A Scoping Review: What is known about Indigenous Women in Canada Accessing Services for Substance Use?

by

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Dedication

I dedicate this work to Indigenous women in Canada accessing services for substance use, who have continued to build resilience in the face of adversity.

Acknowledgements

For three years, I have cherished the relationships that I have built or strengthened while completing this program. I am eager to thank all of the people who have entered into my life throughout this journey and as such, made me a better individual both personally and professionally. Thanks to God for instilling in me, the things that man cannot even begin to comprehend.

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Abstract

Background Despite a highly appraised, publicly funded health care system, access remains a challenge for Indigenous peoples in Canada. Indigenous peoples have experienced racism, social exclusion, discrimination and stigmatization in accessing health care services. Indigenous peoples are over represented in opioid-related deaths and at the same time, Indigenous women face discrimination related to marginalization from mainstream health. **Method** A 'hybrid' approach to the scoping review method which combines the five stages of the Arksey and O'Malley framework, and the recently refined Joanne Briggs Institute's (JBI) approach to the conduct of scoping reviews. *EBSCO Discovery* database and *Google scholar* were used to search for literature. Based on inclusion and exclusion criteria, total of six studies were included in the final analysis. **Findings** Salient themes emerged from this scoping review; the issue of safety in mixed gender settings, lack of culturally appropriate programs, racism and triple marginalization, lack of access and post treatment support, and treatment or child apprehension. **Conclusion** This scoping review provides opportunities for health care providers, especially nurses, to promote social justice across intersecting oppressions such as race, gender and class. In order to break the cycle of policy-based systemic oppression, the Truth and Reconciliation Calls to Action should be applied in all levels of nursing; education, practice, research and policy. The ongoing need for trauma informed care, cultural humility and eventually cultural fluidity is discussed.

Keywords: scoping review, Indigenous peoples, Indigenous women, Aboriginal peoples, racism, healthcare, substance use, cultural humility, Canada.

Table of Contents

Title Page i

Dedication ii

Acknowledgments ..... iii-iv

Abstract v

Table of Contents vi

List of Tables and Figures vii

List of Appendices viii

List of Abbreviations ix

Introduction 1-3

Self-Location 3-7

Conceptual Framework 7-8

Method 8-10

Stage 1: Identify the Research Question 10

Stage 2: Identify Relevant Studies 10-15

Stage 3: Study Selection 16-17

Stage 4: Charting the Data 18-27

Stage 5: Reporting Results 28-34

Discussion 35-40

Implications 40-44

Limitations 44-45

Conclusion 45

References 46-53

List of Tables and Figures

Table 1
Search Categories and Terms 12

Table 2
Database Search Strategy 13

Table 3
Details of Included Studies 18

Figure 1
Search Results Flow Diagram 17

Figure 2
Visual Representation of Thematic Analysis 34

List of Appendices

Appendix A

Scoping Review Frameworks 54

Appendix B

PRISMA Flow Diagram 55

Appendix C

PRISMA-ScR Checklist 56-57

List of Abbreviations

PHAC	Public Health Agency of Canada
FNHA	First Nations Health Authority
CBC	Canadian Broadcasting Corporation
WHO	World Health Organization
MHSU	Mental Health and Substance Use
CADTH	Canadian Agency for Drugs and Technologies in Health
CANLII	The Canadian Legal Information Institute
WWUD	Women who use drugs
DTES	Downtown east side
OPS	Overdose prevention site
APWUID/A	Aboriginal peoples who use illicit drugs and/or alcohol
IPWUID/A	Indigenous peoples who use illicit drugs and/or alcohol
NFA	No fixed address
TRC	Truth and Reconciliation Calls to Action
DRIPA	Declaration on the Rights of Indigenous Peoples Act
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples

Introduction

Canadian healthcare is highly praised for its publicly funded system framed upon and grounded in five fundamental principles: accessibility, comprehensiveness, portability, universality and public administration (Coburn, 2004). Despite Canada's rating in the top fifteen percent for accessibility, availability of healthcare services for [1]Indigenous peoples living in Canada remains a challenge (Tang & Browne, 2008; WHO, 2000). Studies show that Indigenous peoples in Canada experience higher morbidity and mortality rates compared to the non-Indigenous population (Adelson, 2005; MacMillan et al., 1996). More concerning is that Indigenous peoples experience racism, social exclusion, discrimination and stigmatization in accessing health care services (Browne, 2017; Browne et al., 2011; Tang & Browne, 2008; Browne et al., 2001). According to Wood et al., 2005, people who share their Indigenous identity with service providers, are less likely to receive treatment for [2]substance use. First Nations peoples are five times more likely to experience an opioid- related overdose and are three times more likely to die from an opioid-related overdose than non-First Nations peoples (Belzak & Halverson, 2018). Browne et al., (2001) found that First Nations women were particularly exposed to discrimination related to marginalization from mainstream health services when they tried to access care from a Canadian urban emergency room. In a recent evidence synthesis of the Canadian opioid crisis in both British Columbia and Alberta provinces, First Nations women aged 50 to 54 years old represented a higher proportion

[1]In this paper, when used, the term *Indigenous* will refer to all three Indigenous groups in Canada: First nations, Inuit and Métis (*Constitution Act*, 1982, s 35). The legislated term Aboriginal, which refers to First Nations, Inuit and Métis peoples, is only used in this paper in the term of work for authors cited. Use of this term will remain respectful to the unique identities of each woman in all three Indigenous groups in Canada recognizing the difference and uniqueness between history, culture and present-day circumstances.
[2]The term *substances* used in this study refers to illicit drugs and/or alcohol.
[3] *Active users* are individuals who were using substances at the time the study was conducted.

of all opioid related deaths compared to men who were younger 30 to 34 years (Belzak & Halverson, 2018).

Nationally, there have been 15,393 reported opioid-related deaths between January 2016 and December 2019; 3,823 of these deaths occurred between January and December 2019 (Public Health Agency of Canada [PHAC], 2020). Since its debut in January 2020, COVID-19 disruptions have contributed to an increase in overdose deaths. In British Columbia, First Nations peoples accounted for 16 per cent of overdose deaths between January and May 2020; a 93% increase from the same period in 2019. This is a staggering percentage as First Nations peoples represent only 3.3. per cent of the population in BC (First Nations Health Authority [FNHA], 2020a). First Nations peoples died at 5.6 times the rate of other BC residents in 2020, compared with 3.8 in 2019 (FNHA, 2020a). In 2020, First Nations women died from overdose at 8.7 times the rate of other women in BC (FNHA, 2020a). Compounding the overdose crisis, COVID-19 safety measures have contributed to a disruption in drug supply, thereby making the current supply more potent and toxic (FNHA, 2020a). As well, safety measures such as physical distancing and staying home may have decreased access to harm reduction services, enhancing the likelihood of people using in isolation (FNHA, 2020a). In June 2020, 181 overdose deaths in BC were reported; higher than ever in the history of this province (British Columbia Coroners Service, 2020). The important role of nurses in the wake of the overdose crisis is very much reflected in a recent release by BC's provincial health officer, Dr. Bonnie Henry, where she issued an order that authorized registered nurses and registered psychiatric nurses to prescribe pharmaceutical alternatives to street drugs. Henry's intent was "to help separate more people from the poisoned street drug supply to save lives and provide opportunities for ongoing care, treatment and support" (Canadian Broadcasting Corporation [CBC], 2020).

Due to intergenerational trauma stemming from colonization, Indigenous women are more likely to turn to using substances as a coping strategy (Niccols et al., 2010). The legacy of physical and sexual abuse in residential schools has led to effects ranging from family violence to alcohol and substance abuse (Stout, & Kipling, 2003). Colonization led to the suppression of Indigenous cultures and identity as well as displacement and disconnection from their communities (Urbanoski, 2017; Stout, & Kipling, 2003). The structural and systemic disadvantages that resulted from colonization continue to have adverse effects on the health of Indigenous peoples (Urbanoski, 2017). The constraints that have come from colonization have led to the development of certain unique skills that are needed to improve resilience and transcend oppression (Burnette, & Figley, 2017). Resilience, which can be at the individual, family, community and cultural levels, is the ability of Indigenous peoples to adapt and transcend historical oppression (Burnette, & Figley, 2017). Despite a difficult life of poverty, substance use, homelessness and other factors, the author of this scoping review has seen clients successfully commit to jobs and community involvement while ensuring positivity. This elevated self-esteem has been identified as a protective factor against alcohol and substance abuse and contributes to a strong sense of identity for Indigenous peoples (Burnette, & Figley, 2017; Stout, & Kipling, 2003). It is crucial to focus this area of work beyond the experiences of trauma and oppression from colonization, by giving space to individual strengths and positive outcomes of Indigenous peoples, that have been seen in practice and literature (Kirmayer et al., 2011).

Self-Location

The World Health Organization (WHO) has an ongoing project entitled the *Indigenous Peoples and Substance Use Project* which seeks to empower communities from 12 countries by giving them responsibility and control over their own health. Some of these Indigenous

communities include the Canadian First Nations and the Ogonis of Nigeria (WHO, 2018). As a Registered Nurse working in the area of Mental Health and Substance Use (MHSU), I am aware of my location in relation to this study. The process of self-location, or researcher preparation, is crucial to Kovach's (2009) decolonization approach. Kovach (2009) discussed the importance of reflecting on the insider/outsider status, claiming it is useful in situating one's self in relation to the research. Self-location allows for the identification and mitigation of power differentials, thereby contributing to social justice (Kovach, 2009). In an effort to be clear about the personal and academic motivations that have led me to conduct this review, there is the need to provide an explanation of who I am.

My mother is from the Idah tribe, and my father is from the Ibaji tribe in the Kogi state of central Nigeria. In my culture, the child would claim the father's place of origin, so that makes me Indigene of Ibaji in the Kogi state. I completed a Bachelor of Science in Nursing Degree in British Columbia, Canada where I have lived as a Canadian Citizen for several years. I situate myself as a Nigerian-Canadian and this positions me as a non-Indigene of Canada, engaging in Indigenous research and/or review. That being said, I am a black woman whose ancestors have endured slavery and colonization. I believe that the teachings passed down from my parents and ancestors have added to the way I view Indigenous health, contributing to my overall interest in decolonization. I am open to experiencing deep deconstructing and reconstructing of my position of power and privilege as a non-Indigenous researcher and a Registered Nurse within the field. I am also aware of the influence of my sensitivities stemming from a history of colonization and how I might view the data that is collected from the review. As suggested by Kovach (2009), in order to be a part of deconstructing health systems in relation to Indigenous women accessing health service for substance use, I will use reflexive journaling as a way to record my personal

reflections in a holistic manner throughout this study. I will be engaging in multi-layered reflexivity as suggested by Rix (2014), as this will ensure that all three aspects of reflexivity-self, interpersonal and system- are captured. *Self-reflexivity* will allow me to explore my biases while being aware of what I bring to the study from my past experience with colonization. *Interpersonal reflexivity* ensures that power imbalance in relation to Nurse-Client relationships are examined as I continue to work in this area of Mental Health and Substance Use. *System reflexivity* is aimed at scrutinizing any institutional policies and practices that may have negative impacts on Indigenous health (Rix, 2014). I believe that conducting this research as a Registered Nurse within the field, puts me in a position of privilege to create change as a health care provider who remains in direct contact with Indigenous women accessing services for substance use, while broadening my understanding on a deeper personal level (Kovach, 2009). The event that personally motivated me to conduct this review happened about four years ago. I was engaged in a routine appointment with a client and realised that she had to use the washroom numerous times. When I asked her why, she said that she was having her period. At the end of our appointment that day, I went and brought a big pack of sanitary towels to hand to my client. As soon as she saw it, she ended our session rather abruptly and left without the sanitary pack. Three weeks later at our next, very quiet appointment, I decided to ask her what I did wrong the last time that made her leave quickly. What she told me awakened my thinking to date; she said that she never used sanitary towels as she made her own traditionally. I was taken aback and paused for a few seconds. Fast forward to today, I realise that my approach was completely wrong. I assumed that as a Registered Nurse, I knew what was "best" for her and perhaps assumed that "heroic" role. Indigenous peoples are not victims who need to be saved. As a health care worker, I believe that I have a huge responsibility with regards to supporting Indigenous

peoples, especially women, in their pursuit and sustenance of resilience (Stout & Kipling, 2003). I believe that conducting this review with a decolonization approach, is one way to engage in my responsibility to Indigenous women accessing services for substance use. I am interested in furthering my own understanding of access to health care services as a non-Indigenous health care provider, particularly in relation to substance use services delivery to First Nations, Inuit and Metis women. This inquiry extends out from a personal perspective and profession experience that there are significant barriers to First Nations, Inuit and Metis women who are accessing services for substance use.

My personal experiences with racism have influenced how I view the health care system. Despite being in a position of power within the health care system, when I am a patient, I am treated differently. I remember attending the emergency room of a health authority in British Columbia a few years ago as I was actively miscarrying. Since I was on the verge of my second trimester, it was a very painful experience as I passed large sized clots while waiting for my gynaecologist to arrive. I was mostly bent over, holding on to my belly in the waiting room of the emergency room. When the pain was unbearable, I asked one of the nurses if I could get something stronger for pain. She told me that she would not be able to give me anything without asking me to pay for it. I was shocked and asked her why I would be billed for medications when I am a Canadian citizen with health insurance. She told me that because I wasn't admitted to the emergency room per say, she would have to bill me for it. I was in so much pain, that I had to say yes just to get the medication. Fast forward a few weeks after, I actually got a bill of about $15 from the health authority for two tablets of Percocet. After thinking on the matter for several weeks, I decided to pay the bill. I was already grieving my loss in addition to recovering from the procedure to clear out residual tissue, so I did not have any strength left inside of me to fight a

system that in my opinion was deeply flawed. Till today, I keep thinking about the nurse and how in my opinion, she broke one of the strongest codes for nurses; advocacy. This nurse did not attempt to advocate on my behalf. I was already in physical and emotional pain from that whole experience and had to deal with the system at the same time. This experience of discrimination in the health care system continues to shape how I view the health care system and my desire to impact change as a Black Registered Nurse. I believe that such encounters have further strengthened my commitment to anti-Black and Indigenous-specific racism and discrimination in the health care system. I continue to view myself on a lifelong allyship journey as I am well positioned within the health care system to advocate and take action against Indigenous-specific racism and discrimination on multiple levels of the health care system; micro, meso and macro in order to achieve sustainable and meaningful change.

Conceptual Framework

The dearth of research that delves into the healthcare expriences of Indigenous women using substances remains a pressing concern. The reviewer conducted a scoping review in an effort to identify gaps and existing knowledge about Indigenous women accessing services for substance use. The impact of COVID-19 has further emphasized the need for a scoping review to search, select and synthesize existing knowledge with regards to the over representation of Indigenous peoples in recent overdose deaths. In this scoping review, the reviewer has chosen to utilize a decolonization approach as this honours Indigenous worldviews and is accountable to the community (Kovach 2009). Decolonization is a process “which engages with imperialism and colonialism at multiple levels” (Smith, 2012, p.58). As such, decolonization involves analysing power differences between groups and giving space to those who have suffered a long history of oppression and marginalization by using strategies that resist silencing and

marginalization of the colonized (Chilisa, 2012; Kovach, 2009). A decolonization approach will provide a deeper analysis of what happens at the clinical practice level with attention to historical contexts that shape healthcare relations and access to services; in this case, the many impacts of colonization (Browne, 2017). According to Chilisa (2012) decolonization is a process of "centering the concerns and worldviews of the colonized Other so that they understand themselves through their own assumptions and perspectives" (p.13). In order to achieve decolonization in nursing research, there is the need to revisit the methodologies that imposed the western view on knowledge production (Smith, 2012). Previously, dominant Western approaches have consistently promoted the false belief that Indigenous peoples possess certain cultural attributes that contribute to their illness (Tang & Browne, 2008). The reviewer will conduct this scoping review with an emphasis on resilience of Indigenous peoples, while recognizing the many impacts of colonization. The reviewer will also engage in decolonization at the individual level (researcher preparation) by means of frequent entries into a reflexive journal to pour out biases or pent-up emotions during this process (Kovach, 2009).

Method

The scoping review approach provided a framework to systematically search, select and synthesize existing knowledge in the area of Mental Health and Substance use, particularly with regards to Indigenous women accessing services (in-patient withdrawal treatment, safe consumption sites, overdose prevention sites, harm reduction sites and out-patient treatment programs) for substance use. A scoping review contributes to the mapping of key concepts that underpin a research area and the main sources and types of evidence available (Arksey & O'Malley, 2005). A systematic review, though a common type of literature review, is not suitable in this case as it focuses on addressing precise, well defined questions (Peters, et al.,

2017). Unlike a systematic review, a scoping review addresses broader questions and study designs and, in this case, will provide a map of the range of available evidence which is useful in an area where such evidence is still emerging (Peters, et al., 2017). It is expected that the choice of a scoping review will provide a foundation for future systematic reviews that can identify research and evidence gaps in this topic (Arksey & O'Malley, 2005; Peters, et al., 2017). Beyond supporting future systematic reviews, scoping reviews can inform clinical decision making and practice in the relevant area. In this case, a scoping review will frame what is known about Indigenous women accessing services for problematic substance use, particularly in regard to what type of evidence is available to address and inform this complex topic (Arksey & O'Malley, 2005; Peters, et al., 2015; Peters, et al., 2017). In this paper, a 'hybrid' approach to the scoping review method-as shown in Appendix A-was applied by utilizing the five stages of the Arksey and O'Malley framework in addition to the recently refined Joanne Briggs Institute's approach to the conduct of scoping reviews: 1) Identify the research question; 2) Identify relevant results; 3) Study selection; 4) Charting the data; 5) Reporting the results (Arksey & O'Malley, 2005; Peters, et al., 2017). A hybrid approach will ensure the latest development in methodology is applied. A hybrid approach in this case, refers to the utilization of the Arksey & O'Malley (2005) framework in addition to enhancements proposed by Peters et al. (2015, 2017, 2020). This provided explicit detail regarding each stage of the scoping review process while enhancing clarity and rigor of the scoping review process (Peters et al., 2020). For instance, the recent refinements to the Joanne Briggs Institute approach such as making consultation a required component for scoping reviews is very relevant to this work, as the reviewer is able to consult with the institution librarian and key Indigenous contacts within the community. Another advantage of the utilization of a hybrid approach is with regards to summarizing the results in

multiple forms such as a charting table, narrative and visual representation. A final key area is the need to focus study implications on relevant areas such as practice, policy, and research. This hybrid approach ensures that all relevant aspects as emphasized in the *Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist* (Appendix C) are covered. The reader is guided through each stage of the scoping review process to show how each stage builds on the other to answer the overarching research question for this study: What is known about Indigenous Women in Canada Accessing Services for Substance Use?

Stage 1: Identify the Research Question

The purpose of this scoping review is to examine the literature on Indigenous women in Canada accessing services for substance use with an emphasis on possible facilitators and barriers to care. The overarching question is: what is known about indigenous women in Canada accessing services for substance use?

Stage 2: Identify Relevant Studies

Eligibility Criteria

Eligibility criteria was determined based on the JBI framework of participants, concept and context as follows:

Participants

Participants were adult women with a minimum age of 19, from all three unique Indigenous cultures in Canada; First Nations, Inuit and Metis. Participants were active users[3] of illicit drugs and/or alcohol who accessed, or attempted to access services for substance use in Canada. The women also accessed or attempted to access services for substance use in Canada. Exclusion criteria for this paper were men, any woman below the legal age of 19, Indigenous

women in Canada who were not using substances, and Indigenous peoples from outside of Canada.

Concept

According to Peters et al. (2020), concept includes details that pertain to the elements of the scoping review, such as the "interventions", and/or "phenomena of interest", and/or "outcomes". In this case, the concept of interest is the facilitators and barriers to care for Indigenous women accessing services for substance use.

Context

In keeping with the refinements by Peters et al. (2020), context in this scoping review refers to the consideration of geographic location, social, cultural, or gender-based interests. The location of the participants was extended to urban regions within Canada with participants located in either acute, primary or community health settings. This review was limited to only Indigenous women living in Canada

Search Strategy

An initial search was conducted in July 2019 with a more current search in October 2020. Searches were conducted on *EBSCO Discovery* and *Google Scholar* with a combination of terms under three search categories. The search categories which consist of participants, concept and context, are shown in Table 1. EBSCO Discovery is an 'all inclusive' search platform that searches a variety of sources including: academic journals, electronic books, magazines, conference materials, reports, etc. Google scholar is another platform that allows researchers to search for scholarly literature. The reference list of all studies that were included in this review, were also examined for additional relevant studies.

Table 1: Search Categories and Terms

Participants	Concept	Context
Indigenous Native Aboriginal Indians First nations Woman Women Female Females	Substance use Substance abuse Drug abuse Drug addict* Drug use Services Programs Intervention Resources	Canad*

Database Searching Strategy

Searches were limited to current English sources from 2010 to 2020. The search was first conducted on the *EBSCO Discovery* database which yielded results from: CINAHL Complete, Complimentary Index, Academic search complete, Medline, and other sources as shown in Table 2. A second platform, *Google scholar* was searched for related articles, this yielded additional results as shown in Table 2. A third search for grey literature was conducted using the Canadian Agency for Drugs and Technologies in Health (CADTH) (5) and the Canadian Legal Information Institute (CANLII) (6) website. None of these latter search findings yielded results that met the inclusion criteria. Results were also obtained from the First Nations Health Authority (FNHA), a BC provincial regional health survey report.

Table 2: Database Search Strategy

Search ID #	Keywords	Limiters	Results
EBSCO Discovery Database			
S1	AB indigenous or native or aboriginal or Indians or first nations	Published: 2010-2020	1,141,004
S2	AB (indigenous or native or aboriginal or Indians or first nations) **AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use)**	Published: 2010-2020	102,384
S3	AB (indigenous or native or aboriginal or Indians or first nations) AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use) **AND AB (woman or women or female or females)**	Published: 2010-2020	11,498
S4	AB (indigenous or native or aboriginal or Indians or first nations) AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use) AND AB (woman or	Published: 2010-2020	1,267

	women or female or females) **AND SU (services or programs or intervention or resources)**		
S5	AB (indigenous or native or aboriginal or Indians or first nations) AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use) AND AB (woman or women or female or females) AND SU (services or programs or intervention or resources) **AND TX canad***	Published: 2010-2020 Language: English	380
S6	AB (indigenous or native or aboriginal or Indians or first nations) AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use) AND AB (woman or women or female or females) AND SU (services or programs or intervention or resources) AND TX canad*	Published: 2010-2020 Language: English Geographic location: Canada, British Columbia & Ontario	70
Google scholar Database			
S1	AB (indigenous or native or aboriginal or Indians or first nations) AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use) AND AB (woman or	Published 2010-2020 Related Articles	101

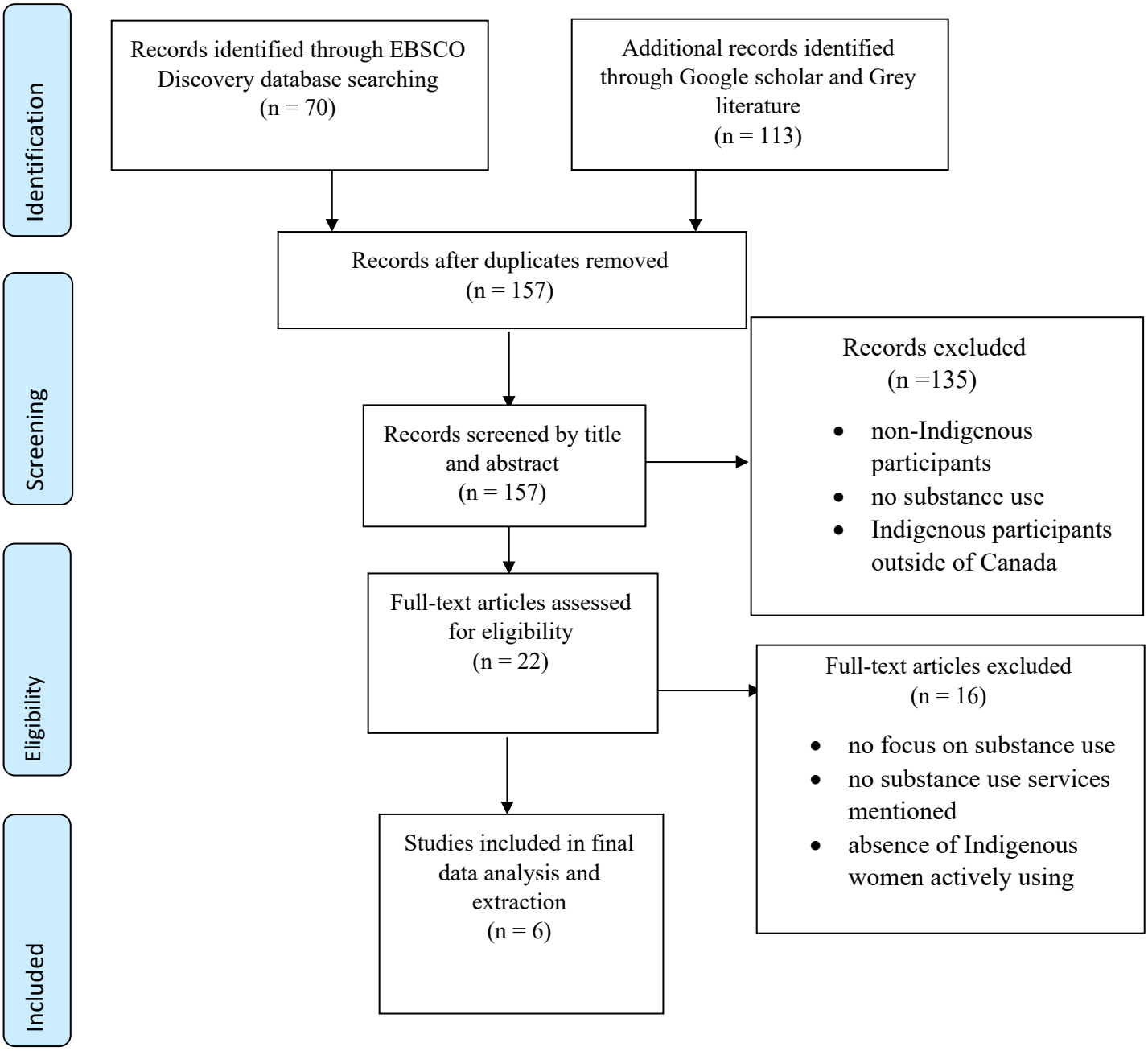
	women or female or females) AND SU (services or programs or intervention or resources) AND TX canad*		
Grey Literature			
CANLII (6) CADTH (5) FNHA (1)	AB (indigenous or native or aboriginal or Indians or first nations) AND TX (substance abuse or substance use or drug abuse or drug addict* or drug use) AND AB (woman or women or female or females) AND SU (services or programs or intervention or resources) AND TX canad*	Published 2010-2020	12

Note. The bolded sections show additions to the search string. AB refers to Abstract, *TX* refers to All Text, while *SU* stands for Subject term.

Stage 3: Study Selection

In this stage of the review, the selected studies were exported into RefWorks for initial screening for eligibility. Consultation with the supervisor and institution librarian occurred throughout this process as needed. A total of 183 records were found from *EBSCO discovery* (70), *Google scholar* (101), and grey literature (12). Studies were selected based on inclusion and exclusion criteria (Arksey & O'Malley, 2005). During the initial screening by abstract, studies were included if they focused on substance use services being accessed by Indigenous peoples in Canada. Studies were excluded if they did not have Indigenous participants in Canada who were actively using at the time of the study. Studies were also excluded if there was no substance use focus. Following the abstract review, a total of 22 articles were included for full text analysis. Full text analysis yielded six articles that met the inclusion criteria and were included in the final scoping review analysis (Figure 1).

Figure 1: Search Results Flow Diagram



Adapted from: Moher et al., 2009

Stage 4: Charting the Data

In this stage, a draft charting table was developed which provided a logical, descriptive summary of the results that aligned with the questions of the scoping review (Peters et al., 2020).

Table 3: Details of Included Studies

No.	Author Year Title Country	Purpose	Methods	Participants	Major Findings/Themes
1.	Boyd, J., Collins, A. B., Mayer, S., Maher, L., Kerr, T., & McNeil, R. (2018). Gendered violence and overdose prevention sites: a rapid ethnographic study during an overdose epidemic in Vancouver, Canada. *Addiction (Abingdon, England)*, *113*(12), 2261–2270. https://doi.org/10.1111/add.14417 . Vancouver, Canada	To understand how the 'intersectional risk environment' shapes the experiences of WWUD as they access OPS in the DTES; specifically, with regards to illicit fentanyl-driven overdose epidemic.	Rapid ethnographic fieldwork	*N*=35 WWUD {*n*=20 Indigenous women (57.1%)}	Four themes were discussed in this study. ***i. Heightened risk environments*** Participants perceived more risk when using fentanyl laced drugs in public versus OPS. The risk to Indigenous WWUD is much severe due to marginalization such as homelessness. Risks such as robbery, and opportunistic predatory physical and sexual violence were discussed. ***ii. OPS as safe havens*** A sense of safety from overdose death and violence (especially from men) was expressed by Indigenous women in the OPS sites. Having access to safe, private and non-judgemental space felt like a "safe haven"

					for many participants especially Indigenous women. The **lack of Aboriginal-based program** was noted by one of the Indigenous women. ***iii. Partnerships and assisted injection*** Having peer or assisted injections, meant that the needs of participants who could not self-inject for various reasons, was met safely. Without this option, they would have to access unsafe options such as reaching out to strangers in alleys. ***iv. OPS as 'masculine' space*** As the OPS was dominated by men, participants expressed sharing these spaces with abusive men or stalkers. Women, were being harassed by men as these **spaces are mixed-gender**. The male staff who worked at the OPS, were reportedly disrespectful to the women. These male staff also promoted the 'double standard' with regards to

					stereotypical roles which placed the women as the caretakers and providers. These actions only sought to privilege the needs of men accessing the OPS while further marginalizing women; especially Indigenous women.
2.	Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., Kerr, T., & Western Aboriginal Harm Reduction Society (2017). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. *Social science & medicine (1982)*, *178*, 87–94. https://doi.org/10.1016/j.socscimed.2017.01.053 Vancouver, Canada	The authors sought to understand the positive and negative health care experiences of Aboriginal peoples living in DTES; using an intersectionality framework.	Indigenous methodologies: Talking circles	*N*=30 APWUID/A {*n=12* Indigenous women (40%)}	***Racism:*** Participants provided accounts of interpersonal and institutional racism when accessing healthcare services which stopped one participant from seeking services for upwards of 25 years. ***Triple Discrimination:*** The researchers found that women face triple discrimination because they are Indigenous, women, and using substances.
3.	Lavalley, J., Kastor, S., Tourangeau, M., Western Aboriginal Harm Reduction Society, Goodman, A., & Kerr, T. (2020). You just have to have other models, our DNA is different: the experiences of indigenous people who use illicit drugs and/or alcohol accessing substance use treatment. *Harm reduction journal*, *17*(1), 19. https://doi.org/10.1186/s12954-020-00366-3	Explore the experiences of IPWUID/A when accessing substance use treatment.	Indigenous methodologies: Talking circles	*N*=35 IPWUID/A {*n*=8 Indigenous women (22.9%)}	Four themes stood out in this study. ***1. Lack of access and support*** Participants experienced lack of access to treatment facilities owing to an intersection of long wait times, individual and

	Vancouver, Canada				**systemic factors**. Such barriers dictated what was offered to participants. Long wait times had negative consequences whereby participants were no longer interested in treatment when it was their turn to get in. Lack of support post treatment posed a significant negative impact, as recovery without support afterwards, meant a higher risk for relapse. ***2. Structure and rules within programs*** Mainstream treatment models often come with rules that further marginalize Indigenous peoples. Participants expressed frustrations with being expected to abide by others' rules. ***3. Lack of Cultural appropriate practices*** These mainstream treatment models contributed to decreased access as the lived experiences of Indigenous peoples were not recognized in these settings. The impacts

					of colonization which includes intergenerational trauma were disregarded; this meant a setting with lack of culturally appropriate practices, in addition to prioritized Christian-based models. Participants alluded to the fact that these treatment centers did not take into consideration their experiences of trauma. ***4. Children Apprehension*** Being told to choose between going to treatment and having a child apprehended was the norm for many Indigenous participants. The broader impacts of colonization now extend intergenerational with an over representation of Indigenous children in the child welfare system. Policies that prevented family members (especially children) from attending treatment, contributed to barriers in getting support and further crippled participants' autonomy.

4.	Li, X., Sun, H., Marsh, D. C., & Anis, A. H. (2013). Factors associated with pretreatment and treatment dropouts: comparisons between Aboriginal and non-Aboriginal clients admitted to medical withdrawal management. *Harm reduction journal*, *10*, 38. https://doi.org/10.1186/1477-7517-10-38 Vancouver, Canada	This study examined the differences in pre-treatment and treatment drop out rates between Aboriginal and non-Aboriginal clients as they accessed an inpatient withdrawal program.	Multivariate logistic regression analyses	*N*=2231 {*n*= 451 Aboriginal; *n*=207 Aboriginal Female (46.0% of 451)	***Pre-treatment drop out*** Aboriginal participants 41% non-Aboriginal participants 32.7% ***Treatment Drop out*** Aboriginal participants 25.9% non-Aboriginal participants 20.0% Overall, Aboriginal participants had a higher drop out rate for a total of 72.8% versus 70.8% for the non-Aboriginal. Of note, drop out reasons included; NFA, alcohol as substance of choice, cocaine as substance of choice and poly-drug use. Other factors, such as age and female gender, were statistically insignificant.

5.	Niccols, A., Dell, C. A., & Clarke, S. (2010). Treatment Issues for Aboriginal Mothers with Substance Use Problems and Their Children. *International Journal of Mental Health & Addiction*, *8*(2), 320–335. doi.org/10.1007/s11469-009-9255-8 City not specified by Author, Canada	In this paper, the authors reviewed research on the issues experienced by Aboriginal mothers with children when they access substance use treatment.	Literature Review	Focus on Aboriginal mothers using substances	The three overarching themes in this study are summarized below. ***1) Gender and social issues*** The researchers discuss the influence and implications of using as a woman; relationship problems, social stigma and weak support systems. ***2) Trauma and mental health*** In comparison to men, women use substances as a means to cope with what's going on in their lives. Such as history of physical or sexual abuse and intimate partner violence. ***3) Access to care*** The researchers found that women would not access services for various reasons such as; **fear of children apprehension**, **fear of forced treatment,** lack of treatment readiness, lack of transportation, **stigma**, and so on. **Systemic barriers** such as health care provider

					attitudes were also found to be a major deterrent in women when they consider accessing services for substance use. Women do not feel safe in **mixed gender treatment facilities** as some of these women have experienced partner violence. Of note, the researchers reviewed integrated programs that include children (*New Choice*), as well as women only Aboriginal programs (*Sheway*).

6.	Tait C. L. (2013). Resituating the ethical gaze: government morality and the local worlds of impoverished Indigenous women. *International journal of circumpolar health*, *72*, 10.3402/ijch.v72i0.21207. https://doi.org/10.3402/ijch.v72i0.21207 City not specified by Author, Canada	To examine and present the intersecting factors involved in the life of Impoverished Indigenous women; One participant's life is narrated in this study.	Narrative summary	Focus on a First Nations Woman's life	The Key themes identified in this narrative are as follows: ***1. Invincibility*** Women who are Indigenous, poor and marginalized, are the most in need yet, they are often faced with barriers and significant service gaps when seeking services for substance use. In addition, there is a lack of funding and/or a complete absence of women-specific programmes. Strict rules with regards to support services have been discussed in this narrative, as women such as the participant in this study, do not meet certain criteria when they are not pregnant or living with children. They are viewed as the social "throw aways". ***2. Living policy*** The researchers discuss the effects of government policies on the lives of Indigenous peoples. Such devastating effects can be seen in areas of child apprehension, and barriers to therapeutic care in *MHSU.* ***3. Intergenerational trauma*** As a child, the participant lived on a reserve with parents who were **residential school survivors**. She

					was 4 when child and family services **apprehended this participant and her siblings**. The participant was placed in a non-Indigenous **foster home**. She suffered a life of **sexual and physical abuse** as a child. This participant has had all four of her children apprehended. Despite her resilience, this cycle has continued for over four generations.

Note: WWUD-Women who use drugs; *OPS*-Overdose prevention site; *DTES*-Downtown east side; *APWUID/A*-Aboriginal peoples who use illicit drugs and/or alcohol; *IPWUID/A*-Indigenous peoples who use illicit drugs and/or alcohol; *NFA*-No fixed address

Stage 5: Reporting Results

Salient themes emerged after multiple readings of each article, applying the lens of the guiding questions (Arksey & O′Malley, 2005). Table 3 offers a data charting approach outlining study characteristics, while Figure 1 provides a visual representation of key study themes. Using a hybrid descriptive analytical approach (Arksey & O′Malley, 2005; Moher et al., 2009; Peters et al., 2020; Peters et al., 2017; Peters et al., 2015), the author narrated the findings, offering implications for practice, education, policy and research.

Characteristics of Included Studies

A total of six studies published in English were included in the final analysis of this review paper (Table 3). All of the studies were conducted in Canada between 2010 and 2020. Of note, four of these studies (Boyd et al., 2018; Goodman et al., 2017; Lavalley et al., 2020; Li et al., 2013) were conducted in Vancouver, BC. Three of the studies (Boyd et al., 2018; Goodman et al., 2017; Lavalley et al., 2020) were qualitative in nature and one study (Li et al., 2013) adopted a quantitative approach. The remaining two studies (Niccols, Dell & Clarke, 2010; Tait. 2013) were review and narrative papers, which focused on the experiences of Indigenous women accessing services for substance use. These four studies (Boyd et al., 2018; Goodman et al., 2017; Lavalley et al., 2020; Li et al., 2013) captured the experiences of both men and women accessing services for substance use. The themes that were developed after reviewing and analyzing the studies included: safety in mixed-gender centres, lack of culturally appropriate centres, racism and triple marginalization, lack of access and post-access treatment, and a false sense of autonomy; treatment or child apprehension. There were no original studies on the experiences of an Indigenous women-only group.

Theme 1: Safety

Indigenous women who use illicit drugs and/or alcohol (IWWUID/A) expressed feeling a sense of safety when they accessed mixed center overdose prevention sites (OPS), as it took them away from a marginalized life of poverty and homelessness to a 'safe haven' (Boyd et al., 2018). The risks associated with using substances/drugs in public, such as robbery and opportunistic predatory physical and sexual violence, were no longer a concern for these women as they were now housed albeit, temporarily (Boyd et al., 2018). In Boyd et al.'s study (2018), people who used illicit drugs and/or alcohol (PWUID/A), especially Indigenous participants, expressed feeling safer to use in OPS settings versus a friend's home without fear of death from overdose or exposure to risk environments where racialized violence is of concern. Some women felt a sense of safety in OPS even though it was a mixed-gender facility This sense of safety in a mixed gender OPS, was further elaborated on by an Indigenous participant who praised the peer system in the OPS stating she did not feel judged (Boyd et al., 2018). The peer system refers to the involvement of people who use drugs in harm reduction services, such as training on how to administer naloxone (Bardwell et al., 2018). At OPS, peer workers are hired as staff to provide leadership and services to those who access these services.

Despite the expressions of safety within mixed-gender OPS, female-only substance use in patient treatment programs showed greater retention overall (Niccols, Dell & Clarke, 2010). The majority of treatment programs are mixed-gender and adopt a dominant male substance use model utilizing strategies such as group discussions. The expectation for public sharing with men was identified as contributing to feelings of non-safety in women and was suggested to contribute to enhanced attrition (Niccols, Dell & Clarke, 2010). Women also experienced cases of partner violence in mixed-gender OPS sites (Boyd et al., 2018; Niccols, Dell & Clarke, 2010). The masculine space within the OPS site as discussed by Boyd et al.,

(2018) consolidated participants' experience of past trauma from abusive men and stalkers; the same stalkers that they were trying to avoid. Women reported being harassed by men in these settings, in addition to dealing with disrespectful behavior from the male staff who worked at the site (Boyd et al., 2018). The actions of the male staff promoted a double standard which sought to privilege the needs of men accessing the site, while further marginalizing women; especially Indigenous women (Boyd et al., 2018). Li et al., (2013), examined the differences in pre-treatment and treatment drop-out rates between Aboriginal and non-Aboriginal clients as they accessed a mixed gender inpatient withdrawal program and found that Aboriginal participants had a higher drop-out rate of 72.8% versus 70.8% in the non-Aboriginal group. Of note is that 46% of the Aboriginal clients in the study were women.

Theme 2: Lack of Culturally Appropriate Programs

Boyd et al., (2018) found that while the women expressed a sense of safety in mixed-gender OPS centers, they identified an absence of culturally appropriate services at these same facilities. Goodman et al.'s (2017) study of the experiences of Aboriginal peoples living in the downtown east side of Vancouver identified that the offer of a designated space for Aboriginal individuals to use for cultural traditions was, in fact, not utilized. The authors later discovered that this designated space had been locked to the very individuals it was intended to serve; only accessible to a few staff and security at that facility. Lavalley et al. (2020), found decreased access for Indigenous peoples to mainstream treatment centers as the lived experiences of Indigenous peoples with intergenerational trauma was not recognized as problematic. Instead, these settings prioritized Western ethnocentric Christian-based models to define what constituted a mental health issue worthy of intervention. Conversely, Lavalley et al.'s (2020) participants emphasized a need for substance abuse recovery models that were rooted in culturally appropriate, peer-led programs. Indigenous participants further

emphasized the need for holistic treatment that encompassed cultural practices as well as Indigenous ways of healing and knowing as central to recovery (Lavalley et al., 2020). This theme brought out a lot of pent-up emotions which was entered into the reviewer's journal:

> I recall a similar experience that I had with the healthcare system in British Columbia. When I visited a public health clinic for my child's immunization, the nurses (a mentor and student nurse) had a few questions before the vaccine was administered. One of those questions was about where my one-year-old slept. I answered the nursing student telling her that my child and I co-slept. She paused and looked at her mentor as if needing some help. Her mentor then said she should provide me education on the risks associated with co-sleeping. She spoke about a few things including the risk of rolling over onto my child, which can be fatal. When she was done, I told her I was well aware of all these things as a Registered Nurse myself, but that I am also aware of the many benefits of co-sleeping. I went on to add that this is something my family has done for several generations, and will continue to do. The student nurse said "oh okay" and then again, looked at her mentor who said she should make a note on the computer. The mentor said the notes should reflect that the risks were discussed and understood so that she would have "covered your bases". I did not push the matter further because I was already discouraged by the level of naivety and closed mindedness of the mentor as there was no attempt to hear more about my cultural practices. The priority was about "covering bases" and in my opinion, trying to get me assimilated into a western approach with regards to the 'right way to care for my child' thereby disregarding my culture. In trying to protect myself from being viewed as culturally sensitive, I did not address the matter as I was worried it would not be viewed beyond the multicultural aspect. I did not want this to end up as an opportunity for the nurses to critique my culture and tradition rather than

exploring inequalities in power relations. According to Nairn et al., (2004), the complexity of cultures and the way they intersect with class and gender becomes erased in over-generalisations and cultural essentialism" (Nairn et al., 2004).

Theme 3: Racism and Triple Marginalization

Indigenous participants expressed being treated 'differently' when interacting with health care providers (Boyd et al., 2018; Goodman et al., 2017). Participants also shared examples of interpersonal racism, such as one participant's account of dismissal by hospital staff (Goodman et al., 2017). Systemic barriers related to health care provider attitudes were also found to be a major deterrent for women considering accessing services for substance use (Lavalley et al., 2020). Institutional racism was experienced by one participant who shared the negative impact of hospital policies on Aboriginal peoples' health and wellness that prohibited infant smudging (Goodman et al., 2017). Such accounts of interpersonal and institutional racism when accessing healthcare services stopped one participant from seeking services for upwards of 25 years (Goodman et al., 2017). These same researchers found that Indigenous women faced triple marginalization because they were Indigenous, women, and using substances (Goodman et al., 2017). Niccols, Dell & Clarke (2010) drew relationships between relationship problems, social stigma and a lack of support systems if the one using was a woman.

Theme 4: Lack of Access and Post Treatment Support

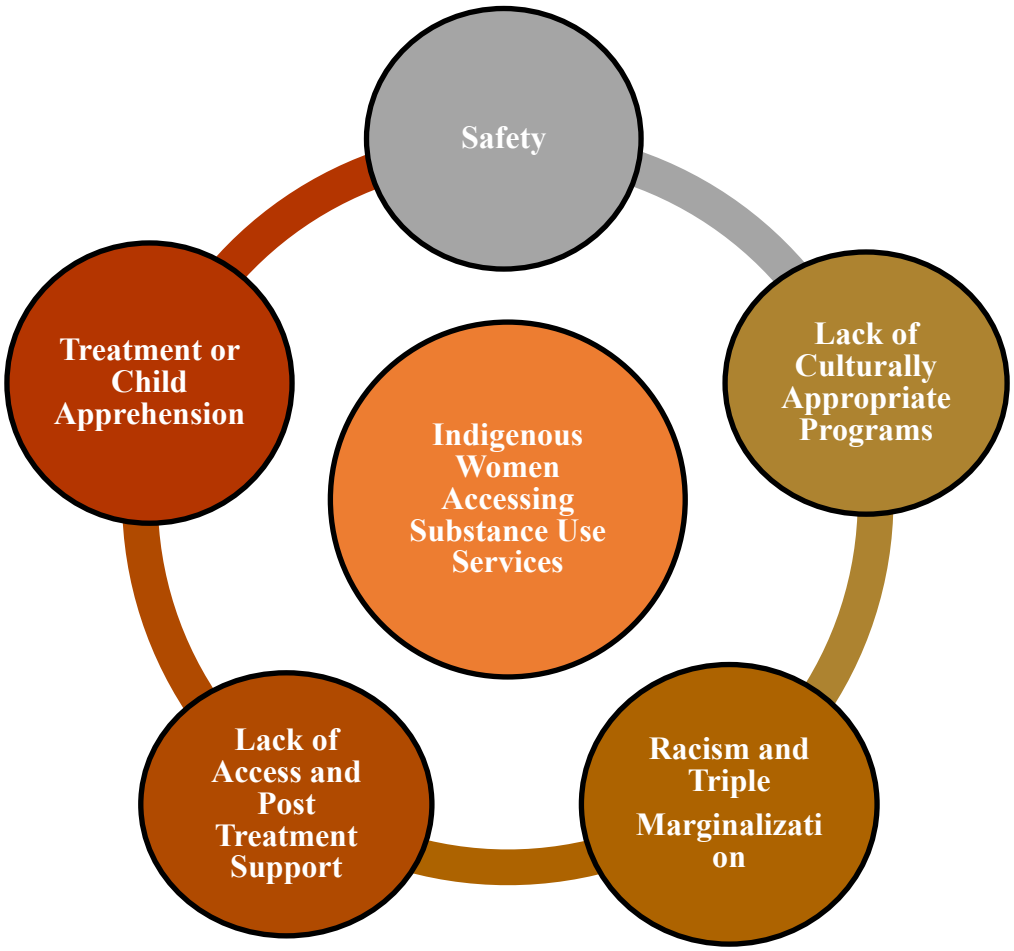
Lavalley et al. (2020) identified that participants experienced explicit barriers in accessing in-patient and detox substance use services that included an interplay of long wait times, individual, and systemic factors. Of significance was the issue of long wait times as participants were no longer interested in treatment when it was their turn to be seen by a healthcare provider (Lavalley et al., 2020). The lack of support post-treatment further resulted in a higher risk for relapse (Lavalley et al., 2020). Niccols, Dell & Clarke (2010) also found

that women would not access substance use services for reasons such as lack of treatment readiness, lack of transportation, stigma, fear of forced treatment and child apprehension.

Theme 5: Treatment or Child Apprehension

Tait (2013) found a lack of funding and/or a complete absence of women-specific programs that were directed at meeting the needs of substance users who were mothers. Indigenous women who had children were expected to choose between treatment for their substance use or having their child apprehended (Lavalley et al., 2020). As shared by Tait (2013), child and family services apprehended one participant's children when she did not complete treatment, without providing counseling or therapeutic support to that participant. As Tait (2013) suggested, this leads to an over-representation of Indigenous children in the child welfare system. Policies that prevent children from attending treatment with their parent further contributes to barriers in getting support and further cripples women's autonomy (Tait, 2013). One Indigenous female study participant explained how she was forced into treatment in order to keep her children; by the same token, attending treatment meant that many of these women could not keep their children in their care (Lavalley et al., 2020). Ironically, Tait (2012) intimated that when Indigenous women are not pregnant or living with children, they are no longer a priority; they are viewed as social "throw aways".

Figure 2: Visual Representation of Thematic Analysis



Discussion

This scoping review has revealed several gaps in knowledge related to Indigenous women accessing services for substance use. As presented earlier in the paper, while some women found OPS mixed-gender center a 'safe haven', other women experienced the OPS site as promoting a male dominance and triggering past trauma. Women who were trying to escape sexual predatory attacks in back alleys were now sharing spaces with their stalkers (Boyd et al., 2018). One Indigenous female peer-worker experienced harassment from other male peer-workers (Boyd et al., 2018). According to Boyd et al. (2018), such experiences contributed to the social reinforcement of power relations. In order to address the power imbalance resulting from male dominance, it is important to understand the intersection of social location on women's engagement with overdose focused interventions (Boyd et al., 2018). According to McGibbon and McPherson (2011), feminist intersectionality is a term that allows for the "interrogation of power in society and the structural precursors of oppression" (p.61). The structural precursors referred to here include oppressive elements that are supported by political, economic and social structures in society. The deconstruction of these structural causes of inequities is complex. Complexity theory, which views the healthcare system as a complex adaptive system that "holds great promise for unpacking the complexities inherent in health inequities", can be applied as an approach to such deconstruction and the reorientation of cause and effect related to structural inequities (Mcgibbon & Mcpherson, 2011, p.72). Both feminist intersectionality and complexity theory are linked to the analysis and reconstruction of systemic power structures as these concepts speak to the complexity of social locations and experiences and help us to understand differences in health needs and outcomes (Mcgibbon & Mcpherson 2011; Rogers & Kelly 2011). When applied to practice, complexity theory supports the amelioration of inequities in

women's health. As suggested by Boyd et al. (2018), a theoretical lens can assist women peer-workers to address gender specific needs.

Another key finding from this review was participants' expressions of the absence of culturally appropriate services (Boyd et al., 2018; Goodman et al., 2017; Lavalley et al. 2020). It is important that substance use treatment centers for Indigenous women struggling with substance use address treatment needs holistically, with an Indigenous worldview and a strength-based approach that includes cultural components and family support (Niccols, Dell, & Clarke, 2010). The implementation of holistic care can transform thinking about cultural difference from being a problem to having the potential to transform the culture of healthcare and actually promote culturally safe care (Browne, et al., 2016). In British Columbia, there is a shortage of women-only substance use treatment centers that operate from a trauma informed lens. The Sheway center in Downtown East Side, is a highly appraised Indigenous women-only pregnancy outreach drop-in center (Vancouver Coastal Health [VCH], 2020). Sheway, a coast salish word, means "growth" (VCH, 2020). Sheway offers pregnancy support such as: nutrition support, prenatal and postnatal care, sexual health education, addiction counselling and parenting classes (VCH, 2020). Sheway also works with families in recovery program, 'FIR' at the BC women's hospital and health center, to provide care for women who use drugs (WWUD) and their newborns in a single unit. This ensures that women and their newborn are together, while they stabilize and withdraw from substances; care is also continued into community thereby providing support post treatment (VCH, 2020). The reviewer's philosophy on health and healing is to foster a holistic approach that is guided by the client. My personal experience as earlier shared with regards to co-sleeping is one example of where the western approach is attributed more legitimacy than traditional, cultural practices that have keep ethnic groups healthy for several generations. Being strongly attached to my culture promotes personal strength for me as I am able to build resistance to a

dominant culture (Nairn et al., 2004). Rather than challenging cultural health practices, I encourage health care providers to seek to know more and find avenues to provide support.

The findings of this scoping review suggest that Indigenous women experience interpersonal and institutional/structural racism when accessing services for substance use (Goodman et al., 2017). There are certain unspoken assumptions and colonizing discourses that influence how healthcare providers read and interpret the needs of Indigenous peoples (Tang & Browne, 2008). Browne (2017) reported that racialization operates in association with factors such as poverty and gender inequity. Indigenous peoples have reported an expectation of being judged by health care providers before they even enter a hospital (Browne et al., 2011). Tang and Browne (2008) drew on ethnographic studies to inform racialization and egalitarian discourses. The researchers situated Aboriginality as a political category subject to racialization. This label is further embedded in political and colonizing discourses that shape how Aboriginal peoples are seen, or their behavior interpreted, by non-Aboriginal peoples. Power inequities between health care providers and patients, say Tang and Browne (2008), are perpetuated and intensified by race. Tang and Browne (2008), further offer a very thought-provoking reminder that:

> Even if a person does not intend to act in a discriminatory manner, his/her historical location as a member of a privileged group is implied by and implies the systemic and historical relations that sustain his/her existing location as a privileged member of society. (p.124)

Health care providers working in these settings must remember that they are a part of a privileged group. Rather than consciously or subconsciously using their power to marginalize Indigenous women accessing services for substance use, providers are obligated (especially nurses) to use their positions of power to influence change. Those providers working in the area of Mental Health and Substance Use should build

long lasting relationships with Indigenous groups to ensure that racism in the healthcare system is eliminated. When it comes to discussions about racism, Indigenous peoples are often omitted, contributing to the "continual writing over of Indigenous experiences of racism…along with strategies that can resist racism" (Allan & Smylie, 2015, p.4). Goodman et al. (2017) have emphasized the importance of focusing on the experiences of marginalized populations within their own context rather than comparing them with cultural norms of other Indigenous or non-Indigenous peoples.

Lack of access and post treatment support was also identified as a barrier in this scoping review. The context of this finding relates to detox units as participants expressed long wait times which prevented them from attending when there was readiness and need for support (Lavalley et al., 2020). One of the participants kept calling a detox unit and was told to call back on multiple occasions, this participant believed that perhaps there were beds but they got put on a wait list due to illicit drinking (Lavalley et al., 2020). The lack of sustained recovery and engagement post treatment was also discussed by Lavalley et al. as participants did not have any recovery plans post treatment. Lack of post treatment support leads to a higher risk of relapse (Lavalley et al., 2020). In addition, operational policies and procedures within treatment facilities such as detox have been found to reduce treatment access and retention among IPWUID/A (Lavalley et al., 2020). There is the need to examine these intersecting factors from a social justice perspective as social justice issues reflect current practice guidelines that may seem fair yet are differently enforced through discriminatory practices which push Indigenous peoples who uses substances, closer to the margins of inequity (Hill & Bilge, 2016). In an effort to ensure equitable access for Indigenous peoples, there is the need to move beyond the universal health system to more alternative services that are aimed to meet the needs of underserved populations such as Indigenous peoples (Lavoie,

2014). Funding should target such alternative services as they have been found to be more responsive to the needs of Indigenous peoples particularly as this will address the issue of access to treatment and post-treatment support (Lavoie, 2014). Although some alternative services in British Columbia are funded by the federal government, there remains the issue of vulnerability to funding in addition to funding being restricted to those services located on reserve (Lavoei, 2014). This does not address the issue of lack of access in larger urban cities where Indigenous peoples may be seeking substance use services.

Indigenous women should not have to choose between treatment and keeping their children in their care. Policies that prevent women from attending treatment with their children have contributed to barriers in getting support (Lavalley et al., 2020). Such policies continue to contribute to the overrepresentation of Indigenous children in the system (Tait, 2013). Peardonville House in Abbotsford, British Columbia is an adult women's treatment facility that allows clients to bring their children into the residence while they access treatment. This ensures that they get daycare support for their children, while maintaining control as primary caregiver during treatment (Peardonville House Treatment Center, 2020). Since this facility is open to all women, in the absence of Indigenous specific centers, perhaps IWWUID/A can access this service. Health care providers will have to ensure that care is provided from a trauma informed lens in order to address intergenerational trauma. Intergenerational trauma, is an unfortunate experience where trauma is passed on from one generation to another (Tait 2013; Torchalla & Strehlau, 2015). As emphasized in the Sheway trauma training curriculum, women should not have to deal with the impacts of transgenerational trauma in addition to recovery (Torchalla & Strehlau, 2015). According to Torchalla and Strehlau, when working with Indigenous women who are accessing services for substance use, health care providers must ensure that they learn about background, history, culture and identity of these clients; particularly with regards to colonial history. Part

of this process involves initiating trust by prolonged engagement with clients remembering that these women have endured oppressive histories (Torchalla & Strehlau, 2015). Health care Providers should work with an open mind when it comes to traditional Indigenous healing practices (Torchalla & Strehlau, 2015).

Implications

This scoping review sought to understand the current knowledge of Indigenous women accessing services for substance use in Canada. Findings reveal opportunities for healthcare providers, especially nurses, to take action in education, practice, research and policy. As recommended in the Truth and Reconciliation Calls to Action (TRC), (2015), nursing schools should ensure that teachings on Indigenous health are a part of the curriculum, with emphasis on "the history and legacy of residential schools, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Aboriginal rights, and Indigenous teachings and practices" (Truth and Reconciliation Commission of Canada [TRC], 2015, p.3). The TRC further calls for action in the area of cultural competency training for nursing students and health care professionals (TRC, 2015). An awareness of socio-historical positioning of Indigenous peoples could lead to the development of knowledge and practice that disrupts racializing policies and practices in the healthcare system.

In keeping with the recommendations from the TRC calls to action, I recall taking the San'yas Indigenous Cultural Safety Training in Dec, 2015 & Jan 2017 with a focus on *Core ICS Mental Health*. Health care workers were mandated to take this course as a way to build self-awareness and promote positive relationships between Indigenous peoples and health care providers (San'yas Indigenous Cultural Competency Training, 2020). The recent report, *In Plain Sight* on Indigenous specific racism and discrimination in the British Columbia healthcare system discussed the "price is right" game allegation that gained media attention

in the June 2020 (Turpel-Lafond, 2020). In this "price is right" game, health care workers guessed blood alcohol levels of Indigenous patients as they came through the emergency room (Turpel-Lafond, 2020). It was interesting to note that this originated from a San'yas participant's post shared on April 27, 2020 in which the participant said it seemed normal as that was the culture of the department (Turpel-Lafond, 2020). Indigenous people have asked for training of health care workers to address such stereotypes (Turpel-Lafond, 2020). Beyond cultural competency training such as the series provided by San'yas, is the recommendation to include cultural humility as this would promote best practice (Hughes et al., 2020). Cultural humility is a lifelong process of critical self-reflection which seeks to address power imbalances by promoting respect, empathy and learning from the patient; this is divided into intrapersonal, interpersonal and systems level (Hughes et al., 2020; Tervalon & Murray-García, 1998). Practicing nurses can develop *intrapersonal humility* by examining and critiquing their personal beliefs through activities such as reflexive journaling (Hughes et al., 2020). *Interpersonal humility* involves "questioning and understanding the values and cultures of patients, families and colleagues (Hughes et al., 2020, p.31). The reviewer suggests Indigenous women peer-workers for overdose prevention sites as a way to attend to culturally specific needs pertaining to Indigenous women accessing services for substance use. The *systems level* of humility focuses on the support of diversity and cultural humility in the missions and visions of organizations (Hughes et al., 2020). When cultural humility is practiced at all three levels, cultural fluidity (the highest form of cultural humility), is achieved (Hughes et al., 2020).

Research has shown that the impact of colonialism and residential school attendance will continue to define present day experiences and shape new forms of inequity if nurse researchers do not realize the impact of people's individual, collective and socio-historical positioning in society (Browne et al., 2005). Post-colonial theory and the framework of

intersectionality have been applied to the examination of the experiences of marginalized groups in research and practice (Browne, 2017; Browne et al., 2005; Czyzewski, 2011; Goodman et al, 2017; Hankivsky, 2014; Rogers & Kelly 2011; Ross et al., 2015; Shahram, 2016). Post-colonial theories provide nursing research with "the need to revisit, remember, and 'interrogate' the colonial past and its aftermath in today's context" (Browne et al., 2005, p.20). This suggests that the word 'post' does not imply that we have moved 'past' or 'beyond' colonialism. Rather, there exist new formations of inequalities which continue in the legacy of colonialism that shape opportunities in the Indigenous population. Thereby promoting racism and oppression such as social policies as embedded in the Indian Act. Such 'vestiges' of the colonial past, shape life opportunities, economic conditions and the overall health status of indigenous peoples (Browne et al., 2005). Colonialism has been considered a distal (root) determinant of Indigenous peoples' health; distal because it reflects the structural and systemic causes of causes which shows how current ideologies and historic events influence the health of Indigenous peoples (Czyzewski, 2011). Intersectionality is a framework that "seeks to understand what is created and experienced at the intersections of axes of oppression" (Hankivsky, 2014, p.225). For instance, rather than looking at gender, class, race and other factors as single categories that make the Indigenous woman face triple marginalization (woman, low income, indigenous and using substances), intersectionality seeks to show how they simultaneously interact with each other and larger systems by revealing processes of oppression and domination (Goodman et al., 2017; Hankivsky, 2014).

It is crucial for policy makers to understand how structural influences and assimilation tactics such as residential schooling, are still in existence as colonial policies and historic events continue to spill over into the present (Browne et al., 2005). In order to address systemic racism, policy changes can be made in areas such as professional practice and targeted funding towards anti-racist healthcare practice as well as alternative services that

meet the needs of vulnerable groups beyond the reserve (Lavoie, 2014; McGibbon et al., 2013). Nurses who are currently involved in various healthcare sectors such as practice, licensing and public health to name a few, have the opportunity and responsibility to take up leadership roles where they can influence policy (McGibbon et al., 2013). Nurses are well positioned to break the cycle of policy-based systemic oppression by advocating and taking political action (McGibbon et al, 2008). Nurses have the power to lobby at the policy level for equity in the healthcare system; a system where nurses make up the largest number of health care professionals in Canada (Canadian Institute for Health Information, 2020; McGibbon et al., 2008). The concept of a critical cultural approach has been discussed as a way for nurses and other health care providers to understand the role of culture in the health of Indigenous peoples as it can influence the perception of overall Indigenous peoples' health (Varcoe & Browne, 2006). According to Henry et al., (2000), organizations such as healthcare settings, are filled with highly skilled professionals who are deeply committed to their work and "as such believe themselves to be liberal, yet they unknowingly contribute to racial inequality" (p.160 as cited in Varcoe & Browne). As highly skilled practitioners, nurses can and should address the power relations that exists in nursing practice thereby allowing nurses to attend to issues of oppression and privilege associated with a strictly biomedical model of health care delivery to Indigenous women who use substances. Policies should be critically examined from anti-racist, anti-oppressive policy lens with the TRC integrated into organizational strategies in an effort to promote social justice across intersecting oppressions such as race, gender and class (McGibbon, 2019; McGibbon et al.,2013). Such examination will lead to the achievement of Indigenous health practices - one of the TRC calls to action:

> We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of

> Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients. (TRC, 2015, p.3)

One of the recommendations from the report *In Plain Sight* supports a human rights approach to Indigenous health in British Columbia and Canada. In British Columbia, the Declaration on the Rights of Indigenous Peoples Act (DRIPA) was passed in November 2019 (Turpel-Lafond, 2020). DRIPA, which was co-developed with Indigenous peoples ensures that the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) is used by law. In the report, Hon. Dr. Mary Ellen Turpel-Lafond has called on government and public institutions as they "must consider the human rights of Indigenous peoples when determining how to act in accordance with B.C.'s laws, including in health" (p.177). To my knowledge, this is the first scoping review about Indigenous women accessing services for substance use in Canada. This scoping review could be used as a framework to advance further study in this critical area.

Limitations

A few relevant limitations should be highlighted. Generalizability of this review is limited due to the minimal number of studies that fit the criteria for inclusion. The review focused on a unique group of women; therefore, findings may not be transferrable to other Indigenous groups outside Canada. While findings may be applicable within Canada, it is important to note the difference and uniqueness between history, culture and present-day circumstances within all three Indigenous groups in Canada. In addition, the majority of the findings presented here originated from studies conducted in Vancouver, British Columbia; as this is an impoverished neighborhood in an urban area, findings may not be reflective of other areas such as the rural interior region of British Columbia. It is unclear in the articles included in the scoping review analysis if the authors were Indigenous or non-Indigenous. Self-identification and including potential limitations as a non-Indigenous person when

conducting research about Indigenous people is an important consideration. Finally, as scoping reviews do not require study appraisals, variable rigor has been applied to the included studies.

Conclusion

This scoping review sought to explore the gap that currently exists in the literature with regards to Indigenous women accessing services for problematic substance use. This review has established that there are critical barriers to treatment for Indigenous peoples, including underlying systemic racism and experiences of stigma among IWWUID/A. Recommendations in the areas of education, practice, policy and research have been made that if applied, could reduce or eliminate the interpersonal and/or structural racism that marginalizes Indigenous women seeking access to substance use services. This scoping review has further emphasized the need for trauma informed care, as well as greater cultural safety and humility, in the approach to health services. Commitment to action from leaders in healthcare will lead to the changes that are needed.

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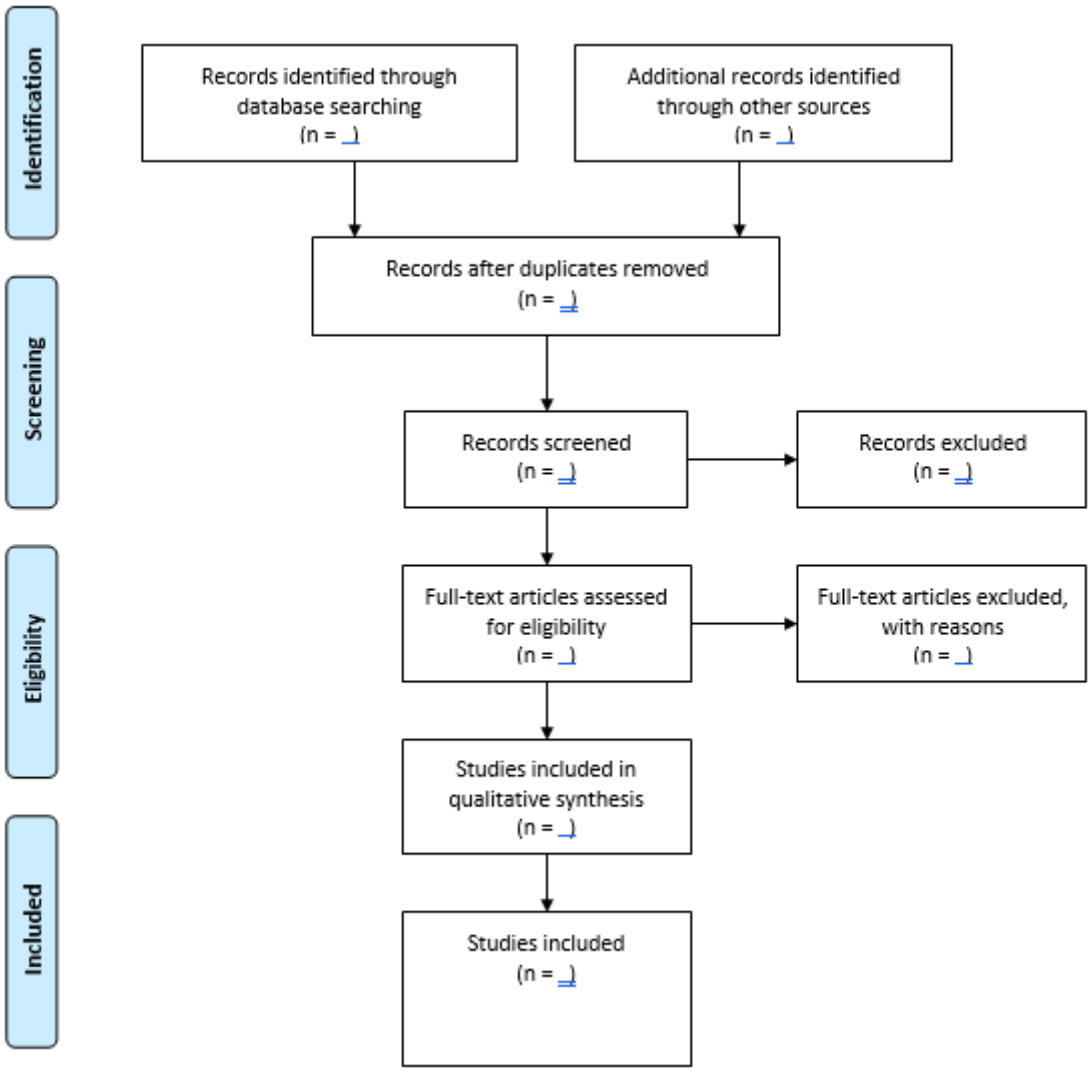
Appendix A: Scoping Review Frameworks

	Arksey and O'Malley framework (2005, p. 22-23)	Enhancements proposed by Levac, Colquhoun and O'Brien. (2010, p. 4-8)	Enhancements proposed by Peters et al (2015).
1.	Identifying the research question	Clarifying and linking the purpose and research question	Defining and aligning the objective/s and question/s
2.	Identifying relevant studies	Balancing feasibility with breadth and comprehensiveness of the scoping process	Developing and aligning the inclusion criteria with the objective/s and question/s
3.	Study selection	Using an iterative team approach to selecting studies and extracting data	Describing the planned approach to evidence searching, selection,
4.	Charting the data	Incorporating a numerical summary and qualitative thematic analysis	Searching for the evidence
5.	Collating, summarizing and reporting the results	Identifying the implications of the study findings for policy, practice or research	Selecting the evidence
6.	Consultation (optional)	Adopting consultation as a required component of scoping study methodology	Extracting the evidence
7.			Charting the evidence
8.			Summarizing the evidence in relation to the objective/s and question/s
9.			Consultation of information scientists, librarians, and/or experts (throughout)

From: Peters, M.D.J., Godfrey, C., McInerney, P., Baldini Soares, C., Khalil, H., Parker, D. Chapter 11: Scoping Reviews. In: Aromataris, E., Munn, Z. (Editors). *Joanna Briggs Institute Reviewer's Manual,* JBI, 2017

Appendix B: PRISMA Flow Diagram



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Appendix C: Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) Checklist

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
TITLE			
Title	1	Identify the report as a scoping review.	i
ABSTRACT			
Structured summary	2	Provide a structured summary that includes (as applicable): background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.	v
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.	1-3
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.	10-12
METHODS			
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.	Not Done in this case
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.	10-11
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.	11-12
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.	13-15
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.	16
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.	18-27
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.	Not done in this review
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).	Not done in this review
Synthesis of results	13	Describe the methods of handling and summarizing the data that were charted.	18
RESULTS			
Selection of sources of evidence	14	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review,	16-17

SECTION	ITEM	PRISMA-ScR CHECKLIST ITEM	REPORTED ON PAGE #
		with reasons for exclusions at each stage, ideally using a flow diagram.	
Characteristics of sources of evidence	15	For each source of evidence, present characteristics for which data were charted and provide the citations.	18-27
Critical appraisal within sources of evidence	16	If done, present data on critical appraisal of included sources of evidence (see item 12).	Not done in this review
Results of individual sources of evidence	17	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.	28-34
Synthesis of results	18	Summarize and/or present the charting results as they relate to the review questions and objectives.	28-34
DISCUSSION			
Summary of evidence	19	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.	35-39
Limitations	20	Discuss the limitations of the scoping review process.	44
Conclusions	21	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.	40-45
FUNDING			
Funding	22	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.	iii* Partial financial support to MN program as listed

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.
* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.
† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).
‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.
§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy document).

From: Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA Extension for Scoping Reviews (PRISMAScR): Checklist and Explanation. Ann Intern Med. 2018;169:467–473. doi: 10.7326/M18-0850.