# Honouring the Legacy, Creating New Pathways: Advancing Indigenous Harm Reduction Through a Culturally Safe Program

By

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BA CYCC Douglas College, 2017

A Project Submitted in Partial Fulfillment of the Requirements for the Degree of

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I acknowledge and respect the lək̓ʷəŋən (Songhees and Xʷsepsəm/Esquimalt) Peoples on whose territory the university stands, and the lək̓ʷəŋən and W̱ SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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This project is shared with respect for Indigenous ways of knowing, where knowledge is a gift and a responsibility. You are welcome to share or cite this work, provided it is done respectfully and with proper context. Please include the author's name, affiliation, and community, and acknowledge the background and significance of the teachings when possible. Knowledge is one of the greatest gifts an Indigenous person has to offer, and with that comes a responsibility to honour the context and teachings it holds. This knowledge should not be used for commercial purposes or taken out of context without permission.

As an Indigenous woman from the ɬəʔamɛn (Tla'amin) Nation, I gratefully acknowledge that the land which I live on is the stolen and occupied lands of the Snaw-naw-as First Nation.

**Abstract**

Since 2016, British Columbia's toxic drug public health emergency has claimed more than 16,000 lives, hitting First Nations communities hardest: mortality rates are up to seven times higher than among other residents. These deaths stem from colonial harms - Indian Residential Schools, the Sixties Scoop, punitive drug laws - that fractured families, suppressed culture, and reshaped the social determinants of Indigenous peoples' health. To address this crisis, the First Nations Health Authority (FNHA) launched *Not Just Naloxone* (NJN) in 2017, a three-day, in-person train-the-trainer workshop delivering Indigenous-led harm-reduction education. Demand soon outpaced capacity, and the length and emotional weight of the sessions led to delivery challenges, limiting both capacity and reach. This project converted NJN into a self-paced online course rooted in Indigenous ways of learning yet accessible to remote and time-pressed learners. Course development drew on an integrative literature review, monthly meetings with youth and adult peers, Elder guidance, and modular design that blends digital storytelling with flexible activities. Regional consultations and an in-person peer review further refined content. The completed course offers eight interactive modules grounded in culture-based knowing, trauma-informed practice, and BC First Nations narratives. Elders' prayers open and close the learning journey, and digital stories highlight Indigenous harm reduction and decolonized substance-use care. Early feedback shows the platform supports relational, story-based learning when directed by knowledge keepers and lived experience. Ongoing success will require regular updates, fair compensation for peers, and strategies to dismantle stigma and anti-Indigenous racism.

## Acknowledgments

To Dr. Doris Kukuru – Thank you for stepping in as my supervisor when I needed it most. Your guidance and steady approach helped me navigate the final stages of this project, and I am deeply appreciative of your time and commitment to seeing it through.

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To my Ancestors – Thank you for walking beside me, for whispering strength when I needed it, and for reminding me who I am. This work is part of a longer journey toward justice, healing, and reconnection, and I carry your teachings with me every step of the way.

## Dedication

To the ‘Ones Who Came Before Us’:

This work is dedicated to those we have lost to the toxic drug public health emergency - those who died from a poisoned supply, from being forced to use alone, from systems that treated their lives as disposable. Your absence is felt deeply, and your memory carries this work forward.

To the early harm reduction champions who showed up with care, courage, and whatever they had to offer. You created safety in unsafe places, built grassroots movements in the face of indifference, and held community when systems would not.

To those arrested, silenced, or killed by drug laws rooted in racism and fear. To the families torn apart by criminalization. To those who died without justice.

To Indigenous peoples who have carried the weight of colonialism, systemic racism, and white supremacy. Those who survived Residential Schools, the Sixties Scoop, and every attempt to erase your identity, your connection, and your community.

This work walks in your footsteps - with grief, with gratitude, and with the promise to keep going.

You are not forgotten. You are the reason this work exists. You are the reason it must continue.

ʔimot (Thank you)

## Table of Contents

## Reframing Substance Use Through Language[1]

Before engaging with the content of this paper, it is important to reflect on the language we use when discussing substance use. Language shapes how we understand and relate to one another, and it plays a powerful role in either reinforcing or challenging stigma. For this reason, I have included a chart outlining appropriate and respectful language that will be used throughout this work. This chart serves as a guide for the reader and reflects a commitment to using people-first, non-stigmatizing, and medically accurate terms. Language is not static - it evolves over time. As such, I encourage each of us to ongoing learning and openness to changeeven beyond the scope of this paper.

| **Instead of…** | **You will see…** | **Why?** |
|---|---|---|
| • Opioid crisis<br>• Overdose crisis<br>• Overdose | • Toxic drug public health emergency<br>• Drug poisoning<br>• Toxic drug poisoning | • The word "overdose" is commonly used, but it can carry a sense of blame or imply that the person intentionally used too much. It suggests they knew the dose and the outcome, which isn't always the case. In many situations, "poisoning" may be a more accurate way to describe what's happening - similar to how we use the term "alcohol poisoning" to describe the body's reaction to too much of a toxic substance. |

[1] *The language choices reflected in this work are shaped by community knowledge shared over many years through relationships, conversations, and lived experience alongside Elders, peers, and harm reduction champions. In keeping with Indigenous oral traditions, this knowledge is acknowledged through practice rather than formal citation. These insights are rooted in over a decade of frontline work in Vancouver's Downtown Eastside and three years supporting all 203 First Nations communities across BC through the First Nations Health Authority.*

| | | |
|---|---|---|
| • Illicit<br>• Illegal<br>• Street drugs<br>• Party drugs | • Unregulated substances or supply | • Words like "illicit" and "illegal" can carry heavy moral judgment and often make people sound like criminals, which adds to stigma. |
| • Addict<br>• Junkie<br>• User<br>• Druggie<br>• Abusers | • People or person who uses substances | • Person-first language puts the focus on the individual, not their substance use. It helps avoid labels that define someone by their actions or diagnosis and pushes back against the stigma that treats substance use as a moral or personal failing. |
| • Drug abuse<br>• Substance misuse<br>• Problematic drug use | • Drug use<br>• Substance use<br>• People or person with living experience<br>• Substance use harms | • Terms like "drug abuse" or "problematic use" can make it seem like substance use is a personal or moral failing, rather than recognizing it as a complex health issue influenced by many factors. |
| • Clean<br>• Sober<br>• Reformed addict<br>• Former addict | • Wellness journey<br>• Recovery journey<br>• People or person with lived experience | • Using terms like "clean," "sober," or "former addict" can reduce someone to their past or behavior, rather than seeing them as a whole person. For many, that kind of language feels dehumanizing. |
| • Dirty needle<br>• Clean needle | • Used needle<br>• Sterile needle | • Using clear, medical terms like "used needle" or "sterile needle" - just like we would with any other health equipment - helps keep the language neutral and reduces stigma. |

## First Nations Vs. Indigenous Terminology

Terminology plays a critical role in how communities are represented and understood. In Canada, the term ‘Indigenous’ has been widely adopted following the federal government's endorsement of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) in 2016. It serves as an international umbrella term referring collectively to First Nations, Métis, and Inuit peoples. While often used in national legislation, policy, and research, Indigenous does not always reflect the specific histories, rights, and governance structures of individual Nations (First Nations Health Authority, 2013).

In British Columbia, the term ‘First Nations’ is frequently preferred, particularly when referring to the 203 distinct Nations across the province. BC is home to the greatest diversity of First Nations in Canada, with over 60 Indigenous languages spoken and the majority of communities existing outside of treaty agreements. While these Nations remain within the jurisdiction of the Indian Act, their relationships to land and governance are distinct. The First Nations Health Authority (FNHA), established in 2013 through a tripartite agreement with provincial and federal governments, uses First Nations to reflect its commitment to serving rights-holding Nations in BC (First Nations Health Authority, 2013).

This project follows the terminology approach used by FNHA - using First Nations when referring specifically to Nations within BC, and Indigenous when discussing broader frameworks or contexts. These choices are informed by years of community dialogue, evolving legal and political contexts, and the importance of respecting Nation-specific identity and self-determination.

## Introduction

On April 14, 2016, British Columbia's (BC) provincial health officer declared a public health emergency in response to a rapidly escalating emergency: a sharp and unprecedented rise in toxic drug deaths. That year, 235 people in Vancouver alone lost their lives, largely due to the growing presence of fentanyl in the unregulated drug supply (Nowell & Masuda, 2020). This emergency has continued to evolve, driven by an increasingly toxic and unpredictable drug supply, contributing to a decline in life expectancy in the province - a trend not seen in decades (Nowell & Masuda, 2020; Steinberg et al., 2022). Between April 2016 and December 2024, more than 16,000 British Columbians died from toxic drug poisonings, now the leading cause of death for people aged 10 to 59, surpassing all other unnatural and natural causes combined (BC Coroners Service, 2024).

Yet these harms have not been experienced equally. First Nations people in BC have been disproportionately impacted since the start of the public health emergency. In 2024, although First Nations people made up only about 3.4% of BC's population, they accounted for 19% of toxic drug deaths. In 2024, the emergency continued with 427 First Nations individuals dying - at a rate 6.7 times higher than other BC residents, marking the largest disparity since 2016. First Nations women were especially affected, dying at 11.6 times the rate of other BC women, while First Nations men died at 5.2 times the rate of their non-Indigenous counterparts (First Nations Health Authority [FNHA], 2024). Among youth, the inequities are equally alarming: between 2016 and 2021, First Nations youth aged 15 to 29 represented just 4.1% of BC's youth population, but made up 17.4% of youth toxic drug deaths. Rates among First Nations female youth were 10 times higher than other young women, and 7.5 times higher for First Nations male youth compared to other young men (FNHA, 2024).

These numbers are more than just data sets - they represent lives, families, and communities enduring immense grief and loss. Each life lost reverberates through generations, leaving behind children, parents, loved ones, and community members. The long-term impacts on children and youth who experience these losses are profound and must be central to how we understand and respond to this emergency.

To prevent further loss, BC has expanded access to naloxone, a fast-acting medication that reverses opioid poisoning by restoring breathing (BCCDC, 2025). Initially used only in medical settings, naloxone became more widely available as toxic drug deaths climbed. The BC Centre for Disease Control (BCCDC) launched the Take Home Naloxone (THN) program, distributing kits and overdose response training through community-based sites. Paired with the creation of Toward the Heart, a platform offering harm reduction education, and a "train-the-trainer" model, these efforts helped distribute over one million kits by 2021 (BCCDC, 2021; Tsang & Buxton, 2021).

However, despite the reach of these initiatives, significant gaps remain. Many harm reduction tools and training materials fail to fully integrate Indigenous perspectives and knowledge systems. Too often, Indigenous-specific content is limited to a single section or appendix, reinforcing a divide between general services and culturally appropriate care. Recognizing this, organizations have taken steps to develop resources that center Indigenous cultural safety, self-determination, and ways of knowing in harm reduction education. Indigenous ways of knowing are integral to substance use conversations, offering culturally grounded approaches that foster healing and resilience. For example, in British Columbia the First Nations Health Authority's Courageous Conversations on Substance Use Toolkit (FNHA, 2023) emphasizes the importance of incorporating Indigenous cultural practices, such as sharing circles

and traditional teachings, to create safe and supportive environments for dialogue. These practices honor the interconnectedness of individuals, communities, and the land, facilitating open discussions about substance use without judgment. These efforts aim to move beyond inclusion toward full integration - embedding cultural safety as a foundational principle rather than a supplementary add-on. Additionally, the national organization Thunderbird Partnership Foundation's Sacred Breath of Life campaign developed a resource kit aimed at increasing awareness, understanding, and engagement among First Nations leaders and community members, including individuals and families affected by substance use. The resource kit highlights the positive outcomes of harm reduction and its role in supporting community health and well-being (Thunderbird Partnership Foundation, 2022).

Recognizing everything above, this Master's project and accompanying paper explore the intersections between the toxic drug public health emergency and its impact on First Nations communities in British Columbia, with a particular focus on youth, gender, and culturally safe harm reduction. It also highlights the urgent need for resources and training that are not only trauma-informed and evidence-based but also guided by Indigenous ways of knowing, being, and doing. As the province enters its ninth year of this public health emergency, a shift toward Indigenous-led, culturally grounded approaches is not just necessary - it is life-saving.

## Self Location

My work in substance use care has spanned over 13 years and has always been rooted in supporting First Nations individuals, youth, and families. Currently, I serve as the Provincial Harm Reduction Program Advisor at the First Nations Health Authority - a role I have held for over three years. This work has given me a deep understanding of harm reduction strategies and

the policies, data, and relationships that shape substance use care across the province. But my connection to this work runs deeper than professional experience.

I am a mixed Indigenous woman with Tla'amin and Scottish ancestry on my mother's side and English ancestry on my father's. I carry the stories and strength of my ancestors while navigating the realities of being disconnected from culture for much of my early life. Like many others impacted by colonialism, intergenerational trauma, and displacement, I did not grow up within my Nation or community. It was not until I was 25 that I was able to reconnect with my family and begin reclaiming my culture. Since then, I have been on a journey of learning and remembering - bringing Indigenous ways of knowing, being, and doing into my everyday life.

I am also a mother, a partner, a sister, a daughter, and a granddaughter. I have experienced the impacts of mental health challenges, substance use, and precarious housing firsthand. These experiences shape how I move through the world - not as something that defines me, but as something that grounds me. They influence how I show up in my work: with care, humility, and a strong belief that harm reduction must be both culturally safe and community-driven.

I walk in this work with the teachings of those who came before me, and the hope of those who will come after. My commitment is to ensure that harm reduction does not exist in isolation from Indigenous voices, knowledge, and leadership - but is built around them. This is not just a professional responsibility for me; it is deeply personal, political, and relational.

## Literature Review

### Toxic Drug Public Health Emergency

#### *History and Data*

British Columbia's toxic drug public health emergency has developed over decades, rooted in complex social and systemic issues. In the 1990s, Vancouver faced two overlapping

health emergencies: a sharp rise in drug-related deaths and a spike in HIV/AIDS among people who inject drugs. Between 1991 and 1993, deaths from HIV/AIDS and toxic drug poisonings more than doubled. By 1997, worsening conditions led to a public health emergency in Vancouver due to rising drug poisoning deaths and the spread of infectious diseases like hepatitis A, B, and C, syphilis, and HIV (Kerr et al., 2006).

While drug poisoning deaths steadily increased in the early 2000s, the emergency escalated rapidly starting in 2013. In 2016, BC became the first province in Canada to declare a province-wide public health emergency in response to the growing number of drug poisoning deaths (Government of British Columbia, 2016). Public health emergencies allow authorities to mobilize resources quickly and coordinate across sectors to protect population health. This declaration came as fentanyl - an opioid up to 100 times more potent than morphine - became the leading cause of drug poisoning fatalities (BC Centre for Disease Control [BCCDC], 2023). By 2015, Vancouver's heroin supply was largely replaced by fentanyl, which was cheaper, more potent, and far more dangerous (Ickowicz et al., 2022). The emergency declaration enabled the province to collect real-time data, track emerging risks, and expand harm reduction services.

From 2015 to 2017, drug-related deaths in BC surged from 510 to 1,473, a 400% increase from 1993 levels (BC Coroners Service, 2025). In 2019, BC saw a brief decline in drug poisoning deaths due to increased access to overdose prevention sites and opioid agonist therapies. However, the COVID-19 pandemic reversed much of that progress. Social isolation, reduced service access, and disruptions in treatment contributed to a new wave of toxic drug poisonings (Tobias et al., 2023). Simultaneously, restrictions on prescription opioids drove more people toward the unpredictable and increasingly toxic unregulated drug supply.

Data shows that the main cause of drug poisoning deaths in British Columbia is the increasing toxicity of the unregulated supply, not an increase in overall use (Government of British Columbia, Office of the Provincial Health Officer, 2019). Because the supply is illegal, there are no safety standards. People often do not know what or how much they are taking, and cross-contamination is common. This is especially dangerous for those who have not used opioids before, have relapsed, or use stimulants, alcohol, or benzodiazepines and accidentally consume fentanyl or its analogues. As the drug supply becomes more toxic, the risk of death also rises (Government of British Columbia, BC Coroners Service, 2024).

In 2024, an average of 6.3 people died every day in BC due to toxic drugs. Seventy percent of those who died were between ages 30 and 59, and 74% were men. Notably, 81% of these deaths occurred indoors, often in private settings (BC Coroners Service, 2025). Papamihali et al. (2020) identify several reasons why people may choose to use substances alone rather than accessing overdose prevention sites. These include restrictions on observed smoking, long wait times, crowded and potentially overwhelming environments, and geographic inaccessibility. Additionally, women may feel safer using alone rather than in male-dominated OPS sites, underscoring the need for substance use services that are specifically designed to support women.

Stigma remains a powerful barrier to accessing care for people who use substances. Many individuals continue to use alone, away from public or supervised spaces, to avoid judgement and discrimination. Papamihali et al. (2020) emphasize that stigma can prevent people from seeking health care and can lead to non-disclosure of health conditions, further isolating individuals who use substances. Shame and stigma associated with drug use are frequently cited

reasons why people hide their drug use, increasing the likelihood of using alone and in unsafe settings.

Boyd and MacPherson (2019) argue that discriminatory drug laws and policies, including those related to child protection, housing, and treatment, “activate stigma” against people who use criminalized substances and produce social inequality. As a result, experiences and outcomes of substance use are shaped not only by individual choices but also by one’s social status and environment. Government of British Columbia, BC Coroners Service (2024) notes that anyone can use substances - not just those who are unhoused or marginalized. However, stigma is felt by everyone who uses substances, regardless of background. The stigma, racism, and discrimination that accompany substance use create societal, institutional, and personal barriers that prevent people from accessing the services they need to stay safe.

While substance use disorders are a significant risk factor, BC Coroners Service data from previous death review panels show that many of the people who have died from toxic drug poisonings did not have a substance use disorder diagnosis. This finding highlights a segment of the population that could particularly benefit from access to safer supply and harm reduction services (Government of British Columbia, BC Coroners Service, 2024). There is widespread global recognition that the failed “war on drugs” and the resulting criminalization and stigmatization of people who use drugs have not reduced drug use but instead have increased health harms (Government of British Columbia, BC Coroners Service, 2024). The stigma associated with substance use disorder remains a barrier for many who might otherwise seek help. Recognizing substance use as a health issue, rather than a criminal one, can encourage people to access support rather than hide their use out of fear of punishment or public disapproval.

Today, toxic drugs are the leading cause of premature death in BC. In 2024 alone, 2,253 people lost their lives - surpassing deaths from motor vehicle accidents and suicide. Fentanyl or its analogs were involved in 78% of those cases (BC Coroners Service, 2025). The emergency has far-reaching roots in mental health challenges, housing instability, and the social isolation that many people who use drugs face (Canadian Centre on Substance Use and Addiction [CCSA], 2022). The toxic drug public health emergency in British Columbia continues to devastate individuals, families, and communities, with more than 16,000 lives lost since the emergency was declared in 2016.

***Youth***

Young people are feeling the full force of the toxic drug public health emergency - it is affecting them now, and the consequences are escalating. BC Coroners Service (2024) released a report that highlights between January 1, 2019, and December 31, 2023, British Columbia recorded 126 unregulated drug toxicity deaths among individuals under the age of 19 - an average of 25 deaths per year. During this period, unregulated drug toxicity was the leading cause of unnatural death among youth, surpassing suicide and motor vehicle incidents. Key findings highlight the heightened risks facing young people: more than half of the deaths occurred when youth were using substances alone, and over 70% took place in private residences. Notably, approximately two-thirds (66%) of those who died had received current or past services from the provincial Ministry of Children and Family Development (MCFD). Fentanyl or its analogues were involved in 83% of the deaths, either alone or in combination with other substances, underscoring the extreme toxicity of the unregulated drug supply.

### *First Nations People in British Columbia*

First Nations people in British Columbia continue to be hit hardest by the toxic drug public health emergency. In 2024, 427 First Nations individuals lost their lives to toxic drug poisonings - a slight drop from the 458 deaths reported in 2023. But even with that decrease, the death rate was 6.7 times higher than that of other BC residents, the highest it has been since the public health emergency was declared in 2016 (FNHA, 2024). In 2024, there were 3,400 toxic drug poisoning events among First Nations people which is a small decrease from the 3,713 reported the year before.

When looking at gender, the disparities are even more concerning. First Nations women died at a rate 11.6 times higher than other women in the province, and First Nations men died at 5.2 times the rate of their non-Indigenous peers (FNHA, 2024).

First Nation's youth have been especially affected. Between 2016 and 2021, First Nations youth aged 15 to 29 made up just over 4% of the youth population in BC but accounted for 17.4% of all toxic drug deaths in that age group. The gender gap appears again here: toxic drug event rates were 10 times higher for First Nations female youth and 7.5 times higher for First Nations male youth compared to their non-Indigenous peers (FNHA, 2024).

### *Data Disparities*

Indigenous Peoples are among those most affected by drug poisoning across Canada (Lavalley et al., 2018). However, the extent of the crisis is likely underreported due to limited data collection on Indigenous identity. In British Columbia, data is only collected on status First Nations people, the numbers do not capture the experiences of Métis, Inuit, or non-status First Nations people, which means the true impact is likely higher.

Another issue is how gender is recorded in the data. Two-Spirit, transgender, non-binary, intersex, and gender-diverse people are often only listed by their biological sex at birth, making them hard to identify in the data. This erases important aspects of identity and can lead to their needs being overlooked in substance use services.

The data makes it clear that it is not just about how many people use drugs but about the toxic and unpredictable supply that is killing people. The numbers show how hard First Nations communities and young people are being hit by this crisis, and how gaps in data make it harder to understand its full impact - especially for Indigenous, Two-Spirit, and gender-diverse people. Moving forward, we need stronger harm reduction efforts, safer supply programs, and real changes to how we treat people who use substances. It is critical to make sure that those most affected are involved in shaping the solutions.

**History of Anti-Indigenous Racism and Drug Prohibition in Canada**

When we talk about Indigenous health, it is impossible to ignore the deep and ongoing impacts of colonization. Health, housing, education, and justice systems were never designed with Indigenous Peoples in mind; they were tools to control, remove, and erase. These are not simply historical harms - they shape every aspect of wellbeing today (Allan & Smylie, 2015; NCCIH, 2022).

Drug prohibition is one of the clearest examples. Beginning in the late 1800s, moral panic and racism drove laws that singled out racialized communities. The Indian Act's alcohol ban subjected First Nations people to fines and jail time until the 1960s, while police were granted sweeping powers of detention (Campbell, 2008). The Opium Act of 1908 targeted Chinese workers amid rising anti-Asian sentiment, all while substances such as morphine and alcohol remained acceptable for white Canadians (Boyd, 2017; Boyd & MacPherson, 2018). These

policies entrenched the idea that certain drugs - and by extension, certain peoples - were deviant, setting the stage for a punitive “war on drugs” that still treats substance use as a criminal rather than a health issue (Boyd, 2019; Fonseca, 2020). Understanding Canada’s war on drugs as a continuation of colonial control reveals how deeply it is intertwined with structural inequities. Drug laws are part of a wider pattern of policies used to control Indigenous peoples; from bans on cultural ceremonies to the Residential School system and the Sixties Scoop (Fonseca, 2020).

The same colonial thinking shapes the social determinants of health today. Poverty, forced displacement, child apprehension, and systemic racism make it difficult for many Indigenous people to secure safe housing, adequate income, or food security (Kastor et al., 2018; Lavalley et al., 2018). Surveillance and stigma remain high, especially around substance use, despite evidence that stereotypes of an inherent “addictive nature” are false and harmful (Browne, 2017; McKenzie et al., 2016).

Drug policy has deepened these inequities. Indigenous people are more likely to be arrested, prosecuted, and incarcerated on drug charges despite similar rates of use across populations (Daniels et al., 2021). Criminalization drives people away from help and into an increasingly toxic, unregulated supply which is fueling today’s toxic drug public health emergency (Boyd, 2019). In British Columbia, 84 percent of drug-poisoning deaths occur indoors and in isolation, illustrating how stigma and fear push use behind closed doors (FNHA, 2024).

Colonial structures have also shaped mainstream health and treatment services. Many programs rely on Christian-based or deficit-focused models that exclude traditional knowledge and leave Indigenous clients feeling unseen or further harmed (Kastor et al, 2020; Lavalley et al., 2020). Health systems rarely address intergenerational trauma or the broader contexts of poverty,

land loss, and cultural suppression that drive substance use. Legal and health experts now call for redirecting resources away from punitive enforcement toward harm-reduction services, decriminalization, and policies that honour Indigenous self-determination (Daniels et al., 2021; Koutouki & Lofts, 2018).

Additionally, the high rates of substance use and drug poisoning deaths among Indigenous youth are rooted in a long history of family separation and colonial control. For over 100 years, the Residential School system removed Indigenous children from their families, cultures, and communities in an effort to "kill the Indian in the child" - a policy that has since been recognized as cultural genocide (Allan & Smylie, 2015). Survivors carry the scars of abuse, neglect, and disconnection, and these impacts have not ended with them. The harms of the Indian Act have passed through generations, shaping the lives of their children, grandchildren, and great-grandchildren.

Indigenous child removal did not stop with Indian Residential Schools (IRS). Today, Indigenous children are still being taken from their families through the child welfare system. They are vastly overrepresented in foster care across Canada, often for reasons tied to poverty, housing, or food insecurity - conditions that stem from systemic neglect and colonial policies (Allan & Smylie, 2015). Widespread assumptions about Indigenous parents and especially mothers continue to fuel this cycle, reinforcing harmful ideas that they are unfit or irresponsible (Browne, 2017). These removals create deep ruptures, contributing to long-term struggles with mental health, substance use, and suicide (NCCIH, 2022).

At the same time, structural racism continues to shape every part of young people's lives; whether it is health care, housing, education, or access to income. Indigenous families and communities often face barriers that leave them without the resources they need to cope with

trauma or support youth through hard times (Browne, 2017). With limited access to culturally safe supports, many young people turn to substances to manage emotional pain, loss, and disconnection. And when they do, they are met with judgment, criminalization, or no support at all. This is especially dangerous in the current toxic drug public health emergency, where even one use can be fatal.

The overrepresentation of Indigenous youth in substance-related harms is not about individual choices - it is the result of generations of policy decisions that have separated families, disrupted cultural knowledge, and embedded inequality into nearly every system they interact with. Real solutions need to start there: with reconnecting families, supporting communities, and investing in youth-led, culturally grounded approaches that honour the strength and knowledge already present in Indigenous communities.

Addressing substance use among Indigenous people therefore requires confronting colonial policies at their root - shifting power and funding to Indigenous governance, restoring land-based practices, and embedding culture in every level of care. Only then can we respond effectively to the intertwined crises of substance use, racism, and ongoing colonial violence.

**Harm Reduction**

Harm reduction has emerged as a key response to the toxic drug public health emergency in British Columbia, focusing on reducing the health, social, and legal harms associated with substance use without requiring abstinence (BC Centre for Disease Control, 2022). However, the concept of harm reduction in the Western context emerged in the 1980s in response to the HIV/AIDS epidemic, particularly as public health officials recognized the urgent need to reduce HIV transmission among people who inject drugs. During this time, interventions such as needle exchange programs and education on safer injection practices were formalized as key harm

reduction strategies to prevent the spread of infectious diseases (Canadian Drug Policy Coalition, n.d.).

At its core, harm reduction meets people where they are, supporting them in a way that respects their choices and autonomy. It recognizes that substance use is complex, and that individuals use drugs for various reasons. This approach includes a range of practical strategies, such as distributing naloxone to reverse toxic drug poisonings, providing sterile needles, and offering safe spaces to use. Broader harm reduction measures include safer supply prescribing (Barker et al., 2024), supervised consumption sites, drug-checking services, and real-time public health monitoring through tools like the Substance Use Harm Reduction Dashboard. While these measures have saved lives, experts emphasize the need for further policy reform, including decriminalization and regulated access to safer substances, to better reduce the risk of fatal poisonings (Government of British Columbia, Office of the Provincial Health Officer, 2019).

Harm reduction is not just about services - it is rooted in justice, human rights, and evidence. It aims to ensure that people who use substances are treated with dignity and respect. By framing harm reduction as an integral part of the health system, it has been able to expand and reach more people over time (Nowell & Masuda, 2020). As such, harm reduction promotes compassionate, non-judgmental, and culturally safe support for people who use substances.

The historical development of harm reduction strategies in BC highlights the significance of grassroots efforts led by people with lived and living experience (PWLLE) or sometimes known as “peers”. PWLLE are individuals who have firsthand experience with substance use and the systems that impact their lives. They bring the “voice of users” into mainstream discussions, ensuring that the perspectives of those directly affected are included in decisions and initiatives that shape their communities (Greer et al., 2021). In British Columbia, the inclusion of PWLLE

has been identified as a crucial element of overdose response efforts by both the Government of British Columbia and several provincial overdose task groups.

Needle exchange programs, first implemented in the early 1990s by PWLLE, emerged as a direct response to the heroin public health emergency in Vancouver's Downtown Eastside, where overdose deaths were rising (Greer et al., 2021). These programs aimed to reduce the transmission of HIV, hepatitis C, and other bloodborne diseases by providing clean injection equipment and a safe place to exchange used syringes (Elkhalifa et al., 2020). Over time, these services expanded to include other safer use materials, such as pipes, mouthpieces, cookers, different-sized syringes, alcohol wipes, and screens, to address the diverse needs of people who use substances (BC Centre for Disease Control, 2022).

Overdose prevention sites (OPS), also known as supervised consumption sites (SCS), were another grassroots harm reduction initiative championed by people with lived experience, later adopted by the federal government (Nowell & Masuda, 2020). While OPS and SCS are often used interchangeably, OPS typically operate without federal exemption during declared public health emergencies and can be peer-run, whereas SCS sites have federal exemptions. Notable sites include Insite, SafePoint, Dr. Peter Centre, and Hope 2 Health (BC Centre for Disease Control, 2022). OPS/SCS provide people with a safe, hygienic environment to use their drug of choice while being monitored by staff or peers trained to respond to overdoses (Nowell & Masuda, 2020). An OPS can be located in a variety of settings like hospitals, tents in parks, alleyways, or parking lots and this ensures that harm reduction services are accessible to those most in need.

Framing harm reduction as a public health intervention has been key to its integration into policy and practice (Nowell & Masuda, 2020). However, as the unregulated drug supply

becomes increasingly toxic and unpredictable, ongoing efforts are needed to expand harm reduction services and develop new strategies that address the evolving risks. Harm reduction's emphasis on meeting people where they are, prioritizing their safety, and promoting equity and dignity remains a cornerstone of an effective response to the toxic drug public health emergency in BC.

The toxic drug public health emergency in BC is ongoing and since the 2016 emergency declaration, more than 16,000 people in BC have died from toxic drug poisonings. Addressing this requires sustained investment in harm reduction, safer supply programs, and policies that prioritize health and dignity over punishment.

***Naloxone***

Naloxone is a fast-acting opioid antagonist that plays a central role in British Columbia's response to the toxic drug public health emergency and harm reduction efforts. It works by temporarily reversing the effects of opioids, restoring breathing in someone experiencing a drug poisoning (BCCDC, 2025). When opioids overwhelm receptors in the brain, they can slow or stop breathing. Naloxone knocks these opioids off the receptors, allowing the body to function normally again (Toward the Heart, n.d.).

In 2012, BC launched the Take Home Naloxone (THN) program to help reduce drug poisoning deaths. The program provides free kits to people who use drugs, as well as their friends, family, and frontline workers. Naloxone is available at over 1,800 sites across the province, including pharmacies, health centres, and harm reduction programs with no prescription required (BCCDC, 2023; Toward the Heart, n.d.).

Naloxone is safe for all ages and can be administered in two ways: by intramuscular injection or as a nasal spray. Both forms are included in naloxone training offered by health

authorities and harm reduction services. Training also teaches how to recognize a drug poisoning and follow the "SAVE ME" steps to respond quickly and effectively (Toward the Heart, n.d.). Naloxone usually takes effect within three minutes and lasts between 30 and 120 minutes. Since it wears off quickly, medical help is still needed after use (BCCDC, 2025). Common signs of opioid poisoning include slowed or stopped breathing, extreme drowsiness, and unresponsiveness. Acting fast and administering naloxone and calling for help can prevent death or brain damage due to lack of oxygen (Toward the Heart, n.d.).

Studies show that wider naloxone access is linked to fewer drug poisoning deaths (Lei et al., 2022). Still, barriers remain. Stigma, fear of legal trouble, and mistrust in the system often stop people from using naloxone. To address this, BC introduced Good Samaritan laws that protect those who assist during a drug poisoning and expanded peer-led outreach and training to reach those most at risk (Mehta et al., 2021; BCCDC, 2023).

Naloxone is not a solution on its own, but it is a critical part of BC’s harm reduction efforts. Ensuring it is widely available and people are trained to use it helps save lives and reflects a shift toward treating substance use as a public health issue, not a criminal one.

**Indigenous Harm Reduction and Decolonized Care**

Substance use in First Nations communities cannot be separated from the harms of the Indian Act (including Residential Schools), child welfare (historical and current), and systemic racism in health and social services (Government of Canada, 2020; Lavalley et al., 2018). Indigenous harm reduction responds to these colonial harms, not merely to drug use. It treats health as relational, between people, land, ancestors, and spirit, and places culture, ceremony, and community at the centre of wellness (Substance Use and Addictions Program, 2021).

Five elements shape strong Indigenous harm-reduction programs: they are rooted in culture, trauma-informed, culturally safe, Indigenous-led, and blend Indigenous and Western knowledge as communities see fit (Gordon, 2024). In British Columbia this translates into naloxone training in band offices, peer outreach in health centres, and mobile teams serving remote areas (FNHA, 2024). These services protect life in places where mainstream care is scarce and often unsafe.

Community control is critical. Many First Nations people have highlighted that they did not connect with standard harm-reduction tools until those tools were adapted and delivered by local leaders (Levine et al. 2021). Programs that ignore local knowledge can do more harm than good, whereas services that create space for ceremony, language, and Elders foster both immediate safety and long-term dignity (Rowan et al., 2014; Substance Use and Addictions Program, 2021.)

Decolonizing care pushes further. It seeks to dismantle the colonial systems that drive poverty, displacement, and trauma, and to return authority over health services to Indigenous communities (Eni et al., 2021). Leaders therefore have called for decriminalization, Indigenous-led services, and policies that name colonialism, and not personal failure, as the root cause of today's multiple health crises. (Koutouki & Lofts, 2018; Lavalley et al., 2024).

Indigenous people who use substances describe true healing as relational and culture-based, delivered by Indigenous staff through traditional practices rather than punitive systems (Lavalley et al., 2024). Culture-centred programs challenge stigma, rebuild identity, and strengthen community. In this way, culture is not an add-on to harm reduction - it is the strategy itself.

**Conclusion**

British Columbia's toxic drug public health emergency did not begin overnight. It is the result of decades of layered harm including racist drug laws, colonial health systems, and policies that have criminalized poverty and substance use instead of offering care. Since the public health emergency was declared in 2016, over 16,000 people in BC have died. These are not just numbers; they are family members, friends, coworkers, and community members. While harm reduction efforts like naloxone distribution, supervised consumption sites, and safer supply programs have made a difference, they alone are not enough to address the deeper structural issues that continue to drive this emergency.

First Nations people in BC have been hit hardest. The rates of death and drug poisoning events among Indigenous adults and youth are far higher than those seen in the general population. These outcomes reflect generations of colonial policies, trauma, and systemic racism in health care and social systems. But they also reveal something else: despite limited resources, First Nations communities are leading life-saving responses. Community-based programs rooted in culture, relationships, and trust are showing what works.

This work shows that harm reduction is more than handing out supplies. It is about meeting people where they are, listening without judgment, and creating space for healing. It is about changing how we talk about substance use, how we treat people who use drugs, and how we challenge the systems that have caused so much harm. The efforts already underway in Indigenous communities reflect deep knowledge, care, and resilience.

There are still major challenges. The drug supply is changing fast. Stigma continues to silence people and isolate them. Additionally, people who might benefit most from harm reduction may not yet be ready or willing to engage with it due to that stigma. Keeping harm

reduction efforts relevant and up to date will require resources, consistent staff, and long-term commitment - not just short-term programs or crisis responses.

Still, the future holds promise. Indigenous harm reduction is not a trend or a temporary fix. It is a pathway forward. Supporting Indigenous-led programs and initiatives can help shift the work from reaction to prevention. What is needed now is not just more government created services, but more trust in Indigenous communities to lead this work on their own terms.

The toxic drug public health emergency is ongoing, but so is the strength of the people responding to it. This project is one part of a larger response - a call to keep showing up, keep speaking the truth, and keep building systems that honour life, dignity, and care.

## Project Outline

### Project Description

This project focuses on creating a culturally grounded, self-paced e-learning course based on the First Nations Health Authority's *Not Just Naloxone* (NJN) training. Originally developed by the Indigenous Wellness Team (IWT) at FNHA as a three-day, in-person workshop, NJN was created in response to what First Nations communities were asking for during the early days of the toxic drug public health emergency. Back in 2017, when IWT asked communities what they needed, the message was clear: "We're not going to naloxone our way out of this crisis, and we're not going to arrest our way out of it either" (FNHA, 2019). That powerful truth led to the creation of NJN as a training rooted in Indigenous ways of knowing - bringing together harm reduction, wellness, cultural teachings, and community connection.

Over time, the training shifted from a three-day "train-the-trainer" model to a shorter, two-day format after participants reported the material was emotionally heavy and difficult to keep current in a fast-moving emergency (Levine et al. 2021). Even at two days, many people

find it challenging to step away from work or caregiving duties to attend (NJN Anonymous Evaluation, 2023). Each workshop is capped at twenty-four seats so facilitators can meet participants' learning and spiritual needs, and demand far exceeds supply (Levine et al., 2021). A standing wait-list of about fifty people means some applicants wait a full year before they can join the single virtual facilitator's two or three annual sessions. In-person NJN deliveries are prioritized for First Nation communities, but travel time and scheduling further limit the number that can be offered each year. Staff turnover and burnout within health services reduce the pool of qualified facilitators, and only Indigenous trainers can present on topics such as racism, colonial impacts, and Indigenous harm reduction - further narrowing capacity (Levine et al., 2021).

That is where this project comes in: to build a digital version of NJN that keeps the heart of the training intact while making it more accessible. It will not replace the in-person connections, shared meals, and ceremony but it will help more people access this knowledge when and how they are ready. The course is designed for First Nations community members, health staff, peers, Elders, youth, and anyone supporting people who use substances. It is meant to serve Indigenous communities first and foremost, with FNHA prioritizing access for BC First Nations before opening it more broadly.

**Project Rationale**

There is a major gap when it comes to harm reduction resources that reflect Indigenous voices, experiences, and knowledge. Most existing resources created by non-Indigenous organizations treat Indigenous perspectives as something extra - tacked on at the end or limited to a single section. That kind of approach reinforces a divide rather than building something truly inclusive and rooted in cultural safety. The toxic drug public health emergency continues to hit

Indigenous communities the hardest. As stated previously, in 2024, First Nations people in BC died at 6.7 times the rate of other residents. First Nations women died at rates over 11 times higher than non-Indigenous women (FNHA, 2024). First Nations youth, especially those aged 15 to 29, accounted for 17.4% of youth drug-related deaths in BC, despite being only 4.1% of the youth population (FNHA, 2024). These are not just numbers - they are lives, families, and futures.

This course responds to what communities have been asking for: harm reduction education that is trauma-informed, culturally safe, and grounded in Indigenous strengths (FNHA, 2024; Levine et al., 2021). It also reflects public health priorities and social determinants of health - addressing aspects such as trauma, housing, stigma, and the intergenerational impacts of colonialism.

Digital storytelling plays a big role here. It offers a way to share teachings, experiences, and community wisdom in a format that is accessible, engaging, and rooted in oral tradition. In Indigenous contexts, storytelling is more than just a method of communication - it is a way of knowing, a tool for teaching, and a means of preserving cultural identity. By using digital platforms, these stories can reach wider audiences while still honouring the voices and knowledge keepers behind them. This project builds on those teachings while using technology to expand access - particularly for communities where in-person training may be limited. Through a partnership with the FNHA Communications team, stories from all five regions of the province have been gathered and woven throughout the course content. These regional narratives bring in unique perspectives from different Nations, allowing learners to hear directly from people with lived experience, cultural knowledge, and community insight.

Linking these stories into the course keeps the material relevant and grounded in real-life context. It also ensures that the training reflects the diversity and richness of Indigenous cultures across BC, not as static or historical, but as dynamic and evolving. By regularly updating the course with new stories and teachings, the learning stays alive - just like oral tradition. This approach not only enriches the educational experience but also helps strengthen cultural continuity and community connection across generations and geographies.

**Project Significance**

This work matters because Indigenous people deserve access to harm reduction education that honours who they are and where they come from. The course is grounded in Indigenous ways of knowing and learning - not added in later but woven throughout from the very beginning. It centres community connection, storytelling, ceremony, and care. It supports healing, wellness, and self-determination in the face of ongoing loss.

A digital self-paced NJN course is also a practical tool. Not everyone can travel for a two-day training, especially in remote or rural communities. This digital version allows people to learn at their own pace and return to the teachings when they are ready. It will strengthen capacity among community champions - people who are already doing this work on the ground - and support them with tools that reflect the realities of the people they serve.

For FNHA, this project supports ongoing efforts to create First Nation-led, culturally safe harm reduction approaches. It also speaks to broader work within child and youth care by addressing the impacts of trauma, loss, and disconnection on youth and families, and by offering a framework that is relational, strengths-based, and deeply grounded in community. At its core, this course is about carrying forward teachings from those who came before us, and building something strong for those who are still to come.

# Methodology & Course Development

## Curriculum Design Framework

The self-paced, module-based NJN e-learning course is designed to reflect the core teachings of the in-person training while increasing accessibility for those who may not be able to attend live sessions. This digital version will retain the foundational themes of NJN - harm reduction, substance use education, and culturally grounded responses - while adapting the material for an online learning environment hosted on the RISE platform.

Each module will include evidence-informed content on substances, harm reduction language, and the ongoing toxic drug public health emergency, drawing on data from the BC Coroners Service and FNHA's health surveillance team. The course will also explore the history of racism, colonialism, and prohibition to situate current challenges within a broader social and political context. By examining the role of stigma, the impact of criminalization, and the need for culturally safe care, the curriculum offers a holistic and justice-oriented approach to harm reduction.

In alignment with Indigenous ways of knowing, the course design prioritizes relational learning, storytelling, and experiential engagement. Interactive elements, including guided reflections, videos, and knowledge checks, aim to replicate the relational tone of NJN and maintain cultural integrity in a digital format. Importantly, this course reflects the diversity of Nations in BC and does not take a pan-Indigenous approach; care has been taken to ensure that content reflects local realities and is adaptable to regional contexts.

## Course Content Development

A central feature of NJN is the inclusion of lived experience, community knowledge, and cultural teachings, which is often shared through story. These narratives are not supplemental;

they are foundational to how learning happens, reflecting the importance of oral tradition in many Indigenous communities. As NJN transitions into an online format, special care is being taken to honour these stories and the knowledge they carry. This includes thoughtful decisions about how they are presented, ensuring they are offered in ways that are respectful, emotionally resonant, and aligned with Indigenous ways of learning and teaching. By centering community voices and cultural knowledge, the course creates space for relational learning - where healing, understanding, and skill-building happen together even when learning apart.

While in-person NJN sessions are shaped by real-time discussion and participant contributions, the online course aims to reflect this dynamic nature through thoughtfully curated video content, readings, and experiential learning activities. These include historical context such as the Indian Act and the history of drug prohibition in Canada which is essential for understanding why harm reduction must be approached differently in Indigenous communities. The course development process is being informed by ongoing input from Elders, peers, youth, and frontline workers across the five FNHA health regions, ensuring it remains First Nation-led and First Nation-driven.

This course is not intended to replace in-person training, but rather to expand it and offer a flexible option for those who may not be able to commit to a two-day training due to geography, workload, caregiving responsibilities, or personal readiness. It will serve as a foundational resource for Indigenous community members, youth, families, and service providers, and support broader capacity-building efforts across health and social service sectors.

**Ethical Considerations**

This project is grounded in relational accountability and guided by ethical principles rooted in Indigenous protocols. All stories and teachings shared in the course are included with

consent and care, with the option to remain anonymous or be named based on the storyteller's wishes. Cultural knowledge will be clearly attributed, and content will be reviewed to ensure it aligns with community values and teaching protocols.

The course reflects FNHA's commitment to First Nation-led and First Nation-driven health transformation. It is being created with ongoing feedback from each of BC's five health regions and with guidance from people with lived and living experience, youth, Elders, and subject matter experts. This ensures the course remains responsive to current realities, culturally safe, and grounded in the strengths of First Nations communities.

To assess engagement, the course will include interactive learning activities, module-level knowledge checks, and a final assessment to confirm understanding of key concepts. Learners will also be invited to complete a post-course survey to reflect on their confidence in applying harm reduction strategies and their understanding of Indigenous harm reduction approaches. The feedback gathered will inform future updates to ensure the course remains relevant and responsive over time.

Ultimately, this course is designed to support Indigenous youth, families, Elders and communities by increasing access to culturally safe harm reduction education. It aims to strengthen local capacity, promote healing, and support a shift toward relational, community-led responses to substance use that reflect the values and lived experiences of First Nations peoples in BC.

## Community & Stakeholder Engagement

At the heart of this project is the commitment to meaningful, ongoing engagement with First Nations communities, youth, Elders, Knowledge Keepers, elected leadership, and people with lived and living experience/peers. The development of the NJN e-learning course is guided

by the principle of "Nothing about us without us," ensuring that the people most impacted by the toxic drug public health emergency are actively involved in shaping the curriculum from start to finish.

Elders have always been at the heart of *Not Just Naloxone*. From the beginning, Elders from different regions across British Columbia have helped guide the work, opening sessions with prayer, offering teachings throughout, and closing gatherings in a good way. Their presence reminds us that harm reduction is about relationships, care, and responsibility, not just training or information.

Some of the Elders who helped shape the in-person and virtual Not Just Naloxone sessions have since stepped back, deeply affected by the ongoing losses in their communities due to the toxic drug public health emergency. For the development of this online version, I had the privilege of working with a respected Elder of Cree ancestry, residing in the Fraser Salish region. She reviewed the course outline and learning outcomes and provided critical cultural guidance to ensure the content remained aligned with Indigenous teachings, values, and ceremony.

This Elder also recorded the opening and closing prayers for the course. Her voice welcomes learners into the space with intention and care, and concludes the course in a way that encourages thoughtful reflection and respect. These prayers, along with her insights, help hold the learning experience in a way that is both relational and ceremonial. These qualities are essential to Indigenous approaches to education and wellness. Her contributions shape the spirit and tone of the course in meaningful and lasting ways.

Cree is one of over 60 distinct Indigenous languages spoken across British Columbia, where more than 200 First Nations communities each carry their own unique cultural knowledge, teachings, and ways of knowing. While this course includes one Elder's contributions, learners

are invited to reflect on and bring in their own teachings, community wisdom, and cultural practices throughout. The goal is not to present a singular truth, but to create space for culturally relevant engagement rooted in personal and collective experience.

Peer engagement has been a central and ongoing part of this course development. A youth peer, who has been active in NJN for over four years and is one of the founding members of FNHA's Youth Advisory Council, has offered consistent and thoughtful contributions through monthly meetings. Their insight has been instrumental in shaping curriculum content that is relevant, accessible, and meaningful to Indigenous youth. By sharing ideas on tone, activities, and delivery style, they have helped ensure the course speaks to real-life experiences and resonates with younger learners who may be navigating substance use, grief, or leadership in their own communities.

In addition to youth voices, several adult peers have been involved, each bringing their own lived experience and expertise in harm reduction, community health, and peer support. Their feedback on specific modules helped refine the tone and content, making sure it remained grounded in community realities. These peers did not just offer edits; they brought forward important questions about accessibility, cultural safety, and how best to support people who may be carrying heavy stories into their learning.

To deepen this work, a full-day in-person peer engagement session was held in Vancouver. This session brought together youth and adult peers from different regions to do an in-depth review of the curriculum. The gathering offered a chance to workshop the materials, share reflections, and build connections that informed how the course would be finalized and delivered.

These on-going consultations ensured that the learning journey is shaped not just by theory or policy, but by the lived knowledge of people already doing the work in their own Nations and communities. Their voices helped anchor the course in reality, care, and community leadership.

Further feedback has been gathered in phases and across multiple levels to ensure the course is community-informed and organizationally supported. After initial input from peers and Elders, the draft content is reviewed internally by FNHA's Toxic Drug Response team, followed by feedback from the program director, executive director, vice president, and ultimately the FNHA Board of Directors. This multi-tiered process ensures alignment with FNHA's values, governance structures, and strategic priorities. Once all feedback was incorporated, the course was shared with a "test cohort" of internal FNHA Indigenous Harm Reduction Educators to evaluate the overall flow, usability, and accessibility of the material.

Ongoing regional engagement is also a core part of the process. Feedback was gathered from all five FNHA health regions - Vancouver Coastal, Vancouver Island, Fraser Salish, Interior, and Northern - to reflect regional realities and diverse community needs. In-person and virtual consultation opportunities were provided throughout the development phase, with additional feedback welcomed at any point from community members and stakeholders.

This collaborative approach ensures that the final curriculum is grounded in Indigenous knowledge systems, responsive to community priorities, and reflective of the diverse lived experiences across BC. It also supports the broader goals of self-determination, capacity-building, and cultural safety in harm reduction education. As a living document, the course will continue to evolve over time, shaped by the voices of those who walk with and support individuals, families, and Nations impacted by the toxic drug public health emergency.

## Expected Outcomes & Impact

Transforming NJN into a self-paced, online course will improve access to culturally safe harm reduction education for First Nations communities in BC. The flexibility of the digital format allows participants to learn in their own time and space, which is especially important for those who may not be able to attend in-person training due to work, caregiving responsibilities, or geographic barriers. Learners will also be able to return to the material when they need it, helping reinforce key concepts and deepen their understanding over time.

One of the most powerful outcomes of this work is reducing the stigma around substance use. Creating space for people to talk openly and respectfully about substance use is a step toward healing. This course helps build that confidence. When even one person changes how they speak about substance use, it can influence their family, their workplace, and their community. Shifting the conversation from blame to care makes a real difference. The course offers practical tools and culturally grounded language that supports safer, more respectful conversations.

For Indigenous youth and families, this project goes beyond education. It offers a sense of recognition and connection. Youth voices have helped shape the curriculum, and their perspectives are reflected throughout the course. When young people see their realities, experiences, and knowledge included in harm reduction education, it helps build trust and belonging. For families, the course offers insight into how to support loved ones in a way that is relational, not punitive. It strengthens the capacity of whole communities to respond with compassion and understanding.

This course will also support staff across FNHA and within First Nations health systems to build stronger harm reduction practices. By including teachings on the history of colonialism,

the impact of systemic racism, and the current realities of the toxic drug public health emergency, the course invites reflection and growth. It helps learners see how substance use is connected to broader systems and supports them in responding in ways that are culturally safe and community-driven.

Over time, this training could also influence broader change. Including this course in onboarding for FNHA staff or other health organizations would help ensure that Indigenous harm reduction is not an afterthought but part of the foundation of healthcare. By offering education that highlights systemic barriers and promotes cultural safety, it creates space for shifts in practice, policy, and organizational culture.

Ultimately, this work is about creating lasting change. It is about building a shared understanding of harm reduction that is grounded in Indigenous knowledge, shaped by community voices, and rooted in care. The course is one tool among many, but it can help create safer, more informed, and more connected responses to substance use in Indigenous communities across the province.

## Limitations and Future Directions

Bringing Not Just Naloxone online is a meaningful step, but it comes with some real challenges. One of the biggest is how quickly things change. Language around substance use is always evolving. New research and data are released regularly, and the toxic drug public health emergency continues to shift in unpredictable ways. Although the course was designed to be adaptable, keeping it current will require ongoing time, attention, and dedicated people to implement necessary updates as things change. As Indigenous harm reduction practices grow and evolve, so too does our understanding of what constitutes culturally safe and respectful

language. To remain relevant and effective, the course must stay flexible, open to feedback, and ready to evolve alongside communities and the people doing the work on the ground.

Another challenge is sustainability. Staff turnover is common in public health and community work, and the people who helped shape this course may not always be in the same roles in the future. Without a long-term plan, there is a risk that the course could drift from its original intent or lose its connection to the communities it was designed for.

There is also the reality that the people who may need this training the most might never take it. Harm reduction is still misunderstood in many places, and stigma around substance use runs deep. While the course was created for Indigenous frontline workers, peers, and health professionals, there are others that are both in and outside of healthcare who may hold judgment or discomfort around this kind of work. This course has the potential to shift some of those views, but only if people are willing to show up and engage with the content.

Another limitation is FNHA's peer network. Right now, there is no formal policy for hiring or compensating peers, which makes it hard to bring more peer voices into the development and maintenance of the course. This means NJN is working with a smaller group than ideal, even though the value of peer involvement is clear. We continue to connect with regions and peers doing good work, but there is a need for stronger infrastructure to fully support that engagement.

Despite these limitations, this course represents an important step in Indigenous harm reduction education. It opens the door for future possibilities, such as youth-specific modules, regional content tailored to different Nations, and additional resources for community facilitators. There is also potential for the course to become part of onboarding and professional

development across Indigenous health organizations, creating a stronger foundation for culturally grounded substance use care.

The future of Indigenous harm reduction is being shaped every day by the communities who are leading the response. This course is one part of that broader movement. It aims to support conversations, deepen understanding, and encourage action that centers care, culture, and connection. Most importantly, it is built to grow and adapt with the people and Nations it is meant to serve.

## Conclusion

This project was created in response to what communities have been asking for: harm reduction education that is culturally safe, accessible, and rooted in Indigenous knowledge. By transforming *Not Just Naloxone* into a self-paced online course, this work builds on years of in-person training while recognizing that not everyone has the time or ability to attend. The course brings together teachings, stories, and practical tools to support First Nations community members, health staff, peers, and others responding to the toxic drug public health emergency in British Columbia. It reflects Indigenous ways of learning, knowing, being, and doing while using digital tools to expand access.

What this work shows is that Indigenous harm reduction is not only possible, but already happening. First Nations communities have been leading their own responses to substance use for a long time, often without enough resources or recognition. This course helps support that work by creating space to share knowledge, language, and approaches grounded in care and cultural safety. It also challenges dominant models of harm reduction by centering Indigenous values like relationship, community, and healing. The course is designed to be practical, not

theoretical, offering learners something they can take back to their work, families, and communities.

The potential impact of this work is real. It can help change how people think, speak, and respond to substance use. When someone changes how they talk about substance use, they shift how others feel about it. That alone can reduce stigma and open the door for connection and support. This course can also strengthen FNHA's ability to train new staff and build consistent, culturally grounded harm reduction practices across the province.

At the same time, there are limitations. The toxic drug public health emergency continues to evolve quickly. New substances, shifting data, and changing community needs mean the course will need ongoing updates. Language also continues to shift, especially as more people with lived and living experience take the lead in shaping how substance use is talked about. Staff turnover and resource limitations could affect the long-term maintenance of the course. And while the course is built for Indigenous communities, those outside these circles - particularly those who hold stigma - may not choose to engage with it.

This course lays the groundwork for a range of future training that reflect the needs and strengths of Indigenous communities. It could lead to youth-focused modules that use peer learning and relatable content, or land-based training that brings together traditional medicines, ceremony, and seasonal teachings. Community facilitator programs might help local leaders deliver the material in ways that fit their Nation's knowledge systems. Training could also support frontline workers and first responders to approach substance use through a trauma-informed and culturally safe lens. There is potential for family-focused content to help caregivers support loved ones, and for sessions designed specifically for policymakers or health care leaders to better understand Indigenous harm reduction. Digital storytelling workshops

could give communities the tools to share their own teachings and experiences, keeping future learning grounded in lived reality. These directions reflect a growing movement toward community-led, culturally rooted approaches to education, wellness, and change.

In the end, this course is about more than training. It is about care, connection, and the right to access knowledge in ways that make sense to the people it is meant for. It is about honoring those we have lost, supporting those who are still here, and building a future where Indigenous communities can lead harm reduction in ways that reflect their strengths, values, and vision.

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# Appendix A

**Welcome to *'Not Just Naloxone'* (NJN)**

We are grateful to have you join us for Not Just Naloxone (NJN) - a program designed to equip participants with the skills, tools, and confidence to lead safe, meaningful conversations about substance use and harm reduction and the impact on First Nation communities.

The original in-person course was first created in 2018 in response to the growing need for Indigenous-specific harm reduction education in the face of the toxic drug public health emergency. First Nations peoples continue to be disproportionately impacted by this public health emergency - not because of individual choices, but due to the lasting and ongoing harms of colonialism, systemic racism, and white supremacy. These forces have created barriers to culturally safe care, deepened stigma, and contributed to high rates of substance-related deaths in our communities.

NJN is not just about naloxone - it is about community empowerment, cultural connection, and systemic change. The original curriculum was built through extensive dialogue with First Nations communities and is delivered in partnership with the First Nations Health Authority's (FNHA) Toxic Drug Response team, regional FNHA staff, community harm reduction champions, Elders, youth, and People with Lived and Living Experience of substance use.

Our goal is to support participants in transforming how harm reduction is understood and practiced - ensuring that services, programs, and interventions are not only effective but also culturally informed, relevant, and safe.

We are honoured you are here. Let's get started!

# Appendix B

## Disclaimer

For the purposes of this project, this supplementary paper submitted to the University of Victoria includes learning objectives and module outlines only. The full, self-paced, module-based e-learning curriculum will be shared with the supervisory committee during the defence and made publicly available in early 2026 through the First Nations Health Authority (FNHA) website. As a living document, the curriculum will continue to evolve in response to the ongoing toxic drug public health emergency and the changing needs of First Nation communities across British Columbia.

In alignment with Indigenous ways of knowing and being, updates to the curriculum will be guided by continuous feedback from all five health regions - Vancouver Coastal, Vancouver Island, Fraser Salish, Interior, and Northern - as well as from Elders, youth and individuals with lived and living experience. This education series is intended to be First Nation-led and First Nation-driven, ensuring it remains relevant, culturally grounded, and accountable to the communities that FNHA serves.

For registration information or to access the curriculum once released, please contact NJN@FNHA.ca.

# Appendix C

## Course Learning Outcomes

1. Demonstrate an understanding of traditional and unceded protocols of First Nations Peoples.
2. Understand the toxic drug public health emergency and the harm reduction strategies used to address it.
3. Describe the factors uniquely affecting First Nations communities in the toxic drug public health emergency.
4. Demonstrate an understanding of the history of prohibition and racism toward First Nations in Canada.
5. Understand the language and stigma surrounding substance use.
6. Learn how to respond to an individual experiencing a toxic drug poisoning through naloxone training and other support.
7. Describe how to decolonize substance use care and Indigenize harm reduction practices.

# Appendix D

## Not Just Naloxone Modules

### Module One

***"Introduction"***

Module one will cover the following learning objectives:

1. Understand cultural protocols for First Nations acknowledgements and traditional introductions.
2. Describe the history of First Nations Peoples in British Columbia, Canada, and North America.
3. Utilize this course to create a safer and more inclusive environment for First Nations Peoples.
4. Understand what caring for oneself looks like when learning how to be culturally safe.

This module will include the following headers:

- Territory Acknowledgement
    - What is a Territory Acknowledgement?
- Greeting and Acknowledgment by Cree Elder
- Introduction to Not Just Naloxone
- Course Description
- Intention Setting
- Reflection question
- How we talk about substance use
- An introduction to Indigenous Ways of Knowing; gaining an understanding of First Nations cultures and traditions

- Two Eyed Seeing (Etuaptmumk)
- The Social Determinants of Health from a First Nations Perspective
- Video: The Social Determinants of Health from a First Nations Perspective Presented by Gwen Phillips, First Nations Health Council, citizen of the Ktunaxa Nations
- History of First Nations Peoples in British Columbia, Canada and North America
- Protocols
- Indigenous Cultural Safety
- The Seven Sacred Teachings: A Guide to Living with Honor
- Indigenous Self-Care
- Self-care checklist
- Culturally Safe and Trauma-Informed Services
- References

**Module Two**

***"Establishing a Common Understanding of Substance Use and Related Impacts"***

Module two will cover the following learning objectives:

1. Understand key terms in substance use and harm reduction.
2. Learn about different substances, with a focus on opioids and fentanyl's impact.
3. Apply Indigenous harm reduction practices in professional and community settings.
4. Explore culturally safe treatment options for recovery.
5. Value the perspectives of individuals with lived or living experience in this work.

This module will include the following headers:

- Module Two Learning Objectives

- Toxic Drug Public Health Emergency
- Toxic Drug Poisoning Event
- Harm Reduction Strategies
- What are opioids?
- Difference between "regulated" and "unregulated substances
- What is fentanyl?
- What are benzodiazepines?
- Video: “Benzodiazepines 'a major problem' in illicit (unregulated) drug supply”
- Other substances often found in the unregulated toxic drug supply
- How to respond to a toxic drug poisoning when benzodiazepines are mixed with opioids
- What is withdrawal?
- What is tolerance?
- What is harm reduction?
- What can harm reduction look like from a cultural lens?
- Video: "Connecting to Culture" series; Indigenous Harm Reduction
- What is a Peer/Person with lived and living experience (PWLLE)?
- Strategies for reducing harms
- What is stigma?
- What is drug decriminalization?
- What are drug alerts?
- Opioid Use Disorder
- What is Opioid Agonist Therapy (OAT)?
- FNHA Storytelling: “Family Day: A story about substance use and healing”

- Examples of Opioid Agonist Therapy (OAT)
- What are prescribed alternatives (safer supply)?
- What can prescribed alternatives do for an individual?
- Study: “Experiences implementing and receiving prescribed safer supply in Northern BC”
- Wellness from a First Nations perspective
- Video: "Increase the Support. Reduce the Harm." series
- Knowledge check
- References

**Module Three**

***“Toxic Drug Public Health Emergency”***

Module three will cover the following learning objectives:

1. Describe the toxic drug public health emergency and how it started.
2. Reflect on ways the toxic drug public health emergency has affected British Columbia.
3. Understand how the toxic drug public health emergency affects First Nations People including women and youth.

This module will include the following headers:

- Module Three Learning Objectives
- The evolving toxic drug public health emergency in BC
- Video: “Overdose Crisis: A Community Responds”
- Toxic drug public health emergency and the statistics
- BC Coroners Report

- Impacts on Youth
- Video: “Inside Vancouver’s fentanyl crisis through the young people at its core in the Downtown Eastside”
- Disproportionate impacts on First Nations communities
- Video: “First Nations Health Authority Chief Medical Officer Speaks about Canada's toxic drug public health emergency” (2024)
- First Nations Health Authority Data
- Impacts on First Nation women
- Video: “First Nation in B.C. declares emergency after toxic drug deaths”
- Report: “First Nations Population Health and Wellness Agenda: First Interim Update” (2024)
- Knowledge check
- References

**Module Four**

***“History of Racism and Prohibition in Canada”***

Module four will cover the following learning objectives:

1. Describe the history of prohibition in Canada.
2. Analyze the link between racism and prohibition in Canada.
3. Relate the resultant impacts of this prohibition policymaking to First Nations Peoples of British Columbia.

This module will include the following headers:

- Module Four Learning Objectives

- What is drug prohibition?
- Brief history of drug prohibition and links to anti-Indigenous racism
- Alcohol prohibition and First Nations Peoples
- Alcohol Laws in the Indian Act
- Consequences of Alcohol Prohibitions
- Changes over time and the lasting impacts of alcohol prohibition
- Other racialized policies and their impacts on First Nation Peoples
- Prohibition = Potency
- Misconceptions about substance use
- Knowledge check
- References

**Module Five**

***"Toxic Drug Poisoning Response and Naloxone Training"***

Module five will cover the following learning objectives:

1. Be able to explain how naloxone (Narcan) works.
2. Explore naloxone programs in British Columbia.
3. Reflect on ways naloxone saves lives.
4. Describe and recognize signs of a toxic drug poisoning.
5. Describe and walk through the SAVE ME steps for both the muscular injection and nasal naloxone.
6. Describe aftercare for a toxic drug poisoning.

This module will include the following headers:

- Module Five Learning Objectives
- Video: "Increase the Support. Reduce the Harm." series
- What is naloxone (Narcan®)?
- How does naloxone work?
- New naloxone recommendations
- Signs that someone is experiencing a toxic drug poisoning
- SAVE ME - S is for Stimulate
- Why call 911?
- What if you have to leave someone alone temporarily?
- SAVE ME - A is for Airway
- Why give rescue breaths?
- SAVE ME - V is for Ventilate
- SAVE ME - E is for Evaluate
- SAVE ME - M is for Medication
    - Steps for administering intramuscular naloxone
    - Steps for Administering Nasal Naloxone
    - Naloxone dosing and timing
- Nasal naloxone considerations
- SAVE ME - E is for Evaluate
- What if you don't have naloxone?
- SAVE ME step knowledge check
- What if the person is breathing but still sedated?
- Opioid poisonings and cardiac pulmonary resuscitation (CPR)

- When help arrives
- Aftercare for the individual
- Aftercare for you too!
- The Good Samaritan Drug Overdose Act
- BC 'Take Home Naloxone' program
- Site Finder search tool for naloxone kits
- Video: “How to access nasal naloxone through FNHA”
- Video: "Increase the Support. Reduce the Harm." series
- References

**Module Six**

***“Decolonizing Substance Use Care”***

Module six will cover the following learning objectives:

1. Analyze the root causes of addiction and explore factors that foster connection.
2. Evaluate beliefs around supporting people with addiction.
3. Explore some of the common myths that surround addiction.
4. Describe ways to dismantle stigmatizing language around substance use.

This module will include the following headers:

- Module Six Learning Objectives
- Decolonization 101
- How is the News Media Covering the toxic drug deaths in Canada?
- Video: “Decolonizing Substance Use & Addiction | Len Pierre | TEDxSFU - April 8th 2020”

- The opposite of addiction is connection
- 'What We Hear' vs. 'What We Know'
- Stigma and Language
- Language matters
- How can we reduce stigma?
- Knowledge Check
- References

**Module Seven**

***"Indigenous Harm Reduction"***

Module seven will cover the following learning objectives:

1. Identify how First Nations cultures and traditions relate to Indigenous harm reduction.
2. Describe Indigenous harm reduction principles and practices.
3. Assemble community strategies for delivering Indigenous harm reduction including for women and youth.

This module will include the following headers:

- Module Seven Learning Objectives
- Video: "Increase the Support. Reduce the Harm." series
- Indigenous Harm Reduction principles
- Video: "Connecting to Culture" series; Harm Reduction Practices in Communities
- Video: "First Nations Youths Speak on Harm reduction" series
- 'All Paths Lead To Wellness'
- Range of use

- Video: "Connecting to Culture" series; Connecting to Others as Part of Harm Reduction
- Land-based healing
- Implementation of Indigenous treatment and land-based healing
- Knowledge Check
- References

**Module Eight**

***"Closing and Reflection"***

This module will include the following headers:

- Leaving in a Good Way
- Revisiting self-care strategies
- Course Evaluation
- Closing by Cree Elder
- Support available 24 hours a day
- Other culturally-safe supports