immense loss and destabilization as Indigenous people continue to be grossly overrepresented in the number of overdose deaths and substance-related harms. One in four Indigenous Canadians have a substance use disorder, a rate 47% higher than the general population (Toth, 2022). Recent public health data indicates that "First Nations people are five times more likely to experience an overdose and three times more likely to die from overdose than

non-First Nations people" (CAAN, 2019). Indigenous Canadians, especially those who inject drugs, experience higher rates of HCV and HIV infection. By 2017, HIV infection became so widespread across Indigenous communities that Indigenous people represented 20% of all HIV diagnoses despite comprising just 5% of the total Canadian population (CAAN, 2019; Statistics Canada, 2024). In addition to disparities in rates of blood-borne infections, Indigenous communities suffer a disproportionate burden substance-related deaths compared to their non-Native counterparts.

In response to the unabating overdose and opioid crisis in Canada, the federal government endorsed harm reduction as a viable public health strategy for mitigating harms and preventing further deaths (CAAN, 2019). In 2016, $30 million was allocated to bolster community-based harm reduction initiatives over the next five years. Part of these funds were directed towards strengthening structural harm reduction services in Indigenous communities, such as lowering access barriers to Narcan and medications for opioid-use disorder (CAAN, 2019). These life-saving resources address immediate needs but have been alone insufficient at closing the gap in health outcomes between Indigenous and non-Indigenous Canadians. This suggests that an indigenized and de-colonized approach to harm reduction is critically necessary to redress the socio-cultural, economic, and political realities of First Nation, Métis, and Inuit people that drive intergenerational problematic substance use.

3.0 Methods

The author used a scoping review to inform this critical literature synthesis. The author worked closely with the University of Pittsburgh's health sciences librarian to review extant literature on Indigenous harm reduction interventions in Canada. All searches were performed on online databases as specified below.

3.1 Search Strategy and Information Sources

The search strategy was developed by the author and health sciences librarian, who has years of systematic review experience. To ensure transparency and rigor, the author and librarian adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) protocol for a single author scoping review (Tricco et al., 2018). Key concepts that informed the search were: Indigenous/Aboriginal Canadians, harm reduction, and interventions. Two online databases, Medline (Ovid) and APA PsycINFO (Ovid), were searched by the author and health sciences librarian. The initial search was performed on Medline using a combination of Medical Subject Heading (MeSH) terms and title, abstract, and key words. The search was then adapted to explore APA PsycINFO to identify additional literature sources. The health sciences librarian used the Amsterdam Efficient Deduplication (AED) method to remove duplicates (Otten et al., 2021). The librarian performed an additional screening for duplicates in EndNote 20 (Clarivate) to identify any duplicates not found during the search process. See **Appendix A** for greater detail on the search strategies used for the review.

3.2 Study Selection

After removal of duplicates, 133 items were uploaded into an Excel workbook developed specifically for single author reviews (Vonville, 2023). The initial round of study selection was performed at the title/abstract level in the Excel workbook. The names of the author(s) and journals of publication were excluded in the Excel workbook to minimize potential bias in study selection. The author reviewed each title and abstract to determine whether the study should go on to full text review based on pre-determined inclusion and exclusion criteria. Studies that advanced to a full text review were then reviewed by the author based on additional exclusion criteria. See **Table 1** for a complete list of the criteria.

Table 1. Screening Inclusion and Exclusion Criteria

Inclusion Criteria
1. The study includes Indigenous Canadians as the population of interest
2. The study includes and describes an Indigenous harm reduction intervention
3. The study is published in a research journal
4. The study is written in English
Exclusion Criteria (Title/Abstract)
1. Non-Canadian Indigenous population
2. Not a drug or alcohol use related study
3. Study on substance use prevalence, outcomes, attitudes, sentencing, etc.
4. Study on risk factors for substance use
5. Study population <12 years of age
6. Other disease focus of study (i.e., HIV, HepC)
7. Study on a non-Indigenous harm reduction intervention
8. Study on association between substance use and another health issue or behavior
9. Study on substance use cessation
10. Study on Indigenous harm reduction for pregnant people
11. Study on adherence to substance use disorder treatment
12. Other
Exclusion Criteria (Full Text Review)
1. Thematic analysis of multiple Indigenous harm reduction interventions
2. Insufficient description of Indigenous harm reduction intervention

4.0 Results

The initial search on Medline (Ovid) and APA PsycINFO (Ovid) online databases identified 172 articles. After duplicates were removed, 133 articles were screened for exclusion criteria at the title/abstract level. Out of 133 articles, 13 qualified for full text review. Three articles were unable to be retrieved for review. Of the remaining 10 articles, 6 were identified to be relevant and were included in this review (**Figure 1**).

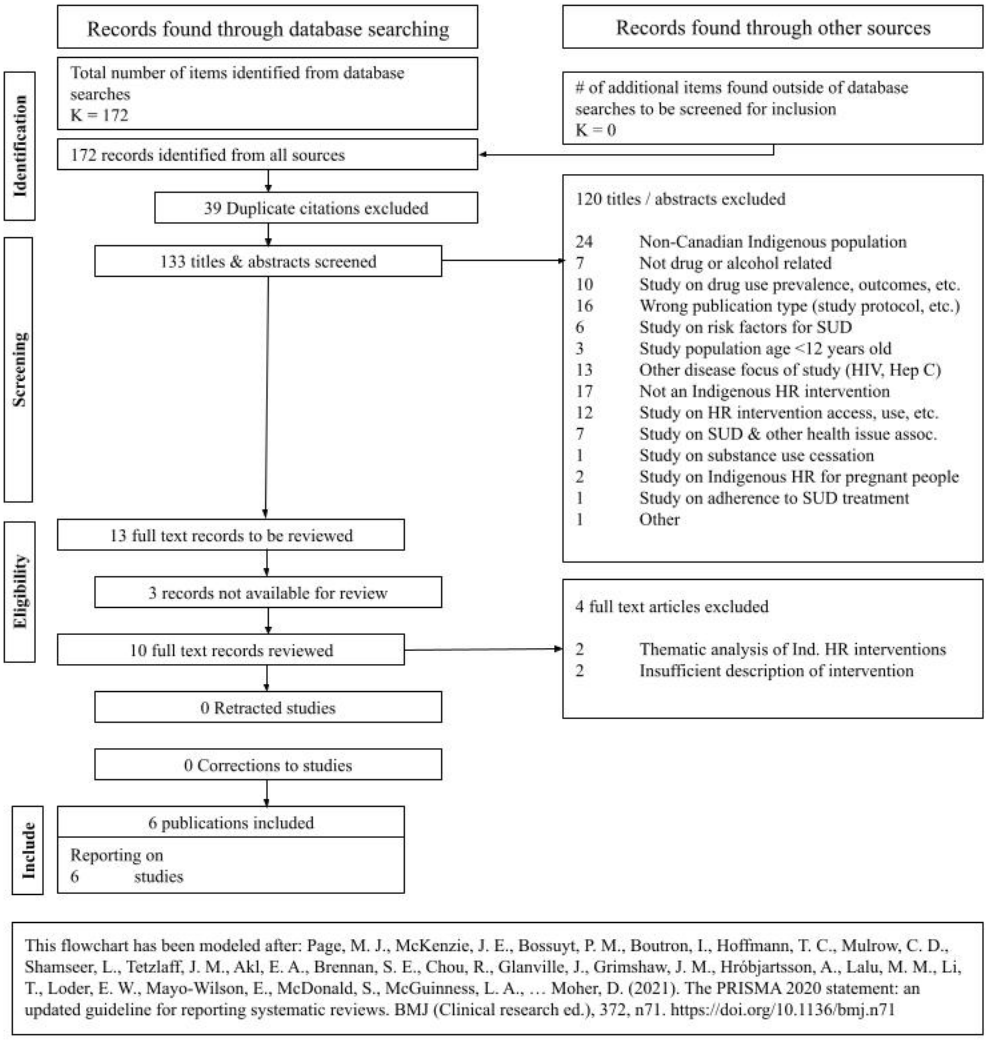

Figure 1. PRISMA Search and Screening Results

4.1 Characteristics of Indigenous Harm Reduction

Upon review of the relevant articles detailing Indigenous harm reduction interventions in Canada, five characteristics of Indigenous harm reduction were identified: culture, trauma-informed, cultural safety, Indigenous led, and integrative (**Table 2**). These characteristics frequently emerged as distinct, easily identifiable themes in the literature. There was considerable heterogeneity in the focus and structure of the harm reduction interventions across the reviewed articles. The harm reduction interventions reached different tribal communities, commonly referred to as "Bands," and spanned across urban, rural, and remote areas in Canada. The literature covered harm reduction initiatives in both adult and adolescent Indigenous populations. The type of intervention ranged from short-term withdrawal management services and extended stays at residential treatment facilities to weekend retreats and local alcohol harm reduction policy enforcement. The divergence in intervention type led to further variation by programmatic activities and substance(s) of focus. Despite significant diversity in the literature, the five characteristics: culture, trauma-informed, cultural safety, Indigenous led, and integrative - cropped up consistently across articles. These findings suggest that the identified characteristics are fundamental attributes of Indigenous Canadian harm reduction that can inform future best-practice models.

Table 2. Reviewed Articles and Indigenous Harm Reduction Characteristics

Article	Culture	Trauma-Informed	Cultural Safety	Indigenous Led	Integrative
(Argento et al., 2019)	x	x	x	x	x
(Dell et al., 2011)	x	x	x		x
(Gliksman, et al., 2007)	x			x	
(Gone, 2011)	x	x	x	x	x
(Kiepek et al., 2012)	x		x	x	x
(Marsh et al., 2022)	x	x	x	x	x

4.1.1 Culture

Thematic analysis of the literature identified culture as a core characteristic of Indigenous harm reduction. Culture was integral in guiding the structure and delivery of services in all six of the Indigenous harm reduction programs included in this review (Argento et al., 2019; Dell et al., 2011; Gliksman et al., 2007; Gone, 2011; Kiepek et al., 2012; Marsh et al., 2022). Culture emerged not as an isolated theme, but rather as an influential agent that shaped the other five characteristics. The interrelatedness of culture and the other characteristics established the incorporation of local Indigenous cultural values as an essential component of efficacious harm reduction services for Indigenous patients.

Despite diversity in the interventions included in this review, all the Indigenous harm reduction programs distinguished themselves from Western models of care in that they included the revitalization of Indigenous culture as both a strategy and outcome of harm reduction. This distinctive feature of Indigenous harm reduction stems from the recognition of widespread problematic substance use in Indigenous communities as a common coping mechanism for intergenerational trauma due to the oppression and assimilation of Indigenous Canadians (Dell et al., 2011; Gone, 2011; Marsh et al., 2022). Centuries of assimilationist policies and practices

dissolved Indigenous culture and knowledge systems, which continues to have detrimental effects on the health and well-being of First Nations, Métis, and Inuit people. The literature positions Indigenous harm reduction, rooted in the restoration and reclamation of Indigenous ways of knowing and being, as a "culture-based model of resiliency" that recognizes Indigenous cultural identity as a requisite for minimizing harms related to problematic substance use and other manifestations of colonization (Dell et al., 2011).

The main strategy for embedding culture into the Indigenous harm reduction programs was the application of Indigenous concepts of health and well-being to guide program curriculum. From an Indigenous worldview, health extends beyond the physical state to include the mental, emotional, and spiritual dimensions. Good health is also defined by a state of harmony and connectedness between the individual, the community, and the natural world (Dell et al., 2011). Thus, program curricula across harm reduction interventions regularly included Indigenous ceremonies, practices, and community-based events for individuals to develop a renewed sense of self derived from enhanced connection to cultural values (Argento et al., 2019; Dell et al., 2011; Gliksman et al., 2007; Gone, 2011; Kiepek et al., 2012; March et al., 2022).

Examples of cultural integration from the literature include the use of Indigenous plant medicine for treating substance use disorders (Argento et al., 2019) as well as the other Indigenous approaches to healing such as talking circles, smudging, tobacco offerings, pipe ceremonies, and prayer (Gone, 2011; Kiepek et al, 2012; Marsh et al., 2022). Three of the six programs also offered on-site sweat lodges, which provided patients with the opportunity to heal and connect with their spirituality in a non-clinical setting (Dell et al., 2011; Gone, 2011; Marsh et al., 2022). The Sioux Lookout Meno Ya Win Health Centre offered additional cultural programming aligned with First Nations approaches to healing such as the use of animal guides and traditional art-based activities

(Kiepek et al., 2012). To ensure the delivery of these services was culturally sensitive and well-received by patients, cultural services and activities were both developed and led by Indigenous Elders or other trusted Indigenous community members (Argento et al., 2019; Dell et al., 2011; Gone, 2011; Kiepek et al., 2012; Marsh et al., 2022). Testimonies of the transformative nature of cultural activities and teachings was consistent across the articles, suggesting that culture is a key facilitator in meeting health and wellness goals for Indigenous peoples with a substance use disorder.

4.1.2 Trauma-Informed

A trauma-informed approach to care was another key characteristic of the reviewed Indigenous harm reduction programs. In this context, trauma refers specifically to the trauma caused by acts of colonization such as the killing of Indigenous peoples, land dispossession and forced relocation, as well as physical, emotional, sexual, spiritual, and cultural abuse (Allan & Smylie, 2015; CAAN, 2019). This trauma is passed down through Indigenous families as subsequent generations continue to grieve cultural losses and face compounded disadvantages from colonial structures and systems that limit Indigenous peoples' access to social determinants of good health. A trauma-informed approach to Indigenous harm reduction, thus, recognizes the impact of intergenerational trauma on substance use disorders and offers patients strategies to understand and manage their trauma.

In a study evaluating the efficacy of ayahuasca-assisted therapy for substance use disorders, Argento and colleagues (2019) found that group talk therapy and individual self-reflection exercises regarding trauma had a profound effect on individual's ability to resolve internal conflicts that contributed to their problematic substance use. Another trauma-informed approach

to care was implemented at an Indigenous residential treatment program in Northern Ontario, where clinicians often provided their patients with a dual diagnosis of a substance use disorder and intergenerational trauma (Marsh et al., 2022). This dual diagnosis allowed Indigenous patients to understand their substance use not as a moral failing, but as a "symptom of distress and a coping mechanism in response to the collective oppression of Indigenous persons" (Marsh et al., 2022).

Similarly, Gone (2011) and Dell et al. (2011) took a trauma-informed approach to mental health and substance use by integrating lectures on colonization and assimilation into their respective treatment programs. At a First Nations Community Treatment Center, the historical teachings also included interactive activities in which participants "traced the consequences of residential schooling for their own families" (Gone, 2011). Evaluators of the program found that this deeply personal approach to unpacking intergenerational trauma allowed participants to contextualize their substance use disorder, which provided many with a renewed sense of commitment to their recovery (Gone, 2011).

4.1.3 Cultural Safety

Cultural safety appeared frequently throughout the literature review, cited by authors and program participants alike as a fundamental characteristic of Indigenous harm reduction (Argento et al., 2019; Dell et al., 2011; Gone, 2011; Kiepek et al., 2012; March et al., 2022). The concept of cultural safety was developed by Indigenous clinicians who recognized that the adoption of culturally competent practices in healthcare settings was insufficient at redressing health inequities for Indigenous people and other minoritized ethnic groups (Curtis et al., 2019). Cultural safety goes beyond the recognition of cultural differences. It affirms the identities and experiences of

Indigenous patients and acknowledges limitations to clinical effectiveness when power and privilege differentials exist between the patient and provider (CAAN, 2019; Curtis et al., 2019).

Cultural safety shifts the focus away from being "competent" in the culture of the patient. Instead, cultural safety places the responsibility on the provider to understand how their own culture, biases, and assumptions impact the quality and uptake of services for their Indigenous patients (Curtis et al., 2019). In this way, affirming, high-quality care is not defined by the provider's perceived cultural competency, but by patient's determination of whether the clinical experience made them "feel physically, mentally, emotionally, spiritually, and culturally safe" (CAAN, 2019).

Upon review of the literature, it became evident that cultural safety was a priority focus that shaped the structure and provision of Indigenous harm reduction programs. Cultural safety was achieved through embedding cultural programming into service curricula, hiring local Indigenous people as providers of both clinical and cultural services, and establishing the programs nearby or in Indigenous communities (Argento et al., 2019; Dell et al., 2011; Gone, 2011; Kiepek et al., 2012; Marsh et al., 2022).

In the ayahuasca-assisted therapy retreat, the retreat was organized by and located within a small, isolated First Nations community in southwestern British Columbia (Argento et al., 2019). The retreat was held in the band's longhouse, which is a traditional ceremonial space. This familiar, non-clinical setting provided participants with a safe space in which First Nations people could come together to immerse themselves in Indigenous culture and spirituality. The retreat team, although predominantly Indigenous, included a non-Indigenous Canadian physician, who embraced traditional Indigenous therapeutic modalities, rather than imposing western approaches to substance use disorder treatment. Participant accounts of the retreat repeatedly relayed gratitude

towards the retreat team, including the non-Indigenous physician. This suggests that the physician prioritized the cultural safety of the participants. Through this culturally safe approach to care, participants were able to "delve more deeply into aspects of their psyche that had been inaccessible with other treatment approaches" (Argento et al., 2019).

In the articles studying Indigenous residential treatment centers (Marsh et al., 2022; Dell et al., 2011; Gone, 2011) and withdrawal support services (Kiepek et al., 2012), cultural safety was achieved by engaging local communities in the development of the services. This included the contribution of Indigenous perspectives, strengths, and values in the structuring of treatment program curricula as well as the employment of local Indigenous people in both leadership and service delivery roles (Marsh et al., 2022; Dell et al., 2011; Gone, 2011, Kiepek et al., 2012). These community-driven programs created welcoming, safe spaces in which racism and power differentials between Indigenous and non-Indigenous Canadians were absent. Patients were encouraged to heal through learning about and practicing Indigenous culture, spirituality, and language.

4.1.4 Indigenous Led

An Indigenous approach to harm reduction demands that harm reduction programs and services are designed, implemented, and delivered by Indigenous people. Thus, being Indigenous led is a defining characteristic of Indigenous harm reduction. The assumption of leadership roles by First Nations, Métis, and Inuit people was present across all six articles. Marsh et al. (2022) noted a remarkable uptick in the efficacy of Benbowopka Treatment Centre services once it was adapted from a Western abstinence-based model of care to an Indigenous Healing and Seeking Safety (IHSS) model. This innovative approach to service delivery was proposed and actualized

by the local Tribal Council. Under the guidance of Indigenous community leaders, the Benbowopka Treatment Centre became an exemplary illustration of how local communities can thrive when they have control over their health services.

In other articles, Indigenous led care was exemplified by the employment of Elders and other local Indigenous community members (Argento et al., 2019; Gone, 2011; Kiepek et al., 2012). Indigenous people fulfilled clinical and non-clinical positions including board directors, administrators, nurses, psychiatrists, counselors, medical interpreters, traditional healers, and cultural and spiritual mentors. This widespread representation ensured that services were appropriate, responsive to community needs, leveraged existing community strengths, and redressed historical power imbalances between patients and providers. The success of these Indigenous led programs demonstrates that Indigenous people can achieve health, wellness, and self-determination when they have control over how, when, where and from whom they receive care.

Gliksman and colleagues (2007) offered another example of Indigenous leadership in their article detailing the establishment of an alcohol harm reduction policy in four First Nations communities. The initiative to create and institute the alcohol harm reduction policy emerged from growing demands in the communities to reduce alcohol-related harms. The policy was developed by a committee comprised of Band Council staff and a diverse group of local Indigenous community members that represented a wide range of personal interests. The decision-making process adhered to a consensus-building model that reflected shared community goals, values, and norms. Adoption of the policy yielded sustainable reductions in alcohol-related harms in all four First Nations communities. Gliksman et al. (2007) attribute this success to the initiative being

Indigenous led and remark that community-driven approaches to harm reduction "holds promise for the future of First Nation communities as they move to an era of self-government."

4.1.5 Integrative

Another defining characteristic of Indigenous harm reduction is that it integrates Indigenous and Western knowledge systems. The integrative nature of Indigenous harm reduction stems from Two-Eyed Seeing, which is a philosophy developed by First Nations Elder, Albert Marshall (Wright et al., 2019). Two-Eyed Seeing refers to "viewing the world through one eye using the strengths of Indigenous worldviews and with the other eye using the strengths of Western worldviews, to see together with both eyes to benefit all" (Wright et al., 2019). This perspective acknowledges the co-existence of different knowledge systems and the respective strengths of Indigenous and Western ways of knowing and being. The adoption of this philosophy in Indigenous harm reduction provides recipients of harm reduction services with the opportunity to benefit from the best practices that Indigenous and Western approaches to care have to offer.

Marsh and colleagues (2022) referenced Two-Eyed Seeing as a foundational component of the Benbowopka Treatment Centre's model of care. Four other articles detailed Indigenous harm reduction programs that employed an integrative approach to care, but the authors did not explicitly link the integrated services to Two-Eyed Seeing (Argento et al., 2019; Dell et al., 2011; Gone, 2011; Kiepek et al., 2012). Integrated harm reduction services in the literature were demonstrated by the consistent utilization of both Indigenous and Western treatment modalities. This included the availability of both Indigenous and Western medicines at treatment centers and the opportunity to opt-in to cultural and spiritual programming to compliment evidence-based harm reduction strategies (Dell et al., 2011; Gone, 2011; Kiepek et al., 2012). Indigenous patients

identified the exposure to different cultural approaches to care as a major strength of their program in all five articles (Argento et al., 2019; Dell et al., 2011; Gone, 2011; Kiepek et al., 2012; Marsh et al., 2022).

5.0 Discussion

The aim of this critical literature review was to identify the characteristics of Indigenous harm reduction models in present-day Canada. The author identified five key characteristics of Indigenous harm reduction models that were consistently present in the literature: culture, trauma-informed, cultural safety, Indigenous led, and integrative (Argento et al., 2019; Dell et al., 2011; Gliksman et al., 2007; Gone, 2011; Kiepek et al., 2012; March et al., 2022). There was significant heterogeneity in type, structure, and locale of Indigenous harm reduction interventions across the reviewed articles. The recurrent emergence of five distinct characteristics across diversified interventions suggests that the identified characteristics are fundamental attributes of Indigenous Canadian harm reduction models.

Indigenous culture informed the development and delivery of Indigenous harm reduction models in all six articles. The findings identify culture as the cornerstone of Indigenous harm reduction, from which the four other characteristics are derived. The integration of culture was exemplified by the alignment of harm reduction goals and strategies with traditional Indigenous conceptions of health and wellbeing. This included the utilization of community-based healing modalities and Indigenous plant medicine (Argento et al., 2019), as well as the provision of cultural programming to educate participants on Indigenous spirituality, language, and history (Dell et al., 2011; Gone, 2011; Kiepek et al., 2012; Marsh et al., 2022).

The four other characteristics identified in the literature: trauma-informed, Indigenous led, cultural safety, and integrative – demonstrate the instrumental role of culture in shaping the foundation of harm reduction models. An Indigenous approach to harm reduction leverages the power of culture-centered services to mitigate the harms associated with profound cultural

loss. Thus, trauma-informed care emerges as a necessary component of Indigenous harm reduction. A trauma-informed approach to care centers the Indigenous narrative, acknowledging that cultural and institutional racism create the socioeconomic arrangements that influence the inequitable distribution of and access to determinants of good health and well-being such as housing, education, employment, and income.

Explicitly acknowledging the historic and daily realities of Indigenous peoples exposes the relationship between intergenerational trauma and problematic substance use. This allows patients to contextualize their substance use disorder, an element of trauma-informed care that was identified in the literature as a catalyst for healing and managing substance use (Marsh et al., 2022). The interconnectedness of trauma and substance use disorder among many Indigenous Canadians illustrates the decolonizing nature of Indigenous harm reduction. When substance use disorder is understood as a manifestation of colonial harms, a person's recovery does not simply connote alleviation from substance dependence. Indigenous harm reduction facilitates the mental, emotional, physical, and spiritual recovery from colonialism. In this way, recovery can be seen as a remarkable act of resistance that empowers Indigenous individuals and communities to achieve not only a state of optimum health, but also liberation and self-determination.

Providers that employ a trauma-informed approach also understand that the health care system often presents another avenue in which Indigenous people experience race-based trauma. When providers lack cultural sensitivity and fail to recognize the connection between trauma and poor health outcomes, the sense of trust and safety between the patient and provider is dissolved. Thus, Indigenous harm reduction hinges on the understanding that trauma-informed care, which recognizes the impact of overt and covert racism at structural and interpersonal levels, is a requisite for achieving cultural safety. When engagement with harm reduction services is

determined by the patient to be culturally safe, the patient's receptivity to interventions increases. Receptivity to intervention is paramount for meeting each patient's personal goals for safer and/or decreased substance use. The literature consequently identifies trauma-informed care and cultural safety as key characteristics that distinguish Indigenous harm reduction from mainstream harm reduction.

In the literature, trauma-informed and culturally safe elements of Indigenous harm reduction were strengthened by engaging local Indigenous people in the development and delivery of harm reduction interventions (Argento et al., 2019; Dell et al., 2011; Gone, 2011; Kiepek et al., 2012; Marsh et al., 2022). The author found that Indigenous leadership was a common theme across all six articles. Indigenous community members and Tribal Councils led the initiative to develop or modify harm reduction interventions to better serve Indigenous Canadians. This allowed Indigenous communities to leverage the strengths of local cultural values and practices to offer healing methods that were salient to Indigenous people who use drugs.

Indigenous-led initiatives resulted in the establishment of an Indigenous workforce, which fostered a sense control and self-determination among local communities. Additionally, the delivery of services by Indigenous clinicians and cultural mentors ensured that power imbalances were absent from the patient-provider relationship. This was integral for providing trauma-informed and culturally safe care. Moreover, a robust Indigenous workforce that provides Indigenous ways of healing alongside Western clinical approaches to care underscores the highly integrative nature of Indigenous harm reduction. The success of the interventions in the literature, all of which were carried out predominantly or wholly by Indigenous staff, highlights that harm reduction for Indigenous Canadians excels when Indigenous people fulfill diverse healthcare roles. This finding demonstrates that Indigenous leadership is a critical characteristic of Indigenous harm

reduction. However, Indigenous leadership should not be confined to community-based Indigenous harm reduction spaces. Indigenous harm reduction means reducing the harms of colonialism, which extends beyond the scope of problematic substance use. Thus, Indigenous people must be represented in a range of leadership positions in all dimensions of society that proximally and distally affect the health, well-being, quality of life, and self-determination of Indigenous Canadians.

5.1 Limitations

This critical literature review has several limitations. Only two online databases were explored in the literature search. While Medline (Ovid) and APA PsycINFO (Ovid) are robust databases, it is possible that there was relevant literature not captured in the search. Publication types such as study protocols, case reports, editorials, and public comments were excluded during review at the title/abstract level and did not undergo a full-text review. These parameters for searching and reviewing may have contributed to the exclusion of literature in a way that impacted the synthesis of literature for this review. Additionally, the author was the only person involved in the article review process and thematic analysis of the 6 relevant articles. This creates an opportunity for personal bias to affect the selection of articles as well as the interpretation of Indigenous harm reduction characteristics identified in this review. Nonetheless, this review provides valuable insight regarding the core attributes of Indigenous harm reduction in Canada not found elsewhere.

6.0 Conclusion

This critical literature review identified five defining characteristics of Indigenous harm reduction in Canada: culture, trauma-informed, cultural safety, Indigenous-led, and integrative. The characteristics appeared in the literature as distinct attributes yet also revealed themselves to be deeply interconnected. Together, the five characteristics work to rectify the harms of cultural loss and collective oppression by positioning cultural programming and other Indigenous healing methods as harm reduction modalities of the same value and importance as Western evidence-based methods.

Indigenous harm reduction interventions explored in this literature review demonstrate the remarkable remedial and empowering nature of culture when it is thoughtfully embedded into service development and delivery. The author's critical review of the literature not only identified core characteristics of Indigenous harm reduction, but also demonstrated how the characteristics contributed to the successful reduction of substance- and colonial-related harms. Thus, this essay contributes to a growing body of literature that testifies to the efficacy and value of Indigenous harm reduction.

The identification and definition of Indigenous harm reduction characteristics provided in this critical review serves as a helpful tool for practitioners to understand the key attributes of harm reduction service design and delivery that are most salient and effective for Indigenous people who use drugs. The author encourages a coordinated, widespread adoption of trauma-informed, Indigenous approaches to healing and wellness across the nation's public healthcare system. This works to ensure that Indigenous harm reduction is not constrained to small, community-based services or pilot programs located on or near a limited number of Indigenous reserves. Nation-

wide adoption of Indigenous harm reduction would equip providers at clinics, hospitals, substance use disorder treatment facilities, and other social services with the knowledge and resources to best serve their Indigenous patients located across all regions of Canada.

This essay also serves as a valuable reference point for public health agencies and governing bodies as Canada continues to incorporate harm reduction initiatives into its national public health strategy. The findings from this critical review suggest that Indigenous harm reduction must be endorsed and receive sustained material support on a national scale to eliminate health inequities in substance-related harms that persist among Indigenous populations. Indigenous harm reduction should not be adopted in replacement of mainstream harm reduction, but rather as a complementary addition to existing harm reduction strategies. The author recognizes the value of structural harm reduction interventions such as Naloxone distribution, syringe services programs, access to sterile smoking and snorting equipment, safer consumption sites, and medications for opioid use disorder. These resources are critical for reducing substance-related harms at the individual level. Findings from this critical literature review, however, highlight the importance of prioritizing systemic change to the same degree as individual behavior change. This entails interrogating and reforming the colonial structures and policies that create the conditions in which Indigenous health inequities arise.

The Canadian government and other entities with political influence must understand that harm reduction is not strictly bound to substances. Harm reduction policies can and should extend beyond legislation that increases access to structural interventions and decreases the legal and social consequences associated with substance use. The findings in this essay assert that harm reduction includes legislative and social reform that promote equitable access to determinants of good health including income, employment, land, food security, and adequate housing. These

reforms must arise from a collaborative effort between Indigenous communities and non-Indigenous allies that seek to rectify historic power imbalances and center Indigenous realities. Only when Indigenous lives, Indigenous culture, and Indigenous knowledge systems are wholly valued and constitutionally protected can First Nation, Métis, and Inuit people enjoy the same degree of health and wellbeing as non-Indigenous Canadians.

Appendix A Search Strategies

Table 3. Summary of Online Literature Databases Searched

Table ID	Vendor / Interface	Database	Date searched	Database Update	Searcher(s)
1b	OVID	Medline® ALL	April 17, 2024	1946 to April 16, 2024	Helena M. Vonville Annie H. Gordon
1c	OVID	APA PsycInfo	April 17, 2024	1806 to April Week 1 2024	Helena M. Vonville Annie H. Gordon

Table 4. Medline® Search Strategy

Provider/Interface: Ovid
Database: Medline®
Date searched: April 17, 2024
Database update: 1946 to April 16, 2024
Search developer(s): Helena M. Vonville; Annie H. Gordon
Limit to English: Yes
Date Range: No limit by date
Publication Types: No limit by publication type
Search filter source: Adapted US filter from: https://hsls.libguides.com/Ovid-Medline-search-filters/limiters

1	indigenous canadians/ or inuit/ or "Indians, North American"/ or "Indigenous Peoples"/ or (Aboriginal or Aleut or Aleuts or Eskimo or Eskimos or (First adj (Nation or Nations)) or Inuit or Inuits or Inuk or Inupiat or Inupiats or Kalaalit or Kalaalits or Metis or ((indigenous or native) adj2 Canadian*)).ti,ab,kf.
2	1 not ((exp africa/ or exp asia/ or exp australia/ or exp central america/ or exp europe/ or exp south america/ or exp united states/) not (north america/ or exp canada/))
3	Harm Reduction/
4	(harm adj (reduction* or minimization or prevention)).ti,ab,kf.
5	(addiction adj2 (counsel* or therapy or treatment*)).ti,ab,kf.
6	Needle-Exchange Programs/
7	(((needle or syringe) adj (distribution or exchange)) and ((distribution or exchange) adj (program or programs))).ti,ab,kf.
8	(((safe or supervised) adj inject*) and (inject* adj (assisted or center or centers or centre or centres or facilities or facility or opioid* or public or site or sites))).ti,ab,kf.
9	(((safe or safer) adj consumption) and (consumption adj sites)).ti,ab,kf.
10	Naloxone/ or Narcotic Antagonists/tu
11	(narcan or naloxone).ti,ab,kf,rn.
12	(methadone adj maintenance adj2 (program* or therap* or treatment)).ti,ab,kf.
13	(Overdos* adj1 (prevent* or response or training)).ti,ab,kf.
14	Medicine, Traditional/ or ((cultural adj intervention*) or (healing adj tradition*) or ((indigenous or traditional) adj (led or medicine)) or (Seeking adj safety) or (two adj eyed)).ti,ab,kf.
15	3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
16	2 and 15
17	substance-related disorders/ or alcohol-related disorders/ or alcohol-induced disorders/ or alcoholic intoxication/ or alcoholism/ or binge drinking/ or amphetamine-related disorders/ or drug misuse/ or prescription drug misuse/ or prescription drug overuse/ or narcotic-related disorders/ or exp opioid-related disorders/ or substance abuse, intravenous/

18	((addiction or addictive or alcohol or drug or drugs or prescription* or substance*) adj3 (abuse or abused or behavio?r* or disorder* or harm or harms or illicit or misuse or "use")).ti,ab,kf.
19	(alcohol or alcoholism or amphetamine* or heroin or IDU or ((injection or injecting or intravenous) adj (drug or drugs)) or methamphetamine* or narcotic* or opioid*).ti,ab,kf.
20	17 or 18 or 19
21	16 and 20
22	limit 21 to english language
23	22 not ((exp infant/ or exp child/) not (adolescent/ or exp adult/))

Table 5. APA PsycINFO Search Strategy

Provider/Interface: Ovid
Database: APA PsycINFO
Date searched: April 17, 2024
Database update: 1806 to April Week 1 2024
Search developer(s): Helena M. Vonville; Annie H. Gordon
Limit to English: Yes
Date Range: No limit by date
Publication Types: No limit by publication type
Search filter source: Language filter: https://hsls.libguides.com/PsycInfo-search-filters/limiters

1	indigenous populations/ or inuit/
2	("indigenous canadians" or inuit or "Indians, North American" or "Indigenous Peoples").mh.
3	(Aboriginal or Aleut or Aleuts or Eskimo or Eskimos or (First adj (Nation or Nations)) or Inuit or Inuits or Inuk or Inupiat or Inupiats or Kalaalit or Kalaalits or Metis or ((indigenous or native) adj2 Canadian*)).ti,ab,id.
4	1 or 2 or 3
5	canada.lo.
6	(canada or canadian* or alberta or (british adj columbia) or calgary or edmonton or Iqaluit or manitoba or montreal or newfoundland or (nova adj scotia) or Nunavut or ontario or ottawa or quebec or regina or Saskatchewan or toronto or vancouver or winnipeg or yukon).ti,ab,id,in.
7	5 or 6
8	4 and 7
9	harm reduction/ or needle exchange programs/
10	(harm adj (reduction* or minimization or prevention)).ti,ab,id.
11	(addiction adj2 (counsel* or therapy or treatment*)).ti,ab,id.
12	(((needle or syringe) adj (distribution or exchange)) and ((distribution or exchange) adj (program or programs))).ti,ab,id.
13	(((safe or supervised) adj inject*) and (inject* adj (assisted or center or centers or centre or centres or facilities or facility or opioid* or public or site or sites))).ti,ab,id.
14	(((safe or safer) adj consumption) and (consumption adj sites)).ti,ab,id.
15	narcotic antagonists/ or naloxone/ or buprenorphine/
16	(Harm Reduction or Needle-Exchange Programs or Naloxone or Narcotic Antagonists).mh.
17	"Substance Use Prevention"/
18	"Medicine, Traditional".mh.

19	((cultural adj intervention*) or (healing adj tradition*) or ((indigenous or traditional) adj (led or medicine)) or (Seeking adj safety) or (two adj eyed)).ti,ab,id.
20	9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19
21	8 and 20
22	("substance-related disorders" or "alcohol-related disorders" or "alcohol-induced disorders" or "alcoholic intoxication" or "alcoholism" or "binge drinking" or "amphetamine-related disorders" or "drug misuse" or "prescription drug misuse" or "prescription drug overuse" or "narcotic-related disorders" or "opioid-related disorders" or "substance abuse, intravenous").mh.
23	"substance use disorder"/ or drug dependency/
24	drug abuse/
25	drug addiction/ or addiction/
26	alcoholism/ or alcohol abuse/
27	drug abuse/ or exp drug addiction/ or exp intravenous drug usage/ or prescription drug misuse/
28	amphetamines/ or methamphetamine/
29	((addiction or addictive or alcohol or drug or drugs or prescription* or substance*) adj3 (abuse or abused or behavio?r* or disorder* or harm or harms or illicit or misuse or "use")).ti,ab,id.
30	(alcohol or alcoholism or amphetamine* or heroin or IDU or ((injection or injecting or intravenous) adj (drug or drugs)) or methamphetamine* or narcotic* or opioid*).ti,ab,id.
31	22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30
32	21 and 31
33	limit 32 to all journals
34	33 not ((albanian or arabic or bulgarian or catalan or chinese or croatian or czech or danish or dutch or estonian or farsi iranian or finnish or french or georgian or german or greek or hebrew or hindi or hungarian or italian or japanese or korean or lithuanian or malaysian or nonenglish or norwegian or polish or portuguese or romanian or russian or serbian or serbo croatian or slovak or slovene or spanish or swedish or turkish or ukrainian or urdu) not English).lg.

35	34 not ("12611368" or "31489731" or "20835301" or "19998424" or "30211453" or "8607039" or "30156433" or "19839288" or "20429917" or "17319116" or "23975866" or "14707793" or "30977417" or "37214599" or "19016172" or "21688759" or "31657103" or "32087841" or "25397635" or "21345231" or "20800976" or "21704461" or "21333034" or "29981036" or "17645904" or "26980712" or "35639622" or "18075913" or "21052824" or "30703666" or "29723011" or "22954518" or "27867445" or "10906924" or "18625824" or "25821874" or "15964714" or "14557313" or "26160514" or "23094953" or "9447075" or "16203397" or "27730106" or "32209101" or "30559278" or "9512840" or "24325629" or "18018810" or "20302638" or "22931079" or "28209683" or "26335006" or "25989833" or "36149060" or "21676557" or "15850026" or "25812975" or "33596901" or "17870461" or "19191041" or "30549896" or "37040993" or "21700154" or "12023501" or "15167294" or "20825372" or "21810077" or "24976814" or "36261234" or "35351781" or "31045405" or "23731672" or "1072385" or "27156564" or "29021079" or "24621085" or "20364539" or "18358759" or "27431046" or "22046224" or "26141750" or "37532474" or "18155336" or "18207725" or "33166826" or "18218101" or "36833982" or "21718531" or "33334959" or "34994696" or "16203454" or "33679247" or "23627784" or "28701461" or "12660536" or "16356659" or "17176481" or "23585610" or "29914717" or "37848654" or "34137739" or "12025434" or "17034636" or "23630985" or "33097315" or "27568508" or "16040375" or "17606937" or "37297550" or "21355933" or "28173807").pm.

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