

Difficulty Accessing Substance Use Treatment Among Indigenous People in a Canadian Inner City Setting

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Volume 16, Number 3, 2026

URI: <https://id.erudit.org/iderudit/1125493ar>

DOI: <https://doi.org/10.18584/iipj.2026.16.3.19234>

[See table of contents](#)

Publisher(s)

Scholarship@Western (Western University)

ISSN

1916-5781 (digital)

[Explore this journal](#)

Cite this article

Jeffery, T., Hayashi, K., DeBeck, K., Gregg, D., Western Aboriginal Harm Reduction Society, Milloy, M. & Kerr, T. (2026). Difficulty Accessing Substance Use Treatment Among Indigenous People in a Canadian Inner City Setting. *The International Indigenous Policy Journal*, 16(3), 1–15. <https://doi.org/10.18584/iipj.2026.16.3.19234>

Article abstract

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Methods: Data was derived from three prospective cohort studies of people who use drugs in Vancouver. Generalized estimating equations (GEE) were used to identify barriers to substance use treatment access among Indigenous people from June 2015 to May 2022.

Results: This study included 784 Indigenous people who use drugs (median age 37.74, 48.41% who self-identified as women). At baseline, 55 (7.0%) participants reported difficulty accessing substance use treatment, increasing to 128 (16.33%) participants during follow-up. In multivariate analyses, homelessness (AOR): 1.63, 95% confidence interval [CI]: 1.08 - 2.47), sex work (AOR: 1.66, 95% CI: 1.12 - 2.47), and experiencing violence (AOR: 1.87, 95% CI: 1.25 - 2.81) were positively associated with difficulty accessing treatment. In sub-analyses, participants primarily found detox programs and treatment centers to be most inaccessible, with the primary barrier being long waitlists.

Discussion: The study revealed that a small, but significant, proportion of Indigenous participants, including those possessing marker of overdose risk, struggled to access treatment. These results highlight the need for specialized approaches to enhance access to culturally sensitive substance use treatment and trauma support for Indigenous individuals.





April 2026

Difficulty Accessing Substance Use Treatment Among Indigenous People in a Canadian Inner City Setting

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Recommended Citation

Jeffery, T., Hayashi, K., DeBeck, K., Delilah, G., Western Aboriginal Harm Reduction Society, Milloy, M. J., & Kerr, T. (2026). *The International Indigenous Policy Journal*, 16(3). <https://doi.org/10.18584/iipj.2026.16.3.19234>

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Keywords

Indigenous People, Opioid Epidemic, Harm Reduction Services, Access Barriers, Substance Use Treatment

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Difficulty Accessing Substance Use Treatment Among Indigenous People in a Canadian Inner City Setting

Canada is currently facing a major public health crisis due to contaminated and toxic drug supply, with rates of overdose deaths continuing to rise over time. Since 2016 the drug supply, including opioids and stimulants, have been increasingly contaminated with synthetic opioids, such as illicitly manufactured fentanyl, and more recently benzodiazepines (Fischer & Robinson, 2023). According to recent reports, an estimated 52,544 people in Canada have died as a result of exposure to unpredictable, toxic drug supply between January 2016 and December 2024, and the country has one of the highest rates of opioid-related deaths per capita in the world (Public Health Agency of Canada, 2025). Indigenous Peoples are among the groups most affected in Canada. First Nations, Inuit, and Métis people experience disproportionately high rates of drug-related harm and overdose deaths compared to non-Indigenous populations (First Nations Authority, 2024; Lavalley et al., 2018). In British Columbia, Indigenous people who used drugs in 2023 had a mortality rate five times higher than that of non-Indigenous people who used drugs and accounted for 17.8% of overdose deaths, despite representing just 3.4% of the total population (First Nations Authority, 2024). The challenges facing Indigenous populations in accessing substance use treatment services are complex and multifaceted (Lavalley et al., 2020). Past research has revealed that access to healthcare is too often limited for marginalized groups, particularly racialized and minority drug users (Pearce et al., 2020; Saunt et al., 2025). Urban Indigenous people, who are more likely to experience health-related harms due to comparatively higher rates of homelessness, suicide, tuberculosis, HIV/AIDS, diabetes, and substance abuse (Bethune et al., 2019), also face significant barriers in accessing appropriate healthcare services (Goodman et al., 2017). Although the Canadian Health Act requires that timely and medically necessary care be accessible to all citizens based on their need rather than their income ("Canada Health Act," 1985), the ability of Indigenous people to access healthcare is not solely determined by physical proximity or availability of services but is also influenced by broader social and historical factors, including the legacy of colonialism, as well as the way healthcare is delivered and practiced (Burnett et al., 2020; Hamed et al., 2022; Morin et al., 2022).

There is a need for ongoing research that highlights the unique individual and social-structural factors influencing Indigenous peoples' ability to access drug or alcohol treatment, and it is also necessary to address current health inequities, particularly given the recent escalations in overdose deaths. Past studies have indicated that the high rates of drug-related harms and overdose among Indigenous populations in Canada are driven in large part by stigma, discrimination, historical trauma, and the ongoing impacts of colonization (Anderson et al., 2006; Burnett et al., 2020; Lavalley et al., 2024). Indigenous people are also known to experience barriers around substance use care and often do not derive the same benefits of treatment as non-Indigenous people (Andersen et al., 2021; Li et al., 2013). However, there is a lack of longitudinal cohort-based research characterizing the extent of the difficulties Indigenous people face in accessing substance use treatment, as well as a lack of research identifying the factors that shape such access. Therefore, we undertook this study to assess the potential relationship between various individual characteristics, contextual conditions, and the inability to access drug or alcohol treatment among Indigenous people who use drugs in Vancouver, British Columbia.

Methods

The Western Aboriginal Harm Reduction Society (WAHRS)

In an effort to ensure appropriate consideration of the perspectives of Indigenous people who use alcohol and drugs, this work was undertaken in collaboration with the Western Aboriginal Harm Reduction Society (WAHRS). WAHRS is an Indigenous-led organization operating under the Vancouver Area Network of Drug Users (VANDU) that has held longstanding relationships with the researchers leading this work (Goodman et al., 2017; Lavalley et al., 2020; Lavalley et al., 2018; Lavalley et al., 2024). WAHRS represents current or former users of illicit drugs and alcohol, focusing on harm reduction and enhancing the quality of life for other Indigenous people who use illicit drugs/alcohol through the development of support, education, and training programs aligned with Indigenous values. Prior to our initial data analysis, we consulted with the WAHRS Board of Directors, who supported the initiation of the research project. Once initial results were obtained, we returned to the WAHRS Board in order to contextualize the characteristics associated with the inability to access addiction treatment identified in our analysis. Specifically, each of the relationships identified in our analysis were discussed with WAHRS Board members, who aided in interpretation and shared their relevant lived experiences. One of the WAHRS Board members then agreed to participate as a co-author who would review drafts of the manuscript, peer review guidance, and final revised drafts.

Data Sources

Three ongoing prospective cohort studies, the AIDS Care Cohort to Evaluate exposure to Survival Services (ACCESS), the Vancouver Injection Drug Users Study (VIDUS), and the At-Risk Youth Study (ARYS) were the sources of data used in this study. Both VIDUS and ACCESS have been described elsewhere (Milloy et al., 2011; Wood, Lloyd-Smith, et al., 2007). In brief, VIDUS enrolls HIV-negative adults who report injecting an illicit drug at least once in the month prior to enrolment. ACCESS is a cohort of adults living with HIV who report using an illicit drug (other than or in addition to cannabis) in the month prior to enrolment. Participants had to be at least 18 years old and provide written informed consent before enrolment. If a VIDUS participant undergoes HIV seroconversion, they are offered recruitment into the ACCESS study. ARYS is an ongoing open prospective cohort of street-involved adolescents and young adults (AYAs) who use drugs and are recruited through self-referral and street outreach in Vancouver, Canada. AYAs aged 14 to 26 who have used any illicit drug (other than or in addition to cannabis) in the month prior to enrolment are eligible for study enrolment (Debeck et al., 2013).

Participants in VIDUS, ACCESS, and ARYS complete a questionnaire and provide biological samples (blood, urine) for diagnostic testing at baseline and every six months. The questionnaire covers a range of topics, including demographics, drug use patterns, health and social service utilization, sex work engagement, criminal-legal involvement, and experiences of physical or sexual violence. The procedures and questionnaires for both cohorts are harmonized to allow for cross-cohort analyses. ACCESS receives annual ethical approval from the University of British Columbia/Providence Health Care Research Ethics Board, and VIDUS and ARYS receives annual ethical approval from the Simon Fraser University Research Ethics Board.

Study Sample and Primary Outcome Measure

Participants were included in this study if they self-identified as being Indigenous (First Nations/Aboriginal/Inuit, Metis) and if they completed a baseline and at least one follow-up interview between June 2015 and May 2022.

Study Variables

The primary outcome for this study is self-reported difficulty accessing any form of treatment for drug or alcohol use in the last six months at the time of follow up interview. Specifically, the question asked, “In the last 6 months, did you try to get into any treatment for your drug or alcohol use but were unable?” A range of potential confounding variables were selected based on existing literature, our familiarity with the local environment, and previous studies using involving Indigenous people who use substances (Fischer & Robinson, 2023; Hamed et al., 2022; Hirschak et al., 2023; Hoffman et al., 2011).

Sociodemographic variables considered included: age; gender (self-identified as men vs. women); and relationship status (married, common law, living with regular partner vs. others). Social-structural factors considered included: homelessness (yes vs. no); Downtown Eastside residency (yes vs. no); sex work involvement (yes vs. no); employment (earned regular income from job vs. not); recent victim of violence (yes vs. no); education (\geq high school vs. <high school); recent incarceration (yes vs. no); and non-fatal overdose (yes vs. no). Other individual-level substance use factors included: heavy alcohol use (yes vs. no); defined as > 7 standard drinks per week or > 3 standard drinks per day at least once weekly for women or > 14 standard drinks per week or > 4 standard drinks per day at least once weekly for men (Lavalley, 2018); daily illicit opioid use (yes vs. no); daily stimulant use (yes vs. no); and current enrolment in addiction treatment (yes vs. no). Unless otherwise specified, all behavioural variables/exposures refer to the previous six months.

Statistical Analysis

We first compared the baseline sample characteristics stratified by self-reported difficulty accessing any drug or alcohol treatment in the last six months using Pearson’s χ^2 test for categorical variables and Wilcoxon rank-sum test for continuous variables. Then, to identify potential factors associated with being unable to access any drug or alcohol treatment, we conducted bivariate and multivariable generalized estimating equation (GEE) analyses. The multivariable GEE analyses were constructed using a priori-defined model building procedure. All variables of interest with a univariable p-value < 0.1 were included in the multivariable model selection procedure. Current addiction treatment enrolment was also forced into the final model to ensure adjustment for this key variable in the analysis. The final model was achieved using a backward elimination technique, with the variable with the least significant likelihood ratio statistic removed at each step until reaching the minimized Quasi-Likelihood Information Criterion (QIC) values. All statistical tests were two-sided and considered statistically significant at $p < 0.05$.

Finally, as a sub-analysis, we examined descriptive statistics detailing which types of treatment Indigenous participants were trying to access and why they were unable to access those treatments. All analyses were conducted using SAS version 9.4.

Results

From June 2015 to May 2022, a total of 784 Indigenous people who use drugs were included in this study. Of this total, 351 (48.41%) identified as women and 374 (51.59%) as men, and the median age at baseline was 37.74 (1st–3rd quartile = 28.67–48.39). At baseline, 55 (7.0%) participants reported being unable to access any drug or alcohol treatment, and another 128 (16.33%) unique participants reported the same outcome during study follow-up. Baseline characteristics of the participants stratified by baseline inability to access any drug or alcohol treatment are shown in Table 1.

The bivariate GEE analyses are shown in Table 2. The only factor negatively associated with being unable to access any drug or alcohol treatment was age (odds ratio [OR]: 0.98, 95% confidence interval [CI]: 0.96–0.99). Factors positively associated with being unable to access any drug or alcohol treatment included: residing in the Downtown Eastside (OR: 1.53, 95% CI: 1.04–2.25), daily illicit opioid use (OR: 1.43, 95% CI: 1.03–2.00), non-fatal overdose (OR: 1.29, 95% CI: 0.89–1.85), incarceration (OR: 1.61, 95% CI: 1.03–2.53), sex work involvement (OR: 2.04, 95% CI: 1.38–3.01), homelessness (OR: 2.05, 95% CI: 1.42–2.96), and experiencing violence (OR: 2.40, 95% CI: 1.63–3.52).

In the multivariate GEE analysis, also shown in Table 2, age (adjusted odds ratio [AOR]: 0.98, 95% CI: 0.96–0.99) remained negatively associated with being unable to access any drug or alcohol treatment. The factors that remained positively associated with being unable to access any drug or alcohol treatment included: homelessness (AOR: 1.63, 95% CI: 1.08–2.47), sex work involvement (AOR: 1.66, 95% CI: 1.12–2.47), and experiencing violence (AOR: 1.87, 95% CI: 1.25–2.81).

In sub-analyses including those Indigenous participants who indicated that they were unable to access any kind of drug or alcohol treatment, the most common kinds of treatment attempted to be accessed were detox (n=58, 32.8%), treatment centers (n=58, 32.8%), and recovery houses (n=14, 7.9%). Indigenous participants' inability to access drug or alcohol treatment was primarily due to waiting lists (n=88, 49.7%), but also included being turned down by the treatment program (n=19, 10.7%) and being unable to access treatment due to COVID19 restrictions (n=6, 3.4%).

Table 1: Logistic regression analyses of socio-demographic factors associated with being unable to access any addictions treatment service among Indigenous adults at baseline (n = 839).

Characteristic	Overall n (%), n = x	Able access Tx n (%), n = y	Unable access Tx n (%), n = z	Odds Ratio (95% CI)	p-Value
Age					
Q1	28.79	29.07	25.09	0.98 (0.96 - 1.01)	0.186
Median	37.97	38.36	33.27		
Q3	48.78	48.86	47.73		
Gender					
Female	409 (48.8)	385 (49.0)	24 (45.3)	1.16 (0.66 - 2.03)	0.602
Male	430 (51.3)	401 (51.0)	29 (54.7)		
Homeless_L6M*					
No	584 (69.6)	554 (70.5)	30 (56.6)	1.80 (1.02 - 3.21)	0.042
Yes	248 (29.6)	226 (28.8)	22 (41.5)		
Relationship					
No	491 (58.5)	462 (58.8)	29 (54.7)	1.18 (0.68 - 2.07)	0.554
Yes	347 (41.4)	323 (41.1)	24 (45.3)		
N/A	1 (0.1)	1 (0.1)	0 (0.0)		
Education					
Other	488 (58.2)	461 (58.7)	27 (50.9)	1.35 (0.77 - 2.37)	0.293
≥ Highschool	341 (40.6)	316 (40.2)	25 (47.2)		
Employment_L6M*					
No	597 (71.2)	561 (71.4)	36 (67.9)	1.19 (0.65 - 2.16)	0.572
Yes	240 (28.6)	223 (28.4)	17 (32.1)		
Daily Opioid Use*					
No	615 (73.3)	583 (74.2)	32 (60.4)	1.89 (1.06 - 3.35)	0.028
Yes	224 (26.7)	203 (25.8)	21 (39.6)		
Daily Stimulant Use*					
No	543 (71.7)	429 (71.1)	109 (74.2)	1.49 (0.84 - 2.64)	0.167
Yes	214 (28.3)	174 (28.9)	38 (25.9)		
Addiction Treatment					
No	434	33 (60.0)	401 (55.3)	0.83 (0.47 - 1.46)	0.574
Yes	346	22 (40.0)	324 (44.7)		
Overdose_L6M*					
No	719 (85.7)	677 (86.1)	42 (79.3)	1.89 (1.06 - 3.35)	0.166
Yes	120 (14.3)	109 (13.9)	11 (20.7)		
Sex Work_L6M*					
No	725 (86.4)	682 (86.8)	43 (81.1)	1.55 (0.76 - 3.14)	0.225
Yes	112 (13.4)	102 (13.0)	10 (18.9)		
Heavy Alcohol Use*					
No	646 (77.0)	607 (77.2)	39 (73.6)	1.22 (0.65 - 2.29)	0.542
Yes	193 (23.0)	179 (22.8)	14 (26.4)		

Table 1: Logistic regression analyses of socio-demographic factors associated with being unable to access any addictions treatment service among Indigenous adults at baseline (n = 839).

Characteristic	Overall n (%), n = x	Able access Tx n (%), n = y	Unable access Tx n (%), n = z	Odds Ratio (95% CI)	p-Value
Incarceration_L6					
No	761 (90.7)	716 (91.1)	45 (84.9)	1.81 (0.82 –	0.133
Yes	78 (9.3)	70 (8.9)	8 (15.1)		
Reside DTES_L6M*					
No	344 (41.0)	328 (41.7)	16 (30.2)	1.66 (0.91 –	0.098
Yes	459 (59.0)	458 (58.3)	37 (69.8)	3.03)	
Violence_L6M*					
No	670 (79.9)	639 (81.3)	31 (58.5)	3.19 (1.8 –	<0.001
Yes	164 (19.6)	142(18.1)	22 (41.5)	5.68)	

* L6M = in the last six months

Table 2. Bivariable and Multivariable GEE analysis of factors associated with being unable to access any addictions treatment service among Indigenous participants (n = 839)

Characteristic	Unadjusted		Adjusted	
	Odds Ratio (95% CI)	<i>p</i> - value	Odds Ratio (95% CI)	<i>p</i> - value
Age				
(continuous)	0.98 (0.96 – 0.99)	0.002	0.99 (0.97 – 1.00)	0.116
Gender				
(men vs. women)	0.98 (0.67 – 1.43)	0.900		
Homeless (L6M)				
(Yes vs. no)	2.05 (1.42 – 2.96)	<0.001	1.63 (1.08 – 2.47)	0.021
Relationship				
(Yes vs. no)	1.04 (0.75 – 1.44)	0.833		
Education				
(> HS vs no HS)	1.26 (0.85 – 1.86)	0.255		
Employment				
(Yes vs. no)	1.08 (0.77– 1.52)	0.649		
Daily illicit opioid (L6M)				
(Yes vs. no)	1.43 (1.03 – 2.00)	0.035	1.05 (0.75 – 1.48)	0.779
Daily stimulant (L6M)				
(Yes vs. no)	1.24 (0.91 – 1.70)	0.178		
Addiction treatment				
(Yes vs. no)	1.13 (0.81 - 1.57)	0.480	1.24 (0.88 – 1.76)	0.220
Overdose (L6M)				
(Yes vs. no)	1.29 (0.89 – 1.85)	0.174		
Sex work (L6M)				
(Yes vs. no)	2.04 (1.38 - 3.01)	<0.001	1.66 (1.12 – 2.47)	0.012
Heavy Alcohol				
(Yes vs. no)	1.20 (0.85 – 1.69)	0.301		
Jail (L6M)				
(Yes vs. no)	1.61 (1.03 – 2.53)	0.038	1.26 (0.80 – 1.99)	0.321
Reside DTES (L6M)				
(Yes vs. no)	1.53 (1.04 – 2.25)	0.032	1.36 (0.90 – 2.06)	0.149
Violence (L6M)				
(Yes vs. no)	2.40 (1.63 – 3.52)	<0.001	1.87 (1.25 – 2.81)	0.002

Discussion

In this study of barriers faced by Indigenous individuals in Vancouver who use drugs in accessing substance use treatment services, we found that a small but significant proportion of participants experienced difficulties in accessing treatment, particularly those who were homeless, involved in sex work, or experienced violence. Detoxification programs were identified as the most commonly inaccessible service, with long waitlists being the primary barrier.

Our findings align with existing literature, underscoring the struggles Indigenous individuals who use alcohol and drugs face in accessing treatment services (Denning et al., 2025; Lavalley et al., 2020). The intergenerational impact of residential schools and historical trauma has been connected to social and health inequities experienced by Indigenous Peoples, including substance abuse, violence, and poverty (Barker et al., 2019; Lee et al., 2014; Wilk et al., 2017). This historical trauma often exacerbates substance use problems, including heavy alcohol use, a significant issue in Indigenous communities (Myhra, 2011) from which the associated violent victimization becomes a contributing factor for difficulty accessing treatment in our study (Edwards et al., 2023).

Homelessness is also a prevalent issue, as Indigenous populations have a higher prevalence of homelessness compared to non-Indigenous populations, especially in urban areas such as Vancouver, where Indigenous people comprise up to 38% of the homeless population (Bingham et al., 2019) despite representing only 5.0% of Canada's population (Statistics Canada, 2023). Unstable housing, forced displacement, and limited access to healthcare services have all detrimentally affected the health and well-being of many Indigenous people. Other factors also condition treatment engagement among Indigenous people who experience homelessness, including the lack of post-treatment support to prevent relapse, the financial resources required to enter treatment, and the logistical barriers faced by individuals in the process of seeking help.

Lastly, involvement in sex work intersects with significant challenges related to substance use, violence, and homelessness, highlighting the urgent need to address barriers around drug and alcohol treatment services for Indigenous sex workers. Studies have consistently demonstrated that sex workers face pervasive stigma, discrimination, and the harmful effects of criminalization, all of which severely hinder their ability to access essential healthcare and social services (Landsberg et al., 2017; Singer et al., 2021). Notably, street-based sex workers encounter a multitude of barriers such as a limited availability of substance use treatment programs, financial constraints that impede their ability to seek help, and the constant fear of legal repercussions that discourage them from accessing necessary support (Goldenberg et al., 2020; Pan et al., 2013). It may be that sex workers also face unique challenges due to unconventional work hours and a complex predicament of potential income loss and debt obligations upon entering treatment (Western Aboriginal Harm Reduction Society Board of Directors [WAHRS], 2024; Nelson & Abikoye, 2019; Sawicki et al., 2019). Indeed, past literature has pointed to the role of gender-based violence, including the coercive control of women engaged in sex work, as barriers to accessing healthcare (Shannon, Kerr, et al., 2008). Sex workers are also often forced to work in remote locations as a result of police pressure, and this may place them beyond the reach of healthcare providers and programs (Shannon, Rusch, et al., 2008). These social, structural and systemic obstacles contribute

to a dire situation where sex workers are left without adequate resources and support to address their substance use issues, perpetuating a cycle of vulnerability and marginalization.

Our results underscore the need for targeted interventions and policy initiatives that address specific barriers faced by Indigenous people seeking substance use treatment. These may include developing models of culturally appropriate and trauma-informed care, reducing wait times for treatment, and addressing the root causes of homelessness and involvement in sex work (Cedar Project et al., 2008; Hirschak et al., 2023; Marsh et al., 2015; Wolfe et al., 2023). Trauma-informed care involves accommodating trauma survivors' needs, recognizing their vulnerabilities and strengths, and providing support to ensure they have autonomy and power in their healing (Madden et al., 2024; First Nations Health Authority, 2025). One study found that trauma and violence prevalent in the lives of First Nations, Métis, and Inuit women were often connected to substance use, and that trauma-informed approaches help avoid re-traumatization and establish safe, non-hierarchical relationships (Poole, 2013). Other authors have highlighted participants' dissatisfaction with encountering barriers when accessing treatment, such as extensive wait times and culturally inappropriate program structures (Denning et al., 2025; Lavalley et al., 2020). Furthermore, this work revealed that participants' accounts of the waiting period often centered around treatment facilities not being sensitive to the "fleeting" moment when people felt ready to attend, demonstrating that excessive waiting periods dissuaded participants from continuing to seek support to improve their health and well-being (Lavalley et al., 2020). Indeed, some participants felt their hope diminish significantly while waiting for admission, resulting in relapses to substance use, sometimes further exacerbated by subsequent feelings of guilt arising from an inability to enter treatment (Carr et al., 2008; Hoffman et al., 2011).

Our findings also support the establishment and maintenance of various harm reduction measures to support Indigenous people who experience difficulty accessing treatment services. Indeed, past research has shown that harm reduction services such as supervised consumption sites attract individuals possessing similar markers of risk as those identified herein who experience barriers to substance use treatment (Wood et al., 2006). Further, these same harm reduction programs have been shown to increase access to treatment services (Strathdee et al., 1999; Wood et al., 2007). More recently, efforts to integrate harm reduction approaches into Indigenous-led treatment services have been found to improve treatment completion rates (Morin et al., 2022).

However, conventional harm reduction approaches have also been criticized for being overly individual-focused and lacking attention to historical and socio-cultural drivers of drug-related harm, including colonization (Lavalley et al., 2020). In turn, various authors and organizations have called for more culturally sensitive approaches to harm reduction for Indigenous people, including those that incorporate cultural practices. For example, the First Nations Health Authority (FNHA) in British Columbia has articulated principles and practices for Indigenous-focused harm reduction programs and policies, including the incorporation of cultural humility and safety; understanding of the impact of cultural oppression, intergenerational trauma, and land-loss; as well as social, environmental, and economic conditions (First Nations Health Authority, 2025). At the level of practice, FNHA recommends incorporating Indigenous beliefs, values, and practices: medicinal plants, ceremony, and consultation with Elders (First Nations Health Authority, 2025).

Limitations of this study include reliance on self-reported data, which may be subject to recall bias and social desirability bias. Additionally, our sample may not be fully representative of broader Indigenous populations, as participants were drawn from three prospective cohort studies in Vancouver, BC. Our results may not be generalizable to Indigenous people who use drugs in other regions or those who did not participate in the cohort studies. Furthermore, the study did not explore the potential impact of specific cultural or historical factors that may influence Indigenous people's access to treatment services.

In summary, our study highlights the significant barriers faced by Indigenous individuals in accessing substance use treatment services in Vancouver, Canada. Future research should further explore the complex interplay of individual, social, and structural factors contributing to these barriers and investigate the effectiveness of targeted interventions designed to address these challenges, such as treatment-on-demand initiatives. Further, by developing and implementing culturally appropriate and trauma-informed policies and practices in partnership with Indigenous people, including Indigenous people who use alcohol and drugs, efforts can be made towards reducing disparities faced by Indigenous populations in accessing vital substance use treatment.

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