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TECHNICAL REPORT FOR STAKEHOLDERS

Perspectives, Pathways and Priorities of People with Lived and Living Experience of Substance Use: Informing Policies

With Foreword

What is Indigenous harm reduction, treatment, and recovery

by Jessica Daniels

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Foreword

What is Indigenous Harm Reduction, Treatment, and Recovery

By Jessica Daniels

If Harm Reduction is a set of principles and practices that help people reduce the harm of their drug use… what is Indigenous harm reduction? Is it simply those same principles and practices being applied by, with and for Indigenous people who use drugs? Do Harm Reduction and Treatment agencies and services, who often have a majority Indigenous clientele in Canadian Prairie cities, need to provide services differently in order to meet the needs of Indigenous peoples? Are there Indigenous Harm Reduction and Treatment services that operate from a different perspective, that may have a divergent set of principles and practices and what can they contribute to Wise practices for all peoples? What do Indigenous cultures have to say about the principles and practices of Harm Reduction, treatment modalities, and addiction recovery that can inform their efficacy in meeting the needs of people who use drugs? And what do Indigenous people with lived experience have to say about their own experiences of Harm Reduction, treatment and recovery and that of their families and communities?

These questions have been swirling around in my mind for many months now. I was asked to write forward to ***The Perspectives, Pathways, and Priorities of People with Lived and Living Experience of Substance Use: Informing Policies*** (P5 Project YXE) from an Indigenous perspective, informed by both cultural knowledge and teachings, and my own lived experience with substance use, treatment and recovery. The researchers were able to bring forth a data rich story, useful, practical, informative, but it was felt that something more needed to be considered to truly position the data within the larger narrative and context of Indigenous peoples, their experiences, their perspectives, their pathways and their priorities. My hope is to bring some of that to their good work. I am both humbled and grateful to have an opportunity to participate in their search for truth, and the ways this truth can become practise.

Wahkohtowin (Kinship) & Miyo Pimâtisiwin (Living the Good Life)

Miyo pimâtisiwin is a concept of health within Nehiyaw teachings that encompasses a broad range of connections, actions, feelings, and is the result of being in good relations with the land, with our kin, and with ourselves. Miyo pimatisiwin is a state of being where your mind, body, spirit and emotions are tended to and where your obligations to community are kept. You do your part, you are responsible, accountable and prosperous… you live in abundance and are aware of the many ways you owe this Good Life to the practices of your people from time immemorial. Practices embodied in ceremony, passed down through story and lived in everyday life. Central to this was the concept of Prayer… but prayer is the English word and it doesn't completely capture the Nehiyaw word which I was taught means something closer to

“making a connection to that which is most holy” and that we are meant to be in a constant state of prayer. Meaning, everything we do in a day, every single day, is done in a state of prayer. This was explained to me by Elder Jo-Ann Saddleback, who began this teaching by asking me what the first thing I did each morning was. She went on to explain the importance of making your bed which at the time made me groan a bit, but I continued to listen as she went on to explain why.

She told me you make your bed every morning to keep your spirit with you, it journeyed far in your dreams, and the process of making your bed was an important ritual to call it back to you. You need your spirit with you to meet the day. She went on to describe the process of getting ready for the day and all the many rituals and ceremonies that you performed while doing it. She talked about how braiding your hair was a prayer you kept with you, that ensured balance and protection, she talked about praying for the life of the water you used to wash up, that it is the most powerful medicine on Earth and how we must pray for it when we use it to wash or to drink. She went on to explain why we set aside small amounts of food to feed our ancestors and pray before we eat, whether we are eating a traditional feast or a bag of chips… we feed the ancestors in gratitude for our own lives. In doing these things you strengthen your connection to Creator and to all living spirits in the Universe, that you are kin to all living spirits in the Universe.

Subsequent discussions with this Elder included talks about rites of passage and how one had to demonstrate mastery of adulthood in order to be considered either a man or a woman or any other gender. Children would spend most of their time observing and shadowing, through play, the skills needed to be part of the community and there would be ceremony and celebration along each step of the way as they learned. One teaching that struck me deeply was one about the conduct of warriors and that the first responsibility of the warrior is Peace.They must become masters of Peace, through practice, through right action and by seeking truth and putting truth into practice. She talked about the necessity of learning art and craft, such as bow making, and beadwork, as part of the mastery of adulthood and how the process of making wasn't just utility but mediation and prayer. That these processes connected you to the Universe.

When I was actively using drugs, I remembered these teachings as I fought my way back. So much of my life was spent trying not to feel pain and shame, and for a time, substances helped. When they began to hurt more than they helped and they began to be the cause of more pain and more shame, I turned to these teachings to help… and they did.

Sakihitowin & Miyohtwawin (Love and Kindness)

I was taught that the greatest thing you could achieve as a human being is kindness and compassion, that if you accomplish nothing else in this life, you have accomplished Everything. Love is the feeling, and kindness is how you demonstrate that feeling to your fellow spirits. It is

important to put things into practise… our words and actions must be congruent. Much like the warrior whose first responsibility is Peace, Kindness is the practice of Love and it is our responsibility to keep it. It took me far too long to understand that kindness and niceness are not the same. Kindness has boundaries, because boundaries are necessary to have kindness and compassion for oneself. Niceness has no boundaries, it isn't necessarily genuine and can sometimes enable unjust and intolerable things to occur.

Kindness can be non-interference; there are some lessons that only experience can teach.
Kindness can be listening to pain without letting it trigger our own.
Kindness responds to situations to ensure good outcomes for all.
Kindness can be saying no… even when someone you love is asking.

Siksika Niita'pitapi (Self-actualization)

I had the privilege of sitting with Elder Narcisse Blood in multiple sessions through my work at Nechi Institute and he related the story of Abraham Maslow and his time spent at Siksika in 1938. Narcisse had undertaken research about this story and his research revealed that much of Maslow's work was heavily influenced by his time spent with the Siksika people, including the Hierarchy of Needs and the concept of self-actualization. Although Maslow's interpretation, in Narcisse's words, was limited. In the Blackfoot way of life, things like food, clothing,and shelter, water, air, safety are givens - there is no one who would go without these things. Self-Actualization is a necessary prerequisite for being a member of such a community. Much like in Nehiyaw ways of being, you are responsible for the care and safety of ALL the children in the community. There were no such things as orphans, or abused, abandoned or neglected children because we were (are) ALL their parents and grandparents, with all the love and duty that entails. A society where children would go without food or shelter while others enjoyed more than what they needed is one of the few "sins" you could commit.

He also talked about the importance of Language and of the Land, and the importance of spending time with the Earth… that the Earth has lessons to teach if we spend time sitting or walking with her. He related that much of Blackfoot ways could only be understood in the Blackfoot language - that so much of their knowledge and ways of being is embedded in the language itself.

In talking with Elder Jerry Saddleback, he affirmed that this is also true in Nehiyaw ways. The sounds themselves, the words spoken make up the fabric of reality itself… that to lose an Indigenous language, is to lose a Universe of understanding and knowledge. That what we say brings things into being and that many concepts in Indigenous languages do not have equivalents in English. Without those sounds being spoken, our shared reality loses parts of itself. I understood this to mean that at a very basic level, the Language is essential to the health of the Land, and to our Health as Indigenous people.

Nâkateyimôwin - Taking Care of Oneself in a Holy, Sacred Way…

I spent some time with Elder Jerry Saddleback asking him about how you would say the words or relate the concept of Harm Reduction in the Cree language. In addition to being a preeminent scholar of the Cree language and a holder of the History of Creation Story, he has done a lot of work and given a lot of thought to the idea of Harm Reduction and Nehiyaw culture, beliefs and ways of being. Without hesitation he gave me this word: Nâkateyimôwin. I asked him further what its etymology and story were and he said "to take care of oneself, in a holy sacred way". I had always believed that Harm Reduction was special work, but to hear an Elder call it Sacred, for me was overwhelming and shattering.

I still carry shame with me because of my use and eventual addictive and destructive pattern of using drugs… but I remember the powerful voice that cut through when I was at my lowest, a voice that told me that it was not ok to destroy myself, not just because of the hole it would leave in the lives of my children and family, but because… I matter. I am a Sacred being, even as an addict, my choices about my life do not take away from that Sacredness… and helping me to preserve my life with tools and support, is Sacred work.

Indigenous Perspective on Addiction - Wîhtikow and Prophecy

I have had occasion in my life to hear many stories about the Wîhtikow, a fearsome monster spirit consumed with a voracious appetite for human flesh, whose hunger caused it to chew off its own lips and consume entire families and communities. Wîhtikow stories are part of Nehiyaw and other Indigenous belief systems and they have been used as a way to reinforce community norms and warn against the consequences of bad behaviour among many other things. When I was wrestling with addiction in my family and how it consumed every part of it… physically, emotionally, mentally, and spiritually I was reminded of these stories. The Wîhtikow is a powerful allegory of greed, consumption, compulsion, even to one's own destruction and the destruction of those we hold most dear.

I was told a story from the 1800s about a medicine man in northern Alberta who prophesied the coming of a Wîhtikow that would consume us all, and that story continues to resonate for me in the context of addiction. Deep reflection on this metaphor provided me with some insights that were essential to my own recovery: addiction is not just about individual behaviour, it is about our relationships, our community, our history, our environment and our recovery from the impacts of that Wîhtikow who came… Colonialism. The Wîhtikow for me is not a description of addiction or people who use drugs, but colonialism itself and its continuing impact. The journey of Recovery includes us all. Decolonization is Recovery, language preservation is Recovery, cultural perpetuity is Recovery, land stewardship and protection is Recovery. Reclaiming and expressing our humanity as Indigenous people is Recovery.

I currently work in the arts and am part of a team that produces an Indigenous film festival. Recently, as part of my work, I watched a film from New Zealand that chronicled a Maori women's story of recovery from her Methamphetamine addiction. My struggle was also with Methamphetamine and I saw much of myself in her story. The pain, the loss, and the reconnecting with the teachings of her people on her road to recovery all really resonated… but the part of the film that struck me down "to my bones", was a voice-over in the Māori language during the closing credits that said:

> *There is a demon on its way.*
> *It is a demon that will arrive stealthily and deviously.*
> *You will not see it coming.*
> *You will not see its here until you see it in the eyes of your grandchildren*
> *And when you do, do not punish your grandchildren.*
> *But cloak them with the cloak of love, of family*

- *Prophesy of Aperahama Taonui, 1883*[i]

For my granddaughter

[i] From the Film *Mana Over Meth,* 2022. Holly Beckham Director

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Acknowledgements

This report would not have been possible without the time, dedication, and commitment of many individuals and organizations. The team would like to thank and acknowledge each member of the project advisory board, your thoughtful contributions and willingness to share expertise are the foundation for this success. We would also like to thank the advisory members for relaying information about the project through your networks and assisting project recruitment.

The wisdom and guidance of Elder Jo-Ann Saddleback has kept our team focused on the real aims of this research; **to build connections and long-term supportive relationships that will flourish beyond a project timeline or funding allocation**. We have made many new friends and enlivened long-standing personal and professional connections in this work together. These relationships are foundational for a strong and generous community of care. Thank you for always reminding and returning us to the purpose of this work.

The project team would also like to acknowledge the superb work and contributions of project knowledge ambassador Carli Down, Operations Director for Prairie Harm Reduction. Thank you, Carli, for your work and passion – they are an inspiration to us all. Making pathways for systems change is no easy task, and you do it with style. We also offer additional thanks to Daniel Hearn, host of the livestream video and podcast show, Hard Knox Talks, for promotion of the project with his audience, and encouraging project recruitment and visibility.

Last, but certainly not least, we would like to thank University of Saskatchewan Graduate Research Assistants Natasha Istifo and Kacie Kushniruk for their diligent work transcribing, organizing, and coding the data we review in this report. The team would also like to thank all project affiliates past and present; your talent, engagement, and contributions are foundational to these outcomes. Keep kicking buttermilk!

Most importantly, the team is thankful and grateful to all who participated by sharing their stories, wisdom, and experience. Without your voices, this project would not have been possible.

Executive Summary

In this report, we provide a technical summary of data and findings from The ***P**erspectives, **P**athways, and **P**riorities of **P**eople with Lived and Living Experience of Substance Use: Informing **P**olicies* (P5 Project YXE). Our team conducted 41 interviews across three socioeconomic groupings of people with lived and living experience (PWLLE) who accessed or tried to access harm reduction, recovery, or treatment service in the Saskatoon, Saskatchewan area within the last five years. Content coding and analysis of the interview data highlights participants' perspectives, pathways, and priorities of the current nature of substance use services.

PERSPECTIVES

To determine the **perspectives** of participants, we asked for their personal definition of three key concepts: harm reduction, treatment, and recovery. Firstly, for participants, *harm reduction* referred to safety, a physical location or space, substitution practice, and as part of treatment. Secondly, *treatment* was described as a medicalized location, receiving support from others, working towards stopping problematic substance use or "getting clean", and as addressing the root problem(s) contributing to harmful substance use. Finally, participants viewed *recovery* as substance abstinence or "working the program," an individualized process, and as a form of life improvement.

PATHWAYS

The **pathways** of PWLLE were described through participants disclosing their lived experiences of navigating the health care system and their journey to accessing substance use services, including harm reduction, treatment, and recovery. These narratives highlight both obstacles and facilitators to services. Regardless of cohort, PWLLE identified long waitlists and wait times, experiences of stigma and discrimination (specifically racism, HIV status, substance use, and internalized stigma) as prevalent obstacles. Further, PWLLE identified limited hours of service operation by facilities, time poverty of having to 'pause life' to attend inpatient treatment, and a prohibitively complex health system that creates obstacles when attempting to access services. Conversely, PWLLE identified specific facilitators for improving accessing harm reduction, treatment, and recovery services. Regardless of cohort, participants identified employment supports, a supportive service environment, a peer support network, their own privilege, and additional crisis services offered during the COVID-19 pandemic as new or improved facilitators to engage in service access or continue access.

PRIORITIES

The **priorities** of PWLLE identified two avenues of substance use service delivery and policy improvement. General priorities, according to PWLLE, included amendments to existing services and the creation of new services to fill gaps in the system. For enhancing programs and service practice, participants identified trauma-informed training for staff, program and service incorporation of Indigenous culture and values, increasing the number of services available, increasing service access, taking a more individualized approach, enhanced integration of support systems, and changes to the current housing and shelter system. PWLLE were aware that policy change is essential for improving service experience and recommendations include access to a safer supply, decriminalization of drug use to change police response, increased service funding, specific support for Indigenous populations,

greater mental health resources, raising awareness around substance use with the general population, and meeting basic needs, such as safe and affordable housing.

KNOWLEDGE TRANSLATION AND EXCHANGE

For knowledge translation and exchange activities, participants suggested sharing information through a wide variety of methods like a short documentary video, a community lunch and learn gathering, sharing circles or other group activities. Additionally, participants emphasized the importance of communicating results broadly and through social media. The top three suggested ideas are 1) youth education, 2) an audiovisual knowledge translation product, and 3) an awareness campaign on the lived experiences of substance use. A summary chart of all ideas is provided in Appendix D.

PROJECT LIMITATIONS AND OPPORTUNITIES

The team identified limitations and future opportunities for this research project. Several limitations developed during the project related to institutional research policies and priorities resulting in cumbersome administrative processes and timeline delays that reduced overall capacity for additional analysis or outputs at this time. However, these same aspects are the foundation for short and long-term opportunities emerging from the project. Short-term opportunities include a secondary analysis of the dataset for methadone/suboxone engagement patterns, a gender-based analysis of service engagement and trends, and the influence of the Saskatchewan Income Support (SIS) program on housing and substance use service access. Long-term opportunities include retention of strong relationships to advance province-wide understanding of service gaps, interest for larger intersectoral analysis that includes ‘drivers of disparity’ that influence substance use trends and patterns (i.e. housing, safer supply, and criminalization of people who use substances) along with workplace and union support opportunities that can benefit people who use substances in Saskatchewan.

Project Introduction

The ***P**erspectives, **P**athways and **P**riorities of **P**eople with Lived and Living Experience of Substance Use: Informing **P**olicies* (P5 Project YXE), is a research study led by Dr. Barbara Fornssler, Adjunct Faculty in the School of Public Health at the University of Saskatchewan. This study is funded by a Sprout Grant, offered in partnership by the Saskatchewan Centre for Patient-Oriented Research (SCPOR) and the Saskatchewan Health Research Foundation (SHRF), with additional funding support from the Canadian Research Initiative in Substance Misuse (CRISM) Prairie node. In this report, we aim to share the finding of the perspectives, pathways, and priorities of PWLLE for accessing harm reduction, treatment, and recovery services in the Saskatoon area. Using findings from the folks that have or continue to use these services, we summarize their recommendations and the next steps and areas of additional exploration.

Background

In 2017 Dr. Lori Hanson led a College of Medicine Research Award (CoMRAD) project from the University of Saskatchewan that was a year-long study titled *Consolidating perspectives on the nature of Saskatoon's evolving opioid crisis* (Consolidating Perspectives).[1] Dr. Hanson acted as Principal Investigator, Dr. Peter Butt as Co-Principal Investigator, Dr. Barbara Fornssler as Research Manager, and James Dixon and Maryellen Gibson as Graduate Research Assistants. The *Consolidating perspectives* team spoke with stakeholders across the continuum of care whose roles were implicated by the opioid crisis. Due to the short-term nature and smaller budget of the study, the researchers were not able to properly support the inclusion of PWLLE voices in the interviews, a significant gap in the study. To address this shortcoming, the *Consolidating Perspective*s team, developed a community-based and patient-oriented research project to illuminate the voices of PWLLE that became P5 Project YXE.

The P5 Project YXE team includes: Nominated Principal Investigator: Barbara Fornssler (University of Saskatchewan); Co-PI: Lori Hanson (University of Saskatchewan); PWLLE Family Advisor: Marie Agioritis (Moms Stop the Harm); PWLLE Advisor: Brandi Abele (Canadian Association of People who Use/d Drugs); Project-Guiding Elder: Jo-Ann Saddleback (CRISM Prairies); Healthcare Provider: Peter Butt (Academic Family Medicine); Decision-Makers: Kayla Demong (Prairie Harm Reduction) [formerly Jason Mercredi (Métis Nation – Saskatchewan)], Jack Saddleback (OUT Saskatoon); Co-Investigators: Maryellen Gibson (University of Saskatchewan), Lindsey Vold (University of Saskatchewan), Rachel Loewen Walker (OUT Saskatoon, University of Saskatchewan); Project Coordinator: Maggie Coupland (University of Saskatchewan); Graduate Research Assistants: Natasha Istifo (University of Saskatchewan), Kacie Kushniruk (University of Saskatchewan); Undergraduate Research Assistants: Roha Shahzad (University of Saskatchewan); Research Affiliates: James Dixon (University of Saskatchewan), Mark Hammer (University of Saskatchewan), Macala Harriman (University of Saskatchewan), Alexa Thompson (University of Saskatchewan); 10 Member Advisory Board of PWLLE of substance use.

Aims, Purpose and Objectives

Engaging PWLLE in research is essential for supporting and directing systems-level change and fostering engagement with health services. The *aims* of this research were identified by PWLLE of substance use. The aims are to 1) reduce stigma, 2) enhance service accessibility, and 3) amplify the voices of PWLLE for policy change in harm reduction, treatment, and recovery supports.

The *purpose* of this study is to amplify and mobilize voices of experience to develop and enhance pathways of care for PWLLE of problematic substance use in Saskatoon, Saskatchewan. Not all

substance use is 'problematic' in Canadian society, but substance use related harms may occur without, or prior to, a medical diagnosis of dependence. To understand the care pathways that people who use substances are seeking, the study required appropriate terminology that would prompt participant engagement, while avoiding stigmatizing and less accurate terminology (i.e., addiction). For the P5 Project YXE, substance use is classified as 'problematic' when its use impacts employment, relationships, or well-being.

There are five *objectives* for this study, including:

1) To consolidate and compare **perspectives** of PWLLE of problematic substance use in accessing harm reduction and recovery service supports in the Saskatoon area.
2) To identify **priorities** for equitable[ii] community and health system supports for PWLLE of problematic substance use.
3) To map and identify gaps of current care **pathways** for PWLLE of problematic substance use.
4) To identify short- and long-term **actionable changes to policies** impacting PWLLE of problematic substance use.
5) To disseminate findings in ways that **honour the stories** of lived and living experience, diminish stigma, and create public dialogue.

[ii] Inequity refers to the unfair, avoidable, and unjust differences in social, economic, and health status due forms of prejudice, and the failure of governments in acting to address those differences.[2]

Research Questions

This project has three guiding research questions:

1) What do the perspectives of PWLLE of problematic substance use reveal about the current nature of harm reduction, treatment, and recovery services in Saskatchewan?
2) What are the actual pathways of PWLLE of problematic substance use as they navigate harm reduction and recovery services?
3) What are the priorities of PWLLE of problematic substance use for programs, services, and policy changes?

Methodological Approach

The P5 Project YXE values the importance of lived and living experience in all facets of research. To incorporate these values in the research project development, data collection, and knowledge exchange, the team embraced the following approaches: patient-oriented research (POR) and Community Based Participatory Action Research (CBPAR).

PWLLE voices are the forefront of this project, and this is made possible through a POR approach.[3] POR recognizes the important contribution of patients and patient-partners at all stages of the research process for improving patient outcomes. This approach means those directly affected by health services and policy are meaningfully involved with the process of determining the aims and outcomes of that policy. The P5 Project YXE team does not use the term 'patient' in this study because some of our partners and participants have never formally addressed their substance use as 'patients' in the health care system. The terminology most used in substance use research – people with lived and living experience – reflects the historical exclusion of these voices from formal systems of care. The term is retained in reporting about service provision because one of the research goals is to identify barriers for accessing formal care. Embracing the POR approach meant engaging PWLLE voices as experts who could inform the desired patient experience, while acknowledging this effort is still largely happening through community-based work.

Complementing the POR approach in community health settings, the team engaged community members through a CBPAR approach).[4-8] CBPAR is a well-known research strategy for engaging community members as partners in the research design, collaborative knowledge creation, intervention development, and health policymaking, to eliminate racial and ethnic health disparities.[3,9-14] CBPAR is an approach that is especially important for disenfranchised groups who are historically more likely to be 'researched' than engaged as active communities creating and sharing expertise to inform the research approach and effort. Participants in our project were not passive subjects, but rather active constituents across the research process. Core CBPAR principles include; participation of community members, cooperation and equal contribution between community members and researchers, co-learning, systems development and local community capacity building, empowerment, and a balance between research and action.[6] Prairie Harm Reduction (PHR) and OUT Saskatoon were instrumental in informing an appropriate and community-specific study design, data collection, analysis, and integration of community-informed expertise in the project. Drawing on ethnographic methods for data collection[8] and thematic coding for data analysis,[7] these methods offer a structure for analysis yet a flexible enough approach to collection, coding, and analysis that align with CBPAR core principles. CBPAR offers a direct but flexible approach to data collection, drawing on iterative dialogue with participants and advisors, to reach a meaningful understanding that is 'actionable' rather than static.[3,4] P5 Project YXE study findings

are meant to prompt actions, both short- and long-term, including policy change, program development, and educational outreach, to provide not only evidence-based recommendations systems change, but also recommendations that hyper-local and contextually informed.

Training and Interview Process

To facilitate appropriate engagement with PWLLE during the interview processes, all research has enhanced research method training, which was tailored for PWLLE. This additional training included weekly training sessions that were supported by additional funding from CRISM Prairies, which evolved to a formal group called Substance Use Research Group for Engagement (SURGE). Beginning in the fall of 2020, SURGE met weekly for 12 weeks to provide knowledge exchange and skill development opportunities to trainees. Discussion topics included: P5 Project YXE background, research funding structures, ethical review processes, knowledge exchange approaches, harm reduction concepts, appropriately engaging PWLLE in research, PWLLE advocacy efforts, and community-based research methods deemed relevant to the project. The training was not restricted to P5 Project YXE stakeholders. We were happy to offer SURGE to interested students from allied disciplines, so they may enhance their knowledge of the subject area. The broad interest in this training was surprising, however, and suggests a strong desire for additional knowledge sharing in this area. With the limiting nature of the SARS-CoV-2 (COVID-19) pandemic restrictions, group training fostered knowledge exchange with community organizations, reduced the burden of independent knowledge exchange with partner community organizations, and enhanced research process knowledge for project trainees and partners to better facilitate the interview process. Additionally, research team members responsible for data collection and management also completed *LivingWorks Start* Training[15] that provides a four-step model for suicide intervention and safety. Each of the previously described training processes was essential for ensuring success in developing the interview guide.

The interview guide was developed in consultation with patient/family advisors and research team staff (Appendix A: Interview Guide). A total of 41 interviews were conducted with PWLLE who had accessed or attempted to access substance use services connected to the Saskatoon area. The research team recruited and interviewed individuals representing three different cohorts (Table 1), according to socioeconomic (SES) status, employment and educational background or occupational training certification. High SES includes salaried professionals and degree holders, middle SES includes manual labourers or those employed in the trades industry. Low SES includes under-waged or unemployed individuals. Project recruitment occurred through service providing organizations, social media advertisements, and word-of-mouth promotion by project advisory members (Appendix B: Recruitment Material).

Table 1: Employment and educational background by cohort

	White Collar A	Blue Collar B	No Collar C
Employment	Professionals or Licensed positions	Trades worker or unlicensed positions	Underwaged or underemployed
Socio-Economic Status	High	Middle	Low

Due to COVID-19 Pandemic restrictions, all interviews were conducted by WebEx, Zoom, or telephone from June 1, 2021 to November 30, 2021. Interviews were facilitated by graduate research assistants (38

interviews) and the project PI (3 interviews conducted, 3 interviews observed). Interview length varies between 21 minutes to almost 3 hours, as determined by participant interest. A demography table is included as Appendix C: Participant Demography. In the original study design, both PHR and OUT Saskatoon were to act as community partners appointing knowledge ambassadors to facilitate data collection. Due to unforeseen circumstances and resource shortages during the pandemic, OUT Saskatoon could not act in this role, but the organization remains engaged with the project through advisory committee membership. Carli Down, Operations Director, acted as a community knowledge ambassador (KA) for PHR. The KA is an interlocutor who holds specific relevant knowledge within and about a community context.[16] The KA contributions make elements of the research process visible that might otherwise remain unseen. The dyad of GRA Maggie Coupland and KA Carli Down fostered connection, skill development, and knowledge sharing throughout the data collection and interview process.

Interview Outcomes

In this section, we review the content outcomes of perspectives, pathways, and priorities (defined in Table 2) in alignment with the interview guide (Appendix A). Data findings highlight the perspectives, pathways, and priorities of PWLLE who have accessed, or attempted to access, harm reduction, recovery, or treatment service in Saskatoon, Saskatchewan. To provide an overview and clarity of the content analysis, we can provide a timeline of this iterative process upon request to core researchers or members of our advisory committee.

Table 2: Definitions of key concepts

Concept	**Definition**
Perspectives	Participants' definitions of "harm reduction", "treatment", and "recovery"
Pathways	Participants' process of navigating access to substance use services
Priorities	Participants' ideas around future directions for substance use programs, practices, and policies

Perspectives include personal definitions or expressions of 'harm reduction,' 'treatment,' and 'recovery' terminology. They are best characterized as the outcome of personal experiences with the healthcare system or knowledge of another person's experience with the healthcare system when seeking substance use services. **Pathways** are most frequently described by participants through a narrative reflection about their personal journey to accessing services or meeting personal needs for healing. These narratives often reflected multiple barriers on a pathway to participant defined success (e.g., achieving personal goals). More frequently, these narratives illustrated barriers and difficulties encountered, along with strategies for gaining access to resources and services, despite system fragmentation and divagation (i.e., no one, clear pathway present). **Priorities** are most commonly expressed as to how participant journeys could be better facilitated and how needs could be better met through programs, practices, and policy change. In identifying priorities, participants provided specific remedies for addressing barriers to care, which were previously identified in the pathways section above. Finally, participants identified their preferences for knowledge translation and exchange activities which are summarized in the final section of this report.

For the purpose of this report, participant ID numbers were re-randomized, but cohort identification was retained. Qualitative work often assigns pseudonyms for the purpose of data reporting, but given the large nature of the dataset and the importance of the cohort identifier for contextualizing lived experience, new numbers were assigned as the participant identifiers.

Perspectives

To determine the **perspectives** of the participants, interviewers asked them for their personal definition of three key concepts: harm reduction, treatment, and recovery, which we review in detail next

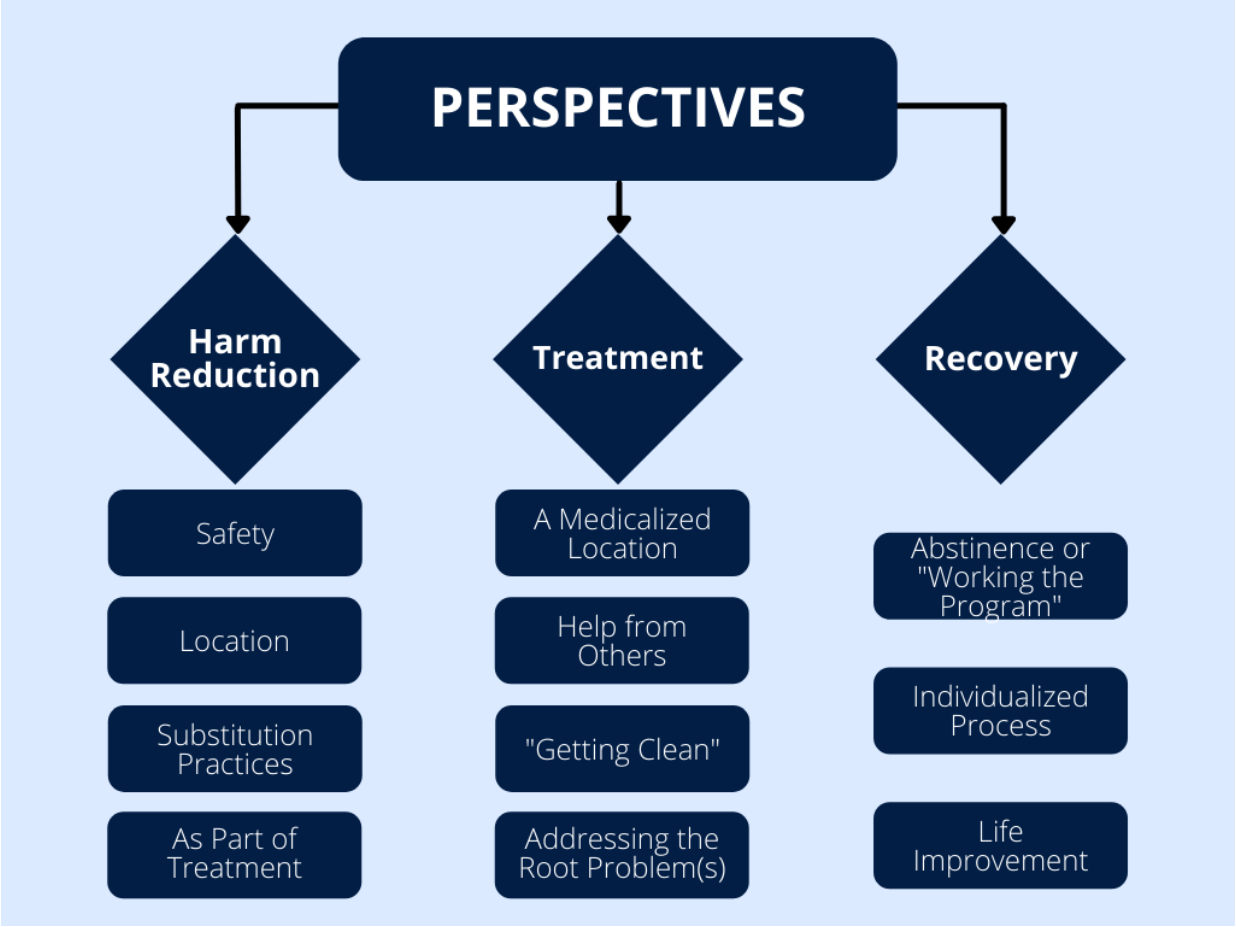

Figure 1: Perspectives

Harm Reduction

Participants characterize and understand the term 'harm reduction' in four distinct ways: 1) as safety; 2) as a location; 3) as substitution practice; and 4) as part of treatment. Each category below provides a brief description and example statement**.**

Safety

Participants note that 'harm reduction' are measures undertaken to increase the level of safety for individuals who use substances. PWLLE noted varying differences in how this safety may be practiced, but the main goal was to ensure that substance use, if performed, was as safe as possible or at least less harmful to overall wellness.

> "Well, that means you make it as safe as possible for the people that are addicted to whatever they're addicted to. To get what they need, or what they want while they are trying to figure out how to stop doing what they're doing." (Participant 1B)

Location

Participants note that harm reduction could also be more than actions and could also be seen as a place where individuals can be safe when using substances. Often, these places are known to provide

resources or supplies. Primarily, participants characterize the environment itself as a form of harm reduction.

> "…somewhere to go and be and feel safe. I find it really safe here… safe consumption site is awesome." (Participant 10C)

In other cases, participants communicate how harm reduction locations are not service centres or program facilities but could be any place where someone could live and use substances safely.

> "So that's harm – harm reduction, my harm reduction for my daughter was not kicking her out…. She was safe. I knew – if she was home, I knew, even if she was high, I knew she was safe." (Participant 9A)

Substitution Practices

Participants also provide situations where individuals may change their substance of use to reduce the harms, or in other words, "doing a lesser of the evils" (Participant 4A) as harm reduction. When prompted, participants noted that the substituted substance did not necessarily have to be legal or prescribed to be considered harm reduction.

> "People with addictions – when I was in my active addiction, I was medicating. I was medicating the daily trauma of my life and the other residual traumas of my life. And so, I was not going to go and be on an anti-depressant, I was going to do heroin. Might seem extreme to some people but it worked out for me …. This was my choice. You couldn't have me stop doing heroin when that's what I wanted to do. But what was – again – part of this whole white privilege business in my life – I dated a guy who could order heroin on the Silk Road. So, we were actually getting really pure heroin. It was considerably less dangerous to use than when we would buy on the street. So already then in my addiction, I practiced harm reduction without even knowing." (Participant 11B)

As Part of Treatment

Participants also characterize harm reduction as a step towards treatment or integration into the treatment process. For some, harm reduction and treatment are intertwined and inseparable.

> "So, for me harm reduction is a form of treatment it's… the initial process that was the initial idea behind the harm reduction approach. It was a way for people to get treatment for their addiction." (Participant 5A)

> I: "Okay. Would you say that harm reduction can be treatment? Or do you think those are two separate concepts?"
>
> P: "They can be together. They can. If they had a – more qualified staff for it, you know? Exactly." (Participant 10C)

Treatment

Participants characterize the term 'treatment' in four distinct ways: 1) as a medicalized location; 2) as help or support from others; 3) as "getting clean"; and 4) as addressing the root problem. Each category below provides a brief description and example statement.

A Medicalized Location

Participants understand treatment as a location, but this differs from harm reduction. To elaborate, the places described or mentioned were often medicalized environments, and referred to as institutional facilities that addressed the mental and physical health impacts of substance use.

> "A treatment – treats symptoms…. treatment for me would be like going to a treatment centre. Treating my disease." (Participant 4B)

> "...going to treatment does include nurses and doctors and hospitals, and therapists and stuff like that" (Participant 9B)

Help from Others

Beyond the medicalized location, participants also view treatment as a place to access professionals who could "look after you" (Participant 5B), "help", "heal", or provide "advice" (Participant 11C). In some cases, this medical advice was to reduce use, but others note this kind of advice may address additional aspects of wellness beyond substance use.

> "Treatment is another person helping somebody else that needs it. Whether that's drugs or any mental issues. It's getting help." (Participant 2B)

Some participants highlight that treatment includes the access to medical professionals, again, reflecting the medicalization of the treatment space.

> "Going to treatment does include nurses and doctors and hospitals, and therapists and stuff like that." (Participant 9B)

"Getting Clean"

In many instances, participants feel that treatment is connected to a process of "get[ting] clean" (Participant 1A), "dry[ing] out" (Participant 2A), or "detox[ing]" (Participant 4C). For many, the term treatment is synonymous with abstinence from substance use. The term is also used as a synonym for withdrawal management,

> "Treatment? Treatment's like getting your body clean and from all the chemicals that you're doing from doing the drugs and whatnot." (Participant 7C)

> "Treatment to me is, I'd think of like MACSI or like a treatment centre where you go to get clean basically. (Participant 1A)

Addressing the Root Problem(s)

Some participants define treatment as actions that work to uncover and address the root causes of why a person may be using substances in hopes of eliminating substance use.

> "The term treatment? So, I guess it means a lot of things. Just you know somewhere to not just dry out but actually take a look at why you drink or use or engage in this addictive behaviour. And you know, ultimately, sort of try to get to the core of why that is and discover and learn tools to combat that. That's what it ultimately means to me, I think." (Participant 2A)

Some participants feel addressing deeper root causes also includes educational opportunities to learn coping strategies and life skills, with the goal of reducing substance use or dependence.

> "In my experience, a facility that you go to and there's, depending on the place, there's different strategies and approaches to it. Some places focus on more life skills, some with like coping strategies. Different maybe – and preparing you a bit better to get back out into the world." (Participant 3A)

Recovery

Participants characterize and understand the term 'recovery' in three distinct ways: 1) as abstinence or "working the program"; 2) as an individualized process, unique to them; and 3) as life improvement. Each category below provides a brief description and example statement.

Abstinence or "Working the Program"

For some participants, recovery clearly reflects living free from any substance use. This perspective was notable when participants use terms like "you kicked it" (Participant 19C) or being "abstinence-based" (Participant 5A). Recovery in this category is about abstinence from use and feeling better.

> "Recovery? Where you no longer like doing drugs and that. And you're like better, like how I am" (Participant 15C)

Other participants believe recovery is connected to a specific treatment program. Recovery, in this view, means that you are "adhering to the program" (Participant 3A) or "working the program" (Participant 4B) as intended. Some did note, however, that this route does not necessarily work for everyone.

> "Recovery means to me you are having sobriety in your recovery; you are going to AA or NA meetings or you recover from sickness." (Participant 16C)

> "Recovery's almost like meeting requirements to something that I've heard of, read in a book but never actually seen. Very few people, well I should say, very few ladies I know have been in recovery. It's a real hard part of life out there. I've seen recovery mostly in the AA program, the older clients and mostly with men, unfortunately not so much with the girls or the people on the streets." (Participant 8C)

Individualized Process

Some participants feel that the definition of recovery should be left to the individual seeking it, with the goal of happiness or being who you want to be.

> "Recovery for one person is not gonna be exactly the same for another person. More intense or less intense. But it's the helping of somebody for yourself or others and to recover from the problem that you're dealing with…There's no blanket answer or question that can be asked on a situation like that. Every indication of anything, any point is different. May sound the same but it isn't in this case, just because it looks like a duck doesn't mean it's gonna go quack." (Participant 11C)

Many participants gave examples of what recovery may look like. and note that sometimes this personal definition of recovery may not include abstinence.

> "Recovery – well – to me it's an important distinction. Recovery is not just living without the use of drugs and alcohol or sex or gambling or whatever your addiction is – eating – or whatever. So, recovery is actually becoming a productive member of society. And – and that – definition is different to every person. Whatever you feel. So, I mean, my version of a productive version is different than others." (Participant 7B)

> "Yeah, that's something my perspective has kind of shifted and grown with too over the past few years cause I think at first it was like recovery means you're working your 12 steps and going to meetings, have a sponsor and completely substance free. Which is great. I've been there before, but I think it essentially can look differently for every person, so I guess, recovery would be like recovering from a worse way of things that used to be. Living your best life. Living in freedom. Whether that's breathing and yoga or 12 step meetings or cutting down your liquor intake – it works for some people." (Participant 8A)

Life Improvement

Regardless of whether an individual was using substances or not, all participants see recovery as improving life circumstances. Some participants were able to concisely define recovery as "happiness" (Participant 17C) or "freedom" (Participant 2A). Importantly, participants stress that recovery is a journey, rather than a destination.

> "It's basically a life taught, lifelong battle on you know, staying away from drugs and alcohol. You know, making sure you're in the right mind set, that you're continuing your life in a positive, healthy way…when I got in recovery, I thought I would get a diploma at the end, and I be would be – I wouldn't have to think about fighting my demons anymore but obviously that's not the case, so I know it's going to be a lifelong battle. Recovery basically, uh, trained me for a marathon and when I finished my program, I guess that uh, I just start the marathon type of deal." (Participant 5B)

Pathways

To determine the **pathways** of the participants, interviewers asked them to describe their lived experiences of navigating the health system and their journeys in accessing substance use services. The following pathways are presented as two distinct categories, barriers to service and facilitators to service.

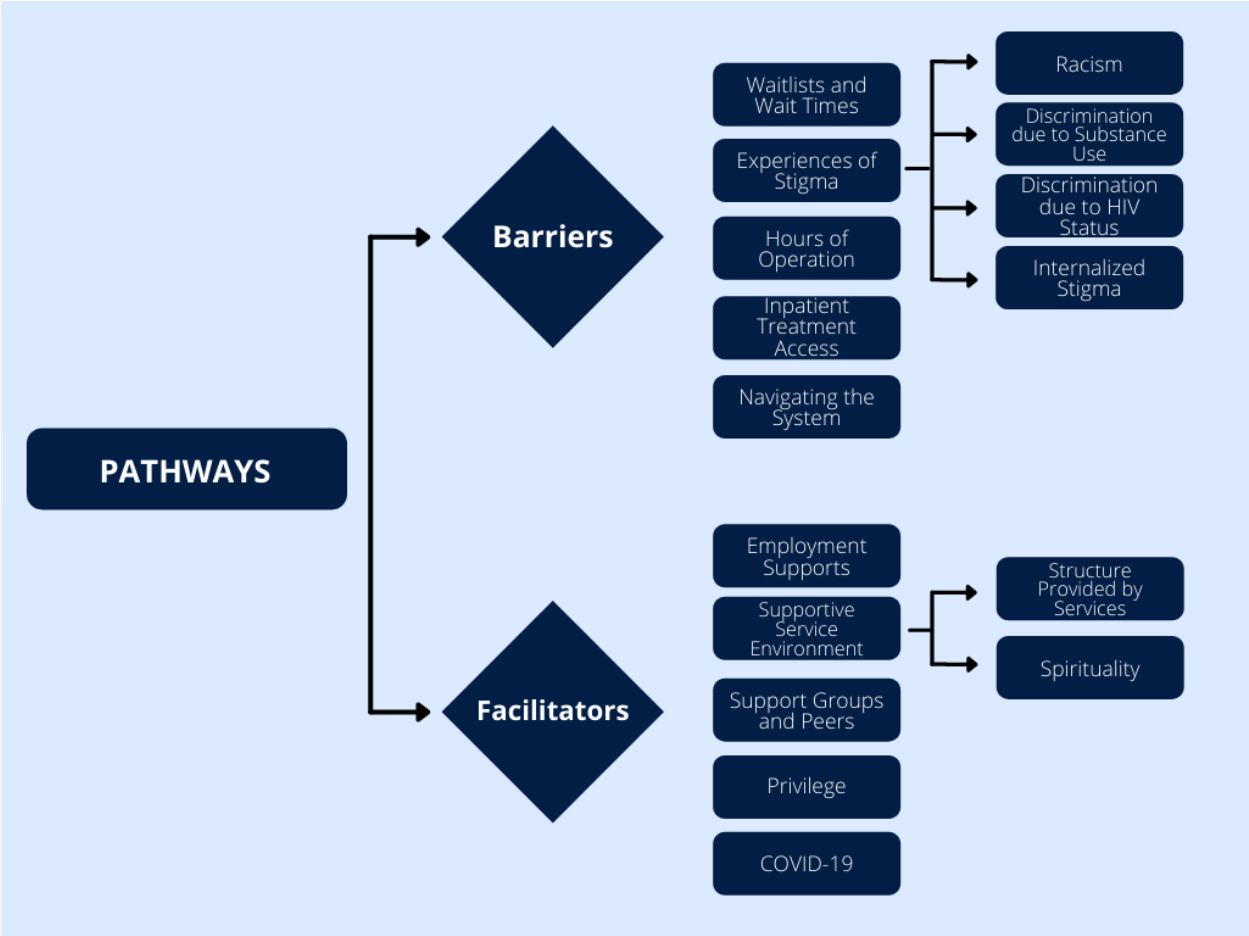

Figure 2: Pathways

Barriers to Service

Participants were asked to identify if they had experienced any barriers to accessing harm reduction, treatment, or recovery services. Participants across cohorts identify long waitlists and wait times, experiences of stigma and discrimination (specifically, related to racism, HIV status, substance use, and internalized stigma and shame or fear of judgment), limited hours of service operation, time poverty (Giurge, Whillans & West, 2020) preventing them from attending inpatient treatment, and too much complexity navigating the system.

Waitlists and Wait Times

Participants unanimously note that long waitlists were one of the largest barriers to accessing treatment in Saskatchewan. Waitlists for detox, post-detox treatment transition, and many other services were said to be significantly long, reaching lengths of six months or more. Furthermore, to remain on the waitlist, individuals are often expected to call the centre daily, which for some, is not realistic and further jeopardizes their ability to access services.

> "I'll go to the [treatment centre] sometimes there's a waiting list. And they, they want you to call every day. And a lot of times, they don't even do that. Yeah, and the only reason they've done that is because they're full right now." (Participant 12C)

Participants said that waitlists were not only frustrating to hold your position on the waitlist, it also led to situations where individuals no longer desired the services or in the worst cases, have died from harms of substance use before they could enter any facility.

> "Because I'm sure they do it for a reason. There's probably not enough beds. And the serious people who really want to – like you gotta call every day if you really want it. But I mean you're sick at that time, and you don't think like that. But in hindsight I get it kind of. But when you're in that state, you're not thinking 'oh I really want it. I better call every day.' You just want to get high." (Participant 4B)

> "[Treatment Centre] had way too long of a waiting list. And you know – it's sad. Even now, it's worse off. Right? Like, no addict in active addiction is going to wait 6 months for a bed. They can't wait six – The person can't wait 6 hours for their next fix let alone 6 months to get a bed for a safe place to sleep." (Participant 2B)

These seemingly excessively long wait times also impact the available options individuals' could choose to access. Some participants note that waitlists direct what center they could attend, effectively limiting their equality of autonomy in treatment choice.

> "But there was some inpatients like one in [town]…There was stuff like that. But the leave time, I couldn't get in right away, you know, stuff like that where [centre] was able to take me in like, like the next day if I really wanted to right… But that sort of, I don't know exactly all the different places, but I just know there was times that I couldn't get in or I had to wait a while or whatever the case would be, right?" (Participant 5B)

Additionally, the ability to pay for treatment allowed some individuals to circumnavigate waitlists from publicly funded treatment centres to accessing private treatment centres.

> "There were other, other places, I tried to get into. I tried [centre] and there were a couple in Alberta that I was willing to pay to go to just to get in faster." (Participant 8B)

> "And yeah, it was going to be like it was an upfront thing. We would have had to come up with the money. There was definitely a bed available." (Participant 2A)

The participants also spoke on their experiences of the COVID-19 pandemic impacting these waitlists, capacity issues, and the time that it took to access services.

> "I think it is, people are saying they're only taking a certain amount of people now, not as much as they were taking before because of the COVID, and I understand it's COVID is like a health risk and stuff but and everyone's gotta be safe so." (Participant 14C)

Experiences of Stigma

Most participants experience negative interactions with healthcare professionals and other service providers. They note that these negative experiences not only impact the quality of care they received, but also influenced their willingness to commit to a full treatment admission or program, or even return to services in the future. In many instances, participants highlight these experiences as a reason they would *not* engage with the healthcare system, unless experiencing extreme duress.

Racism

The Indigenous participants in this project shared their experiences of racism in the healthcare system. They note that the colour of their skin and the stereotypes associated with Indigenous people in Canada impact the quality of care they receive.

> "For one – it's like – the hospital. One. You know? To go there and you're Native, they seem like they frown down on a person. Yeah. That's what I get…. You're Native. They think you're drunk or an alcoholic." (Participant 10C)

> "But again, like it's not systematic the way it is for a lot of people of colour. It's very systematic, you know? It's so ingrained into the systems that we work with. Like the Health Authority, if you're a status native, your number's right at the top of that medical file. That distinguishes you, that puts you out, that points you right out and it's just a file, it's just paper." (Participant 5A)

Non-indigenous participants also note the difference in healthcare experiences, compared to their Indigenous counterparts.

> "Or the difference of – if I walk in to an ER and an Indigenous person walks into the ER, both of us have the same exact issue that we're presenting, but with me, I guarantee I'd be hooked up to a drip and having dilaudid into me instantly. Whereas that person would be handed Advil. And that's BS." (Participant 7A)

Discrimination due to Substance Use

The participants also note that when some service providers were aware that the person was using substances, the provider might treat them differently or completely refuse service.

> "I have, I have knee problems and I went, I'm giving you an example. I went to [Hospital Name] because I had an appointment with my – with a knee specialist. Right as soon as he walked into the door, he said 'I can't help you because you're an addict'…. He didn't sit down with me, and that's the first thing he said to me: 'I can't help you because you are an addict, you're a known user' and I was like 'wow'." (Participant 16C)

Unfortunately, this kind of experience is not limited to healthcare providers interactions, but also discriminatory interactions with police services.

> "So, within a four hour span I had two overdoses in my room. I was the only one who did not. And the cops came and was like – 'you think this is a fucking party? You think this is

> cute?' And I was like – 'you know what? I am a professional like you. You think this is fun? Do you think I'm having a fun time? I feel so gross that this is how my day has gone.' And it was just like – he was kind of talking to me like I was a useless junkie. And it's like – no no no – make no mistake – I have school just like you. So that's another one actually – the police. Those ones are probably the shittiest to deal with." (Participant 3A)

Discrimination due to HIV Status

Participants share experiences of discrimination due to their own or others' HIV status. Living with HIV was seen as a reason some healthcare providers gave less than adequate service or used stigmatizing language around their patients.

> "The emergency room, yep. That place, and just the hospital in particular… [other patient] came running down the hallway and… she said 'you know what they were saying about me?' and I said 'What? Who?' she said 'The nurses' I said 'What?' she said 'they thought I was sleeping, so this is the second morning – the first morning I just pretended to sleep, I didn't say nothing, I didn't get out of my bed, but today they said 'what is she still doing here', 'yeah, she's got HIV', 'well get some other people in here, there's probably older people that need to be in here.'' And I was like what the fuck." (Participant 18C)

Internalized Stigma when Accessing Services

Regardless of socio-economic status, participants consider internalized stigma or self-stigma (shame, fear, judgment) as a significant barrier in accessing services and asking for help.

> "I think a lot of people don't like to ask for help. There's a lot of – what's the word- stigma around it. They don't do it cause they think they're gonna be, be judged. Also, like, I remember going to treatment – calling around – that was really hard for me. The first time I also went to [treatment centre] – my friend had to do it for me. I wasn't in any condition to do it. (Participant 4B)"

> "[Stigma] stops people, it stops everything from using every service. The stigma and this hate, it stops me from having a heartbeat." (Participant 17C)

In many cases, the participants note that they did not want anyone to see them accessing services. The risk of being seen accessing services, or that others would know that they use substances was what many participants feared most. This was particularly true for individuals in the middle- and high-socioeconomic groupings.

> "I mean again, on a personal level – maybe just shame or embarrassment surrounding it. I mean that used to be a big thing for me was I don't want anyone to know so I'm not gonna try to access it. You know what I mean?" (Participant 2A)

> "And this is, so this is getting to the point. Yes, harm reduction, would, would the guy that owns his own company and makes like literally 8 million dollars a year, that comes to our group, would he go use meth or heroin or crack, because crack is huge, I don't know if you know that or not…Would he go down to Prairie Harm to do that? No. He's just going to do it in his own house. Right?" (Participant 9A)

The stereotypes associated with geographic location and neighbourhood also limit the willingness of individuals to access services. This was predominantly described in ways that connote the racialization of space in Saskatoon and reflect historical divisions (East vs West) in the city.

> "But I know like, when I was using, there's no way I would have gone to use that facility because even though I was doing all the same drugs, as everyone there, I still didn't want to be mixed up in… in the gang stuff and sex work and violence that a lot of those people that go to that service are dealing with…. People might not use those services because they don't want to go to the hood to inject in a supervised site." (Participant 3B)

> "…It's having – those resources available to people in all parts of town because there's lots of people that may not be comfortable going there." (Participant 7A)

Hours of Operation

Participants note that the limited operating times of some services impacts their ability to access those services. They note a need for 24-hour services, specifically mentioning the needle exchange, and PHR as specific services needing longer operating hours.

> "The services are like 'don't have a crisis outside of Monday to Friday 8-4, and we're closed over lunch hour.'" (Participant 9A)

> "I think just at nighttime, like at night because services aren't open if you're needing clean supplies, you know? And you're searching for that so that you don't have to put yourself in a situation where 'oh my god I gotta use something dirty' or you know what I mean? So, basically being open all the time would be a lot helpful." (Participant 14C)

Inpatient Treatment Access

Participants express one of the most limiting barriers to accessing inpatient treatment services is time poverty. To commit to treatments and programming, individuals may need to take weeks or months away from their lives, which is not possible due to asking for time off work and bill payments.

> "I couldn't leave. Like I needed to – I needed income to pay my bills and everything like that. Yeah. That was kind of one of the reasons why I didn't go…. And I couldn't take that much time off and I didn't want to be away from my family for that long cause they were kind of my solidness. They were helping me." (Participant 10B)

Participants also note that their responsibilities to their children and the absence of other caregivers further exacerbates the barriers to accessing inpatient treatment.

> "If you've got kids you don't want to go to treatment…I had family that would take care of my kids but not everybody has that. So, there's that. And work, taking the time off work. Some people can't do that. But for me, if I didn't, I would have lost my job anyway so."(Participant 4B)

> "So yeah, that's one thing that would be hard about accessing stuff… I can't just like, I got to pay my rent, I've got a fucking kid, my job might not be there if I'm like trying to go away for two weeks to detox and then four weeks to fucking rehab." (Participant 13B)

Navigating the System

Participants express their confusion and frustration when trying to access substance use services. In many cases, participants do not know how or where to access services. Navigating the complex health system is simply too much of a barrier and effectively prohibits continual attempts to access services.

> "Because when it's so frustrating and that's when you're like okay I don't know what to do, well never mind I'm just going to go get high then. Since I don't know what I'm supposed to be doing." (Participant 15C)

Secondly, in many cases, participants find navigating the system is a tedious process that requires strong relationships with healthcare providers or an ability to meet the complex requirements of the various service providers and centres.

> "For most centres you have to have an addictions counsellor refer you and do all the paperwork and if somebody could just go online or go pick up the phone and put themselves on the list, I think more people would be willing to go through the whole process and get to the centres." (Participant 8B)

Facilitators to Service

Participants were asked what would make accessing harm reduction, treatment, and recovery services easier for them. Participants across cohorts identify employment supports, a supportive service environment, support groups of peers, their own privilege, and the COVID-19 pandemic as things that have made it easier to engage in service access or continue to access services.

Employment Supports for Treatment

Participants note that a supportive employment environment allows them to have more open and honest communication with their employer. In some cases, companies will financially support their employees to engage in treatment. The support from employers alleviated some of the stressors individuals were feeling when trying to access treatment.

> "So, I reached out to my work who had substance abuse lady. And she did a thing with me. I wasn't 100% honest with her, but then I was honest with her, so we looked at all the different options in and around Saskatoon – inpatient, outpatient, obviously, it's very tough to put your life on hold and go to an inpatient. So, you know, in Saskatoon area, there is very, very few outpatient places…" (Participant 5B)

Despite support, it is worthwhile to note that some individuals do feel pressure from their employers to succeed in treatment, regardless of completing the program successfully or in a timely manner.

> I: "You said that you went to [centre], your work sent you to [centre]?"
> P: "Yeah, and I continued to get paid 100% so I mean I got to give them credit for that. But here's the thing: I say I gotta give them credit for that, but I believe that's their legal obligation now, right? I don't know that for sure, but it seems like once I got into the second rehab, their demeanour with me was as far as – 'we're here and we want you happy and healthy and want you back to your old self.' They went from that to – after the second one – it's like, 'okay now we've fulfilled our fucking obligations to him. Get him on a last chance agreement'." (Participant 1B)

Supportive Service Environment

For the majority of the participants, the environment in which they accessed services has integral influence on their likelihood of completing the program or finding benefit from it. Specifically, the programs that create an environment of safety, understanding, and support are the most positive. This support was further seen through acts of caring by staff.

> "[Treatment centre] as an example because really that's the gateway to recovery…. I've been there 10 times and they've treated me like gold every time. They get a 5 star on that…. You know they don't expect much out of you and they, they want you to succeed."(Participant 12C)

> "I had good workers behind me though, like the one lady she – I missed an appointment and I had never missed appointments and there was like - everywhere I went there was somebody telling me they were looking for me, eh? [laughter] And she says 'it's because you never missed an appointment, I thought something was wrong, eh?' That helps having people like that, that actually care, you know? So, it's really nice to have that backup, you know? If you don't have it, you're kind of lost, you know?" (Participant 3C)

Further, participants feel some programs support their unique needs and treated them as individuals, which was a positive element that supported recovery.

> "I had a pretty good relationship with one of the male staff there who, he was goofy and laid back and we got along really good and he would sit down and talk to me. There was twice I was quitting, I was leaving, I was going home and he came and talked sense into me and just kind of reminded me why I was there. And in the first week they do a blackout, you're not allowed to have any contact with the outside world. But he let me phone my kids twice. Because he knew it would help." (Participant 8B)

For some participants, the positive relationship with their care provider is an important aspect of their recovery journey. Participants note the best physicians had qualities such as non-judgmental support, active listening to the desires and goals of the patient, and a general sense that they cared for their patients.

> "She's a retired doctor now which I was super sad about it. No, she was super cool about it. Did not judge. Did not bat an eye. She was just like 'okay and this is what we're gonna do' and just very supportive and suggested AA and I told her I was, and she was happy about that. She was like, very very supportive and non-judgemental." (Participant 9B)

> "I don't know, I got, when I was in Alberta I went to my doctor and I more or less told him what I wanted and that. How I was gonna, my plan was to reduce my intake and they started me off with 50 Kadian and I told 'em that don't cut the mustard, [they] gave me 100 Kadian. You know what, within 3 months I was clean, I wasn't using anymore, and I was only on 15 Kadian every day. I was able, my life was back in order, I was out doing things. Just simple communication with my doctor. I was on my meds, I was getting my liver treated, I wasn't dope sick everyday looking [to] go out and score. Just by him being not, not putting me in a category where he thought I was drug-seeking or looking down his nose

at me and saying 'you're, you'll never change' or whatever. I did it. I got off everything and I was 2 years over there." (Participant 13C)

Structure Provided by Services

Similar to spirituality, some participants note that highly structured and routinized programming is much more beneficial compared to other forms of programming. While not ideal for all participants, many were adamant that the structure provided by some programs are integral to their recovery.

> "Supportive community is helpful. I started doing the steps and I continued to jump from 1 – 2 – 3, 1 – 2 – 3, but yeah, no, mostly yeah it's the going in and the feeling you get after you're done a meeting. Cause you'll like – you feel like you accomplished something I don't know." (Participant 10B)

> "Working the program has been absolutely critical. And you know [Treatment Centre] was really good for me for the fact that it was like – you are… in a place that you cannot use – you do not have a phone. Like I was able to get 30 days in a row. So that was awesome. And then the three meals a day and the consistent like here are your meds." (Participant 3A)

Spirituality

While not applicable to all participants, spirituality is an integral part of the recovery journey for many of the participants interviewed. Some found spirituality through Indigenous ways of knowing.

> "I came to learn about Native spirituality when I was in the pen, what do you call it? I was curious about it and I liked what they had to say about the culture about the people and about colours and all races and nationalities, all religions. And that is one part of what was missing with me. Because they have certain stigmas and stipulations, how to be Catholic, how to be a Protestant, how to be something Adventist, how to be this, how to be that." (Participant 11C)

For some participants, spirituality reflects a state of mind or mindfulness.

> P: "A spiritual like, how they have it at my band, at our clinic in [town] they have a woman's room, a man's room, they have the kitchen, story-telling room, the kid's lounge, the adult lounge, and then they have the spiritual room. And the spiritual room has like couches and like beds like, but they're not beds like on metal, they're like big, big, big cushions and you can go in there and you can lay there and it's serenity. You can pray, you can listen to not music, but listen to like mood, mood - what the heck is it called, like – I can't even think of it, you know those kind of tunes you listen to when you go and do mind… "
> I: "Like mindfulness stuff?"
> P: "Yeah! Like to help, to make you calm down and stuff like that." (Participant 18C)

Other participants note that acknowledging a "higher power," as often explored in AA or NA programs, is helpful for their journey.

> "I used to go to church when I was a kid. So, I'm not – I don't not believe in God or whatever but I don't go to church now and I kind of not so much have a hard time with that but I kind of went down the path of like AA as my higher power and that's – you don't have to believe that it's God's will. Your higher power can be a doorknob and all.

> Yeah, for a little while it was a doorknob and then, it became AA meetings was my higher power." (Participant 10B)

Support Groups and Peers

Participants note the positive impact of having a strong support system is essential to their recovery journey. For many, connecting with peers who have gone through similar situations also positively impacts their recovery.

> "Just having a support group, a system. People that you can trust, that you actually can trust without them saying a bunch of stuff about you and whatnot. Someone you can just pour out your feelings to, for you not to slip up. Like going to see Elders, or going to see a drug counsellor, or just having a support group in your life is one thing that you really need to survive in this world that we're living in right now is to have a support group. And just people you can talk to and whatnot so you don't keep going on the exact same route and keep on doing the exact same things and try to break the cycle. I just find that it's just a lot easier to talk to people even if it's another person that was addicted to crystal meth too, it's just to share the same info or the same kinda storyline. You know peoples' stories and stuff like that are totally different compared to other peoples' and you never know what they've been through compared to you, sometimes it's the same things too, but you know everything's all different in how you look at it." (Participant 7C)

Some participants note that support groups became like family to them, bringing a sense of community to their lives they may not have had otherwise.

> "And they come through together. I have people in my life that I really rely on. They're like my sisters, they're not actually my blood sisters but I rely on these women cause they know exactly where we came from. They've come through this with me right like we've all gone through different journeys to get here. Not all of us are sober today, but the majority of us are right…I have a sister that works in this field, trained in this field, she has all this education. So, when I phone her and I'm so frustrated and I'm so angry and I cry about what happens, she understands because she works in this field. I have another sister, you know what I mean, I've created these supports. But then my support systems have to go through this shit too. So, they know what works and they know what doesn't, right?" (Participant 5A)

> "But anyways, the NA program in Saskatoon is strong. And the NA program in Regina is strong and it's a very tight knit community and it's a very supportive community. And it's a very loving community." (Participant 7B)

Privilege

In many instances, participants note the privileges in their lives that allowed them to access and stay in treatment. Participants note finances, familial support systems, ability to take time off as factors which made accessing and staying involved with services easier than other circumstances.

> "Because I was afforded – life of privilege – like I grew up on a farm and we have horses and my parents are very supportive.... Because I could take a step back from my addiction and

think about those things. If I didn't have my parents where would my son have gone for 6 weeks while I went to treatment?" (Participant 11B)

"Yes. Again, I'm very, very privileged. And have supports. And have means. Like I found a program because I have an aunt who works a program as well. Or else I wouldn't have never have even ended up in the room. Cause I had never even heard of it. I didn't know it was a thing. Like NA. So I can't imagine if you are living in a situation where you have to work four jobs to feed your kids. You don't have time for that and to be looking into those things. Or even having access to the internet or whatever, right? Lots of little things." (Participant 3A)

COVID-19 Pandemic Allowed for Alternative Communication and Engagement Methods

Participants express that the COVID-19 pandemic created alternative methods of engaging with some programming. Some participants feel the electronic or distance participation was an opportunity for them to try out programs and get comfortable with the idea of certain programs before engaging in person. Others mention accessing carries of methadone as being facilitated by COVID-19 pandemic prescription measures.

P: "I went – I've been going to AA. I started off with the [inaudible] and that would have been in April, the Thursday… that that was my first Zoom AA meeting and then I went to two a week and that was very helpful I find. And like the online looking at – trying to find all the different meetings for whatever I found that that was very helpful. They were all free to choose what you want to go to."
I: "Okay. Are you attending in person now or are you still doing the Zoom ones?"
P: "Hybrid?"
I: "Cool. How do you find it? What's the difference?"
P: "I kind of like the Zoom…I didn't have to be – I have a hard time talking in front of people and like I've been slowly getting better. More comfortable. Just because I'm familiar with the people now. But yeah I've found it easier to talk on zoom than talking in person, but I feel like in person is better? Like, more hands on. Real people. You're actually talking to a person." (Participant 10B)

"When I first started methadone, I had to – my urine had to be clean of other drugs before I could even get them, so I think the only reason I got my carries is because of this COVID, because my urine's never been clean [laughter]." (Participant 19C)

Priorities

To determine the **priorities** of the participants, interviewers asked them to identify areas for improvement. The priorities of PWLLE were captured for two levels of substance use service: service delivery and policy. Priorities included amendments to existing services or the creation of supports or services to fill gaps in the system. Policy shapes practices and programs, but the mechanisms of policy change were not the focus of conversation with participants. For this report, when the participant did not identify the priority as either policy or practice-based, the research team classified policy-related priorities based on the ability of governmental decision-makers to impact the outcome desired by participants (i.e., "I want trauma-informed care training to be integrated into the medical school curriculum set out by the Canadian Medical Association"). Practice and program-based priorities could be enacted by individuals or on an informal basis (i.e., "I want my doctor to listen to me more"). In places where practice/programs were not separable from policies based on these definitions for each category, the team classified according to the outcome the participant is seeking.

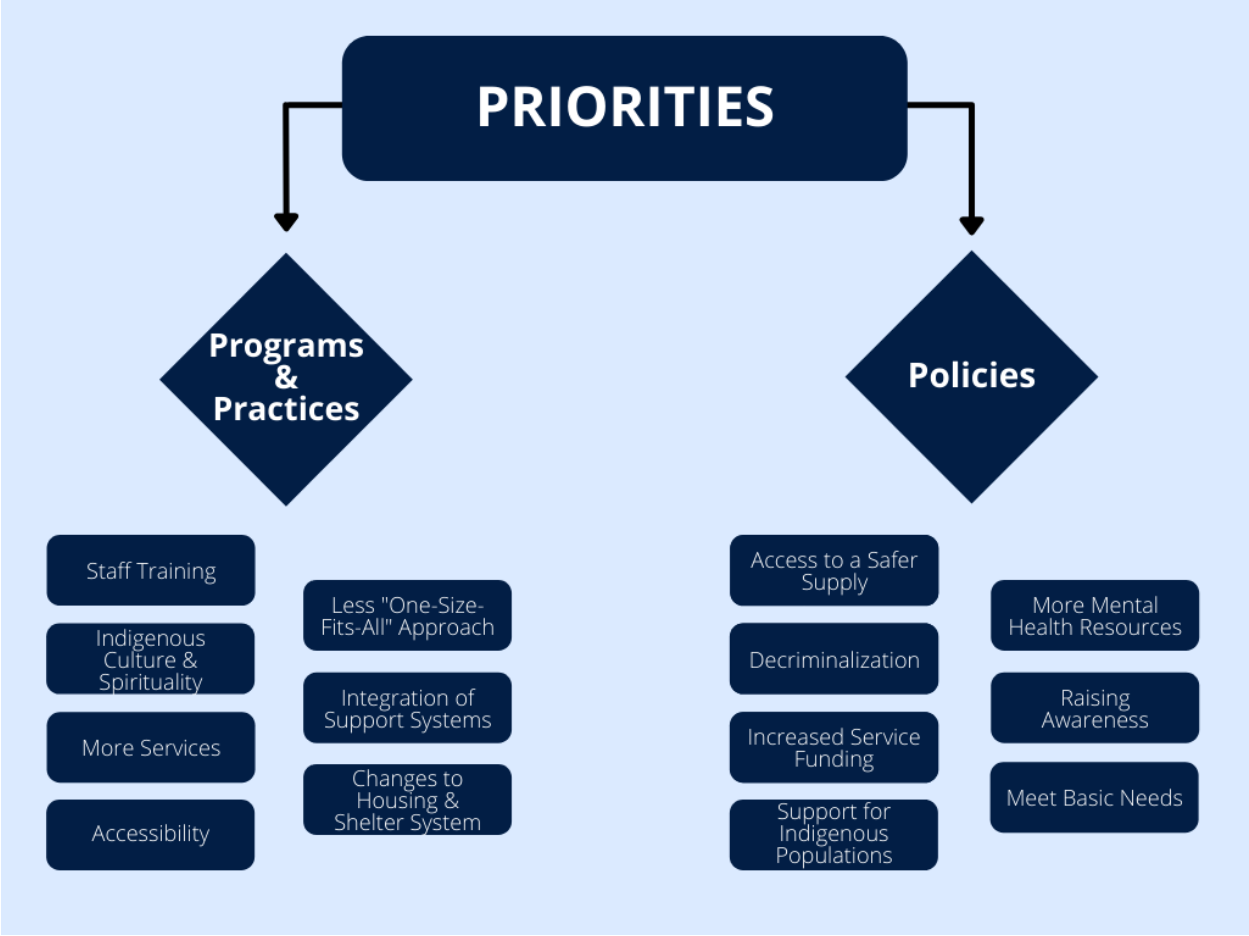

Figure 3: Priorities

Programs and Practices

Participants were asked to identify areas where service delivery could be improved for programs and practices. Staff training, incorporation of Indigenous culture, an increase in the number of services available, making services more accessible, a more individualized approach, better integration of support systems, and changes to the current housing and shelter system as areas for services to ameliorate.

Staff Training

When asked what they would tell someone beginning a career in the substance use services field, the majority of participants want substance use service providers to be further educated in substance use and addiction. Additionally, participants hope all service providers would be better educated in the mental health and lived experiences of people who use drugs

> "Get educated about addiction. And don't – yeah. I don't really know. Educate yourself." (Participant 4B)

> "Which is why I think they have to have trauma informed training. If you don't understand that there's a REASON that these people are an addict, that it's NOT a choice, that they're medicating something that already exists, and that there is something in there that may or may not ever fix. If people don't have that, then they're never going to be able to do it. That's why I'm a really strong supporter of people with lived experience." (Participant 11B)

Additionally, participants recognize this knowledge would support more empathy and understanding in the field.

> "So many things. I would say the biggest thing is I guess the amount of pain, suffering, trauma, neglect, abuse, depression, mental health issues, whatever it is – that's underneath. And the driving factor for drug and alcohol or any addiction for sure. And so, it's like if you can switch the lens from 'this is just a shitty bum who can't stop using' to 'this is a really hurt person' and just being able to listen." (Participant 8A)

> "Number 1, these addicts are people and they need to be treated as people. Just like if you brought somebody in, in I don't know with a broken leg you know? You would give them the utmost respect; the utmost care and I think that's number 1 what needs to happen with alcoholics and addicts because we're still people. Like – We're not – an addict is not less than somebody with a broken leg. We both have issues, they're both medical, let's address the issues and maybe for the broken leg it's a cast but maybe for the addict it's 'hey here's some methadone'." (Participant 1A)

Participants also want frontline workers to have a better understanding of sexually transmitted and blood borne infections, which may also be experienced by people who use drugs and can be a further stigmatizing factor in accessing care.

> "That you're gonna be probably working with people with mental illnesses and that to know that what kinds of things that can happen while working there. Like with HIV, with Hep C, and to be the precautions and stuff like that, and just knowing that you can't get it, you know? Because I know that nurses don't take a lot of training on addictions and shit like

> that, and when you're, when there's HIV, there's addiction. There's definitely addiction. And I'm not saying that everybody with HIV gets addicted, but most of the percentage of it, they do. And it's a bad thing, but that stems from a long, lot of bullshit that's going on, so I think that that needs to be incorporated in it. Like I don't know how I would say, but I just know that being patient, and kind, and courteous goes a long way with people that are, going through a lot of shit." (Participant 18C)

Some participants also note for Indigenous people accessing substance use services, frontline workers need to have an understanding of the history of Indigenous people in Canada.

> "It's not a personal attack and I'm sorry you take it personally, but I feel if you're going to work in this field and you're going to come and help save my people then learn, then learn about us. Learn about the history, learn what a residential school is, learn about what happens you know, what happens the cause and effect of those residential schools because that's what you're seeing." (Participant 5A)

Indigenous Culture and Spirituality

Participants also noted that given some of the individuals who access substance use services, more services should incorporate Indigenous culture and spirituality to support Indigenous clients.

> I: …You've mentioned cultural healing – do you think that is more important and needs to be integrated more into treatment and harm reduction services?
>
> P: Yes, yeah it's true. Probably have their own sweat at each place. And at [treatment centre], they should probably make their own sweat area where they have at least like sixteen sweats or like four hundred sweats. (Participant 1C)

Building on this concept, others note that current service delivery offers some Indigenous concepts, but could benefit from further incorporation of traditional practices and beliefs surrounding wellness.

> "For me, I would look at the Indigenous model, the medicine wheel model. To run people through to have recovery I would look at that wheel. We're looking, were not just doing a quick pepper, season it with a little were going to provide a little bit of culture like sprinkle it in like seasoning, right? I find that really condescending and ignorant and people in my family life that have fought for us to openly practice and speak our language…. So, for them to quickly sprinkle it in, were just going to put it in a little bit here, a little bit there. Oh, you'll talk to an elder, you'll talk to a talking circle. We're putting a sprinkle of the culture of the identify of who people are. We're expecting them to be like 'hey you can do it now', I would look at that whole model. And make sure we have services and resources that connect each model." (Participant 5A)

More Services

Overwhelmingly, participants note that while some services do exist, the long wait times, lack of capacity, and few options severely limit the ability for individuals to access treatment, seek recovery, and in some cases survive their addiction.

> "I think that a lot of the times when you're dealing with somebody who is struggling with a substance abuse, you are looking at life and death situations. And – you know – that could mean a person's life in like a day. Do you know what I mean? So, we don't have the resources for people to access and they need it now or yesterday or two days ago – you're looking at somebody's life. And that's a huge deal. That makes a huge difference."(Participant 4A)

Participants also note that there should be services tailored to specific substances being used, especially in withdrawal management, as they believe alternative interventions may be more impactful for certain substances.

> "So, if I could have my way, I would have a separate detox for opioid addicts. I would have a separate detox for crystal meth and cocaine addicts. And then I would also continue that on into a treatment center. Because they do such different things to the people. Yes, there are a lot of similarities, but how those drugs you know – make your brain – and make you react and all that crap – they are different. And you know what works for one person won't work for the other type thing. So I think if there was more of a focus on splitting up that stuff in a treatment center rather than just throwing everybody that's trying to quit anything into the same building, you might have more successes in that aspect also." (Participant 7A)

Accessibility of Currently Available Services

Even for the services generally available, participants communicate the need for a better way to navigate the system. They often note that accessing existing services was nearly impossible without the proper connections or knowledge.

> "Just more information being accessible to people… Absolutely. Cause it's – it's not really easily accessible unless you know the right person." (Participant 2B)

> "This roadmap would map out, okay you've got your drug counsellor, you've got the rehab facilities, the different rehab centres in the city, around the city, even maybe in the province." (Participant 1A)

Building off of this concept, participants identify the need for current services to expand their hours and be more accessible to PWLLE of substance use.

> "That's right and another thing that they should do is have 24hr services. Welfare should not be closed at 5 o'clock – Because the troubles are 24hrs, you know? There should be a night staff." (Participant 8C)

Not only do participants want more accessible hours for services, but they also have a desire to be able to stay in programs longer, so they may stay without fear of early discharge until they are ready to return to the community.

> "No. 28 days don't fix nothing. What it does is it opens wounds and then keeps them open and then when you get out of treatment you're back at 'er. And unless you have a good support system and the person itself is actually at that state of mind where they're ready to quit. Until then, it ain't happening, no." (Participant 18C)

> "Maybe if they like went longer, like, like people going through detox because like that's like the worst, it's hell. Yeah. Like this shouldn't, like it takes longer than 7 days or 24 hours. I don't understand the 24-hour thing like I guess it's just to make sure a person's safe. Like kind of like the 7-day thing, like, like I think there should be way longer than that. It's really hard." (Participant 9C)

Participants also note that one aspect missing from current services, is adequate transportation options. Some participants mention the need for more bus passes, and others note a need for a pick up and drop off services for connecting to substance use services.

> "And then they want us to go in and get help but they won't give us transportation to get to and from. It is. So, literally unless we're going to go pull a trick and get a ride pulling a trick – you can't get there." (Participant 8C)

Less "One-Size-Fits-All" Approach

A common critique of current substance use programming is a lack of individualized services; hindering participants' opportunity autonomy and self-determination. While autonomy is desired for treatment choices, a wider variety of programming is also desired within the service itself.

> "Something that I would really like to see is longer times in the treatment centre. The 28-day programs are great; however, they're not for everybody. If you're just going back into the same type of situation once you're done, that makes it really hard to have your success continue. So something like a sober-living facility. Those types of situations with a longer treatment stay and obviously you know – the programming is only four weeks so if I did end up staying longer at [centre], which a lot of the times I did for different reasons, then you're going over the same stuff over and over again. Which isn't a bad thing; however, I think longer stays like – you know – 90-day programs – or even like 6-months or – a year – I think can be really really beneficial for people who are struggling with addiction for sure."(Participant 4A)

> "For me, what works for me might not work for the next person, so, but this is just like what works for me would be treatment centres. It did work. And they were program-based. But I've never been to one let's say – holistic. That's – whatever -based or ones that have swimming pools. I've never been to any like that." (Participant 4B)

Better Integration of Support Systems

Participants note having a strong support system made accessing services easier and having a greater chance of success. Few programs, however, fully integrate the development and maintenance of

support systems into their services. For many, support systems are represented by peers and peer groups who could connect with clients.

> "Yeah like, like people who been there, like especially people who been there because then you're like– sitting there with somebody who's just like read about something or heard about something is totally different than like the staff members – there're staff members here that I like get along with like really well. And they, we like laugh and talk – it's just like a friendship, like because you know like they talk about their experiences and then it makes me feel way more comfortable talking to them about, you know, anything." (Participant 9C)

Participants also praise the knowledge of peers and the guidance they offer. Many participants note that peers know more about reaching recovery than many of the trained professionals who did not have a lived or living history of substance use.

> "How I think of it is like – a car with a mechanic. You're asking me questions about cars and I've never seen one. You can be book smart as you want but until you can speak or been through it and know the struggle. Cause it's not necessarily the substance that you use it's just a complete and total lack of – steps of thinking and the zero coping skills with even good things. To be around other people that know those feelings and what they've done and connecting to somebody else that maybe does have a lot of the same experience as you. How they've internalized the situation is so helpful. Better than any therapist." (Participant 3A)

Participants note that support systems also include their families, yet often they are not integrated into the service programming.

> "Not really, not, not, not for families who are together and that. They more have like, because usually, I guess usually it's mostly only the dad getting the kids back or just like one parent. But with me and my husband, it's like me and him been together 9 years and been doing drugs 9 years together, well like practically, almost 9 years, we've been doing drugs together and that. And now we're completely off of them together and getting my daughter back together so it's like yeah. And they're like trying to separate us by saying he has to go do like man – like go out and do stuff with the boys. And he's like looking at me 'like you're my backbone and I'm your backbone' and yeah it's like I know, if they separate us when we're not together and that, then I'm going to be like 'okay well he's not here with me to tell me, no you don't need to do drugs' like you know? So it's better if we're like together." (Participant 15C)

By addressing the whole family, participants believe services can be more impactful.

> "So, it's like, ideal situation it'd be so beautiful to have a centre that heals all the trauma for the families. Not just the individual….Right, not just looking at the individual like, fix this one person then well give them back their kids. No man, let's do it right at the first time right. Let's do one big thing the first time. Why just look at one individual, why not look at the kids and why not deal with the trauma that happened when the parents were in active addiction losing the kids or abused. Let's just deal with everybody. Let's deal with the family, lets heal the family right. Let's have a centre, let's have a centre where they can look

> at all this and not, ok well like here treatment centres like, we're only supposed to deal with addiction right. Don't deal with grief, don't deal with sexual trauma, we don't deal with this. We're going to give you an anger management counsellor, were going to give you a sexual assault counsellor, we're going to give you a grief counsellor. It's the reason people use in the first place, but were not even looking at why people use in the first place but we're going to help you with your addiction." (Participant 5A)

Changes to the Current Housing and Emergency Shelter System

With no financial constraints, participants describe their ideal substance use service. Many participants note that housing, accessible shelter, and transitional housing was something missing from the current landscape and would be first on their list of desired services.

In many instances, participants describe a shelter system which addresses people's basic needs like clothing, food and shelter all in one place. Further, these systems do not have time limits of those staying there, reducing the fear of eviction.

> P: if I ever win the lottery first thing I'm gonna get built is a homeless shelter where they don't have to get kicked out at a certain time and be back at a certain time. It's bullshit. Excuse my language.
> I: By all means swear, that's totally fine.
> P: Yeah no that's like – fucking- that's bullshit. And me, if I ever built a homeless shelter it's gonna be a place [inaudible] breakfast, dinner supper, you can chill out, watch TV if you want. They can have as much as they want. You know? (Participant 10C)

> "Something for - like a little shelter I guess, with so many beds. People who could use a place to crash or whatever. And snacks and stuff. And clothing." (Participant 19C)

> "But at the same time Saskatoon could use an addiction home, where people that wanna get clean and that don't wanna live on the streets and whatnot could come to. And then put it somewhere they could start for their first starting and what not. I don't know - I have so much - I wanna go to school, I wanna go back to school. I wanna get educated so I can do something like this and this is gonna be my business. I wanna do something like this, you know? And have staff there 24 hours, day in and day out, whatnot. And that they could just come home and you know? Check up on them see how they're doing, see if they need someone to talk to, like a place but like a home." (Participant 7C)

Participants highlight the need for transition housing programs, specifically post-detox into treatment centres.

> "The huge barrier for me is going from detox to treatment. If those dates don't line up then you go out of detox and then oh they go "about a month and a week", you can – is your admission date. So, you just have to stay clean for a month and a week. Well if we could do that, why are we [not]?" (Participant 8C)

Participants also desire transition housing from treatment back into daily life.

> "I think that detox to treatment transition would have been huge and obviously getting into detox within a few days instead of a few weeks. So like getting into a facility – I'm safe – I

know I'm safe at a supervised facility. And then maybe I transition out of there after 7 – 10 days to a treatment centre in Saskatchewan and as far as ideal experience, yeah, I mean, you know 30 – 90 days probably of healing and just connection and support to guide where I don't have to – there's no guarantees in life but I like to think an ideal situation. Cause I've been to treatment multiple times, and if it was the situation the first time I might not have to suffer as much more than I did. To leave there and just be connected – game plan obviously, support network, and yeah." (Participant 2A)

"Sober living. Yeah 100%. There is none here. And it's so critical for being released back into the wild." (Participant 3A)

Policy Priorities

Policy priorities were identified by PWLLE as being essential for improved service experience. Some of the policies include access to a safer supply, decriminalization and changes to police response, increased service funding, support for Indigenous populations, more support for mental health resources, raising awareness around substance use, and meeting the basic needs of people who use drugs.

Access to a Safer Supply

Participants want to get access to substances that will not have as high of a risk of poisoning or other negative side effects.

"And I think if we did prescribe these people stuff, they could probably get weaned off of it. And a doctor can take care of them because this stuff, I'm telling you it's poison. Like it's not, it's not controlled. Like I would rather see it pharmaceutically made." (Participant 12C)

"Actually, how well this is what I think. That they should give fentanyl out like methadone. Like make them sit down and make sure they're taking it and not selling it, you know? Because that's hurting a lot of people, like killing people. So, make them sit there, make sure they're taking it. That's what I think, and it could be safer, I think." (Participant 19C)

Participants also note that access to a stabilizing amount of a substance will allow people to not enter withdrawal and go about their daily lives.

I: Do you think if there was like a controlled supply…and then it was regulated do you think it would be helpful?

P: Oh yeah. The reason why – I watch David Suzuki, he's smart. But in Europe, they do that all the time. In Europe they prescribe heroin all the time, that's basically it, it's prescribed heroin and they've got their lives. When I was on heroin, I was on heroin for about thirteen years. I went to work every day. I mean I did everything. I just lived a normal life. I had to have this shot in the morning and one at night but I'm still able - I had a well-working life. Eatin' good you know, doin' everything, your body is your body but if it's hooked on opiates it's gonna be like that forever. It's not going to change. And they have so much success down there just prescribing heroin. (Participant 6C)

Decriminalization & Changes to Police Response

Participants provide mixed responses to their thoughts on the idea of decriminalization in Saskatoon. They voice some concern around decriminalization not providing an opportunity for individuals for an impetus to seek recovery, which engagement with the justice system can cause, or the intricacies of the policy may not actually help individuals or could cause other problems.

> "I really don't know. That's a touch-and-go subject, what's enough? What's small? What's…is it daily use, hourly use, like one person could use something that's only a couple milligrams another person might need an ounce, you know? What's the classification, what's the product, what's the package so to speak, you know? That you gotta live under. There's gotta be rules and stipulations, otherwise we're gonna have total anarchy, you know? You can't do that, you can't have that and you need some kind of structure to live by. Sometimes it's not good for you but you gotta live with it and fit into that thing. But it's how they fit you in, is the way that causes some problems, you know?" (Participant 11C)

On the other hand, many participants note that coming into contact with the justice system can have long-term devastating effects.

> "I think [decriminalization] would be helpful. Even just looking at Saskatoon drug user population and homeless population is largely Indigenous and then mix in systemic racism and how many people of colour are locked up for fucking possession charges even for marijuana which is now legal, I think from that point of view that would be a really good thing. I don't think there could be any harm in that. Yeah, I really like that idea." (Participant 8A)

Participants agree that other supports should be integrated into the justice system to make it more impactful.

> "Yeah, and maybe – maybe – yeah I totally agree. I think [decriminalization] would be. Cause what's going to happen? They'll go to jail? And then it's worse in jail. It's just a vicious cycle. Maybe like – refer them to a treatment or something. Maybe they – something like that." (Participant 4B)

One specific example offered by multiple participants is the integration of detox and treatment supports into the justice system.

> "One big thing that comes to mind is getting arrested. And going and sitting in a provincial correctional. I actually talked to one of the methadone doctors about this. In the States, some of the – there's specific areas I can't remember which ones off the top of my head – that have enacted bringing in nurse practitioners or methadone doctors into these correctionals, having these people assessed upon intake if they say 'I am a fentanyl user or opioid user' and getting them started on those – suboxone or methadone – as soon as they step foot in that jail. So that they're not going to withdrawal while they're in there. And so, the second they get out they're not running out trying to break the law again to get their next fix." (Participant 7A)

For other participants, asking them about their thoughts on decriminalization led them to advocate for a safer supply of substances through prescriptions to reduce the need for decriminalization.

> "You know I think that question about prescribing, prescribing people a little bit of that – Crystal meth – There you go. I think that's your solution. There is no other solution. It would knock out all the dealers, wouldn't it? If the government gave these people what they wanted, and kind of maintained it, it would definitely interfere with the flow of things because if you're getting it for free, you're not going to pay for it. So, that I think is the biggest thing to do because we gotta stop the flow of it happening and if these guys get a doctor to prescribe them something similar to that – That, and design it like methadone. I mean come on like we've got the genome down, we've got the DNA down, I'm sure we can figure that out." (Participant 12C)

Increased Service Funding

Many participants mention a need for more funding for harm reduction, treatment, and recovery services in Saskatoon. Some participants explain they are seeking services in different provinces because of a lack of options in Saskatchewan.

> "So when he did get into that substance use cycle, he just had no, like there was – I was even looking around, I was looking at programs in BC, I was looking at programs in Ontario because there wasn't really any good programs here close to our home. Like there's nothing…Like there really is nothing. People say there is, there isn't, there's no good programs. So, that whole area needs to be sort of supported and funded in a better way. And then it's, it's the overall kind of stigma reduction because even our provincial government still doesn't treat mental health like a health issue. It's very underfunded. It's, it's still stigmatized." (Participant 6A)

Participants also stress the need for more government funding for existing services.

> "I think it's cause of funding. A lot of it. You know? The government won't fund them much, you know. And it's ridiculous because without this place here, like I said earlier in the interview, a lot of people would be dead because of it." (Participant 10C)

Participants note that funding can reduce waitlists and increase the capacity of current services so that clients can be supported when they need it rather than waiting.

> I: So what do you think would make accessing treatment services easier?
>
> P: More beds… I mean they just – they just announced six beds in Swift Current. And I – it – to me – you might as well not even invoke… an insult. It's an insult to the opioid epidemic. I mean, a friend of mine who passed away recently due to an overdose was four and a half months [waiting] for [centre]. Four and a half months. (Participant 7B)

Other participants feel that provincial funding is not allocated in the correct way.

> "Yeah I guess I feel like there is not the funds from my understanding or not going where they are needed. I remember the Saskatchewan government or Saskatoon didn't give money to [centre] but they run campaigns or something about drug use or substance use.

> So it just doesn't make sense to me because they couldn't give to something that actually would have made a difference, but instead they made posters." (Participant 10A)

Furthermore, participants note that due to funding restraints, staff at substance use services are often not supported as much as the participants felt they should be, especially given the emotional toll these positions can cause.

> "Well, the first thing is I would pay the people who are actually doing the job a livable wage, where it removes one stress. You know? I, speaking from personal experience, like I'm literally one paycheque away from being homeless and on the streets again and possibly relapsing, right? I would pay my staff, I would pay the people who are doing this a livable, like a livable wage for the economy we're living in so that they don't have to at the end of the day worry about 'okay well you know what like, I've got to make sure I have food, that my rents paid.' You know what I mean? In like, make sure that I have enough money for daycare like I would just take care of the people that I have being the service providers. Because this job already is so hard. It is so emotionally draining." (Participant 5A)

The participants also voice a concern for lack of government oversight for programs that are currently running. They express a desire for a standard or other means to keep current services accountable.

> "And there – there should be like anything – should be a minimum standard that these [treatment centres] have to meet as far as having trained people that actually can diagnose mental problems and stuff like that cause there's a lot of mental problems. I mean – I don't want to say – I'm obviously not fucking normal because I wouldn't be in there if I was. But there was – the whole – bipolar schizophrenia – it's like – I saw a whole lot of people in bad, bad shape." (Participant 1B)

Support For Indigenous Populations

Participants note that Saskatchewan must recognize the Indigenous population who may be using substances. Understanding the history and continued challenges of Indigenous people in Saskatchewan is an important aspect to addressing substance use in the province.

> "You can talk to probably anybody in the inner-city community and they'd be like 'well yeah it's colonialism, it's leftovers of residential school.' We KNOW why they're falling in. Are we ready to address that? No…. It's not taking accountability. It's not saying so like if you are a residential school survivor or a descendent of a residential school survivor – here's all of these things you can come access to try to help you through this. That is not something that is offered." (Participant 11B)

Participants also advocate for more equity-based policies to address the gaps experienced by Indigenous peoples.

> "Everybody's like 'we're all equal, we're all created equal', no we're not. We're not all equal, in a utopia we are supposed to be all created equal and we're not and it would be to understand that we're not all created equal, and we don't want equality we want equity. You know? We want - we do want policy changes that provides that equity. That equity of

> care you know, that, those services, those equity services that meet us where we're at and help us so we can function." (Participant 5A)

Given that some PWLLEs in Saskatchewan are Indigenous, participants recognize that Indigenous-based interventions should be made more readily available across Saskatchewan and be supported through funding.

> "Absolutely, and that kind of leads me into, why are these only available in Saskatoon and Regina? What about up North?... What about North Battleford, PA, up at the reserves like Buffalo Narrows and stuff like that, like everyone's entitled to sound mental health and addictions services. But everyone has to come to Saskatoon?" (Participant 1A)

More Support for Mental Health Resources

Participants stress the common connection between substance use and mental health. Many participants note situations where they were unable to access support while experiencing a significant mental health concern.

> "There isn't like, they're always busy and it's hour and hours and it's not – if you came in there with a, having a heart attack it's not treated with the same attention that it is when you come in with a mental health issue…. And I don't think that's acceptable by any means…. Mental health issues are 100% just as important as any other health issue… Like how – is it any less of a health issue if you want to jump off of Broadway bridge and kill yourself, than if you have a heart attack. That is 100% a valid issue, you know?" (Participant 1A)

Many participants discuss the lack of accessible mental health professionals. Accessibility is a concern because of price and waiting times. Participants feel there is a need in Saskatoon to have more resources for mental health support which, in turn, can address some substance use concerns.

> "More access to people that will help you deal with your shit that makes you a fuckup in the first place. Or whatever not a fuckup but you know what I mean right?... But yeah, access to therapy and affordable and like really, yeah. Deadly therapists…. yeah there's different preferences. So just more access." (Participant 13B)

Raising Awareness of Substance Use

Participants were asked how they felt substance use knowledge should be shared and what was missing from current substance use programming. Many participants note a need for greater awareness among the general populations along with targeted educational campaigns.

> "There's so much of a need for awareness, campaigns, and stuff like that. It kind of goes back to what we were talking about earlier just the whole policymakers and politicians – just seeing – on a bus – driving by – something saying – this year – 5000 people died from opioid use." (Participant 7A)

More specifically, many participants stress the need for education and programing for youth.

> "I would say more knowledge for the kids as they're growing up, because there's so many kids out there that don't know about addiction or you know – Al Anon? Or what it can do to families. Because some families just hide it away. They don't talk about it. I was – I was very in that aspect. My dad was a recovering addict too so it was really fresh in the household. He worked at the detox centre. Services available – so I'm very fortunate in that account. But there's a lot of people out there who just don't know – and could start in the classroom when kids are young. Not when they're teenagers already in active addiction and don't give a shit anymore. Like, actual – um – classes for the kids." (Participant 2B)

Meet Basic Needs

Participants communicate how environmental factors and basic needs must be addressed by policy makers. One participant summarizes this concept in this way: "They're set up to fix the flower, in reality when a flower doesn't grow, we don't fix the flower, we fix the environment that's grown in it" (Participant 5A). Other participants note basic needs that are not being addressed in their communities and therefore, substance use becomes a less important factor to address until the basic needs are met.

> "What can you do? You can't incarcerate them and put them into a program to bring them back to reality and you can't leave them out there wandering the streets and that freezing to death or just being a danger to themselves and everybody around them. So, I don't know what the solution would be and that eh? Like we don't want to see people going hungry and that. That's one thing we could do for the harm reduction, we try and feed them, clothing and that for the weather conditions, places to stay whatever it's like, bus tickets or whatever for their trips to go to see the doctors. And whoever, if they're asking we've gotta be there to help them. That's about all I can think of." (Participant 13C)

In particular, participants stress the need for secure and affordable housing as a pathway to wellness.

> "Yes – Yeah I just wanted to say – the homeowner part was actually an interesting contribution to me being able to continue my addiction. Bought my house like 13 years ago. I bought my condo for $72,5 – my mortgage is like $400/month. And only having to pay $400 a month enabled me to be in my addiction and not die. Cause I never ended up homeless. Because it only cost my $400 a month to live where I live. And the only reason I got a mortgage is because I come from a privileged family and they could co-sign. So, if you could give somebody – and then I always had a place to live and I made sure that that is how I did not die – and then I was able to get to recovery. So, giving someone somewhere affordable to live – that's a lived experience that I had. It's huge." (Participant 11B)

> "I'm not homeless. And I have zero problem with a bit of my tax money going toward that. So that people are sleeping inside – I'm totally good - because I'm not doing good if the people around me aren't doing good. And it solves a few problems – I was telling somebody – the only difference – and its just where I call myself with - it helps me sort of reason – the only difference between me and the junkie behind the dumpster behind the apartment is that I have an apartment to do it in. There's really no difference between us. It's poverty that sets us apart. And then it makes certain people look worse than. And the Indigenous community gets shit on. Make no mistake. I am doing the same things. I'm just privileged." (Participant 3A)

Participants also note that a lack of housing can lead to other significant barriers to accessing services, therefore there is a need to addressing housing and the requirements for accessing services.

> P: There should be no barriers. You don't have a healthcare number? Fine. We'll figure it out. You don't have a social insurance number? Fine. We'll figure it out…. and it's really hard to get an ID when you don't have a home or have mailing address or a phone number or an anything. Part of it is just being like there's a person standing in front of me and I don't care if they're documented on paper anywhere, this PERSON needs HELP. So, we will get them help. But, in order for billing and all of these things, they have to have a number assigned to them that follows them around. (Participant 11B)

Knowledge Translation and Exchange

To address our last research question, participants were asked how they would like researchers to present information gathered in the study. Responses ranged from specific activities that the participants wanted researchers to undertake to more general concepts.

Across cohorts, social media and technology are promising methods to disseminate information. Others identified print media as an effective method.

> "I don't know. I think like YouTube Videos and like things like that online are getting – people just access stuff online a lot more. But some conferences are good too. And going to do talks with schools and stuff." (Participant 3B)

> "People pay attention to pamphlets, I would suggest it be colourful and every letter in a different colour and every fuckin colour in a different out border liner through a different colour felt … or the colour rising and then it all be ultraviolet light, the light working."(Participant 1C)

Many participants identify the need for an in-person gathering as being beneficial for the community and a way to effectively share results.

> "I'm thinking also that [trying to get] teenagers to have sharing circles if they want to share their [stories] because maybe someone else's story will change them, prevent them from using when they're an adult, you know what I mean? 'Cause I know it starts at a young age."(Participant 14C)

> "Maybe you can have like a dinner? And then have some presenters come and present stuff, like maybe have a showing, like not story-telling not shit like that, I don't know. Like people come and talk, I don't know, presenters. And just have a supper and you know snacks and stuff and giveaways and shit like that, people come to that. That's where people like to come." (Participant 18C)

Some participants share more generally how they'd like the information to be conveyed, with no specifics on activities.

> "Well, I understand it's going to be anonymous sort of thing, you know? So, I don't see why it would hurt to you know…just as share it as completely as you can, you're gonna kinda unify it all, blend it together, try and come up with something, I guess. [KA] explained a bit to me about what your plan was, so we kinda have an idea but I think that's pretty good what you're doing, actually." (Participant 3C)

Others identify a general audience for knowledge translation.

> "Yeah, because I think a lot of pressure's already on the people who use substances to try to figure out all of these things. And I think for the most part, people who are making these policies just don't, they don't understand. And I think the more we stigmatize it by, by putting messages out that it's homeless people in the back alley's doing this stuff. The more people can say, "oh that's not going to happen to me" (Participant 6A)

Some participants do not identify how they wanted the findings to be disseminated, indicating they are not experts in knowledge translation or that they trust researchers to know best.

> I: How would you like us to present the information that we gather in this study?
> P: Just doesn't matter to me (Participant 7C)

A table quantifying the ideas (Appendix D: Knowledge Translation Table) is provided so readers can discern the desirability and top choices of participants. The top three ideas are youth education, an audiovisual knowledge translation product, and an awareness campaign on the lived experiences of substance use.

Project Limitations and Opportunities

Writing project limitations and opportunities in the same section reflects the process of continued change that was typical during the P5 Project YXE. Upon encountering a limitation or barrier to research, the situation prompted an opportunity for learning and adaptation from the team. These are described as institutional, additional research support requests, and team capacity and funding limits. As a result, separating the limitations and opportunities did not make sense for this report.

Institutional

This project began in March 2020 and was significantly impacted by the COVID-19 pandemic due to public health orders to mitigate the spread of the virus. Modifications to the original project design were necessary to ensure researcher and participant safety, while recognizing the increased demand placed on community organization partners during this time. The impact of the pandemic was three-fold for the project: 1) institutional guidance and guidelines for appropriate research conduct were not released by the University of Saskatchewan until May 2020; 2) the Research Ethics Board was also delayed due to integration of new guidelines and processes (i.e., appropriate data management with remote technologies) in addition to the project requiring a full board review; and 3) data collection was implemented through technological methods rather than the preferred in-person conversation. Due to the lack of in-person community engagement and ability to meet face-to-face, the team believes that the level of desired rapport was not reached, and this led to a lower participation rate overall. The team found this process made it more difficult to reach PWLLE, build trust, and form relationships in the community.

Requests for research support

In June 2021, the Saskatoon Board of Police Commissioners (SBPC) and Saskatoon Police Services (SPS) requested guidance from the P5 Project YXE team regarding the possible impacts of decriminalizing the personal possession of substances in the City of Saskatoon. This request was met with the provision of a rapid evidence review submitted for SBPC review in June 2021. The P5 Project YXE team was noted to be the only 'team on the ground' exploring substance use policy change locally. This initiative grew into the provision of a full report and semi-independent project led by P5 Project YXE co-PI Dr. Lori Hanson. A final report examining the impacts of decriminalization of personal possession of substances in Saskatoon has been provided for review at the April 21, 2022, Saskatoon Board of Police Commissioners meeting. This form of research support for municipal-level decisionmakers will be continued by team members since as it fosters a broader understanding for leadership and will assist the P5 Project YXE aims of promoting and informing evidence-based policy change. This municipal support also resulted in enhanced relationships with the City of Saskatoon Mayor's office and invitation to the Mayors Caucus Mental Health and Addictions working group of the Saskatchewan Urban Municipalities Association (SUMA). This collaboration will support municipal-level service change and knowledge of substance use approaches with leadership across the province. However, due to these unexpected requests for research support, our team experienced an unanticipated increase in workload with tight timelines. Ultimately this was an excellent opportunity for our team and suggests that enhanced collaboration is possible in the future.

Team Capacity & Funding Limits

Many aspects of the project were influenced by pandemic complications, but this also presented positive future opportunities. All graduate and undergraduate research assistants have expressed interest in remaining involved in this project and future initiatives. This enthusiasm highlights the investment of project staff and advisors for achieving project objectives. In November 2021, James Dixon stepped back as project manager to focus on his doctoral work and Graduate Research Assistant Maggie Coupland stepped into his role. This transition, while beneficial to the project aim of developing research capacity and infrastructure, did result in some delays for the proposed project timeline. Overall, the cumulative project modifications meant an increased focus on content coding and production of this technical report to share outcomes, with the opportunity for thematic analysis to support publication or key community questions that remain. Additional analysis can expand upon the work presented in this report to include a thematic analysis of pathways data to promote a fuller understanding of service navigation trends. Shorter-term secondary analysis could engage three aspects: methadone/suboxone engagement, gender-based analysis of service engagement and trends, and an analysis of the impacts of the Saskatchewan Income Support (SIS) program on housing and substance use service access.

Next Steps

The full P5 Project YXE team will discuss the findings set out in this report and consider preferred routes to sharing and mobilizing the information. A full team meeting is planned to discuss these findings and next steps for sharing the outcomes. If you have any feedback about the project, this report, or next steps in the project please contact the team at your convenience. We value and welcome your ideas, wisdom, and experience.

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Appendix A: Interview Guide

Interview Guide

Perspectives, pathways and priorities of people with lived and living experience of substance use: Informing policies

Interview script:

Thank you so much for meeting with me today. As you know from [NAME KNOWLEDGE AMBASSADOR] and our review of the consent form, we're seeking your perspective on the practices, programs, and policies around substance use in Saskatoon. We're particularly interested in your opinion of harm reduction, treatment and recovery services.

Overall, I am interested in hearing your thoughts and experiences navigating harm reduction, treatment and recovery services in Saskatoon. While we have a few guiding questions for this study, if you want to include additional information or if you think we've missed something, please feel free to include that too!

I'll start by asking a few questions to get us started and we will get as far as we can in the 60 minutes. If you would like to skip a question, take a break, or end the interview at any time please just let me know. I have turned on the audio recorder, and you may ask to have it shut off at any time. You are welcome to say as much, or as little, as you like about any particular question as you like. Your $50 honorarium and free naloxone kit for participation in the study will be provided to you now, so there is no pressure or obligation to continue. Do you have any questions or concerns before we get started?

Now we can get into the more formal study questions and please feel free to say 'that doesn't make sense' or 'what does that mean' if anything is not clear.

Project questions:

1. ***Perspectives:*** We would like to know your thoughts and ideas about harm reduction, treatment, and recovery services in Saskatchewan.

- What does the term 'harm reduction' mean to you? Or, what do the words 'harm reduction' mean to you?
- What does the term 'treatment' mean to you? Or, what does the word 'treatment' mean to you?
- What does the term 'recovery' mean to you? Or, what does the word 'recovery' mean to you?

2. ***Pathways:*** We would like to know about your access to harm reduction and treatment and/or recovery services in Saskatchewan.

- Have you tried to get into or use harm reduction, treatment, or recovery services in Saskatoon or Saskatchewan?
    - IF YES,
        - Which of the following services did you try to get into or use: harm reduction, treatment, or recovery services?
        - Which of the following services did you actually get into or use: harm reduction, treatment, or recovery services?
        - Of the services you actually did use selected above, did they align with your ideas/thoughts of the service as you described in the previous question? (Ie: Was the service you used what you expected it to be? Was it different than you expected? Can you give an example of how it was the same or different?)
        - Did you find the services useful or helpful? How could they be more useful or helpful?
        - Which agencies did you actually use or get into? Would you recommend this place to a friend or family member? Why?

- Of the services you tried but were unable to get into or use, what were the challenges preventing you from getting into or using these services?
    - IF NO,
- Since you have not used harm reduction, treatment or recovery services in Saskatoon or Saskatchewan – What stopped you from using these services? Would you like to use these kinds of services? Why/Why not?

3. ***Priorities:*** We would like to know what you think is most important for programs, practices, and policies about substance use in Saskatoon and Saskatchewan.

- What is the most important thing for people to know about when providing harm reduction, treatment or recovery services?
- What do you think would makes accessing harm reduction, treatment, or recovery services easier? What makes it harder?
- Do you think prescriptions to supply substances would assist you or others? Why/Why not?
- Is there anything you think is missing from the services available right now (might not even be about substances)?
    - Like a puzzle piece that could make the picture more complete if added? Or maybe something should be taken away?
- In a perfect world what would harm reduction, treatment or recovery service look like for you?

I'm going to ask you for some demographic information – this helps us understand where folks are at in this discussion and how things like income level might be connected to wanting more employment opportunities. Sound good?

4. **Demographic information:**

Name/pseudonym:
Age:
Gender:
Ethnicity:
Sexual orientation:
Dis/ability:
All education certifications received:
Current housing:
Currently employed (Y/N):
If currently employed, what is your employment type/job/role:
If currently unemployed, for how long:
If currently unemployed, what was your last employment type/job/role:
Main source of income:
Average monthly income:
City within which you currently live (city/RM):
City within which you currently work (city/RM):
Typically see a doctor, nurse practitioner or other health care professional at [Family doctor, clinic, service org, ED]:
Preferred substance of use (primary):
    Typical amount of substance used per week:
Other substances of use (less frequent and/or less amount and/or availability):
    Typical amount of other substances used per week:
At approximately what age when you started using substances?

Thank you for providing that information.

5. **Knowledge translation questions:**

- How would you like to see the information from this project used?
    i. Do you think it could be useful for other people who use substances?
    ii. Do you think it could be useful for people who do not use substances?
- How do you think we should share our research results so that it can reach more people, and not just people in the field of substance use?
    i. Would something like a play, video, song, escape room, or walking tour make sense to you?
- Do you have interest in attending a follow-up discussion where we share results and provide opportunities for feedback on whether the findings make sense? Options will be available so you can participate without revealing personal information or your identity to protect your confidentiality.
    i. If yes, how would you prefer to be notified about the discussion forum? Email or telephone?
- How would you prefer to receive information about the study results? Email, poster at organization, website?) Or any other suggestions for best ways to get feedback?

Do you want this interview to be used in our study?

Appendix B: Recruitment Material

Facebook Advertisement:

Appendix C: Participant Demography

Appended the demographics of participants. We are sharing ethnicity as identified by participants for service providers to understand the PWLLE backgrounds and associated experience of individuals seeking service to ensure appropriate resources and supports are in place. For example, enhanced training around intergenerational trauma and reducing the harms of colonization should be considered when Indigenous ancestry is identified. Our primary categories are Indigenous, Indigenous and non-indigenous heritage, and non-Indigenous. Only one participant identified a non-European ancestry under the non-Indigenous category.

From our research, we have a narrow range of ethnicities accessing services in Saskatoon. This signals a potential opportunity to collaborate with the Saskatoon Open Door Society and Global Gathering Place to encourage newcomers to access services. There may be barriers to newcomers in speaking to researchers about health services. There are other cultural barriers that exist depending on the country of origin. Aligning services is an opportunity in Saskatoon for community-based organizations.

Participant Age Demography				
	Total	**Cohort A**	**Cohort B**	**Cohort C**
15-24	3	2	0	1
25-34	7	2	2	3
35-44	16	4	8	4
45-54	4	0	2	2
55-64	6	0	1	5
Did not respond	5	2	0	3

Participant Ethnicity Demography				
	Total	**Cohort A**	**Cohort B**	**Cohort C**
Indigenous	13	3	1	9
Indigenous and Non-Indigenous Heritage	1	0	0	1
Non-Indigenous	23	6	12	5
Did not respond	4	1	0	3

Participant Gender Demography				
	Total	**Cohort A**	**Cohort B**	**Cohort C**
Female	19	6	5	8
Male	16	2	8	6
Non-Binary	1	0	0	1
Did not respond	5	2	0	3

Appendix D: Knowledge Translation Table

Knowledge Translation Method	# Participant Requests
Youth Education (Elementary/High School)	10
Video/Movies	10
Awareness & Education Campaign (Commercial/Advertisement)	10
Social Media/Internet	9
Education/Training for Health Professionalsincluding Indigenous History	9
Presentation (School, Treatment Centre, Workplace, Government, Public, Policymakers)	9
Storytelling	5
No preference	5
Pamphlet/Brochure	4
Conference/Live Interview/Guest Speaker/Interactive Webinar with Community Engagement	4
Walking tour to roadmap/navigate around Saskatoon/province in small groups	3
Poster	3
Billboard/Lit up signs when enter the city	2
Song	2
Interactive Escape Room	2
Posting information on Usask Campus	2
Dinner with snacks and giveaways	1
Testimonials or quotes from people's stories with a photo	1
Comic Book	1
Play	1
Families Support Class for Addictions 101 Training	1
Free Naloxone/CPR Training Sessions	1
Education campaign on a bus	1
Infographics at PHR or at music festivals	1
Service directory of where to go, who to call	1
Advocacy for more Treatment Centres	1
Educational Retreat	1