First Nations Health Authority
Health through wellness

Indigenizing harm reduction in response to the overdose crisis:

Knowledge gathering with First Nations in BC to create an Indigenous Harm Reduction Framework

PHASE 1: SUMMARY OF FINDINGS | OCTOBER 2025

First Nations Health Authority
Health through wellness

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We thank the many First Nations and organizations across BC for welcoming us into their territories and spaces for this phase of our work. We raise our hands in gratitude to the Elders, Knowledge Keepers, peers, youth and community members for their generosity in sharing their time, knowledge and expertise with us. We extend our gratitude to our partners at Simon Fraser University for their support in implementing this study. We also thank the Canadian Institutes of Health Research for funding this research.

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Research Advisory Committee

We raise our hands in gratitude to the members of our Research Advisory Committee who generously shared their wisdom and expertise to guide Phase I of this work. This phase of the research was strengthened by feedback and input from the following people who carry a wealth of knowledge in Indigenous community health, harm reduction, community-based research and culturally grounded programs and services.

Annalee Stearne
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Sherri Pooyak

Indigenous Harm Reduction Community Council

The Indigenous Harm Reduction Community Council (IHRCC) includes people with lived and living experience of substance use, Elders, peers, youth and service providers working in and practising harm reduction across the province. IHRCC members contributed to many aspects of this work, including facilitating relationships and connections with community-based harm reduction programs, recruiting participants, co-interviewing participants, validating findings and facilitating knowledge translation and mobilization.

Artists

Jessie Recalma is a Coast Salish artist and member of the Qualicum First Nation with deep roots in the Musqueam First Nation. Although carving is one of Jessie's favourite means of artistic expression, he also devotes his time to painting, digital design and Indigenous languages.
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Ocean Hyland is an artist who works in the realms of painting and digital design. As a young woman, Ocean received the ancestral name ts;simtelot that was shared with her by her mother. This name has been passed down through her family on her Cheam side. On her matrilineal side she is Tsleil-Waututh, Squamish, Cheam, Hawaiian and Chinese. Through her father she is Scottish and Irish. The richness and diversity of her cultural heritage inspires Ocean in her many artistic practices.
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Study Team

The Indigenizing Harm Reduction (IHR) Study team, nested in the larger Research and Knowledge Exchange (RKE) team at First Nations Health Authority (FNHA), has gone through many changes since the study's inception in 2018. We would like to thank all staff and leadership, past and present, who have contributed to carrying out this work, from formulating the project proposal to finalizing the report.

Data collection for the IHR Study was completed by past and present staff on the IHR Study team, alongside peers from the IHRCC. The data analysis and writing of this report was completed by current FNHA staff researchers on the IHR team, with Indigenous and non-Indigenous settler identities, and diverse experience working with Indigenist, community-grounded, qualitative and quantitative research methodologies. RKE team staff and leadership also provided essential writing support and feedback on this report.

While we hold differing identities and worldviews, we share a commitment to addressing health inequities in our work and personal lives, and we view this work as an extension of this commitment. We are fortunate to work together in a collaborative and multidisciplinary research environment where respectful and equitable relationships are supported—a value that guides our research approach. Our team sought to engage reflexively in order to contextualize how and why we have approached this work, with the acknowledgement that our lived experiences shape our realities and how we understand and interact with the world.

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Executive Summary

FNHA is committed to providing health programs and services that meet the needs of First Nations in BC. Since the surge of drug-related overdoses and deaths was declared a public health emergency in BC in 2016, more than 14,500 people have died due to toxic drugs, with First Nations people being disproportionately impacted. In response to the ongoing and unrelenting crisis, FNHA has made the prevention of drug poisoning deaths and other substance-use-related harms a top priority across all levels of the organization.

To scale up its response to the crisis and better meet the needs of First Nations individuals and communities in BC, FNHA aimed to develop a First Nations-led, Indigenized model of harm reduction for substance use that is adaptable to the specific cultural and contextual needs of communities. In 2018, the IHR Study was initiated to understand current First Nations community-led approaches to harm reduction and conduct research with First Nations service providers, peers and other harm reduction experts across the province. This study seeks to determine the current community needs, priorities and wise practices in harm reduction, with the goal of developing a provincial harm reduction framework specific to BC First Nations.

In 2023, the IHR Study team completed a literature review on Indigenous harm reduction interventions in Canada, the United States, Australia and Aotearoa (New Zealand) to better understand wise practices in Indigenous harm reduction. Following this, IHR Study team members met with 56 service providers and people with lived and/or living experience of substance use to gather knowledge about their experiences providing care to First Nation clients or accessing care themselves. These interviews highlighted the critical need for health services that support wholistic well-being, rooted in the First Nations Perspective on Health and Wellness. Participants emphasized the importance of prioritizing connection and relationships; integrating culture, ceremony, traditional medicines and land-based practices into programs; and delivering these services with love and respect for our relatives who use substances. Clear within these discussions was the pressing need for a continuum of care that wholistically addresses the social determinants of health—such as access to health care, housing, food, childcare, culture and economic support. These findings, presented through a strengths-based lens, illustrate the positive impact of First Nations-led initiatives and the thoughtful design of programs tailored to meet the needs of First Nations individuals and communities in BC and beyond.

This summary discusses these key findings alongside examples of First Nations community-led interventions being delivered throughout BC, highlighting the strength of initiatives designed and delivered by First Nations to meet the needs of their community members. Integration and implementation of these wise practices—and the feedback and expertise gathered throughout this work—will be crucial to responding effectively to the toxic drug crisis that continues to disproportionately impact Indigenous communities across Turtle Island.

Background

FNHA works with First Nations, government partners and others to support First Nations individuals, families and communities to achieve the highest level of health and wellness. With the mandate to incorporate and promote First Nations knowledges, beliefs, values, practices, medicines and models of health and healing into health programs, FNHA carries out research in the area of First Nations health and wellness alongside First Nations communities in BC. This FNHA-based research project explores harm reduction perspectives and practices using a BC First Nations lens and identifies ways to weave diverse Indigenous knowledges and experiences into harm reduction services for First Nations people.

Indigenous Peoples in BC and across Turtle Island are disproportionately impacted by the toxic drug crisis due to the ongoing effects of intergenerational trauma caused by settler colonialism, oppressive policies and systemic racism[1]. Between April 2016 and April 2024, the drug toxicity crisis has claimed over 14,500 lives in BC[2]. Despite the scale-up of various mainstream harm reduction initiatives (such as naloxone distribution programs and supervised consumption sites), Indigenous Peoples shoulder a disproportionate burden of toxic drug deaths[3]. Between January and December 2024, First Nations people died from toxic drugs at 6.7 times the rate of other BC residents[4].

In response to the toxic drug crisis, the FNHA initiated the IHR Study in 2018 to develop a harm reduction framework that responds to the cultural and contextual needs of First Nations people in BC, which are not currently being met by existing, mainstream harm reduction approaches[5]. The project was halted during the COVID-19 pandemic, re-started in 2022, and repurposed in 2023 to create a First Nations community-driven harm reduction framework aimed at reducing substance-use-related harms, promoting wellness and creating a wholistic, adaptable framework. The research team, consisting of both Indigenous and non-Indigenous researchers, committed to employing a Two-Eyed Seeing and culturally safe approach to achieving optimal health and wellbeing for First Nations people. The first phase of this project aimed to gather harm reduction knowledge and experience through interviews and reviewing harm reduction services in First Nations communities in BC. This report provides an overview of the initial findings from our analysis.

Methods

In 2023, the IHR Study team completed a literature review on Indigenous approaches to harm reduction in Canada, the United States, Australia and Aotearoa (New Zealand). The purpose of this review was to better understand the scope of Indigenous community-based harm reduction practices on a global scale. Findings from this review informed our knowledge gathering with First Nations harm reduction experts across BC as we sought to strengthen our understanding of First Nations specific approaches to harm reduction.

The IHR Study team also gathered knowledge from 56 service providers and people with lived and/or living experience of substance use about their experiences providing care to First Nation clients or accessing care themselves. These conversations focused on existing harm reduction programs and services across the province and explored community-identified needs and priorities in harm reduction for substance use. Individuals identified throughout this document consented to the use of their name and or/community or organization alongside their quotes.

Recruitment and Participants

The study team used a relational approach to engage with and recruit study participants. The team worked with the FNHA's regional harm reduction, mental health and wellness, and engagement teams to facilitate participant recruitment via a purposive sampling methodology. Regionally based FNHA team members who had knowledge of and relationships with harm reduction experts within their regions supported connections between the study team and potential participants who have knowledge, expertise and/or experience about harm reduction care for First Nation people in BC. The study participants included:

Harm Reduction Community Champions, representing a diverse set of First Nations Peoples in BC, including Elders and Knowledge Keepers; peers; people with lived and/or living experience of substance use; service providers who provide harm reduction care to First Nations individuals and communities; and other community members engaged in First Nations harm reduction.

Harm Reduction Grantees, representing First Nations communities and organizations, and agencies that serve First Nations, who have received one of FNHA's one-time harm reduction grants that support community-based, Nation-driven harm reduction initiatives and programs.

Knowledge Gathering

Knowledge was gathered with participants between October 2023 and March 2024. Conversational interviews were conducted either virtually or in person with 21 Harm Reduction Community Champions and 23 Harm Reduction Grantees. A conversation guide was used to guide the interviews, with questions focusing on the concept of Indigenous harm reduction, the inclusion of culture in care, what is working well, and current barriers and needs in harm reduction services. Storytelling and conversational methods were used to privilege Indigenist research methods and to create space for multiple ways of knowing about health and wellness experiences for individuals and communities[6,7]. Knowledge was also gathered through questionnaires completed by 12 Harm Reduction Grantees. The same questions included in the questionnaire were used to guide interviews with Harm Reduction Grantees.

Questions were co-developed with the Toxic Drug Response team, and had three main topics:

- Current community-driven approaches to harm reduction
- Harm reduction priorities of First Nation communities in BC
- Recommended paths forward to address community needs

Initially, four peers were interested in being co-interviewers for interviews with Harm Reduction Grantees. However, due to competing priorities, one peer withdrew from their role as co-interviewer. Three peers, who have expertise in harm reduction as well as training in research ethics, supported this work as co-interviewers for conversations with Harm Reduction Grantees.

Interview guides were shared with participants ahead of the interview to provide context for the conversation and allow participants time to prepare. However, the interview questions were only used as a guide for the conversation and participants were invited to speak to any aspects of their experience or knowledge related to harm reduction that they felt comfortable sharing. The study participants who participated in an interview were provided a $250 honorarium, and those who completed the questionnaire were provided with a $75 honorarium for the time they invested in sharing their experiences and expertise.

Analysis

Audio recordings of the interviews were transcribed by the Canadian transcription service Transcript Heroes. The interview transcripts were first reviewed by the interviewers. In alignment with Indigenist and relational approaches to research and cultural protocols in story work, our team aimed to ensure that the voices of participants were accurately captured and represented. We did this by sharing the interview transcript with the participants for their review, validation and approval. Participants were given an opportunity to add, edit or remove any information to ensure their perspectives were represented accurately. To honour participant voices, the study team collaboratively developed a coding framework that was rooted in the harm reduction priorities, needs and experiences of participants and then inductively coded the interview transcripts using NVivo 14. The themes and sub-themes that surfaced from the coding framework were then developed and refined through an iterative and reflexive process. We validated the initial findings through virtual sharing circles with study participants, Indigenous community-based and FNHA-based harm reduction experts, and through engagement with First Nations health leadership and community members at Regional Caucus sessions in the fall of 2024.

Initial Findings

Key Findings from the Literature Review

A total of 23 published articles were included in the final review and 14 grey literature resources were included in the literature review. We highlighted grey literature to amplify voices that are often not captured in peer-reviewed, published work, including the voices of Indigenous communities and non-profits who may face barriers to academic publishing. Our review of grey and published literature found that successful harm reduction interventions included approaches that:

Are Indigenous-led and delivered, informed by the needs of Indigenous communities (8-19,25,36,37)

Include culture, ceremony, traditional medicines and knowledges (9,20-37)

Weave together Indigenous and western approaches to health and/or Two-Eyed Seeing (10,11,17,18,26,27,29-34,37)

Are strengths-based (12-17,20,27)**, providing opportunities for capacity building** (15,27-29,35,36) **and including peers in programming** (19,23-26,28)

Support intergenerational collaboration (8,13-16,23,37)**, guided by Elders and Knowledge Keepers** (8-12,15,22,30,35,37)

Prioritize connection and relationship building (8,11-13,24)**, as well as the inclusion of family** (9,15,26) **and community** (9,11-17,26,28-30,32-37)

Provide opportunities for connection with the land and engaging in land-based activities (9,12,15,26,30-34,37)

Seek to achieve wholistic health by addressing mental, emotional, spiritual and physical well-being (10,12,16,21,26,27,32-35)

Ensure wraparound supports (25-27,35) **across a strong continuum of care** (9,16,35)

A BC First Nations Definition of Harm Reduction

For First Nations Peoples across BC, the definition and practice of harm reduction expands upon mainstream approaches to substance use to include traditional knowledge, values and ways of being when caring for our relatives who use substances. Conversations with participants underscored the importance of weaving together mainstream harm reduction practices with community- and culturally based teachings. To address existing gaps in mainstream approaches, the key components of harm reduction for First Nations in BC were identified through knowledge gathering and were further refined by the study team, representing a community-based definition of harm reduction.

Building on this community-based understanding, the Medicine Basket emerged as a culturally grounded way to express how harm reduction is lived, shared and offered with love, respect and connection within First Nations communities across BC. The Medicine Basket represents the careful and respectful gathering of medicines to support our relatives who use substances, guiding them along their healing journeys. Rooted in the teachings of many First Nations communities, this approach reflects the intentional offering of culturally safe and relevant supports—ensuring they are offered with care, respect and compassion. First Nations individuals and communities understand harm reduction for substance use to include relational approaches to practice and a wholistic understanding of health and wellness across the life cycle. This approach to harm reduction care draws upon the ancestral strengths of culture, community and kinship, and respects an individual's needs, priorities and autonomy in their healing journey.

This definition of harm reduction care is wholistic in scope, strengths-based, rooted in relationships and person-centred. Just as we gather plant medicines with gratitude for the gifts they offer us, we also gather knowledge, supports and resources with intention to honour the wisdom and resilience of those we walk alongside. Through this lens, harm reduction becomes an extension of community care, where each medicine in our basket strengthens the collective journey toward wellness.

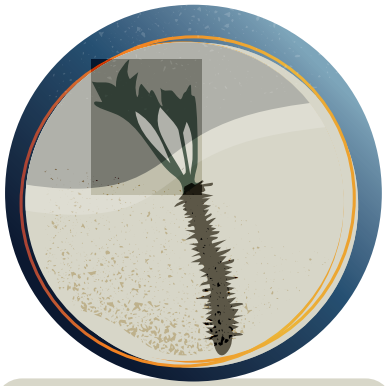
Figure 1. First Nations Definition of Harm Reduction

Four key aspects of harm reduction for First Nations in BC were identified through knowledge gathering with study participants:

Relational Practice

Wholistic Health

Strengths-Based Approaches



Person-Centred Care

1. Relational Practice

First Nations harm reduction is rooted in relationships, connection and love, and acknowledges that a relational approach to care is foundational in building trust and creating a sense of safety for our relatives who use substances.

Indigenous harm reduction means connection. It ensures that connection, love and compassion are central to programming, while acknowledging the power of relationship building: "We come from the perspective that harm reduction is love and harm reduction is compassion. And so we basically create our programming around that concept."

– Polly Sutherland, Team Lead, AIDS Network Kootenay Outreach and Support Society (ANKORS) Cranbrook

Integrating intergenerational collaboration between Elders, youth, Knowledge Keepers, peers and families builds strength through connection and facilitates intergenerational knowledge transfer: "Connecting with Elders, and listening to stories from peers that are also in recovery, is really important because to Indigenous people, the most important thing is a sense of community."

– Koral Hamilton

2. Wholistic Health

Participants shared that First Nations community-led approaches to harm reduction for substance use are wholistic in scope, providing care that wraps around the person to support their physical, spiritual, mental and emotional wellness on their healing journey.

Wraparound care weaves together cultural and western approaches to address social determinants of health and promotes continuity of care:
"When you're reducing harm by reducing the harm of a substance, you also have to reduce the harm that's being done to the spirit."

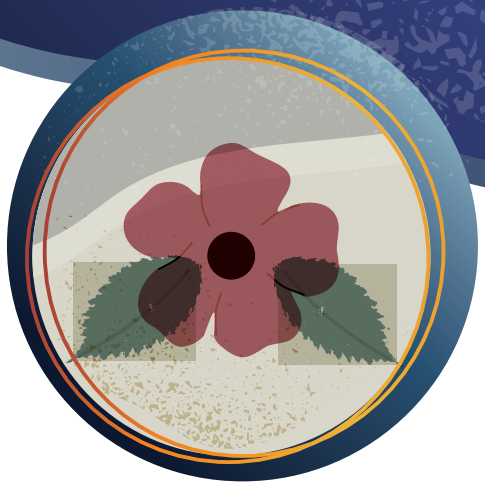
– Koral Hamilton

Including culture in programming supports wholistic health and well-being:
"I'm a firm believer that now that I got to experience culture in my life, it saved my life."

– Participant from the Vancouver Coastal Region

Land-based activities promote healing and wellness:
"I remember taking a trip to [the bush]...I saw animal footprints in the snow. And that woke me up. My ancestors are out there...there's a different life rather than the five blocks I lived in [for years in Vancouver's downtown eastside]."

– Sekani, Dakelh Nation



3. Strengths-Based Approaches

First Nations approaches to harm reduction care draw on the ancestral strengths of culture, community and kinship to provide unconditional and inclusive care for all community members.

Culture is for everyone:
"It really is about having those cultural traditions, but also making space for new ones. And being creative in spaces where not everybody who uses substances can always access those, but being creative in ways of allowing people to have access to culture, regardless of where they are in their healing journey."

– Participant from the Vancouver Coastal Region

Peer-led programs leverage expertise from lived experience and foster connection, inclusivity, safety and kinship:
"We have staff and people who are using. We're all in the same room. We're all peers. It's relational. There's no hierarchical thing. We all care about this piece. We're not judging."

– Maureen Schat, Addictions and Recovery Worker, Kwakiutl Nation

4. **Person-Centred Care**
   A relational and compassionate approach in harm reduction extends to the concept of person-centred care, which respects an individual's needs, priorities and autonomy in determining their care plan and allows for the flexibility to meet each individual's unique needs.

Meets people where they're at with care, and without judgment:
"So really meeting folks where they're at, and supporting them and just being honoured enough to be able to walk alongside them in their journey, I think is something that the whole team does a really great job of."

– Lacey Jones, Director, QomQem Coastal Connections

Care is flexible to the unique needs of individuals:
"...working with the people that I do work with and not having to give them just an hour-long time slot if they need five hours, if they need eight hours, I can do that. So, it's meeting them in their space. And I think that has a lot to do with the Indigenous lens of things. Because through the Indigenous culture, you're not strapped to a clock. If it takes one hour, it takes one hour. If it takes five hours, it takes five hours. Sometimes it takes all week. And the flexibility...it's been great."

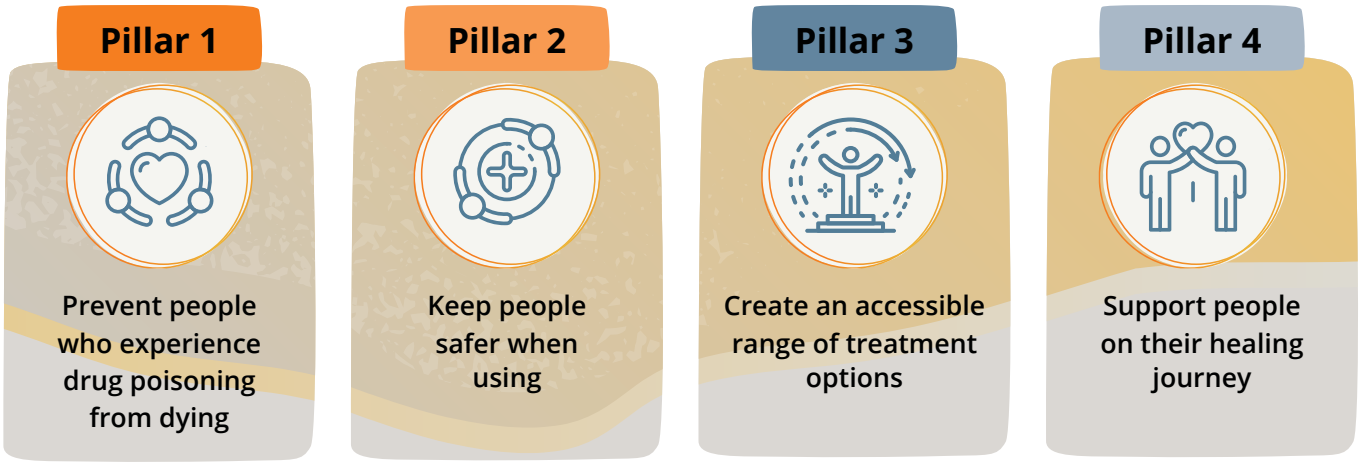
– Participant from the Fraser Salish Region

Current Harm Reduction Programs and Priorities

Participants described a range of harm reduction services offered in BC, including those administered on reserve by First Nations, and programs delivered in rural or urban areas by Indigenous and non-Indigenous organizations and care providers. The following lists some of the community-based harm reduction services available in some communities:

- Clinical services, such as the distribution of harm reduction and safe sex supplies, on site and via outreach,
- Naloxone distribution and training, with many favouring nasal naloxone,
- Drug-checking services, with some communities using advanced tools like Fourier Transform Infrared spectroscopy (FTIR) machines, while others distributed test strips for fentanyl, xylazine and benzodiazepines,
- Overdose prevention sites, opioid agonist treatment (OAT) clinics, and safer supply prescribing in some communities that have access to in-community doctors and nurses,
- Clinical and addictions counselling,
- Cultural and land-based services such as the use of traditional medicines, cultural gatherings, traditional art-based activities and land-based programs,
- Culturally safe detox services were limited, although external referrals to detox were common and
- Peer-led services, support involving Elders and Knowledge Keepers, wraparound services and food programs.

In both the interview conversations and through the questionnaire, Harm Reduction Grantees were presented with the Framework for Action that was developed by the FNHA in response to the toxic drug crisis. The framework consists of four pillars or shared goals to reduce harms associated with toxic drug overdoses, which include:



Harm Reduction Grantees were asked to reflect on the four pillars and identify if one or more stood out as a priority or focus in their harm reduction work with First Nations communities in BC.

Pillar 1 was prioritized by 42.9% of respondents. Participants primarily focused on the need for overdose prevention initiatives, such as providing naloxone kits, drug checking and supervised consumption sites.

Pillar 2 was referenced as a priority by 57.1% of the participants. Responses highlighted considerations around decriminalization policies, the importance of safe consumption sites and providing compassionate, judgment- free care.

> "Pillar two is our priority. In the 1980s and 1990s, community-based addictions programs for substance misuse emphasized abstinence as a prerequisite for recovery, necessitating a sober lifestyle. However, contemporary approaches now recognize that substance use may still occur and focus on providing resources and tools to ensure safety and survival during use. Although harm reduction strategies are relatively new, not all community members are aware of the shift towards prioritizing member survival over mandating abstinence for those actively using substances."
>
> – Mackenzie Sparrow-Gomez, Squamish Nation

Pillar 3 was the most commonly referenced priority, with 68.6% of respondents. This pillar speaks to creating an accessible range of treatment options for substance use and harm reduction care. Participants often spoke of the need for a full spectrum of options, including culture and land-based programming, to tailor care to the individual.

> "When people are ready to accept help, we're looking for a way that makes sense for them. It's not just this way, it's a range of treatment options, but also accessibility."
>
> – Participant from the Interior Region

Pillar 4 was referenced as a priority by 60% of respondents, and speaks of the need to support people on their healing journeys. Participants often described the importance of taking approaches to care that meet people where they're at, offering both western and traditional care options, and prioritizing relationships with clients.

These pillars align with the wholistic, First Nations Perspective on Health and Wellness and are well-suited to community-led programming. Participants highlighted the importance of consistent access to non-judgmental, culturally relevant care that fosters connection and provides an accessible range of treatment options that integrate a full spectrum of care throughout the healing journey, addressing the goals of all four pillars in the Framework for Action. When these conditions are met, our relatives who use substances have the autonomy to make informed choices that support their wholistic health and well-being.

Barriers to Care

Study participants pointed out several systemic barriers that they observed through their own experiences accessing substance use services and/or their experiences working with First Nations clients. The most commonly reported barriers included the toxic drug supply, service inaccessibility, discrimination, stigma, and capacity and funding issues.

The Toxic Drug Crisis

One-third of participants identified the unrelenting nature of harms stemming from the toxic drug crisis as a major challenge in their lives and work, and a source of ongoing grief for communities. Participants were especially worried about impacts of the crisis on youth.

> "I think one of the barriers, too, is that people keep dying. It's a really big uphill battle, like when you're battling and trying to make a difference and you're constantly faced with people around you dying. I think that's a big barrier because who wants to do that? Who wants to be constantly faced with death and losing loved ones and trying to care for people?"
>
> – Participant from the Vancouver Island Region

Fifteen participants stressed that the unpredictability of the drug supply was unmatched, and 10 noted that new toxic substances in the supply were causing more frequent and severe drug poisoning events in their communities.

> "Unfortunately, it is a toxic drug supply and despite us using all of those tools to try and help people be safer, addictions don't go away. And neither does the toxic drug supply. And so, despite numerous, not just our team, numerous teams and the caps that are set up all over the province, there's still an opioid crisis of people dying every day of opioid poisoning."
>
> – Participant from the Fraser Salish Region

Eleven participants underlined the urgent need for scaled-up harm reduction measures, like naloxone, OAT, safer supply and supervised consumption sites to prevent further deaths and provide immediate support to those at risk.

> "If we had the capacity to have a SAFER program in every building, I would just be breathing so much easier. Because for me, the concept of people actually being able to stabilize and not fear drugs in itself is a breath. And no one that I know other than the few people that actually are engaged in the SAFER program actually are able to have that breath. Everybody else in the community ...[understands] that they might die."
>
> – Participant from the Vancouver Island Region

Access to Services

Participants spoke at length to the limited availability of clinical substance use services in their communities. A key challenge was the shortage of detox and hospital beds both on-reserve, and in rural and urban communities. For rural and remote communities, the long distances to services, and the difficulty of sourcing reliable transportation to these sites was a persistent issue. The few accessible drug testing sites and their restricted hours of operation posed a similar challenge. Many participants also discussed the limited availability of harm reduction supplies on reserve, which were often not available after hours when people tended to need them the most.

> "I think a lot of people who are trying to access harm reduction are limited to specific hours at this clinic, and specific hours at the pharmacy. And people have to spend so much time waiting in line sometimes for food and things like that, so it's a lot of time and energy that's being put out by folks."
>
> – Participant from the Vancouver Coastal Region

Treatment-specific barriers included long wait times, complex paperwork, restrictive criteria to attend programs (i.e., adult age, negative tuberculosis test results, sobriety, successful detox, no criminal record). Participants also reported the issue of individuals being sent home from treatment too early, without adequate supports in place (i.e., housing, family, health care), or being sent home for "non-compliant" behaviour (i.e., using substances).

> "They have to wait months and months and months to get into treatment. They're going in and out of substance use quite consistently. Which is not part of their goal but unfortunately, because they're not being supported comprehensively and almost immediately, that's kind of the situation that I feel we're putting them into because we don't have a quick solution."
>
> – Participant from the Vancouver Coastal Region

Sixteen participants shared some of the challenges specific to rural and remote communities. These included a lack of nearby, accessible social and health care services, including a lack of overdose prevention and harm reduction services, unaffordable food and housing in communities, insufficient Wi-Fi and cell service, transportation and travel challenges, the impacts of extreme weather on transportation and unhoused individuals, and an unpredictable, toxic drug supply in the community, leading to more drug poisoning events.

> "In terms of remoteness, the clients don't have access to cell phones or stuff like that, so they are in a very vulnerable position. And if they're supplied with the injection, naloxone, it's not really that easy to use in a remote location, in the spur of the moment. Especially if it's somebody that could be under the influence of substances and trying to navigate operating a syringe in that state … it's difficult."
>
> – Participant from the Fraser Salish Region

Racism, Discrimination and Colonial Systems

Racism and discrimination were frequently discussed as barriers to care for people accessing services. Participants spoke to the need for systemic changes to how substance use is addressed by the health care and criminal justice systems. Also, many mentioned the need for more acknowledgement by governments of the ongoing impacts of colonization and the role of intergenerational trauma in perpetuating substance use related harms among First Nations Peoples.

> "One of the things that we noticed is that not only if we're brown or poor, but also if we're addicted, when we go to emergency for harm reduction supplies, they ostracize and stigmatize and are pretty rough on our clients. So that's why we invented the backpack program so that our folks didn't have to go to the hospital so much for harm reduction supplies just to receive stigma and hate. So a lot of racism and classism."
>
> – Mel Bazil, Dze L̓ K'ant Friendship Centre

To address experiences of racism and discrimination, particularly within mainstream health care settings, participants emphasized the need for Two-Eyed Seeing approaches to create culturally safe and relevant spaces and services. Substance use programs rooted in culture and community contexts that also include clinical mainstream approaches are necessary for delivering safe and effective care and addressing harms often experienced within colonial systems.

Treatment-specific barriers included long wait times, complex paperwork, restrictive criteria to attend programs (i.e., adult age, negative tuberculosis test results, sobriety, successful detox, no criminal record). Participants also reported the issue of individuals being sent home from treatment too early, without adequate supports in place (i.e., housing, family, health care), or being sent home for "non-compliant" behaviour (i.e., using substances).

Stigma

Several participants spoke to stigma within communities towards substance use, and the difficulty this presents for individuals who wish to live in their home communities and Nations.

> "Stigma is still the number one barrier to keeping people safe, alive and supported to heal. There is so much shame and blame around drug use and it leads to so many stigmatized activities..."
>
> – Participant from the Northern Region

> "I understand when you see your communities suffering so much, and you're just so tired of watching them suffer, that you just want people to quit using substances ... but we can't just tell people to quit ... and it really speaks to why a lot of youth and people who use substances end up leaving the reserves, are leaving the small communities, and then they end up dying alone in the city."
>
> – Sekani, Dakelh Nation

Capacity and Funding

Other key barriers reported by participants were related to systemic issues surrounding resourcing, such as organizational capacity and lack of funding for operations. Notably, staff well-being was discussed by many frontline workers, which included conversations around staff burnout, too much overtime and understaffing. Many participants mentioned the toxic drug crisis as an endless source of trauma and grief for frontline staff and community members dealing with frequent drug poisoning deaths. Other challenges included low numbers of Indigenous staff, Knowledge Keepers and Elders.

> "One of the biggest pieces is making sure staff are taken care of. When you have your frontline human beings working with your other human beings, sometimes, especially nowadays, you've got four people doing the job of eight people, and making sure that those folks are well cared for and appreciated and heard...because those are the folks that are on the ground doing some of that tough stuff, hearing those tough stories right there. They're slogging it out and they're trying to lift up folks. And I think they need to be lifted up as well."
>
> – Participant from the Vancouver Island Region

Staff retention was also discussed in relation to the lack of funding needed to keep staff on full time, small workspaces, and the limited housing available to retain staff in remote communities.

> "There's just not enough money to hire people, or space to put people, that want to do the work or have the ability to do the work long term. Such high staff turnover."
>
> – Jennifer Hoy, Central Interior Native Health Society

Many participants also spoke to the need for sustainable and flexible funding to support cultural and land-based programs, minimize administrative burdens and address well-being among clients beyond substance use services (i.e., transportation, housing, food, clothing, etc.).

> "I think we need more funding and resources to address the social determinants of health…if our families are overwhelmed with the social determinants of health, the recovery comes second."
>
> – Tillicum Lelum Aboriginal Friendship Centre

Paths Forward

This section describes examples of key components of programs and practices successfully carried out by organizations and service providers in First Nations communities throughout BC, and it includes suggestions from participants about what they feel is required to better meet the needs of communities and respond effectively to the toxic drug crisis. These are community-based practices that align with a wholistic, First Nations perspective on health and wellness.

Culture

Cultural Inclusion

Participants emphasized the importance of cultural inclusion and ensuring there are opportunities for people who use substances to have safe and appropriate access to culture and ceremony, "regardless of where they are in their healing journey" (participant from the Vancouver Coastal Region). Participants spoke to the valuable connections that resulted from access to culture and ceremony for people facing social exclusion, including unhoused individuals and people actively using substances.

> "So every Wednesday on the block around Pandora, we have Elders and drummers that come right down to Pandora and sit with us for about three to four hours... And we bring fry bread and fish soup or chowders down. It's just a space for our people, our relatives that are on the streets to connect back to ancestral strength, to sit with Elders, to eat some of our ancestral food. and just kind of gain strength that way."
>
> – QomQem Coastal Connections

Cultural Identity

First Nations approaches to harm reduction are rooted in cultural knowledge and ways of being, and draw upon the teachings *"our ancestors had left for us to maintain our ancestral connection and our spiritual strength" (Lacey Jones, Director, QomQem Coastal Connections).* Participants saw significant, positive impacts to the well-being of individuals when they began accessing cultural activities that involved ceremony, storytelling, art and language learning. These activities were reported to provide a great deal of healing for individuals dealing with grief and loss.

> "We have care cupboards that we installed in partnership with Vancouver Coastal Health in 2021 and 2023 as part of a project called CARE – Compassionate Access to Resources for Everyone. We call them CARE cupboards. One is installed at the fire department, and we have one on the side of our harm reduction building. And that's 24-hour, seven-day-a-week access to safe use supplies and naloxone, sharps, containers, condoms, whatever. So when we're closed or no one's around, or it's midnight on a Saturday and somebody needs safe stuff, they can go and take what they need from those cupboards."
>
> – Participant from the Vancouver Coastal Region

Land-Based Healing

Relationship with the land has since time immemorial been a core aspect of Indigenous peoples' health. Participants explained that engaging in activities like fishing, hunting, foraging, camping, healing baths, animal- assisted programs and traditional medicine harvesting provide cultural learning and connection for individuals. Participants stressed the importance of incorporating land-based practices, like brushing and smudging, into healing programs, and stated that these methods had been central for many in their journeys.

Connection and Relationship

Relational Approach

Participants explained that harm reduction is deeply rooted in respect, love and compassion, and stressed the importance of building strong relationships with clients. The success of programs relies on these relationships, which are developed over time and are essential for fostering trust. Participants also highlighted that harm reduction involves treating everyone like family. Food security programs and free hot meals were often brought up as a medicine that nourishes and brings people together.

Peer Leadership and Inclusion

Several participants spoke to the sense of belonging and safety provided by peers to individuals accessing services. Participants mentioned providing training to peers in mental health, first aid, overdose response and counseling, and how peers are often best suited to deliver these services through personal experience. Some organizations employed peers to distribute harm reduction kits and supplies on foot, by vehicle and in person, which helps reduce stigma. Other organizations had working groups and peer advisory councils to plan programs and connect with community members.

> "We started incorporating a harm reduction breakfast. It's a peer-based one run by peers and volunteers who want to help. Sometimes it'll be like the drug user network group—we're really connected with them. Maybe someone comes to the breakfast and we say, 'Hey, do you want to work today for 20 bucks? We need an extra hand.' But it's all about how food is love and so we call it the 'Food is Love' program. We also have food recovery. We have a community fridge we fill up every Tuesday and Thursday for people. We cook food. Today on Wednesday, we have someone from a church bring us food and we give it out."
>
> – ANKORS Cranbrook

Intergenerational Support

Several participants spoke to the importance of nourishing intergenerational connection and knowledge sharing between Elders, Knowledge Keepers and youth. Youth were highlighted as a key population to involve in cultural and land-based activities and preventative programs.

Collaboration

Participants shared the value of working with other Indigenous organizations and individuals doing work in communities as a way to foster connection and reduce administrative burden, capacity constraints and financial constraints. Participants spoke to the effectiveness of collaborating with non-profits, clinical care teams, friendship centres, drug user networks and band offices.

Wholistic Wraparound Care

Two-Eyed Seeing

Participants explained that integrating cultural and western practices is essential for effective harm reduction. Participants maintained that by weaving together clinical and ceremonial methods, clients can access services that feel safe and relevant. Examples included culturally supported detox and withdrawal management, integrating community listeners into clinical counselling, providing traditional medicines alongside safer medications supply and distributing smudge kits with harm reduction kits.

> "We have a team here that does home support detox...We have a nurse here, we have a clinic where there's a doctor and a nurse that would go and check in on the client as they're detoxing. We'll get the family to empty out a room, we'll get a candle, we have water, we have cedar boughs, traditional medicines to help cleanse and detox. Then we have Elders who would go in and talk to the one who is detoxing and just have full support with the cedar brushings every morning or when needed, drumming and singing for the one who's detoxing."
>
> – Cecily George

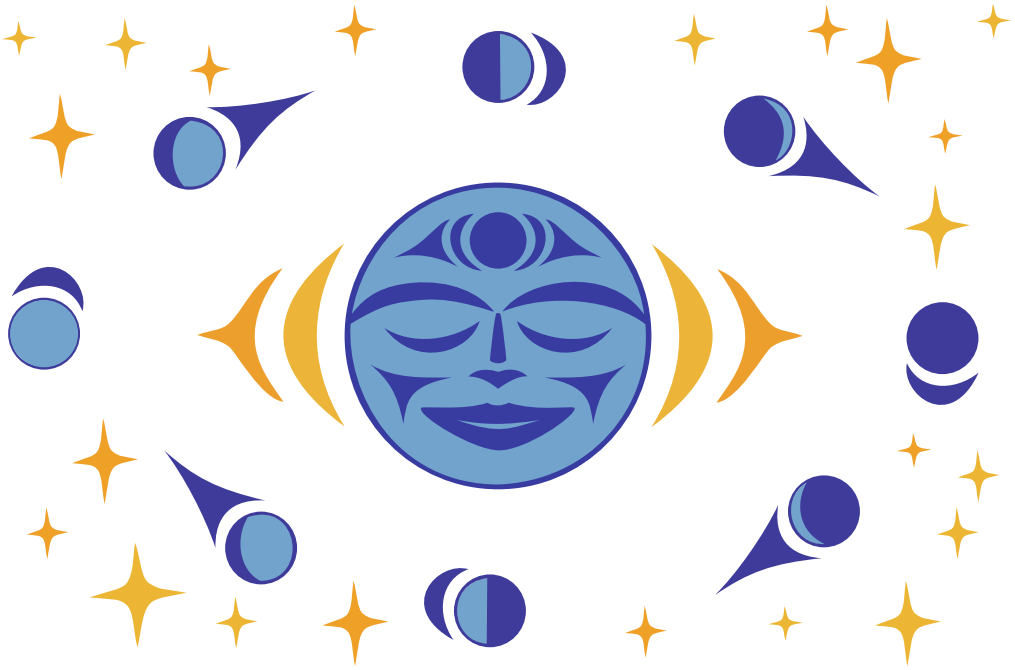


Figure 2, The Moon Phases symbolize the Continuum of Care in harm reduction.

Continuum of Care

Providing support within a wholistic continuum of care was highlighted by numerous participants as being central to First Nations approaches to harm reduction and substance use care. This means providing a comprehensive and accessible range of treatment options that integrate a full spectrum of care, including prevention, harm reduction, treatment, aftercare, reconnection with community and ongoing support to ensure long-term well-being. It also means addressing the social determinants of health and integrating culture and cultural supports into care throughout the entire continuum.

> "I also had a single mothers program where I taught them to go and pick up their seafood, can their seafood, get it prepared for the winter. It allowed them to learn financial responsibility of paying for their rent, their hydro, their food before they do anything with their funding. I had anywhere from six to 10 in each session. And I did three sessions. And some of them continued on into the next session because they were having issues. And then I also supported them if they were having issues with social services or Usma or with the ministry."
>
> – Alice Sam

Intergenerational Approach

Participants spoke to the importance of integrating whole-family programs that bring together extended families —from Elders to infants—to revive cultural practices and address intergenerational trauma. Participants mentioned programs like cooking, crafting, playing, land-based activities and participating in talking circles.

Accessibility of Care

Cultural Safety

Cultural safety was a theme that came up repeatedly and was central to the conversation around accessibility. Programs designed by Indigenous staff that include ceremony, culture and traditional medicines ensured relevancy and uptake. Participants frequently mentioned the value of training of non-Indigenous staff about colonization as well as the value of Indigenous frontline staff in providing safety for Indigenous clients.

Reducing Stigma

Stigma was identified as a primary barrier for participants, particularly those living in smaller communities. Participants mentioned that some community members would not access harm reduction services if staff knew them, over fears that their anonymity may not be maintained. Participants mentioned mitigating this through programs like after-hours care cupboards and vending machines to allow for more discrete access. Some communities were also scaling up efforts to provide training to community members regarding harm reduction and substance use as a response.

Availability of Harm Reduction Supplies

Numerous participants mentioned how essential it is to have harm reduction supplies available for keeping people safe in their communities. Participants mentioned that in addition to these kits, the availability of drug testing strips, naloxone (particularly nasal kits due to ease of access), FTIR testing sites, and safe supply and OAT prescribers in the community were key. Having a variety of methods of distribution of kits was also deemed necessary; participants mentioned mobile outreach on foot and via trucks, care cupboards and vending machines to ensure low-barrier access. Many participants brought up the value of safer supply and the need to scale this up.

> "When I started here, the Elders, they were so progressive. They were like, get the condoms out to the community, get the harm reduction supplies out. We love what you're doing. Keep it going because our youth are dying and we need to stop it."
>
> – Shuswap Band

Rural, Remote and Northern Considerations

Significant accessibility challenges were brought forward by participants from rural and remote communities, including the availability of harm reduction and overdose prevention sites and services, transportation challenges for people to access services outside the community, and the unpredictable unregulated drug supply, which can cyclically cause drug poisonings as the supply varies. Mitigation strategies included distributing naloxone kits, encouraging downloads of the Toward the Heart app, doing mobile outreach (like backpack programs) and using camper vans as mobile overdose prevention sites, drug testing sites and hubs for hot meals and counselling services.

> "We also distribute harm reduction supplies from our camper trailer. And we can also host people inside it for a bit to warm up. Our next step is we want to get internet onto the Jeep so people will come and use our Wi-Fi while waiting for their turn to sit in the trailer and have some street counselling. We've really been focused on meeting people where they're at."
>
> – Mel Bazil, Dze Ļ K'ant Friendship Centre

Building Community Capacity

Training, Education and Resources

Numerous participants suggested offering training programs to staff in harm reduction, overdose response, mental health crisis response, first aid and inclusivity to help keep people safe and reduce stigma. This training also provides opportunities for peers (actively using substances or not) to work as frontline staff, to share their valuable knowledge through lived experience and provide kinship for those accessing services.

> "Once a month, we all kind of meet up in the peer group – it's another form of harm reduction and a safe place where all the peeps can meet up, see what's working, what's not working, decide on which events they want to engage in or what they actually want to do. And they're supplied with non-violent crisis training and suicide prevention training."
>
> – Participant from the Fraser Salish Region

Staff Capacity
Participants mentioned issues of burnout among frontline staff and the difficulty of retaining qualified staff with adequate and sustained pay. Many said that their organizations were collaborating more on programs, and hiring more peers as a staffing solution, but more funding was needed to sustain permanent, full-time staff.

Community Support
Community support for harm reduction initiatives was identified as an important way to reduce stigma and increase community cohesion, thus providing safety. Participants stated that effective ways to increase support included distributing naloxone widely, providing overdose response training, and bringing in speakers with lived experience to community meetings and schools to share and provide education.

> "What we're doing is a beaded heart and carved paddle by one of our folks. And so [community] members will wear a heart or a paddle... [that signifies] "I am on a recovery journey, and you can come talk to me any time, right?" So that we build some sort of community here in the village."
>
> – Kwakiutl Nation

Funding
A number of participants raised concerns about the availability of funding and restrictions on what specific types of programs and activities funding could be used for. In particular, organizations desired funding that was sustained, flexible and culture-specific, meaning that it could be used for a variety of cultural activities. A few participants mentioned wanting to be able to fairly compensate Elders and Knowledge Keepers for their important contributions.

Conclusion

Findings from this phase of the study highlight that for First Nations in BC, harm reduction care is wholistic in scope – drawing on mainstream harm reduction practices while being deeply rooted in the ancestral strengths of culture, community and connection. These findings will inform Phase 2 of the study, which will involve community-based research to assess the effectiveness of community-led interventions to reduce harm and promote healing. Translation of the initial findings into optimal knowledge and wise practices will help FNHA and its partners provide more culturally safe, relevant and effective services for First Nations individuals in BC who use substances, and will be instrumental in responding to the toxic drug crisis that is affecting Indigenous communities across Turtle Island.

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