Vancouver CoastalHealth

Promoting wellness. Ensuring care.

Family Connections

JULY 2024-EDITED BY ISABELLA MORI, SARAH LALLY, AND TAO-YEE LAU

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B.C. Centre for Substance Use Conference

The 6th BC Centre For Substance Use Conference May 31st to June 1st 2024 was a province-wide conference held by health care providers, researchers, community agencies, and persons with lived and living experience. Two Family Support and Involvement team members and a Vancouver Family Advisory Committee member attended. This edition of the newsletter gives a small taste of the conference – new provincial plans for substance use care, a new harm reduction program at the Segal Centre, interviews with conference presenters, and more.

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). If you or someone you know needs withdrawal management supports call Access Central. Information for both is provided below:

AAC Contact Information:

Hours: 7:30 am - 10:00 pm 7 days/week

Phone: 604-675-3700

Access Central information:

Hours: 9 am-7:45 pm 7 days/week

Phone (toll free): 1866-658-1221 (Voicemails left after hours are answered the following morning)

AAC Address: Joseph & Rosalie Segal Family Health Centre, 803 West 12th Avenue, Level 1 (at Willow between 12th and 10th)

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Territorial Acknowledgement

Vancouver Coastal facilities lie on the unceded and occupied lands and waterways of the fourteen First Nation communities of Heiltsuk, Kitasoo-Xai'xais, Lil'wat, Musqueam, N'Quatqua, Nuxalk, Samahquam, Sechelt, Skatin, Squamish, Tla'amin, Tsleil-Waututh, Wuikinuxv, and Xa'xtsa.

To find out more about the Indigenous land you reside on one option is the website native-land.ca

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!

Vancouver Family Advisory Committee (FAC)

A Partnership with Vancouver Mental Health & Substance Use Services

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.

If you feel inspired to join our efforts, or simply want to learn more about the FAC, please check out our webpage.

Website: https://www.spotlightonmentalhealth.com/vancouver-family-advisory-committee/

To connect, email us at: VancouverFAC@vch.ca

We're always looking for new members!

NOTES FROM THE CONFERENCE: by Carol Anderson, Family Advisory Committee Member

Peers

- Persons with lived and living experience (PWLLE) are leading research projects, stepping up as keynote speakers, advocating for system changes, and contributing to policy.
- Peer support of folk struggling with Mental Health and Substance Use (MHSU) is unpaid or underpaid.
- There is a burden of loss from poisoning deaths and a need to address peer guidance and compassion fatigue.
- When two peers in a northern community call 60 people daily and deliver medication twice weekly, there are 53% fewer deaths. For deliveries 5 days a week, there are 91% fewer deaths. They witness use of safe supply for around 30 people.
- There is acknowledgment that the safe supply is not necessarily the person's drug of choice.
- The concern about safe supplies being resold rather than used for personal consumption is somewhat mitigated by reports that in over half the cases, clean drugs are being shared with friends who are more in need (in withdrawal) rather than being sold to strangers.
- Some peers do a night walk, waking everyone they find sleeping to confirm they are fine.

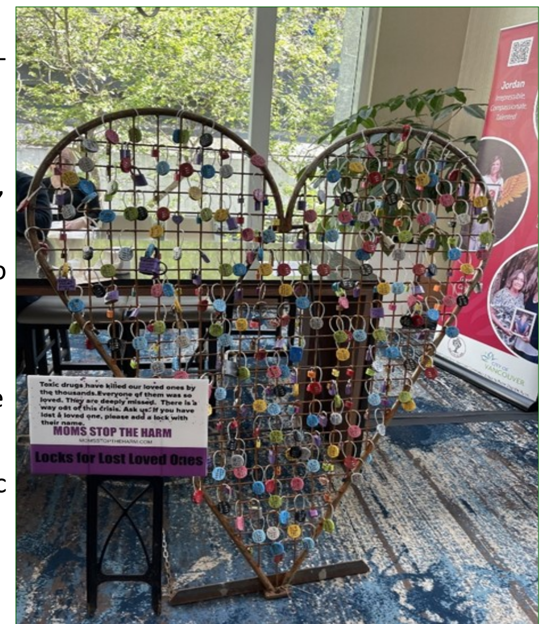
"Recovery is about survival. It should be fun, I should want to come back"

Youth and the term "Recovery"

Some Youths find the word "recovery" feels impossible, full of pressure to fix things with no room for missteps. Instead, they prefer words like "feeling or getting better." "For me, recovery is not about the drugs." "Recovery is about survival. It should be fun. I should want to come back." "Return to use" is preferable over "relapse. Many adults define "recovery" individually. It no longer refers exclusively to abstinence.

An Indigenous Lens

Almost every presentation had an Indigenous lens, whether through an Indigenous keynote speaker or a panel with an Indigenous elder, youth, or 2-spirited person. We heard about atrocities, oppression, discrimination, racism, intergenerational trauma, and forced sterilizations. There are an estimated 10,000 unmarked graves of children who were buried without family on the residential school grounds. They succumbed to malnutrition, TB, and abuse. Historical genocide continues today with disproportionate poisoning deaths of Indigenous people (6-fold). Indigenous women are dying at 12X the average rate in the toxic drug crisis.



Locks memorial hosted by Moms Stop The Harm

We were invited to honour the loss at several memorials, including closing a lock with their name on it. We saw newspaper advertisements to buy Indigenous children for $10 during the 60's scoop (forced adoption). To the incremental progress in responding to the Calls to Action from the Truth and Reconciliation Commission, Sliammon Elder Elsie Paul replies; "All our relations, we are in it for the long game."

One elder sought common ground by illustrating how Star Wars and The Mandalorian offer the "Who has loved us into being? Culture is medicine. Medicine is culture." Dancers told us their stories, ceremonies. Songs are sacred, with some protected for private use. Yet the medicine that heals you is the medicine for all the people.

A dedicated space was provided for ceremony and healing, including cleansing cedar brushings and blanket wraps for protection and courage. The conference was an opportunity to learn from Indigenous knowledge.

Quotes

"Wounding and healing are not opposites. They're part of the same thing. It is our wounds that enable us to be compassionate with the wounds of others. It is our limitations that make us kind to the limitations of other people. It is our loneliness that helps us find other people or even know they're alone with an illness. I think I have served people perfectly with parts of myself I used to be ashamed of."- ***Rachel Naomi Remen, MD***.

"How we walk with the broken speaks louder than how we sit with the great." "White people typically avoid black (brown) space but black (brown) people are required to navigate white space as a condition of their existence."- ***Elijah Anderson.***

"I think I have served people perfectly with parts of myself I used to be ashamed of" - Addictions Doctor, Naomi Remen

A BLUEPRINT FOR AUTHENTIC ENGAGEMENT

Written by Isabella Mori

As Carole Anderson notes in her article on pages 3 & 4, a thread woven throughout the conference was the importance of including the voices of people affected by substance use – people with lived and living experience and their families. A memorable presentation about this topic was by the BC Coalition of Organizations by and for People Who Use Drugs (a list of members of the coalition can be found here https://www.impactabby.com/judicial-review/) They developed a Blueprint For Authentic Engagement Framework specific for people who use drugs. It could be used across the board, for everyone who uses healthcare services (collectively I'll call them 'affected communities' below.) Some of the ideas are already enshrined in VCH's Community Engagement team. Below is a shortened version of the blueprint.

Recognize affected communities as experts in their own experience

1. Inclusivity

Establish formal structures within organization to ensure representation from diverse backgrounds, across all decision-making bodies, committees, and advisory groups. Develop targeted outreach strategies that prioritize marginalized groups. Develop inclusive language and communication strategies.

2. Co-Creation

Foster collaborative partnerships between affected communities, policy makers, researchers, and service providers to co-create solutions and interventions that reflect the lived experience and needs of affected communities. Prioritize their involvement in the design, implementation and evaluation of programs/services that affect them. Use participatory research methodologies. Foster mutual respect. Acknowledge and address power differentials. Recognize affected communities as experts in their own experience.

3. Ongoing Feedback

Implement regular evaluations, including real-time feedback loops that enable rapid responses. Demonstrate tangible response actions. Establish formal and informal channels for soliciting feedback from affected communities. Regularly review and analyze data to identify trends, gaps, etc. Cultivate trust and transparency by updating affected communities on how their feedback has been used.

4. Capacity Building

Invest in training, development and mentorship for affected communities to enhance their skills, knowledge, and leadership capacities in advocating for meaningful change. Provide resources and funding to organizations led by affected communities engaged in advocacy/community organizing. Promote opportunities for affected communities to share their expertise and lived experiences. Foster a sense of community and solidarity among affected communities by creating spaces for peer support, mutual learning, and collective actions.

5. Systemic Change

Advocate for policy reforms and institutional changes that prioritize the rights, dignity and well-being of affected communities. Challenge structures that perpetuate tokenism. Challenge institutionalized stigma. Advocate for reforms that promote equity and justice. Make sustainable changes to discriminatory practices. Engage in strategic alliances and coalition building with diverse stakeholders, including policymakers, researchers, healthcare providers and community organizers/organizations.

For people who use drugs specifically, the Blueprint also calls for advocating for policy reforms that prioritize the human rights, dignity and agency of PWLLE, including the decriminalization of drug use.

A NEW ROAD TO RECOVERY

Written by Isabella Mori

Dr. Seonaid Nolan, clinician scientist at the BC Centre on Substance Use gave a presentation on streamlining substance use services province-wide. Some salient points:

- There is no single road to recovery. Recovery means something different to everyone.
- Among 9 Canadian provinces, drug toxicity is the 4th most frequent cause of death and the leading cause among those 10-59 years old, despite alcohol remaining by far the most used substance
- The way forward is through a combination of primary prevention, early intervention, harm reduction, safer supply, decriminalization, treatment and recovery, individualized care plans, and aftercare support
- We are moving from a disjointed system to a seamless, integrated substance use system of care
- This will be accomplished through increased treatment capacity and improved operational efficiency through system integration and redesign.

- Vancouver Coastal Health and Providence Health Care withdrawal management beds (e.g. Vancouver Detox, R2R at SPH) have now one single “front door” with Access Central
- In April 2024, 1891 calls were made to Access Central. 20% requested withdrawal management. 94% of those were clinically assessed and received same day care
- In the fall of 2023,the new model for Access Central was implemented, the first R2R 14 bed withdrawal

We want to move from a disjointed system to a seamless, integrated substance use system of care

management unit opened at St. Paul's hospital, and 20 new transition beds were contracted with community service providers.

- In the fall of 2024, an additional 11 bed withdrawal management unit will open at St. Paul's hospital and the 20 transition beds will move to St. Paul's hospital. In 2025, 50 new in-patient treatment beds will open.
- Providence Health Care is in the process of developing a team of aftercare clinicians to support patients following stabilization from substance use as they integrate back into community. Aftercare clinicians support clients longitudinally (up to 5 years) to work towards their goals including, longer term housing, vocational training, addressing legal issues, re-establish supportive networks, navigation of substance use services, and more.
- PHC is working in partnership with Coast Mental Health to create 26 short term (up to 12 months) aftercare housing units.
- A Provincial Addiction Recovery Treatment and Support network (Prov-ARTS) was formed, similar to what currently exists for other chronic conditions such as cardiac, renal care. This group is working towards a provincially coordinated system of care with common standards of care, ensuring that substance use services can be accessed anywhere, and care plans following patients if/when they move.
- There is an ongoing need for increased collaboration between health care and other government sectors such as housing and employment.
- The R2R program at St. Paul's will be evaluated quantitatively (statistically) as well as qualitatively (interviews, etc.), including the views of persons with lived experiences and their supporters. Special attention will be given to the voices of Indigenous persons, women, perinatal populations, and youth. These evaluations will form the basis of creating R2R throughout BC.

In-Hospital Take-Home Naloxone Training

A Project by Farinah Kadir, Clinical Nurse Educator, RPN, BScPN

Farinah Kadir

As part of BC's efforts to reduce deaths due to toxic drug poisoning, this project was undertaken at the Segal Centre to increase distribution of take-home naloxone kits ("kits"; also known as NARCAN kits) and to provide education to staff, patients and families on the use of the kits. Discharge from hospital is a particularly risky time for people who use substances; ensuring clients have kits and training is an important intervention to decrease this risk.

Methods – How Was This Done?

The project was planned with the leadership of the hospital unit where the pilot project was held. Training was offered to patients and other interested parties who had the cognitive ability to participate. Group-based training for kits was conducted every Friday, twice a day, over a 6-week period, including essential skills such as opening glass ampules, preparing syringes, and administering intramuscular injections and using retractable needles. The training included all substance users, moving beyond the traditional focus on opioid users, as well as including individuals that are not using substances, but want to be able to help if the need arises. Patients completed brief pre and post surveys to measure the effectiveness of the training as well as the likelihood that participants would take home a kit upon discharge or going on authorized leave from the unit.

Results – What Happened?

A total of 17 participants completed training, two of whom took the training more than once. When asked if participants intended to carry a kit upon leaving the unit, 16 said yes, 2 said no and 2 were unsure. The amount of kits dispensed rose more than 3-fold, from 5 kits in the 6 weeks prior to groups being held to 17 kits in the project's duration. Anecdotally, the impact of the training sessions expanded beyond patients learning about kits to sharing personal experiences regarding to overdoses and engaging in meaningful discussions about the broader implications of substance use. The experiential approach empowered patients to feel confident in their ability to respond to an overdose effectively.

Recommendations – What Should Happen Now?

- In-person, hands on approach for effective training: this can be done in small group settings to reduce time requirements and foster a sense of community among participants.
- Dedicated staffing for training: contributing to consistency and ensuring high-quality service delivery.
- Expand training audience: broaden the scope of training for anyone interested, regardless of their substance of choice.
- Equitable access: offer training to everyone regardless of their presumed risk or need.
- Alternative formulations: provide alternative training to people who may face challenges with injectable naloxone.

Following these recommendations, these training groups are now becoming a regular feature at Segal Centre.

Offer take home naloxone training to everybody, regardless of their presumed risk or need

Navigating Systems of Care: Challenges and Recommendations

By Isabella Mori and Ashley Cole

The conference hosted a world café guided around the theme *Navigating Systems of Care*. Breakout groups facilitated discussions on the healthcare experiences of people with lived and living experience (PWLLE) with substance use, families and caregivers of PWLLE, Indigenous-focused care perspectives and improving the system of care. Co-Facilitators were Jenny McDougall, Co-Founder & Peer Navigator, CSUN; Correne Antrobus, Family Navigator, Mom's Stop the Harm; Keshia Cleaver, Harm Reduction Program Advisor, First Nations Health Authority; Ashley Cole, Community Engagement Lead, BC Centre For Substance Use; and myself, Isabella Mori. Below are excerpts of the findings, in three parts: A. The current experience of Families and PWLLE; B. that of Indigenous PWLLE; and C. Recommendations.

A. Families and PWLLE: What has been your experience navigating systems of care?

People who use substances and those that support them focused on ongoing challenges preventing access to care, largely due to a lack of services, providers, and funding, and a health care system that is system centered, not client centered. Large gaps remain within and across systems of care. Inconsistencies in services across the province, especially outside of urban centres, increase these challenges. Existing services remain siloed, with no interconnecting network, and no province-wide framework to effectively support British Columbians to move between services.

Families are often tasked with being default navigators, providing transition services and follow up care as those services are often not readily available to patients within their healthcare settings. When first needing to access these services, knowing where to start can be overwhelming, and the experiences of ongoing stigma as well as being third parties to a patient's care make families' roles uniquely challenging. Many of the comments mentioned by families overlap with those made by PWLLE.

Families are often tasked with being default navigator, providing transition services and follow up care

Quotes *"The system isn't broken; we don't have a system", "The system overwhelms people", "[I shouldn't need to] use my role as a healthcare professional to help navigate my own family", "What is easy about navigating the system of care?" Everyone present: "Nothing."*

Examples of barriers

Access:

- Few outreach services
- Having to go to multiple services to get needs met
- Pharmacy access: limited service in many regions as well as for individuals who are banned from their pharmacies and have nowhere else to turn
- The 'hot potato' effect of being passed around from service to service without receiving the care needed
- Not enough supports for unhoused individuals. There remains a great need to bring services to people, not people to services
- Rural access - limited or no cell & WIFI services. Reliance on landlines makes access to care limited and disconnected.

Communication / Information:

- Too much information to navigate causes confusion; at the same time, service providers are unaware of resources and therefore not connecting patients to them
- Not feeling listened to
- Lack of rapport/meaningful relationships with health care providers – e.g. providing explanations for decisions, supporting patients to make informed decisions
- Families advocating/navigating dismissed by providers

Other:

- Lack of early intervention; often individuals only access help when things have progressed to a more serious level
- Additional challenges for individuals with co-occuring conditions (polysubstance use, mental health, etc.)
- Inadequate discharge planning
- Insufficient culturally safe service delivery

B. Indigenous-Focused Care Perspectives

Indigenous people attempting to navigate healthcare services face the same barriers to access as others, with the added challenges that stem from having to deal with Indigenous-specific racism, or navigating colonial institutions that conflict with Indigenous healing methods. What services do exist are often based in urban settings, leaving large gaps in services in rural and remote areas.

Healthcare settings remain impacted by ongoing colonial harms

- Unfriendly/ inaccessible hospital care that frequently conflates health issues with substance use, making it uniquely difficult for Indigenous patients to seek treatment for either
- Treatment remains primarily clinical in focus. Limited referrals to holistic care such as prescriptions to culture, land, teachings, community
- Intake systems are very western and colonial, making them inaccessible for many (ex. forms/ paperwork, internet access, literacy levels, forced intimacy without trust building)
- Non-status members don't get access to the same services as status members. Limits support to those 'unattached' to their nation's services due to colonial notions of 'status.'

Limited services available

- Provider shortages cause a struggle to connect people to care
- While some hospitals have Indigenous liaisons, these are very limited positions and not all healthcare providers are aware of them or make it part of their regular practice to refer people to them
- Need sustainable funding across organizations
- Where Indigenous services do exist, barriers remain (e.g. being remote and needing transportation)
- Many supports only offered during 'business hours'

Need referrals to holistic care such as prescriptions to culture, land, teachings, and community

Lack of continuity of care

- Hard to learn which resources are available in different nations (example: 54 in Northern BC)
- Lack of communication between systems (FNHA/regional health authorities) and local nations and communities. "How do these systems work together?"
- Different healthcare systems are inconsistent and variable, between service providers, health authorities, offering quality and consistent care can be challenging.

Rural and Remote Services

- Existing barriers are amplified in rural and remote contexts with significantly less access to harm reduction, treatment, pharmacy, and recovery services and programs compared to more urban areas
- New services/funding are often funneled into urban areas, leaving insufficient access for rural/remote communities, often forcing them to travel to urban settings (e.g. for detox)
- Limited access to public transportation to get to appointments, pharmacy, etc.
- Limited infrastructure such as internet and cell services
- High staff turnover in rural and remote communities
- Limited to no outpatient services
- Increased experiences of stigma, discrimination, and racism

C. Recommendations: What are examples of improvements needed?

Healthcare Staffing

- Constantly pulling staff from one pilot to another, never adequately hiring across programs only redirects the problem, it does not solve it
- Enough staff for individualized and follow-up care

More PWLLE & Indigenous liaison roles in all service settings

- Emergency rooms: dealing with security, informing patients of services available to them (harm reduction, treatment, and recovery), advocating for the patient's rights
- Medication delivery: helps stabilize patients when they have extra care and supports where they are
- Transportation: clients to appointments, pharmacy, etc. Example: Peer-based 'safe ride' services.

Interdisciplinary, integrated collaboration

- There are opportunities to learn from each other and streamline work. For example, oncology uses a good model of care that includes families, peers, and physicians
- Documentation platforms - should be the same across the province and accessible across the province. "Everyone calls the same service something different"
- Wellness and health services beyond the clinical. "It's not just about throwing pills at someone. It should involve holistic care."

Build out more youth services

- Need to significantly improve services for youth: prevention, harm reduction, treatment and recovery.
- Youth services are needed across the province, not just in urban centres
- The design and implementation of youth services should be done in partnership with youth

A response to the challenges of Indigenous populations, as outlined above

“Just Anything They Need” – A One-Stop Program In Quesnel Saves Lives - By Isabella Mori

I had the privilege of a conversation with Jenny McDougall from Quesnel, Founder of the peer-led Clean Team (a team that cleans up drug paraphernalia and litter, now run by the City of Quesnel), Co-Founder of Coalition of Substance Users of the North (CSUN), founder of Prescription Alternatives and Peer Advocacy Program (PAPAP). Jenny tells us that she lives, works and plays on the unceded traditional and ancestral lands of the Lhtako Dene Nation, colonially called Quesnel in the Cariboo Regional District of B.C.

She learned a lot in AA “but just didn't fit into the clique there; I was harassed because of my methadone use”

What brought you to becoming an activist in this area?

25 years on the street with substance use disorder. About twelve years ago, Jenny almost died from HIV/AIDS. She was laying in an alley in Surrey, so weak that she could hardly wave an arm to flag down an ambulance. Because of a staph infection, her legs were paralyzed for six weeks. She was “sick and tired of it” and didn’t want to die. Her life was saved four times by an OPS (overdose prevention site) and ambulances in Vancouver. She eventually got on Methadone and returned to Quesnel to reunite with her children. She spent four years in AA where she learned a lot, changed her way of thinking and gained control over her life “but just didn’t fit into the clique there; I was harassed because of my Methadone use.”

In Quesnel, she met Charlene Burmeister. Together they founded the Coalition of Substance Users of the North (CSUN) of which Charlene is now the executive director. It just began with a few meetings but then they applied for and received funding and opened the first OPS in Quesnel, a city of 23,000.

What happens at the OPS in Quesnel?

Supervised consumption and overdose prevention sites are safe spaces to use, where overdoses are prevented, for example through checking street drugs for their contents, esp. fentanyl, and others can recover from overdoses. Quesnel has two OPS sites, run by peers from CSUN, and one that is run by staff from Northern Health. The CSUN OPS also sounds like a community centre. They serve food, have bathroom services, free WiFi, movie nights, TED talks, arts and crafts, a dudes’ club, a women’s group, give out free toiletries, etc.

Prescription Alternatives and Peer Advocacy Program (PAPAP)

Jenny also founded PAPAP, which delivers OAT (opiate agonists like Methadone, Naloxone/ Buprenorphine, Kadian) to those with a prescription but who struggle to make it to the pharmacy daily. This program was started during the height of Covid, when it was hard for people to access medication. She fought for it to continue; she and her Indigenous partner now work with five doctors to deliver medication to people who might otherwise miss doses.

The program is a pilot; Jenny hopes it will be continued. “But if they stop it, I would just drive people to the pharmacy. It would just take more time” and they wouldn’t be able to take the medication in the comfort and safety of their own home.

In their advocacy role, Jenny and her partner work closely with doctors and other health care staff, are in constant communication with mental health teams, go to shelters, etc. They also support

Jenny also provides a lot of one-to-one support for families who are struggling to understand their loved ones substance use.

those who wish to go into detox or treatment facilities, and help with housing. Communication with other programs is key. Jenny and her partner help with issues concerning probation, problems relating to child custody and the Ministry of Children and Family Development. They let them use a phone when the person doesn't have one. They take people to the food bank, to the emergency department or court appointments, and advocate for them there – "just anything they need." Says Jenny, "when I was where they are at right now, if it wasn't a one-stop service, I just gave up."

"I wasn't expecting it to be so successful," Jenny says. She mentions a report by Dr. Bonnie Henry (see references below) who expresses that this type of program should be available throughout the province. When a person gets safe supply 2-3 times a week, the chance of death is decreased by 64%, and if it is 4 or more times, the chance of death decreases by 91%. Since Jenny started her program, no-one who participates in it has died because of the toxic drug. Before, some of them had overdosed daily. In the beginning, none of the people in the program had housing; now almost 90% do.

How do you work with families and friends?

If Jenny has permission from the person, she can tell families how their loved one is doing. Jenny knows how important that is for families; she has two adult children who use substances. Jenny also provides a lot of one-on-one support for families who are struggling to understand their loved one's substance use. Families often tell her how helpful that is; they had never thought about substance use from the point of view of their loved ones. This being a small community, families often ask whether Jenny has seen their loved ones. Jenny suggests a lot of resources to families, including AlAnon and Moms Stop The Harm. When their loved ones are in the correctional system, they connect them and their families to resources such as Unlocking The Gates Society https://unlockingthegates.org/. Occasionally, Jenny has had lunch with families, or facilitated a meeting with the family and their loved one.

What are you biggest challenges?

Advocating for people is never easy, particularly in a small community. Jenny knows how important her relationship is with all the community partners, and speaking up for the person so that their needs are met needs to be done diplomatically "but I have to speak up when something is unjust." Another challenge is that people who are not housed can have tents by the river but that sometimes interferes with the Department of Fisheries and Oceans.

What are your dreams?

Jenny would love to have a big house, maybe eight bedrooms, to be able to offer accommodation to people as they transition to their own independent living situation. She'd like better treatment services: for example, people newly on methadone often take some time to adjust to it, during which time it may be difficult for them to fulfil expectations most treatment places have. And of course she'd want total decriminalization and for substances to be regulated, and an end to the drug war.

References:

A review of Safer Supply Programs in BC https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/a-review-of-prescribed-safer-supply-programs-across-bc.pdf, esp. p 22

An Alternative to Unregulated Drugs https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/special-reports/alternatives_to_unregulated_drugs.pdf esp. p. 60

Isabella Mori Wins BC Centre for Substance Use Award

By Jen Glasgow

On May 31 and June 1, more than 1,100 people from across BC and Canada attended the BC Centre for Substance Use 6th annual conference, which centered on the theme "From Idea to Implementation."

During the conference awards ceremony retired Family Support and Involvement Coordinator Isabella Mori was presented with the “Family Support and Advocacy Leadership Award”. Isabella was presented the award by last year’s recipient Leslie McBain, co-founder of Moms Stop the Harm.

Leslie had the following to say in her presentation:

This award honors individuals who have significantly advanced the interests of families affected by substance use and addiction in British Columbia by reducing stigma, supporting advocacy and education efforts, and providing leadership to families and their loved ones. This year's recipient is honored for her decade long tenure at Vancouver Coastal Health where she has transformed perceptions within the health care community regarding the vital role families play in substance use care. Through her editorial work on the Family Connections newsletter she is known for her thoughtful interviews and focus on empowering families as they navigate challenges. She co-facilitated the Vancouver Family Connections support group and innovated both a drop in community Q & A group and Expert Talks to ensure that families have access to reliable and accurate information and support. Her advocacy work has reduced stigma and empowered families to move forward with more confidence and knowledge. Her impact and invaluable support extends beyond retirement as she continues to connect with families and loved ones.

Isabella’s acceptance speech included:

I want to dedicate this award to one person and to one group. The one person is my father. He was a brilliant artist, and he was a very wise and funny man. He also lived with bipolar disorder and used just about any substance and behavior under the sun (and because he was creative, he made a few more). I was very lucky that I grew up in the 50s and 60s and for some reason my family never kept it a secret that my father was dealing with these things. And so, I grew up without the burden of these things, which is very unusual. In my work with families, I know that in the majority of the cases there exists stigma of all forms and people cannot talk about the experience that they're having… I also think of my brothers and sisters all over the world and especially in BC, who are using substances in unhealthy ways and who don't have families or whose relationships with their families are broken. For them I wish that those who lost their relatives and who are without family find and enjoy chosen families and that those whose relatives are still alive are blessed to heal what is broken. We all need each other, and it takes a village.

Congratulations to Isabella on this important and distinguished recognition. We are so lucky that you have been and continue to be part of our family support and involvement team.

Tidbits from the Family Connections Support Group

By Tao-Yee Lau

This edition's Tidbits include a selection of resources and information that we discussed in our VCH MHSU Family Connections Support groups.

Variety of Local Resources:

CMHA Get Set & Connect Program, as well as Open Door Group

- **Website:** https://www.getsetconnect.ca/ **and** https://www.opendoorgroup.org/
- **Description:** When people are getting better, it can still take a little while until they are ready to work full or part time. Sometimes volunteering is a good step, or getting more engaged in recreational activities. The above organizations can help. Open Door provides both employment and volunteer/leisure services.

Variety of Educational Tools:

Concept of "Stigma by Association" impacting family members of those with serious mental illness (York University study, 2023)

- **Website:** https://www.yorku.ca/news/2023/04/27/at-least-one-in-three-family-members-of-those-with-serious-mental-illness-feel-stigmatized/
- **Description:** Researchers describe the stigma felt by family members themselves as an under-discussed public health issue.

Buddha's Five Things to Consider Before Speaking

- **Website:** https://brightwayzen.org/five-things-to-consider-before-speaking/
- **Description:** Conflict communication. I mentioned the Buddhist ideas about "right speech." I've found these communication guidelines helpful, especially in dicey or potentially dicey situations. Is what I am about to say:
    - factual/true?
    - necessary/helpful?
    - spoken with kindness and good-will (that is, hoping for the best for all involved)?
    - spoken gently, in a way the other person can hear?
    - timely (e.g. is this the best time to say this? Would it be better to wait?

Book Suggestions:

The Trauma of Everyday Life by Mark Epstein

- **Website:** https://www.goodreads.com/book/show/16158591-the-trauma-of-everyday-life
- **Description:** Mark Epstein, M.D., argues that trauma is an indivisible part of life and can be used as a lever for growth and an even deeper understanding of change. When we regard trauma in this way, understanding that suffering is universal and without logic, our pain connects us to the world. A family member shared she found this helpful in accepting the journey of her family and loved one.

Websites, Resources, Books, recommended reads!

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 the Family Support and Involvement Team for the Zoom link at:

familyconnections@vch.ca

"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

SMART Recovery meetings for families are back! Tuesdays 6:00-7:00pm, https://smartrecovery.zoom.us/j/91012011101 Meeting ID: 910 1201 1101; Also search for a local meeting here: https://meetings.smartrecovery.org/meetings/location/

BC Schizophrenia Society Family Support Groups - for family members supporting someone with serious mental illness. Local listings of BCSS support groups across B.C. regions can be found here: https://www.bcss.org/support/bcss-programs/family-support-groups/. You can also contact the Coastal Manager @ 604-787-1814 or coastmanager@bcss.org for more details on the groups and to register.

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 Sunday at 4pm. 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/weekly-support-groups/

Pathways Clubhouse Chinese Family Support Group – Catered to Chinese-speaking (Cantonese and Mandarin) individuals and families, who are caring for a loved one with mental health issues. 2nd Saturday of each month from 1:00pm to 4:00pm via Zoom. Part 1 (1:00pm-2:30pm) is a free talk delivered by a guest speaker and Part 2 (2:45pm-4:00pm) is a Heart to Heart Support Group Sharing. Additionally the 4th Saturday of each month has a face to face support group at the Pathways Clubhouse. Contact Lee Ma at Lee.Ma@pathwaysclubhouse.com or 604-761-3723 for details.

Alcoholics Anonymous— Support groups for individuals looking to stop problem drinking. Local meeting locations can be found here: https://www.aa.org/find-aa