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Fostering Equity in Virtual Care for Substance Use: What We Heard

Findings from a Qualitative Participatory Research
Study

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Conflict of Interest

The authors have no conflicts of interest.



Executive Summary

Key Findings

- Despite the strong potential to increase access to substance use services and supports, virtual care can remain out of reach for equity-deserving populations due to systemic barriers.
- Providers of virtual services and supports should ensure patients are satisfied with the virtual relationship and should allow patients to choose their preferred care option (e.g., virtual, in person or both).
- Virtual care can be a viable alternative to in-person services and supports for people who have experienced stigma accessing care.
- Involving people with lived or living experience of substance use and members of equity-deserving populations when developing, delivering and evaluating virtual services and supports can help to better tailor these services to their realities, needs and preferences.
- To improve equity in virtual care access and experiences, policy makers should address intersectional barriers to virtual care, develop equity-focused standards for virtual substance use care delivery and strengthen health system resources to support new and emerging virtual services and supports for substance use.

Virtual substance use care has become increasingly available since the COVID-19 emergency response started in 2020. However, there is a gap in knowledge about the experiences of members of equity-deserving populations who face barriers to access (i.e., people with socioeconomic challenges, members of racial and ethnic groups, 2SLGBTQ+, women, people living in rural or remote areas). In response to this knowledge gap, the Canadian Centre on Substance Use and Addiction (CCSA) conducted a qualitative participatory research study to understand how virtual care affects the experience of members of the above equity-deserving populations when accessing and using substance use services and to gather their recommendations for improvements in virtual care.

Partners with lived or living experience of substance use were involved in all stages of this project. Between October and December 2022, a researcher with lived experience conducted in-depth focus groups and interviews with 40 members of equity-deserving populations living with substance use issues in Newfoundland and Labrador. This report focuses on findings that are transferable to other Canadian jurisdictions.

This report is intended for federal, provincial, territorial and municipal decision makers across Canada, health and social service providers (e.g., primary care physicians, nurses, social workers, community service workers), regulatory bodies, and health and technology agencies. It provides readers with an understanding of the key actions needed to improve equity in virtual care policies and practices for substance use. This report will also be of interest to researchers, policy analysts and organizations led by people with lived or living experience of substance use. It highlights how involving people with lived or living experience is critical to both knowledge and policy advancement in this field.

In terms of access to virtual services and supports, our findings show that virtual care has the potential to fill service gaps (especially in rural and remote areas), to reduce the interference of substance use treatment on other aspects of participants' lives (e.g., work, childcare) and to reduce



mobility-related barriers for those living with disabilities or chronic pain. However, participants reported systemic barriers accessing virtual care, including those related to healthcare systems, providers, accessing and using technology and finding information about available virtual services and supports.

In terms of relationships with providers, participants expressed that virtual care was beneficial in reducing social isolation, especially for those living with mental health challenges, such as anxiety. Participants were only satisfied with virtual relationships when providers showed interest and compassion. They felt that video encounters offered more opportunities for emotional connection than telephone encounters. Participants preferred in-person care for serious physical or mental health issues requiring examination or diagnosis.

Participants reported multiple experiences of stigma in health care that could prevent them from seeking further help for their substance use. They felt that virtual care could minimize the risk of experiencing stigma and therefore increase their access to services. However, stigma was experienced differently virtually than in person. Several participants raised confidentiality and privacy concerns about potential exposure to stigma in virtual settings (e.g., possible detrimental consequences of sharing intimate information virtually).

Participants' recommendations to tailor virtual care to their realities, needs and preferences included:

- Involving people with lived or living experience of substance use in developing, delivering and evaluating virtual services and supports;
- Ensuring equitable access to information about virtual services and supports through strategic advertising on multiple platforms;
- Ensuring equitable access to technology and digital literacy through public policies and community-based training;
- Developing standards for virtual substance use care to ensure relationships with providers are high quality;
- Increasing funding, resources and training to support providers in offering high-quality virtual substance use care to equity-deserving populations; and
- Developing low-barrier and quickly accessible virtual services and supports for substance use and mental health.

This innovative participatory study provides unique insights into virtual care experiences and recommendations directly from the members of equity-deserving populations.

To ensure sustainable and equitable access to virtual substance use care beyond the COVID-19 emergency response, policy makers should adopt an intersectional lens on the multiple challenges faced by members of equity-deserving populations. Policy makers should also address digital health inequities at the health system and societal levels (e.g., ensuring adequate infrastructure and resources across Canadian healthcare systems, creating targeted information campaigns about virtual services and supports in the community).

Equity-oriented training, resources and competencies should be developed to support service providers in offering compassionate and destigmatized virtual care to members of equity-deserving populations with substance use issues. Providers should be aware that brief and impersonal telephone encounters do not allow for the development of a trusting relationship and can increase



feelings of stigma among members of equity-deserving populations seeking help for their substance use. Guidelines for virtual substance use care provision should ensure that virtual relationships meet standards of quality care.

Greater recognition of the experiential expertise of people with lived or living experience and their inclusion in decision making can strengthen the development of more equitable virtual care policies, programs, services and supports.



Introduction

Background

The COVID-19 pandemic led services and supports in the field of substance use¹ to adapt quickly to a rapidly changing public health emergency. In 2020 and 2021, to prevent COVID-19 infections among service providers and clients, many services and supports across the continuum of care made a partial or complete shift to virtual care (i.e., remote service delivery through technology, such as phone, mobile apps, the internet) (Bruneau et al., 2020; Perri et al., 2021).

The shift to virtual care led to both positive and negative consequences. Access to some services was improved due to measures allowing faster prescription of opioid agonist therapies (OAT) through telemedicine and reduction of transportation-related issues for clients (Goodman et al., 2022; Melamed et al., 2022; Russell et al., 2021). However, important barriers accessing virtual services and supports have been identified, such as challenges accessing the internet and devices, digital literacy, lack of a safe or private space to access virtual care, and challenges building a virtual relationship with practitioners (Goodman et al., 2022). The compounding negative consequences of the COVID-19 pandemic and the drug poisoning crisis also reinforced substance-related harms when some in-person services (e.g., assisted injections) were no longer available (Bonn et al., 2020).

Socioeconomic status, gender, age, race and ethnicity, housing conditions, and geographic location (i.e., rural or urban) are major social determinants influencing access to and experiences with virtual services and supports (Canada Health Infoway, 2021; Goodman et al., 2022; Health Canada, 2021; Richardson et al., 2022). Members of equity-deserving populations (i.e., people experiencing socioeconomic or housing issues, members of racial or ethnic groups, gender or sexual minority groups, women, people living in rural or remote areas)² can

Key Definitions

Virtual services and supports refer to “any education, health care or treatment (e.g., counselling, peer support) provided through technology” (Canadian Centre on Substance Use and Addiction, 2021).

Virtual care refers to “any interactions between patients and/or members of their circle of care that occurs remotely, using any forms of communication or information technology.” (Canadian Institute for Health Information, 2022)

Digital health is a broader concept that refers to “the field of knowledge and practice associated with the development and use of digital technologies to improve health, [which encompasses] a wider range of smart-devices and connected equipment” (e.g., artificial intelligence, robotics). (World Health Organization, 2021)

Telehealth refers to “the use of digital technologies to deliver medical care, health education and public health services.” (Canadian Institute for Health Information, 2022)

Telemedicine is “a practice of medicine involving the use of information and communication technologies to administer health care to patients.” (Canadian Institute for Health Information, 2022)

1 Substance use includes use of unregulated drugs (e.g., opioids, stimulants), alcohol and cannabis, as well as substance use disorder diagnosis.

2 Equity-deserving populations refer to the communities experiencing systemic inequities based on gender, race, socioeconomic status or other social factors. Our study includes people living in rural or remote areas in this category because they can experience specific systemic challenges accessing healthcare services, including virtual services and supports.



experience challenges accessing both virtual and in-person care for substance use and mental health (Adams et al., 2022; Chaiton et al., 2021; Harris et al., 2022; Perri et al., 2022). Equity-deserving populations are also overrepresented among people experiencing substance-related harms in Canada (Milaney et al., 2022; Wallace et al., 2021). Access to virtual care for members of equity-deserving populations has been highlighted as one key indicator to be tracked over time in Canadian healthcare systems (Canadian Institute for Health Information, 2022).

With most pandemic measures lifted across Canada, some services that were offered virtually earlier in the pandemic are now returning to in person, while others are remaining virtual or offering a hybrid involving the two modes. There are uncertainties around how barriers accessing virtual services and supports will be addressed in the long term, and how the improvements offered by virtual services and supports could be maintained in different areas of substance use care (e.g., OAT, counselling, peer or user-based support, harm reduction). Members of equity-deserving populations may be left behind if no equity-oriented measures are taken.

In the field of substance use, there is a lack of qualitative research investigating virtual care experiences among members of equity-deserving populations. Little is known about their preferences, expectations and needs in terms of virtual services and supports. Understanding their experiences and amplifying their voices is essential to providing policy makers and practitioners with recommendations to better tailor virtual services and supports to the realities of members of equity-deserving populations.

Objectives

To address this knowledge gap, CCSA undertook a qualitative study aimed at:

- Understanding experiences with virtual substance use services and supports among members of equity-deserving populations. More precisely, our study explored the effects of virtual services and supports on substance use care access and experiences from the perspective of members of equity-deserving populations.
- Empowering members of equity-deserving populations to suggest policy and practice recommendations to improve their access to and experiences with virtual services and supports for substance use. This project aimed to foster equity-oriented virtual care by ensuring that the services are tailored to the realities, preferences and needs of members of equity-deserving populations.

Our study is one of the first in the substance use field to provide policy and practice recommendations for virtual care directly from the members of equity-deserving populations.

Conceptual Framework

Our study used the conceptual frameworks of health inequities and intersectionality (Braveman, 2006; Hankivsky, 2011), to examine the intermingling systemic disadvantages in wealth, power or prestige (e.g., based on gender, race and ethnicity, socioeconomic status) that contribute to poorer health outcomes among members of equity-deserving populations (Braveman & Gruskin, 2003; Hankivsky, 2011). This approach helps to understand how the social determinants of health can influence experiences with virtual care. Digital health equity is defined as “equitable access to digital healthcare, equitable outcomes from and experience with digital healthcare, and equity in the design of digital health solutions” (Richardson et al., 2022).



Methodology

Methodological Approaches

Qualitative Approach

We used qualitative methods to collect the perspectives of members of equity-deserving populations. To best adapt to the different realities and challenges of the participants, especially those facing barriers accessing technology, we offered diverse options for participation in the study: in-person or online options, focus groups or one-on-one interviews. We conducted six focus groups (five in person and one online) and eight semi-structured in-person interviews, across the island of Newfoundland.

Participatory Approach

The expertise of people with lived or living experience (PLLE) of substance use was included in all stages of the project, from the definition of the study design and objectives, to the collection and analysis of the data, and the development of this report (Vaughn & Jacquez, 2020).

Study Design

Co-design

We designed the study based on guidance from partners with lived or living experience of substance use (LLE partners) from CCSA's lived or living experience working groups. At the planning phase, we also consulted with members of organizations that took part in CCSA's previous virtual care work (i.e., Canada Health Infoway and the Royal Ottawa Mental Health Hospital).

Six members of CCSA's lived or living experience working groups were involved in the decisions about the study design. We met with each of them individually or in small groups of two to discuss the objectives and methods. We also asked them about the most appropriate approaches for connecting with members of equity-deserving populations who may face challenges accessing virtual care.

It was essential to obtain input from both lived experience and living experience partners, to ensure that diverse expertise and perspectives on substance use care were included. A few LLE partners were members of organizations led by PLLE. Some also had roles as peer or community workers, and some had previous experience of collaborating with researchers. They came from various backgrounds and lived in different provinces across Canada. Several of them self-identified as members of sexual, gender, racial or ethnic minorities.

They provided the following guidance, which shaped the study design and methodology:

- Hiring a facilitator with lived or living experience to conduct the focus groups and interviews, as well as to analyze the data.
- Meeting members of equity-deserving populations in the facilities of the community services they were using (e.g., harm reduction services) and leveraging a local network of service providers to help connect with them and make participation easier.
- Offering different options for participation to ensure access to the study and adapt to participants' diverse challenges.



- Recruiting participants who are members of various equity-deserving populations and collecting sociodemographic data.
- Creating a welcoming and friendly space in the focus groups and interviews through ice-breaking activities to make participants more comfortable.
- Ensuring that all participants in focus groups and interviews were fairly compensated with cash as a low-barrier and confidential means.

The LLE partners also contributed to developing or reviewing the project materials (e.g., study protocol for ethics, discussion guides, recruitment materials, consent forms).

Discussion Guide

The discussion guide for the focus groups and interviews (see Appendix A) was developed based on the literature, results from CCSA's previous quantitative survey of virtual care perceptions (Goodman et al., 2022), and discussions with LLE partners. All questions were phrased in a non-stigmatizing and easily understandable way. The guide included two main sets of questions:

1. Questions about participants' past and current experiences with virtual care for substance use, including positive and negative aspects of their access to virtual services and supports.
2. Participants' suggestions and recommendations to improve virtual services and supports for substance use, and to make these services more tailored to their realities, preferences and needs.

Data Collection

Participatory Data Collection

The guidance from our LLE partners led the team to opt for a participatory design involving a peer researcher with lived experience using substances (LE researcher) who was contracted by CCSA to conduct the focus groups and interviews, and co-analyze the data.

Focus groups and interviews were conducted from October to December 2022 on the island of Newfoundland by one of the project's LLE partners based in Newfoundland and Labrador (J. Harnum). The study highly benefited from her extensive knowledge of the local services to facilitate collaboration with providers and ensure that participant recruitment and data collection were done in a respectful and appropriate way. In addition, having an LE researcher highly improved participants' trust, comfort and sense of safety during the focus groups and interviews. Several participants expressed that their anxiety about possible negative judgments was immediately relieved when they were told that the interviewer had lived experience and was able to understand what they were living.

Building on her previous experience facilitating groups, the LE researcher received additional training on how to conduct and analyze focus groups and interviews, as well as regular support from the research team and LLE partners throughout the process.

Community-based Recruitment

Given the qualitative and participatory methodology, it was essential that this project be conducted with a community-based approach to participant recruitment and data collection. Therefore, by its nature, this type of project could not be conducted across Canada and had to be deeply embedded



in a local community. Overall, Newfoundland and Labrador has received less attention from substance use research than some other Canadian jurisdictions. In addition, although we considered the possibility of replicating the study, as detailed below, it appears that most of the findings describe general experiences with virtual care that are not directly tied to the local context and are transferrable to other Canadian jurisdictions.

To encompass a variety of experiences, participants were recruited in different rural, semi-urban (small- to medium-sized cities) and urban areas of Newfoundland.³ The focus groups and interviews took place in different community-based services used by members of equity-deserving populations (e.g., harm reduction services, outreach services, peer-support networks, services providing meals, shelters). To maximize the diversity of the sample, the LE researcher ensured that a variety of services were represented. Conducting the focus groups and interviews on-site in the services helped increase participants' access to the study and comfort levels. Service providers facilitated the recruitment of participants through posters, pamphlets or direct contact with their clients. Participants also had the option to phone the LE researcher to schedule an interview.

Participants and Procedures

To be eligible, participants had to be of legal age (i.e., 19 years old in Newfoundland and Labrador), self-identify as people who had a past or current experience with substance use (e.g., illegal drugs, alcohol, cannabis) and reported having an experience or expressing an interest in using virtual services and supports for substance use. They also had to self-identify as a member of one or more of the following equity-deserving populations:

- People experiencing socioeconomic issues or housing issues (e.g., homelessness, low income, unemployment, “struggling to make ends meet”);
- Members of a racial or ethnic minority;
- Women;
- Members of the 2SLGBTQ+ community; or
- People living in a rural or remote area.

The LE researcher screened participants' eligibility before each focus group or before scheduling an interview. As much as possible, the LE researcher aimed to recruit members of different equity-deserving populations to ensure the adequate representation of several perspectives and realities. However, due to regional realities, members of racial and ethnic minorities were less represented.

The focus groups included three to six participants and lasted 60 minutes on average (range: 50 to 83 minutes). The one-on-one interviews lasted 30 minutes on average (range: 13 to 44 minutes). The focus groups and interviews were audio-recorded and transcribed verbatim. At the end of their focus group or interview, participants were asked to complete a short anonymous sociodemographic questionnaire (see Appendix B). After participation, they received \$100.

The study was approved by the Newfoundland and Labrador Health Research Ethics Board (Reference 2022.166). All participants provided verbal informed consent before participating in this study. They were given a copy of the consent form as well as a list of resources in case they needed any support after the focus group or interview. To maximize anonymity and confidentiality,

³ Despite our efforts, it was not possible to recruit participants from Labrador.



participants were asked to use pseudonyms during the focus groups and interviews. In addition, to prevent any form of identification of the participants quoted in this report, focus group numbers have been replaced with colours and interview numbers have been replaced with fruit names.

To ensure that the final sample represented a wide range of virtual care experiences, we continuously assessed data redundancy and information power before deciding to stop recruiting new participants. Information power assessment is used in qualitative research to make sampling decisions based on the quality of the information collected and its potential to meaningfully address the research objectives (Malterud et al., 2016).

In total, 40 individuals took part in the study. Their sociodemographic characteristics are summarized in Table 1. In addition to these characteristics, several participants reported experiencing both substance use and mental health challenges. Most participants also mentioned having a past or current experience with opioid use or OAT.

Table 1: Sociodemographic Characteristics of Participants

Characteristic	Focus group participants	Interview participants	Total
Total number of participants	32	8	40
Gender (multiple identifications allowed)	Focus group participants	Interview participants	Total
Woman	15	5	20
Man	13	3	16
Gender diverse	3	0	3
Prefer to self-define	1	0	1
Prefer not to answer	0	0	0
Unknown*	1	0	1
Age range	Focus group participants	Interview participants	Total
19 to 29	8	3	11
30 to 39	6	4	10
40 to 49	10	1	11
50 to 59	4	0	4
60 to 69	3	0	3
Prefer not to answer	0	0	0
Unknown*	1	0	1
Racial or ethnic minority identification	Focus group participants	Interview participants	Total
Yes	2	0	2
No	28	8	36
Prefer not to answer	1	0	1
Unknown*	1	0	1

continued

Table 1: continued



First Nations or Métis person or Inuk	Focus group participants	Interview participants	Total
Yes	2	0	2
No	28	7	35
Prefer not to answer	1	1	2
Unknown*	1	0	1
Housing issues in the past 2 years	Focus group participants	Interview participants	Total
Yes	17	5	22
No	14	3	17
Prefer not to answer	0	0	0
Unknown*	1	0	1
Economic challenges in the past 2 years	Focus group participants	Interview participants	Total
Yes	27	8	35
No	4	0	4
Prefer not to answer	0	0	0
Unknown*	1	0	1
Living area	Focus group participants	Interview participants	Total
Urban	15	7	22
Semi-urban	8	1	9
Rural	7	0	7
Prefer not to answer	1	0	1
Unknown*	1	0	1
Experience with substance use	Focus group participants	Interview participants	Total
Current experience	11	8	19
Past experience	15	0	15
Prefer not to answer	5	0	5
Unknown*	1	0	1

*One focus group participant did not complete the sociodemographic questionnaire, so their characters are unknown.

Co-development of Virtual Care Recommendations with Participants

Participants were invited to actively take part in the development of policy and practice recommendations to improve virtual services and supports for substance use. They were asked to provide their suggestions for new virtual services and supports, and to make recommendations about how virtual care policies and practices could better meet their realities, preferences and needs. The recommendations described in this report (see Results, Participants' Recommendations



to Improve Virtual Services and Supports) represent participants' key priorities for advancing equity in future virtual services and supports for people who use substances.

Data Analysis

A reflexive thematic approach was used for data analysis (Braun et al., 2019). Using an interpretive and inductive approach, the analysts developed themes drawing from the focus groups and interviews to report on the main dimensions of participants' experiences and recommendations. An interpretive approach considers that the themes are constructed by the analysts through the connection of different data and the capture of recurrent meanings (Braun & Clarke, 2016). An inductive approach roots the analysis in participants' narratives rather than existing theoretical conceptions (Braun et al., 2019), which was essential to make ensure the final themes were grounded in participants' views.

All focus groups and interviews were co-analyzed by the LE researcher (J. Harnum), research and policy analyst (L. Dassieu), and knowledge broker (C. De Moor). Throughout the analysis process, the team regularly discussed their interpretations and the key themes to be highlighted from the focus groups and interviews. The diverse backgrounds of the three team members enriched the analysis and fostered reflexivity by providing different lenses on the data (Barry et al., 1999; Berends & Johnston, 2005). The research and policy analyst used MAXQDA 2022 software to support data management (e.g., thematic coding, retrieving quotes related to specific topics) and drafted this report based on the team's collective analyses.



Results

Impacts of Virtual Care on Service Access

Positive Impacts of Virtual Care on Service Access

Virtual Care Has the Potential to Fill Service Gaps

Virtual care increased access to substance use services and supports by filling some gaps in in-person services. In rural areas where few in-person services are available, some participants were able to see providers who were based in other regions and to benefit from treatment options that otherwise would have been unavailable to them. Participants also reported that virtual care enabled continuity of service provision when the provider or the patient moved to a different region. This prevented participants from having to seek a new provider and to re-explain their story to a stranger.

At the time, I had a different doctor and whenever she wasn't available, she was all over the place, she was in the [United] States, she was on the other side of the country, every month she was somewhere else. So, instead of having to see a different doctor to have my prescription refilled or whatever, I could still see her. And I felt like I didn't have to start all over. We already had conversations started from the last appointment that we could continue with this appointment, and I liked — you know, she still got to see me, so. But, yeah, I like telehealth when my doctor was away. (Yellow Focus Group)

Several participants also mentioned virtual harm reduction and overdose prevention services as being essential, allowing remote support for people who are using substances alone. These services were either informal or offered by PLLE-led organizations (e.g., the National Overdose Response Service).

Virtual care could also ease service access by reducing wait times. This allowed faster response, especially for counselling services.

All of a sudden, they accelerated it, and you could access [walk-in counselling service] virtually five days a week. And it was excellent. And all the counsellors were happy ... I was on a wait list for like 36 months for an actual regular counsellor, and they could pepper virtual appointments between their in-person [appointments] once they restricted in-person. (Green Focus Group)

For some participants who already experienced barriers accessing in-person care (e.g., those who did not have a family physician or were not enrolled in regular treatment), virtual care provided some access to services and supports. However, several participants felt that it rarely provided them with proper continuity of care. Several participants described this ambivalence by stating that virtual care was “better than nothing.”

Those saying this is better to have a voice — any voice — except for your own voice because your own voice, your own head, it could kill you. But at least sometimes, you know, if you're talking to someone, whether it's on the phone, whether it's whatever, is better than nothing.” (Green Focus Group)



Where I'd already had a history with my supports and stuff like that, I reached out. I take whatever I could get, you know what I mean. I'm not going to turn something down when there's only a couple options there. (Cranberry Interview)

Virtual Care Reduces the Burden of Treatment in Everyday Life

Most participants reported that virtual care significantly reduced the interference of healthcare appointments with their daily activities. This was especially true for participants receiving OAT. Virtual or phone prescription renewals were described as convenient and easy to fit around participants' work schedules, childcare and other activities. With virtual options, they no longer had to re-arrange their day to attend a doctor's appointment or miss work to wait several hours in a waiting room for their monthly prescription. They were able to focus more on other aspects of their lives and still receive care when they needed it. Several participants preferred virtual care over in-person care for that reason.

The benefits for the virtual care, like for daily living, it was less time consuming... If I had to work, I could be at work and pop out to the bathroom and take my phone call and not have to take the day off or take time off to go to the appointment. It's a big transportation thing that was like, and time consuming. So, I found that it was more beneficial to have the virtual care than to go in person. (Raspberry Interview)

Virtual care options were also seen as beneficial for transportation issues and unforeseen events (e.g., winter storms) that might make it impossible to physically get to the provider's office. Some treatment programs have strict enrolment rules that do not allow for missed appointments. In addition, with OAT, missing a prescription renewal often means experiencing withdrawal symptoms. Virtual care ensured continued access to services when participants were unable to travel, especially for those who lived far from the services.

It's there, so we can avail it now if we need it. We don't have to have bad weather or, you know, transportation or childcare that's going to restrict us from getting our medicine, our counselling or what we need. (Blue Focus Group)

Participants also mentioned that accessing care from home required less preparation and effort in terms of presentation, which alleviated some stress.

For me, to get off and go down to see [my doctor], got to get a shower and you got to do something with your hair, and you got to get in this dress. At home, it's like, hello, right? (Yellow Focus Group)

Virtual Care Reduces Some Health-Related Barriers to Accessing Services

Participants described virtual services and supports as a more accessible option for people living with chronic pain or disabilities, who may experience mobility issues.

The positive of it was once I got used to doing virtual things, it was more accessible for me because I struggle with chronic pain on the daily, which is being investigated now. (Pink Focus Group)

Virtual care also provided access to services for people living with anxiety or other mental health conditions that make it more challenging to leave their home. They could benefit from continued care while staying in their "safety zone."



It was anxiety issues for me. So, being able to just talk, my own experience with it is through appointments with my doctors on the phone but, you know, not having to go out and deal with people, it can be very nice sometimes. (Purple Focus Group)

Participants also outlined the importance of virtual care for people who do not want to use in-person services because of COVID-19 related risks.

Most of the support systems did go online for two years, three years. And things are only going back to the way they were now. But really ... in my opinion, they should keep the virtual because for some people, they still don't want to go out. (Cranberry Interview)

Barriers Accessing Virtual Services and Supports

Despite several positive impacts on participants' access to substance use services, virtual care can remain out of reach for equity-deserving populations due to various types of barriers. Participants had unequal access to virtual care. Some had little opportunity to use virtual services and supports or were not even aware of their existence. Barriers to accessing virtual services and supports could negatively impact their broader access to substance use care.

Health System Barriers

Health system factors such as funding, infrastructure and human resource challenges in public hospitals and community health services could hinder the availability of virtual care for participants. Some participants living in one rural region noted that virtual care was inconsistently available, although it was supposed to be in place. They felt that providers and health administrators were “dropping the ball.”

They say it's an option, but I haven't seen someone over telehealth in two years, three years, I think. (Yellow Focus Group)

Other participants mentioned long wait times before being able to access virtual services, especially counselling and psychotherapy services. Although wait times were often shorter compared to in-person services, many participants deplored still having to wait several months to access a psychologist virtually.

You're given a referral sent to psychologist and the length of time it takes someone to call you back or messenger or virtually whatever you want to call it — I can understand he can only fill so many appointments a day in person, but how long does it take to call someone back within a reasonable time to talk to him for five or 10, 15 minutes or something like that, and then go on to the next one? It shouldn't take seven or eight months. (Green Focus Group)

Moderator: What do they offer virtually?

Participant: Counselling. Like, it's to help you get on your feet, so counselling to help you get a job, and addictions and all that, but it's hard to get into groups, six months to a year wait. (Red Focus Group)

Provider-Related Barriers

Participants described disparities across providers in terms of options offered, which directly influenced their access to virtual services and supports. Some providers offered video appointments,



while others offered telephone options only or in-person options only. Some providers allowed their clients to choose their preferred care options, while others did not.

It was just phone call with the doctor once every couple of weeks. No video appointments. That's all that we did.... My ex-partner, he was also on the program, but he was with a separate doctor. And his doctor actually did do, they had an app and everything, and they did video appointments and everything like that. And they do them even now. (Raspberry Interview)

Several participants had no choice in their care options and felt that some providers prioritized their own convenience over their patients' needs.

In my experience, they choose. So, when my doctor, well, nurse practitioner, was in, or she knew she was going to be in, she would decide I'd come in and see her. And if she wasn't going to be in nobody asked me, "Do you want to do this over the phone or do you want to come in?" And there was no telehealth option. It's over the phone or come in, they would tell me: "OK, next appointment is going to be over the phone." I get a piece of paper, and it would say in person or over the phone. (Yellow Focus Group)

When they were not offered different options, participants could be forced to choose against their preference to keep the long-time relationship with their provider.

My preference is virtual. But like I said, I'm more familiar with the other [doctor]. So, I'd go in person just because, and it was the sooner. I was able to get in with them sooner than I was with the other virtual. (Raspberry Interview)

Providers' low digital literacy can be an additional barrier to virtual care availability. Some participants reported that their providers lacked time to implement virtual care or had insufficient training and skills to use technology.

I used telehealth to speak to a doctor, and they were really unorganized. They had trouble setting everything up, and it was in a different room every time, and there was a huge wait period trying to get them to set up their computer and everything. But when it was successful, I preferred it to the phone but they're — yeah, they had a hard time. (Yellow Focus Group)

Technology-Related Barriers

Access to the internet and devices, as well as knowledge of how to use them, were important determinants of participants' access to virtual care. Technology-related barriers were often intertwined with both socioeconomic factors and the place of residence (i.e., rural or urban).

Some participants did not have a personal cellphone nor computer. This caused disruptions in their access to services, especially when many in-person services were closed due to the COVID-19 measures. Sharing a phone with a partner, family member or neighbour was common among participants. This often came with restrictions on access, such as time limits or the inability to use the data plan for video appointments. Lost or stolen devices were also common experiences that could result in a loss of access to virtual services and supports. Some participants mentioned receiving or borrowing devices from schools or community services, but this was often limited in time and did not allow for sustained access after the COVID-19 emergency response ended.

I was really blessed ... because when I started at the [adult education service] during COVID, I got a Chromebook covered by income support. They paid \$300, and I just



gave the 300 to the school and the school gave me a Chromebook.... But they're not doing that now because it's back to normal. (Blue Focus Group)

Furthermore, despite having the equipment, several participants did not have regular access to a phone plan, data plan or internet connection. Both the cost and quality of phone and internet services were significant barriers to accessing virtual care. In rural areas, internet access was sometimes non-existent, and often more expensive and slower than in urban areas. This was both an economic and a technical barrier to accessing virtual care for rural participants.

In addition, low-quality or inconsistent internet or phone service could reduce the benefits of virtual care and create communication issues with providers.

I don't have a phone plan right now. So, I have to use a TextNow plan.... And that's a barrier too, I think, for virtual care.... My phone cuts out when I'm talking to people bit by bit because of TextNow. So, I noticed the doctor was probably getting frustrated with it until I mentioned it. And I'm able to speak up for myself and advocate for myself in that way. Some people aren't comfortable with it, right? So, I had to let them know, "You have to talk slower, so it doesn't cut out on me. And you're going to have to be patient with me because it's going to cut out on me as well." (Pink Focus Group)

Due to technical issues, some participants preferred not to use virtual services or stopped use them, which could be detrimental to their substance use.

You can't always hear what they're saying because the audio might be distorted or audio might not even work or the visual might not work or— So, the NA [Narcotics Anonymous] meetings, I stopped them online, which was a bad idea because I kind of fell back into [substance use]. (Strawberry Interview)

I don't really have the great Wi-Fi and stuff at my house, so that's not the greatest option for me to have access to online stuff to do. So, it's kind of not really a thing. (Blueberry Interview)

Several participants mentioned that they had subscribed to plans offered by internet companies to low-income households. However, some participants did not know about these options or did not use them because they doubted the quality of the service. In addition, participants who owed money to internet companies could not subscribe to the low-income plans, thus leaving them without any affordable options.

Well, I know Rogers and Bell, I think, have this low-income [plan], but if you had a bill with them, you just can't get it.... I had service in my name, and my ex, he beat up [damaged] the equipment, so that's \$4,000 there. I have a \$4,000 bill with Rogers because the equipment wasn't returned and because he beat it up. So, now I can't get service because of that. (Strawberry Interview)

Some participants mentioned using the internet or devices available in public places, such as hospitals, libraries or restaurants, but they raised privacy and confidentiality concerns about accessing virtual care in such settings (e.g., other people in the place can listen in, internet may not be secure).

Another important barrier to accessing virtual care was participants' unequal knowledge and skills in using technology, also known as digital literacy. For example, some participants who had spent several years in prison experienced a technology gap when they were released.



Well, I still got to have somebody come to my house and do it [set up the connection to Zoom meetings]. I don't know. When I got out of jail this time, I was looking for a pager. Everybody was laughing at me. Cellphone, you know, but slowly I'm learning. (Purple Focus Group)

Participants explained that it takes time to learn how to use technology and that access to virtual care is more difficult during that learning period. Some participants benefited from the help of professionals or peers in learning to use devices and software.

I think who showed me was somebody in a meeting with a support group.... Over the phone, he explained how it's done or might have been my teacher – one or the other. Once I got it, it was easy to apply. Great, it's just straightforward. It's one of the easiest things that I do [on] my computer, Zoom meetings. (Blue Focus Group)

Inequities Accessing Information About Virtual Care

If you went around this building and asked 10 people, “Do they know about the mental health crisis line?” or whatever, half of them would say no. (Red Focus Group)

Lack of information about existing services was one of the main reasons for reduced access to virtual care, especially for participants who were socially isolated due to marginalization. Several participants had never heard about any virtual care services and had no idea how to get that information despite their ability to use the technology. Some participants expressed feelings of powerlessness and injustice, and believed there was no willingness from policy makers and providers to convey the information to those who needed it most.

There's so many ways that little tidbits can get out so much quicker. But they all ... say nothing. And it's not right. It's not fair to people who want help and are looking for help but don't know where to go, don't know where to turn, don't know who to reach out to. That was me. I didn't know where to go, how to get anywhere, who to contact, what to do, where to go. (Apple interview)

You don't hear about it. I've been to everywhere. You don't hear about it. You don't hear from professionals on the pharmacies ... It is not talked about, unless it is, and I'm not in the right spot at the right times. (Lemon interview)

In fact, the focus groups and interviews were often opportunities to discover new virtual services through resource sharing with other participants or with the interviewer.

More broadly, participants described their challenges navigating the healthcare system to find services. They highlighted that this process required knowledge, advocacy skills and perseverance. Navigating the healthcare system could be even harder for participants coming from a different region, province or country. They also mentioned frequent roadblocks while seeking both virtual and in-person care (e.g., lack of connection between different services, inadequate referrals, restrictive admission criteria), which could negatively affect their mental health and substance use.

Expecting people in recovery or an active addiction to have to bear [it] all, navigate it all on their own and really keep advocating for themselves, like that adds to the pressure on yourself to stay sober. (Green Focus Group)

A few participants reported seeking help from a system navigator, which was extremely useful to get information about services. However, the system navigator has limited capacity (one employee for the province), and not all participants knew that this service existed.



Impacts of Virtual Care on Relationships with Providers

Benefits of Virtual Relationships

Benefits for Social Isolation and Mental Health

Participants felt that virtual care was an essential tool to break social isolation and receive remote support from trusted providers or peers. Breaking isolation through virtual care helped participants' mental health, as they were able to get support for many aspects of their lives while isolated in their homes due to the COVID-19 pandemic measures.

Well, I talk to them [a community service for homeless youth] on the phone a lot. It could be anywhere from walking me through — for example, applying for school or something like that. Something that I might need help with. It'd be anywhere from them kind of walking me through that or just if I just need to rant, you know what I mean? ... Not having anyone [else] to talk to kind of makes me able to just pick up the phone and have them there.... Ever since COVID started too, a lot of the in-person stuff has just stopped a lot, and that was something that I really depended on.
(Blueberry Interview)

Virtual options also enlarged participants' circle of relationships for peer support. Virtual peer-support meetings (e.g., NA meetings) allowed participants to connect with people anywhere in the world at any time of the day or night.

I've done 24-hour Zoom at the worst of my addiction when I was really low. I would sit on the meetings for all night. I'd leave it on. And I'd wake up in the morning, and it'd still be going. When I really need it to not be alone. (Blue Focus Group)

Virtual access increased their chances of meeting peers who understood their struggles as they could not necessarily find such support locally.

Now I can call my sponsor, or I've got a couple of other connections. I got one in Long Island. I got two in New York. These four women that I talk to ... when I'm inside my head and when my mental illness is taking me over ... When something makes me tick, I need to call somebody who's going to not make me tick more. And through this virtual platform, I've been given the blessing of having that where people can pull me out of that mental state that I get in. (Blue Focus Group)

Participants reported that virtual peer-support meetings enabled them to access a safe space where they could truly be themselves and empathize with each other.

For the most part, the peer group was beneficial, being able to meet people that have similar lived experiences, and just showing up and existing, and not having to mask. You can just be who you are, where you are in that moment. You don't have to put on this 100 per cent fake, everything's wonderful, everything's fine [mask]. And you can just genuinely be like, "Yeah, it's really hard right now." And people genuinely understand what you mean. Because when I say I'm tired, most people just think I didn't sleep well. But my soul is tired. I'm tired of advocating. I'm tired of struggling ... I keep saying — my brain doesn't work well. So, I'm just tired in general, and they don't get that. And obviously you're not going to explain everything to every person that asks you how you are, but saying, "I'm tired," and people understanding that it means more than just I didn't sleep well. (Pink Focus Group)



A Beneficial Virtual Relationship Requires Time and Compassion

Participants were satisfied with virtual relationships when providers showed interest and compassion for their situation, took time to ask questions and give detailed explanations. They enjoyed virtual relationships with clinicians that were based on a holistic and person-centred approach to care, as opposed to discussions focused only on the medication.

It really helped me a lot with my psychiatrist because I'm able to open up a little more that way with him. He's able to pinpoint when I'm getting upset, and he's always reassuring me on the chat that that's not his goal to make me upset. And he's explaining, and he's getting more detailed than maybe if we were in person, so I find that that point of that is great.... I was supposed to have a 15-minute interview. It turned into an hour and 40 minutes because he was bringing things up from my past. But when I was getting my voice or whatever going on, it was like he could pick right up on it, and he would get into detail why he was doing it, then would calm and help.
(Purple Focus Group)

In many cases, participants described positive virtual relationships when there was already a pre-existing positive relationship with the provider before moving to virtual care.

In general, participants were more often satisfied with video appointments than with phone appointments. They felt that seeing each other's face offered more opportunities for emotional connection between the provider and the patient. They were usually more comfortable sharing their mental health and substance use struggles over video than over the phone.

Even adjusting to doing my counselling virtual, we did a couple of phone appointments, and then we started doing the Zoom stuff, and that was a bit better. Because you could see the person.... Not being able to see that body language and to be able to look someone in the eye, when you're trying to access services in some of your most vulnerable states, being able to at least have it through Zoom or Teams or whatever, it adds that little bit more of a personable touch that you could see the other human that you were trying to get help from.... I felt like the phone created this barrier of the humanity part of it. (Pink Focus Group)

However, as stated above, video care was rarely available, and most providers offered the telephone as the sole remote care option.

Limitations of Virtual Relationships

“Sometimes you just need a hug”: Less Opportunities for Emotional Connection

Most participants found that it was harder to connect emotionally with providers virtually, and especially over the phone.

Phone appointments were often described as “cold,” and “impersonal,” like “talking to a robot,” lacking the human component of a provider–patient relationship. Several participants explained that phone encounters tended to be shorter than face-to-face encounters. On the phone, providers used pre-scripted questions that often focused only on prescribed medications (e.g., OAT), and participants had no opportunities to raise new issues or concerns. Some participants became disengaged from the relationship.



Participant 1: Where over the phone, it's like a 20-second conversation.

Participant 2: Yeah, and it's the same conversation every week.... It's programmed in my head. "You on this? Yes. Yeah, yeah, yeah. OK, you're still going on. Your medication on Saturday? Everything good? Perfect."

Participant 1: Yeah, I hear [Participant 2] on the phone, "Yeah, yeah, yeah." Oh, that was the doctor!

Participant 2: Right, there's no, actually, talking. (Yellow Focus Group)

Several participants deplored that the quality of care offered on the phone was often at its minimum. Some participants voiced concern that some physicians doing many short phone appointments were only doing it for financial reasons.

In addition, non-verbal elements were more difficult to identify over the phone, which could cause communication problems. Providers could be unable to notice that something was going wrong and provide further support when participants could not verbalize a problem. Some participants also mentioned that they found it harder to communicate on the phone. Misunderstandings were more likely to happen on the phone than in person.

And a negative for me is I have counselling sessions over the phone. And a lot of the times, I don't feel heard, or I don't feel like they're getting what I'm trying to say. So, I find a lot better to be in person. You can't see somebody's facial expression, see how they're feeling, you know, or body language and stuff like that. (Pink Focus Group)

Participants with ADHD and those on the autism spectrum reported specific communication challenges with virtual care (e.g., difficulty focusing on the conversation, expressing their needs to the provider).

I have a hard time with communication due to autism spectrum disorder. So, communicating my needs and my barriers with new people can be really difficult for me. And doing that virtually is even more difficult for me. (Pink Focus Group)

In addition, several participants felt that video or phone relationships would never replace in-person connection, where emotional support can be conveyed through many other means than language.

One of the things lost with Zoom is social interaction. It's made me become more anti-social. That's not been a benefit really. And we're humans. We need human interaction. And sometimes you just need a hug. You can't get that over Zoom. You really can't. There is something to be said for being in person and just feeling their energy. (Blue Focus Group)

Virtual Care Complicates Clinical Examination, Diagnosis and Intervention

Several participants considered that virtual care was convenient for minor health issues and prescription renewals but felt that it could not replace an in-person encounter for more serious health problems. In-person care was preferred for issues requiring a diagnosis, physical examination or urgent intervention, like in the case of a mental health crisis or an injection-related infection. Some participants considered it difficult to assess symptoms over the phone, which could lead to a misdiagnosis and increased harms.

The phones are good, but at the same time, sometimes they're not. Big, big one is infections. How is the doctor going to prescribe the proper medication if he can't see where the infection is? Or what the infection is? Like, for example, I know a couple



people who have had cotton fever. And they call their doctor, “I don’t feel well, and this is what I’m at. And I don’t feel well.” And the doctor can’t do nothing because they’re not into the office. So, they’re prescribing them antibiotics, and those antibiotics aren’t doing anything because it’s cotton going through their blood. So, they really do need to be in a hospital on IV and get their system flushed. But some people don’t know that that’s what’s going on. They do their shot. And then that day later, they don’t feel well, they don’t know why. And when you’re calling the doctor, the doctor can’t see where that shot was done. Can’t see you or physically check your temperature. You could have a thermometer and it’d be off by 20 degrees, you don’t know. So yes, it’s OK for prescription refills. But when it comes to infections, they should have more video options for doctors and psychiatrists and therapists. They should have a video option for people who can call and be like, “So, I have this. Is that an infection?” And then they can actually see and not have to explain. Some people don’t know how to explain what something looks like or what it really feels like. They just know they feel off. So, it’s a toss-up. It’s good, but it’s bad at the same time. There’s a lot of little twerks and twists that could be made to better a lot of the programs.” (Apple Interview)

Indeed, some participants noted that many people who use substances do not have sufficient medical knowledge to accurately describe their symptoms over the phone. Virtual care may increase health inequities based on patients’ level of medical literacy.

If a crisis, or if something new presents itself, I think it’s very important that that person gets seen in person because we are the layman. We are not the doctor. So, if you go, and you just get a phone appointment, and you’re just telling the doctor your symptoms, the doctor though, if they see you, and they weigh you, and they see your behaviour, or they see any physical stuff going on, like listening to your heartbeat, something else might come up and a list of symptoms.... You don’t have the knowledge to assess yourself and then give that assessment to the doctor. The doctor’s the one that had the education, that has the experience too. And they should be able to be given a full picture in order to provide the safe care of their patients. (Green focus group)

Impacts of Virtual Care on Stigma Experiences

According to several participants, virtual care can represent a good alternative to reduce the stigma experienced in in-person services. However, some participants felt more vulnerable to stigma in virtual settings than in person.

Virtual Care Can Minimize the Stigma Associated with In-Person Care

Multiple Stigma Experiences During In-Person Care

Participants reported pervasive experiences of stigma during their in-person interactions with healthcare providers. They described situations where stigma led to severe consequences, such as mistreatments, discrimination through care denials or unwanted public exposure of their substance use. Stigma experiences often prevented participants from further seeking help for substance use or other conditions, which negatively affected their substance use and mental health.

I had to go to the emergency room and was treated like a dog because I went in under [the influence of] substances. And I was treated completely like I was the



[pariah] of the hospital. They didn't even want to look at you. And that's not right when you're going to try to get help, and you're made to feel like a piece of [crap] for trying to get help. Then it makes you not want to go back again to get help. (Apple Interview)

Stigma could take multiple and subtle forms. Participants described a wide range of stigma experiences, including gossip (especially in smaller communities like rural areas), labelling (e.g., being considered “drug seeking” when seeking care for pain or mental health), lack of empathy, judgmental language, attitude or behaviours (e.g., being stared at in a doctor's waiting room or at the pharmacy).

Virtual Care as an Alternative to Reduce Stigma

Several participants saw virtual care as a viable option for accessing services without fear of being stigmatized for their substance use. In particular, many participants had concerns about confidentiality and anonymity due to their past experiences with stigma. They did not want to be seen accessing substance use services in person. For example, several participants were isolated from services and obtained injection supplies through their friends or partners who were accessing harm reduction services for them. Virtual care was helpful in ensuring the confidentiality of service use.

Participant: I wouldn't mind seeing [harm reduction service] online. As far as helping and stuff like that, I find I don't want to get into the whole, like, going somewhere for help because I did that when I was 17 years old, and I was on the news for it....

Moderator: So, it sounds like you would prefer to access services virtually?

Participant: Yeah. As opposed to going somewhere and have any risk of, I guess, people misjudging you. (Mango Interview)

In addition, virtual care sometimes prevented providers from activating common biases against people who use substances (e.g., the “drug-seeking” stereotype). This allowed participants to be offered treatment options that they might have been denied in person due to stigma:

I went through all that with the opiates in your [medical record] system and everything, and “drug seeking,” yes. But when stuff like virtual, which I find interesting, when I was trying to get some help for my car accident, when I was in an abstinence and methadone program, the first thing that they tried to give me was morphine because it was virtual, and I guess they didn't have my chart. (Pink Focus Group)

Stigma Experiences and Confidentiality Concerns in Virtual Services and Supports

Stigma Experiences in Virtual Services and Supports

Participants mentioned specific experiences of stigma in virtual care settings due to providers' judgmental and uncompassionate attitudes. Several participants who sought support from a mental health helpline faced judgment and lack of compassion when they mentioned substance use. These stigmatizing attitudes could leave them without any support when dealing with serious issues, such as suicidal thoughts.

Participant: When I called the line, I was in a hard way. I was feeling suicidal myself. And when I was trying to talk to her, she was more focused on the cocaine use than



the mental health thing. I was really, I mean, “You’re going to have to come get me.” And she wasn’t very compassionate.... As soon as I said the cocaine, she did not help me.... I told her I was on methadone and that was, like, you can hear in her voice.

Yeah, I was flabbergasted. Couldn’t believe it.

Moderator: So, what did you do then? Was there another service you could access?

Participant: No, no. I ended up out for a couple of days. Like, just running amok. (Red Focus Group)

Participants explained that providers expressed stigma over the phone not only through the language they used but also through a dismissive tone of voice.

Participant 1: It’s not even words. It’s the tone of their voice changes....

Compassionate voice is a lot better to open up to than someone who is being snotty. You know what I mean?

Participant 2: Just don’t have that sarcastic or judgmental tone in your voice. Just answer it like a normal person. (Red Focus Group)

Some participants also reported situations in which providers hung up the phone on them without any explanation. These situations, as well as the brief and impersonal phone encounters described above, reinforced the sense that providers did not really care about their situation and about people who use substances in general. This increased participants’ feeling of stigma and devaluation. One participant felt that virtual care dehumanized people who use substances in the eyes of providers.

There’s this huge disconnect. And because they’re not seeing us, like, they don’t see us as people anymore. Not that they ever did, maybe. But there’s definitely this huge disconnect in our humanity. And I feel like it gets brushed off so much more now because it’s virtual. And it’s just like hanging up the phone and out of sight, out of mind. (Pink Focus Group)

Confidentiality Concerns and Virtual Exposure to Stigma

Several participants expressed confidentiality and privacy concerns about their potential exposure to stigma in virtual services and supports. Virtual counselling and virtual peer-support groups were described as the most concerning. Participants were especially worried about not knowing if someone else in the other person’s room could hear them sharing personal information. Participants could also have people around them hearing their private conversation with a counsellor.

I’ve done phone counselling, which has been OK. But it’s hard to feel the sense of, I guess, privacy because you’re not in a counsellor’s room alone with him or anything like that. Anybody around can hear whatever you’re saying. So, it’s definitely a lot less comfortable than in person. (Pink Focus Group)

In online peer-support groups, several participants were concerned about not knowing exactly who was in the meeting, especially when participants used pseudonyms and did not turn their cameras on. The anonymity of some peer-support groups was described as a double-edged sword. While it increased the confidentiality of using these services, it also created new concerns about revealing intimate matters without a clear view of who was listening. Several participants advocated strict rules requiring attendees to turn on their cameras. Seeing other people’s faces increased trust and was reassuring for new participants in these support groups.

Participant 1: I think there’s good and bad to not being seen on camera. If you’re new, and you literally really just want to remain anonymous, I think that’s great. I fully support and on board with that. But if you’re a known member, and it’s like I’ve



looked at a screen where I've only seen four living faces and 20 black screens, you know what I mean?

Participant 2: And you wonder who's behind that. I wonder, sometimes —

Participant 1: You don't know who's behind that screen.

Participant 2: And are they there for the right purpose? Because I definitely know people who have logged onto meetings just to follow somebody, just to find somebody, and they log in with whatever name they want to. They don't show their face. They are not there for support. They're not there for recovery. They're there to troll people basically, and that's a very slippery slope. (Blue Focus Group)

Regarding virtual encounters with healthcare providers, some participants reported that some providers breached confidentiality online by posting stigmatizing information about patients on social media. This could increase participants' reluctance to use online tools for care.

And then they're posting stuff on Facebook, which they should be fired for posting stuff on Facebook about patients, calling them a crackhead and a pill head and a junkie.⁴ ... She took a selfie in the freaking office with the computer screen in the back with our date of birth and blah, blah, blah. And she had to remove it, but there was no repercussions. (Yellow Focus Group)

Participants' Recommendations to Improve Virtual Services and Supports

Involving PLLE in Developing, Delivering and Evaluating Virtual Services and Supports

Participants recommended a more systematic involvement of PLLE of substance use in their own care trajectory, as well as in the provision, development and evaluation of virtual services and supports.

Allowing Individuals to Choose How They Access Care

At the individual level, participants wanted to be able to choose the way they accessed care for their substance use and mental health. They recommended that providers systematically offer in-person, telephone and video options on a sustainable basis beyond the COVID-19 emergency response.

Having virtual connect as a given option on the regular, instead of it just being COVID related or extenuating circumstances. (Purple Focus Group)

Many participants advocated for being offered video appointments instead of having the phone as the only virtual option available.

If doctors, instead of an email or on the phone, do like the Skype and FaceTime, so you can see each other not just talk. Being able to see that person. (Strawberry Interview)

⁴ The phrase "a crackhead and a pill head and a junkie" is used in this quote as it was the terminology used by a participant. CCSA recognizes there is stigma associated with these terms.



Participants would like to be able to choose the care options that best meet their needs and constraints depending on the situation (e.g., being able to see their physician in person or on video for serious health issues but still having the phone option for routine prescription renewals that do not require further investigation). They would like to be allowed to make that choice for themselves, in a shared-decision process with providers, instead of having to comply with the provider's choice. Being able to choose between virtual and in-person care was described as an important factor in improving their experience of and access to substance use services and supports.

Recognizing Experiential Expertise and Hiring PLLE in Services to Reduce Stigma

Participants wanted to be involved and, more broadly, to see PLLE involved in the provision of virtual services and supports. They felt that employing people with personal experience of substance use as service providers (e.g., helpline operators, counsellors) was the best way to prevent stigma and turn services into safe spaces based on trust, solidarity and empathy.

Many participants reported that they would feel more comfortable using a virtual service if the provider had lived experience as they would not fear being negatively judged for their substance use.

Moderator: What would you recommend needs to change?

Participant 1: Get some operators ... [who] even maybe had substance [use] problems themselves? Maybe they could. They know what we're talking about, like, deal, because people that don't do drugs don't really know what you're going through.

Participant 2: It's kind of hard to explain to them. Especially when they judge you as well. (Red Focus Group)

Participants advocated for better recognition of their experiential expertise (i.e., the knowledge and skills acquired through the physical and social experience of substance use). They felt that the knowledge provided by lived or living experience was critical to understanding the unique needs of people who use substances (e.g., the urgent need for support during withdrawal). Being employed in the services was seen as an important recognition of their expertise. Although this is true for both virtual and in-person services, participants emphasized the importance of hiring PLLE in virtual services and supports to improve their virtual care experiences.

Including PLLE in Decisions to Develop, Evaluate and Improve Virtual Services and Supports

At the policy and health system level, participants pointed to the need to involve more PLLE in both the development and evaluation of virtual services and supports to ensure the services meet the realities and needs of members of equity-deserving populations. They appreciated being formally consulted on how to improve existing services, seeing it as a sign of respect and a recognition of their expertise.

Nothing for us, without us. So, don't have people around the table that have never experienced these things and have them make the programs and protocols that are supposed to help us. They don't understand. So, whether they've gone to school for years, or they have master's [degrees], I don't care. Not that I don't care, but that doesn't live up to my lived experience or the people's lived experience around the table. (Pink Focus Group)



In terms of service development, participants shared a lot of ideas about new virtual and hybrid services that would meet their needs. Some examples of their suggestions are summarized in the blue text box at the end of this section.

In particular, participants in one focus group collectively brainstormed a new peer-run hybrid service that they named the Virtual Hug Pub. People who do not have their own devices or internet access would be able to come to the Virtual Hug Pub, and they would be loaned the device of their choice (e.g., computer, tablet) for the duration of their visit. They would be able to access virtual care (e.g., appointment with their primary care physician or counsellor) in separate and confidential booths within the service. This place would also offer in-person first aid treatment for minor health issues as well as coffee and opportunities to socialize with other PLLE. All staff at the Virtual Hug Pub would have lived or living experience with substance use and would also have received appropriate training. They would also be able to support people in using technology. Participants described the Virtual Hug Pub as a safe and welcoming space, free of stigma and judgment, guided by the values of choice, autonomy, confidentiality, privacy, professional competence and empathy. This example highlights some essential elements that should be present in services for people who use substances and particularly for members of equity-deserving populations.

Participants' Suggested Virtual Services and Supports

- Mobile apps to access physicians, addiction counsellors and harm reduction services
- Typing or text-based services
- Addiction helpline with PLLE as operators
- Virtual peer-support groups for people in the 2SLGBTQ+ community
- Virtual services for families to address intergenerational trauma
- Phone line to help navigate the healthcare system
- Virtual resources that people could download and consult offline when they do not have regular internet access
- Safe spaces online to chat about anything (not necessarily substance-focused conversations)
- More options for virtual counselling and psychological supports
- Phone line to report providers' stigmatizing behaviours and identify their potential training needs

Fostering Equitable Access to Information About Virtual Care to Empower People Through Knowledge

Promoting Virtual Services and Supports to Ensure the Information Reaches Those Who Need It Most

Participants explained that developing relevant services is not enough. Better promoting virtual services and supports to members of equity-deserving populations is essential to reduce inequities in service access. Access to services should not be determined by individuals' capacity to navigate the healthcare system and find information. The promotion of virtual services and supports is also



essential to empower members of equity-deserving populations in finding and choosing the services that best meet their needs. Participants recommended that governments and local health authorities take more concrete actions to properly convey the information to them.

It's not advertised. So maybe something to work on is advertisement, letting people know that there are options for virtual care.... Because as of right now, little to no advertisement for online virtual care. We know there are online virtual cares. But how do we find them? How do we go about accessing them? How do you get to them? How do you contact someone on them? There's all these different questions. Yes, OK, you're making the steps to put out these apps. But you're not advertising that it's available. You're not advertising that this group is here this time, you download the app, you can message, someone will call. Like same-day counselling. It took almost six months before people really knew about that because there was no advertisement for it. (Apple Interview)

Participants emphasized that a better advertising of virtual services and supports would allow a preventive approach enabling people to ask for help before they are in a crisis rather than accessing the information when it is too late.

Like there are so many little things that can be done that nobody's doing. Like for our mental health crisis line, most of the time, the only time you're getting any information about them is if you're calling the police, or you're calling the hospital, or you're at the hospital, Then they're like, "Oh, well, you know, there's a mental health crisis line." "No, no, I didn't." Why is it not advertised more? (Apple Interview)

Using Multiple and Recurrent Promotional Strategies

Participants suggested a variety of advertising techniques to ensure those who need virtual substance use services and supports are aware of the resources available to them. Recommended advertising strategies included posters and flyers in health and community services (e.g., pharmacies, clinics, harm reduction services, community social services for homeless people); pamphlets in harm reduction supply bags; flyers in mailboxes, posters in public places (e.g., buses, utility poles); information in the newspapers, TV and radio; as well as online advertisement on social media like Facebook or YouTube.

Participants stressed the importance of using a comprehensive advertising strategy for spreading the message on different platforms to maximize the reach of information to members of equity-deserving populations who are marginalized, isolated or do not use traditional ways of accessing information.

Moderator: How do you think that information should be shared?

Participant 1: In a way, I hate to say, a way people like us are all going to see it. We don't read the newspaper.

Participant 2: Some people would see it on the news. Some people would see it on the radio. Some wouldn't. All people that come here, that got addictions, but they don't have phones, they don't have access to internet. [If they] put it in the Google Hangout too. Where else? Tweet message—

Participant 1: [Anonymized: local community services and supports for homeless and unemployed people].

Participant 2: Yes, like the [Anonymized: community social service for people experiencing criminal justice issues]. Do it like — even [at] methadone clinics and all



that ... Yeah, posters and stick them up.

Participant 1: But you've got to put them in the right places. (Red Focus Group)

Moderator: What are some ways service providers could advertise better?

Participant: Facebook. Facebook is the biggest one in the world right now. Post stuff on Facebook, the radio, the news, flyers. Like there are so many little things that can be done that nobody's doing. (Apple Interview)

Notably, several participants believed that Facebook would be an efficient means for advertising virtual services online because it is the most widely known and used social media.

When you're scrolling down through your Facebook, not that I use Facebook, but most people do, but a little ad that comes up. (Cranberry Interview)

Put up posters [on] little bulletin boards and stuff, and even online on Facebook and stuff. Why can't you make a page? If everything is so virtual now ... Facebook and all these places, why can't you make a page specifically about what's [available] — unless there is, and I don't know about it. I don't know. I'm just shooting in the dark. (Lemon Interview)

Participants added that promoting virtual services and supports through a variety of platforms would reduce PLLE's reliance on providers or people in their circle to get the information about services, thereby empowering them and fostering their autonomy.

That's the big one, is spreading the word. But if you're only spreading the word to substance users, the word is not going to be spread around because they're not going to tell their friends about these programs, because they want their friends on the drugs with them. But if you advertise it on the radio, on the buses [and] flyers, people see it more. They'll hear it more. People are always listening to the radio, watching TV and [looking at] Facebook. There's so many ways that it could be put out there and advertised more. YouTube is nothing but commercials. So, it's like, you say there's no way of it. But there's so many ways of it. It's just you're being too lazy to look into "How can I advertise this?" Yeah, because you can advertise it. You don't want to. And that's not fair to the people who need the supports. Because you're trying to say, "Oh, yeah, the supports are available." But how do we know? How does anybody know they're available? (Apple Interview)

For some participants, repeated exposure to the information was essential to meet people where they are at and give them time to think about using the services. Having the information always available would allow them to access the services when they are ready.

There's a lot of room in that [harm reduction supply] bag. A pamphlet's only a little thin thing.... Two or three more of them and with different avenues and things like that. And even if they throw it away a few times, eventually they might need to filter, like read a little bit. Yeah, then they throw that away and get it again, and actually, you never know, you may have a rough day and call it or something. (Mango Interview)

Ensuring Equitable Access to Technology Through Public Policies and Considering Technology as a Human Right

Providing Universal Access to the Internet and Computers



Participants recommended that governments provide more access to technology for equity-deserving populations. They stated that public policies should be developed to facilitate access to the internet and devices to those who are the most in need for virtual care. For example, having outstanding charges with private companies should not be a barrier to accessing low-income internet plans. Participants highlighted that access to technology should be considered a human right because it is necessary to access health services.

Having access to phone and internet, to me, is not a privilege. To me, it's a human right. Because especially with so [many] things going virtual, not being able to access these services, some of the most vulnerable people are the ones that need the most and are completely cut off from it.... So, if we could have a government plan where you have phone available and just the basic internet, so that everyone at least is starting off with, you know, the base level of some type of connectivity. (Pink Focus Group)

Some participants also suggested that substance use services could distribute or lend devices to their clients.

Maybe putting something into policy that if people are under a certain budget, a certain threshold in their income, that maybe they can avail of a cellphone for a certain amount.... Maybe if someone is going through opiate treatment or substance [use] treatment, and they opt to do the virtual, maybe provide them with the device to be returned. (Raspberry Interview)

Offering Tailored Training to Use Virtual Tools

Participants expressed the need for more training to reduce inequities related to digital literacy and help members of equity-deserving populations to learn how to use technology and online tools.

Moderator: So, let's talk about some recommendations. How can we improve virtual services for substance use? What do you think is missing?

Participant: I guess [we need] more [support] groups ... to learn how to do it [use technology]. Because most people ... don't even know what Zoom is, or what a Zoom platform is, even though it [can be accessed using] a phone number. (Cranberry Interview)

Some participants suggested that the training could take place in community services and could be dispensed by trusted service providers or by other PLLE.

Maybe community-based organizations could implement some of that into their programming. They could educate some of their guests how to use devices and stuff. So then if they want, they can avail of virtual care. (Raspberry Interview)

Another important suggestion was to implement workshops about security and privacy of online services to help people protect their private information online (e.g., preventing scams). Such training could also reassure those who have confidentiality concerns about virtual care.

I think more knowledge or like more workshops for people to understand how to use it and how to go, and that it is safe, and that it is confidential. Right? I don't think the knowledge base is out there for people. Especially for people that are using substances and that aren't really — I don't want to say in touch because that's not the right word, but in touch like with society.... That's what I was getting at with confidentiality and the safety of it, and what they think third parties can see. I think



there's a lot of [speculation] in people's mind [about] the third party. Can a third party be watching this? Can a third party be seeing this? I think there's a stigma around that. And that's something that can only be acknowledged in workshops and seminars and telling people that it is confidential, that if you get on a Zoom platform with your counsellor, it's just you and the counsellor, nobody else. I think that's why a lot of people are really wary on virtual, is confidentiality, right? (Cranberry Interview)

Ensuring that Virtual Relationships Meet Standards of Care Quality

Providing Services with Sustainable Resources to Ensure Quality Virtual Care

In terms of policy and health system changes, participants highlighted the importance of providing sufficient and sustainable funding to community-based and public healthcare services to offer virtual care for substance use beyond the COVID-19 response.

Now that like COVID's over, there's no longer the pots of money for those things.
(Purple Focus Group)

For participants, appropriate funding is essential to ensure the quality of virtual services and supports, and ensure equity-deserving populations will be adequately served.

And it complicates an already complicated healthcare situation as far as my TV tells me all over the globe. We don't provide enough money via our taxes to maintain what we have decided we need as a healthcare system. Somebody's going to fall through the cracks. That's just the way it is. (Green focus group)

Stop being afraid to put money into it. They're too cheap. They don't want to put money into it. (Red Focus Group)

Participants also recommended providing services with enough qualified staff to ensure virtual services and supports are consistently available and appropriately delivered. This recommendation was repeated in rural and semi-urban areas.

I feel like they're understaffed, and there's people there who don't really want to be there. They're there because ... the clinic is getting desperate, and they need people.
(Yellow Focus Group)

What I understood here is, particularly in this community, it was that there's two psychiatrists and they were serving thousands of patients. (Green Focus Group)

Do you know how many people have worked at crisis line at the same time? No? Maybe they need more people. (Red Focus Group)

Ensuring that Service Providers Receive Training on Virtual Care, Substance Use and Stigma

Participants considered that educating providers was one of the most critical ways of ending substance use stigma in health care. Participants recommended mandatory training about stigma for all providers who may interact virtually or in person with people who use substances, especially non-specialized health and social service professionals (e.g., medical and nursing students, primary care physicians and nurses, operators in mental health crisis lines, psychiatrists).



Participants also wanted providers to be held accountable for their stigmatizing behaviours. One participant suggested implementing a phone number where people who use substances could report stigmatizing behaviours, so that the providers could be offered further training on stigma awareness.

There should be a phone number you can call and let somebody know how this doctor made you feel. And then maybe after so many, like three or four, then that doctor can get a phone call or something to say, “Hey, is there something going on with you? Why are you making patients feel like this?” Sometimes just that little check because some doctors don’t realize that they’re making you feel like a piece of [crap]. So sometimes just that little nudge on the shoulder, nudge on the arm and say, “Hey, you realize you’re not putting off the best attitude or the best body language,” is all someone needs. But when there [are] no policies or no one there to help understand that or to give someone that little nudge, they feel like they can get away with it. They keep doing it, and they keep doing it, and they keep doing it. But if there was someone there to give them that little nudge, “Hey, you got to treat everybody with the same respect.” If police officers have to treat everybody with the same respect, why doesn’t the doctors? (Apple Interview)

Participants also emphasized the need to train providers in using virtual care tools, like video conference software and apps, to ensure they can offer appropriate virtual care to their clients.

I guess just educating people, like educating more doctors on it, the virtual care and implementing it into their practice. (Raspberry Interview)

They’re not trained to do the system for it, I guess. There’s so many different nurses and not everyone can use the machine. And that’s what they need. They all have to know how to use the machine to be able to offer the service.... A lot of training needs to be done for that. (Yellow Focus Group)

Developing Quality Standards for Virtual Substance Use Care

Most participants favoured a government regulation and standards to ensure that providers offer high-quality virtual care for substance use. Participants had diverse views of what these standards should contain. For example, some participants suggested an amount of mandatory in-person time to strengthen the patient-provider relationship, whereas others wanted mandatory video options, a minimum time requirement for video and phone appointments, or policies outlining a list of issues that should not be dealt with virtually.

Their recommendations converged on the idea that there should be policies ensuring that virtual care allows for in-depth interactions with providers to build quality relationships and adequately address patients’ health issues. Standards for virtual care could minimize providers’ variation in the level of virtual support offered and ensure providers are not the only ones deciding what type of care they offer.

Can’t build a relationship with [my doctor].... If he’s prescribing you that, there should be some professional level of relationship there for the doctor and patient to have, build something to help you get better. To me, it’s just a ... quick phone call to get the meds. (Lemon Interview)



Improving Accessibility and Creating Low-Barrier Virtual Services and Supports

Improving Service Accessibility

To foster equitable access to virtual services and supports, several participants mentioned the need to make virtual services more accessible to people living with disabilities, including visual, hearing and speaking impairments.

And to have it in accessible formats, like have it available in ASL [American Sign Language]. Have like other things available in Braille, if that's what's needed, or alternate formats and live transcripts for things like this. Or, you know, what other type of accessibility needs are we not meeting? (Pink Focus Group)

One participant explained that text-based services would be the most helpful option to access virtual care with their speech impediment. They reported that voice-based virtual services are likely to expose them to more stigma, given that providers may confuse their symptoms with the effects of substances.

Something too that I want to bring up with speaking about accessibility is for me, when I was young, I suffered from Bell's Palsy. I had it at a very young age. So, I do have some speech issues like lisp and sometimes a speech impediment. I do still there from time to time, especially if I'm nervous or really excited. And I find myself with virtual care, especially with a new doctor, I'll stutter more.... I actually had a doctor ask if I was under the influence, but it was not because of that. I just stutter because I'm nervous. And sometimes I would prefer to just type to the doctor, you know, and type to the person I'm speaking to because maybe I'm having a hard day with my stuttering. Maybe I'm on a new medication that's affecting my ability to speak. So, I'd just be able to type to the doctor, even if in a live thing with that something like an assessable thing. I think that should happen. Some people have social anxiety, all this kind of stuff. And sometimes typing is just a lot easier than having to speak. (Pink Focus Group)

Being able to bring someone else to a virtual appointment (e.g., friend, caregiver, family member) was also cited as another possible avenue to improve virtual care accessibility for people living with anxiety or disabilities.

Developing Timely Available Virtual Care for Immediate Support

More broadly, participants would like to see improvements in the availability of virtual services and supports. Developing low-barrier services without specific admission criteria that limit access would ensure that everyone can get support when they need it.

The need to develop flexible and rapidly available services was a recurring theme in participants' recommendations. They would like to be able to access virtual services and supports 24 hours a day, seven days a week to respond to their urgent needs without waitlists or wait times. They made this recommendation especially for counselling and psychological services and supports.

Access to psychiatrists over the phone —quick, quick access to psychiatrists, psychologists. (Green Focus Group)



I think counselling would be, I would like to see in the future, not like when I need a counsellor like in the moment. He's not always available to see me in the moment or talk to me in the moment. So having someone to really talk to about what's going on in the moment would be really helpful. (pink focus group)

For a GP to call and get on with you, somebody 24/7 you can call and ask questions. (Apricot Interview)

Participants provided critical recommendations to tailor virtual services and supports to their realities and develop more equitable policies and practices. However, it is essential to acknowledge that due to internalized stigma and previous negative experiences, several participants had little confidence that their opinions mattered or would be listened to. Some of them felt that it was difficult or intimidating to make policy and practice recommendations. Some others felt it was useless, had little hope for positive change and low trust in policy makers due to past experiences of stigma and discrimination. Systemic inequities can influence people's ability to add their voice to the conversation and to make their voices heard. Addressing stigma is essential to empowering members of equity-deserving populations to contribute to policy and practice change.



Discussion

This qualitative and participatory study provided original insights into both positive and negative experiences with virtual services and supports for people who use substances. Our findings showed that many members of equity-deserving populations are willing to use virtual care because of its potential to reduce stigma and positively affect their experiences with substance use services and supports. However, several systemic barriers remain, resulting in unequal access to virtual services and supports, inconsistent quality of virtual relationships with providers, and possible exposure to stigma.

This study has provided recommendations for virtual care directly from the members of equity-deserving populations. The participants' recommendations offer important opportunities to begin policy and practice changes to foster equity in virtual care experiences and empower members of equity-deserving populations accessing virtual services and supports.

Ensuring the Sustainability of Virtual Services and Supports for Substance Use

Our study demonstrated that virtual care has the potential to empower members of equity-deserving populations by giving them more control over their treatment course and daily activities. Virtual care alleviates the burden of treatment on their daily living, improves service access and prevents the stigma experienced in in-person services. Several participants expressed that virtual substance use services and supports should be made available on a sustainable basis beyond the COVID-19 emergency response.

Some recent Canadian research also suggested the strong potential of virtual care to improve the continuum of care for people who use substances, support efforts to address the drug poisoning crisis (Perri et al., 2021), and enable gender-responsive substance use services meeting the needs of women and gender-diverse individuals (Perri et al., 2022). Perri et al. (2021), recommended developing a sustainable digital health strategy for substance use by scaling up emerging programs and developing new ones. Partnerships with community members and PLLE are essential to developing a sustainable strategy that addresses equity, legal and ethical concerns (e.g., protection from sharing health information with law enforcement) (Perri et al., 2021).

Recognizing Experiential Expertise and Enabling PLLE Participation

Our study shows that involving PLLE of substance use in the development, delivery and evaluation of virtual services and supports is a key element to tailoring virtual care to the realities of members of equity-deserving populations. Participants' recommendations testify to the expertise of members of equity-deserving populations in deciding what is best for themselves and their desire to be more involved in policy and practice changes.

Our study highlights the experiential expertise of PLLE to understand the unique challenges of their peers and provide appropriate support. The involvement of PLLE in providing virtual care has great potential to improve access to services and create safe spaces that foster trust for those who face stigma. Some recent research highlighted the role of PLLE in the development of virtual harm reduction innovations, such as remote overdose monitoring (Mamdani et al., 2022; Matskiv et al.,



2022; Olding et al., 2023; Perri et al., 2023). This research supports our findings, demonstrating the unique expertise that comes from lived experience and its value in developing appropriate ways to connect and support people who use substances.

However, participants' narratives and recommendations also demonstrate that due to remaining stigma, PLLE's experiential expertise is still insufficiently recognized and used in developing policies and practices for virtual substance use care. The concept of "epistemic injustice" (Fricker, 2007) refers to "those forms of unfair treatment that relate to issues of knowledge, understanding, and participation in communicative practices" (Kidd et al., 2017). This concept describes the systematic devaluation of knowledge coming from those who face power imbalances and their unequal ability to gain the trust of others (Fricker, 2007; Kidd et al., 2017). Our findings suggest that epistemic injustice is a core component of inequities accessing virtual care, contributing to a mismatch between existing practices and the needs of members of equity-deserving populations living with substance use issues. Better recognizing the experiential expertise of PLLE and enabling their participation in their personal healthcare choices, the provision of virtual care and policy decisions about virtual services and supports are essential paths to equity and empowerment.

Using the Lens of Intersectionality in Policies and Programs to Address Complex Digital Health Inequities

Participants in our study described multiple structural barriers that affected their ability to access virtual services and supports, and develop meaningful virtual relationships with providers. Participants lived in complex situations, facing intermingling challenges related to social issues (e.g., housing, child custody, criminal justice), physical and mental health, substance use, and structural discrimination. Some of these challenges were intensified by social determinants of health, including their socioeconomic situation, gender identity and expression, race and ethnicity, place of residence (i.e., rural or urban), disability, and education level. Social determinants of health influenced:

- The accessibility and acceptability of virtual substance use services for participants,
- The participants' concerns about confidentiality and exposure to stigma,
- Their access to technology and digital literacy, and
- Their ability to navigate the healthcare system and obtain information about virtual services and supports.

According to the intersectional perspective (Collins & Bilge, 2020; Crenshaw, 1989; Hankivsky, 2011), it is essential to understand that inequities related to the social determinants of health are intertwined and interdependent (Bauer, 2014; Bowleg, 2008).

To advance equity in virtual care access and experiences, policy and practice approaches should integrate the multiple inequities faced by members of equity-deserving populations, rather than addressing each social determinant of health in isolation (Hankivsky et al., 2014). For example, participants' recommendations highlighted the need to develop targeted promotional campaigns about available virtual services through multiple platforms. This would increase the chances of reaching members of equity-deserving populations with information that is in line with their multiple realities and challenges in accessing information. Such initiatives should use an intersectional approach to address the complex and unique situations of members of equity-deserving populations.



The intersectionality-based policy analysis framework (Hankivsky et al., 2014) provides an applicable model to integrate intersectionality into the development, evaluation and transformation of health policies. This framework could guide policy makers in ensuring that virtual care policies for substance use and mental health address the intersecting factors that create barriers to virtual care for members of equity-deserving populations.

Addressing the Health System Factors that Contribute to Digital Health Inequities

Some of the most significant challenges described by participants in our study were related to health systems and policies. The detrimental effects of health system barriers could worsen virtual care experiences for members of equity-deserving populations. Insufficient funding, human resources, infrastructure and other barriers could lower access to virtual services and supports, result in poorer relationships with providers and increase exposure to stigma. These factors could in turn be detrimental to participants' substance use, mental health and overall health.

In their Framework for Digital Health Equity, Richardson et al. (2022) highlight the urgent need to go beyond an approach focused only on individual-level barriers to equity and take policy actions that address digital health inequities at the community, health system and society levels. Their research states, "disparity populations are less likely to benefit from interventions focused on individual-level determinants, as barriers, including limited resources and competing priorities, are greater in these populations" (Richardson et al., 2022).

Richardson and colleagues describe both community and societal levels of influence that should be used to foster digital health equity. These levels of influence include (Richardson et al., 2022):

- Community infrastructure (e.g., quality internet broadband access, especially in rural and remote areas),
- Healthcare system infrastructure (e.g., digital equipment at local health services and supports),
- Community technology norms (e.g., preferences for certain virtual tools in a specific community),
- Community partners (e.g., groups involved in promoting digital health equity at the community level),
- Technology policy (e.g., federal, provincial and territorial policies regulating technology development, adoption and security in health care),
- Data and design standards (e.g., standards for virtual tool accessibility to those with disabilities), and
- Social norms and ideologies (e.g., social beliefs influencing who develops and uses virtual services).

Community and society-related factors should be used to begin changes in substance use and mental health policies and programs to foster equity in virtual care access and experiences.



Developing Equity-Oriented Quality Standards for Virtual Care and Allocating Resources to Implement Them

Participants in our study were in favour of more regulation for virtual encounters with providers to ensure high-quality virtual care and to meet participants' needs for substance use and mental health support. Such standards proved to be essential in designing a national digital health strategy in other countries, like in Australia (Australian Digital Health Agency, 2020; Perri et al., 2021). During the past few years, some notable efforts have been made by provincial and territorial regulatory bodies and national health organizations to develop virtual care guidance and best practices for healthcare providers (Collège des médecins du Québec, 2023; College of Physicians and Surgeons of Nova Scotia, 2021; Newfoundland and Labrador Medical Association, 2020), including in the field of substance use (Bruneau et al., 2020), and mental health (McGrath et al., 2018). However, programs often insufficiently consider equity-related issues. Creating Canadian standards that address equity in the provision of virtual substance use care and holding providers accountable for using these standards would help improve consistency in the quality of virtual care options and ensure that the needs of equity-deserving populations are met. Drawing on the principles of cultural safety, trauma-informed care and harm reduction, the Equity-Oriented Care Framework (EQUIP Health Care & Canadian Institutes of Health Research, 2017) could offer pathways to develop standards for providing virtual substance use care that is tailored to members of equity-deserving populations.

Ensuring sustainable and equitable virtual substance use care across Canada will also require supporting service providers with appropriate training and resources. Several participants in our study recommended that provider training include issues of substance use stigma. Providers should be made aware of the detrimental effects of stigma on the health and well-being of people who use substances. Training should be particularly targeted at providers who do not work directly in the field of substance use, but who meet people who use substances in their work (e.g., primary care physicians, nurses, counsellors). Such training could be included in medical, psychology and nursing schools' curricula, and in mandatory continuing education throughout providers' career. Although the need for training in substance use and stigma awareness is not specific to virtual care, our study shows that it is even more important in virtual care settings to prevent poor forms of care in low-quality telephone encounters. In addition, it is both essential and possible to integrate compassion into virtual care training and delivery (Kemp et al., 2020).

Finally, to create the right conditions for providers to deliver quality virtual care, it is essential to address the funding and human resource crisis in Canada's public healthcare systems. Strengthening resources for virtual services and supports in public and community healthcare services is imperative to ensure consistent, appropriate and accessible virtual care. This could be achieved through sustainable federal funding for virtual substance use services and supports, which could be distributed to provincial and territorial health authorities and community services.

Study Strengths and Limitations

Using qualitative and participatory methods, our study provided an in-depth exploration of the experiences and recommendations of members of equity-deserving populations regarding virtual substance use services and supports. Equity-deserving populations are often underrepresented in large-sample quantitative surveys, resulting in a general lack of attention to equity issues in both research and policy.



Nevertheless, like any study, this one has some limitations. First, despite our best efforts, not all equity-deserving populations could be adequately represented in our study. Due to the population makeup of Newfoundland, members of racial and ethnic minorities are less represented. The extent to which our findings fully apply to them is therefore uncertain. Future studies could focus on members of these populations to ensure that virtual substance use care meets their specific needs and challenges. Studies exploring virtual care experiences and recommendations specifically for First Nations, Métis and Inuit communities should also be developed in partnership with Indigenous-led organizations.

In addition, our recruitment process did not always allow us to conduct separate focus groups with members of different equity-deserving populations. Because focus groups had a mix of people, it was difficult to identify challenges that would be specific to any specific equity-deserving population. However, as the intersectional approach demonstrates, the factors that contribute to health inequities are complex and intertwined. Many participants in our study were members of multiple equity-deserving populations at the same time, which would make a separate analysis partially irrelevant.

Finally, our study was conducted in only one part of one province to allow for a close connection with a local network of community services. Therefore, characteristics of the provincial healthcare system may have influenced some of the data collected. However, our findings are consistent with recent studies conducted elsewhere. This ensures the general validity and transferability of our findings and the potential to use the participants' recommendations in a broader Canadian and international context.



Conclusion

Our qualitative participatory study highlighted the need to promote equity in virtual substance use care and to better address the realities of members of equity-deserving populations. To achieve this goal, efforts are required at the policy and practice levels. Federal, provincial and territorial health authorities across Canada should ensure sustainable and equitable access to virtual substance use services and supports. This can be done through:

- Policies that address intersectional barriers to care,
- The development of quality standards for virtual substance use care delivery using an equity lens, and
- The strengthening of health system funding and human resources to support new and emerging virtual substance use care services and supports.

PLLE participation in the development, delivery and evaluation of virtual services and supports is essential to improving the experiences of members of equity-deserving populations and further destigmatizing substance use in virtual services and supports.



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Appendix A: Discussion Guide for Focus Groups and Interviews

General Facilitation Guidance

- Questions can be rephrased or reordered to adapt to the discussion.
- To the extent possible, always ask open-ended questions. Try not suggesting answers. Use probes when topics are not spontaneously being discussed, or to encourage participants to delve into some topics of interest.
- Do not hesitate to follow-up on a previously asked question, to reword a question if someone believes they have nothing to say about a specific topic.
- Give enough time for the participant to think and reflect so that they can answer the questions. Do not try to fill in the silences.
- If a participant becomes tangential, try not cutting them off, but rather reorient the discussion toward one of the questions when there is an opportunity to do so (e.g., when someone mentions something that could be related to one of the questions, or when there is a silence).
- For focus groups: to make the discussion more interactive, do not hesitate to ask if other participants' experiences are similar/different from what someone just said.
- Do not hesitate to make quick summaries of the discussion, this can help participants to give more details, makes sure you understood them well, and confirms to them that they have been heard.
- Use terminology that participants are most familiar with. Avoid as much as possible scientific terminology, unless someone uses it spontaneously in an interview. Avoid using stigmatizing words (e.g., abuse, misuse, addict) even when a participant is using them.



Introduction

Thank you for joining today's discussion. My name is Jill [add details re. who you are, if you want to]. I am working on this research study with the Canadian Centre on Substance Use and Addiction. We are here today to chat about your experiences with virtual care for drug or alcohol use. I would also like to hear about your ideas and suggestions for making virtual services and supports more accessible and adapted to your preferences and needs.

Examples of virtual care services and supports include video or phone appointments with a provider, mobile apps, online peer-support groups, online or phone prescriptions of methadone or buprenorphine, etc. You are welcome to talk about the services you accessed or would like to access. I invite you to use a pseudonym of your choice during the discussion.

Consent form:

- Give participant(s) a copy of the verbal consent form and give them sufficient time to read it carefully.
- After making sure participant(s) had time to read the consent form, explain each section of consent form to participant(s).
- Ask participant(s) if they have questions about the consent form, and answer their questions if needed.
- Inform participant(s) that if they need to take more time before deciding whether or not they want to participate, they are allowed to do so and will still be able to participate later.
- Read the "Oral consent" section of the consent form to ask for their verbal consent.
- If participant(s) say "Yes": start the recording.

Questions

Ice-breaking Questions:

Could you please tell us your pseudonym, and tell us, in one or two sentences:

[Facilitator asks one of the following ice-breaking questions]

- If you could be any animal, which would it be and why?
- Who is your hero? (a person that inspires you)
- What is the best movie you ever saw, and why?
- Could you tell us a word that represents you at the moment?
- What is your favourite season of the year?

[Facilitator starts the discussion by saying her first name, and answers the ice-breaking question]

Topic 1: Your Experience with Virtual Services and Supports for Substance Use

1. Could you tell us more about **how you accessed services** for drug or alcohol use during the last two years? In particular: How has the shift to virtual care impacted your access to services?

Probes (optional, depending on the discussions):



- What were the **changes** in your access to services for drug or alcohol use during the pandemic measures/lockdown? And how is it **now**?
- Have you experienced any **discontinuation** of service access? How does not having access to services **impact** you?
- How have you felt about going **back to in-person** services recently? What would you prefer (virtual or in-person)?
- How did you discuss going virtual or in person with your providers? Have you had a chance to **choose the options** that were convenient to you? (*if relevant: ask if they can describe an example of the discussions they had with their providers*)

2. Could you tell us more about **how you have been accessing and using virtual care services** for drug or alcohol use? (*note: can be before, during, and/or after the pandemic measures*)

Probes (optional, to adapt to the discussions):

- If you have continued/discontinued/never used virtual care: could you describe the reasons?
- What are the **positives and negatives of, or good and bad experiences with** virtual care from your perspective?
- Have you experienced any **issues accessing** virtual care? How have you addressed these issues (got any support?)?
- How does your **access to internet, smartphone, or computers** look like? What are/were your challenges using these technologies for virtual care (e.g., learning how to use them)?
- How are/were the relationships with providers? Are/were you **able to connect (emotionally)** with them? What are the **barriers to connecting emotionally** with the provider in a virtual setting?

3. How has **virtual care affected your daily living** (positively and negatively)?

Probes (optional, to adapt to the discussions):

- Has the switch to virtual care caused any changes to your **substance use** and substance-related risks (e.g., overdose/poisoning)?
- Has the switch to virtual care caused any changes to your **treatments**?
- Has the switch to virtual care caused any changes to your **social, family, and work life**?
- Has the switch to virtual care caused any changes to your **mental health**?

Topic 2: Your Recommendations for Improving Virtual Services and Supports for Substance Use

4. **What virtual services** would you like to access **in the future**? (e.g., harm reduction, treatment, peer-support, counselling, etc.)

Probe (optional, to adapt to the discussions):



- Which services do you prefer accessing in person and which services would you like to access virtually in the future? And why?
- 5. Can you think about **circumstances** where virtual services and supports **should not be used**, or where they may cause “more harm than good”? How can these circumstances be addressed?
- 6. How could virtual care **benefit you**?
 - Probe (optional, to adapt to the discussions):
 - How can virtual care **make services more available** to you?
- 7. How could virtual care better meet your needs and your preferences?
 - Probes (optional, to adapt to the discussions):
 - How could we improve your **access** to virtual care?
 - How could we improve your **comfort/sense of safety** when using virtual care?
 - How could we improve the **quality** of virtual care?
- 8. What would you suggest to **decision makers** to make virtual services more **accessible** and **adapted** to your situation?
- 9. What would you suggest to **service providers** to improve the **relationship** in a virtual setting?
- 10. What would you suggest to **service providers** to **help you engage** in virtual care in the **long term**?
 - Probe (optional, to adapt to the discussions):
 - What would help you to **stay committed** and motivated?

Ending Questions:

- 11. Do you have anything to add that we could have missed?
- 12. What are the most important aspects you want us to remember about today’s discussion?



Appendix B: Sociodemographic Questions

1. What gender do you identify with?

- Woman
- Man
- Gender diverse
- Prefer to self-define: _____
- Prefer not to answer

2. What is your age range?

- 19 to 29 years old
- 30 to 39 years old
- 40 to 49 years old
- 50 to 59 years old
- 60 to 69 years old
- 70 years old or more
- Prefer not to answer

3. Do you identify as a member of a racial or ethnic minority (examples: Black, East/Southeast Asian, Middle Eastern, South Asian, etc.)?

- Yes
- No
- Prefer not to answer

4. Do you identify as a First Nations, Inuk/Inuit, and/or Métis?

- Yes
- No
- Prefer not to answer

5. During the past 2 years, have you experienced any housing issues (examples: homelessness, unstable housing, etc.)?

- Yes
- No
- Prefer not to answer



6. During the past 2 years, have you experienced any financial challenges (example: “struggling to make ends meet”)?

- Yes
- No
- Prefer not to answer

7. Do you live in...

- An urban area
- A semi-urban area
- A rural or remote area
- Prefer not to answer

8. What is your experience with substance use?

- Current/ongoing experience
- Past experience
- Prefer not to answer