Vancouver Coastal Health

Promoting wellness. Ensuring care.

Family Connections

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Medical/Pharmaceutical Approaches to Substance Use Treatment

In the last few years, we have recognized more and more that we need to respond to harmful substance use not only with behavioural approaches such as counselling, 12-step programs, and the like. This Family Connections issue describes how family physicians, nurses, pharmacists and acupuncturists contribute to improving the lives of people who want to make a change in their substance use. We also have an article by a mother who talks about how she came to accept that her adult child currently needs opioids. Finally, our Family Advisory Council asks you: "If there is anything you could change, what would it be?"

Image by Josh Estey/DFAT

Sometimes supporting your loved one requires you to acknowledge that you are not able and/or capable of providing them with what they need.

Please remember that if your loved one is at risk to themselves or others, the best resources are your local Emergency Department, and 911. In Vancouver, for non-emergencies please contact the Access and Assessment Center (AAC).

AAC Contact Information

Hours: 7:30 am - 11:00 pm 7 days/week; 365 days/year

Phone: 604-675-3700

About us…

This Newsletter is brought to you by Vancouver Coastal Health's Family Support and Involvement Team. We assist families with resources, education, information, support, and with facilitating the inclusion of family in the care of their loved ones. We also work with patient and family partners to ensure that clients and families are involved in planning and decision making across Vancouver Coastal Health's Mental Health and Substance use Services. You can find our contact information on the front page.

The *Family Connections Newsletter* is available electronically, direct to your email inbox. If you don't already receive *Family Connections* via email and would like to stay up-to-date about programs and services for families who are supporting a loved one with mental illness and/or substance use, sign up at www.spotlightonmentalhealth.com

By going to this website and clicking on the Family tab you can find our ***Community Resource Guide for Families,*** Vancouver Coastal Health's Family Involvement Policy and much more.

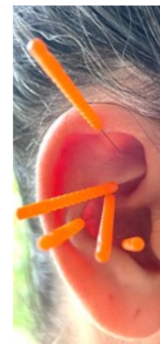
Thanks for reading!

Want to hear more about the topic of addiction? Try this podcast
https://multi-hazards.libsyn.com/the-opioids-crisis-with-guy-felicella

The opioids crisis is ravaging our communities. How can we all respond in a better, savvier way? Join Guy Felicella, addiction educator, harm reduction advocate and public speaker, and Multi-Hazards podcast host Vin Nelsen as they discuss how Canada, the US and the world can work smarter in dealing with opioids and all addiction pandemics that we face.

ACUPUNCTURE—AN ADJUNCT SUBSTANCE USE TREATMENT

By Isabella Mori



I had the pleasure of speaking with Nancy Cameron, a Registered Acupuncturist in BC and the US., who also has a Masters in Traditional Oriental Medicine.

Nancy treats clients with acupuncture in a community group setting at various mental health and substance use teams at Vancouver Coastal Health. Acupuncture is a modality approved by the WHO (World Health Organization) for substance use (including alcohol and tobacco), for anxiety and stress reduction, body pain, depression, insomnia, nervousness and PTSD.

In this distinctive setting clients sit fully clothed in comfortable chairs. The areas that are treated are the head, particularly the ears, as well as hands and arms. As the treatment's foundation, Nancy follows the NADA auricular (ear) protocol, which involves the gentle placement of up to five small, sterilized disposable needles into specific sites on each ear. NADA stands for National Acupuncture Detoxification Association (https://acudetox.com/) The treatment is effective at the early withdrawal phase for clients, helping them to manage their symptoms of anxiety, depression, anger, mood swings, grief and sadness, sleeplessness, and/or disturbed sleep from nightmares. Nancy adds that it can also strengthen their determination and willpower, facilitating their commitment to their recovery process. Acupuncture can also be useful for pain conditions and PTSD (which, for some clients, are the reasons why they began using substances in a problematic way.)

According to Traditional Chinese Medicine (TCM), a broad range of medicine practices developed in China based on a tradition of more than 2000 years, the body contains a number of micro-systems for treating the whole body; the ears and hands are two of them (reflexology on the feet is a more well known micro-system). These micro-systems mirror what is going on in the rest of the body; for example the kidneys and liver both organs involved in detoxification can be treated via the correlating auricular points. Another theoretical aspect of TCM for maintaining balance in the body is the idea that energy, referred to as *qi* or vital life force, needs to move and flow freely. In turn, physical or emotional problems are related to an energy flow that is too strong/excessive, too weak/deficient, and/or blocked/stagnant.

Furthermore, each organ has correspondences within the emotional/psychological systems.

For example, liver qi stagnation is said to manifest in irritability, mood swings, or depression - all symptoms that people in early recovery often experience. Inserting an acupuncture needle at the correct point in the ear helps to rectify the flow of liver qi, in turn minimizing or often eliminating these symptoms. Another example is the acupuncture point between the two eyebrows, yin tang, which is also known as the third eye area; acupuncture in that area helps with reducing anxiety and sleeplessness.

Nancy typically sees groups of up to eight people, in a 90 minute session. She inserts needles in each person. They then sit with the needles "working their magic" for 30 to 45 minutes.

Acupuncture is approved by the WHO for substance use, anxiety, stress reduction, pain, depression, PTSD

One of the reasons why acupuncture works so well for some clients is that they don't have to interact much with clinicians; particularly in acute withdrawal some people prefer minimal verbal interaction

The acupuncture room has comfortable, low lighting, with pleasant, soft music playing. Ideally, clients meditate during this time, which supports the efficacy of the treatment, although some may nap or just sit quietly, possibly reading a book. Nancy recommends reading something uplifting, again to support the treatment's desired effect. The acupuncturists document each client's treatment in the PARIS documentation database used by all VCH clinicians.

Clients thoroughly enjoy the treatment. They report deep relaxation, reduced stress, minimized cravings, elimination of withdrawal symptoms, better sleep, more energy, elimination or reduction of pain, improved appetite, and a clearer mind with enhanced focus and concentration. Nancy shared the experience of Grace, a competitive runner (identifying characteristics have been changed). Very early in her withdrawal, Grace was quite irritable, not particularly pleasant with the receptionist and also short with Nancy when she first arrived for treatment. As soon as the needles were inserted, she calmed down and softened. At one point she started crying, saying, "I just want these cravings to go away, and this period of my life behind me." (One of the benefits of acupuncture is that it can help one feel their deepest emotions.) At some point, Grace fell asleep. When Nancy took the needles out, Grace said that she felt amazing, " blown away" by where she went for the hour, also sharing that she had been in a dream that took her out into the universe.

Some clients in early recovery come regularly for the recommended two to three month length of time, while others may continue to come for years, and they all look forward to it. For the first two to three months it is best to receive treatment 3-5 times a week. After that, it is recommended to attend sessions as needed, for example, when clients have experienced an emotional upset or possibly a flare-up of their cravings.

Clients find acupuncture does not only help them maintain sobriety but also that it can intervene after a relapse. When people have been to acupuncture and they have a slip, they often know to get back on board quickly with acupuncture, intuitively recalling the positive, uplifting experience that it provided them.

One of the reasons why acupuncture works so well for some clients is that they don't have to interact much with clinicians; particularly in acute withdrawal some people prefer minimal verbal interaction, or otherwise simply prefer not talking at all about their substance use. In this connection, it is interesting to note that NADA points out that their name is not only an abbreviation of their association but also means "nothing" in Spanish – "no-nonsense, non-verbal, no-drugs, no barriers."

Nancy clarifies that acupuncture for mental health and substance use is not meant to be a stand-alone treatment, but rather to be part of an integrative approach along with other modalities such as counselling, dietary and lifestyle modifications, or recovery groups.

Nancy's enthusiasm for what she does is obvious the second you start talking to her. "This is so powerful. I feel most blessed to be doing this work and serving others in this way."

PHARMACISTS AND ADDICTION MEDICINE: A TRUE AND EFFECTIVE COLLABORATION BETWEEN DISCIPLINES

This is an article about George P. Budd, Pharm.D, FBCCSU, B.Sc.Pharm, RPEBC, R.Ph., Research Associate-Mental Health and Substance Use Services, Vancouver General Hospital

George Budd is the first pharmacist to complete a fellowship in addiction medicine at the B.C. Centre on Substance Use. No formal program existed for pharmacists, so he designed a program tailored to his interests. His experience is being used as the centre officially launches a pharmacy-based fellowship this month.

George became a practicing pharmacist after graduating from Cairo University in 1992, but his interest in addiction medicine sparked in 2005, when he attended a Canadian Society of Addiction medicine conference. "I had very little knowledge of addiction at that point," he said. "Prior to that, I was a dispensing pharmacist, so I had dispensed methadone, but back then there was no requirement for pharmacists to have any training in addiction medicine. Methadone was just dispensed like any other medication."

George began work for the B.C. College of Pharmacists where his expertise in addiction medicine grew, including completing a related rotation while pursuing his PharmD. He worked in collaboration with the College of Nurses and Midwives of B.C. and the College of Physicians and Surgeons of B.C. on numerous decisions to curb the opioid crisis, including contributing to the work required to allow nurse practitioners to prescribe opioid agonist treatment. Until recently, he was the only non-physician on the board of the Canadian Society for Addiction Medicine.

All his previous work was from the policy and administrative side, so in 2018, he approached the medical director of fellowship at the B.C. Centre on Substance Use to see if he could pursue a fellowship.

George set his own rotations, mirroring the other disciplines for how many hours for clinical work and research was needed. He said that he had to use all his years of connections and networking skills to secure rotations with physicians. He worked in hospitals and primary care clinics in B.C.

"When I did the fellowship, it was all under medicine. I did not do any pharmacy rotations," he said.

"What I was trying to achieve was a true and effective collaboration between disciplines," he said. "We've always spoken about how the best outcome for patients would be if different disciplines collaborate for that patient, but I had never done that and I had never seen that," he said.

If it was interdisciplinary collaboration he sought, he found it. George was in the fellowship with nurse practitioners, physicians, social workers and others. "I got a chance to see how they do it

George Budd, a researcher at VCH, is the first pharmacist to complete a fellowship in addiction medicine at the B.C. Centre on Substance Use

from their perspective, and how a pharmacist can come in with our specialized knowledge and really improve the patient's health outcome," he said.

One of the many rotations was at the Royal Columbian Hospital with an addiction medicine specialist. "I saw how a physician can see the patient and how a pharmacist can have an input," he said. He looked for areas where pharmacists can contribute to addiction care. For example, a pharmacist could help by conducting a drug use history with a new patient. They could also help with a patient's assessment of self, talking to patients about their therapeutic choices or monitoring treatment.

Pharmacists provide addiction care, can monitor for patients for problematic use, watch for unnecessary medications, work with prescribers, and steer the patient into better choices for treatment

"I was also trained on motivational interviewing; how do you get the patient to commit to the treatment, how do you identify potentials for change, how do you make a patient understand where they are on a scale of readiness to change," he said, adding that pharmacists can collect information, discuss it with the prescriber, and then bring it back to the patient. Pharmacists can definitely bridge a lot of those gaps.

He paid out of pocket to participate in the year-long fellowship. "I really believe in knowledge and education," he explained.

George believes that the healthcare system could harness the potential of pharmacists when it comes to addiction medicine. Community pharmacists not only provide addiction care, but can also monitor for patients crossing over into problematic use of substances, he said. They can watch for unnecessary medications, and work to discontinue medications that can be addictive, such as benzodiazepines. They can work with prescribers and steer the patient into better choices for treatment.

"I do believe that pharmacists are underutilized in the system. A lot of what we do in administrative," he said "The clinical part and the communication services that a pharmacist can provide are still behind—pharmacists could do a lot more."

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"This is about saving lives. We know people take drugs. We don't have to condone it but nor should we judge people or bury our heads in the sand. It's our job to do whatever we can to help people make informed choices about the risks they're taking."

From https://harmreduction.tips/

DR. DEVIN TUCKER, ADDICTIONS MEDICINE SPECIALIST

Interview by Isabella Mori

What do you do as an Addiction Medicine specialist?

I am a family doctor with a speciality in addiction. I am certified with the American Board of Addiction Medicine (https://www.abam.net/.) I became interested in this field because I spent some time working as a doctor in remote communities in Ontario and BC where patients had difficulties with substance use but there were few services for them. When I returned to Vancouver, I had more encounters with patients suffering from addiction, and decided to pursue further training. Now I practice at some of VCH's mental health and substance use teams, at Richmond Hospital, the START team at home detox program, and a longer-term supportive recovery program. We try to meet patients at various stages of recovery, and thereby avoid them "slipping through the cracks".

Mostly I work with patients who use opioids. When I first meet with them, I try to find out what path they wish to take. Since they are seeing me, it will often be medication or a combination of medication and other treatment approaches.

The medications I prescribe are typically long-acting replacements for highly addictive illicit drugs like heroin, fentanyl, or carfentanyl. Each of the prescribed medications, or Opioid Agonist Therapies (OAT), occupies the brain's opioid receptors to prevent withdrawal symptoms and reduce cravings for illicit use. Most often, these medications are taken daily, and carefully titrated to each person's needs.

Suboxone is administered orally, and contains buprenorphine and naloxone. Buprenorphine is the active portion, and naloxone is only added to prevent misuse by injection. Once a person is stabilized on suboxone, they can now choose to switch to a newer formulation called Sublocade, which is injectable under the skin on a monthly basis, and therefore can be easier to take reliably.

Methadone is another option, and is taken in liquid form. A third option is Kadian, a slow-release form of morphine in tablets. In some cases, hydromorphone tablets are prescribed in addition to OAT, to assist a patient in reducing their need to consume the poisoned illicit drug products while their doses are adjusted.

For patients suffering from alcohol use disorder, naltrexone or acamprosate may be indicated to help reduce heavy drinking and alleviate cravings for alcohol; the older medication disulfiram, also known as Antabuse, is still used in some select patients.

I became interested in this field because I spent some time working as a doctor in remote communities where patients had difficulties with substance use but there were few services

When I speak with families, I try to shed some light on the steely power of the substances their loved ones are dependent on

What do your patients find the most helpful?

Most of my patients have experienced a great deal of stigma, as well as negative interactions with the healthcare system. They may be reluctant to engage. I find it important to meet with each person without signalling any judgment, to "meet them where they are." Then they often open up, and we can build trust.

One of the surprising things that have come out of Covid are the opportunities telehealth has opened up. Contacting people via phone or over Zoom often feels less restrictive for patients as there is no need to show up physically at a specific time, which is helpful for people who have been unstable for a long time, have to travel long distances by public transit, or who are having a hard time staying organized.

Patients are thankful when I even briefly check in with them over the phone. All of this can contribute to fewer lapses in using the prescribed medication.

Do you also talk to clients' families?

Sometimes I do, but I can only discuss a patient's specific situation with the patient's full consent. I am professionally bound to respect the patient's' autonomy and privacy. Furthermore, sometimes patients may have experienced abuse from a family member, or have been the subject of negative judgments or stigma from family members. I think we humans all aspire to exert iron-clad "willpower" in our decisions, but this can be overemphasised in some situations. When I speak with families, I try to shed some light on the steely power of the substances their loved ones are dependent on, and how they may change the brain to focus almost solely on attaining more of this substance. Most people have heard someone relate the story of a long-established ex-smoker deciding to take "just a puff" of a cigarette, in a social setting, and then fully relapsing to heavy smoking. In the case of nicotine, it only takes 15 seconds for the addictive pathways to be reactivated.

We humans are a species of learned, repeated, patterns, it goes with our ability to build habits. However, fatigue, anger, frustration and most importantly pain, whether emotional, psychological, or physical, can drive addictive habits with negative consequences in anyone, but so much more so when other factors are also at play, such as past trauma, or the overwhelming potency of substances like fentanyl.

What is the most helpful thing a family member can do?

Be patient, but don't give up.

Recognize that relapse is part of addiction; it is not a sign of failure. It is understandable that many family members want for the addiction to be extinguished and for everything to go back to normal, however, unfortunately, it's not always so clear cut. Recognize small changes, be accepting and open, and most of all, stay away from judgment because that usually just makes things worse. Judgment and the shame that comes with it create pain, and the reaction to pain for the addicted person is all too often to reach for their substance of choice.

“YOU KNOW WHAT’S ALWAYS WORKED – OPIOIDS”

This is the story of Petra Schulz, as recorded by Isabella Mori. Petra is one of the co-founders of Moms Stop The Harm https://www.momsstoptheharm.com/, a network of Canadian families impacted by substance use related harms and deaths.

Petra Schulz at a TEDx talk

Opioid Agonist Treatment For The Second Time

Substance use is often not an isolated situation. In our case, we first lost our youngest, Danny, in 2014, to an accidental fentanyl overdose. Our oldest, Millie, was also using substances and was on opioid agonist therapy (OAT) with Suboxone for several months. They tapered off but a few months later started to use again. Their second try with OAT was with methadone and they stayed on that until they became stable. This worked for Millie for several years, but they were still struggling with their underlying mental health issues and trauma, including being autistic, undiagnosed ADHD and being a non-binary person growing up in the wrong body. During Covid, it became really, really challenging for them to cope with the social isolation. These challenges were at a crisis point and Millie and I were talking about their difficulties. They said, “You know what always helped.” I knew what the answer was. Opioids.

The thought of street drugs was frightening for me. But I knew that the psychiatric medication that had been prescribed for them wasn’t helping. That conversation with Millie was a difficult process to work through, and I eventually understood that to be safe they needed to go back to OAT. They agreed that would be helpful. Fortunately, they found support for that, with Kadian (see page 7) and now with a combination of Kadian and Oxycodone.

As a family member, I hadn’t realized they could go back on OAT when they were at risk of using street drugs again. I thought you had to be used to go back on OAT. Altogether, the options are better now than before. For example, Kadian was not an option for Millie when they first thought of treatment.

OAT alone is not enough

When Millie and I had the conversation, one of the things to think about was once they had tapered off the methadone, they had achieved more personal freedom. These medications tie you down – to a pharmacy, to a physician. For example, Millie won’t be able to visit us for Christmas. And for a moment, it felt to Millie like that they had failed. But I said I don’t see it that way, but that it shows strength instead. It was really the right thing at the right time. I don’t know why we have such a difficult time with prescribing opioids – we have no problems with psychiatric medication. I’ve heard from so many people that opioids are the only thing that helps. Society and health care professionals need to listen to that. “You know what always worked” – that’s what Millie said,

I don’t know why we have such a difficult time with prescribing opioids – we have no problems with psychiatric medication

so why not just go back to it then? Of course, it's not perfect. Millie still needs trauma care; the trauma doesn't go away but life becomes more manageable again, especially now when people are isolated with Covid.

When Danny relapsed we didn't know how to respond. With Millie, I had learned to listen to them, and to believe them when they said "you know what always worked." I'm so glad I know now that OAT is available even in a preventative way without the person having to use again. Thankfully, Millie is in BC because it would probably be more difficult to get a prescription for Kadian in Alberta, where we are from – it would need a brave prescriber.

I deal with my fear by talking to fellow moms

Fear, anxiety – and anger

There was and is so much fear and anxiety. When Danny used, we were always afraid that he might die, and then it happened. You can imagine how you feel, having another child who uses substances. You know what the consequences could be. Several families at Moms Stop The Harm have lost more than one loved one. There is this constant fear, how it could take another child. It is hard to describe, like strangulation, makes it hard for me to breathe, and I have a knot in my stomach. That's why it was such a huge relief when Millie went on OAT again, I call it prophylactic treatment.

I deal with my fear by talking to fellow moms. I also have good allies in academia and healthcare. It was good hearing from physicians who practice addictions medicine, and to have the uncertainty resolved – yes, OAT is a good idea. When I have the fear and anxiety it is also mixed with anger that seven years after Danny's death, Millie is facing greater risks. It's easier to deal with anger, though. I can channel it into advocacy. The fear, I have a good counsellor I can go to. I went to her for trauma counselling after Danny died. Before you lose your child, you have lost them a hundred times. Detox, relapse, detox, relapse; dropping out of school, breaking up with the love of his life – all this trauma you deal with. You're the walking wounded by the time your child dies, you're in bad shape. That makes it even harder to deal with loss and the worry about your other child.

From overprescribing to correct prescribing

As a society, we've gone from one extreme to another – from Oxycodone for a teenager with wisdom teeth extraction when that's hardly necessary, to a doctor taking someone with chronic pain off opioids, driving them to the street – both wrongful prescribing. We shouldn't focus on overprescribing, we should focus on correct and incorrect prescribing, prescribing the right medication for the right person at the right time with the right dose. But some are still unwilling to take on patients like Millie or others who need safe supply.

There needs to be greater awareness. People think once a person is off drugs, they're off for good. We have lost so many members who have been using for a long time, experienced users, who didn't make it when they used again. Plus, Covid cut back some harm reduction, health and social programs. There needs to be more education and awareness. If you feel you need the help it should be there for you, like managing diabetes. If a person can manage it with diet and exercise, but then they hit a rough patch and take insulin again, we don't say, don't take the insulin. When it comes to substance use, it is still morally driven rather than good evidence-based decision making. Drug poisoning is a controllable risk that we have solutions for. We just fail to implement them.

WHAT DOES AN ADDICTIONS NURSE DO?

From an interview by Isabella Mori with Jenny, an addictions nurse at a VCH mental health and substance use team

I start the day with meeting with my colleagues at our interdisciplinary team and a check-in with the fellow addictions nurse, Sonya . There may be a client in hospital or with a recent Emergency Room visit that we need to check in on.

Currently, we are fortunate to have three addictions doctors on the team, all working in the office from Monday to Friday. Because I am still fairly new to the team I sometimes do joint appointments with the addictions doctor, especially if I feel I need to get to know the client better or have concerns I would like to bring up as a team. Also, it obviously helps a great deal to have a face to the name, rather than just a voice over the phone.

To prepare for the next day clinic, we conduct a medication check on the pharmaceutical database Medinet to see if doses received are consistent with the dosing as prescribed. Pharmacies generally let us know when medications have been missed but mistakes happen, so we double check. This is important. For example, if a person missed three days of Kadian (see page 7) you can't continue with the same dose, you have to go to a lower one again. My colleague and I also make sure that prescriptions are up to date. That is imperative as the expiry dates for narcotics prescriptions are usually very close to clients' appointment times with little leeway for extensions by the pharmacies. That includes safer supplies like Dilaudid.

When a client comes in for a clinic appointment, we usually ask for a urine test. Normally, we send those to a lab but sometimes we do a rapid in-house test. That test is not 100% accurate but it gives us a good amount of information to work with. Quick access to the results could impact whether medication or treatment may need to be adjusted. Also, sometimes a client may have used recently and may want to know if their products were tainted. For example, did their product contain benzos when that was not what they had wanted to buy?

We never use urine tests as punishment; rather, we are simply looking for perspective on how to treat and educate.

We never use urine tests as punishment; rather, we are simply looking for perspective on how to treat and educate. Sometimes we call in people for random urine tests if we need to have a clearer understanding of their drug use. Sometimes the care plan says a urine test should be done at a specific time. Also, the BC Centre for Substance Use's *Guideline For The Clinical Management Of Opioid Use Disorder* (https://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf) suggest regular urine screening according to specific schedules for certain types of treatment.

Our clients' experience ranges from complete abstinence to full relapse . We take a harm reduction approach. Some clients are completely abstinent, and others are abstinent for a while but then something happens and they use again. Our goal is to always help them get back on the road or recovery.

As part of being holistic in my practice, I also want to know how a client is doing overall. We have access to client health databases like EMR and PARIS so some of this can be checked easily for help-

ful information like whether there have been hospital visits or housing problems. I come from a mental health and case management background and feel strongly that we need to look at all aspects of someone's life. I personally find it hard to separate mental health and addictions. I always believe they go hand in hand.

We are starting to have our clients do more in person visits to get some face to face interactions. It is good to be able to see their demeanour. Are they well kempt, sleepy, anxious, do they show withdrawal symptoms, signs they have been using? What's their body language, eye contact? How are they coping? Even whether they show up or not is useful information.

Communication by phone has become very common during the pandemic . We also have a designated substance use nurse cell phone that we use as another form of communication to text clients for appointment reminders or text them for a quick check in.

We also do Naloxone training. We give out kits to any clients or families that would like one and make sure that anyone with an opiate use history has a kit, or refresh it if theirs has expired or has been used.

It's important to include family as part of the recovery circle

Another thing we do is Sublocade injections (see page 7.) More and more clients are choosing to go that route. It is administered once every 28 days, so the person doesn't have to go to the pharmacy all the time. It's freeing for clients, especially for people who are working or are otherwise busy. That was new to me coming into this job from Manitoba but it's a really good option.

Recently, I did an outreach visit and gave a Sublocade injection in the client's private driveway. She was rushing off to work and I had everything right there with me.

We also do referrals to other resources within the team – counselling, groups, acupuncture, mental health, support for their family. I share some clients with case managers. It's great to be able to just walk down the hall and collaborate. In those cases, we try to coordinate things and have clients come in to see the addictions team and the mental health team on the same day. We also try to work with clients' family doctors, or try to connect them to one if they don't have one. RAAC (the Rapid Access Addictions Clinic located at St. Paul's) is another service that we have close ties to. And then of course we promote groups such as SMART Recovery or Alcoholics Anonymous, or, if the client is interested, treatment facilities.

Depending on family dynamics, it's important to include family as part of the recovery circle. I'm thinking of a little success story: The client lived with her grandparents, and the grandparents were deeply affected by the substance use. There were so many issues, including the client using various substances, and using the Emergency Room multiple times. The police was also involved. The family was at their wits' end and in crisis a great deal. It was pretty chaotic. The team organized a family conference via zoom where the client agreed to go on Sublocade, and to have more frequent involvement with our team. We also referred her to counselling. Initially she only went because everyone wanted her to but now she he continues to attend even though she does not have to. Baby steps to small successes! We've been able to build a much better relationship in the last few months and the crisis and chaos have calmed down.

As mentioned before, I work with Sonya, another addictions nurse . She was working solo for some time so it was a lot of work for one person to manage. I've gained a lot of knowledge since starting here in April and continue to learn every day! It is great to have a cohesive team to work with. Our leadership team is absolutely fantastic, one of the best teams I've worked on so far. I always feel supported and have great guidance.

VANCOUVER FAMILY ADVISORY COMMITTEE (FAC)

A Partnership of Families with Vancouver Coastal Health & Substance Use Services

"Being a member of the Family Advisory Committee has helped me understand how mental health and substance use services are structured and delivered. This has helped me advocate more effectively for my son. Being a part of implementing strategies to improve family involvement and engagement, seeing growth in family support and services because of the effort of the FAC has been rewarding and has provided me with many personal benefits that more than balance the commitment of time and effort. The work of the FAC is helping to ensure better services for my own and other families in the future. It's good to be a part of that." *FAC member, Pat Parker*

Who Are We?

We are Vancouver parents, siblings, adult children and friends of those living with serious mental illness and substance use. We are individuals with lived experience. We are community agency representatives, Mental Health/Substance Use professionals, and the VCH Family Support & Involvement (FSI) team. Together, we are the Family Advisory Committee, The FAC provides a strong family perspective to improve services for our loved ones, and expand communication and supports for caregivers and families.

The FAC formed out of a desire to not only dream change, but participate in it as well. We wanted families to partner with mental health and substance use services alongside our loved ones, and out of this need for change came the Family Involvement Policy – used throughout VCH to encourage family engagement. We wanted to bring opportunities for education to those supporting loved ones and out of this need for change came the Annual Family Conference – a coordinated effort by FAC members and VCH that brings invaluable learning to families on this journey. As individuals, we see many areas where change is needed to support our loved ones with mental illness and/or substance use challenges. Together, we can turn our hopes into reality. Come imagine change with us!

"My nephew's first episode of psychosis about 12 years ago was the start of a journey like no other. It would have been impossible to navigate the extremes of confusion and despair (both with his illness as well as with the healthcare system), without the help of other families going through what we were. Finding like-minded, passionate, and caring people in the FAC has been wonderful. I so appreciate how much the FAC has been able to achieve since it started, and I'm excited to join their efforts and be a part of making things better for deserving people like my precious nephew." – Lisa Kofod, FAC member

"If there was one thing I could change"…

How would **YOU** answer that question? What change, as it relates to mental health and substance use, would you like to see? It could be something that improves the quality of life for your loved one, or makes your life as a caregiver smoother, or changes the vision of health care for the future or…

If there was one thing I could change it would be better access to the services that are needed to have my ill relative assessed and treated.(SC)

If there was one thing I could change, it would be to establish intense programs to help our loved ones transition from acute care to community mental health teams. (PP)

If there was one thing I could change it would be the criteria for admitting someone experiencing psychosis into hospital. Even someone in psychosis still knows the "right" answers to give to avoid hospitalize tion. (JD)

If there was one thing I could change, it would be the stigma that "ill people are stuck in denial" and promote a vision for recovery for everyone through persistent motivational discussions with peers, family and professionals. (CA)

If there was one thing I could change, I would expand supports for independent living/better transition from hospital to community living – and supportive housing. (HH)

Join the conversation! Email your thoughts to: VancouverFAC@vch.ca

We're always looking for new members! Want to learn more? https://www.spotlightonmentalhealth.com/vancouver-family-advisory-committee/

Suicide prevention

You didn't cause the illness!

Common medica-tions

And more!

TIDBITS from the Family Connections Support Group

In this column, we list selected resources we have discussed in our regular Family Connections Support Group (see next page). Let us know what you think!

The website for World Suicide Prevention Day and their initiatives:

https://www.iasp.info/wspd2021/

Examples of Safety planning apps:

- HOPE by CAMH
- Be Safe by mindyourmind

- "Coping with suicidal thoughts" document: *Copies of this document can be downloaded at no cost from the B.C. Ministry of Health, Mental Health and Addiction website (www.health.gov.bc.ca/mhd) or from the Consortium for Organizational Mental Health (COMH) website (www.comh.ca).*

The 4 C's – you didn't cause the illness, can't cure it, can't control it – but can cope with it with compassion

https://www.spotlightonmentalhealth.com/no-cause-no-cure-no-control-but-coping-with-compassion/

Common psychotropic medications, which are medications that affect how someone thinks, behaves, and relates to the world around them:

- Patient counselling materials from VCH Pharmacy Services: https://one.vch.ca/dept-project/lower-mainland-pharmacy-services/pharmacy-services-vancouver/vch-patient-counseling-materials-va
- CAMH website on common medication therapies for MH and SU: https://www.camh.ca/health-info/mental-illness-and-addiction-index?query=*&facets=filter_tags:FBE2D610F63F4BB0A530F89F7899D21F

Some additional resources mentioned:

Our website where you can see our (Family Support & Involvement Team) contacts: https://www.spotlightonmentalhealth.com/family-involvement/

How to refer to VCH Community Mental Health services, which should typically go through the Access and Assessment Centre (AAC) at (604) 675-3700: http://www.vch.ca/your-care/mental-health-substance-use/community-mental-health-services

Car 87 (Mental Health Car) which is a partnership between VPD and VCH. It can be reached via the Access & Assessment Centre at 604-675-3700 or 911: https://vpd.ca/police/organization/investigation/investigative-support-services/youth-services/community-response.html

The Family Connections Support Group

The ***Family Support and Involvement Team*** has a support group for family and friends of individuals with mental illness and/or substance use concerns. The group is co-facilitated by a Family Support & Involvement Coordinator and a family member.

We aim to create a welcoming and supportive space in which family members can share their experiences with each other and feel supported and strengthened in their efforts to help their loved ones. The group has a small educational component. Participants also receive twice-monthly emails with the contents of the educational part.

Like many other resources during COVID, we have moved our groups to ZOOM meetings. Family and supporters are free to attend on a regular basis or drop in as needed, like in our regular meetings. If you would like to receive an invite to our Support Group, please contact us and we will happily add you to our invite list!

We meet online on the following days & times:

DATE: Every first Thursday and third Monday of the month

TIME: 6:00 – 8:00 p.m.

PLACE: In the comfort of you own home

**We do not meet on STAT holidays.*

Contact Tao-Yee Lau at taoyee.lau@vch.ca for the zoom link

"Whatever you are struggling with, there are others out there who understand."

MORE FAMILY SUPPORT GROUPS

PLEASE CALL/EMAIL AHEAD TO CONFIRM DATES AND TIMES

Parents Forever – Support group for families of adults living with addiction. Group meets weekly via Zoom on Friday evenings. Contact Frances Kenny, 604-524-4230 or fkenny@uniserve.com

Holding Hope— peer led bi-weekly support groups for families affected by their loved one's substance use challenges. Connected to Moms Stop The Harm. Currently held via Zoom.
Email: canadaholdinghopenational@gmail.com

SMART recovery meetings for families are back!. Tuesdays 6:00-7:00pm, https://smartrecovery.zoom.us/j/91012011101 Meeting ID: 910 1201 1101

BC Schizophrenia Vancouver Family Support Group - for family members supporting someone with serious mental illness. Please contact the Vancouver Manager @ 604-787-1814 or vancoast@bcss.org for more details on the online group and to register.

St Paul's Hospital Family Support Group- Support for families who have a loved one living with mental illness. Groups take place on the last Thursday of every month from 6-7:30 over Zoom.
Please pre-register at 604-682-2344 local 62403.

VCH Eating Disorder Program – Family & Friends Support Group – for friends and family members of individuals living with an eating disorder. Contact Colleen @ 604-675-2531.

Borderline Talks - for individuals living with Borderline Personality Disorder (BPD) or Traits, and their loved ones. Zoom group every Wednesday at 7. Check https://bpdsupportgroup.wordpress.com/finding-help/

Pathways Serious Mental Illness (formerly Northshore Schizophrenia Society) - weekly online support groups, and family to family education sessions. For more information on the next support group: https://pathwayssmi.org/monthly-support-groups/.