COM-CAP
Community Opioid / Overdose Capacity Building

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RAPID REVIEW

Substance Use Services with, and for, Indigenous Communities

September 2023

Note: This review includes '**invitation to reflect**' prompts throughout the document, where we pass on some of the guidance, teachings, and wisdom that Knowledge Keepers and partners had generously shared with us during the development of this resource. The first reflection is below, and came up during our early discussions with Knowledge Keepers on how to promote learning and listening in this process.

> **[Invitation to reflect]** "There is learning, commitment, and un-learning. This is an invitation to invest in making changes, spend time in contemplation, and reflect critically on our own systems to have a lasting change. Use privilege to invite the whole body- spiritual, mental, physical, and emotional, into this work and give back to partners who are fully invested in this work." (In a 2022 correspondence with an Indigenous Primary Health Care Council (IPHCC) Knowledge Keeper).

Key Findings

- The majority of the search results on substance use services with Indigenous communities focused on general recommendations and/or research findings on barriers, needs, and facilitators. I.e. the literature on implemented and/or evaluated programs is limited, and points to a significant gap in the documented literature on what programs and services with, and for, Indigenous communities can look like in practice.

- Approaching services from an anti-colonial and Indigenized lens means drawing on multi-faceted ways and practices that emphasize wholistic health (emotional, mental, physical, spiritual) and approach Indigenous identity and culture as sources of strength and medicine.

- Common threads across reviewed services and programs included: centring Indigenous knowledge and practice, encouraging learning and sharing, providing opportunities for participation within Indigenous ceremonies, leading skills-building/strengthening around Indigenous culture, and leveraging the power of physical traditional Indigenous spaces for healing such as within a longhouse or on sacred sites.

- The reports and conversations repeatedly highlighted the diversity of Indigenous communities and the importance of rejecting a standard pan-Indigenous approach to substance use services (or any other health domains). Instead, working with Indigenous communities must be rooted in building relationships and taking the lead from partner communities on what meaningful services look like.

Acknowledgements

As the Public Health Ontario team who worked on writing the first draft of this review, we acknowledge our position as settlers. We currently work and live on the traditional territory of many nations including the Mississaugas of the Credit, the Anishnabeg, the Chippewa, the Haudenosaunee and the Wendat peoples, the first and rightful inhabitants of Tkarón:to (Toronto). We acknowledge our responsibility individually and as a group to root our working principles in reconciliation and de-colonization. In practice, we have worked on building relationships with diverse Indigenous partners, taking their lead in discussions and decisions, investing in our team members' education on/along the cultural care continuum, and embedding transparency in all our processes and approaches. We also recognize that Indigenous communities are "over-worked and under-resourced",[1] highlighting the importance of working together in ways that are mutually beneficial, responsive, and minimize burdening partners.

We recognize that we are not experts in the lived reality of people who use drugs, particularly those in Indigenous communities who continue to practice resistance and reclamation from the ongoing and historical legacies of colonialism. We also appreciate the labour, wisdom and teachings of community members whose work we have learned from, and who have generously shared their time and knowledge to guide this work.

Term "Indigenous"

The use of the term "Indigenous" aligns with the analysis put forward by Allan and Smylie (2015) in their discussion paper on the impacts of colonialism and racism on the well-being of Indigenous peoples in Canada.[2] It is used to describe persons and communities who identify with, and/or have historical continuity with "First Peoples" whose civilizations span (what is now known as) Canada and the United States and predate those of colonizing populations. It's widely acknowledged that Indigenous communities have distinct social, economic, and political systems, as well as distinct languages, culture and beliefs.[3] They also continue to exercise strong connection with the regions, lands and surrounding natural resources, and live with determination to pass on culture, practices, and teachings to future generations.[4]

While the term is rooted in those complex underlying dimensions, we acknowledge that it masks the diversity within and between communities including First Nations, Métis, and Inuit. Also, the term "Indigenous" does not align with how many community members self-identify, where multi-layered identities can include (but not limited to) nation, territory, family, band, and/or clan.[5] It is important to note that our use of this term is distinct from self-determination and self-identification, and we recognize its roots and necessity due to ongoing colonization.

Finally, "Indigenous" is also commonly used in a Canadian context, but the literature we reviewed uses a wide variety of terms. They include Aboriginal, American Indian/Alaska Native, Native, and at times use greater specificity such as a clan name. For the sake of accuracy and completeness, this review will use the authors' original terms when discussing their specific work.

Scope

This Rapid Review addresses the following question: What are the characteristics and approaches of substance use treatment and harm reduction services that have been (co)designed and (co)implemented with Indigenous communities?

- This review aims to share research with rather than on Indigenous peoples. Therefore, all included records explicitly clarify and explain the role of Indigenous partners; i.e. whether the

work is Indigenous-led, a collaboration initiated by an Indigenous partner, or a collaboration initiated by a non-Indigenous partner. Records that do not demonstrate an Indigenous partnership are excluded from the review.

- Research included both documented knowledge (articles, reports, and other relevant writings) as well as wisdom and teachings shared orally in conversations and consultations with Indigenous Knowledge Keepers and partners.

- The purpose of this review is to summarize knowledge and practice on centring Indigenous communities' experiences in the design and delivery of harm reduction and treatment services.

    - 'Harm reduction' refers to meeting people where they are at in their substance use, particularly those who are not seeking abstinence. This is done through services, education, and programming. Both research and lived experience illustrate that harm reduction saves lives and improves the quality of life for people who use substances.[6]

    - 'Treatment' refers to a range of approaches commonly focused on medical and psychosocial services and programs for people who use drugs. Some may include harm reduction, some may have a focus on abstinence, or a combination of both.[7]

- Papers in this review were published in English, between 2011-2021, and limited to services in Canada and the US. The choice of time period and location were intended to increase relevance and meaning to a local Ontario context.

- Documents were excluded if:

    - Programs/services were not implemented (i.e., proposed services, theoretical frameworks, editorials, commentaries were excluded).

    - Focus on substances was limited to alcohol, tobacco, or cannabis.

    - Substance use services did not include treatment or harm reduction (e.g. prevention).

Background

Indigenous communities' have been leading innovative and impactful substance use services and practices that centre traditional Indigenous knowledge in health and promote self-determination, governance, language, medicine, and wellness.[8,9] While often described as 'innovative' within mainstream discussions, these ways have been developed and practiced since time immemorial and continue to be central to communities' work on healing and addressing the legacy of colonialism.[6,9] The work of Indigenous communities on prioritizing Indigenous knowledge and ways, including culturally appropriate and safe care models, has become an important feature of the medical landscape.[8,10,11]

The stories, data, and writing on structural and systemic inequities are extensive and robust, and include a number of dimensions:

- Access (i.e. timely and appropriate care): Indigenous people who use drugs are less likely to receive potentially life-saving treatment (including opioid agonist treatment),[12] and report barriers and delays in accessing services.[13]

- Experiences (i.e. experiences in health and health care settings): Indigenous community members experience persistent discrimination and harm while receiving services or supports,[14] and express frustration and continued exclusion of Indigenous ways of knowing.[15]

- Outcomes (i.e. wellness and quality of life): Data from 2016 Canadian census indicates that although Indigenous people represent approximately 4.9% of the population,[16] they are overrepresented in substance use-related mortality (19%).[13] They also carry disproportionate burdens of harms related to substance use including criminalization and violence within the criminal justice system.[17] [Current statistics grossly underestimate the number of Indigenous peoples living within Canada, particularly in urban environments].[18]

Substance use and related harms are closely connected to the historical, ongoing and intergenerational trauma (IGT) resulting from colonialism and its structures, including dislocation and disconnection from communities and lived environments.[19,20] IGT, which refers to the cumulative mental, emotional, and psychological harms experienced in one's own life and through subsequent generations, is particularly significant for Indigenous experiences within the context of over 400 years of colonialism.[21] Furthermore, research has found that recognizing the impacts of IGT and integrating Indigenous healing can enhance the health and well-being of people who use substances.[21] The structural nature of colonialism, colonial policies, and racism also mean that action on IGT and substance use requires parallel action on structural and system change.[22]

In the context of service design, it is important to reflect on how mainstream science, research, and evidence production have contributed to historical and ongoing harms for Indigenous communities. This includes medical colonialism and violence, experimentation in residential schools,[23] exclusion from life-saving medical trials for people who use drugs,[24] Indian hospitals, under-resourcing,[25] and an over-reliance on a colonial medical system. Furthermore, Indigenous knowledge and wisdom, as well as Indigenous approaches to knowledge sharing (such as oral traditions) have been made unequal to other ways of knowing and historically approaches to knowledge gathering are excluded and de-valued.[26,27]

[Invitation to reflect] In our conversations, a Knowledge Keeper with IPHCC advised us to pause:

> "Please pause here and think about the lives behind these experiences and the ongoing impacts on Indigenous communities".

This was impactful for the authors, so we are extending the invitation to the readers to pause here too and reflect on their guidance.

Solutions reside with Indigenous communities themselves, which means that this work should be grounded in, and guided by Indigenous ways of knowing and wisdom.[28,29] The Calls to Action of the Truth and Reconciliation Commission directly speak to this point, "We call upon those who can effect change within the Canadian health care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients".[30]

Seeking strength from culture, cultural safety, and trauma-informed practice are prominent in discussions with Indigenous communities on substance use services.[15,19,20,22] The benefits of integrating Indigenous ways of knowing, knowledge and community perspectives in substance use services have also shown benefits across a wide range of wellness dimensions.[10] These approaches are rooted in strengths-based models, where reviews of Indigenous healing strategies reveal a respectful, persistent and passionate focus on the resilience and resurgence of Indigenous peoples.[31]

Indigenous people who use drugs refer to the importance of wellness, and view it as distinct from mainstream models of health with their focus on being "cured".[19,32] Mainstream models, which tend to be rooted in European or Western knowledge, have historically excluded Indigenous world views on wholistic health and Indigenous systems of wisdom and knowledge on health (such as the Medicine Wheel). Indigenous experiences and stories with substance use services point to practices that provide

very little room for the integration of the whole body, i.e. all of the bodies- mental, spiritual, physical, emotional- and reduce health to the physical body. [33] They also make very little room for the connection, community, and inter-generational relationships that are deeply valued within Indigenous communities.

To summarize, the integration of an Indigenous lens in services and programs means drawing from a wide range of teachings that speak to the central role of wholistic health in all care. That can include:

- Traditional Indigenous practices aim to promote wholistic approaches to health and the importance of balancing spiritual, physical, mental, and emotional aspects of the self.[8,34]
- Multiple explorations of Indigenous worldviews and knowledge describe health as an inter-connection between physical, emotional, mental, and spiritual dimensions of health.[11,18]
- Shifting to wholistic health goals means shifting the way we assess outcomes and experiences. It is also part of de-colonizing the ways we think about impacts of supports or services.[11,26]

Adopting a reflective and critical lens in this work is essential for collaboration and making a meaningful contribution to de-colonizing health. This lens can include re-thinking common approaches to knowledge translation,[35] re-visiting how we prioritize or value knowledge, recognizing the importance of relationship building, and following the lead of Indigenous communities.[36]

About the use of 'Rapid Review'

We acknowledge that the use of a 'Rapid Review' reflects an institutional voice and a mainstream tool of knowledge sharing, and we aim to continuously un-learn and re-learn how our knowledge sharing tools can be approached through an anti-colonial and Indigenized lens. Indigenous knowledge also has distinct dissemination methods that include performance and storytelling, and viewed as not belonging to one person or organization, but used freely to the benefit of all who need it.[37]

In an effort to de-colonize and Indigenize this work, we have integrated a number of practices that include using knowledge produced only through leadership and engagement of Indigenous communities, but also expanding this review to integrate the wisdom and teachings shared orally in conversations and consultations with Indigenous Knowledge Keepers and partners.

[Invitation to reflect] During our conversations on how to critically reflect on this review's approach, **Knowledge Keeper Amy Montour** further shared:

> "Rapid/systemic reviews are mainly a Western concept. Indigenous knowledge is ancient, orally driven and cumulative over time, not subject to the rigidity of knowledge generation in the academic sense".[27]

Knowledge Keeper Amy Montour is a physician from the Six Nations of the Grand River Territory and her roles include clinical service, administration and education with a focus on honouring *Indigenous ways of knowing* to improve health care services.

Methods

Search strategy

- A rapid review was chosen as a method that facilitates responsiveness and feasibility, and aligned with the scope of our question. Rapid reviews are a type of knowledge synthesis whereby certain steps of the systematic review process are simplified in order to be timely.[38]

- Research librarians at Public Health Ontario (PHO) supported the development of specific search terms as well as search strategies for both academic and grey literature based on the review's scope and goals. The search strategies and detailed search terms, are available upon request.
- On December 12, 2021, PHO conducted an academic literature search in five databases: MEDLINE, CINAHL, PsycINFO, SocINDEX, and Scopus.
    - Academic literature includes peer-reviewed content with scientific audience in mind.[37]
- On May 31, 2022, PHO conducted grey literature searches in WorldCat (theses repositories), Google (general web search), and two custom search engines: Ontario's Public Health Units and Canadian Health Departments and Agencies. Based on recommendations by Library Services, the first 50 results were reviewed per search (relevancy drops after the first few pages).
- Grey literature covers content produced from governments, academics, and community organizations. It includes reports, magazines, websites, and policy documents. It is an important element in knowledge syntheses and critical for filling knowledge gaps.[37]
- Due to time constraints, an in-depth review of the methodology of the included records was not performed.

Screening strategy

- The record selection process was completed by multiple reviewers:
    - The initial list of search results was separated into three sections, each screened by one reviewer based on inclusion/exclusion criteria. This was followed up by a meeting to answer questions and discuss 'undecided' categorizations.
    - Articles short-listed for inclusion were independently screened by two reviewers, who also conducted full-text screening.
    - A third reviewer conducted an additional full-text review of all short-listed articles and made final inclusion decisions when the two reviewers' decisions didn't match.
- Data from included records was charted to include record characteristics (e.g., year of publication, study design, geographic location, and community focus), aims, equity considerations, and impacts.
- Thematic analysis was applied to identify common themes in the data. Based on this approach, the records were reviewed for details on the services and programs, as well as service characteristics and design approaches.

Collaboration with Indigenous partners

The PHO team collaborated with Indigenous partners through the multiple stages of this review's development. In addition to their experiential knowledge, their expertise included public health, community-based services, education on cultural care continuum, mental health, harm reduction, and living expertise of substance use. We were also guided by the knowledge and teachings of three Knowledge Keepers. Figure 1 outlines the collaboration journey.

Figure 1. Process for collaborating with Indigenous partners on this Rapid Review

- Knowledge, wisdom, and teachings, shared both orally and in written form were documented for the purpose of integrating this knowledge into the review. Conversations took place between August 29, 2022 and October 26, 2022, including a webinar in October on un-learning mainstream approaches to working with Indigenous communities[39]

- The PHO team also recognized the need to revisit existing research and review processes to ensure safe and respectful ways of collaboration and information sharing. We consequently worked to update a number of practices. For example, we (co)developed a PHO reference style for citing Knowledge Keepers, embedded reflection points to encourage readers to pause, and shared Knowledge Keeper wisdom verbatim only (i.e. we didn't attempt to summarize or paraphrase, as is common in general knowledge syntheses)

Results

Findings and learnings are presented below in two sections: 1. '**Learnings from Documentation**', which covers documented knowledge and integrates guidance and feedback from Knowledge Keepers and community partners; 2. '**Knowledge and Teachings Shared Orally'**, which covers knowledge, teachings, and wisdom shared orally and in presentations from Indigenous partners.

Section One: Learnings from Documentation

A total of nine records met the inclusion criteria for the review. The academic literature database search produced 228 records and the grey literature search led to 286 results. Following abstract and full-text screening of both lists, eight articles were included from the academic search[25,26,34,40,41,42,43,44] and one from the grey literature (which included descriptions of three separate services/programs).[45]

- Three records discuss multiple services or programs. In the case of papers by Hirchack et al[41] and Tipps et al,[44] the services were connected and similar so are grouped together. The policy brief paper[45] highlighted three very distinct services and programs and are discussed separately when additional details benefit the discussion. See Appendix A for details of included documents.

- The most common reasons for excluding articles and papers were: 1. No evidence of implementation or action (i.e. limited to proposals, discussion on barriers and needs, and/or analysis of theoretical models); 2. No demonstration of explicit adaptation or design by/for Indigenous communities.

- The records varied widely in terms of location (within Canada and US), community of focus, community participants, and type of study design. Details are summarized in Appendix A.

- In the final list of included records, three pointed to leadership by an Indigenous government or organization,[25,34,44,45] three were collaborations initiated by an Indigenous partner,[26,40,43] and one collaboration initiated by a non-Indigenous partner.[42] One remaining article outlined a program through the 'Indian Health Service' pharmacists in the US.[41] Table 1 illustrates partner roles.

Table 1. Examples of Indigenous leadership/collaboration roles

Role	Example
Indigenous-led	Pikuni Blackfeet Indians of Montana, in collaboration with community Knowledge Keepers and community leaders, led the development and implementation of a 'culture as treatment' program (designed around Blackfeet ceremonies, skills building, and practices).[25]
Collaboration initiated through an Indigenous partner	Coast Salish First Nations in British Columbia invited a university research team to hold ayahuasca-assisted therapy, co-led implementation, integrated cultural elements (e.g. prepared longhouse), and informed methods for collecting feedback.[40]
Collaboration initiated through a non-Indigenous partner	An academic-Tribal working group in the U.S. collaborated on adapting two existing therapeutic frameworks for Indigenous community members, which included a framework for integrating Indigenous staff, knowledge, and languages in service delivery.[42]

- Five records focused exclusively on treatment services.[25,26,40,42,43] Two records focused primarily on harm reduction services or related training[41,45] and one record discussed both treatment and harm reduction services.[44] The remaining record combined harm reduction services with various social supports.[34]

- In the context of treatment services, the mainstream concept of 'inpatient' care (i.e. to stay in a residential treatment facility for medical care 24 hours a day for multiple days or weeks did not fit with the Indigenous models of care in several of these articles. In those examples, community members stayed for treatment in a non-medical environment that centred cultural practice as part of healing. In examples of land-based healing, one treatment program that was held over four days, community members stayed at a longhouse prepared in the Coast Salish tradition.[40] In another, community members participated in a 12-day camp on the territories of the Pikuni Blackfeet Indians of Montana.[25]

INDIGENOUS SERVICE/PROGRAM DESIGN

Given the importance of intentionally practicing a de-colonial and Indigenizing analysis to services and programs, [25,43] we examined what the integration of an Indigenous lens looked like within those records. Two types of design categories emerged: Services or programs that were Indigenous by design, or Indigenous adaptation of existing service or program.

Two thirds of the records (six of nine)[25,26,34,40,44,45] described services with foundations and frameworks rooted in Indigenous practices rather than Western practices and models. This contrasts with existing reviews that pointed to a dominant focus on using Western models as starting points for adaptation.[11,46,47]

INDIGENOUS BY DESIGN

This category describes programs that were designed or built with Indigenous practices as the foundation, and where elements of Western practices were added later on. These services were also primarily led by diverse types and levels of Indigenous communities, such as the provincial First Nations Health Authority in British Columbia,[45] Tribal government in Washington State,[44] and grass-roots based Indigenous people who use drugs and their allies.[34]

- Two of the records referred to ongoing programs without an anticipated end-date (at the time of the records' publication). Victor et al described[34] a grass-roots program organized by Indigenous community members and supported by settler allies in Alberta. It focuses on setting up a bi-weekly safe space in a park where Indigenous community members who use drugs and are unhoused can receive harm reduction supports, attend to practice drumming, storytelling, mini powwow, crafting, and additional practices rooted in Blackfoot culture.

- A second record by Tipps et al[44] described two programs that focus on opioid agonist treatment, which were run by the Quapaw Tribe in Oklahoma and Muckleshoot Tribe in Washington State. Communities funded and resourced the services out of their own budgets, and engaged in cost-saving measures such as primarily relying on methadone (vs. more costly medications such as buprenorphine (Suboxone)). Both services were staffed with Indigenous community members and integrate pathways to wellness through education and work, and activities such as beading, drumming, and opportunities to work alongside Elders. The Muckleshoot Tribe has additionally invested in harm reduction training (e.g. naloxone) and provides transportation to members who live further away.

- Two of the short-term programs were explicit in their adoption of culture as a strength approach. The first[25] was a seasonal camp where members spent 12 days immersed in ceremonies (such as pipe ceremony, talking circle), traditional skills (such as constructing drums, harvesting sacred plants) and other activities. The guiding principle was to provide a responsive and supportive environment rooted in community and spirituality. Another treatment program (DARTNA)[26] used drumming as a central method. It also incorporated talking circles for group discussions and used the Northern Plains Medicine Wheel as a guiding framework to integrating and discussing health and wellness. In addition to providing education on drumming, the Medicine Wheel, and other topics, DARTNA also referred to *12-Steps and Medicine Wheel* program, which situated the 12 steps from AA/NA within spiritual (steps 1-3), physical (steps 4-6), emotional (steps 7-9), and mental (steps 10-12)(see Figure 2 in Dickerson et al. for details).

- The remaining two records included an article on the work of First Nations Coast Salish in British Columbia, who approached researchers about implementing ayahuasca-assisted on-site therapy incorporating Coast Salish traditions. The last record was a policy brief[45] that described multiple community-run programs that were designed around culturally-grounded healing and practices, including efforts to re-frame fear and stigma around substance use and harm reduction.

INDIGENOUS ADAPTATION OF EXISTING DESIGN

Adaptations of existing designs came about through academic-community collaborations and used the experimental design approach to compare community members in an adapted program to those who participated in a 'traditional'/'mainstream' program.

- The Hirchack et al[42] collaboration resulted in the development of two culturally adapted treatment programs focused on using therapy to support behavioural change through shifts in motivations, community support, and strengthening of relationships (e.g. member-counselor

kinship, family connections). Key Indigenous adaptations were focused on both the community member-counselor kinship ties, as well as wider relationships with family and community. In addition, participants had the option of receiving service in Tribal languages and connecting with traditions through dancing, traditional stories, and other practices.

- In the case of Legha et al.[43] Alaska Natives in Alaska completed an inpatient treatment program participated in tele-psychiatry treatment therapy. Using a 'village council' model for feedback from participating community members, researchers integrated Culture-strengthening activities such as steam baths, cultural outings and activities, spiritual care, and traditional art.

INDIGENOUS CULTURE IN PROGRAMS

A thematic analysis of the records point to four categories on the ways that Indigenous culture can be reflected in substance use services. As a starting point, we used the two categories discussed by Gone and Looking[25], which were 'ceremony' (named 'ritual participation') and 'traditional skill' . We then expanded to add two more based on a grouping of the diverse examples listed in the records. The final four categories are:

Indigenous knowledge and practice: Refers to ways that Indigenous ways of knowledge and practice, knowledge sharing, knowledge keeping, and knowledge-valuing are integrated into services.[25]

> Examples: Talking circles, integrating spirituality in care, or drawing on wisdom of Elders and/or Knowledge Keepers.[25]

Traditional skills: Refers to the strengthening and development of traditional practices.

> Examples: Constructing drums, developing hunting and fishing skills, and/or learning traditional crafts.

Ceremony: Refers to participation in Indigenous ceremonies, gatherings, or activities that are intended to strengthen connections to the physical and spiritual world, and often seen as a part of a healing journey.[25]

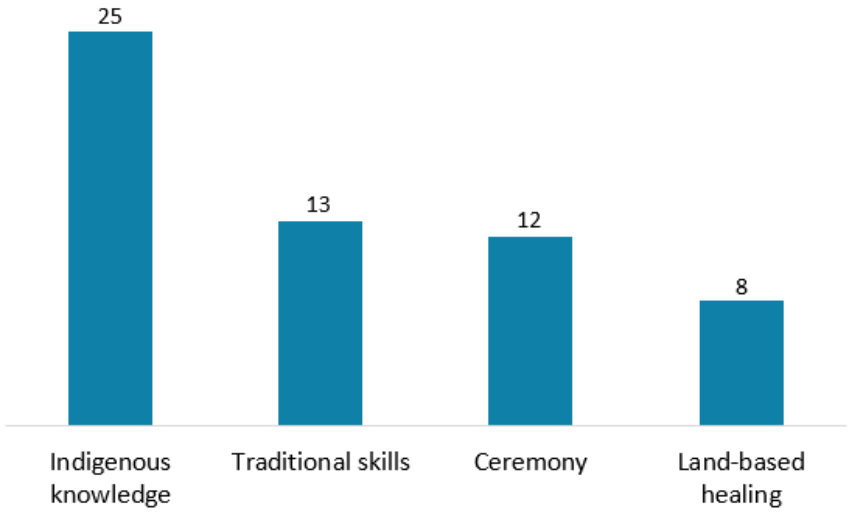
> Examples: Singing, pipe ceremonies, and/or drumming.

Land-based healing: Refers to ways that programs rooted in connection to territory, land, and related history.[48]

> Examples: Holding therapy in a blessed longhouse, trips and stays at sacred and culturally-significant areas, hunting, and/or gathering.

For details on specific examples and approaches by record, please see the table in Appendix B. Figure 2 figure below lays out the frequency of these approaches, highlighting their wide distribution and multi-faceted character. It also highlights the significant reliance on Indigenous knowledge and practice for the foundational development of services for Indigenous communities:

Figure 2. Frequency of integrating Indigenous Culture by theme (Articles included multiple themes, as well as multiple distinct practices within each theme).



This summary of the approaches that were used is not intended to provide a model for replication. It is intended to reflect the complexity of this work and to highlight ways to approach substance use programs and supports. Indigenous leadership have stressed the importance of listening and learning, and recognizing that guidance and leadership around substance use belongs with their communities and is a matter of self-determination.[28]

REFLECTING ON IMPACTS

With the exception of the policy brief report from the grey literature search,[45] all the remaining records included discussions on evaluation, outcomes, or impact. Appendix C provides a more detail on the outcomes examined by study, including outcomes measured and final results.

- Four out of nine records used open-ended interviews to speak with community members who participated in services.25,34,44,40 Interviews were unstructured and the majority of feedback indicated community members' support for continuing these types of services and a resulting closer connection to their community, Indigenous identity, spirituality, and the self.25,34,40,44

- Four records primarily relied on an experimental approach, with two using randomized control trials and one using matched-case control design to compare outcomes between a group who completed an Indigenous-focused program to those who completed a standard program (additional details in Appendix A). Three of the four records reported additional benefits of participating in an Indigenous-focused program or training, including additional improvement in (cognitive & physical) health and decrease in substance use,[26] increase in purchase and supply of naloxone kits,[41] and higher rates of treatment completion and fewer discharged against medical advice.[43] The study by Hirchack et al,[42] which focused on adapting two existing treatment therapy models, showed that both Indigenous and non-Indigenous groups performed equally in substance use outcomes.

- Several articles connected impacts of services or programs to the dimensions of Indigenous wholistic health- spiritual, mental, emotional, and physical health domains[33]:

    - Spiritual health was mentioned most often, both within impact and as a therapy approach. Feedback around spirituality came from community member comments

about feeling increased connection with the spirit and nature,[40] a draw to spiritual beliefs,[26] and finding value in spirituality-based practices.[25,42]

- Argento et al. used interviews on self-perception to capture shifts in mental health and physical health,[40] while Dickerson et al. used validated closed-ended questions to measure changes before and after.[26]

- Dickerson et al.[26] used validated closed-ended questionnaires to examine changes across all components: spiritual, mental, emotional, and physical health. Others three discussed these dimensions in an unstructured manner and with open-ended questions.[25,40,42]

Section Two: Knowledge and Teachings Shared Orally

This section contains the knowledge, teachings, and wisdom shared from a webinar with our Indigenous partners on October 26, 2022 ("Centring Indigenous Ways, Un-learning Mainstream Approaches in Substance Use"). [39] We have outlined the speakers' discussion themes, as well as wisdom and teachings of the Knowledge Keeper who joined us. This knowledge is shared verbatim to ensure the original meaning and wording are passed on.

CULTURAL CONNECTION IN HARM REDUCTION

Speaker: Ashley Smoke is an Indigenous 2-Spirit person from Alderville First Nations whose Spirit Name is Gatherer of Medicines and their roles/responsibilities include caring for the community, gathering medicines, holding the peace pipe and hunting. They shared their knowledge and expertise on cultural connection in harm reduction:

> "It was through learning about familial histories and working in harm reduction at the same time that I started to become intrigued by Indigenous harm reduction. It was something that I craved as someone who used drugs, and something I wish I had access to, but harm reduction never connected me to my culture and roots."
>
> Because of the lack of services and cultural safety that I experienced, I try to find ways to help Indigenous folks in my community that served them and connected them to a piece of their culture, even if it meant having a conversation about their family, their history. I would also use languages and terms that they recognized to allow them to understand that I understood them. Because there's that much better of a rapport when there's an Indigenous person, or a person who understands a lot of those intricacies while serving you. The service is much better, and the care is much better. I would also share teachings through stories that were relatable to them that involved street analogies. I had to be very creative, but it allowed me to build a trusting relationship and gain a reputation of trust and acceptance in the communities that I serve. I help them out in different ways like showing them how to access friendship centres and what ceremonies and programing were offered. I had to really gauge the person and the experience they would have before doing referrals. I didn't have many tools, but I used all the tools I had.
>
> I began collecting sage and medicine so I could smudge folks on outreach. To this day, I always bring medicine to events in case anyone needs to smudge. I also began to gather a list of running ceremonies, cultural events, and would let folks know which coffee shops, libraries, would let folks who were displaced do cultural art space activities. I found any ways to help my Indigenous drug users, and I built real relationships and networks of service providers, and I think that systems navigation is a big piece.

Our communities are different – in a patriarchal world, we have to fit our matriarchal world views within it which is hard to manage. In our culture, there's nine different genders, and with gender binaries, there's a lot of confusion happening with our youth, and it's really needed to empower them to be confident and learn our culture and teachings so they can feel like their true authentic selves and can start healing out communities and ourselves.

We need to come together to build the community's capacity and strength, and I think that we can do that through culture."

WHOLISTIC HEALING

Speaker: Darryl Souliere-Lamb is Anishnawbe and a member of Wikwemikong Unceded First Nation. She is a Registered Social Worker, with a Master of Social Work: Indigenous Field of Study, from Wilfrid Laurier University. Darryl has years of Frontline experience in case management, housing support, and advocacy for Indigenous Community members.

"The medicine wheel is a tool used by many First Nations as a way to understand the world around us. The wheel includes teachings about the four directions, the seasons, the stages of life, races of people, and on and on. Today, I'm going to be focusing on the main quadrants of the mind, the body, the spirit, and the emotion."

Figure 3. Model of Wholistic Health and Wellbeing[33]

"When I talk about wholistic healing, I'm referring to the word wholistic with a W, as in the word 'whole'. So the model of wholistic health and well-being incorporates the emotional, mental, spiritual, and physical elements of well-being, and it's the belief that all elements must operate in harmony, meaning that we have to support all four quadrants to support someone's whole health. For Indigenous service providers and healthcare organizations, we have identified culture as treatment, practicing our culture as a way to support all quadrants of the medicine wheel and to take care of ourselves.

The circle teaches us that we're all connected. Our connection is continuous and there are no separations in between. We are always connected with those who came before (our ancestors) and we will always be connected to those who come after us for the next generation. That's what the circle represents. It also represents that we're all equal. In the circle of life, no one is greater than the other and no one is lesser than another – we all come from the side of the creator and will all

return to the creator's side when the journey is complete. We're all different. We all bring different gifts, abilities, and life experiences to our relationships in the circle, differences to be honoured. We are taught to be open to those differences that we experience in others.

When doing any work with Indigenous peoples, it's important to ensure that the work is being led by these people. We all have different cultures, beliefs, experiences, and we're not just one people, so you want to be including as many people as possible. Work should be collaborative, and involve all members of the community, including individuals, families, and community members. Indigenous programs should be rooted in traditional teachings and culture, and should be guided by a holistic and trauma-informed model of healthcare and well-being."

LEARNING

"Ongoing learning is very key. Also understanding the complexities of what the history is, what the systems and structures have actually done, and doing some of that learning. Make an effort on your own to learn these things. It's even valuable to learn about teachings that you can relate to, that you can introduce, and even having Knowledge Keepers that you can refer people to, opening up networks, engaging those other service providers that can help support as well and helping them build their capacity in helping Indigenous folx(folks). At the same time, it's about empowering us to take leadership in work. When talking about self-determination, I do this work for my self-determination. I hate the way the system is set up for us to fail, there's just blockages and barriers. I think if we empower more people with more opportunities and leadership, and pay people what they're worth, we can do good things. We just need a lot of support, and funding, and not check-box funding. It's about valuing us."- **Ashley Smoke**

"For forever, people have been coming to Indigenous people and taking… Even now, even today there's mistrust of anyone saying they're here to help. I think it is important to build that engagement and trust over time, make safe spaces, and work collaboratively with Indigenous people and organizations… Learning is an on-going thing. It doesn't stop, you don't do one Indigenous cultural safety training and you're done, it's continuous."- **Darryl Souliere-Lamb**

MEANINGFUL RELATIONSHIPS

Question from the discussion: "Where does the intersection lie with building meaningful relationships with communities and Indigenous peoples, that are authentic, meaningful, impactful, but also that intersects with enabling our own self-determinations, our own reclamation?"

"That's what meaningful relationships are all about – going to the community, saying this is what I have to offer, what do you have to offer, and how can we come together to make things better."- **Ashley Smoke**

"I was doing some outreach and engagement to other Indigenous communities, but we were doing it in a way that was rushed, and it wasn't personal or wasn't one-on-one. So a lesson learned from that was to not rush the work. The Indigenous way isn't rushed, and I received teachings on that. We have to take our time when doing these things, but also to make sure that when we are reaching out and asking people for their support or their commitment to be really open and honest, to allow them to lead the work."- **Darryl Souliere-Lamb**

[Invitation to reflect] Knowledge Keeper Adele Madigan closed the session with her reflections and wisdom on listening and moving forward in an intentional way. We invite you to read her words and sit with them as this review moves into the discussion section:

> "Creator, help us put into practice what we've discussed and learned today. May the things we've learned today touch our hearts and minds. May we put those words and thoughts into our actions. Help us to make a difference for our people and for anyone who is mistreated, and marginalized, in any way or form. We need your help, creator, as we go on and do this wonderful work that we've been set out to do on the creator's behalf. Serving the most vulnerable people. Each and every one of us that are here today, that sit together and have taken the time to learn, each and every one of you are good medicine, and have wonderful hearts. Miigwetch Miigwetch Miigwetch Miigwetch."

Knowledge Keeper Adele is a proud Anishinaabe-kwe from the Batchewana First Nation of Ojibway whose Spirit name is Raven Woman.

Discussion

While this review focuses primarily on service-level program implementation and delivery, substance use has to be understood and contextualized within structures and legacies of colonization, loss of culture and language, and the resulting intergenerational trauma.[32] Equally important is the recognition that Indigenous peoples are the experts in their experiences, and that their knowledge is the most appropriate pathway to authentically understanding ways to de-colonize health at structural and individual levels. This approach is particularly important for non-Indigenous partners involved in this work and closely aligns with calls to action from Indigenous leadership.[28,30]

As covered in the results section, the majority of included services were rooted in Indigenous ways of knowing and frequently highlighted the healing role it can play. In practice, that meant centring Indigenous knowledge and practice, participation in Indigenous ceremony, skills-building/strengthening around culture, and leveraging the power of physical Indigenous spaces. Given the importance of wholistic wellness approaches for Indigenous communities, the need for a multi-faceted approach to harm reduction and treatment becomes clear. The Indigenous Determinants of Health affirm the need to go beyond 'mainstream' conceptualizations of health and to include connection to culture, self-determination, and de-colonization are integral parts of Indigenous health and life experiences.[32,49] Therefore, it is important to keep un-learning and reflecting on our use of mainstream models of health (including mainstream 'equity' models) since they may exclude Indigenous perspectives and world views.

A recurring emphasis in the recorded literature, as well as the knowledge, teachings, and wisdom that were shared orally, was the need to move away from looking for pan-Indigenous models. The literature has repeatedly affirmed that standardizing practices and generalizing models will re-produce colonial practices by erasing the diversity of Indigenous communities and their lived experiences. The warning to avoid 'one size fits all' or simple replication of services recurs often in the literature and in our discussions.[26,40, 41,44,45,47] To that end, the summary in this review is not suggesting a pan-Indigenous model for substance use services. It intends to build on the knowledge of perspectives of Indigenous communities, and prompt questions on both- *what* this work may look like, as well as *how* to approach collaboration rooted in Indigenous leadership.

[Invitation to reflect] Knowledge Keeper Amy Montour reminds us that learning goes beyond reviews and must be rooted in partnerships with Indigenous communities:[27]

> "Remember that what would work for one community, is not what should be done in another place. The idea of 'systematic reviews' to say 'yes this is best practice' doesn't work because every community needs to have what they need to have for them. It's more about organizations learning how to work with Indigenous communities to learn what

their resources are, instead of having a pan-Indigenous approach to mental health and substance use."

Gaps in knowledge

The small number of records in the final list provides a narrow lens for reflecting on this work and the efforts on de-colonized approaches to substance use services, recognizing that community-driven efforts often face under-resourcing and discrimination in the path to documentation.[50] Although this resources included knowledge, teachings, and wisdom that was shared orally by Knowledge Keepers and partners, we recognize that it remains incomplete given the wealth of Indigenous knowledge that has been accumulated and shared through oral traditions since time immemorial.[5,27]

Many ongoing discussions around substance use and Indigenous communities were not part of the final list of nine records, and therefore not part of this review. They include two-eyed seeing approaches to balancing Indigenous and Western knowledge,[49] staff comfort and training,[51] and concepts around the cultural care continuum; i.e. cultural awareness, cultural sensitivity, cultural competency, cultural safety, and humility.[52] Their exclusion is not a reflection of their (lack of) importance or prominence in discussions.

Intersectionality and the consideration of overlapping identities and positions of power are critical to work in advancing health. However, the search didn't identify implemented programs that applied that lens, whether considering women, two-spirit persons, people living with disabilities, and additional communities living with layers of marginalization.

- For example included records show a disproportionate focus on males in services and programs (see Appendix A), reflecting colonial harms and exclusion disproportionately experienced by women.[53] This is a serious gap given what we know about the unique challenges and experiences of Indigenous women, such as the impact of separation from children on likelihood of completing a treatment program.[13]

- Another critical factor in the health of Indigenous communities, particularly around access to substance use services, is geographic location (urban, rural, on-reserve, remote, etc). These geographical barriers are also a consequence of colonial practice and the Indian Act, pointing to the ways that colonialism continues to operate structural ways.[54] Including this lens in service planning and discussions is central to discussions in this area.[20]

We wrap up the discussion by highlighting the need to bring humility and reflection to this work, particularly for those who come to it as settlers. This means building in practices or tools that promote self-reflection and accountability, starting with investing in power-conscious relationships. Equally important, it has to start with investing in patient trust-building and taking prioritizing the experiences of Indigenous people who use drugs.

Conclusion

Taken together, the knowledge accumulated in this resources reveals a range of efforts to address substance use-harms within Indigenous communities, primarily (co)led by those communities. The recognition of diversity within communities and the need for community-shaped practices also emerges as a contrast to the model of a pan-Indigenous approach.

These discussions represent a small part of ongoing conversations, documented and orally-shared, on how to centre Indigenous worldviews and ways of knowing in health and wellness. This review is not intended to serve as a complete or definitive analysis on substance use services with, and for,

Indigenous communities. Rather, it is intended to serve as a contribution to ongoing work and discussions on how to map a way forward rooted in collaboration, strengths, and community leadership.

In closing this review, we leave the reader with the wisdom and reflections of **Knowledge Keeper Adele Madigan**, which she shared with us in writing[48]:

> "I was pleased to see that the research was designed with Indigenous people. The focus on harm reduction was also a necessary reality for some of our people. It is stated that solutions on substance use prevention, harm reduction, and treatment must be guided Indigenous Culture and knowledge designed by the communities. This is a true statement as each of our nations are alike in some ways but are different and unique in some of our ceremonies and practices.
>
> I firmly believe that these programs and services designed by our people, for our people are necessary to achieve wellness and live The Good Life. It is also necessary for programs to develop aftercare, and relapse prevention services and put necessary support systems in place. Many of our wounded individuals suffer when attempting to make positive changes in their lives for they lack supportive people in their lives and can easily fall back into self-destructive behaviors when the stressors of life befalls on them. It is also important to remember that dealing with substance use is a process and cannot be achieved quickly. It takes a lifetime of hard work for individuals to overcome and fight the demons that want to control their lives, therefore these programs and services must be designed to be long-term. Anyone who struggles with substance abuse also struggles with mental health difficulties and these concerns must be addressed in conjunction with the addictions. For many years before these two health issues were kept separate and many individuals were set up to fail due to their mental health needs unmet when struggling to heal from substance use."

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Appendix A

Table A. Characteristics of all nine included records

Author	Main topic (service type in brackets)	Location	Specified community	Study design	Sample
Argento et al. (2019) [40]	Exploring ayahuasca-assisted therapy for addiction (Treatment)	Canada – British Columbia	First Nations Coast Salish band	Qualitative: Exploratory interviews (open ended) with community members about their experiences	11 community members: 5 females, 6 males; 19 to 56 years old (mean age 38 years)
Dickerson et al. (2021) [26]	Drum-assisted recovery therapy for Native Americans (Treatment)	United States - California	Indigenous	Experimental: Randomized control trials. Community members were randomly assigned to one of two therapy groups.	63 community members: 38 assigned to intervention (DARTNA); 25 assigned to control group; 4 females, 58 males; mean age 38 years
Duvivier et al. (2017)[40]	Indian Health Service pharmacists expanding access to naloxone (Harm reduction)	United States - Southwest, Midwest, Great Lakes	Indigenous	Quasi-experimental: One group pre-test post-test design. Measured changes in number of Naloxone orders.	Indian Health Service pharmacists (no numbers available)
Gone and Looking (2015)[23]	Seasonal cultural immersion camp using traditional practice (Treatment)	United States - Montana and Wyoming	Pikuni Blackfeet Indians of Montana	Qualitative: Exploratory interviews (open ended) with community members about their experiences.	4 community members; all male
Hirchak et al. (2020)[41]	Development of culturally adapted treatment therapy services (Treatment)	United States - New Mexico	American Indian/ American Native (AI/AN)	Study 1- Experimental: Randomized control trials. Community members were	Study 1- 79 community members: 38 assigned to intervention (MICRA); 41

Author	Main topic (service type in brackets)	Location	Specified community	Study design	Sample
				randomly assigned to one of two therapy groups. Study 2- In progress	assigned to control group; all male; mean age 33 years
Legha et al. (2020)[43]	"Village of Care" telepsychiatry program (Treatment)	United States - Alaska	Alaska Native	Experimental: Matched-case control design, where two programs were compared based on matched or similar community members	206 community members: 103 assigned to intervention group; 103 assigned to control group Community members matched on age (mean is 38.7 years) and gender (120 female, 86 male)
Tipps et al. (2018)[44]	Two Tribal-run programs on opioid-agonist treatment	United Status-Oklahoma, Washington	Quapaw Tribe (OK) & Muckleshoot Tribe (WA)	Qualitative: Observational, description of Indigenous-led programs	N/A
Victor et al. (2018)[34]	Community-based outreach and supports around homelessness and substance use (Harm reduction)	Canada- Alberta	Blackfoot community members	Qualitative: Exploratory interviews (open ended) with community members about their experiences.	N/A
Canadian Aboriginal AIDS Network (2019)[45]	"13 Moon Harm Reduction Initiative", a peer-led, culturally grounded harm reduction project co-led by Indigenous youth (Harm Reduction)	Canada-Manitoba	Indigenous	Qualitative: Policy brief that includes description of practices within three harm reduction programs	N/A

Author	Main topic (service type in brackets)	Location	Specified community	Study design	Sample
Canadian Aboriginal AIDS Network (2019)[45]	"Mamisarvik Inuit Healing Centre" (Harm Reduction)	Canada- Ontario	Inuit	See above	N/A
Canadian Aboriginal AIDS Network (2019)[45]	"Not Just Naloxone" train-the-trainer workshop (Harm Reduction)	Canada- British Columbia	First Nations	See above	N/A

Appendix B

Table B1. Integration of Indigenous Culture through Indigenous knowledge and practice

[Note: 'Y' below indicates the listed practice was included in corresponding article]

Practice	Argento et al.[40]	Dickerson et al.[26]	Duvivier et al.[41]	Gone & Looking[25]	Hirchak et al.[42]	Legha et al.[43]	Tipps et al.[44]	Victor et al.[34]	CAAN and ICAD[45]: 13 Moons Harm Reduction	CAAN and ICAD[45]: Inuit Healing Centre	CAAN and ICAD[45]: FNHA Naloxone
Elders and knowledge keepers							Y				
Experiential knowledge		Y	Y			Y			Y		Y
Indigenous languages					Y					Y	
Kinship and relationships				Y	Y	Y					Y
Medicine wheel		Y							Y		Y
Spirituality in care					Y	Y					
Therapy with Indigenous lens	Y	Y									
Talking circles		Y		Y							
Traditional storytelling				Y	Y			Y			

Table B2. Integration of Indigenous Culture through participation in Indigenous ceremonies

[Note: 'Y' below indicates the listed practice was included in corresponding article]

Practice	Argento et al.[40]	Dickerson et al.[26]	Duvivier et al.[41]	Gone & Looking[25]	Hirchak et al.[42]	Legha et al.[43]	Tipps et al.[44]	Victor et al.[34]	CAAN and ICAD[45]: 13 Moons Harm Reduction	CAAN and ICAD[45]: Inuit Healing Centre	CAAN and ICAD[45]: FNHA Naloxone
Dancing					Y						
Drumming		Y						Y			
Food and diet								Y		Y	
Music						Y					
Pipe ceremony				Y							
Pow-wows							Y	Y			
Singing								Y			
Traditional regalia					Y						
Transfer rite				Y							

Table B3. Integration of Indigenous Culture through land-based healing

[Note: 'Y' below indicates the listed practice was included in corresponding article]

Practice	Argento et al.[40]	Dickerson et al.[26]	Duvivier et al.[41]	Gone & Looking[25]	Hirchak et al.[42]	Legha et al.[43]	Tipps et al.[44]	Victor et al.[34]	CAAN and ICAD[45]: 13 Moons Harm Reduction	CAAN and ICAD[45]: Inuit Healing Centre	CAAN and ICAD[45]: FNHA Naloxone
Longhouse	Y										
Sacred or cultural areas				Y		Y		Y		Y	
Steam bath						Y					
Sweat lodge				Y				Y			

Table B4. Integration of Indigenous Culture through developing/strengthening Indigenous skills

[Note: 'Y' below indicates the listed practice was included in corresponding article]

Practice	Argento et al.[40]	Dickerson et al.[26]	Duvivier et al.[41]	Gone & Looking[25]	Hirchak et al.[42]	Legha et al.[43]	Tipps et al.[44]	Victor et al.[34]	CAAN and ICAD[45]: 13 Moons Harm Reduction	CAAN and ICAD[45]: Inuit Healing Centre	CAAN and ICAD[45]: FNHA Naloxone
Drum construction				Y							
Hides- tanning				Y							
Hunting/fishing				Y		Y					
Music lessons							Y				
Pitching teepees				Y				Y			
Plant harvesting				Y				Y			
Traditional art/crafting						Y	Y	Y		Y	

Appendix C

Table C. Summary of outcome measures and impacts, where included in the records

[Note: 'SR' denotes self-report; 'CG' denotes reported by caregiver (ie service provider)]

Author, Year	Primary outcome or impact measure
Argento et al. (2019)[40]	(SR) Six month follow up: Qualitative interviews with participants about experiences in the program pointed to six themes: **Diminished substance use and cravings**: All participants reported cessation or reduction in substance use **Comparison with other treatment experiences**: All participants contrasted this program with past experiences, pointing to improvement in health, well-being, and transformation. **Enhanced connection with spirit and nature**: All expect one participant expressed increased sense of connection with spirit and nature. **Highlighted connection with sense of self**: Participants reported connection to a 'higher self' and shifts in emotional and psychological well-being **Transformations in relationships with others**: Participants reported improved social relationships, deeper connections, and stronger communication with friends and family **Overall feelings about retreat**: Majority of participants recommended increasing the availability of similar supports.
Dickerson et al. (2021)[26]	(CG) At the end of treatment, those who completed DARTNA were compared to patients receiving the standard care. Significant findings ($p < .05$) indicated that DARTNA patients reported: Lower cognitive impairment Lower counts of physical illnesses Better reported health Decrease in alcohol and marijuana consumption (CG/SR) In the 3 month follow up, those who completed DARTNA reported (p/ .05): Less cognitive impairment Lower anxiety with close relationships

Author, Year	Primary outcome or impact measure
	More drinks and cigarettes per day (authors point to one outlier that may explain increase)
Duvivier et al. (2017)[40]	(CG) Authors compared naloxone kit purchases and increase in supply before and after implementation of opioid safety initiative. They found that HIS tripled the purchasing and use of naloxone in the first half of 2016 for patient services and first responder initiatives.
Gone and Looking (2015)[23]	(SR) Open-ended interviews assessed experiences of camp life, including assessment of the camp as a form of alternative Indigenous treatment.
Hirchak et al. (2020)[41]	Study 1 (CG): Comparison of substance use between MICRA intervention and control group. Both groups performed equally and demonstrated decrease in substance use compared to baseline. Study 2: Study ongoing on CRAFT-AI.
Legha et al. (2020)[43]	(CG) Comparison between intervention (telepsychiatry) and control groups. Compared to the control group, clients in the telepsychiatry group: Stayed 43.8 days longer in treatment Reported fewer discharges against medical advice Showed similar rates of hospitalizations, emergency room visits, and communication about medical needs
Tipps et al. (2018)[44]	(CG) "Quapaw's Counselling Services": Out of 105 in treatment, 71% decreased substance use enough to take-home methadone doses, similar to rates across the US. (CG) "Muckleshoot Behavioral Health Program": Vivitrol compliance rates are at 94%; Between February 2016 and July 2017, the program served 406 community members and exchanged 20,771 needles through the needle exchange program.
Victor et al. (2018)[34]	(SR) Program evaluation followed up with participants and held key informant interviews one year into the program's start. Findings included: Benefits: Participants report having a safe space to socialize and share stories, have a sense of belonging. Challenges: Waning attendance in second year, limited funding, repetitive programming, concern that ceremonies can become a public spectacle, request to expand beyond Blackfoot culture given Indigenous diversity.

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Disclaimer

Community Opioid/Overdose Capacity Building

PHO collaborates with external partners in developing COM-CAP products.

Community Opioid/Overdose Capacity Building (COM-CAP), started in 2019, is a four-year project funded by Health Canada's Substance Use and Addiction Program. The goal of COM-CAP is to support community-led responses to opioid/overdose-related harms in communities across Ontario. The supports focus on strengthening the knowledge, skills, and capacity of the key stakeholders involved.

- The Ontario College of Art & Design University (OCAD U) - Health Design Studio
- University of Toronto- Strategy Design and Evaluation Initiative
- Black Coalition for AIDS Prevention
- Chatham-Kent Public Health
- NorWest Community Health Centres
- The Municipal Drug Strategy Coordinators Network of Ontario
- The Ontario Network of People Who Use Drugs

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For more information visit www.publichealthontario.ca/en/Health-Topics/Health-Promotion/Substance-Use/COM-CAP or contact substanceuse@oahpp.ca

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