Saskatchewan Drug Task Force

Community-based organization (CBO) Focus Group Final Report

PRAXIS
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Submitted By:

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COMMUNITY-BASED ORGANIZATIONS – SUBSTANCE USE ENGAGEMENTS

A CONSULTATION SUMMARY

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Introduction

This document reports the findings from eight (8) community-based focus groups and one (1) mayor/community leadership focus group conducted in September 2021 by Praxis Consulting on behalf of the Saskatchewan Drug Task Force.

The project's purpose was to gain a more informed perspective of the province's current substance use situation in terms of the extent, contributing factors, barriers, and solutions.

Group Composition

The focus groups were conducted virtually through the Zoom platform. Participants were recruited from a list of key stakeholders provided by the Drug Task Force Secretariat. A list of engaged stakeholders and their representing organizations can be found in Appendix A.

The details of the engagements are described in the table below. The moderator's guide is included in Appendix B and the amalgamated focus group transcript can be found in Appendix C.

Focus Group Details		
Date	***Time***	***# Of Attendees***
September 13	6 – 8pm	8
September 14	4 – 6pm	10
September 16	4 – 6pm	3
September 21	1 – 3pm	9
September 22 (Mayor/ Community Representative Session)	1 – 3pm	8
September 23	1 – 3pm	6
September 27	1 – 3pm	3
September 29	1 – 3pm	2
September 30	1 – 3pm	1

Interpreting Focus Groups

Focus groups are designed to reveal qualitative information – perceptions, outlooks, and attitudes. They can be used to deconstruct perceptions, provide indications of how values or expectations combine with experience to create attitudes, and explore how these have developed and may be developed further.

Focus groups can generate insights into range, depth, and intensity. They are more useful for gauging commitment than for estimating the extent of views. As the research is conducted "live", it is possible to follow leads that appear in the discussion and track unforeseen drivers.

The following results should be understood as subjective and personal to the individuals who offered them in the sessions. They are valuable as insights into how opinion is framed and how values lead to attitudes, but because of sample sizes, they are not statistically significant. Nor are the charts and tables showing how participants rated issues. These are included as comparative data to provide a sense of each group's disposition, and to indicate patterns that may be relevant. Numeric data in this report cannot be projected to the larger user and non-user populations.

Citations

Throughout this report, comments from participants are included to provide context and help illustrate or underscore findings. In some cases, these are direct quotes from individual participants; in others,

citations paraphrase discussions, or allow multifaceted or similar comments to be synthesized succinctly.

Focus Group Results

To follow, the focus group discussions have been summarized according to the order questions were asked. The narrative and citations show participant inputs.

Executive Summary

The following summarizes the key findings following multiple consultations with Community Based Organizations (CBOs) and Municipal leaders.

Current situation and contribution to substance use disorder:

- Homelessness, poverty, lack of wraparound services to help people in crisis
- Long waitlists and lack of coordination and communication between detox/treatment/recovery services
- Mental health issues such as depression, anxiety, trauma
- Stigma and lack of education
- Easy access to drugs

Current awareness and effective strategies:

Participants are aware of the following programs, services and approaches in their communities.

- Culturally based approaches to harm reduction, treatment and recovery
- Peer support and mentorship
- Harm reduction services, supervised consumption sites, needle exchanges and access to Naloxone kits
- Outreach and crisis teams
- Programs exist that educate and bring awareness to help reduce stigma, build empathy and show that drug use can impact anyone
- Some services offer longer post-recovery treatment and follow up to keep people in recovery

Barriers and priorities:

- Improve connection between services so that individuals do not fall through the cracks in between detox, treatment and recovery
- Provide 24/7 services (harm reduction, walk ins) including in rural and remote communities
- Lengthen treatment time (28 days is not long enough)
- Reduce public and professional stigma around drug use and improve community buy-in for services
- Increase outreach, education and awareness to support prevention strategies, address trauma in children and youths, address racism, and increase knowledge of where to find support
- Address the issue of housing and income insecurity, including for previously incarcerated individuals
- Other: Decriminalize drugs, reduce waitlist for OAT (Opioid Agonist Therapy) and increase number of prescribers

Short- and Long-term Solutions:

- Provide access to and extend hours (24/7) of outreach, harm reduction services, access to OAT, and supervised consumption sites
- Reduce waitlists and add capacity
- Train professionals and frontline workers and increase public awareness to reduce trauma and stigmatization
- Connect services or provide a hub for all services so individuals only need to ask for support in one place
- Meet people's basic needs – access to affordable housing, food security, income security, access to transportation and communication technology
- Increase representation of PWLEs and apply an Indigenous lens when rebuilding supports and making decisions
- Provide support and resources to Indigenous-led programming
- Decriminalize drugs, treat addiction as a public health crisis, offer drug treatment court
- Educate and provide prevention programs for children and families, address trauma, intergenerational trauma and wellbeing

Impacts and social acceptance:

- Improve responsiveness of existing supports and services
- Provide after-hours and safe access
- Provide trauma-specific training and other training to frontline and healthcare workers
- Provide programs to keep families together while parents with addictions seek help
- Listen and learn from PWLE to change the narrative around substance use and normalize asking for help
- Deliver public awareness campaigns and education to reduce stigma around asking for help
- Offer peer support and mentorship programs
- Other: Decriminalize drugs and engage youth

Current situation and contributions to substance use disorder

Participants representing Community Based Organizations (CBO) and municipal community leaders from across Saskatchewan were asked to describe how concerned they are about the current situation of substance use disorder in their community. Universally, participants noted a high or extreme level of concern. The current situation is compounded by service and program closures or restrictions due to COVID-19, lack of accessible housing, burn out among healthcare providers, and a lack of preparedness and resources in rural and remote communities.

In addition to signs that the pandemic has contributed to increases in drug use and overdoses, participants noted many other factors add to substance use disorder in communities around Saskatchewan. Homelessness, poverty and food insecurity were cited as common reasons along with ongoing stigma as people find it difficult to access supports and services. With lengthy waitlists and lack of coordination between services, many individuals suffering from substance use disorder cannot get the specific support they need when they need it.

Participants indicated that mental illness, anxiety, depression and traumatic experiences with healthcare and incarceration contribute overall to substance use disorder. Of particular concern to many participants is intergenerational trauma, racism and the effects of colonialism on individuals struggling with substance use.

Participants' concerns are showcased in the following common themes and statements about what is contributing to substance use disorder in their communities:

- **Homelessness, poverty and lack of wraparound services for people who have recovered so they are released into homelessness or back into a situation that can cause relapse**

"It is hard to focus on recovery and your health if the basic needs are not being met."

"Many of them have hopelessness and their situation is changing due to a lack of housing within not only our First Nation, but within the surrounding towns. This is a huge factor in addictions. In addition, poverty."

- **Long waitlists and lack of coordination and communication between services**

"There is no cohesive response to how we respond to people who struggle with substance abuse. It ends up being a moral question and this impacts the services that are available, and this is unethical. Everyone has a different take on how to support someone with substance abuse."

"I think that the biggest part of being lost in the system is at that point in time they are in a position to accept and want the help, but we have to get them to wait. We do lose them. The underlying problems are also an issue. When we have them for that 8-week period it is a short time."

- **Mental health such as depression, anxiety and issues caused by trauma**

"About 50% living with an addiction issue are living with a mental health issue."

"We are seeing an increase in stress levels caused by unemployment, underemployment. People do not have good tools to manage this stress – they will use what is available to help them get through a couple of rough weeks."

- **Intergenerational trauma, racism and effects of colonialism**

"Our clients are experiencing ongoing trauma through care and their on-going lives and they are struggling from this and it drives them back into substance use. This gives them a break from how they are being treated day to day."

"Racism is another thing that cannot be overlooked. People feel that they do not belong. They often give up. They need that sense of community and that connection. Otherwise, they want to disassociate, and drugs are very good at helping them with this."

- **Stigma on how drug use (by families/individuals) is perceived in the community, lack of education**

"The biggest issue is stigma and lack of connection. How do we create connection within the community with nowhere to access supports? We need to build an abundant community so that they are able to get the supports."

"Another issue is education. There is a huge gap in what people know and don't know in relation to substance use disorders. There is a stigma. When someone wants help, they often have to wait. It is not nurses or doctors' fault, it is systemic. People are falling through the cracks – they are not getting the help that they need."

- **Easy access to drugs**

"The ease of access. Cheaper than booze in most ways. The ways we are trying to combat it are kind of goofy to me."

Awareness and effective strategies in home communities

When asked about their awareness of and thoughts about current effective strategies in their communities, CBOs and community leaders identified several existing supports and approaches. Many participants noted that harm reduction, needle exchange, supervised consumption sites and equipment, and access to Naloxone kits are effective at reducing the harms caused by drug use. While these strategies are effective, two issues surfaced during this part of the discussion: participants noted that when pharmacies issue Naloxone kits, individuals receiving them are flagged whether the kits are for themselves or someone else. This flag can create problems for individuals if they need prescribed medication. Regarding supervised consumption sites, while these sites are located near services that can offer support should an individual overdose, there was some concern that these sites are not always safe.

Other effective strategies include peer support from people with lived experiences as well as culturally based approaches and sharing circles. Participants noted that Police and Crisis Teams (PACT) are effective as well as others who offer outreach to meet people where they are at rather than have individuals seek out support. For individuals in recovery or treatment, community leaders noted that providing sober living spaces and treatment following recovery helps people stay in recovery. Meanwhile, participants observed that while there are not enough shelters and housing for individuals, those that exist provide support.

Participants shared that education and awareness in schools and through media helps reduce stigma, builds empathy and teaches that substance use disorder can impact anyone. Community leaders mentioned several committees such as the Crystal Meth Strategy Committee and the Social Action Committee are committed to providing education, finding solutions, and helping people navigate services – including housing - in their communities.

The following statements highlight several common effective strategies in communities around Saskatchewan with the caveat that without a continuum of care – or services aware of what each is doing – many will not work well:

- **Culturally based approaches to harm reduction, treatment and recovery**

"We offer, through our knowledge keepers, prayer and spiritual services so that the people who come there are safe. It is a Nurse Practitioner lead model – they all have prescribing ability. It is linked with our primary care facility. Building those relations has been challenging at times, but it has worked. We are

able to offer these services in a non-punitive, and nonjudgmental setting. In other models this is not what is happening. They need to be met where they are at."

- **Peer support and mentorship**

"Peer mentors/Peer supports should be instrumental in all harm reduction services."

"And also peer support – there is so much value to those groups. They may not listen to an addiction councilor but someone who has been in their shoes. That peer support could be further developed. There is a lot of value in that."

- **Harm reduction services, supervised consumption sites, needle exchanges and access to Naloxone kits**

"My thoughts are with the different programs - needle exchange programs, etc. Every organization is doing as much as they can. Everyone has a huge heart. We have some effective strategies, but there is no link between them to ensure that they are working."

"We have dispensing units for harm reduction. This has helped our clients with their usage. We have supports going out and helping with the supply. This has really helped our clients and has taken away some of the stigma of them having to come in all the time to get those tools."

"We offer naloxone kits. We are giving away approximately 30 per night. We cannot keep up."

- **Outreach and crisis teams. Meet people where they are at so they do not have to seek out services when they may not have the capacity to do so**

"Police and crisis team that we have is effective – PACT. It is resources that are mental health people assisting the RCMP and trying to help people who are in a bad state on the street and not necessarily causing issues. We have one of the bigger RCMP detachment centres. We do not want more officers; we want more social workers and nurses. How do you help people who are addicted and standing on the street? They may be scaring people, but they are not harming anyone."

- **Education and awareness to reduce stigma, build empathy and show that drug use can impact anyone**

"We have those education components with parents. How are you supposed to talk to your kids about these things and make good family decisions? We want to support parents and educators. This has to be layered across community. You have to make this choice yourself and here is the information that you need in order to make these decisions."

- **Longer post-recovery treatment and follow up to keep people in recovery**

"The most success I have seen is in the 90 days to 1-year services. I have seen people have great success when they are removed from their community for these longer-term treatment options."

"We are so fortunate to have Residents in Recovery who support individuals following treatment to stay in recovery. They have many great success stories, but funding is a significant issue."

Barriers and Priorities

CBO participants and community leaders discussed the barriers to recovery in their communities and shared ideas of what needs to be prioritized first. Because individuals have different needs and experiences, a one-size-fits all approach will not work for overcoming substance use. The lack of continuum of care serves as a significant barrier to individuals seeking support as well as the short length of time for treatment and situations where people go back to the environment they came from once treatment is concluded. Individuals require continued treatment and access to programs after detox, jail, or childbirth that support their recovery. Participants suggested a 'right door' approach where an individual can access specific support at whatever stage of drug use, treatment or recovery they are in.

Additionally, participants noted the need for 24/7 access to supervised consumption sites, youth support and services, and walk-in services. The current reality with regards to programs is that individuals must wait for call backs, walk long distances because they do not have transportation or a phone, manage multiple appointments, or live in rural communities without services and this creates barriers to receiving necessary supports. Some participants indicated that a single hub that provided support for housing, harm reduction services, and a supervised place to use drugs could help support recovery.

Stigma, lack of community buy-in for harm reduction services, and poor treatment by professionals also serve as barriers to recovery. Individuals need to know that they will be treated with dignity and receive meaningful support and understanding from peers who understand what it is like to be a drug user. Increasing representation of people with lived experience onto task forces and committees should also be prioritized.

Community outreach, education and awareness was cited as a priority, starting with prevention education. Drugs are cheap and many youths and children have experienced trauma and racism which can lead to addiction. Addressing these issues through education and outreach is crucial. Many individuals and youths with substance use disorder do not know what services are available and how to access them so there is a need to raise awareness of available supports.

Numerous participants cited the issue of housing and income insecurity as a significant barrier to recovery. Current government housing programs are setting individuals up for failure and eventual homelessness. People without addresses cannot access services, struggle to apply for a health card and more. Formerly incarcerated individuals who are clean cannot apply for assistance and are discharged into homelessness.

The following statements highlight many common barriers and priorities that participants mentioned:

- **Improve the links and approaches (such as trauma-informed care) between services, improve seamlessness of care, and provide a hub for many services in one place**

"Access to services. We are lucky to have support and other things. There is so much struggle in getting access to other services which would not be in question if they were a part of the general public. There is a challenge with the ongoing support. We get "we do not deal with those kind of people" a lot."

"Trauma informed care across all health services. What is happening in one area may not be the same. They may be encountering different client approaches."

- **Provide 24/7 harm reduction services, supervised consumption sites, family-based recovery, and walk-in support, including in rural and remote communities**

"A lot of our clients have to travel to Regina. I personally do not know of the access to those things in our community – clean needles, methadone, etc. I have been in this field for 9 years, but I do not personally know about them. We are isolated down here. There are no longer bus services. Getting down to Regina is a barrier."

"There is not enough family-based recovery. If someone needs to go away for residential based treatment, there is only one person that can go with them. When people realize that they have to be separated from their kids it blocks them from doing any services."

- **Lengthen treatment time partly so that individuals can avoid returning to the environment they were in while using substances**

"More work needs to be done with the aftercare. There is no chance of them having a different way of life so that they have the hope to continue to be sober. A lot of advocacy needs to be done with the after care. This goes hand in hand to getting them homes. We want them to not be in the same situation as they were before they went into treatment or addiction."

"When people go to treatment and return home to that same environment without supports that's when they struggle and return to that addiction."

- **Reduce stigma by public and professionals and improve community buy-in**

"Political will. We have all these opportunities and often it is how we are communicating it. We are seeing movement in these areas, but we need the greater community to get what we are doing. No one wants to fight for funding. Recovery is a process. The word itself is a misnomer – it is a reduction process. The biggest barrier is getting the community to understand and that comes from our leadership. And you need people with lived experience on those committees."

"Stigma. I still hear people refer to people with lived experiences as addicts and junkies. When we refer to these people who are already marginalized, they are not going to come forward. It is the drug that is the enemy, not the person."

- **Increase outreach, education and awareness to support prevention strategies, address trauma in children and youths, address racism, and increase knowledge of where to find support**

"We find that with a mental health therapist it is a lot of childhood trauma and abuses. They have begun to normalize the way that their life is now. They think that this is normal and that there is no other way to live. There is lots that has to be addressed. It is not just the addictions. They can go to treatment, but when they get out there is not a lot of hope that things are going to change."

"I know some kids who have no clue as to what is available to them. Maybe as simple as having a poster in the hallway may be a good start. If they have access to a phone number that might work too. They were too embarrassed to ask their teachers due to the complications that may incur. They need to have access to this information without having to ask."

- **Address the issue of housing and income insecurity, including for previously incarcerated individuals**

"It is a huge barrier if you don't have access to a doctor. The policies on where you need to get your health card updated. This is another systematic change. You cannot just walk in and say hey this is my name this is my address. Or they cannot even ask for this to be mailed because they do not have an address. So we are losing them.

"The ministry of social assistance are taking people off of the SAP program and are putting them on the CISTS of the SAID program and if people did not apply before August 30th [2021], they were taken off. Social services said that they were going to make it seamless. It was not seamless. And so now so many people are homeless because of this policy change."

- **Other: Decriminalize drugs, reduce waitlist for OAT (Opioid Agonist Therapy) and increase number of prescribers (some healthcare professionals do not want to become prescribers in their area)**

Short- and long-term solutions

When prompted to answer what solutions could practically be achieved over the next 2-3 years with limited resources available, participants suggested reducing wait lists, extending hours of outreach and harm reduction services, expanding access to OAT therapy and drug testing, providing supervised consumption sites and equipment, and increasing the number of detox beds. It was pointed out that taking an inventory of services to find the overlaps and to create a single point of entry to access services would help individuals get the support they need when they ask for it (without having to ask again.) Some participants noted that the province needs to address the root cause of substance use disorder: homelessness and income and food insecurity.

Education in schools and training for frontline personnel and healthcare workers were also identified as achievable short-term solutions. Participants noted that students connect with people who have lived experiences and that increasing the public's awareness of the benefits of harm reduction, and training workers and providers would help reduce trauma and stigmatization of individuals who are in need of support.

The following common themes emerged from this section of the discussions:

- **Extend hours of outreach and harm reduction services and add capacity to reduce waitlists**

"Safe [supervised] consumption 24/7. More managed alcohol and harm reduction supportive housing – we have a model and agencies that work. Having more detoxes so that we have immediate ability to get them in and get them safe."

- **Provide harm reduction services and supervised consumption sites; expand access to Opioid Agonist Therapy**

"Easy access to naloxone kits and clean tools. People are going to use no matter what."

"Fund safe [supervised] consumption, social units and detox units beds, and build into our systems outcome measurements – we need to demonstrate that these services are effective."

"Rapid access to OAT and OED it would be great to have more detox treatment facilities. There are programs operating in the province – could they be expanded to other programs? If there is something running why not expand it or open it up to other areas?"

- **Have a single point of entry and partnerships with various entities**

"Partnerships – government services, Indigenous and community based organizations knowing that they all have something to offer and gain."

"The other place that I would look at is someone taking an inventory of the services and organizations that are available to help and determining where the overlap is. In Regina we have the Canadian Mental Health Association, and then we have another building for the Saskatchewan Mental Health, and then there are several chapters in several cities. There are 3 offices and 3 board and 3 staff complements. I do not know what they are all doing. I thought why would you all not just be working in one office and creating some efficiencies with building space and staff so that the money is used effectively as well. I do not think that it is just the Canadian Mental Health organization that has this problem. Every time I hear about another fundraiser for a new group I ask myself – are they the only group that is doing this? Who else is doing this? Why are we starting up with more infrastructure? I know we have limited resources. Let's make the best use of them."

- **Reduce trauma and stigmatization through training frontline and healthcare workers, educating students and increasing the public`s awareness**

"Start a group that it is non-authoritarian based people and get them trained – all the 7-11, Tim Hortons, McDonalds workers and get them trained on the resources available in our community. This would need to be as limited as a one-hour course."

"We need education at the schools, but the education that I got was scary and inaccurate. When I saw people doing those drugs it was not so scary and so I started to disbelieve what they were saying. We just need to say that you are not a bad person for doing drugs."

"Students really connect with people who have lived experiences. This is a really good motivator."

"How do we change the stigma or general public belief around addiction when they believe in 7-day detox or 28 days in recovery – the government states that this is what is working and they should be fixed. We are teaching the general population the wrong stuff and we need to change that."

- **Address the root causes – homelessness, income insecurity, food insecurity**

"I would invest in more housing. I do not think that people are even looking for big fancy homes. We are opening our doors to blankets and cots for the night. They have these small singular homes that people would cherish. Just something that they could call their own and that they could go to at night."

"People are coming because they do not have access to warmth or to cool off or use a bathroom. We saw 21,000 people in 3 months or about 500 people a day. We get single moms, we get grandmothers caring for their kids, we get homeless people, we get people with mental health and addictions. We feed so many people. If we can help you, we are going to help you in any way that we can. That is where it starts."

For long term solutions, participants indicated the importance of ensuring that individuals' basic needs are met first by addressing access to affordable housing, food insecurity, lack of transportation or communication technology (such as a phone) and education. Along with meeting basic needs, reduce waitlists, provide more detox beds, provide 24/7 access to harm reduction, supervised consumption and treatment services, and ensure there is a continuum of care so that individuals are stabilized. Additionally, do not expect individuals to manage their mental health separately from their addiction.

To inform policy and rebuild supports over the long-term, participants recommended applying an Indigenous lens and increase representation of PWLE in decision-making spaces. Treat addiction as a public health issue and decriminalize drugs and individuals who use drugs and invest the money into programs. Participants expressed the need for more education and prevention programs to address trauma and improve wellbeing for children and their families. Additionally, frontline workers should be trained in trauma-informed care so that they are not re-traumatizing individuals and their families and to help reduce stigma.

The following common themes emerged from this section of the discussions:

- **Meet people's basic needs – access to affordable housing, food security, income security, access to transportation and communication technology**

"We need to keep going forward and advocating so that we can hear from the people themselves and see how can we help them. What can we do that will make a difference. I think housing, more opportunities, etc. I think that this would help some of them."

"We have a lot of housing vacancies in non-for-profits. My suspicion is that they are not low barrier enough."

- **Reduce waitlists, add capacity, provide 24/7 access to harm reduction and supervised consumption services**

"Detox beds. When a person comes and says that they need to go to detox, if you get them in there today they will get in the system. As soon as he is in a place where he has to wait, you have probably lost that individual. You have to make that stuff available."

"Providing safe supply for people who are using. We are forcing them to go out and buy off the street and have to spend limited money to get what they can. I have worked with people who are in these situations and they are able to get a prescription for Hydromorphone *and they are able to come in and we are able to give them their other medications and they are able to connect with their supports. They do not want to be abstinent."*

- **Increase representation of PWLE and apply an Indigenous lens when rebuilding supports and making decisions, provide support and resources to Indigenous-led programming**

"The biggest population in Prince Albert is Indigenous. When we talk about AA and those things they are not comfortable going to these things. These circles are often white and there is nothing being said that these people identify with. I think that we need to rebuild these supports and come from an Indigenous lens."

"You need people at those decision making tables who have lived experiences. Or people who deal with these individuals on a day-to-day basis – although they are usually too busy to provide this service. The biggest difference is the gaps. The evidence based harm reduction is there. It is the will of the people who are holding those solutions. I think in the end we are going to save money on health care and other supports. It doesn't mean you solve this issue, but you stabilize them. They do not die."

"Supporting and resourcing Indigenous led programming. Honoring Indigenous sovereignty in how these communities want to address addiction in their community."

- **Decriminalize drugs, treat addiction as a public health crisis, reallocate money into programs to help people rather than criminalize them, offer drug treatment court**

"People who are homeless and living on the street are re-victimized. We need to decriminalize substance use. Adding law enforcement on top of this just compounds the trauma. I understand the trafficking piece. The people we deal with are victimized all the time. They do not need to be harassed by the police or the justice system on top of that."

"Decriminalizing of small possession is one piece. These charges just create employment barriers. If someone goes to jail, they lose their housing and come out homeless. It does not benefit the person when that is the unintended consequences of this. It is a waste of our resources and ties up the justice system. This is already in the works in Regina. In Regina they have already started informally not charging people. It does not improve anybody."

- **Provide a seamless services experience to ensure individuals have care and support at every step of their recovery journey**

"Holistic care. There is a lot of siloing. If you have mental health and addictions, you cannot access both mental health and addictions services. They expect you to deal with one before you deal with the other. I have never met anyone who struggles with addiction who does not have trauma."

"It is the follow up at the end of treatment. People leave feeling alone and that they have nothing. They cannot go back to their friends. It would be nice to see a mentorship program where you can follow up and if you are having a bad day, you can give them a call. To have a treatment centre outside of the community and a mentorship program to follow them after their treatment."

"Prevention efforts – more services without expiry dates. Where they can build relationships with healthcare providers and others. I also agree about partnerships. We also need cross-training for staff. Credentialing staff increases safety – this is where the province is falling behind."

- **Reduce stigma and re-traumatization, provide sensitivity/trauma-informed training to healthcare professionals**

"Retraumatizing people from systematic barriers or discrimination – how do you make people accountable for that? Who is going to police the police?"

"We need to get our medical people trained to be more sensitive to their clients that they are serving. It is so insulting and degrading that this is often the first question to an Indigenous person. If their answer is yes, the quality of care is downgraded immediately. They need to have some culturally sensitive training immediately."

"There needs to be an emphasis on maintaining family unification and residential supports as well. Social services can completely derail someone and if there was more preventative methods to keep the family together and giving them a supportive family to grow up with and prevent the trauma that goes with that family separation needs to be a focus."

- **Educate and provide prevention programs for children and families, address trauma, intergenerational trauma and wellbeing**

"Being able to talk about this and normalizing it. Giving them tools if their friends or parents are using it. Just that education piece."

"We can have all the education pumped out. We have all the centres and can help people in different ways, but that after care is a vital part in trying to help someone who is trying to change their life and quit using. Some people need to be taken by the hand and shown things. They need more help to make changes sometimes. We look at the residential schools and the independence that was taken away from the residential schools. How do you break that when they are so used to relying on government and our system to give them what they need? They do not have the independence that they used to. When you talk about the family break down there is a lot. People did not know how to parent."

Impacts and Social Acceptance

In answer to the question about what services and supports they thought would have the biggest impact in their communities, participants shared various ideas including: ensuring existing supports and services work together and are more responsive; increasing culturally-based, Indigenous-led programming and providing training and trauma-specific training to workers to help them better understand addiction. Other notable suggestions included helping to keep families together, decriminalizing drugs, engaging youth and addressing worker burn out.

To make seeking help more socially acceptable, participants stressed the importance of listening to and learning from PWLE. Storytelling and learning would change the narrative around substance use, humanize individuals who are addicted, and normalize asking for help. In addition, participants felt that public awareness campaigns about substance use disorder and educating service providers would reduce the stigma for individuals seeking help. By making 'every door a safe door,' providing peer support, and ensuring after-hours access to programs and services – along with professionals available at supervised consumption sites – the social acceptability of asking for help would improve.

- **Enhance responsiveness of existing supports and services, ensure they work together, and provide after-hours and safe access**

"Getting some of those safer options in place. It would be nice to eliminate the drugs off the street, but we have come to realize that people are going to use and we need to create those safer harm reduction type options. It is going to happen."

"We need a one stop shop that has all the key components – finances, trauma, treatment, etc. working together in one area and being able to work longer hours, not just 9 – 5 and attaching to that outreach. We need to bring all our services together and allow that person to segue from one thing to another."

- **Increase cultural, Indigenous-led programing**

"When the government gives money it is for a specific purpose. We are being too restrictive. Each community needs to be able to respond to their community crisis. This really restricts the community from doing anything. If the government could give additional resources in community to deal with this. It is really the intergenerational trauma that is the cause of this situation and the more that this is repeated the worse that this gets. We need to help individuals deal with these traumas and give them tools to help them overcome."

"A conversation in the communities is regarding a culturally safe medical program. That does not have necessarily the same timelines as our typical programming and connecting people back to the land. This is a conversation that has been happening and will help people with where they need to be."

- **Provide trauma-specific training and other training to frontline and healthcare workers**

"We need education and training for everyone – a lot of our frontline services including front line services and police. They need a better understanding of how harm reduction works and understanding of being

human. Many people are not treated that way. We are not going to get anywhere if they are not treated that way."

- **Provide programs to keep families together while parents with addictions seek help**

"We do have a crisis with our child services agencies, and they are unable to find homes. I have someone in my family who is trying hard to find a person to look after their children. I see this as being a big problem. A lot of broken families and the couch surfing. You don't trust someone to come into your home because of addiction and habits of stealing. We do have a lot of people who are couch surfing."

- **Listen and learn from PWLE to change the narrative around substance use and normalize asking for help**

"Saskatchewan is a drinking society. We all use substances. We need to start realizing that there is not this them and us. Choice is subjective. No one chooses to live in the life of addictions. They may be content, but they have the right to do what they want with their body. That may be a little too radical, but no one is telling us that we cannot have our drink at the end of the day. I also think that this is unfair to tell someone with trauma that they have to stop using. Maybe this was the one thing that stopped them from suicide."

"I wish that this was viewed and treated through a medical lens. It is not. We need to normalize it. Like Doug Ford being in a trap house smoking crack. Just visibility of people in power talking about their struggles."

- **Deliver public awareness campaigns and education to reduce the stigma around asking for help**

"Education and awareness. Changing behaviours of people and their judgement of others who may be less advantaged or down on their luck. It is difficult to get people to like someone or not make judgements on someone. Perhaps if more people who had made it through and survived the system, the stigma and the addictions, spoke out about their journey that it can happen. It doesn't just happen to disadvantaged people."

"Public campaign about what substance use disorder does and does not look like – there is so much stigma around seeking help. It could be anyone of us. Need to show people what recovery can look like."

- **Offer peer support and mentorship programs**

"Need to make every door a safe door when people go to ask for help. It needs to be socially acceptable. We need to meet people where they are at. We need to have peer supports. We need them to build relationships. This is what makes help more acceptable."

- **Other: Decriminalize drugs and engage youth**

Appendix A: Engaged Stakeholders

Praxis Consulting contacted a list of 117 Community-Based Organizations (CBOs) and 14 Community Leaders (CLs). Of the 117 CBOs, 48 responded and were registered for a focus group, 42 of which attended a session. Of the 14 CLs, 9 responded and were registered for the CL specific focus group, 8 of which attended.

Communication to CBOs/CLs included:

- Introduction to CBO Focus Groups on September 3rd, 2021
    - CLs received a separate time for a specific for CLs
- Reminder of CBO Focus Groups on September 14th, 2021
    - CLs received a reminder for the CL specific session
- Addition of CBO Focus Group dates on September 21st, 2021
- Reminder of remaining CBO Focus Group dates on September 28th, 2021
- Introduction to People with Lived Experience (PWLE) Focus Group Recruitment on September 27th, 2021
- Reminder of PWLE Focus Group Recruitment on October 1st, 2021
- Introduction of PWLE Survey Recruitment on October 7th, 2021
- Reminder of PWLE Survey Recruitment on October 18th, 2021

Representing Organization
Saskatoon Tribal Council Health & Family Services
Primary Health Manager, Saskatchewan Health Authority
Residents in Recovery, Lloydminster
Northern Medical Services, Saskatoon
Primary Health Manager, Saskatchewan Health Authority
Community Advocate, Regina
Moms Stop the Harm, Saskatoon
Saskatchewan Health Authority
AIDS Program South Saskatchewan, Regina
Prairie Harm Reduction, Saskatoon
Registered Nurse, Saskatchewan Health Authority
Safe Community Action Alliance / includes CM Working Group Committee
File Hills Qu'Appelle Tribal Council Health Services, Fort Qu'Appelle
HIV Strategy Coordinator, Saskatoon Public Health
Saskatoon Mobile Crisis
Director, Mental Health and Addiction Services, Regina
Prince Albert HUB Table
Saskatchewan Health Authority, ED St. Paul's Hospital
Prince Albert Mobile Crisis
Estevan/Weyburn HUB Table
Community Health Services Association (Regina) Limited
Ile a la Crosse HUB Table (Northwest La Loche, Ile a La Crosse)
Sanctum, Saskatoon
Prince Albert Indian & Metis Friendship Center

Society for the Involvement of Good Neighbours (SIGN), Yorkton
Lac La Ronge Region HUB Table
Moose Jaw HUB Table
Battlefords Family Health Centre
Newo-Yotina Friendship Center, Regina
Moose Jaw Crystal Meth Strategy Committee
Drug Strategy Action Committee, Swift Current
La Ronge Health Center
Saskatchewan Health Authority
Joe's Place Youth Centre, Moose Jaw
Elizabeth Fry, Saskatoon
Cowessess First Nation
John Howard Society Saskatchewan
Director, All Nations Hope, Regina
Director, All Nations Hope, Regina
Cote First Nation
EGADZ, Saskatoon
Envision Counselling Centre, Weyburn
Representing Community Leader
Mayor of Lloydminster
Mayor of Yorkton
Councillor of Swift Current
Mayor of North Battleford
City Manager, North Battleford
Mayor of Weyburn
Acting Mayor of Moose Jaw
Social Services, Weyburn/Regina

Appendix B: Moderator's Guide

Saskatchewan Drug Task Force Community Engagement
Moderator's Guide – Final

FOCUS GROUP INTRODUCTION [10-15 mins]

- Introduction of moderator + role.
- Explain that focus groups are a way to collect opinions about experiences in more detail than a typical survey. These conversations are exploratory. There are no right or wrong answers. We understand that there are complexities and nuances. We do not want you to set you down a path of expectations regarding outputs following the session. Each person should speak for themselves. Not looking for consensus or agreement – don't hold back if your opinion or what you think or do is different from what others are saying. Any and all input is welcome and very much appreciated.
- The Drug Task Force (DTF) is engaging with Community Based Organizations (CBOs), people with lived experience, community advocacy groups, municipal leaders, and Indigenous organizations who share the common goal of reducing harms caused by drug toxicity including opioids/fentanyl/crystal methamphetamine and other similarly harmful substances.
    - Engaging stakeholders in the early stages of the development of a multi-year action plan is important to obtain their support and commitment to support local actions going forward.
    - Community engagement is an opportunity to gain a shared understanding of local issues and find opportunities to address this issue in the Saskatchewan context.
    - The engagement project has three primary objectives:
        - 1) to discuss with stakeholders the efforts that have been undertaken to mitigate harms;
        - 2) to gain insight from those with lived experience and service providers for a better understanding of how programming could be improved, and future policy considerations; and
        - 3) to consider community specific solutions.
- The ultimate goal for the session is to give everyone the opportunity to express their position, while staying solution focused as much as possible.
- Explain notetaking and recording of the discussion - when we put the report together, we like to listen to the recording to make sure we've covered everything off that was discussed in the group.
- Introduce anyone who is observing the session
- Assure participants that their names won't be associated with anything they say in the report - the data will be summarized and reported in an aggregate fashion without any names attached.
- Duration approximately 2.0 hours; not taking a formal break; please mute phones.

- Include moderator email in chat and explain that participants can email directly if they don't have enough time to say everything they want or think of something after the session has ended.
- Go around and begin with introductions.

MAIN DISCUSSION

The Drug Task Force recognizes that there are many factors to consider through this engagement process, but first and foremost, its interest is to reduce the harms of overdoses and deaths due to toxic substances. It is important that we stay solution focused as much as possible and allow a chance for everyone to speak.

CURRENT SITUATION [20 – 30 mins]

1. To start, how concerned would you say you are about the current situation in your community?

2. What do you think contributes most to substance use in your community? What are the contributing factors?

3. Are you aware of any prevention strategies, harm reduction services, or recovery options available in your community? What do you feel are be the most effective strategies or services that are currently in place?

BARRIERS [10 – 15 mins]

4. What do you feel are the biggest barriers to recovery in your community? What needs to be prioritized or addressed first?

SOLUTION-BASED DISCUSSION [45 - 60 mins]

5. The rest of our discussion will be solution focused. Let's focus on short term solutions first. Over the next two to three years, what can practically be achieved? In other words, if you were the sole decision maker, where would you invest the limited resources available?

6. And, over the long term, beyond five years, what interventions could make the biggest difference in reducing the harms from substance use?

7. What services and supports do you think would have the biggest impact in your community?

8. What needs to happen to make seeking help more socially acceptable?

9. Any final comments or suggestions to pass along?

That brings us to the end of the discussion.

***** Remind participants that they can email any additional thoughts/comments.**

***** Re-iterate/introduce the full scope of project, emphasizing the importance of also talking to people with lived experience. Ask for willingness to support that initiative with helping to recruit for focus groups and/or distributing surveys** (Note: this is a different survey link than the one they were sent)**.**

Thanks very much for spending some time with us this afternoon/evening and providing your feedback.

Appendix C: Transcript

<u>CURRENT SITUATION</u> [20 – 30 mins]

1. To start, how concerned would you say you are about the current situation in your community?

- If something does not change this is an ever-growing epidemic. There is more and more divide, with those most vulnerable being left behind. It is getting worse and worse and killing far too many.
- I agree. It is not even rural; it is also remote. The gap between the haves and the have nots is huge. With COVID-19 we have had a matching number of deaths without resources to manage. This is a growing epidemic. Part of the problem is that the population is treated as a throw away population.
- I have seen the same in my location. The RCMP and EMS have attended more overdoses by the end of August as they did in all of last year. We have had way more overdose deaths in the community and I do not think we have even come close to being at the peak of this.
- We see exponential numbers every week. Within the marginalized community they are losing a lot of people. I have families and struggling parents not knowing what to do after a death – this can be for those who have struggling issues, are recovering or are struggling with the loss of an individual. We need a lot more. It is only getting worse.
- I agree with Regina. I work with the HIV clinic. At least one of our clients will die within a 2-week time frame for when I am gone. That is just within the HIV clinic. In Regina, the numbers are already above what we said last year. The organizations that provide community support have been closed or have reduced hours with the COVID-19 pandemic.
- I echo the comments of others. I have worked in this area for 4 years. I am really concerned. This situation is getting worse. Overdoses have gotten worse in the last few months. Sometimes we have 15 overdoses in a day. We have people overdosing at our backdoor. We also have a housing and mental health/addictions issue. We need more of this support. We need more outreach teams. Overdoses are a huge concern. There was an HIV epidemic in Saskatoon, a lot of the services were closed – testing was not as openly available.
- I agree with what has been said. There are not enough services to meet demand. Attitudes in the community are also a limiting factor to move toward more progressive harm reduction models. There is also a lack of stability. You offer mental health, but they cannot deal with their trauma until they have other things in place. You cannot get any traction. Opioid use is increasing, but we are starting to see a big increase in crystal meth Use. This is being exacerbated by the pandemic and a lack of resources
- I am concerned about not just my community, but the province as a whole. Over the last 10 years HIV has been more common in my home community due to drug use. This is connected to safety and homelessness and poverty and stigmatization. Before it used to be alcohol and marijuana and now it is heroin and cocaine. It is very concerning for not only the individuals affected and the province as a whole.
- We are also struggling with crystal meth use – our clients do not use any downers. They feel that they are only using crystal meth, but there is also fentanyl in it and so they are ending up in the hospital. That is how they are overdosing.

End of Group: 1

- Very concerned about the situation. Opioid poisoning, crystal meth usage, alcohol usage. A number of clients have perished due to their substance use disorder.

- Have seen an increased number of deaths due to alcohol. Liver failure. We have delivered more needles than other years. This shows that we do have a problem. We are also noticing burnout among our providers.
- There are not enough ways to express my concerns. We are concerned enough that we created a crystal meth working group 3 years ago and have engaged with organizations and people with lived experiences to try to find solutions. This is an indication of the magnitude of concern.
- I agree, but I would also add that I am concerned with the secrets that kids are keeping. Not just from kids, but also from adults too – some of the shame that is being hidden and is contributing to suicides.
- Definitely concerned about the current state. There is a ground swell of people who are trying to bring this situation up. It is falling on deaf ears by government. We really do not have concrete action that is focused on the bodies that are piling up. There is real concern. There is a stigma when people do not feel that this applies to them or their families or friends.
- Obviously, I am very concerned. In rural Saskatchewan we have seen a drastic increase in substance use and overdoses. Something needs to be done. Rural communities are not prepared for this. There are not enough resources. There is not addictions care. It is a huge problem. Our clients are afraid. The amount of naloxone kits we have given out is alarming – I am glad they are coming to get it, but it is an alarming situation.
- It is concerning to us. We have lost many of our clients in the last year. We give out naloxone kits and train them. It seems like there is a lot of talk, but no action to back it up. I am glad we are talking, but while we are talking, people are dying. We need consistent, long-term funding and we need people to understand that so that we can get started.
- I echo everything that has been said. The strain and the depth of the crisis is adding to the list of things being addressed by the front-line staff. There is a lot of fatigue. We need to recognize that a lot of people get into this work due to their own lived experience or through family. That strain and fatigue is also putting them at risk of relapse. At what point is our community going to reach that breaking point where our helpers are no longer able to help.
- We are concerned at the extent of use, violence and unpredictable behavior that their loved ones, workers or people they come into contact have to deal with. So, the extent of pressure put on families. I have hope for an action plan.
- Very. This is something that is hard to measure the harm associated with problematic substance use. There is not data that is accessible (publicly or as a health care worker) to gain a true understanding. Most people would likely underestimate the effects of the current situation. I think that this is an everyone issue, not just mental health and addictions. This is playing a role in many other health areas apart from mental health and addictions. There is more attention from other systems – including child and family service programs and policing. We are having to change so much – most services are not this nimble. The kind of support that they provide is a real struggle. It is hard to get funders to realize this. We are struggling – even in the specialized services – to keep up with everything that is changing.

End of Group: 2

- On a scale of 1 – 10, my answer would be 11. It is a problem, and I am not seeing any immediate solutions. There is some research that exists that I believe can assist us. We have a very dark under belly in what appears to be a sleepy town.
- In PA, it is a grave concern. I would agree with 11. What we are doing right now is not working. We need something right now and we need it fast. Our people are dying off and it is atrocious.
- I echo. I am not as close to the situation in Regina, but I certainly hear things. Regina is a big place. People can get lost in the system here. This might be a different problem than Swift Current or Prince Albert.

- It is unreported in the media the number of overdoses and the overdoses that result in death. Several times a month in our small community we experience this. I am seeing this firsthand.

End of Group: 3

- Unfortunately, they call our town Meth Jaw. The sad reality is that in many communities opioids are a real concern. In our community it seems that crystal meth is everywhere. That is a real concern. In the world of addictions, you need to strike while the iron is hot. When they are at that point that they are ready to accept help, help needs to be readily available. That is not always the case. In the time that they are ready to get help things can happen including relapses or something worse.
- I am seeing the impact on our children. Drugs are a big player in lack of attendance, or trauma, or not being looked after. It is really difficult to get support. At the end of these meetings, parents want support, but we do not have sustainable support. We have short-term counselors, but that does not really solve anything for our students. I can really see a change in our schools.
- Both mental health and addiction issues have been exacerbated by the pandemic. One of the unfortunate things is that we do not have enough resources. The people that are there are trying their best, but I am not seeing the differences in the investment in what's available in the frontline. I just do not know where the big resources are going.
- In Prince Albert, the situation is dire. The pandemic has changed things. More doors have become closed or are not accessible due to the pandemic. It has brought the homeless out and they are more visible in our community. There is nowhere but here for them to go. We need to get community buy-in. When someone is ready to go, we need to immediately be able to get them there. It takes a long time to get someone down that path to be ready to make the changes. They often give up and go back harder. We need to get them in immediately and that first immediate time likely is not going to work, but we need that door open to get them that help. A safe [supervised] injection site would make a big difference – but we need to get community buy-in. In the long term this will save us money.
- Users are now sleeping on the street. We are housing, support, mental health and addiction, trauma support poor. People are coming out now due to the pandemic. We are seeing the chaos of addictions. We are in a surge of HIV and syphilis. We are having more and more women coming in testing positive for HIV with their pregnancies. There are very few supports, and it is multi-faceted. They do not want to go to the hospital. It is getting more and more difficult to get in. The trust with the medical system is not there. Our individuals are leaving against medical advice. We have a phenomenal number of overdoses. Every day it is the same, but it seems to be getting worse. There is nothing here. The support is so minute in comparison to what we need to be successful. In the Western world we work in business hours. Many of the people that use it do not just use it in business hours. How can we get that buy-in to support around the clock? We need that support in the evening and the night and it is just not there.
- We are seeing a large increase in the use of opioids. HIV rates are increasing. Overdosing is increasing. Detox beds are at a limit. By the time they are getting into detox they actually need a treatment bed. A lot of people showing up at our doors have nowhere to go. They need a place to stay. What is happening at the urban centers is happening in rural as well.
- The availability of detox and having treatment beds available is such a struggle. Oftentimes they relapse in between and go in deeper because they are upset that they have failed. We need more continuity and care. Detox and treatment. The re-traumatization is happening over and over again. We need to have support for these people to gain their trust. It is not going to get better if we don't gain their trust.
- I echo. I do not work directly with these individuals. With COVID-19 happening, our makeshift homeless shelter will not be open for the winter. We have a housing crisis here.

Even for people with full-time jobs. Everyone gets these 2-year grants, and the money is going into it, but there is no coordination between the agencies. There is an assumption that these services know what the other services are offering. They are not being used to the full extent.

- We have that too. Even in our smaller community. We have that stuff here. We do not have as many injections and drug use. We have crystal meth and cocaine. We have gangs. We have crack houses. It is frustrating, especially when you know the harm that is happening to your families. It is devastating. Northern Medical Services reported that there were 97 attempted suicides in the first 7 months of 2017 alone. It is all related to the drugs and alcohol. They are really trying hard but as soon as they get it in their hand the addiction just blinds them. There are not enough services. We should be relying on culture and healing on the land process, but the resources are limited. There are 14 or 15 hub committees across the province that are helping. You need to allow the healing and the programming.
- I want to echo a lot of the sentiment. We are extremely concerned. There is really good information in the Coroner's Report and the monthly Police Commissioner's Report. At the end of July, it was 72 people who died in a 6-month period due to overdose. They have to confirm this in the Coroner's Report before they will give it to the region. This is a 20% increase compared to last year. We were seeing an increase even before COVID-19. Meth usually does not cause death from the drug itself. It can be a contributing factor. Being able to get people in when they are ready – right now and not in 6 weeks – is a big concern. We are about two blocks away from detox, but to get people into treatment, that is tricky.

End of Group: 4

- We are concerned. We have had an increase in crime rates related to gang activity. Alcohol usage is trending younger year over year. This increases the number of individuals living with addiction in adulthood. There is a stigma around this. We are seeing an increase in the number of deaths related to opioid use and fentanyl especially. We are also seeing an increase in people trying to access supports with long wait times. It is not always available when needed.
- Alcohol and tobacco are the biggest drugs. I just watch the prohibition in the earlier days. Are we looping alcohol and drugs into these things? We are getting back into prohibition when we lump all these things together. When Nixon started his whole thing on drugs and how it failed – what are we looking at? Police have all been told that drug use for class 1, 2, 3, and 4 are just to take away the drugs and throw them away. We have seen alcohol usage in our youth go down, but pot usage goes way up. The burden on the health care is #1 alcohol and then tobacco. The current situation is about less alcohol and more pot. We still have this whole demonization of alcohol and alcoholism. Nobody talks about diet and obesity.
- Can I suggest that we work together to change the culture of alcohol to one of moderation vs the current culture of intoxication that exists in many communities rather than a response of prohibition. In Lloydminster, we have seen a rise in alcohol use across age groups - accessibility and acceptability support increased use.
- There is a lack of response from various government organizations when it comes to treatment for individuals who want to go through treatment. The Pine Lodge Treatment Center in Indian head burned down two years ago – that is not fixed. We have a treatment center in Estevan with limited beds. For individuals who are wanting to come into treatment we are looking at 3 – 4 weeks and even months. If you have insurance or a decent work plan you can go to treatment in other provinces. We are needing a 2-tiered treatment plan. We need to put some pressure on for people to go forward with that.
- We have seen an increase. Due to the pandemic some people were behind closed doors. The number of drug users in our community has gone up 260% from 2020 to 2021. We need more

treatment centers. People are coming forward and saying that they need help, but they are having to be on waitlists, so they are falling through the cracks.

- For years this had been a silent issue. It is something that we keep hearing that is keeping our RCMP very active. In 2019 we were at 60 drug charges, in 2020 we were at 94 and now we are back down to 60. Dory's House is now a youth facility. This is an SHA funded facility. I am hoping that alleviates some of the issues.
- The alcohol situation has kind of diminished a little bit. We do not discuss this as much as we used to – now there are too much marijuana and opioid usage. They are now sitting back because they do not want to bust the kid, but instead see where this is coming from. I think that it was a big mistake to sell marijuana to a child who is 19 years old. Psychologists say that the brain is still growing. Depression and anxiety are coming out of the wood works. Prevention is something that we should be doing. There should be a class about drugs in schools, not just addiction, but drugs and the tools as well.
- Treatment is important followed by funding for recovery and a community that supports individuals living in recovery.
- Obviously, there are a lot of different drugs – we are here to talk to synthetic. The other drugs are increasing our crime rates. There are two ways to deal with this: prevention and treatment. The availability of these types of drugs and the treatment. They are here until the feds can squeeze out the raw materials that produce this stuff. We have to deal with it. We have to treat these people somehow, at least the ones who want to be treated. It is difficult to talk to the province about this stuff. It is hodge podge right now in this province. You might get a treatment center. You might not. We should have regional treatment facilities regardless of politics. We do not have facilities here (in North Battleford). We have the biggest liquor store in our province in the downtown. They make so much money from this and they should be paying for the treatment. Until we can control the flow of drugs, how do we treat these individuals? And municipalities are supposed to deal with this? This is a sin of the provincial government – with marijuana and alcohol. And we are supposed to deal with this?
- Treatment closer to home, supported by recovery support and families/community support.
- I know a lot of people lose their businesses from drugs. This is a huge societal problem. It is so obvious here with our street issues, but there is that other group that is hidden very well. They are creating their own havoc with domestic violence.

End of Group: 5

- Extremely concerned with the current state and current situation.
- We are feeling very concerned. It is impacting us quite a bit. Definitely a big impact on us. We need to support people in their recovery and mental health the best we can and overcome barriers in the supports they need – especially not having the safe [supervised] injection site open.
- In our area I am also concerned. We are seeing poly substance abuse. Our hard to house went from using alcohol to using crystal meth. It is just getting more difficult trying to support people.
- Absolutely concerned. Every community is. We are seeing more severity in poly substance use. Just the drugs that have evolved over the last several years.
- We are also concerned. The client group we work for lives with opioid use disorder. Poly substance use has made this more complicated. Our clients are ending up more now in the ER from overdoses. The poly substance with crystal meth makes it more difficult to work with clients and adds a layer for our clients that complicates things.
- I have seen overdose and people who are on those harder drugs. Right now, we have just been through a period of losing staff members. We do not have an addictions staff counselor right

now. We are struggling to find someone appropriate to hire. This contributes to the lack of services we are able to offer our clients. With COVID-19 this exacerbates everything.
- It is definitely a concern for us as well.

End of Group: 6

- Very concerned. Living in North Central I see it in my neighbourhood. I came from Vancouver, and I thought that was the epicenter of drug use. In Regina it is just not as public. My two biggest concerns here are crystal meth and fentanyl.

End of Group: 7

- Our views around addiction and what needs to happen is different than many individuals.
- I can safely say that we are very concerned in terms of addiction. Our drugs are getting stronger. The long-term damage that it is doing to people is putting them into vulnerable situations. Things get escalated. We have been doing our outreach since 1993. No one would break into our vehicles. It was a taboo to harm the people who help the community. We are now getting broken into weekly. People are doing things now that they normally would not do. We are very concerned with what is going on and we want to be a part of the solution.
- We have a crisis within our communities and within Kamsack. Our programs focus on the people within the local area. We have a high usage rate. We have a lot of death. Right now, our biggest problem is with fentanyl and crystal meth. We do advocacy and education within the centre that our clients are dealing with.
- Being a child welfare agency, the children that we have in care is 90% due to some form of addiction – alcohol, drugs, prescription drugs. Recently in the last 6 months there have been death in the communities with drug relations. This is becoming an issue in all 4 of the communities that we serve. We have no treatment services here at all. No detox, no nothing. When people are ready to go on treatment they are waitlisted and that causes a struggle for these individuals.

End of Group: 8

- There have been a number of drug overdoses. There are some barriers as well to accessing these services. There needs to be more for family members. It is not a one-person issue, but a family issue. It is everywhere. It is not always people in poverty. There are a large number of people who are in upper class who have the money to purchase more expensive drugs. They are functioning addicts. A lot of people around them may not even understand that this is happening. Of course, this is happening in poverty as well.

End of Group: 9

2. What do you think contributes most to substance use in your community? What are the contributing factors?

- Racism and stigmatization. Trauma. Poverty. Homelessness. Those are a couple that I feel are contributing factors. It is hard to focus on recovery and your health if the basic needs are not being met.
- Stigma contributes considerable against people who are homeless and families who have trauma. They are concerned about how their family will be perceived by the community. Timely access to supports. Poor mental health supports – more than anything.
- Mental health supports.
- Any nurse practitioner can prescribe for an opioid. They have to jump through hoops to have a prescriber for opioid agonist therapy. Plus, they have to spend so many hours with a mentor which has been thrown out due to COVID-19. We have very few harm reduction

clinics/strategies. What we do have holds a lot of stigmatization and racism, prescribers and the health care system as a whole. We need trauma centered education and culture education.

- Get caught up in the idea of historical trauma. Our clients are experiencing ongoing trauma through care and their on-going lives, and they are struggling from this, and it drives them back into substance use. This gives them a break from how they are being treated day to day.
- All has been said with racism, trauma, stigma and lack of supports to meet basic needs being top of list in my mind.
- Unresolved grief and multi-generational trauma related to history.
- A lot of the people that we are working with have never had access to their own culture. There is a whole loss that has occurred. When you look at adverse childhood events that is huge. Saskatchewan has really high rates of domestic violence. We can look at childhood trauma and predict drug use and likelihood of suicide. 69% of people who have been taken away from their families and have some sort of abuse have a higher chance of drug abuse. When people are signaling they need help we do not have the resources – not even for the basics. We have a system that does not respond and then we end up blaming these individuals. There are major systemic issues leading to this.
- 100% Racism, the effects of colonialism, stigma, lack of mental health supports, housing and food insecurity, trauma from previous health care experiences which turns them away from accessing in future, also... didn't mention - access to supports and opioid agonist therapies while incarcerated.

End of Group: 1

- Past trauma, current trauma, poverty. With COVID-19 we have heard about people having extra money and so they dabbled into substance use, social determinants of health, mental health issues, no housing.
- Racism is a huge contributor – the history of colonization in terms of trauma. Everything from housing to education, to right across the board. These are group causes that are not easy to address.
- Trauma of the residential schools, poverty, etc. Some of our clients went back to using because of the pandemic and services were not open. Trying to get any kind of assistance was not going to be of use – they do not own phones so they could not call in to get assistance. There is a host of factors adding to this. Poverty. The stigma that is associated with this. People think that because we are giving out needles that we are encouraging the issue and they do not understand that it is for harm reduction. 70 – 80% of our clients are Indigenous. To say that they do not belong in the community is not good
- The majority of our clients have been sexually abused. Even though they may be out of those situations, they may be living in the rough or homeless. They may have traumatic issues going on around them. Racism is another thing that cannot be overlooked. People feel that they do not belong. They often give up. They need that sense of community and that connection. Otherwise, they want to disassociate, and drugs are very good at helping them with this.
- Intergenerational trauma and sexual abuse trauma. It is important that this is an everybody problem – including mothers, fathers, town council, and all the way down to the community level. If we do not have this, it only contributes to an already exacerbated issue. It goes back to intergenerational trauma and the effects of residential schools.
- Talking about the educational piece – it is not just educating the people who are affected by substance abuse, but also the community. With the supports that are needed, what is needed to do that? The community needs to understand and not add to the problem.

- Changing drug supply. Problematic substance use is not new. This is a polarizing issue for our communities. It is less clear than other areas – it is unclear what the best path forward is. At least for decision makers. We have to work harder for something that is evidence based than others.
- It is a very heterogeneous population. There are multiple problems that have brought them into our organization. It is very socially acceptable to use substances. This includes alcohol and cannabis. Most people start at a young age. Drug accessibility. It is very accessible. Mental health. About 50% living with an addiction issue are living with a mental health issue. Genetics. Adverse childhood experiences. Human brains love drugs. The drugs perform a function – they are attached. The person may want to stop but they cannot get their brain to break that attachment.
- We see a lack of consistent support and access to services. People may go misdiagnosed and may be confused or just give up. Wretched housing. During the pandemic there was less services being available for oversight. People do what they do to get a break from this. That is what we are seeing.
- Depending on the population segments there may be different risk factors. I echo racism and the intergenerational issues related to colonization. I come from a small town where drinking is a part of the norm and over the years other substances have become more normal as well. They are able to use their substances behind closed doors. This is equally a risk factor for different parts of our communities.

End of Group: 2

- Poverty, homelessness, lack of resources – mental health facilities and help in a timely manner. Our waitlists are 2 – 3 months long.
- I agree. I get most concerned from the mental health perspective. It seems to be increasing with COVID-19. Our physicians are saying that 85% of the patients they are seeing require some sort of mental health counselor. If you think that 85% need counselling that is a significant number. We are not seeing them all. Where are they going? I see this as a big underlying factor. The lack of proper housing, employment, education are underlying factors as well.
- We do have an epidemic of mental health issues – anxiety and depression. I think this is province wide. Some of it is systemic, some of it is getting lost in the system. This is the number 1 issue we are seeing with people who are wanting to get help. The system is failing us. Poverty and housing, I can see being an issue in bigger centers and here, is it the number 1 issue? Probably not. Mental health is more. We have a lack of supports. Our law enforcement and RCMP officers are taxed/spread thin, and in the health care system they detox them in a bed and then take them to a detox bed. The medical wards are not meant to support someone detoxing. The mental health unit cannot support them with an IV. Their medical needs are often overlooked. There is a breakdown here that is contributing. Access is another issue. I have anxiety and depression, that is an issue, but I have access to an addictive substance. Is that my fault? No, I have anxiety and depression. These entities meant to support us are separate. Another issue is education. There is a huge gap in what people know and don't know in relation to substance use disorders. There is a stigma. When someone wants help, they often have to wait. It is not nurses or doctors' fault, it is systemic. People are falling through the cracks – they are not getting the help that they need. We want to raise awareness and lower the stigma and help others to understand this disease.
- I think that the biggest part of being lost in the system is at that point in time they are in a position to accept and want the help, but we have to get them to wait. We do lose them. The underlying problems are also an issue. When we have them for that 8-week period it is a short time.

- Because those groups are not talking to each other it is hard to navigate and know what supports are available to them and where they need to go to get them. It is hard for someone who is struggling to know where to go and no one is advocating for them to help them find the right place to go.

End of Group: 3

- Poverty and housing. The changes that were made to the income assistance program and how it affects people to get housing is really big. The letter of guarantee and the landlords not being able to get the rent money directly deposited is really affecting their ability to get housing. They are ending up seeing them live together and use together. There is definitely an increase in homelessness. There are more people out and about. That is huge in terms of being unable to address the addictions issues. There is no harm reduction lens being applied to housing. It does not help that the shelters have reduced capacity due to the COVID-19 issue. That does not make sense. It is more dangerous for them to be out on the streets than closer together. There is also trauma and intergenerational violence contributing as well.
- Crystal meth in particular seems to be so available. It is so cheap, available and addictive. You can find it in other addictive drugs. It gets people really hooked in. I understand the link to trauma and those who are impoverished. Crystal meth does not discriminate. It does not matter your socio-economic status. If we knew what prevented people from using in the first place, we would all jump on that bandwagon. We need to talk to young people so that they are aware before they use substances in the first place.
- We are seeing younger and younger kids that are experimenting. They are often on their own – we are diagnosing attachment disorders way more than we ever used to. By the time they are 16 they are ready to leave home and they are hitting downtown Moose Jaw. We have a lot of things in place, but those are some hard things to overcome when we only have them for 5 hours a day.
- I agree. We have a group in our community that have addictions and they do not want to be housed. Life is just easier for them. The legacy that we have inherited from the residential schools is one of the main contributing factors. When you are told and think of as being less than everyone else it is hard to hold your head high. They are kind of shunned by the rest of the community. They often just float around in a group/herd. The rest of the community looks down on them and they hear that loud and clear.
- When it comes to treatment – many have spouses. Many are able to get into treatment, but the other partner is unable to get into treatment or can't get into it at the same place/time. So, the one partner goes in and gets strong and when they come out the other partner brings them back down.
- Trauma. We have that lack of attachment. Over 80% of our population lives with trauma. There are so few resources out there that deal with trauma. Trauma informed care from all levels – healthcare, societal, etc. is not well understood or carried out. There is a lot of education that needs to come forward. We have a lot of people who do not feel that they have a place in society. They often gravitate towards a group that will accept them and oftentimes that involves drugs, the drug trade, and gang violence. Many of the individuals began in the drug trade at the ages of 5 or 6 and were roaming the streets at the age of 9 and were fully addicted by the age of 10. There are no supports. There are so many contributing factors. I am not sure what is the most significant contributing factor.
- Mental health. Children are being born from mothers who are using quite regularly. They are already just damaged. We also cannot have these conversations with parents because they are scared of the repercussions of being honest. We need to be able to have those conversations without the worry of them being incarcerated or their children being taken away.

End of Group: 4

- Reading and seeing this stuff firsthand, it comes down to youth and what type of upbringing you have. Looking at the household people are brought up in. People who were physically and sexually abused or the horrible lives they have had, when you talk and deal with these people who are in these drugs, they have horrific lives. Looking at the stats – down in the states two out of three female inmates have been sexually assaulted at one point in their lives. They are now saying schizophrenia can be contributed to this type of trauma. People are pushing hurt down. You get into communities with low income and education, people go about their days with violence and view their children and significant others as possessions. This is where I see these issues come from.
- RCMP member in Lloydminster - advises that fentanyl and alcohol are the most common drugs.
- A couple years ago when oil was all the rage, we saw a huge cocaine issue because that is what people were doing with their money. Now we are seeing a huge uptake in crystal meth. These people have not had a great uptake. This is an issue that presents itself in times of wealth and poverty. There is a large apartment building that is referred to as heroin heights because a lot of individuals who live there are involved in this stuff.
- We see the individuals in a bad way – that are homeless. There are youth that are couch surfing from house to house. They tend to be the focus. What I am finding is that it is the individuals that are the housewives. There has been a real intake of the women considered stay at home moms that are coming in for treatment. For some it is alcohol and others it is crystal meth and cocaine. The issues are there. The uptake with teenagers here too who are coming from those homes. A lot of the kids that were coming into care were not that much different than kids coming out of well-to-do homes. It was how they were viewed and how it was kept behind closed doors. We may not see this stuff, but it is there.
- Certain trauma and mental health issues. We are seeing an increase in stress levels caused by unemployment, underemployment. People do not have good tools to manage this stress – they will use what is available to help them get through a couple of rough weeks. They never intend for it to turn into a problem. The biggest issue is stigma and lack of connection. How do we create connection within the community with nowhere to access supports? We need to build an abundant community so that they are able to get the supports. We are needing to build our youth and engage our community. We need to invest in that prevention piece and ensure that treatments are available when people are needing it. We are between Edmonton and Saskatoon and we know that they are bringing drugs into our community – selling them and then moving on. We want to make it easier for people to ask for supports.
- I see that we have the left and the right. We have people who have the means to support sports and other things financially and others who do not have the money. Unfortunately, this is what has happened. Our job is to create free amenities to get them busy. If they are busy, they will not have time to sit around and get depressed or get into some of those shady things. We need to create amenities to keep them busy.
- Yes - create opportunities for people to be engaged in active lifestyles by providing easy access.

End of Group: 5

- I think in the south –Weyburn, Estevan, we are very rural. We have a lot of small towns where most of our region is rural and most of our centers are around that 10,000 mark. The isolation is contributing. I think that is the biggest one. There are just not services for everyone to access.
- In my area there is intergenerational trauma, poverty, racism, the health care system with a lot of stigma attached. People are traumatized and feel judged using this system. Housing and all the rules that come with getting housing. Oftentimes you have to sober yourself up to use this housing and many people are not there in their journeys.

- Intergenerational effects, lack of access to services. Not just what we are experiencing in our community but accessing treatment. The wait time just makes people say forget it. People need to be able to go when they are ready. The rural factor. De-stigmatizing the use of mental health supports as well.
- I see a lot of the community who comes out of incarceration. Being released into homelessness and not having the wrap-around supports. There needs to be some strong, government funded supports being put into communities. They need to get real mental health and addictions support while living in supportive living. It is impossible to get into housing. It just does not happen. The key to that is people are being traumatized and they are in trauma response. They are being forced into these uncomfortable living spaces where they are not being supported in the community and that links to it.
- I agree with the systemic factors. The availability and cost are big factors. The supply in crystal meth is so much bigger and the cost has led to more people switching to it. The housing part cannot be spoken to enough. If someone is not housed, we cannot get them stable on medication or get them into supportive services. There are so many problems with the housing piece. The government changing from SAP to CISTS has made it more difficult to access housing. On a program level we have prescribers, but we do not have the supports. We do not have the addictions and office support staff to support the physicians and therefore we are unable to fill our mandate.
- I agree. With trauma, inter-generational trauma, we often feel stuck. There is not enough funding from government to meet the demand. I am worried that we will end up being a storage place for individuals which is not okay. There is just not enough money to pay for the supports. So many contributing factors. There is no cohesive response to how do we respond to people who struggle with substance abuse. It ends up being a moral question and this impacts the services that are available, and this is unethical. Everyone has a different take on how to support someone with substance abuse.
- Sometimes what gets in the way is people who are from First Nations communities and how they are funded. That can be very frustrating. How shelters are funded in our province is bonkers. We are always on the brink of our shelters closing unless our communities fundraise to keep it going. If it is the last resource housing and we do not have it, people are on the street, and it is too cold for that.
- The SAP moving to the CISTS program is huge. In our area there are no shelters, so there are no places for people to go.
- La Ronge is similar, no shelter and very challenging trying to find funding.

End of Group: 6

- Trauma, lack of support (due to COVID-19), accessibility, poverty
- I do not know how much people realize that doctors and the government play in this as well. With morphine gone off the street, there came the fentanyl. When we had morphine on the street at least you knew exactly what you were getting. Our government is way behind the times. We do not have a safe [supervised] injection site. We have people using outside of our building all the time.
- There is twice the national average of AIDS here in Regina than anywhere else. Narcan was pretty foreign to folks 5 years ago. So that is new. Getting the support from the community is difficult. People who use drugs are even concerned that the culture does not support them being there. Poverty and access to waitlists. There are too many high barriers. People want to get off drugs, but they just are unable to access the services to do this.

- People do not want to go into the safe [supervised] injection site. It is 9 – 5 and on the corner of the police station. People are not readily wanting to go there. Just not next to the police station. The treatment is being closed and the detox beds being limited is a huge barrier.
- That safe [supervised] injection site has just opened.
- It is only for injection not for inhalation. A lot of people are overdosing from smoking the fentanyl.

End of Group: 7

- The ease of access. Cheaper than booze in most ways. The ways we are trying to combat it are kind of goofy to me.
- Racism and how we view our Indigenous community (or at least how the mainstream views them). So many young people are walking around with trauma. Drugs are so easy to get ahold of.
- Looking at history, we are doing all these things for harm reduction. Our answer for everything seems to be that if drugs are the problem let's give them more drugs and call it harm reduction. There needs to be a multi-pronged approach to this. Looking back at statistics, the number of overdose deaths is increasing. The more it increases, the more we are planning to give more free drugs away. I agree on harm reduction, but harm reduction does not look to me how it does to our mainstream community. We allow people options, but these people who are out there, if they do not have a voice then my challenge is that we are not doing anything about it when we are gaining their input. There are a lot of assumptions as to what people need and that seems to be created as fact which can be overdone and put people at further risk.
- Many of them have hopelessness and their situation is changing due to a lack of housing within not only our First Nation, but within the surrounding towns. This is a huge factor in addictions. In addition, poverty.

End of Group: 8

- I do not know if the oil field and the boom has played into this. There is not a lot of access to support for those who are using. Where are they turning to?
- The accessibility is the greatest factor. Kids are easily able to access drugs.

End of Group: 9

3. Are you aware of any prevention strategies, harm reduction services, or recovery options available in your community? What do you feel are be the most effective strategies or services that are currently in place?

- The community is supposed to provide a continuum of care – this is the biggest contributing factor. There is no continuum of care. It is a vicious cycle. I needed to go from jail to a treatment program and then look at this – by the time I was done, I was a year clean. We take mothers and babies and put them in a similar program. We also have family sober living, and it is a family reunification program. Without a continuum of care this will never work.
- Is that a model that is funded by the province?
- We get 35% from Sask Health Authority. The rent is covered through their social assistance payments. It has all been community funded.
- The apprehension and diversion program has 5 First Nations bands. They fund this through prevention dollars federally.
- My thoughts are with the different programs - needle exchange programs, etc. Every organization is doing as much as they can. Everyone has a huge heart. We have some effective

strategies, but there is no link between them to ensure that they are working. There is not enough money and resources to link these all together.

- These programs are not accessible. They are often hard to get there and have specific hours (9;00 – 4:00 Monday – Friday). We need that hub – harm reduction, safe [supervised] place to use, supports for housing, etc. all in one place. If you are on some form of treatment, it needs to be available. We need everything and we need it to meet people where they are at.
- Saskatoon has a lot of prevention strategies. Intervention services are already available – needle exchange, Prairie Harm Reduction, mental health and addictions, place for HIV positive individuals, moms who are using, Westside Clinic, etc. While they are all very effective, everyone wants to do their own thing. We are not linked together. There is duplication of services. Everyone is fighting for funding to keep evidence-based harm reduction services available. Not everyone is going to use a safe [supervised] consumption site. They are great and we need them, but we also have to look at the people who are not going to use this.
- I know up north they have vending machines for safer supplies – I have heard really good things about these. Another is having them accessible outside of the needle exchange programs. Rolling these out to the community pharmacies. They have them rolling out for free and included within their budgets. We really have only one in the city. In addition, we have one program bringing in safer supplies to people in hospital. This helps folks who need to be in hospital for other ailments. If they do not have access to these supplies, they may end up leaving and not getting that care – adding to the stigma.
- Persons with lived experience working in harm reduction has been very powerful.
- Wrap around services, culturally appropriate - access to traditional approaches; family approach is important; community-based workers are critical.
- 100%. Peer mentors/peer supports should be instrumental in all harm reduction services.
- Increased access to naloxone.... has helped. Many are still reluctant to walk into a hospital to get one or a CBO. Not enough pharmacies carry free kits. The latest provincial campaign that makes an effort to bring substance use disorder as a reality for every member of our community. It helps reduce the myth fueled by stigma that overdose is a function of poverty or family status.
- From the rural perspective one of our strongest areas is the access to harm reduction supplies. We have harm reduction coordinators. We hand out supplies at multiple locations and we have two federally funded nurses who go out and hand them out.
- We looked at having a vending machine a few years ago but the issue was the glass vending machine and the risk for it being damaged and getting tokens out to our clients.
- What are in those bags? Naloxone kits. Do you also provide safe injection supplies?

End of Group: 1

- Managed alcohol program has been innovative and effective. The additional harm reduction approach that we are using with our participants, who are all voluntary – there is no judgement. It is meeting people where they are at and crafting a plan with different options for quality of life. We see people returning to work and school and better quality of health.
- Safe [supervised] consumption sites. The health authority has some reports. The overdoses around Pleasant Hills dropped significantly. The only difference between these locations is the safe [supervised] consumption site. I do not want the government to focus on an alcohol reduction strategy when it is opioids that are the biggest issues. It is also peer programming. We distribute so many naloxone kits a month and the only reason we are able to do that is because of our peer program. I think that we should look into a Naloxone vending machine. And treatment centers that are more long term – they have much better results than the 28-day treatment centers.

- Safe [supervised] consumption sites without a doubt should not be something that are hard to get funding for. Harm reduction services- we have recovery options. Some of our clients do not want to access addictions care. OAT – we have health care providers who do not want to become prescribers in that area. We need to expand those harm reduction services and safe [supervised] consumption sites.
- I agree. In our community what is effective is we meet them where they are. We go out to communities. Our program is culturally based. It has been successful. We have seen the number of accesses to our services increasing. We created an area that was built and directed by the knowledge keepers based on a needs assessment. This was built based on the people who would use this center. It is critical to gain input from this group and have peer support. It had to be beautiful and reflect the input provided to us. We offer, through our knowledge keepers, prayer and spiritual services so that the people who come there are safe. It is a nurse practitioner lead model – they all have prescribing ability. It is linked with our primary care facility. Building those relations has been challenging at times, but it has worked. We are able to offer these services in a non-punitive, and non-judgmental setting. In other models this is not what is happening. They need to be met where they are at.
- I want to emphasize the longer-term treatment options. We need as many options as we can for people. The most success I have seen is in the 90 days to 1-year services. I have seen people have great success when they are removed from their community for these longer-term treatment options.
- We need some more upstream prevention strategies starting when people are really young – providing education, support and addressing that trauma when they are young. We have a program working with families of individuals who use substances. Once we get them on board, recovery and support is strengthened and the client themselves can move more toward recovery options. I think intensive outpatient treatment options is one piece where they can pursue alternative treatment options wherever they are at. And then after care. This is another area that we can work better at – whether it is residential or community.
- Managed alcohol programs, St. Paul's hospital programming was a huge win because they were actually able to go see people in the hospital when they were ill. We saw the largest number of individuals pass away due to alcohol related issues. What works about harm reduction is it helps to reinstate relationships with people. What could work if it was really intentional would be campaigns to address racism and youth outreach and 24-hour outreach programs.
- Here is a link to the Crystal Meth Working Group report with 29 strategic actions under 5 pillars that closely align w/ the pillars listed in the survey for these focus groups: https://static1.squarespace.com/static/5605b57ee4b09976d54b042c/t/601cae97ca18a4036ef6dc44/1612492501005/CMWG+Final+Report+Feb2021+revision.pdf
- Meeting people where they are at and having interactions with the clients so that they are comfortable reaching out. Once a month we have the police coming out to our organization – 'coffee with a cop'. We are trying to break down barriers so that they feel comfortable calling them and are not worried about getting arrested. Safe [supervised] consumption site and needle exchanges. We give them support so that they do not overdose and take their used needles so that they are not discarded in the community. We do not want people to be left by themselves. We want them to know that care is always there.
- People have mentioned managed alcohol and supervised injection sites, but the need for treatment programs that involve family. This is one of the 5 youth developed actions for crystal meth treated programming. The youth that were involved in the report were instrumental. These are things that they have thought about and talked about. Two other pillars are treatment

and harm reduction. This involves sustainable funding for Indigenous models that are created by Indigenous people for Indigenous people. I think that we are lacking access to the data that we need to tell us what the most effective strategies are and whether or not we have enough of them and if they are making an impact in our community.

- Should we follow evidence based for effectiveness? Yes, we should. I am worried that this question is pitting one against another. We need a variety of effective services. I do not want to encourage that one is better than the other when it involves the difference in the population that it serves. The word 'most' suggests that some are not effective.

End of Group: 2

- We have a homeless shelter focusing on that. Most of the residence are substance users. We have a number of programs in the city for active users. That cuts down that barrier. Homeward Bound and housing has helped for active users. Not that they condone it, but it gives them a place to live and some normalcy in their lives.
- The most accessible options for people here are not that accessible. Weekly I receive an anonymous text asking for help – they have a child addicted, they are struggling, they do not know where to go. We have a church, we have Dory's House, there is another private place (Rock Solid Rescue), I know our pharmacies offer naloxone training and kits. As far as unbiased and inclusive support, I do not have any options for you.
- I know there are services out there for people to go to. I have done work with the YWCA – they work with other agencies to be a one-stop place. We have the Salvation Army and other groups. The funding is spent so much on operations, how do they get that outreach out there? Maybe that outreach needs to come to me. I want to be able to help. Maybe it is educating the larger public and not just targeting the people who need help. In my experience marginalized folks come to us as a safe haven, but our people are not equipped to identify someone who is struggling or might need help. They are not equipped to ask those questions. Not sure if we need someone on the staff who is equipped to ask these questions. We can likely think of places to go, but is that the right place for that individual's challenges?
- Different places are effective for different people's needs. I believe that you need 6 months minimum of treatment. 8 weeks is not enough. People who start using stop developing in one way or another. They stop maturing. The developmental issues come into play. If you use at 14 and use for 5 years you likely still have the mental capacity of a 14-year-old. It is a disservice to do short term. 6 months is very effective.

End of Group: 3

- Prince Albert has Homeward Bound. They take people in with different types of addiction and help them. They are more focused on harm reduction than creating drug free use. They are embraced and accepted for who they are. Sometimes this makes them want to make that change, other times they fail in this type of housing.
- We have dispensing units for harm reduction. This has helped our clients with their usage. We have supports going out and helping with the supply. This has really helped our clients and has taken away some of the stigma of them having to come in all the time to get those tools. They know that they can still come into our harm reduction to get naloxone kits.
- The harm reduction programming that is happening to get needles out to people and hand out naloxone to people and giving them bananas and water. It is really about getting rid of that stigma of getting them to come into the office and instead meeting them where they are at. We have an outreach social worker that goes out and does that stuff and works with those individuals that are struggling. We are seeing this as an effective harm reduction service.
- PACT Team – the police and crisis team. Most of them are social workers. Outreach is really important to go out to those people who need these services instead of thinking that they are

going to come to your office. And also, peer support – there is so much value to those groups. They may not listen to an addiction counselor but someone who has been in their shoes. That peer support could be further developed. There is a lot of value in that.

- We had two overdoses on site on Friday – not fatal. We know that there are times that others are using in moderation. We were getting 10 visits a day earlier this month. That is something. With naloxone – often when EMS is responding people have often used naloxone ahead of time. That never used to happen. A lot of those overdoses that are not getting reversed or dealt with are not being reported.
- The people are feeling more comfortable with asking for a naloxone kit. That is a strategy that was very effective. More and more people are accessing them and using them if need be.

End of Group: 4

- What is not working is enforcement. You can charge all the people you want, but it is not going to change. It is a double-edged sword. They are just taking away the possession and not charging them but charging them does not work. This is a war on drugs. We have worldwide governments pushing the heroin out. It does not work by charging. We need to use the treatment stuff.
- Various models – including the Oxford model which is housing from individuals coming out of treatment. They are self-run. We set them up in Edmonton years ago. They are all residents that are recovering – they pay the rent. They end up staying there for a year to two years. 28-day programs do not work. You are cleaning them up and getting them to start to function and then the program is over, and they go back to the old playground. We need to look at long-term solutions with better results. This needs to work with the individuals' employers and their families.
- Police and crisis team that we have is effective – PACT. It is resources that are mental health people assisting the RCMP and trying to help people who are in a bad state on the street and not necessarily causing issues. We have one of the bigger RCMP detachment centers. We do not want more officers; we want more social workers and nurses. How do you help people who are addicted and standing on the street? They may be scaring people, but they are not harming anyone. That PAC Team is effective – they have 3 resources, but it is still overwhelming. It needs to be distributed across the province and for these intervention teams to work with our province. I would suggest that the PAC Team is something that is working.
- We have a Crystal Meth Strategy Committee. They did a video to deal with people who have drug problems and addiction. They are going to do another one for parents on how to talk to their kids about drug problems and abuse. It will explain to them about how to talk to their kids. It may not be a foolproof strategy, but we need to educate our kids on what is happening.
- InMyHome.com is the Lloydminster Area Drug Strategy whose vision is to "Create a community where kids can grow up great! Every kid. Every day." We focus on prevention strategies for our community and have had many great successes. We have the Social Action Committee and the Community Hub who focus on housing, harm reduction initiatives, and food security. They also help individuals navigate services and get connected. We have the Thorpe Recovery Centre which offers treatment support. We are so fortunate to have Residents in Recovery who support individuals following treatment to stay in recovery. They have many great success stories, but funding is a significant issue. The research on PACT is very positive (Alberta has them as well) - we need to have a team in Lloydminster.
- We have some strategies that we have been doing. We have those education components with parents. How are you supposed to talk to your kids about these things and make good family decisions? We want to support parents and educators. This has to be layered across community. You have to make this choice yourself and here is the information that you

need in order to make these decisions. School counselors have so much impact on the kids that they are connected with. We have the Lloydminster Youth Council, and they make a big impact in our community – they share their perspective on cannabis and tobacco. They are engaged in initiatives. We have a passionate member in our community who started the Residence in Recovery Program. So many people coming out of treatment do not have a place to go. We need to coach the community in how to accept them. We need to increase the opportunities to recreate – to go and play basketball, be active and connect. These things prevent addiction.

- Here in Swift Current, we just implemented the PAC Team. They have had a positive impact so far. We have Drug Response Action Committee – this is made up of RCMP workers, youth workers, passionate citizens, etc. They find people who have been impacted by drug use. They are working on developing stories from these real middle-class families to share that this is an issue that can impact anyone. In a community that does not have a drug strategy response committee, I really suggest you look into that.
- It is honorable to have the police involved, but we are missing the court system. This is wonderful that the police officers are not charging people, but once it hits the court system it does not do anything. When we talk about policing it has to follow through and the court systems are not following through.
- I just googled it, but there is nothing related to treatment. There is counselling, but where is the research that actually says that this is effective. Is it casual? How is going and working with the kids in the school? Is there any benefit? We talk about evidence based and its importance.
- There was a hub set up in many communities. It was spear headed by the Ministry of Justice. It brought together corrections, mental health, the police, social services, the school systems etc. An example would be that there is a child with issues in school and they would be brought to the hub so that they did not end up with the police involved or drug and alcohol involved. This was a resource used extensively. This worked well. It was a resource for everyone.
- Yes, storytelling is so powerful! Lloydminster is hosting a five-day interactive display Opioids Don't Discriminate - to raise awareness, build empathy, and reduce stigma. https://www.strathcona.ca/files/files/fcs_oddie-diy-kit-spreads.pdf

End of Group: 5

- Being in Saskatoon and seeing the work being done by Prairie Harm Reduction, hands down. They are doing a lot of the work in the community that no one wants to do. Even looking at the situation. There is almost a tent city behind PHR. They feel protected and that people are checking on them. They are doing a lot of good work and that is mostly funded through community fundraising.
- In our area, we have youth counselors and adult counselors in the colleges and one person who works with industry support to help address substance use issues in the workplace. We offer take home naloxone. That was not successful initially. A piece of that was getting to those rural areas and the stigma attached to getting to those areas to get the education to take home a naloxone kit. We have some people in those areas who are our go-to. Since we started doing that, our kids are going out more regularly. We have a doctor prescribing methadone and pyridoxine, I think.
- We offer methadone spots. These are fairly safe compared to street opioids. We are looking at ways to partner with community agencies to be more accessible. And offer more take-home naloxone kits. We distributed 2,000 last year and are expecting 10,000 this year. We see them saving lives.
- We partner with the SHA to deliver an opioid recovery program. We have followed up case management to help with transportation issues. We provide safe materials and

have the vending machine. We have a peer program that is offering naloxone and are working with the health team. We also have partnerships for a shelter based managed alcohol program for older guys and gals who use alcohol. A very expensive program. A strategy that is working is our partnerships and working together. We provide these services in culturally safe locations. It is not in the government or hospital building.

- Without primary healthcare teams we have a number of prescribers and case workers who are able to provide some of those safer practices. We have also partnered with our different First Nations communities to bring some of those services to our community as well.
- In Saskatoon we have Edwards's Manor and the Lighthouse which are indispensable programs for the clients we serve. The barrier there is having spaces for people. There just is not enough.

End of Group: 6

- We have housing first. I don't know if it is done the best everywhere, but we are using that language. We have acknowledged that housing is a human right, but people are being kicked out left right and center. We work closely with a treatment center here that was made for first responders struggling with addiction. We have the addiction services through the health region with detox and counselling. There are not enough shelters. Many times, people will go to detox as a shelter. Our cold weather strategy is not the best in my opinion.
- We offer naloxone kits. We are giving away approximately 30 per night. We cannot keep up. We have a lady who comes and does an opioid sharing circle. She is allowing people to come Thursday from 7:00 – 8:30 and then she does a group at risk before from 5:00 – 7:30.
- AIDS Saskatchewan offers clean needles, pipes, straws so that you do not have to share with anyone. Naloxone kits are really important. We have people using right outside our buildings. I think that is because of the naloxone kits and they know that we are here in case they need help. We are not a safe [supervised] injection site. We try to discourage the use of drugs on our property. In Vancouver they actually have a safe [supervised] injection site that provides the drugs on site. Their crime rates and hepatitis rates have gone down there.
- Creative maintenance therapy – Ritalin, concerta and other things to get off crystal meth. They are putting their license on the line by doing that. There are trap houses here and those are the safe [supervised] injection sites. Safe [supervised] injection sites do not exist, but they do, they are just not safe. They are in our McDonalds' bathrooms. What are you supposed to do? Go out to a back alley and use alone? We need to rethink what liability is and until those structures are in place and people are comfortable to go into a safe [supervised] injection site how are we able to facilitate safe use?
- Some of our doctors are using Methadone, Suboxone, and Sublocade where you can get one injection a month. The issue is that these were not created with a detoxing plan at all.
- In Vancouver they are doing a methadone taper. I do not think that they are doing this here, but it makes a big difference.

End of Group: 7

- I know that they have needle exchange programs here, but I do not know enough about Prairie Harm Reduction. I know people are doing harm reduction off of the side of their desks. I know we have treatment and detox. We do things a lot differently. Getting someone cleaned up is only part of it. If the people are living in the same squalor and they have no hope, the long-term successful outcome for these people is often reduced. What are we basing our results on? Is it making someone feel good or are there real outcomes that are set and being measured? If people started having outcomes for the people, they are trying to serve than the strategy is based on something that the people want. I think with COVID-19 we are seeing that people can only put up with it for so long. Talk is cheap, it takes money to buy whiskey. We have people

here with lived experience and we thank them for giving their input, but we do not change anything.

- We have partners that we are working with. We have food security and are now offering one meal a day. This has really made a big difference in the outward appearance of our people. Since 2016 to now we are having a lot of chronic illnesses due to addiction. The numbers in our home care have gone up. We have multiple people on air tanks, and they have damaged lungs. Our numbers have gone up in the care. We are having more people in addictions than we do elderly people in care. We work with Dr. Skinner's office in Regina. We have HIV and Hepatitis C in our area. We are working with the doctors and the nurses.

End of Group: 8

- COVID-19 has put a kink in this. A lot of people are not able to be seen in person. There are different supports. Those in person support meetings were not happening. I think that they are more fairly normal now. There is a treatment centre in Estevan, but I think that there is a waitlist.
- We need more immediate things. If someone wants to reach out or needs support, it would be nice to not have a waitlist. They are in a place today to reach out. They need that support in the moment. Even if you wait a couple of days, you lose that window of opportunity. There is a rapid access counselling program in Weyburn. We do not see a lot of addiction, but a lot of family members.

End of Group: 9

<u>BARRIERS</u> [10 – 15 mins]

4. What do you feel are the biggest barriers to recovery in your community? What needs to be prioritized or addressed first?

- People's perceptions. Recovery does not work the same for everyone.
- One way or one method is not good for all. Will likely need to have a variety of different approaches to best reach all.
- If your basic needs are not being met, and you do not have access to those services, even a friendly face and being talked to and treated with dignity goes a long way. Lots of people do not want to go to certain supports because of how they are treated.
- Walk-in availability is a huge barrier. If you cannot get an individual in at that time the chances of reconnecting with that person are very slim. People would be a lot more successful if they went to detox and then a sober living community. It is not a blanket statement. You have to meet people where they are at.
- Political will. We have all these opportunities and often it is how we are communicating it. We are seeing movement in these areas, but we need the greater community to get what we are doing. No one wants to fight for funding. Recovery is a process. The word itself is a misnomer – it is a reduction process. The biggest barrier is getting the community to understand and that comes from our leadership. And you need people with lived experience on those committees.
- How do we have a task force to talk about drug use when none of them know what it's like to be a drug user? The biggest barrier in my mind is access. The needle exchange here is with the health authority and with mom and babies. Who wants to sit in a room with moms and babies to get more needles? A barrier is even going to a place where you know someone might try to talk to you about recovery. Or some of the places are a 30-block walk. Or you have to call an intake person and they say they are going to call you back, but half the people do not have access to a cellphone – how are you going to call them back?

- I agree. It is so difficult to get access to telephone calls, internet and virtual meetings. Being in person provides that extra touch of connecting with people that cannot be replicated over a video or the phone. Our clients are not able to maintain multiple appointments over various days. This is very discouraging to people who want to access services. The loss of face-to-face interactions – I am just not sure how much traction we can make.
- Harm reduction services need to be made available in rural communities. We see people drive 3 hours just to pick up harm reduction services where they pick up mass amounts and take it back to their communities.
- Task force? Where are the people with lived experience, people with academic expertise in mental health and addictions who work every day on the front lines with persons dealing with substance use disorder?
- We need to meet people where they are at. If they do not have transport they are just not going to get there. When people go to treatment and return home to that same environment without supports that's when they struggle and return to that addiction.
- One of the greatest differences we notice here in Lloydminster is access to OAT. We have one prescribing doctor here with a 2-week waiting list to get an appointment. Alberta residents can call the Virtual ODP program phone number and get prescribed later that day.

End of Group: 1

- Lack of access to the things that are working – outpatient treatment, wrap-around supports, access to treatment programs that are long enough to meet people's needs.
- People dying has been a big barrier to people recovering. We are on track to have more die this year. We cannot get them into recovery if they are not alive.
- Deaths. We are in a crisis state everywhere in this province. When we try to impose our thoughts or plans it is not successful. Another piece is that in many cases that we need to broaden the choices of treatment. Our work expands outside of our community.
- When people do go for treatment, they go back to an environment that cannot support the changes that they are trying to make. This is where it is important to get the families involved. Sometimes they do not see the substance abuse as an issue because it is around them. So, where they go whether it is transitional treatment, so they have support when they leave that environment. Really having that housing before and after.
- We had hundreds of contributors to our Crystal Meth Working Group. This report has been available for a year and a half. The biggest barrier is political will and political courage. I cannot think of a broader consultation than the hundreds of people who were surveyed in making that report. I would also say 24/7 safe [supervised] consumption site – so that we can immediately save lives: and the other piece being youth – immediate 24/7 access to support for youth.
- Accessibility and consistency in the services. We cannot treat dead people. When we are asking for funding for a safe [supervised] consumption site it should also be the resources and education in creating something like this. We need to provide them the information on the naloxone and how to use the training kits.
- If they could access recovery without having to hitch hike or call in everyday – rapid access so that they are not always on waitlists. Not coming home to the same environment – so having supportive living options. There is an issue accessing these services when they do not have a phone or transportation.
- Racism and stigma are huge barriers – not only for accessing services but also for decision makers. We are also in competition with the pandemic for getting attention.
- Social detox access to bed – if I could get access faster, I would get more traction with my clients. We could then get access to other services and collaborate and build upon services that are already there. We also need safe supply of substances; safe [supervised] consumption sites;

housing – people need basic needs; lack of timely access; not having continuous treatment relationships; system fragmentations; the illness itself.

- Getting the drugs off the streets – they are too cheap and available. Drilling down on education and the stigma – not blaming the individual and their families.

End of Group: 2

- I agree about the 28 days. From my uneducated mind. This certainly needs to be way longer. The access to immediate service and the length is priority.
- The time that it takes for someone to get the help that they need. There may just not be enough providers or the right place to go. That is the biggest barrier – getting into some place and having access to it when you have identified that you need it.
- Everyone is being taxed with the overwhelming need. We have 8 pages of potential resources. They are all taxed. It is a vicious circle that keeps going around. Everyone is stretched to the max in terms of funding, staffing or capacity.
- Another barrier is transition. A person goes to a facility – they are supervised, their medication is given to them, their meals are provided. So, when they are released, there is no transition. I know a woman who was previously a substance user. She had frequented treatment facilities time and time again. She had to be clean to go into facilities – detoxing, another problem. Once she completed treatment she would go back to her same apartment – she did not have a job, or money. And she would go back to people who were her accomplices prior to treatment. She is not going to be able to maintain her sobriety. Here, we have a transition team that just began. They are stretched right out. We have this huge problem that is not going away. It is just getting worse. We need to know why people are turning to drugs. People are not turning to drugs because they want to get addicted. They are turning to drugs to numb the pain. As far as different entities working together, we do not have that. And as far as knowing the issue, we do not have that. We need to make decisions based on what we know, not what we think we know. This is what I think about statistics. We do not have good statistics on young people. If we cannot measure it, we do not know how serious the problem is. Talking about it is the first step. Now we need to be proactive. Denmark has a great strategy. Can we emulate some of what they are doing?
- I wonder if some of the education needs to happen with some of the health providers. If you are going to a physician for some problem – if a physician could tell me that 80% of patients require mental health counselling, that is a bigger issue that requires more funding or effort at than some of the physiological illnesses we are looking at. How many patients in the hospital go in for some physical ailment which may or may not be indicative of an underlying mental health issue. They are just treating the physical issues and not the underlying issues. Some of the education has to be where people will be able to notice that there are underlying issues. Maybe it is in the schools or the mental health sector.
- What is the exit strategy? We should really take a look at other countries. For example, our federal inmates are provided a job so that we are not setting them up for failure. I think setting them up with jobs or with housing will help set them up for success. We have had our most successful clients move through our shelter and are now in the 2nd stage. Not all are, but our success rate is very positive.
- Part of the reason that I support the decriminalization of hard drugs – instead of spending the money on criminalizing people for having an addiction and being high. If we stop incarcerating people for drug use and reallocate that into programs for drug use. It is disappointing how caregivers, RCMP, teachers, students do not have enough education. Is our messaging working? No, it is not working. We educate people on drinking and driving, we educate people on not driving under the influence. We know that anxiety and depression are a major epidemic right

now. Maybe part of the solution is training our children with healthy tools. We have a whole generation of children suffering and drugs give them a temporary relief. Of course, they are going to do them. Maybe we need to tailor or message to different demographics so that they understand what substance abuse really is.

End of Group: 3

- Stigma. I still hear people refer to people with lived experiences as addicts and junkies. When we refer to these people who are already marginalized, they are not going to come forward. It is the drug that is the enemy, not the person. If any of us were to try crystal meth, we would likely become addicted too.
- Meaningful mentorship within our families. Consistent, meaningful support in the family that is available. The number of people who qualify as sustainable mentorship – this is very limited. There are such strict criteria for reaching any type of support. Really it is a peer mentorship that they bond with. Maybe it is a person that shares a life story with them.
- I think that a big barrier is community buy-in to understand that things can be done. That a safe [supervised] injection site is not going to have people flocking to drug use. There is a lot of misconception. When we talk about people coming to reach out – that trust needs to be built. That takes a lot of time. Perhaps we can work together with other supports. We cannot have someone coming in and telling us the best way to operate. When dealing with the government they often tell people what the best way is to deal with it and that does not work and has been happening for hundreds of years. I am glad that you are connecting with people with lived experience.
- Housing and the current policies around income assistance. Income assistance is an easy fix. That is something that I think should be a priority.

End of Group: 4

- Our pharmacies are dishing out OxyContin and then the pharmacies are cutting them off. They would then go to something that equally had the same effect. In the United States, in Illinois they push out more prescription opioids than the other states. It is basically a factory to push out these drugs. The pharmacies and doctors dish this out and then cut them off. It always starts with a back injury and a pain management technique.
- Unemployment, housing, mental illness. We need to take an approach to support recovery long-term. This is an investment. Maybe looking at a pretreatment – a bridge between detox or jails and treatment. By creating those safe environments and holding them accountable. And then helping them with their other vices – single parents, housing, employment, ongoing recovery programs. I lost a nephew to an overdose a couple years ago. He was in 3 treatment programs in one year. Something would happen that was a trigger, and he would use this. He needed that support year-round. We need that story telling. This can really inform that strategic direction.
- In regard to housing, in Weyburn, I work with a lot of men coming out of treatment programs. One of the things that is difficult is having access to affordable housing. I was looking at Sask Housing. There is probably 30% of those units that are empty. I wonder why? I know that housing is a big barrier. I wonder why one part of government has not worked with another part of government? A young woman coming out of treatment may need a place to live so that she can get her children back, but she cannot get housing. I know of a young couple who are doing fairly well, but they are having to live with his parents which is not great. Unless they are able to come up with a fairly substantial amount of housing to put a down payment, they cannot afford social housing. What is social housing if it is not affordable to these people? I would like housing to come up with a reason for why these houses are empty.

- Sober living (for men, for women, for mothers with children) is available through a local agency that gets funding support from government & community donors. https://www.residentsinrecovery.com/ (x2)
- People who are living in addiction or recovery often do not have a cell phone. With COVID-19 a lot of things are online. Technology is a barrier. They do not have access to make these connections. Housing, transportation and technology are all barriers.
- I know some kids who have no clue as to what is available to them. Maybe as simple as having a poster in the hallway may be a good start. If they have access to a phone number that might work too. They were too embarrassed to ask their teachers due to the complications that may occur. They need to have access to this information without having to ask.
- On the back of bathroom stall doors. Posters with info.
- Our drug strategy has an anonymous "asking for a friend" tab - and the questions we get are incredible, and sad.
- I agree with the lack of knowing where to turn for health. The court system may be months and months and months, but then it is thrown out. I think that their needs to be a little bit more consequence or if the court implemented some sort of treatment.
- The people on the streets – the police officers are the ones most available. This is a starting point where people need to be trained. In Ottawa, taxi drivers were trained to provide recommendations because they were the people who made contact. Maybe have a strategy to have people at gas stations and train them to hand out these cards to those kids.
- The court can mandate treatment, but then the wait time for treatment is so long. Natural community helpers - train them to navigate services. Every door is the right door - this is the approach that is needed. Yes, making this the responsibility of community.
- Drug Treatment Courts are available in a limited number of cities. And it has proven successful for many people.

End of Group: 5

- Many people do not feel safe going to the hospital to access detox.
- Trauma informed care across all of health services. What is happening in one area may not be the same. They may be encountering different client approaches.
- There is not enough family-based recovery. If someone needs to go away for residential based treatment, there is only one person that can go with them. When people realize that they have to be separated from their kids it blocks them from doing any services.
- Access to detoxing services. A lot of our people detox as a safe place to go. They often end up in the ER and that is not a safe place to go. They feel that hospitals treat them poorly. Access to harm reduction or any kind of recovery. The mindset that everyone needs to be in some sort of recovery is a barrier. Some people do not want to be in recovery. They just want to manage how they are using better. Stigma and people's mindsets might be a barrier.
- I would extend the comment on trauma informed training- I think the Ministry of Corrections, Justice, and Social Services desperately need more trauma informed training as well as harm reduction models.
- Access is a huge barrier, need more options for after-hours like vending machines etc. for our area.
- Generally, you have to have access to a phone and transportation to get to Sturdy Stone. The place is structured like a prison. We need to work in partnerships to provide more flexibility in meeting clients in the community and how we meet with them and when.
- Access to services. We are lucky to have support and other things. There is so much struggle in getting access to other services which would not be in question if they were a part of the general public. There is a challenge with the ongoing support. We get "we do not deal with

those kind of people" a lot. If there are people who are smoking a pipe in front of our building, they (the health authority) will just call their manager and say that it is not safe here. Most of the people we are serving are using. It is about harm reduction. There is a battle between client care, prioritization and the union battle. Are people uncomfortable that people are using meth or is it a safety issue? We have lots of individuals who because they are using drugs, they do not get access to other services besides under our roof (The Lighthouse) because they are not welcome.

End of Group: 6

- Poverty, homelessness, getting sober. When you are using, you are not hungry, so you do not worry about the food. Access -we do not have the beds. We cannot get them their fast enough and there is such a small window.
- Social assistance. The ministry of social assistance is taking people off of the SAP program and are putting them on the CISTS or the SAID program and if people did not apply before August 30th, they were taken off. Social Services said that they were going to make it seamless. It was not seamless. And so now so many people are homeless because of this policy change.
- Some of our guys were going to be given a warning eviction letter because they haven't paid rent. But now they won't be, now that I have been told that. Huh. We had someone looking into that and did not know this. They were going to be evicted.
- Social services were working on giving clients control of their money. So that it wouldn't be going directly to their bills and their rent. And now they get it. This is setting them up for failure.
- No one is going to rent to anyone on income assistance because they are not going to get direct deposits anymore.
- This city is so racist. It is systemic and in our institutions. It is bad. You talk about trauma and wonder if this is changing, and it is bad. It blew my mind at how racist of a province that this is.
- If we could prioritize this, I do not know how we would even be able to address this when it is in the system.
- If you are incarcerated, you cannot apply for assistance. You need an address. People are discharged to homelessness or a shelter and often they are not working with them unless they are in remand. Chances are that they are cleaner when they are in jail, but then they are put right back out. This is a small change that the ministry could make that would have a big impact. Any time we open up a housing program we get a lot of referrals from corrections.
- It is a huge barrier if you don't have access to a doctor. The policies on where you need to get your health card updated. This is another systematic change. You cannot just walk in and say hey this is my name this is my address. Or they cannot even ask for this to be mailed because they do not have an address. So, we are losing them.
- We do not have enough naloxone kits.

End of Group: 7

- We are starting to look at recovery and things that are needing to be done. Recovery is a lifelong process. We will put you on methadone and let you use. No one is looking past that. Spend all the money you want on recovery and treatment, but past that, what are you going to do? There is no hope for a job. They are back into it. They have nothing to look forward to. Without hope this is a big waste of money.
- More work needs to be done with the aftercare. There is no chance of them having a different way of life so that they have the hope to continue to be sober. A lot of advocacy needs to be

done with the aftercare. This goes hand in hand to getting them homes. We want them to not be in the same situation as they were before they went into treatment or addiction.

- It has to be that hopelessness. We have people that we try to advocate for, but they just say no. They are supposed to be in hospitals or get treatment. They just do not want to go. They have given up. They do not see anything changing within their lives. Maybe it is hard for them to think about being without the drug or the numbness that they feel. It does not just happen overnight. We find that with a mental health therapist it is a lot of childhood trauma and abuses. They have begun to normalize the way that their life is now. They think that this is normal and that there is no other way to live. There are lots that has to be addressed. It is not just the addictions. They can go to treatment, but when they get out there is not a lot of hope that things are going to change.
- I do not think that enough people are talking about this. We see it over and over again. I will never forget this elder. She looked at the judge one time and mentioned that brown people are a huge industry. They make a lot of people a lot of money. Until we address the issues with poverty, people are hopeless. What are they going to do tomorrow when life is sh--ty today? It is almost like recovery leads to what is the easiest thing to do. Helping someone is a lot of work when they bring all their issues to the table. Who is raking in all the cash? SHA workers, addiction's workers. There are things that we can do as a community to help these people. We have 9 people and kids that are no longer on the welfare system. They have bought themselves vehicles and have worked really hard for it. There is nothing wrong with that. They are able to start making choices based on fairness and an equitable system.
- I think that it is the isolation. The poverty. Lack of employment. A lot of our young adult youth are homeless, and they are couch surfing. They stay where they can for as long as they can. I cannot imagine living in that circumstance. We have some situations where there are students who are going to high school and do not have anywhere to live or stay. He was living on a bench. That is the issue: poverty, lack of housing and lack of services for our young people.

End of Group: 8

- I think that there are a lot of things that we do not know about. A lot of our clients have to travel to Regina. I personally do not know of access to those things in our community – clean needles, methadone, etc. I have been in this field for 9 years, but I do not personally know about them. We are isolated down here. There are no longer bus services. Getting down to Regina is a barrier.

End of Group: 9

<u>SOLUTION-BASED DISCUSSION</u> [45 - 60 mins]

5. The rest of our discussion will be solution focused. Let's focus on short term solutions first. Over the next two to three years, what can practically be achieved? In other words, if you were the sole decision maker, where would you invest the limited resources available?

- Expand the use of drug testing. Not just at safe [supervised] consumption but at needle exchange. I see that reaching more clients that are using. We need access to more drug testing strips. We are giving out a lot of naloxone kits. We need to extend the hours of outreach and harm reduction services. This needs to be 24/7.

- We need to roll out the nasal and the injection for naloxone kits. They need to have access within the community and the entire province. Need to change restrictions around OAT prescriptions. Hopefully this would increase access to long-acting morphine and methadone.
- Take home naloxone availability, safer drug supply, immediate access to ODP programs.
- Need to expand access to OAT therapy. I would like to see this expectation set for physicians. I appreciate harm reduction provides a setting for people to get started on OAT and they do not feel judged. We need to dispel the idea that people with addiction are different than people we see in our everyday lives. This is part of everyday health care. We need to see an expansion of this service. Crystal meth in our area is sort of more retractable. The drug induced psychosis in these areas just is so far away. There is always room for improvement. I want to see OAT not be a specialized medication and serve a larger portion of our population.
- We have seen the trend for many years of those who were previously using only opioids get on methadone/suboxone and then start using crystal meth or other substances because the main root cause of the substance use wasn't addressed.
- Short-term, amend prescriber requirements for OAT prescribing. Safe [supervised] consumption increase. Naloxone access that is wide - rural volunteer first responders are purchasing their own kits because the health region restricts their access - however they are most often first on sight at an overdose.
- We need almost a navigator type role. They need to see the strengths of the person and the family and what are the services around them? It is difficult to get access to mental health and basic primary health care. I think that all prescribers should access primary care. We cannot build this on a one-person situation. We need to be able to move based on what those individuals need. Some of them it might not be moving into recovery but having stable supply for a while.
- My third item - SHA roll out handing out safer use supplies to all inpatients who ask for them.
- One entry door. You should not have to make another call. If you have been brave enough to ask for assistance, you should not have to do it again.

End of Group: 1

- Investments. There has been success in B.C. with overdose response teams. They have been able to do more outreach in limited locations and availability. We have a shortage of investments.
- It is going to take a long time to build up capacity – we have the documentation, resources, buildings. You are eating up the extremely limited capacity. The other is on nasal naloxone. We are seeing more uptake. It is a lot easier to train people to use nasal naloxone than injection. I think that also safe [supervised] injection sites. I think that this question makes government think that there is limited money and they do not have the ability to invest here, but they do especially if they free up federal dollars.
- Safe [supervised] consumption 24/7. More managed alcohol and harm reduction supportive housing – we have a model and agencies that work. Having more detoxes so that we have immediate ability to get them in and get them safe.
- Safe [supervised] injection sites. This is a long-term issue. We need consistency in providing that service and making sure that it is accessible, and that people have that education. I agree though with naloxone. And to have confidence in the people who are doing this and that they can make the judgement. Our clients trust us, so the government needs to trust us.
- I echo the framing – it implies that there are not higher-level choices to be made in where we can invest public dollars. There is a lot of frustration hearing where the government is investing dollars.

- Safe [supervised] injection and consumption sites. That is where we should invest in the short term. We also need community education. Not sure if that is short-term or long-term
- Funding Prairie Harm Reduction. This is proven. Rapid access to OAT and OED it would be great to have more detox treatment facilities. There are programs operating in the province – could they be expanded to other programs? If there is something running why not expand it or open it up to other areas?
- We have tried and true models that could be expanded. We have data that shows that services save lives and improve the quality of life. Give those who are doing a good job more money.
- I echo the safe [supervised] consumption, managed alcohol and the detox. I also see a lot of babies being born addicted or toddlers accessing dangerous substances if we could get more focus on prevention.
- Fund safe [supervised] consumption, social units and detox units beds, and build into our systems outcome measurements – we need to demonstrate that these services are effective.

End of Group: 2

- Looking at other models. Other countries have done this well. They have lowered their rates. What can we do to be more like them instead of doing our own research? There are success stories out there.
- I agree. That is what I would do as well.
- That is a great place to start. The other place that I would look at is someone taking an inventory of the services and organizations that are available to help and determining where the overlap is. In Regina we have the Canadian mental health association, and then we have another building for the Saskatchewan mental health, and then there are several chapters in several cities. There are 3 offices and 3 board and 3 staff complements. I do not know what they are all doing. I thought why would you all not just be working in one office and creating some efficiencies with building space and staff so that the money is used effectively as well. I do not think that it is just the Canadian mental health organization that has this problem. Every time I hear about another fundraiser for a new group, I ask myself – are they the only group that is doing this? Who else is doing this? Why are we starting up with more infrastructure? I know we have limited resources. Let's make the best use of them.
- We can reallocate where we are spending money. The decriminalization of hard drugs and let's reallocate the money and invest it in helping people with substance abuse recover. There are resources available, and they are being invested ineffectively.
- **End of Group: 3**
  There is no easy fix. What I would say is to do a lot of public education around addiction and what it is and what it does to the brain. Informing people about the benefits of harm reduction. People do not understand the value of it and how it saves lives. There is stigma around it. We do need more detox and treatment centers. We need more information education out to public. People will not come forward until the community and public say that it is okay to do so.
- I would definitely get a safe [supervised] injection site and then the relationships could be built there. I agree with the education piece. This needs to be done in the schools. We need to also educate about the social issues that we are being faced with now. If we can intervene with the child, it is so much easier then when they are in their 30s, 40s and 50s.
- We do this a lot – especially with high school students. We could be doing this a lot more with younger students. They are reacting to circumstances many times. There is lot of teaching that can happen. We are missing some of the younger ones.
- There is a whole continuum we need to look at. Education is a big piece of it. Looking at some other things such as policy development, social determinants of health (education, poverty, housing). Education is important, but there is so much more that we need to do.

- Sometimes we think that schools are not teaching, but it has to be something practical and beneficial. Are they involved in other things – including extracurricular. What is your whole education package (social, emotional, physical, etc.)? We need to look at the whole package of a student. They need to be contributing members of our community. We get the kids from 9:00 – 3:30 and it is not enough. They have not really bonded or engaged with their community. You are so much more successful when they are.
- We need education at the schools, but the education that I got was scary and inaccurate. When I saw people doing those drugs it was not so scary and so I started to disbelieve what they were saying. We just need to say that you are not a bad person for doing drugs.
- Students really connect with people who have lived experiences. This is a really good motivator
- Well-rounded balance of a child – this is also a barrier. Schools have lost so much money to have that community balance. If their family is not strong, they do not have the money to be involved in hockey, basketball, whatever that may be.
- I think that the supervised injection in relation needs some funding support from the province. We are going to need to save on EMS, but maybe those funds need to be redirected.
  In Saskatoon the EMS got a $1,000,000 increase on their funding and harm reduction got nothing. If you invested in the harm reduction you might not need those EMS calls. I think taking a harm reduction lens with education is not just saying that drugs are bad, but maybe saying, if you are going to use drugs, maybe get them checked first before you use them. Or inhalation is not as dangerous as injection. Another thing is men that work in trades – they are some of the highest death rates. That is not being mentioned at all. That is interesting. I do not know the best way to deal with that. They are folks who are working and may actually be using on the job. That is where poverty is a risk factor. If you don't have income, you are unable to support other areas of your life.
- **End of Group:** 4
  Start a group that it is non-authoritarian based people and get them trained – all the 7/11, Tim Hortons, McDonald's workers and get them trained on the resources available in our community. This would need to be as limited as a one-hour course.
- That approach also reduces stigma.
- Having recovery services to help them to live sober – this can be many different things. We should look at the models out there and come up with a plan.
- Awareness. One thing to work on with limited resources is investing in getting the word out there and where to turn if you need help. And letting people know that every family is vulnerable to this.
- Education starting at a young age in the schools. I do not know of any drug/alcohol training prior to Grades 7 or 8. This needs to start earlier and should include the family. We talk about these problems in our community. They are probably not going to know about any drug or alcohol problems that go on in the community. They would likely not know about this firsthand. For a lot of communities this is out of sight and out of mind. It is about prevention, education and promoting good health. Safe [supervised] injection sites are proven to be effective. They also get education and access to a health checkup when they use these services. We have not done a good job of educating the public to this stuff.
- A $1 investment in prevention saves $6-$10 in treatment.
- Education is so important but layering it. We need it in school but also with the parents and the agencies and those who are the first hand. We need to make sure that we are open to engaging through ideas and that there is money to be invested in that. We need communities to be able to say this is where we are at, and this is funding that we need instead of just blanketing across the province.

- Grade 7 and 8 is not soon enough. Kids have smart phones sooner. We also need to educate the community – they think that safe [supervised] injection sites are just encouraging. We need people to know that if they call for help there are going to be people there to help them. We should have a follow up for people going into drug centers. Sometimes they slip through the cracks.
- This is something that could be invested in. There is sober living and then what. There should be supports for sober living.
- I know that the 28-day programs here in Saskatchewan – there is very little follow up. The longer-term programs have a fairly comprehensive plan before the individual leaves the program, but they also have a built-in meeting once a week for people who are coming out of treatment and the counselors are assigned to have follow up. Our system here in Saskatchewan with mental health and addiction is so overwhelmed right now. They are just not able to do a lot of these things. I hate to put this on the pandemic, but they have slowed things down in detox. We have to manage our resources better during a pandemic. It is the lack of treatment beds in this province that is one of the biggest problems. Is this a capital issue with mental health and addictions, and health? I do not know.
- A backlog was created and the number of people requiring service grew.

End of Group: 5

- Investing in training on trauma informed care and harm reduction, and prioritizing funding to be given to these larger harm reductions that needs to be happening all over the province, but also for PHR to get money for a safe [supervised] injection site.
- I echo. In addition, it would also be to have more housing and housing that has supports.
- Not to forget about rural areas. We have people in rural areas who need the same services and support.
- Getting more equipment for people to test their drugs before they use instead of always focusing on naloxone. A safe [supervised] injection site is not going to happen in all of our communities.
- Everyone always seems to be competing for the same dollars and this often gets in the way of the work. Everyone is trying to get at the same small pot of money. Housing seems to be a big issue. Once they get in homes then we can get them on supports and can find them and they have a safe place to go.
- Funding-more housing options, supports, programming and additional HR supports i.e.) frontline positions.
- Educating the general population on trauma and humanizing people who are substance users and providing information that it is safe, and these are people and de-stigmatizing.
- It is one thing to get people housed, but it is another to keep them housed, especially with substance abuse issues. It is not a whole lot better than being homeless because they are in chaos. They are going from one place to another. People would often leave hospital before they are treated because they feel awful with the way that they are treated and stigmatized.

End of Group: 6

- A safe [supervised] injection site.
- Easy access to naloxone kits and clean tools. People are going to use no matter what.
- We have navigators down here that will help anyone that helps anyone who walks through the doors. Everything is closed. This is pandemic related and funding related. Now they have been closed, how do they reopen? With social services, they really need to let up on people's income. If people do not have money, they are going to turn to other things for money. They need to lighten up on that.

- Drug court alternatives such as remand.
- Open up the shelters. This would make a huge impact and would free up the detox beds for people who need them.
- People are coming because they do not have access to warmth or to cool off or use a bathroom. We saw 21,000 people in 3 months or about 500 people a day. We get single moms, we get grandmothers caring for their kids, we get homeless people, we get people with mental health and addictions. We feed so many people. If we can help you, we are going to help you in any way that we can. That is where it starts.

End of Group: 7

- I would invest in more housing. I do not think that people are even looking for big fancy homes. We are opening our doors to blankets and cots for the night. They have these small singular homes that people would cherish. Just something that they could call their own and where they could go at night.
- I would also invest in education. We found that at the centre there is a low level of education. Many of them never finished their Grade 6, some of them are illiterate, some of them didn't have IDs, some of them were unable to fill out forms. Many of them just did not know how. There is a lot of advocacy that needs to go into helping them to learn more.
- They should also invest more money to help them hold a job. When you are unable to provide for your family you usually just give up. On reserve, social assistance is $210/month. That is why we have so much poverty here on our First Nation.
- Making funding available. We need people who are needing to access the services that they are achieving what they said they would actually achieve.
- We do not need more shelters; we need more homes for people that they can look out for and actually care for. There are so many elders on these First Nations that need help. We have 57 clients that we look after their yards and their snow removal. There are so many things wrong with what is going on in our country right now and the people who are most vulnerable could play a big role in making things better. They need to be involved and paid to do it. There are a lot of people who do not get our help. What did our parents, kokum's, and families do? They would all come together to help each other. My grandmas and my aunties all died at home because we were around to make things better for them. We need to get these people to be an active part of the community.
- When people are feeling homeless, then culture does not play a big role for them, but if they are clean and have some hope, culture is going to play a big role in their lives. I can guarantee that.

End of Group: 8

- Safe places to use, clean needles. These are things that the community and area should be offering.
- Regina Mobile Crisis is something that we should have here to use.
- Transit services to and from Regina.
- Treatment centers without waitlists.

End of Group: 9

6. And, over the long term, beyond five years, what interventions could make the biggest difference in reducing the harms from substance use?

- Government funding. This is needed to have the resources and supports – WHEN they are needed and they have to be individualized, not cookie cutter.
- Making sure it is individualized.
- Making sure that it is available when you need it – no wait list. Regardless of where you are on the continuum.
- You need people at those decision-making tables who have lived experiences. Or people who deal with these individuals on a day-to-day basis – although they are usually too busy to provide this service. The biggest difference is the gaps. The evidence-based harm reduction is there. It is the will of the people who are holding those solutions. I think in the end we are going to save money on health care and other supports. It doesn't mean you solve this issue, but you stabilize them. They do not die.
- A continuum of care regardless of what your recovery path looks like.
- Edmonton invested 1.3 million dollars for a safe [supervised] consumption site for inpatients at their hospitals. We have the data; we just need to show this and break down the stigma with the public. Recovery looks different for everyone. We need our government to come down with the message and the funding.
- How do we change the stigma or general public belief around addiction when they believe in 7-day detox or 28 days in recovery – the government states that this is what is working, and they should be fixed. We are teaching the general population the wrong stuff and we need to change that.
- I would say break down stigma not just in the community but also within health care providers; stable funding; a need for networks so that best practices can be done across organizations/jurisdictions for the benefit of the person.
- Which actually has terrible outcomes - detox and 28 days... thousands of dollars and very high relapse rates unfortunately, with high chance of overdoses.
- This is a systemic issue. The system is perpetuating the harms. It needs a massive overhaul to stop traumatizing people and stigmatizing them into constant failure. The perspective on outcomes needs to change. Our job is to be there consistently over months and over years and when they are ready you are there. The fact that we have to write a funding proposal every 6 months is a misjudgment on what needs to be done.
- We at the ground level - on the front lines of advocacy and care can push the science and the humanity. We need our leaders to meet us in the middle, listen to the science and the community living it when looking for solutions.
- Going back to the systemic piece I think we need to look at the system and the pieces that are not functioning. Stable funding and the funding come from research? That is crazy. We need funding for services and education around what is addiction. This is not inclusive of the other pieces.
- Decriminalizing drugs for clients that have drugs on them or use. We need to look at B.C. and what they are doing for harm reduction and what they do with street drugs, we will go a long ways. If we could move towards that and do more policy making. We really need to look at that.

End of Group: 1

- Long-term prevention work – measures on work.
- Prenatal and young families and that education piece.
- Safe [supervised] consumption site – there is a cost to the community when someone is hospitalized for an overdose. There will be an advantage. We also need to provide that education to reduce harms.
- Safe [supervised] consumption sites, worker burnout – they are struggling with the losses.

- Do more work with youth engagement and that youth can create a sense of belonging when they do not have the family support. We need to set youth up for success.
- Supporting and resourcing Indigenous led programming. Honoring Indigenous sovereignty in how these communities want to address addiction in their community.
- Evidence based perception is lacking. It has to be a multi-pronged approached with both a medium and a long-term approach. We need to address things here and now and in the future.
- Partnerships – government services, Indigenous and community-based organizations knowing that they all have something to offer and gain. Harm reduction apartment options with 24-hour support.
- Prevention efforts – more services without expiry dates. Where they can build relationships with healthcare providers and others. I also agree about partnerships. We also need cross-training for staff. Credentialing staff increases safety – this is where the province is falling behind.
- Youth engagement at a young age and coping strategies and drug strategies, safe supply programming and eliminating the criminal element out of the drug trade. Lack of consistent training for front-line staff provides for a lot of wiggle room for people to work effectively or with ethics with these individuals. Burn-out – now the rest of staff is feeling how we have been feeling for a number of years.

End of Group: 2

- Education. If an 8-year-old child has learned tools to deal with mental health and trauma. If we can educate more effectively the generation coming up, we will see a huge difference.
- In addition, reinvesting into other resources. You will see a difference.
- We have the infrastructure that is not being utilized. We built a youth center as a community. Its operating expenses were not sustainable. It is sitting empty now. I am not sure of the status. They had hoped for government funding. Community members have taken money out of their own pockets. It is heartbreaking knowing the waiting time in treatment facilities across the province.
- Improving communication – social services with the RCMP. They cannot do that. This is a problem.
- They have to talk to each other and share the information. If we spent more money on research and data analysis. I bet it is more effective if we spend the money to educate people while they are young then keep them in prison down the road.
- We are not disadvantaged – we are able to advocate for ourselves and our families. The disadvantaged are not. They do not have the support or the tools. Address that. We will see a difference in 5 years. The child is being punished for this. Although they may be bratty, they are still a child. You take away my child – they are going to think I abandoned them. You charge me with assault – they are going to think I am a criminal. The disadvantaged are extremely disadvantaged, because they cannot advocate.
- Education is key and should be a part of the curriculum and become the norm. Them knowing what is acceptable, and what is normal and not is important. I take for granted what I think is common knowledge. But some of them grow up in households where this is not learned. So, starting in kindergarten is a key factor.
- Our family has also gone through the effects, the after effects and the loss of life. The struggles that we went through trying to navigate this system. You can only imagine how impossible this would be for the disadvantaged. There is a huge barrier with the individuals who are unable to be so vocal.

End of Group: 3

- It becomes a legal issue sometimes. We haven't talked about drug treatment court. This is an important program that can save lives as well. We should look to the government to provide

more support in funding these programs. We need to educate the public in harm reduction and what it is. There are so many different perceptions of what it is. People do not think this is a good use of money because they do not understand it. For example – smoking cigarettes took not only government intervention, but attitude changes from the public.

- I agree that the rest of the community needs to be educated in a really big way and that we would be able to come up with new solutions. We do not have enough minds being put together to come up with a creative solution. We are sometimes blinded by what we do not know so it is good to have fresh ears and eyes in every situation.
- It is the follow up at the end of treatment. People leave feeling alone and that they have nothing. They cannot go back to their friends. It would be nice to see a mentorship program where you can follow up and if you are having a bad day, you can give them a call. To have a treatment center outside of the community and a mentorship program to follow them after their treatment.
- The biggest population in Prince Albert is Indigenous. When we talk about AA and those things, they are not comfortable going to these things. These circles are often white and there is nothing being said that these people identify with. I think that we need to rebuild these supports and come from an Indigenous lens.
- Decriminalizing small possession is one piece. These charges just create employment barriers. If someone goes to jail, they lose their housing and come out homeless. It does not benefit the person when that is the unintended consequences of this. It is a waste of our resources and ties up the justice system. This is already in the works in Regina. In Regina they have already started informally not charging people. It does not improve anybody.
- I think that we have to be committed over the long term. We cannot really keep up with this. This is a long-term plan and there needs to be a long-term plan. We need those relationships and that just does not happen in the short term.
- I commend the province for looking at a multi-sectoral approach to drug use reduction. This involves everyone. It cannot just be health and it cannot just be the police. There is a mental health 10-year plan, but I am not sure how often it is referred to guide the strategic plan. If they are going to put all these resources into a plan, PLEASE resource it well. The people with lived experiences should outweigh those discussions with people sitting at desks. What they have to say will be impactful and the decision makers should make their decisions based on this.
- We need to get our medical people trained to be more sensitive to their clients that they are serving. It is so insulting and degrading that this is often the first question to an Indigenous person. If their answer is yes, the quality of care is down-graded immediately. They need to have some culturally sensitive training immediately.
- We have many frequent flyers who when they come in are not taken seriously at all. There was a man sent home with a broken leg because they did not take his pain seriously because they knew he used drugs.
- There is lots of racism and profiling happening. This needs to be a long-term solution for health care providers to have this training.
- We have that racial profiling as well. We had the residential school right in the community. A lot of that trauma is there. The unemployment is really high. We have some programs that work. They do not acknowledge them though. We have the addictions and mental health programs that are only open from 9:00 – 5:00. After 5:00 there is no service. We have some programs, but we need more. We just got funded for some programming to start up and help some of the people suffering in our communities. We have people that need help, and we need to be there to keep offering them these services to the best of our ability. I hope that funding becomes available for these services – including the mental health piece.

End of Group: 4

- Detox beds. When a person comes and says that they need to go to detox, if you get them in there today, they will get in the system. As soon as he is in a place where he has to wait, you have probably lost that individual. You have to make that stuff available.
- We need to get back to the root reason. What is the root cause for this addiction? Is it early childhood trauma? Are they coming out of abusive homes? We need to identify these individuals. Some of the females coming into this are attracted to the bad boy system. They are attracted to the cycle. Where does this stem from? Long-term, we need to identify the root cause and work with those who are at risk.
- I would like to see government invest in a long-term prevention strategy – long-term wellbeing and prevention. A really good education program for children, parents, community and front-line workers. We need to create connections. We need to wrap around that family and ensure that they get the supports that they need now. They need to get the support that they need to grow up healthy and well and choose not to use drugs. This prevention strategy is significant for addiction and mental health.
- We have to make this a mandatory class like algebra. It needs to be all about family abuse, alcohol and drugs right up to grade 12. Education is power. We can only speculate how many people this will save.
- Investment in infrastructure - capital - repurpose buildings that are not being used. We are lacking in the province in terms of treatment facilities. We need to educate, but also invest in good public policy, invest in navigators (mental health, addiction, etc.). We have done this in cancer. We need to do this in mental health and addiction as well.

End of Group: 5

- People who are homeless and living on the street are re-victimized. We need to decriminalize substance use. Adding law enforcement on top of this just compounds the trauma. I understand the trafficking piece. The people we deal with are victimized all the time. They do not need to be harassed by the police or the justice system on top of that.
- Totally agree with decriminalizing.
- We have aimed our prevention efforts to awareness of drugs and the impact of that. Maybe those prevention efforts could focus more on resiliency and trauma. Instead of trying to treat the individual when the trauma has been so long.
- There needs to be an emphasis on maintaining family unification and residential supports as well. Social services can completely derail someone and if there were more preventative methods to keep the family together and giving them a supportive family to grow up with and prevent the trauma that goes with that family separation needs to be a focus.
- The policy change and education that goes with substance use being a bad thing. Maybe we take a different approach regarding safer use. Maybe we just need to teach them when to check what is in their drugs, and overdoses and when it becomes a problem. This requires a shift and that will be a long-term shift in the way we look at substances.
- Providing safe supply for people who are using. We are forcing them to go out and buy off the street and have to spend limited money to get what they can. I have worked with people who are in these situations, and they are able to get a prescription for hydro morphine and they are able to come in and we are able to give them their other medications and they are able to connect with their supports. They do not want to be abstinent.

End of Group: 6

- Decriminalize drugs and treat them as a health issue.

- Proper mental health supports and counselling for trauma. There are amazing counsellors in this city, but there are not enough. Some trauma informed counselling and services.
- Wholistic care. There is a lot of siloing. If you have mental health and addictions, you cannot access both mental health and addictions services. They expect you to deal with one before you deal with the other. I have never met anyone who struggles with addiction who does not have trauma.
- We have so many people making decisions for the community and everyone else. They have never had to deal with trauma, grief, loss or anything else. We have so many people dealing with addiction and trauma that say why don't they stop or why can't they just deal with it?
- Child protection services is a huge barrier. They are taking children or making them choose between their children or their partner. The children are the heart. For men who may be the abusers, they love their kids, they love their wife. Let's give them supports to deal with this.
- I cannot tell you the number of young women dealing with addictions who have their kids taken away. We need to provide resources and opportunities for reunification. The kids are put into the system where the caseworker has over 100 kids under them. How do you expect them to look after and check in on those children? The parents are now traumatized, and the kids are traumatized. The ranch has a reunification program. They take them on a trip together or have them over for a family dinner.
- Programs like Kids First working with mothers, and children. They are doing amazing work. Having like an intermediary non-profit working with them to provide supports. It would have to be an Indigenous organization that leads that.
- Social services or child protection services shouldn't be involved with the reunification programs this puts a huge barrier on what people can do to help mothers and children.
- We have two programs: Gloria's House and Raising Hope. Both of these places are married to the Ministry of Social Services and with that comes all of the policies and procedures attached to that. If you do not stay clean, or have a slip up, you are on thin ice.
- I have been skeptical of the prescription of stimulants to children. I worked with a crystal meth support group and all those kids were diagnosed with ADHD. Whether they were using more and then got into crystal meth or using both. That is a concern.
- Organizations are working on one-stop shops – doctors, shelters, food banks, counselling, etc.
- Having a pilot or maintaining people on prescribed opioids. If you knew you could have them and they were safe, you would not be overdosing on fentanyl.
- I think that some doctors are able to access the Naomi Project. Often times the doctors won't. A lot of it is political will. It is a matter of changing people's views on it. That is the hardest part.
- I knew a doctor who wanted to open a methadone clinic and then a Hepatitis C clinic. He tried to do this in Yorkton first and the mayor said, "not in my town". He ended up with the one in Regina here – he partnered with the pharmacists, and it was going. But he was too ahead of his time and now he is no longer practicing. So, I just know that the doctors won't. I know people who were on opioids and had to change doctors because they were on them for too long and the doctors were the ones maintaining them. You cannot get prescribed valium, yet alone opioids.
- I walked into a clinic that said right on the desk that it said we do not do addiction treatment referrals here. It blew my mind. They said that they have the right to choose who they serve and to me, that is discriminatory. All the good doctors here go to the big cities. We have a hard time

getting specialists. For example, if you have diabetes you have to go elsewhere, and diabetes is a pretty common illness.

- Retraumatizing people from systematic barriers or discrimination – how do you make people accountable for that? Who is going to police the police?
- We just passed a conversion therapy bill which was actually debated for a substantial amount of time. If we are talking about addictions. How are we supposed to get anything passed?
- Indigenous people are a money-making industry. In 2000 or 2001 we started making a harm reduction resource. I called all the major cities. I did it random and called all the sexual health clinics, needle exchange programs, etc. and asked them how many Indigenous people they had, it was over 80 – 90% of the systems. If we talk about re-traumatizing, why would anyone want to stop it? We have people making their livelihoods over this. It is true and a fact.
- Cowessess First Nations has done some work with child apprehension and it comes back to the community before they would place a child outside of the city. The boards of these are white and they are serving Indigenous folks. How are they to understand? They don't. As a city maybe we focus on that. Giving power back to the citizens that we are serving.
- We should look at Saskatoon they have Sanctum for people living with HIV and they have a safe [supervised] injection and inhalation site. We have women living with HIV and we do not know where to place them because it is Regina and we do not have the services here.
- We have a lot of housing vacancies in non-for-profits. My suspicion is that they are not low barrier enough. I think that we need to review the housing vacancies.

End of Group: 7

- We can have all the education pumped out. We have all the centers and can help people in different ways, but that aftercare is a vital part in trying to help someone who is trying to change their life and quit using. Some people need to be taken by the hand and shown things. They need more help to make changes sometimes. We look at the residential schools and the independence that was taken away from the residential schools. How do you break that when they are so used to relying on government and our system to give them what they need? They do not have the independence that they used to. When you talk about the family break down there is a lot. People did not know how to parent.
- I grew up in a residential school and I was orphaned. I had to learn how to look after my family. I was a 16-year-old mother. To be out and fending for myself and fending for my child, it was a whole process, and I was able to get over that. Many people do not have the strengths or the supports to be able to do that on their own. You take a look at healthy elders. There is not as many as we would like to have. We can even see on the streets that we have 60 – 70-year-olds that are into the addictions. They got out of school when they were 16. I do not know what the long-term action is. We need to keep going forward and advocating so that we can hear from the people themselves and see how we can help them. What can we do that will make a difference? I think housing, more opportunities, etc. I think that this would help some of them.

End of Group: 8

- Something for kids and reduction for ACE-scores (Adverse Childhood Experiences), education in schools.
- More preventative measures
- Being able to talk about this and normalizing it. Giving them tools if their friends or parents are using it. Just that education piece.

End of Group: 9

7. What services and supports do you think would have the biggest impact in <u>your</u> community?

- Getting the existing services and supports to work together. Supervised consumption sites. The basic needs spread out over the city – housing, food security, education, etc. Once these basic needs are met then we can look at everything else. I am trying to stay away from money. People need to be warm, fed, housed and know that people care.
- It comes down to access. People move back and forth – especially in Indigenous communities. We need access to support – mental health, etc. Racism is also another layer. We have many First Nation communities. There are only two healthcare systems and they do not work together. That is a gap, and we are duplicating everything. Our patients suffer because of this. If there is some way to provide increased access – which is difficult that there are so many layers affecting access.
- Access to basic living supports. There is no operating food bank in my area and housing is a huge barrier. This would go a long way in giving people pieces of their humanity back. We need to also look at creating culturally safe access to medical care. This will go a long way in terms of success. Also, the single door policy – making it possible to provide help from a single access point.
- Agree that housing is a big issue in many of our Northern communities as well - overcrowded conditions, homelessness, not just an urban issue.
- Another piece that is interesting. That' doesn't necessarily affect the overdose/deaths in SK. I think it was stated that B.C. is leading with safe [supervised] consumption sites, needle exchange/access to safer supplies vs. SK. In B.C., they have significantly lower rates of new HIV and Hepatitis C infections in folks who use injections. The leading HIV new diagnoses are MSM, not injection drug use - here in SK, it's 70% (in recent years up to 80%). Getting a new diagnosis of HIV can be traumatizing and set people back on their recovery from substance use.
- Access to safe housing. Here to use the foodbank you have to set up an appointment over the phone and not everyone has a phone. It is just not working. Access to transportation is huge. Just the access to what we see as basic human rights.
- or need ID
- Services are set up with no knowledge or understanding of what people are dealing with - the idea that not everyone has a phone or a computer; sometimes people have to hitch hike to get rides to access services and then are turned away; risk of violence/safety issues; so many issues that people don’t even think of.
- access to detox, treatment, OAT, etc.- the negative impacts from delays to service are extremely high.
- Identification!! I had a client who Saskatchewan Health just assumed moved or had passed on, so they cancelled their social assistance and health card. It took almost three months for us to get their services all set back up so we could start him on his HIV medications.
- Access to food, access to shelter facilities for women and children. In addition, psychiatry and mental health.
- Access to mental health supports like group homes are completely blocked for anyone who is using substances; it leaves people in crisis on the streets.
- Access to OAT and mental health services in corrections. At least in RPCC, clients aren't allowed to start OAT if they aren't already on prior to coming to corrections. We need folks to have access to education re: extremely high risk of overdose post-release, safe supplies, naloxone kits, etc.

- Having access for those who want to start their healing journey. Not everyone is ready for this but having access for those who are ready. Our tribal council has a health bus going out to help our communities. We need education and training for everyone – a lot of our front-line services including front line services and police. They need a better understanding of how harm reduction works and understanding of being human. Many people are not treated that way. We are not going to get anywhere if they are not treated that way. And lastly mental health and getting access to those services.
- The biggest piece for me is the humanity and treating people like a human. Community will – there is so much lack of understanding. They disagree with the harm reduction program. They did not understand that we were able to reduce the HIV rates. We had people travelling to our communities to access our harm reduction programs. They do not have access to these things in a timely manner. Without access to the basics – you are not going to care about your health.
- We have used a program called Stronger Families that helps with coping skills around things like anxiety and depression. We have seen some strong empowerment that ultimately led to reduced use, desire to access help, etc. Better support of individuals in learning and using coping skills for the mental health issues - often PTSD, anxiety and depression are common.
- Yes, I agree - humanity should be the driver. If humanity doesn't motivate to accept what the care providers are saying, then it should drive people to ask the questions.

End of Group: 1

- Better access to needle exchange supplies – this reduces diseases related to needle exchange; better access to services; and better social supports.
- Continue services – that meet clients where they are on the continuum of care. Services based on evidence. Expansion of outpatient services – do not like the limited hours, do not like that people have to call in.
- Consistency and accessibility in peer support services. Trying to dispel the stigma. Having access to practical services.
- Harm reduction and 24/7 walk in services.
- Keeping people alive – expanding our harm reduction approach – safe supply, safe [supervised] consumption, etc. So that we can help these people.
- Some concern that this is an impact or the biggest impact – all the services are important to different people for different reasons.
- Expanding land-based programming. Ensuring that the client has transportation to access the programming.

End of Group: 2

- More funding. Our teams are stretched to the max. This would allow them to focus on specific issues. We already have the infrastructures in place. We just need to support them with more funding or women power.
- Where do we go? This does not mean there are not supports out there. The access to them is difficult. If you need to detox you have to go to the ER. They are in crisis. They have to wait several hours to see a doctor. And then more to see a psychiatrist. People with drug problems are going to be in crisis and they are not going to want to wait. They should have access to immediate support. They need help now, not in 8 hours. In 8 hours, they are not going to want that help. Is it the hospitals' fault? No. They are just not equipped with the right tools. It is different in rural. We cannot support the infrastructure like Regina or Saskatoon would. If someone is disadvantaged, they may not have the resources to get to the city to get the help that they need. It would be nice for them to get the help, and not get turned away, and get the support they need. If we could work with the bigger centers more cohesively, how do we get them help?

- And education. We live in a very big rural and religious community. There are big gaps in what people know.
- Friendly, welcoming places. They have knowledgeable people. I think of our attempts to develop an integrative medical community and patients' medical home – meaning that they can go to that place for anything medical that they require. Services and supports can have a big impact on any community if they are in an accessible place. Similar to portable classrooms. You add it to the school. They already all know where to go. I think that if the outreach was better and further out in the community, it would be more accessible for people. People feel safe at the pharmacy because they trust the pharmacy. The infrastructure is there to have that impact. Why are we making the patients come to us for help? Why aren't we going out to help them?
- We have the supports and the services – not all, but we have really good facilities and services, but they are stretched to the absolute max. If we are able to take care of the people doing the jobs and support a couple other positions. It might not be a solution, but it is headed towards that way.

End of Group: 3

- A safe [supervised] injection site that could grow and become a community drop-in center. We need to build that trust and relationships. That would be a good starting point for Prince Albert.
- I agree about a safe [supervised] injection, detox and treatment center here in North Battleford. They have to drive to other centers so there is a wait list and then a long drive after that.
- Safe [supervised] injection sites, vending machines with supplies, dedicated funding for harm reduction and outreach initiatives, and detox beds.
- Safe [supervised] injection, harm reduction and detox sites in every community.
- Mental health and workers to work with mental illness. Two sessions working with mental illness does not do anything. It is a long-term plan. Not a short-term fix. We do not have enough for mental illness to make a difference. I imagine it is province wide.
- I agree. Sometimes two sessions can do more wrong than good. We need to be careful with saying that we need more treatment beds. We do, but we need to be careful with how we say that. If there is not a willingness to go than we cannot do that. With treatment court I worry that people are being forced to do something that they are not willing to do. I know we need more beds, but we need to be careful with how we say that.
- We need a one-stop shop that has all the key components – finances, trauma, treatment, etc. working together in one area and being able to work longer hours, not just 9:00 – 5:00 and attaching to that outreach. We need to bring all our services together and allow that person to segue from one thing to another.
- I daydream about winning the lottery and being able to develop a one-stop shop for services.

End of Group: 4

- A change of our housing authority. It is all income based, but these houses are sitting empty. There has to be a policy made or a quick action movement. The government should start an Oxford system. We should send people to Estevan for treatment and then the next step is to go to an Oxford House in a staging effect with people helping them to navigate the system.
- So many times, you go to people and ask what is wrong with you. That needs to change to what has happened to you? We live in a country where one out of three women are sexually assaulted. This will not change until we deal with this. Until there are changes and abusers are held accountable for their actions.
- We default to the idea that people are good, and we cannot believe that people could do certain things. We need to start listening to the people who are saying that individuals are doing something wrong.

- What's wrong with you to what has happened to you? Yes. What's the matter with you to what matters to you? Yes.
- We were working with the mental health authority, and we cannot get a response. That lack of communication is frustrating. We have the research and infrastructure to make this work, but we cannot get the government to invest into this. It is a small amount of money. We need to be responsive to communities. The other things that is important is that we have a lot of overdoses every week.

End of Group: 5

- (rural) Anything that would provide easier access to harm reduction. We do not have anything like needle exchange or vending machines. We need to provide easier access to harm reduction.
- A conversation in the communities is regarding a culturally safe medical program. That does not have necessarily the same timelines as our typical programming and connecting people back to the land. This is a conversation that has been happening and will help people with where they need to be.
- We primarily focus on women who are in front of the criminal justice system. We are looking at 80% of folks who are incarcerated are Indigenous. We need good programming that is Indigenous based.
- Safe [supervised] injection site and making it easier to apply for OPS sites and having safe supply. These things need to be easy and manageable.
- Housing low barrier with support.
- I agree. We need semi-dependent housing that has supports on site and is affordable and accessible.

End of Group: 6

- I wish that we were tracking Narcan stats. If the public does not know how serious it is unless we are keeping statistics on this. If we are gathering that data already then make it available to the public.
- On 17 different occasions we had to subscribe naloxone to people who were overdosing. I do not know what the biggest impact would be. I do not have a solution for that.
- The Coroner's Report is not released until the police reports have been filed. When you start seeing those numbers it opens up things a lot. The thing about overdose is that it is very traumatizing to lose these people. If you do not have those supports, it just feeds the cycle. We have people who have been clean who then lose friends, family, or clients and they go back to using and then they repeat the cycle. This is similar to war in terms of the loss and the casualties. I just wish that this was taken more seriously. I think that this is only going to get worse.
- October 1, which is this Friday, means that everyone needs to be double vaccinated to go anywhere. If you do not have a health card, or a house or anything than you are not going anywhere. If you want to add more trauma to people, close them off from everything. I see the importance of the double vaccination, but we do not mandate everyone to be double vaccinated to come in and access our services. We sanitize and use masks and are sincere and I think that is why people feel safe here.

End of Group: 7

- Critical response services in the communities. So that people are able to respond to the families. People are often in shock and are unable to deal with their unresolved grief. Education and awareness for our younger, school age kids. In order for us to stabilize and change our

communities we need to focus on our younger generation. This is what we have found in the work that we do because kids grow up in these dysfunctional lifestyles. We need a healthier way of life. That is key into changing things. People struggling right now need to realize that there are resources nearby that are easily accessible to them.

- We do have a crisis with our child services agencies, and they are unable to find homes. I have someone in my family who is trying hard to find a person to look after their children. I see this as being a big problem. A lot of broken families and the couch surfing. You don't trust someone to come into your home because of addiction and habits of stealing. We do have a lot of people who are couch surfing. We are now having an infestation of cockroaches and bed bugs. It is hard for people to get rid of and it is hard for them to completely turn their head away from addictions. This is costing our band a lot of money in fumigations. There is a lot of family breakdown. We do not have enough families looking after their elders. As a result, a lot of people are going into long-term care. We need to build our long-term care centers on reserve because of this. You can see a lot of people want assistance to help their elderly. You are trying to find anything that you can to survive. They wake up in the morning and look for their drug first and then see if they are able to get a meal.
- COVID-19 has not helped. We have had a rise in our mental health issues due to isolation that is causing depression and anxiety. We have a mental health team in our tribal council, but COVID-19 has put a stop on everything. In our area we have had death after death, after death. We are trying to help those in addictions. We have given them naloxone kits and have told them to use the buddy system. We are still having deaths in our area. I think that we need more than just giving them tools to prevent death. We have to improve their way of living and give them opportunities to be able to feel that self-worth and be able to reach out for help. They have fear. This has come with the methadone and people saying that if you miss you are going to die or have a heart attack. Many of them have been on the methadone program for years. I do not think that this program is being used in the way that it was supposed to be used. We were supposed to ween these people off and test them, but no one is watching. They are using methadone and drugs. They are using this in-between their fixes to help them from becoming dope sick. If we used that program the way that it was supposed to be used, we would have a lot more success.
- We base it off of what some scientist or professor recommends, and this leads the supports. I believe in setting things up from the ground. We have a transitional bed for youth created by youth for youth. Other places have trouble hitting 50 – 60% occupancy. We hit 100% occupancy after 4 months and we still have a waitlist. People know that this is set up by other people who know what is going on. We need to try some things. Going back 20 – 40 years they keep doing things over and over and expecting different results. If we start listening to the people who are actually listening, then I am not sure that many people really know. We need to know what they need to make life better for them and their families. We are always talking about housing issues, but what about developing tiny houses and talking to the people who are utilizing these services and actually paying them to help do this. Then they are developing the right skills. Until we start having services based on people and implement it that is what they need. We have not been very respectful of the vulnerable population and what they need. The people with lived experience can actually tell you what life is like living on the street in 2021.

End of Group: 8

- Getting some of those safer options in place. It would be nice to eliminate the drugs off the street, but we have come to realize that people are going to use, and we need to create those safer harm reduction type options. It is going to happen. We need a safer place and safer resources. More access to naloxone kits to prevent the overdose. We do not even have those here at our counselling agency. We have an expired one, but no training on how to use them.
- We need to meet them where they are at right now. Maybe more youth groups. There are family centers for small children, but nothing really for teenagers. If you meet them at their homes or in the community, you are able to see more pieces of the puzzle.
- Just the quick/rapid access to supports.
- Transportation to Regina. They have the services we need, but we are isolated down here.

End of Group: 9

8. What needs to happen to make seeking help more socially acceptable?

- Understanding that recovery is not a straight road and accessing services is not a safe road – there needs to be a level of understanding, education and humanity.
- There needs to be messaging out to the general public. You think humanity would drive it, but people want to know what is in it for them. There needs to be a will to get this messaging out there, to involve people who are living it, and to get the people within the community to come together. I was a naysayer years ago before I lost a son and before my other son became a user. I had such a huge misunderstanding. We need the community leaders to help drive this and then we can meet them in the middle.
- Moms Stop the Harm – the poster awareness campaign puts a face to those. It is not just our Indigenous population; it is not just our homeless. This can affect anyone. We need to change the narrative and the verbage – such as addicts. This dehumanizes the person and makes them less human.
- It is the people with lived experience that need to talk. I know that the minister that made this presentation has not attended a meeting regarding this.
- End of group 1
- Public campaign about what substance use disorder does and does not look like – there is so much stigma around seeking help. It could be anyone of us. Need to show people what recovery can look like.
- Education piece – it can and does happen to anyone. Trauma can happen when you are young or old. Asking for help is an addition to the movement.
- I like the campaign strategy. It is also important that we get out there and talk about it as the leaders in this area. If we talk about it, it starts the conversation at some level. Our teens need to be out in the community working with the firefighters, having that number to call. We need that community engagement piece.
- Business community mobilized, grassroots mobilized, but political leaders are nowhere to be seen. We need leadership right from the top. We have asked for a press conference. We need that level of showing that this issue is serious. We need the elected officials to come onboard.
- Public awareness campaign and resourcing peer support programs. We see this network in the community building up – they have a social media presence and are talking with people about their lived experiences and recovery. It is not directly related to a campaign, but it goes hand in hand. It is more organic.
- I would say a public campaign and public education and educating the youth. So that they know that they can go and get that help when they need it.

- I didn't think that people didn't seek help because it was not socially acceptable. I thought that people did not accept help because it is hard to reach that step, but also because they are treated like garbage. Awareness campaigns will help the general population, and educational campaigns, but I do not think that will help. If we do not get help from above – the politicians, nothing will change. These individuals have lost all hope in their life. It is not easy to access these supports – there are so many barriers.
- Public awareness and education on an ongoing basis. I think that we should have as many as we see on cancer and diabetes.

End of Group: 2

- I am on the fence when it comes to safe [supervised] injection sites. I understand the theory and agree. I think that we need to switch the focus to address the issue instead of making it a safe place to feed the issue.
- Education and awareness. Changing behaviors of people and their judgement of others who may be less advantaged or down on their luck. It is difficult to get people to like someone or not make judgments on someone. Perhaps if more people who had made it through and survived the system, the stigma and the addictions spoke out about their journey that it can happen. It doesn't just happen to disadvantaged people. Maybe a different part of the population needs to start speaking up.
- There is a major stigma attached to drug use and the parents. There are so many misconceptions. We need to educate people. It is not enough to just educate. How do we reduce the stigma? The latest research is that addiction is disease. People who have addiction cannot help themselves. They cannot fix that part of their brain. I have a friend who lost her son to an overdose and there is shame attached to how he died. But no, it is a substance use disorder. It is a disease. We have failed as a society. We have to educate and talk about it. This is a real disease, and we are using an entire generation of young people to it. It is not embarrassing, and it is not shameful. Bad people do not use drugs. Normal people use drugs. It makes normal people do bad things.
- We need to educate children in kindergarten. I am not saying to terrify them. No, you need to educate them and give them the tools. We need to educate on naloxone kits. I don't know if safe [supervised] injection sites are the answer. But we need to talk about it.
- Making professional people available at those safe [supervised] injection sites and harm reduction sites. Bless the hearts of the individuals trying to get them established, but I don't know if most of those people have the credentials to help those who are coming in to use those services.
- We live in a society that glorifies the use of drugs and alcohol. That same society is the first to point their finger when someone falls prey to it. It glorifies substance use. It is all fun and games until someone gets hooked. Are they a bad person? No. The enemy is not the person. The enemy is the substance.

End of Group: 3

- This goes back to education and understanding that this is a disease. We need to take away that stigma. We need people to feel safe to reach out. I am not sure what means this is through.
- Transparency in our conversations in the clients that we work with and society at large. Advocating when we see those opinions being thrown out there. The more we work with these individuals, the more open dialogue that we are getting. If we can get people who struggle with the addiction piece to feel more comfortable and get them that trauma informed care without the stigma. This is a big job, but we are not going to get anywhere without starting.
- It is about stigma judging. There is shame involved with addictions. The mental health movement and all these celebrities coming forward, the more that people are coming forward

and able to talk about it, the better it is. It comes back to informing, awareness, education and the understanding that this is a brain-based issue, and we need to take away the shame.

End of Group: 4

- You have to deal with the stigma of addiction. Addicts and alcoholics are not bad people, they have a disease. They may have been surrounded by learning disabilities and have not done well. Many times, they turn to drugs and alcohol for self-esteem issues and things that have happened to them. There needs to be more done on education. There was a church group that brought in a fellow to talk about his experience. From that, they realized that they needed to be involved and help out as much as they could. There were multiple programs started after that presentation.
- Government programs, policies, practices can help to reduce stigma for people living with a substance use disorder. Language matters!
- I agree, people do not wake up and say that when they grow up, they want to be a drug addict. It is a stigma that we have to address first. We have to educate the public, so that the people who do need help are able to get help without being ostracized by the community. They do not want to be perceived as trouble by the community.
- Build empathy.
- Moms Stop the Harm is a group of story tellers that are working to end the stigma. One of the approaches that we are using is to talk about it all the time. Now, people think that we have such a big problem, but we think that now people are reaching out because they feel more comfortable to get the support that they were needing. I am proud of our community for doing this. It needs to be an approach that is adopted and funded provincially.
- There are privacy issues, but if you get the opportunity to do so, celebrate success stories. Only a small percentage recover from crystal meth use. We need to celebrate those who have been to hell and back and survived it.
- The government has to do their part. Druggies are very accepting. The problem is our communities have to be more accepting. They cannot be this tiered group with a better than you attitude. We need to listen, accept them and help them along as people. If the community does not get behind the whole idea, then we are done for.
- Social acceptance is a difficult topic. There are a lot of different aspects to our society. We have not talked about our First Nation problems. They suffer much higher levels of addiction and mental health issues than non-First Nations, but the provincial government treats them like they do not exist. They say it is not my responsibility. It is a federal responsibility. For those of us with a large First Nations population around us, this plays out in our cities. The highest percentage is with our First Nation neighbors. I do not blame them – they have trauma. Some communities, especially in the North, are the centers that have a large population. They suffer even greater. Because we have 74 First Nations in Saskatchewan, they do not feel a part of this province, but there is an idea that if it is on reserve it is not a part of our responsibility. We all have free movement and are all neighbors. Our social problems migrate from community to community. We have a homeless shelter, and we struggle to fund it. I have a hard time seeing that we are going to change the way the provincial government does things. We are still dealing with these problems. We need to consider our First Nations neighbors when finding solutions.
- Lloydminster's Community Drop-in Centre just closed due to lack of funding. They filled the gap between 8:00 - 5:00 when the shelter is closed. We have a Men's Shelter - sober. No women's shelter. No wet shelter.

End of Group: 5

- Need to make every door a safe door when people go to ask for help. It needs to be socially acceptable. We need to meet people where they are at. We need to have peer supports. We need them to build relationships. This is what makes help more acceptable.
- Taking this away from institutional places this is triggering. We need to have spaces within the community or more of them that are accessible past 4:30 p.m., places that are accessible 24/7 and where they have medical, counselling and harm reduction supports so that it can be streamlined to the right place.
- Compassion needs to happen for the more institutionalized and government forums. People need to be treated like they are human and met where they are at.
- Post incarceration supports. Filling that gap between incarceration and adapting back. They need those supports available otherwise they will fail.
- A safe [supervised] injection site needs to be funded. The general public does not understand enough and maybe that is why it is not being funded.
- Wider understanding about trauma. People do not always understand how trauma impacts addiction.

End of Group: 6

- People who have diabetes need insulin shots. Wouldn't this be great to have retractable pens instead of needle equipment. What if it is for addictions or diabetes? Who cares? People are surviving.
- Saskatchewan is a drinking society. We all use substances. We need to start realizing that there is not this them and us. Choice is subjective. No one chooses to live in the life of addictions. They may be content, but they have the right to do what they want with their body. That may be a little too radical, but no one is telling us that we cannot have our drink at the end of the day. I also think that this is unfair to tell someone with trauma that they have to stop using. Maybe this was the one thing that stopped them from suicide. It is really complicated. Especially if you have not been through it. For example, with transgender people, you do not have to understand it. I do not know how you understand this unless with campaigns and conversations.
- I wish that this was viewed and treated through a medical lens. It is not. We need to normalize it. Like Doug Ford being in a trap house smoking crack. Just visibility of people in power talking about their struggles. I do not really know. The youth know where it is at, and they are doing amazing work. Sadly, this is going to take generations.
- I was going to say starting with the youth, but then there are issues with the parents not wanting their kids to know this stuff. Especially the youth in North Central. Let's make this okay and normal and okay for them to ask for help. Especially if it is their parents. Let's make it normal and not remove the child but help them to get sober.
- There are ads on YouTube for fentanyl overdose. There are ways to get in there without having to go through parent's support.
- Here with the work that we do, we are doing the most amount of work in terms of non-profits and getting the least amount of funding.
- It is a matter of modeling. People who are drug users feel safe using outside of your building.
- Because we treat them like human beings – regardless of what state they are coming to us at, we treat them like human beings.
- During COVID-19, when everything was closed, and we lost our core funding all of our work was around HIV, syphilis and Hepatitis C. We started holding testing days here in the office and we gave people $5 Tim Horton's cards. It was not all about the testing. We started linking people to

care. It is more socially acceptable. If COVID-19 has done anything, these things are now more on the backburner. This seems to be the least important thing that people are looking at. We made testing for these things more socially acceptable by providing a small incentive. We do this once a week and our numbers are growing. We made it more accessible and more acceptable.

End of Group: 7

- Non-judgmental organizations need to just not be judgmental. When we first opened up, we did not have much money for furniture or anything. Everything was donated. We had no janitor and there was no one to help. It was just flooded. Today we feed approx. 80 – 100 people a day. We have so many people looking for that one meal a day. We told them that the centre is theirs. They need to make it theirs. We do not have people to clean or make coffee. So, we told them that they need to come in and clean and make coffee and make it theirs. COVID-19 made us have to step back to keep the community safe. They are the most vulnerable. We did not want them to catch COVID-19.
- I think that another factor is CERB that they have applied for. It was easy to apply. You just got it and so I think a lot of people had extra money for drugs and to purchase. They had more money than they had in the past. I am not sure if they had to pay back. But this did play a big factor.
- Taking into account crystal meth. You use it once and then you are addicted. People want to help their families due to the psychosis. They no longer care about their outward appearance, they do not care where they are going. They become a threat to their community and a threat to themselves. They used to need to get $25 to get their fix and now they just need $5. It has come down considerably and it is mixed with fentanyl. This has made it worse with the COVID-19 and the isolation.
- When the government gives money, it is for a specific purpose. We are being too restrictive. Each community needs to be able to respond to their community crisis. This really restricts the community from doing anything. If the government could give additional resources in community to deal with this. It is really the intergenerational trauma that is the cause of this situation and the more that this is repeated the worse that this gets. We need to help individuals deal with these traumas and give them tools to help them overcome. I think that this is a lack of resources. In the Battlefords' this is the same thing. They do not have the resources to develop a treatment centre. At one point there was a report shared regarding how much the liquor board earned. Where does all that money go? It is a concern. We are not giving them the money to deal with these services. It is frustrating.
- When you look at addictions and you look at how socially acceptable it is, there is a lot of blaming in and around addiction. There needs to be more education. Addiction is the result of something. There are a number of different reasons that people become addicted. We need to spend some time to educate people and treat this more like it is. It is like a disease. We need to focus more. It is not socially acceptable right now. I think socially understandable rather than acceptable. We make excuses for everything instead of coming up as a community to come up with a tangible outcome to make it work. They are a part of our community. They are shunned and not welcomed in our communities.

End of Group: 8

- There is a stigma to mental health and addiction and mental health go hand-in-hand. The community needs education and awareness. The family members do as well. There is a lot of co-dependency and enabling. If they were able to pick-up on things, I think that they would be able

to eliminate more of the overdoses as well. Addiction has affected my personal life as well. I have someone close to me in recovery. I think that when that person was using, a lot of our other family members had no idea. With addiction there is a lot of lying, cheating and manipulation. They are very good at it, but education would be very beneficial.

End of Group: 9

9. Any final comments or suggestions to pass along?

- It is getting the key people (PWLE) engaged. It is also about engagement and the level of understanding. We also need to educate our providers so that they know the stigma and baggage that they are perpetuating.
- Media has historically sold us a Hollywood view of what addiction looks like, and it's been next to impossible to turn that titanic sized false narrative around.
- The importance of peer-to-peer supports and mentorship programs. I do not have lived experience. My words and my understanding only go so far. Funding really needs to be put in to expand the peer support programs everywhere.
- We are often the voices for people with lived experiences. We talk to them and see them daily. We have the relationships with them and so we end up being the voices for them. It is important that we continue to advocate for them.
- A big part of the task force is justice. I have the impression in my community that addiction is a crime, but I do not see many drug dealers being prosecuted. The people who are showing up for substance abuse charges are facing crisis and are not making a living from selling this. The nuisance aspect. They typically do not have the resources to help themselves. Criminalize the sale of drugs and not the addiction.
- There is a level of mistrust. We get consulted and nothing comes of it
- Updating school curriculum and updating DARE training. I think that this NEEDS to involve harm reduction education. This is generational and we need to equip them with this information.

End of Group: 1

- Having to watch the minister brag about the investments regarding mental health and addictions. Many of us work in the fields. Many of the investments were made without consulting us. They were not bad investments, but they were not what many of us would have felt were the priorities. We should be given the respect to be able to represent these individuals and what would help them. We just want this process to be respected for all the people who are coming forward with their breadth of knowledge.
- If this were any other health condition, we would not be talking about this over and over again. Investments come from the top and we often get told where that money is going to go rather than being invested into programs that are evidence based. If it were any other ailment, we would just do it and have all these other fundraisers. We do not do this with any other illness. The stigma is alive everywhere. There is room for improvement.

End of Group: 2

- I appreciate having this conversation. Especially with people from different communities. There are some similarities, and differences. It we are able to bring more people together to work on this we are more likely to get somewhere.
- Not only within our family, but within our community. I am happy for this platform and hope that it manifests into something solution based for everyone.
- I always feel a little arrogant in speaking about this when I do not have the personal experience. I would hope that whether it is Praxis or someone in this whole process that you are asking these questions to survivors who have been through addictions to get their thoughts. They are

the ones who have had to live that journey. They know the barriers and the supports better than anybody.

End of Group: 3

End of Group: 4

End of Group: 5

End of Group: 6

- Make a tent city for everyone who is homeless. I gave two tents away that I had, and I could not believe the gratitude.
- I think that a tent city in Taylor Field. There is no food in the hood. I have a vehicle, but I am just lazy, but for people who do not where do they go?
- It would be nice to show people who come from a privileged place to see what we see and see the state of the people who come in every day.
- It is common that people are firing guns into homes, and this is happening all the time, but if this was happening in Cathedral you better believe that everyone would be up in arms. Education is a big one and everyone normalizes it. Every 3rd guy you see is limping and that is often times from violence and drug use and substandard housing and trauma.
- Our government needs to be accountable. They are supposed to take care of us and the people who need it.
- The voices are not being amplified. They just are not being heard. A change in government would be helpful. This is not going to happen overnight.
- I think that whoever is in charge of distributing the naloxone kits should make it more easily accessible. Everyone should have access to those. The pharmacy that I went to asked for so much information and even tried to charge me for one. I know when you purchase a naloxone kit from your pharmacy you get flagged. I am not a user, but some of my clients are users.
    - That means when she goes to the hospital, she might be flagged to not receive opioids.
- You can get one free naloxone kit every day if you are status. Therefore, me and my family are getting a naloxone kit every day to give out to others so that we are able to save lives. Therefore, we are being profiled. If we are to go to hospital or to the pharmacy, we are running that risk. This is the best continuous way for us to get it for our clients because we cannot get access to enough. Indigenous services give us some, but not enough. This is one of the ways that we keep up with demand.

End of Group: 7

- After the work that you are doing, what is the next step?
- There are a lot of drug dealers popping up all over the place. This is highly visible. You can see this happening in the streets. I think that the RCMP needs to work with people a lot more and charges should be laid on the pressure should be put on these people a lot more. There are more overdoses, so maybe something can be done in that area. If you charge someone for selling a lethal dose, maybe that will prevent others from bringing that lethal drug into the area. We have too many deaths and nothing is being done. You talk to the people on the streets, and this is what they are saying. I don't know if the impoverished people are taking on this to make money, but we need to make an example and start charging.

End of Group: 8

End of Group: 9

Community Based Organizations Pre-Discussion Survey Results

October 2021

PRAXIS

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Methodology

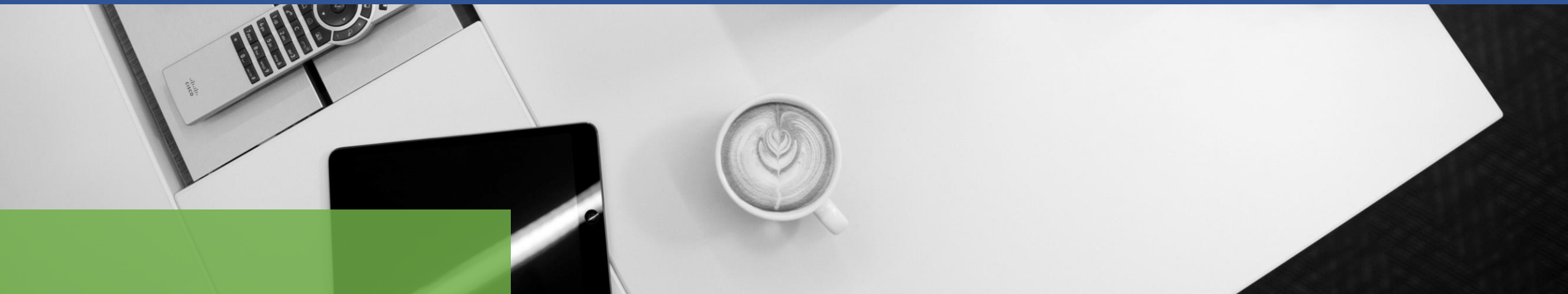
In September 2021, Praxis Consulting invited Community Based Organizations identified by the Saskatchewan Drug Task Force to participate in one of nine focus groups to provide input towards a multi-year action plan to reduce drug-related harms in Saskatchewan.

Prior to participating in one of the focus groups, participants were asked to watch a video from Drug Task Force Secretariat and complete an online survey. The survey was also made available to any Community Based Organizations who were unable to attend a focus group.

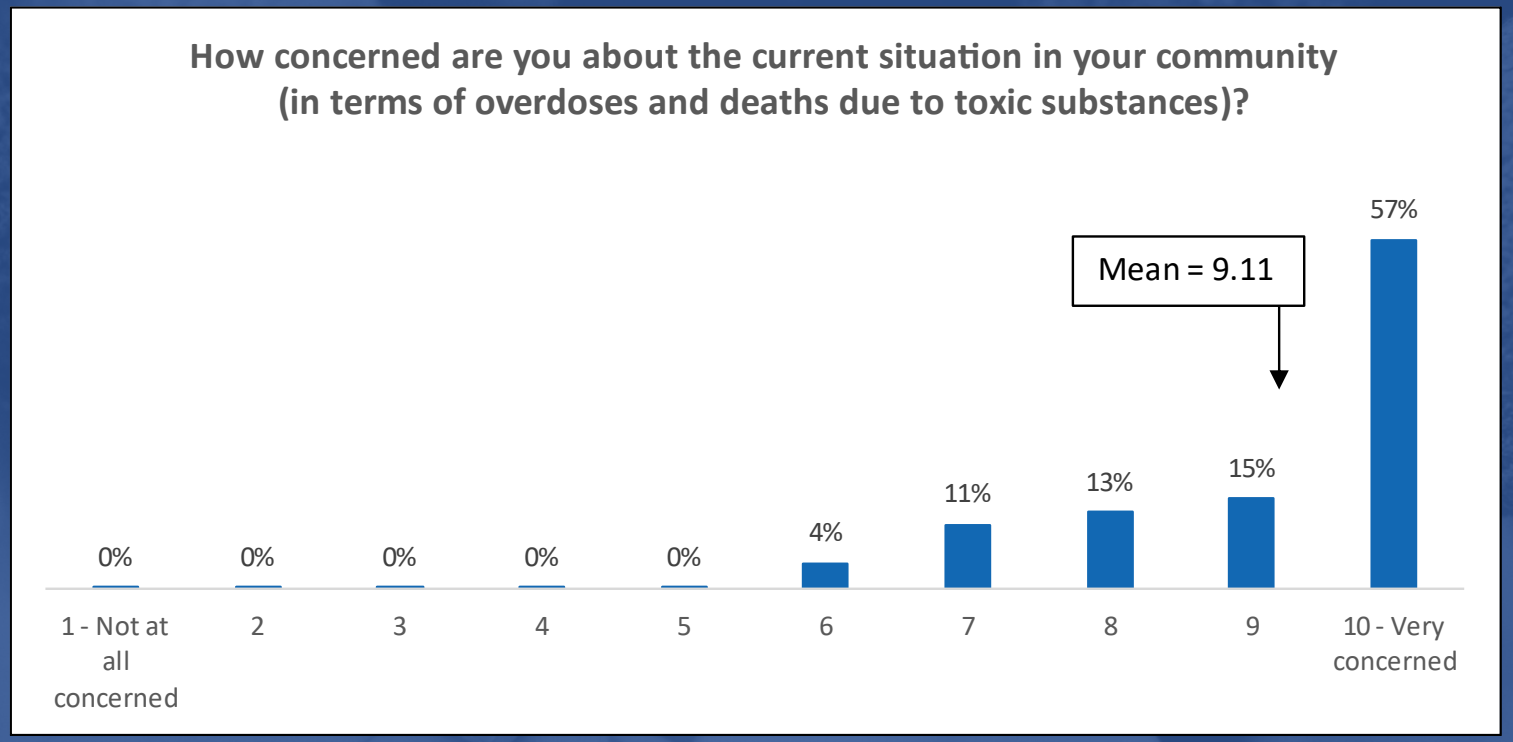
In total, 48 survey responses were collected between September 17 and October 4, 2021. The fieldwork method produces a non-probability sample (since respondents self-selected).

The following report summarizes the main findings from the survey. Responses to open-ended questions are presented alphabetically, in an unedited verbatim format.

SURVEY RESULTS



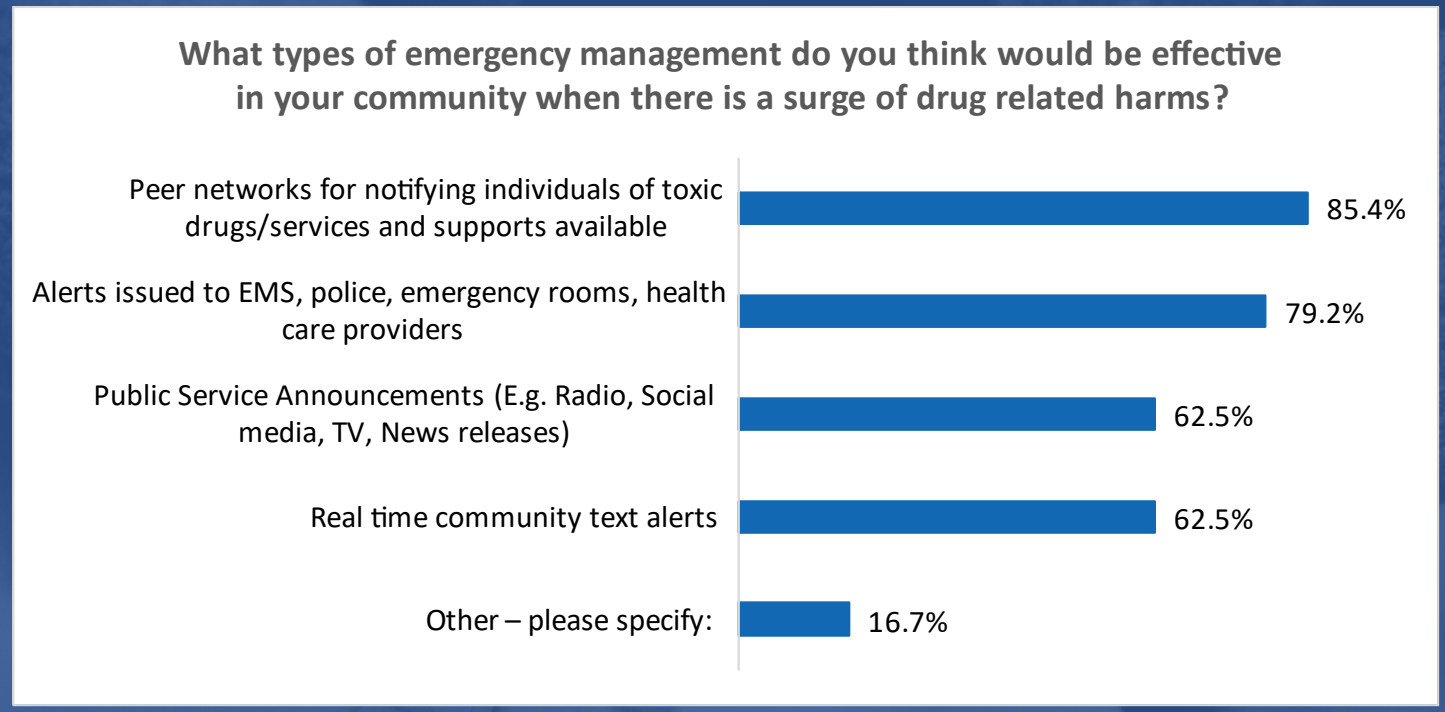
Q1 How concerned are you about the current situation in your community (in terms of overdoses and deaths due to toxic substances)?



Significant Differences

There are no significant differences among the demographics tested.

Q2 What types of emergency management do you think would be effective in your community when there is a surge of drug related harms? Please select all that apply.



Responses to "Other" (listed alphabetically, verbatim)

- *Add school divisions and post-secondary schools to the Alerts*
- *Additional overdose prevention sites/safe consumption sites*
- *all of the above*
- *CBO's and press need to be included in the Alert system.*
- *Coordinated communications, peer networks*
- *Notice to community organizations and schools*
- *outreach teams actively engaged with people on the streets. Safe consumption site 24/7*
- *Real time alerts made to harm reduction sites*

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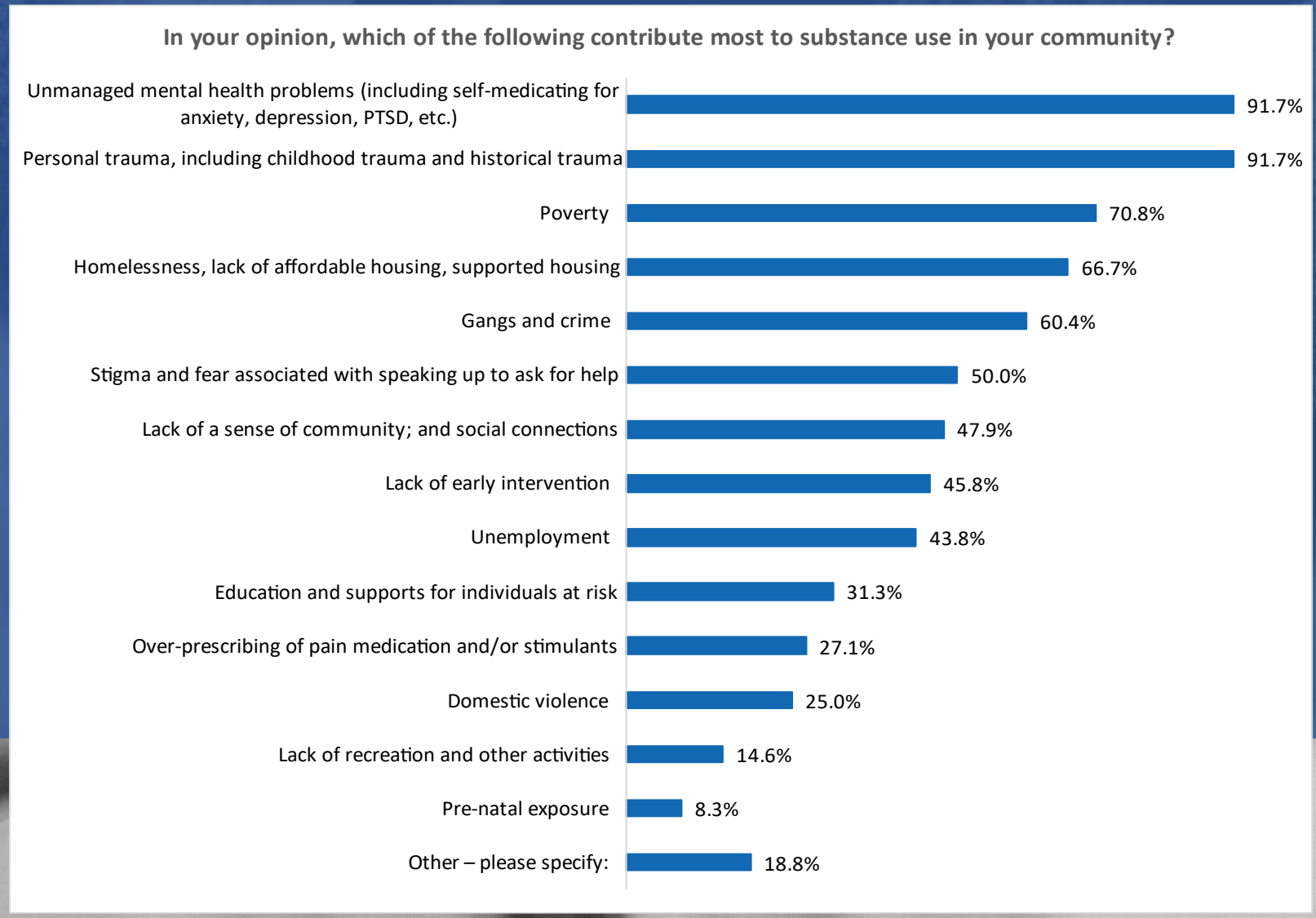
Q3 In your opinion, which of the following contribute most to substance use in your community? Please select all that apply.



Responses to "Other" (listed alphabetically, verbatim)

- *Adults providing drugs to minors*
- *Affects of racism, discrimination, and colonialism*
- *Criminalizing the use of drugs and those using substances.*
- *Easy access to drugs*
- *I believe these are symptoms of the use however not the root cause. For our population which we serve the root cause would be the loss of culture and identity due to intergenerational trauma.*
- *legacy of residential schools, racism*
- *Low education*
- *No safe supply programs.*
- *Recently money from COVID programs has allowed more spending on drugs*

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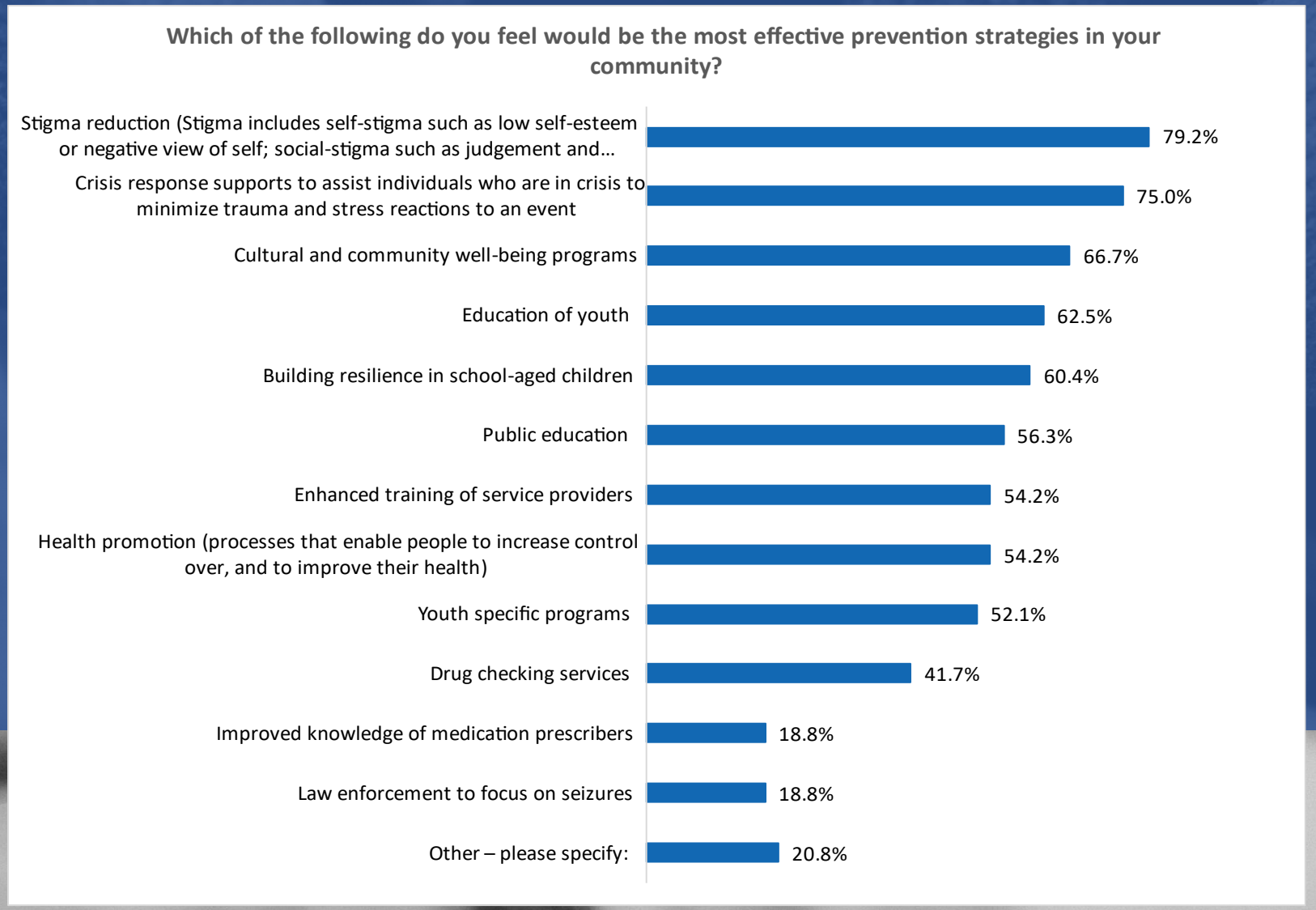
Q4 Which of the following do you feel would be the most effective prevention strategies in your community? Please select all that apply.



Please see next slide for the responses to “Other – please specify”

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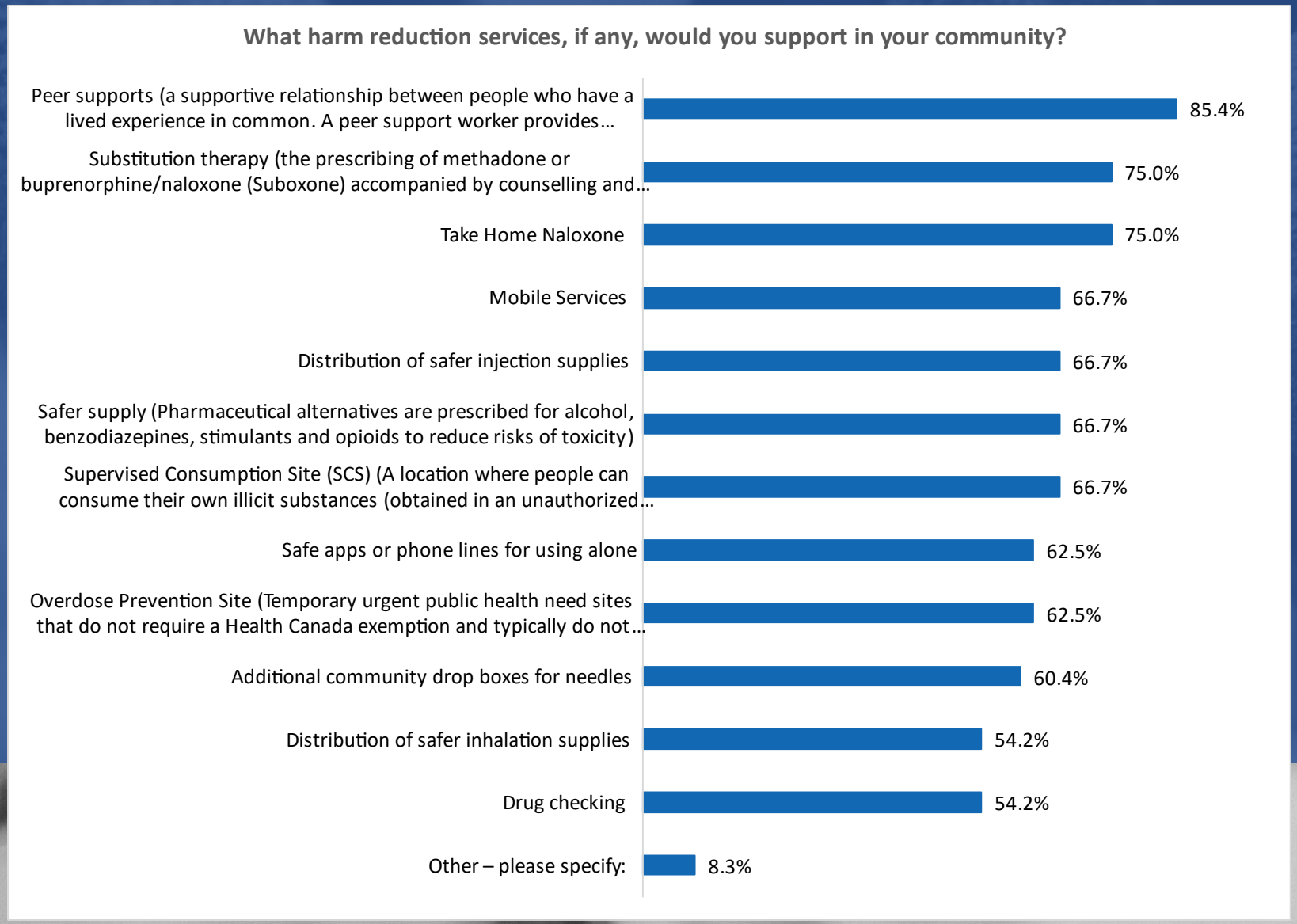
Q4 Which of the following do you feel would be the most effective prevention strategies in your community? Please select all that apply.

Responses to "Other"
(listed alphabetically, verbatim)

- *Adequate low-barrier/high-tolerance, affordable supported/semi-supported housing options in the community. More accessible/low-barrier addictions support in community.*
- *Early intervention strategies for pregnant mothers and mothers with children at risk of apprehension.*
- *Funded Safe Consumption Site Services.*
- *Harm reduction strategies*
- *improving current harm reduction programs (Exchange programs, safe consumption) Improved access to detox, treatment and recovery services.*
- *larger sentencing*
- *MENTAL HEALTH SERVICES. How do we expect people to live a healthier life without substance use if we cannot address mental health and trauma?Increase in social workers, peer support programs. Increase prescribers for opioid agonist therapy. Any physician or nurse practitioner can write a prescription for an opioid but those who want to write a ~~p~~prescription for OAT has to jump through hoops of fire. It truly doesn't make sense and Saskatchewan is one of the few places that has these ridiculous provisions in place. We NEED to get safer supplies out everywhere. Clean needles, cookers, pipes, condoms, etc. Did you know, that there is only one place in all of Regina that you can access clean supplies after 5pm?*
- *Regarding prevention, the report by the Crystal Meth Working Group of the Safe Community Action Alliance identifies the following: 1) Develop, implement, and evaluate a Saskatoon community awareness campaign; 2) Develop a speakers bureau of local experts to compliment the awareness campaign and provide opportunities for training to local community partners; 3) Develop, implement, and evaluate a comprehensive provincial drug and alcohol strategy; 4) Create a tech based training and awareness framework for all human service employees, including a commitment from agencies, partners, and government partners to implement and evaluation; 5) Improve access to age-appropriate curricular tools in the preK-12 education system that focuses on the complexity of addictions, truths, and histories of colonial and intergenerational trauma and the intersection between substance use and trauma; 6) Create a 24-hour drop-in centre and youth shelter providing all services to individuals under the age of 18*
- *safe consumption site. 24/7 community outreach services*
- *Supervised consumption Addressing underlying issues*

Q5 What harm reduction services, if any, would you support in your community? Please select all that apply.



Responses to "Other" (listed alphabetically, verbatim)

- *24/7 community outreach supports*
- *decriminalization*
- *Decriminalize drugs*
- *The phones/apps are good in theory, but most of our clients don't have consistent access to smart phones and/or wifi.*
- *Transportation to overdose prevention/safe consumption sites. We have very few (one in Regina and one in Saskatoon) and while the evidence for them are astounding, they usually only benefit those in a 500m radius as most don't have access to transportation to access. Free bus passes or taxi vouchers. Supervised prescription injection program (prescribed & supervised hydromorphone) - see data out of BC such as Naomi and Salome trials.*

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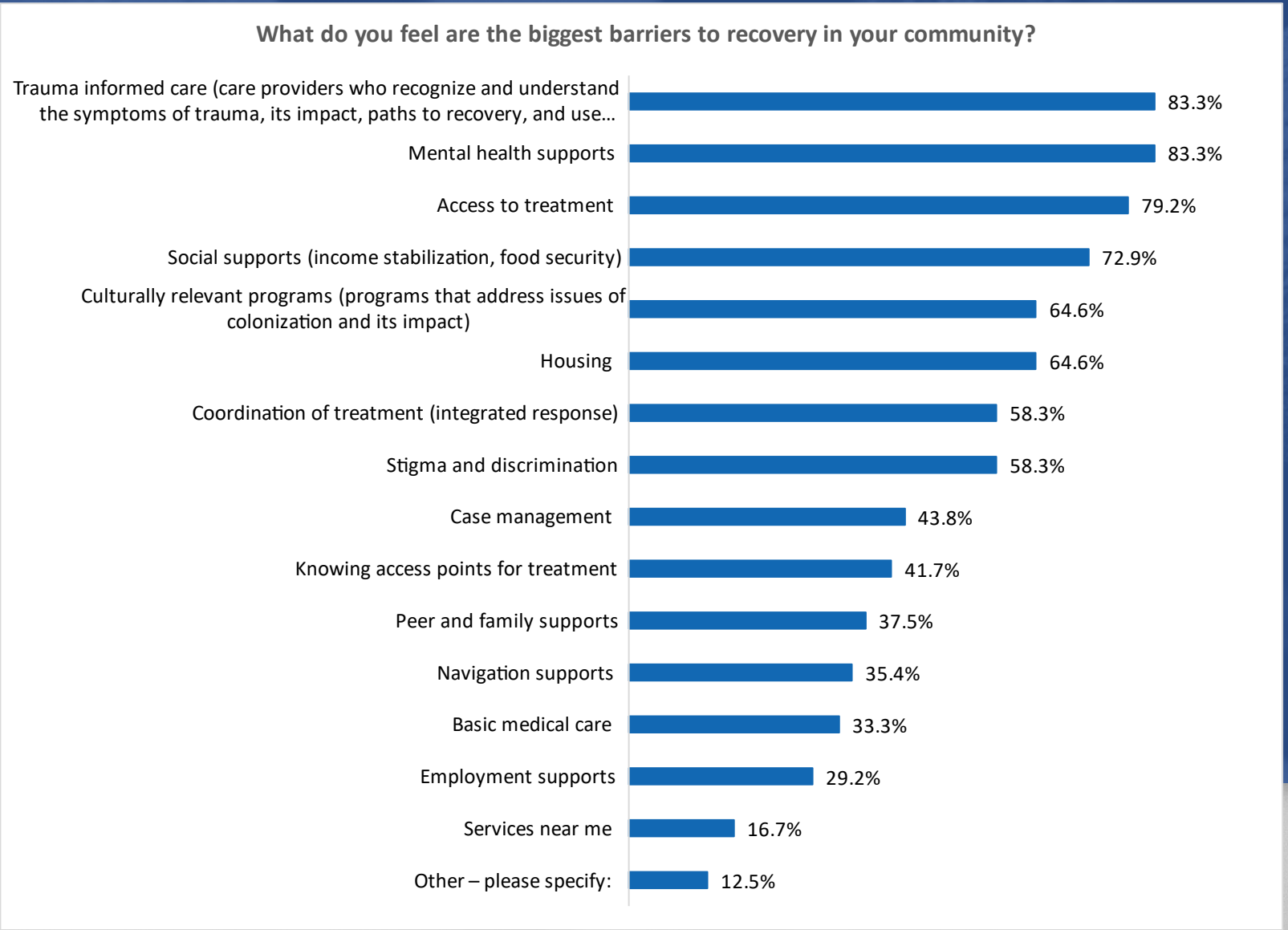
Q6 What do you feel are the biggest barriers to recovery in your community? Please select all that apply.



Please see next slide for the responses to “Other – please specify”

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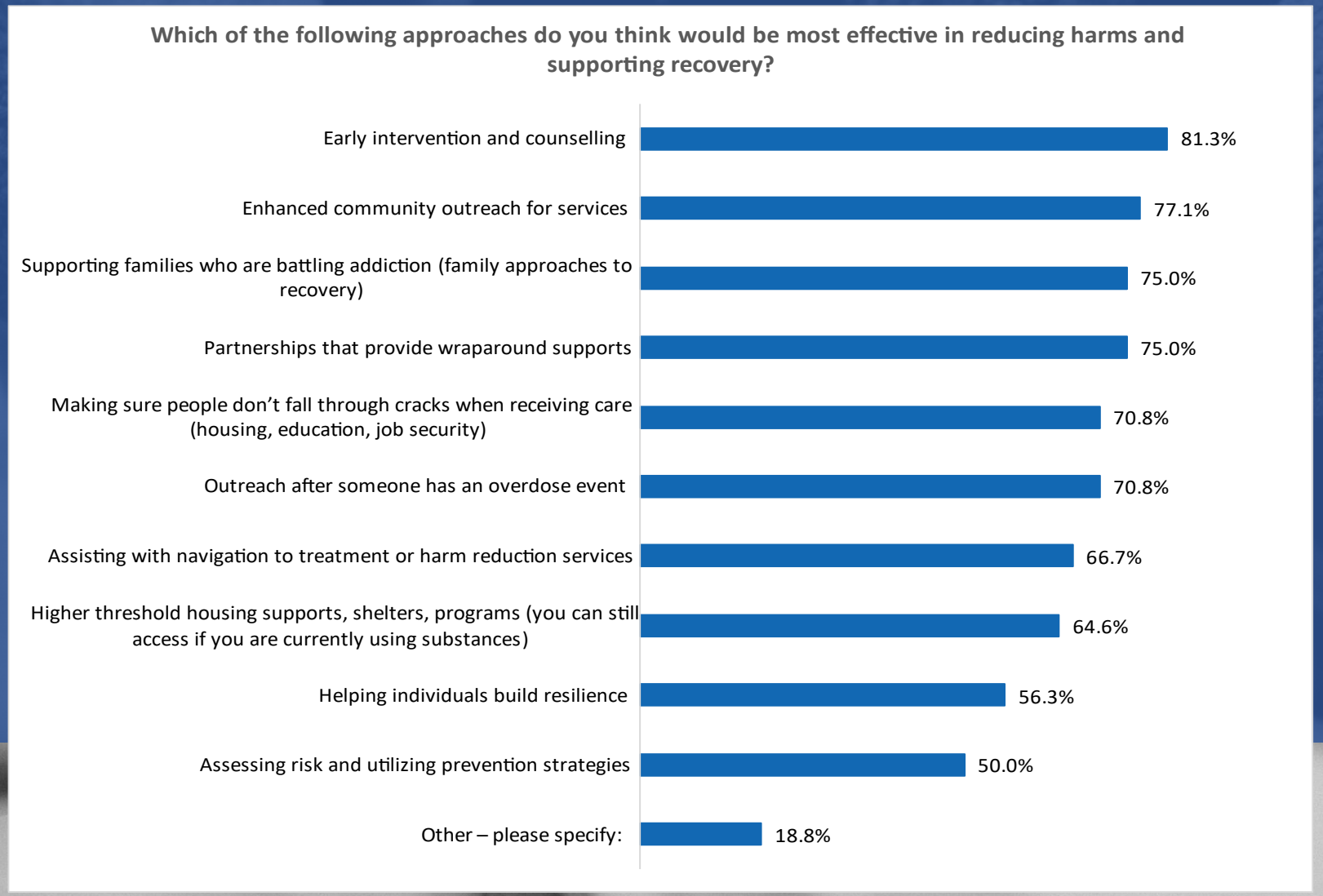
Q6 What do you feel are the biggest barriers to recovery in your community? Please select all that apply.

Responses to "Other"
(listed alphabetically, verbatim)

- *funded safe consumption site services*
- *lack of integrated care for both Mental Health and substance use disorder- 50% of clients who seek help have concurrent disorders Professionals need certification to practice in the area of SUD*
- *Lack of prescribers who can write OAT. We need to reduce barriers. Lack of stigma and forceful prescribing - it's almost impossible to find a prescriber in Regina to write for methadone & long-acting morphine - not every person is at a place where they can initiate suboxone. Lack of access to mental health services cannot be understated.*
- *Need to adopt the Every Door is the Right Door to support navigation and access to supports and treatment.*
- *not enough physicians and addiction counselors for opioid substitution services*
- *Systems are slow to change and respond to the needs of the most vulnerable. Moral discrimination towards people that struggle with drug use.*

Q7 Which of the following approaches do you think would be most effective in reducing harms and supporting recovery? Please select all that apply.



Please see next slide for the responses to "Other – please specify"

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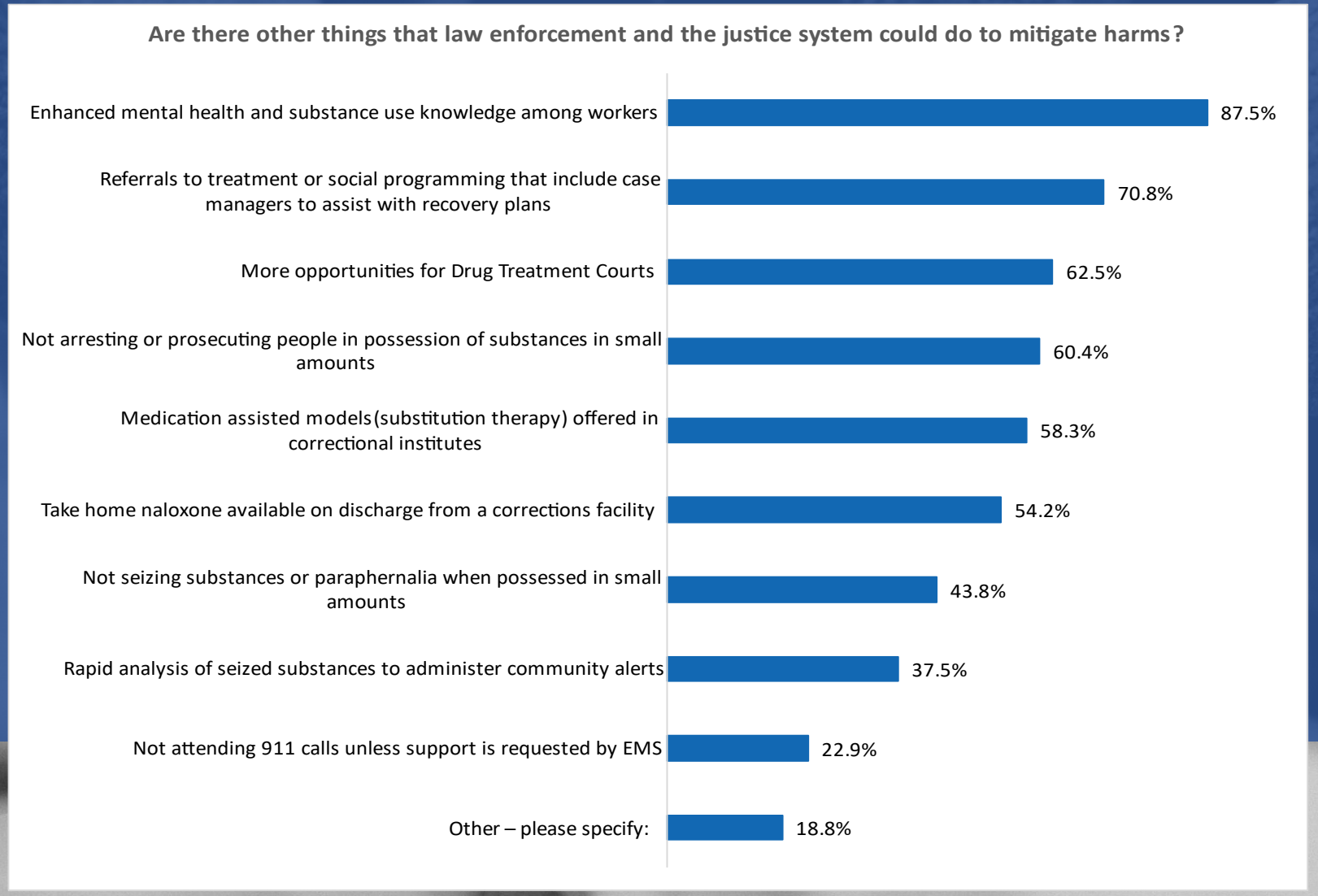
Q7 Which of the following approaches do you think would be most effective in reducing harms and supporting recovery? Please select all that apply.

Responses to "Other"
(listed alphabetically, verbatim)

- *24/7 safe consumption site where you can actively engage with people to encourage recovery and build trusting relationships*
- *certification of service providers so that the services that are provided are evidence based*
- *Drop in centres/warming centres where people can make connections and receive assistance without judgement; not having to go to a number of different organizations.*
- *It is critical the care is Person Directed and non punitive*
- *low barrier access to supports, shelters and programs*
- *Once again, mental health supports*
- *Re: Harm Reduction, the report by the SCAA's Crystal Meth Working Group calls for: 1) Develop a methodology to report on the social return on investment for harm-reduction programs/services; 2) Develop/expand, sustainably fund harm-reduction housing models like Ambrose Place in Edmonton; 3) Develop a comprehensive strategy for 24/7/365 coordinated and sustainably funded street/community outreach; 4) Develop policy and practice that would encourage max use of vacant/underused space in the city, including options for intensive youth programming/supports; 5) Support implementation of supervised consumption sites; Re: Treatment, the report calls for: 1) Research best practices for stimulant replacement/substitution programs; 2) Investigate and support best practices for land-based healing programs/services for Indigenous users of crystal meth; 3) Support consistent, appropriate and sustainable funding to develop, implement, and evaluate a crystal meth treatment/harm-reduction model for Indigenous people by Indigenous people; 4) Create a long-term, publicly funded, inpatient treatment strategy specific for crystal meth substance use disorder that includes prevention and harm reduction and that offers transportation, family accommodation, optional cultural programming, and access to Elders; 5) Work collaboratively to develop, implement and evaluate options for inpatient/outpatient (or a combination) services for community members with active crystal meth substance use disorder; 6) Monitor and support SCAA partners connected to the implementation of the Rapid Access Addiction Medicine Program*
- *Safe Consumption Site services*
- *Something that reaches the "ghosted" demographic. That young man in the trades who uses illicit substances in the weekends. The young woman/man/person who uses after midnight at a party, a few drinks and inhibitions weaken. Much of the offerings above reaches the marginalized demographic- we need to manage that messaging to the greater community better than we do, with that we will reduce the stigma that drives this false narrative that seems to exempt the average demographic from its harms.*

Q8 Are there other things that law enforcement and the justice system could do to mitigate harms? Please select all that apply.



Please see next slide for the responses to “Other – please specify”

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Q8 Are there other things that law enforcement and the justice system could do to mitigate harms? Please select all that apply.

Responses to "Other"
(listed alphabetically, verbatim)

- *Decriminalization*
- *direct engagement with outreach and safe consumption services. Also more cultural responsivity*
- *I feel I need more info to comment. Looking forward to the focus group.*
- *If one accepts substance use disorder as a health issue - there is no room for law enforcement/justice.*
- *larger penalties for breaking the law and providing supports in jail for a longterm period*
- *more training in MH and SUD evidence based interventions*
- *Not attending 911 calls - does work in other communities. It used to be our police officers were first on site and the carry Narcan/naloxone. We need to be careful that we don't close that door. Especially with COVID also bogging down our first responses*
- *Re: suppression, the Crystal Meth Working Group's report calls for 4 things: 1. Investigation into the relationship between enforcement policy/practices for crystal meth and apprehension of children including innovative best practices that support keeping families together; 2) Develop, implement, and evaluate a drug court in Saskatoon; 3) Develop policy and practice that requires implementation of CPTED principles in the design of community spaces; and 4) Mandatory trauma-informed training for police and emergency services to effectively and safely intervene and provide care to users*
- *To have access to supports trained to support individuals with substance abuse problems.*

Q9 The Drug Task Force recognizes that there are many factors to consider through this engagement process. First and foremost, its interest is to reduce the harms of overdoses and deaths due to toxic substances. Do you have any short-term solutions or suggestions?

- *- alerts for unsafe supply - linkage with EDAC's i.e. addictions counselors in emergency departments to train and support naloxone training, provide same to family members when they bring their loved one in - testing supply (make it easy, anonymous if possible) - increase brief detox beds asap*
- *- Case worker assigned to each emergency to counsel & assist in further direction of getting more help that is directed specifically to that situation with the authorization to share all information related. -*
- *1. Quick and easy access to counselling support for clients. 2. Community education. 3. Support for family members.*
- *access to drug testing to identify if there are unknown addictive (crystal meth) in purchased street drugs increase availability of safe consumption and brief detox in every community*
- *As indicated access to services which are community lead and policy directed which is culturally supported. Physician support to choice of treatment available Professional and para-professional supports and services must be non-punitive and nonjudgmental Community Workers must be supported as they are currently struggling with the losses of their clients. Workers assist families as they prepare for funerals, support them in their grieving processes which are taking their toll on the workers as they cope with all the impacts and needs resulting from the deaths. Programming needs to be directed by Traditional Knowledge Keepers and founded/based and built around the culture, with modern/western methods introduced where needed.*
- *Assist addicts whenever possible with whatever programs are available and stiffer sentences for drug traffickers.*
- *Decriminalize drug use by individuals and acknowledging that most are victims of trauma and are only further made to be vulnerable by putting them into the justice system.*
- *Denmark has a very successful strategy. There are a few studies available.*
- *De-stigmatization campaigns. Continue harm reduction programs like Take Home Naloxone, Opiate Antagonist Therapies, needle exchange, etc.*
- *Drug testing available in smaller cities. Better access to addictions medical treatment without stigma*
- *Drug testing strips Safe drug supply Increased access to OAT programs (rapid access) in smaller rural/remote communities*
- *Early interventions and support for our young people (trauma, violence, abuse, attachment)*

Q9 The Drug Task Force recognizes that there are many factors to consider through this engagement process. First and foremost, its interest is to reduce the harms of overdoses and deaths due to toxic substances. Do you have any short-term solutions or suggestions? *(continued)*

- *Easier access to detox and treatment. Far too many times, individuals wait many weeks to enter a treatment facility in the province. Supportive housing for those leaving treatment. Many go back to homelessness or unhealthy housing situations.*
- *For our community I would like to see better access to detox and treatment. We constantly lose people to care because they have to wait so long for a bed. We currently don't have a detox or treatment centre in our community and we have high rates of drug usage and people who are requesting assistance.*
- *Fund Safe Consumption Sites*
- *Fund strategic and evidence-based health promotion in Saskatchewan to focus on addiction prevention and reducing harms associated with substance use. Training for emergency responders and have specialized staff at emergency rooms to support PWLE - reduce stigma. Stigma reduction and building/practicing empathy needs to be the practice of emergency responders and health care workers. My experience speaking with families and individuals who have a lived experience is that they felt degraded by those who take an oath to protect, serve, provide care.*
- *Funding to safe consumption so they can increase their hours.*
- *Get CBO's together to work towards achievable goals to reduce the harms.*
- *Immediately fund the Saskatoon Safe Consumption site 24/7 and get them state of the art drug testing equipment immediately invest in additional physician opioid substitution prescribers and counsellors immediately invest in 24/7 outreach Implement the recommendations from the Safe Community Action Alliance Crystal Meth Working Group's report.*
- *Increase and improve treatment options (see previous comments re: treatment)*
- *Increased access to addictions counsellors as part of OST and outreach services. Expansion of Take-home Naloxone (THN) program (with additional resources for mental health and addiction services staff to provide education and training to individuals as well as distributors and placement sites).*
- *Increased access to transportation supports to manage appointments Life skills mentoring - regular check ins, goal planning, support in maintaining medical appointments and following up with counseling*
- *Meeting the people with addictions where they are at. Then we can sit down and have an open and honest conversation with them. We can learn from them, after all they are the experts.*

Q9 The Drug Task Force recognizes that there are many factors to consider through this engagement process. First and foremost, its interest is to reduce the harms of overdoses and deaths due to toxic substances. Do you have any short-term solutions or suggestions? *(continued)*

- *Narcan spray for post incarceration kits.*
- *outreach 24/7 with area experts working in collaborative teams.*
- *overdose prevention teams that provide follow up and outreach to non fatal overdose situations Analysis of the impact of crystal meth use on inpatient psychiatric units*
- *Quick and easy access to detox services, we have none in the Battlefords and surrounding area.*
- *Rolling out safer supplies so folks have easier access to them. Vending machines, pharmacies, public health offices, peer support groups/CBOs. Make them free. The only pharmacy in Regina that hands out supplies has been fighting for years to have access, she pays out hundreds of thousands of dollars a year to support her clients and the community. That shouldn't be individual responsibilities - most can't afford that or publicly funded locations can't bring them in. Fund the overdose prevention/safe consumption sites. Support & fund new places opening. The money being spent on awareness campaigns would go a heck of a lot further if given to Prairie Harm Reduction or Friendship Centre.*
- *To have a supervised consumption site (SCS) and funding to ensure longevity and consistency in the program. Increased education on safe substance use practices.*
- *To keep people alive while they are receiving the support they need to find hope and learn to deal with the issues leading to substance use, without using. Basic needs and supports need to be in place before anything else can happen.*
- *Virtual Opioid Dependency Program similar to the one in Alberta where individuals have access to drug replacement therapy with a phone call rather than waiting for weeks for an appointment.*

Q10 Do you have any long-term solutions or suggestions?

- *1. Getting drugs off the street. 2. Youth programming. 3. Safe places/needles for using (harm reduction)*
- *Add someone on the task force with lived experience. The current drug task force has three Ministers, three policing, one health and two broad policy makers. Where is the balance? Are we still approaching this as a criminal issue that can be addressed through punishment or consequences? When are we going to start looking at this through the lens of a medical issue rather than a moral one? A task force that is made of these individuals will do nothing to mitigate the internal biases that each of these stakeholders brings to the table. Maybe it is time to bring someone that has actual lived experience to the table and have them help develop the policy.*
- *Additional treatment beds in south and central Saskatchewan de-criminalization of possession for personal use*
- *Better social assistance options for people with substance use disorder (SUD). Additional low-barrier/high-tolerance housing options that are affordable and harm-reduction focused, with social/medical supports on-site.*
- *Decriminalizing minor possession*
- *Denmark has a very successful strategy. There are a few studies available.*
- *Early Childhood Education on drugs & addictions that is a fundamental & mandatory part of the curriculum from 10 yrs to graduation.*
- *Education and reduction of stigma.*
- *Expand availability of and access to detox and treatment beds in the province. Implementation of harm reduction treatment options outside larger centers to increase access to all. Increase availability of navigation for individuals in rural areas. All sectors be trained and fluent in trauma informed care.*
- *Far more social work, medical or addictions workers attached to police services to deal with issues far more quickly*
- *Focus on the already existing harm reduction services in the communities instead of duplicating services. There are lots of CBO's that offer amazing services for the vulnerable population they serve. Improving the core funding so that CBO's can continue to offer services instead of services being limited based on access to funding.*
- *Fund Safe Consumption Sites*
- *I would like to see more programs that start at the detox stage and support people right through the recovery stage with no gaps or waiting for support in between each step. Also, to have some continuity of support so that there is a familiarity and trust relationship built with client to support their recovery.*

Q10 Do you have any long-term solutions or suggestions? *(continued)*

- *Implement harm reduction strategies and models of care throughout all government structures and prioritize the care of vulnerable people opposed to, what is happening now, prioritizing the comfort of the privileged.*
- *In patient and out patient treatment facilities in our area. We have none. When individuals are ready, they end up on a wait list and end up relapsing while they wait for a spot .*
- *Increase in Mental Health Supports. We need to hire more, we need improved access. Drop the requirements for opioid agonist therapy (OAT) prescribers. Once again, anyone in SK can prescribe an opioid but can't prescribe OAT? Clients in corrections need to be provided with either safe supply or OAT. Prior to release, they should be given a phone, naloxone kit, prescription for OAT if they want, drug test kits, and stigma-free counselling/education on the extremely elevated risk of lethal overdose following release from corrections. SHA needs to increase their training to all employees re: needs of those with substance use disorders. They need to provide safe supplies to hospitalized clients. Too many are profiled & discriminated against, refused their OAT treatment, refused pain medication, refused withdrawal support, and then the client eventually leaves AMA to help combat their pain and/or withdrawal on their own without receiving proper treatment to only reappear in ER at a future date for the same concern.*
- *Infrastructure: rapid access to detox - medically assisted detox with a smooth transition to treatment. No wait times(detoxed people overdose far too often while they wait for a treatment bed) Decriminalization of personal amounts of drugs. Drug test strips available at pharmacies or online for a more discreet delivery. Narcan / naloxone too. Safe supply for our communities most marginalized. Funding for safe consumption Age appropriate evidence based and qualified Drug education teachings in the schools. Not say no - it's useless. Early childhood trauma intervention More resources for mental health supports Mental health and addictions action team that work directly with first responders. It's completely unfair and dangerous to our first responders to be out in the decision making arena when dealing with this type of emergency. Hospitals only deal with getting them breathing again, then what? The police respond to minimize immediate danger, that should be their only responsibility. Health care belongs with health care. We need greater Narcan distribution to our rural volunteer first responders. They are often 1st on site and have been buying their own kits. Not acceptable. Health Region [Authority] says they are not trained, Narcan does not require much for training. The community should be made aware of not only overdose deaths, but actual overdose responses period. Failure to report continues the false narrative that it only happens to our most vulnerable. I'm sure I have more but that's it for now*
- *Integration of OAT therapy into primary care settings to provide holistic care of individual Addition of community supports into primary care settings (assistance with housing, detox, navigation supports)*
- *Meet people where they are at Basic needs and supports need to be in place first. One entry point with navigation assistance through the system(s) Individualized plans (not cookie cutter) Harm reduction is a spectrum and what = recovery for one may not = recovery for another. There should not be any condition of stopping using Drop in centres/warming centres connected to OPS or SCS with additional supports (an entry point). Treat people with respect - know their name. Care about people as individuals.*

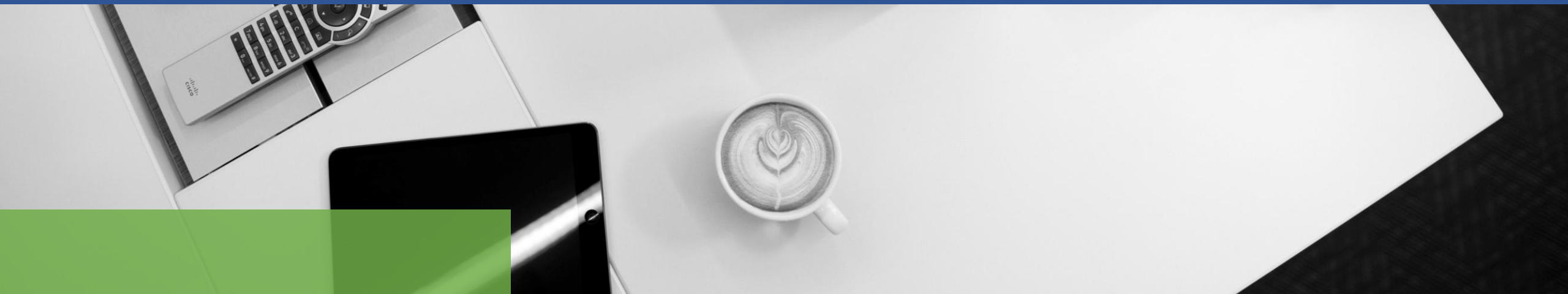
Q10 Do you have any long-term solutions or suggestions? *(continued)*

- *outreach 24/7 with area experts working in collaborative teams ; ability to refer and connect and engage to trauma informed treatment (long term treatment in patient and outpatient).*
- *overdose prevention teams that provide follow up and outreach to non fatal overdose situations supportive housing with fairly intensive supports in place*
- *Policy changes that are punitive for drug use and housing and parenting. Supporting rather than punishing. We need to stop criminalizing drug use.*
- *Putting a focus on the determinants of health and using an Upstream Population Health Promotion approach. There is a higher proportion of individuals that may be in poverty, low education, unemployment or have no available adequate housing that are at high risk of overdose and death due to toxic substances. By focusing on these issues, it has shown to reduce the harms associated with substance use and abuse.*
- *Safe drug supply Increased access to OAT programs (rapid access) in smaller rural/remote communities*
- *Same.*
- *Set up Healing Centres.*
- *Some of the above have short and long term aspects to them.*
- *Support municipalities to adopt policies that reduce alcohol related harms - a good resource is the Alberta - Alcohol Policy for Community Safety, Vibrancy, Health and Well-being Guide. As noted in the PowerPoint and data from Canadian Substance Use Costs and Harms (CSUCH) - Alcohol and Tobacco have the greatest costs and harms associated with them. Invest in reducing alcohol and tobacco/vaping related harms - adopt provincial legislation to regulate them to reduce harms and prevent addiction. The provincial government has a role to play in preventing addictions, in addition to providing appropriate funding - they must also take bold action.*
- *The CMWG's report also identifies strategic actions related to "Data Integration": 1. Create and resource a team of lived experience colleagues; 2. Create a system map that collects current data associated with access to systems for those who are currently involved with crystal meth (including a mechanism to determine recommendations to encourage a no wrong door approach) 3. Work with existing data and evaluation experts to create policy and practice for sharing data specific to crystal meth 4. Develop, implement, resource, and evaluate a centralized data storage/sharing system that creates opportunities for community, government, and systems to share/use data; 5. Create opportunities for community driven research that builds capacity and focuses on the interconnection and reciprocity between community need and researcher need, understanding that outputs should be useful for community policy and practice. 6. Conduct a study examining the syndemic factors contributing to the crystal meth crisis and subsequent comparative study after the above strategic actions have been implemented*
- *The need for increased access to rapid addiction medicine is very important in the north. Additional access to harm reduction supplies IE) vending machines etc.*

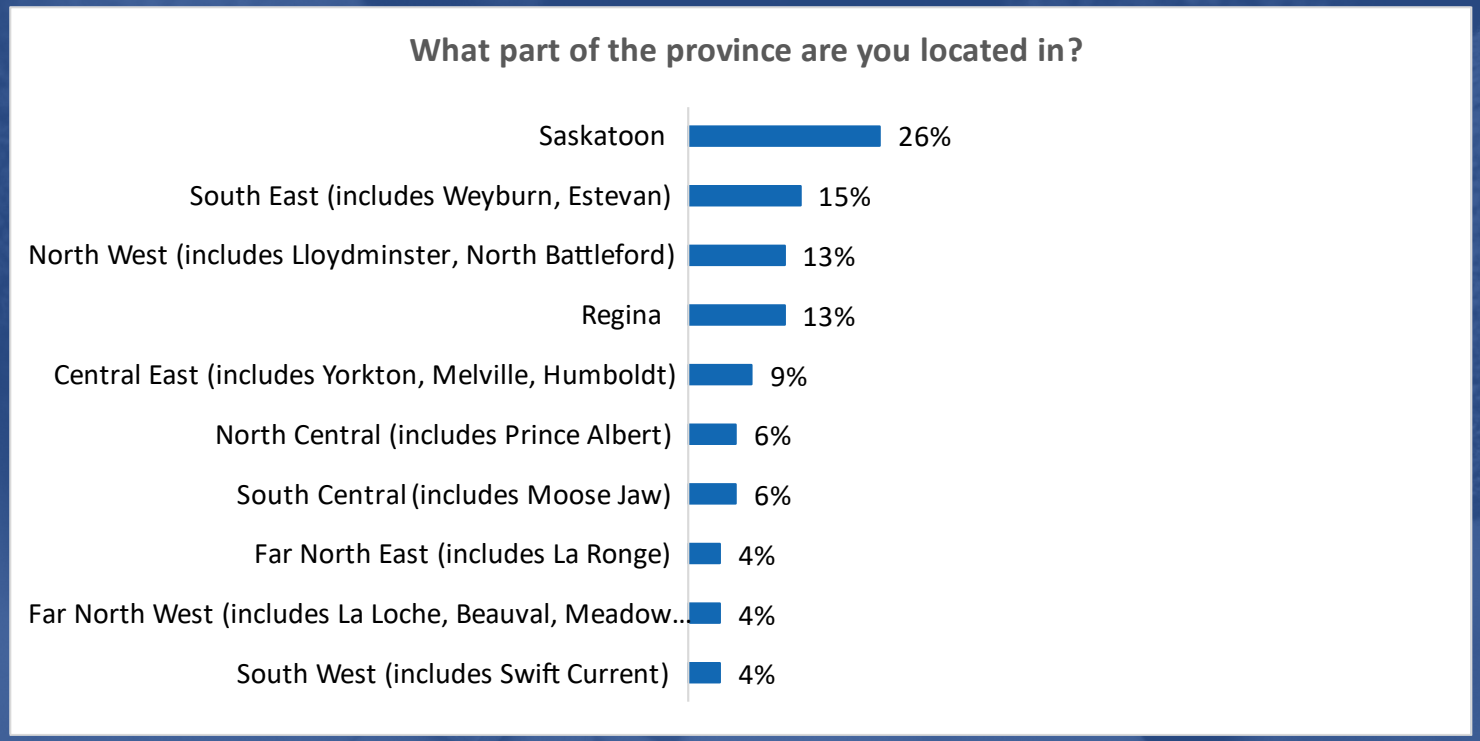
Q10 Do you have any long-term solutions or suggestions? *(continued)*

- *there needs to be more accessible detox and treatment available. When an addicted person requires help they need it right away and all Saskatchewan resources seem to have long wait lists. In the meantime the people are struggling on their own and risk further overdose or death*
- *We need to help our communities heal from the effects of the past. We need to reach a place of equality. We need to instill hope and pride in our most vulnerable people. Once we have reached these goals we can begin to work on the addictions. If we don't reach these goals we will continue to put a band-aid on the wounds and the wound will never heal. This process needs to be led and guided by those who have the addictions. This needs to continually happen through the entire process.*
- *Wrap around housing with mental health services for post incarceration that also includes 30,60,or 90 day treatment. Funding for PHR and other harm reduction strategies.*

DEMOGRAPHICS



Q11 What part of the province are you located in?



Q12 Are you...?