STRONGER TOGETHER

Community Priorities to Address Issues Related to Substance Use and Addiction in Island Health Authority

Findings from Family-Led Dialogues in Victoria, BC
November 28-December 1, 2018

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Stronger Together: Navigating the Personal Impacts of Substance Use
COMMUNITY DIALOGUES SUMMARY REPORT
Victoria, BC | Nov 28-Dec 1, 2018

We gratefully acknowledge the communities and nations on whose unceded territories these events took place, including the Lkwungen (Songhees and Esquimalt) and W̱SÁNEĆ (Tsawout, Tsartlip, Pauquachin, and Tseycum) Peoples.

INTRODUCTION

Background

In the context of the provincial illicit drug overdose crisis over the past two years, too many communities have been personally and tragically affected by drug-related harms. There is an urgent need for stakeholders impacted by a public health crisis of this magnitude to lead and inform overdose response and substance use treatment initiatives. The family members of people who use drugs, in particular, are an important, but undervalued, resource for the health system. They hold a wealth of knowledge on how the system can be improved to support their loved ones, particularly those who are at highest risk of fatal overdose (people using alone due to stigma). Similarly, bereaved families have substantial insights on what systemic improvements could have prevented their loved ones' deaths. However, families have historically been excluded from key decision-making in our province, particularly around substance use services.

Stronger Together is a series of family-led dialogue and learning sessions taking place in eight communities across British Columbia in 2018-19, in partnership with local and regional stakeholders. The primary objectives of the project are to:

1) Mobilize family and service provider knowledge to identify local challenges and barriers for people who use drugs, inform service provision, and improve pathways to treatment and care in Island Health and across British Columbia.
2) Build resilience and increase family members' capacity to support their loved ones by offering tools and resources and fostering local connections.
3) Build local community capacity to support families impacted by addiction and the overdose crisis through the delivery of learning sessions for people interested in running support groups.

In collaboration with Island Health Authority, Victoria, BC was selected as one of the eight host communities. Stronger Together will also be hosted in Nanaimo, BC in 2019.

This report is a culmination of the wisdom and insights offered by families and service providers in Victoria, BC. We hope that what follows will lead to the development of locally-relevant, actionable solutions within each of your systems, in partnership with these key knowledge holders.

Process

We convened six groups in Victoria. This included four dialogue sessions (2.5 hours each):

1. Families whose loved ones are actively using
2. Families who have lost a loved one to substance use
3. Indigenous families affected by substance use
4. Service providers interfacing with people who use drugs and their families

And two learning sessions (8 hours each):

1. Family Support Group Facilitator's Learning Session – for people interested in hosting support groups for families who are coping with their loved one's addiction
2. Grief & Loss Support Group Facilitator's Learning Session – for people interested in hosting support groups for families navigating grief and loss due to substance use

Each group committed to a set of community guidelines for engaging in dialogue:

- Make space, take space.
- Take breaks to support your wellness.
- What we say here, stays here. What we learn here, leaves here.
- We listen to learn rather than to respond or react.
- We gather in a spirit of mutual support and respect.

Host Agencies

The **British Columbia Centre on Substance Use (BCCSU)** is a provincially networked resource in British Columbia with a mandate to develop, implement and evaluate evidence-based approaches to substance use and addiction. The BCCSU's focus is on three strategic areas including research and evaluation, education and training, and clinical care guidance. With the support of the province of British Columbia, the BCCSU aims to help establish world leading educational, research and public health, and clinical practices across the spectrum of substance use.

The **British Columbia Bereavement Helpline (BCBH)** is a provincial leader in providing education, support, advocacy, networking, and information resources for the bereaved, their caregivers, and professionals. The BCBH is committed to assisting the bereaved and their caregivers in coping and managing grief, and recognizes the unique factors that come with a sudden death due to substance use. In addition to a 24-hour helpline, the BCBH provides support programming for the bereaved and training for community members to establish support groups.

Moms Stop the Harm (MSTH) is a network of Canadian families whose loved ones have struggled with substance use or have died from drug-related harms. MSTH aims to advocate, educate, and expand supports for families affected by substance use. We call for an end to the failed war on drugs and embrace an approach that reduces harm and respects human rights.

The host agencies partnered closely with **Island Health Authority** to plan, implement, and identify recommendations and next steps following these sessions, including those relevant to the Island Health services. We also partnered with the South Island Community Overdose Response Network (SICORN), hosted by **AIDS Vancouver Island**, in planning and co-funding these sessions.

A Note on the Definition of "Family"

We acknowledge that not all families are biological or nuclear. To quote Island Health Authority, "Family, specifically family in relation to out-patient substance use service, was in all cases understood as being **defined by the person accessing services**."[1]

[1] McCune S., Pauly B., VanBoven, S. (2017). Disrupting Standard Mode: A Big Picture Story of Family Inclusion in Substance Use Services. Retrieved from: https://www.uvic.ca/research/centres/cisur/assets/docs/report-family-inclusion-substance-use-services.pdf

ACKNOWLEDGEMENTS

BCCSU, BCBH, and MSTH would like to sincerely thank the Province of BC through the Overdose Emergency Response Centre and Community Action Initiative for their significant contribution of $75,000 to make these events possible across British Columbia.

The organizers also wish to thank the following individuals for their key contributions to these events in Victoria, BC: Stephanie McCune and Kristine Douthwright from Island Health Authority for their in-kind contributions, commitment to utilizing community feedback, and overall support and partnership; Jon Rabeneck from First Nations Health Authority for their leadership, guidance, and partnership; Nancy Murphy for their event coordination, facilitation, and meeting support; Alison Gear for their facilitation of the learning session; Jenny Howard and Parm Matharu for additional facilitation and meeting support; Katrina Jensen and Shane Caldler from AIDS Vancouver Island for their financial contribution to the events and planning guidance; Judith Conway for contributing their beautiful artwork; and Jocelyn deMontmorency from Canadian Mental Health Association – BC Division for offering sustained supports to individuals interested in hosting support groups in the Victoria area.

Most of all, thank you to the participants who shared their deeply personal stories of struggle, grief, and loss, and inspiring us with your visions of a better system.

OUTPUTS

Participants

Total number of participants: 31

General demographics

Dialogue session: Families with loved ones in active addiction

Date: Wednesday, November 28, 2018
Participants: 13
Identified as:

- Parent (x7)
- Grandparent (x1)
- Sibling and person who uses drugs (x2)
- Did not identify (x3)

Dialogue session: Families who have lost loved ones to substance use

Date: Thursday, November 29, 2018
Participants: 10
Identified as:

- Parent (x6)
- Sibling (x3)
- Did not identify (x1)

Dialogue session: Indigenous families impacted by substance use

Date: Thursday, November 29, 2018
Participants: 0

We are thankful to the First Nations Health Authority for their leadership in planning this session for the Tsawout First Nation. Unfortunately, due to marketing issues, no participants attended this session.

Dialogue session: Service providers supporting families

Date: Friday, November 30, 2018
Participants: 13
From a variety of service organizations, including:

- Supportive recovery homes
- HIV/AIDS service agency
- Employment services centre
- Shelter home
- Indigenous services agency
- Hospice and grief support agency
- Addictions clinic

Learning session: Coping Families Support Group Facilitation

Date: Saturday, December 1, 2018
Participants: 8
Identified as:

- Parent (x5)
- Sibling (x1)
- Service provider (x2)

Learning session: Grief and Loss Support Group Facilitation

Date: Saturday, December 1, 2018
Participants: 6
Identified as:

- Parent (x3)
- Sibling (x1)
- Service provider (x2)

Resources distributed

- 200 “Gone Too Soon” grief support handbooks distributed
- 200 “From Grief to Action Coping Kit” family support handbooks distributed

OUTCOMES

- Family members and service providers received new tools and resources to enhance and/or establish support groups in Victoria.
    - Connections were made between learning session participants and CMHA-BC staff. As a result:
        - 4 people were provided the opportunity to pursue further training to enhance their skills as support group facilitators.
        - 1 person received support (through in-kind space, training) to establish new support group for racialized youth who use drugs and have lost loved ones to drug use.
- Family members and service providers received new tools to support themselves, one another, and their clientele.
    - Handbooks were distributed and discussed.
    - After learning about them, service providers and community members who participated in the sessions ordered more handbooks online to distribute to their clientele.
- Family members were connected with support groups in their local area.
    - Most participants were previously not aware of support groups in their local area and connected with *Healing Hearts* and *Holding Hope* as a result.
- *To come:* Feedback from the dialogue sessions will be shared with health authority leaders. Impacts from these discussions, including changes made, will be reported.

WHAT WE HEARD

Each session was guided by three questions:

1) What's not working well?
2) What's working well?
3) What are your highest hopes and biggest wishes for your community?

The facilitated discussions surfaced a number of priority areas, challenges, and hopes for the future. Insights from participants appear throughout the report in italicized quotes.

Dialogue session: Families with loved ones in active addiction

Date: Wednesday, November 28, 2018

Summary of Key Issues

Guided by the question, "What's not working well?", participants identified eight main issues impacting their lives and the lives of their loved ones:

1) Limited and hard-to-access information for patients and families
   - Providers not sharing crucial information with caregivers at point of discharge.
     ("No one at the hospital warned me that seizures were a side effect of the medication. [My son] had a seizure in the shower that night. It was horrific to experience.")
   - When asked, providers refused to share information.
     ("He survived an overdose and they called me to pick him up. They wouldn't tell me what was in his system, despite me asking multiple times. As his caregiver, I need to know what might happen to him before I take him home.")
   - Unclear directions, and lack of updated information, from service providers.
     ("Last time I called 211 for shelter, they kept referring me to places that were already full. They don't have the updated information. By the end of the call, they told me to go to a 24-hour restaurant for the night. I ended up having to find a shelter on my own, and I did."
     "I'm tired of searching. I just need a roadmap with clear directions. I just want to sit face-to-face with somebody who gets it, ask them what to do, and do it.")

2) Lack of early intervention and prevention
   - Need to treat the trauma before the addiction.
     ("[My daughter] should have received trauma counselling 5 years ago before her addiction started. Finally, she's getting it now.")
   - Poor health currently a requirement for treatment, instead of prevention.
     ("He had to overdose three times until he could get in [to mental health and addictions]. Can't we let patients in when they present?"

"They wouldn't treat her unless her pee test came out hot. She had to risk overdosing just to get treatment.")

- Many of the participants shared that their loved ones started using as teenagers. Missed opportunities for intervention at that stage.

3) Gaps to seeking recovery
   - Not enough services for people with no fixed address. Patients who are not BC residents have trouble accessing detox.
   - Need to close down flop houses immediately. Too many treatment centres with negligent and/or untrained staff and very little programming for residents.
   - Waitlists are too long, and require people who are very sick to call every day just to stay in queue.

     ("I didn't have a phone when I was trying to get into treatment. The system is made for people like me to fail.")

4) Structural barriers within the health and social system
   - Barriers to accessing housing.

     ("I lined up at the housing office with my kid and fifty other people. It was snowing and freezing. There were mothers with babies. Dealers were selling to people in the line. But Housing didn't allow more than two people in their office at a time despite there being space in the waiting room. When we finally got there, the staff was rude and dismissive.")
   - Limited access to public phones for marginalized people. Ability to communicate with your support network is necessary for survival.
   - Limited services when for youth turning 19.

     ("By cutting her off once she turned 19, they're assuming she's an adult. She sure as hell was not an adult. There needs to be follow-up for young people with addictions.")

5) More supports needed for concurrent disorders
   - Programs that require patients to have a certain amount of "clean time" before accessing mental health services need to remove this entrance qualification. Whole person needs to be treated, not just one part.

     ("I'm not sure if his drug addiction or schizophrenia came first. Almost everyone I know with a drug addiction also has a mental disorder and they need to be treated for both." "The treatment centre wouldn't let her in because they said they couldn't treat both her addiction and her eating disorder.")

6) Silos in service delivery
   - Frustrating and exhausting to repeat story over and over, i.e. to police, social worker, etc.
   - No continuity of care for youth who are turning 19.

7) Stigma from providers
    - Patients with addiction are treated completely differently than patients of another disease.

        (*"She's in recovery and no longer using, but when she went in to get treated for anorexia, the doctor asked her, 'Do you have TB? HIV? Are you still engaging in the unsavoury behaviour [sex work] you did before when you were seeking money to buy drugs?' These are questions I [the mother] would never be asked.")*
    - Lack of compassion and sensitivity among police, front-line providers, and other health care providers when interacting with patients and families.

        ("I ended up in the hospital for attempted suicide. As soon as they saw my drugs, their attitudes completely changed. The nurse said right in front of me, 'She probably tried to kill herself because her parents didn't buy her what she wanted.'"

        "It was years ago, but to this day she still remembers the paramedic saying, 'She's hurting my back. What a waste of life.'")

8) Burden on families and caregivers
    - Oftentimes there is a pattern of generational drug use within the family. There needs to be more supports for the entire family unit to heal in order to prevent a vicious cycle.
    - High financial toll of supporting a loved one in active addiction.
    - Broken relationships a common theme within families affected by drug use.

        ("We have no retirement fund. We're getting a divorce. This has destroyed our family big, big time."

        "I found it easier to walk away from all of my relationships than to explain."

        "I can't handle the stress anymore. I'm 55 but I look 80.")
    - Families often experience the dilemma of allowing their loved ones to stay home, but risk destroying the family or "enabling" the person, or kick them out, but risk their safety.
    - Exhaustion.

        ("Both of us left our full-time jobs just to keep him alive, and still, we need a 3rd parent so we can shower and rest.")

Summary of Positives

Guided by the question, "What's working well?", participants identified several positives that they would like to see more of:

1) Opportunities to gather in mutual support with other families

    ("This is my best support right here. I need a weekly group like this." – Participant who did not have a regular support group.

    "My support group is what saved me. So many weeks go by where I feel like I'm surviving from one meeting to the next." – Participant who had a regular support group.)

2) Providers who offer tools to families on how to navigate a complex system

3) Moments of hope

("Having to go to the pharmacy every day to pick up my script serves as a stark reminder of where I was and where I am now.")

Highest Hopes and Biggest Dreams

Following the discussion of what is and is not working, participants engaged in a solutions-focused brainstorm and offered suggestions for change and future steps.

1) Families as partners in health care decision-making

("I would like to see an option for families to become like an "executor" for our loved ones and be able to make decisions on behalf of the patient if they are debilitated by their addiction.")

2) Greater support for families and caregivers
   - Respite program for caregivers to rest.

     ("Someone to call and say, 'She's home now and will be injecting. I can't stay awake 24/7. Can you come for the night?'")
   - Family navigators in clinics and hospitals. People who have been there, get it, and can give clear answers.
   - Mutual support groups and discussion spaces for families.
   - More supportive and safe spaces for youth, especially racialized youth.

3) Proactive, better quality, and increased access to addictions care
   - Ask for help once, get it immediately. No more waitlists.
   - Focus on prevention and early intervention for all patients, and particularly for youth.
   - Close down flop houses immediately.
   - No more unnecessary "rules" to receiving care. Patient-centred care, not clinic-centered care.

4) Substance use and addictions specialization in every ward and social sector

("I would love to see dedicated staffing to support addictions in every sector, including police, so that we can get referred to compassionate, sensitive workers who understand, instead of people who have to deal with clients that they don't want to deal with.")

5) Community of care available for every patient
   - Community of professionals who meet regularly to co-manage one patient case, including a social worker, physician, nurse, pharmacist, youth worker, police officer.
   - Surround the patient and family with a shared care plan.
   - No more negligence or missed access points.

(*"She was found wandering shoeless in November in front of the Empress hotel by a police officer. He just asked if she was ok and moved on. Now she's missing. They should have taken her to a warm place, given her a pair of shoes, connected her to help.")*

6) Greater supports and more specialized care for youth
   - Young people, in particular, who ask for help once, need to receive it right away. While this is a human right for all patients, young people are particularly vulnerable, and are less likely to be seek help if they do not get it the first time.
   - Professionals in health care, social services, and public services are sensitive, emphatic, compassionate, and appropriately trained.

7) Eliminate stigma
   - Remove the glass in front of triage points. Not necessary, and enforces a power imbalance, which can deter people from accessing care. There are no glasses at the desks in many shelter homes, which are arguably more "dangerous".
   - Professionals in health care, social services, and public services are sensitive, empathetic, compassionate, and appropriately trained.

Dialogue Session: Families who have lost loved ones to substance use

Date: Thursday, November 29, 2018

Summary of Key Issues

Guided by the questions, "What did not work? What did you wish you had?", participants identified seven main issues that impacted their lives and the lives of their loved ones:

1) Intergenerational grief and substance use
   - Grief is a risk factor for substance use and addiction, particularly in young people.
   - Society responds to grief and grief-related behaviours with punishment instead of compassion – very dangerous.

     ("She was suicidal, using drugs, and in response, [the school] expelled her.")

2) Premature discharge from hospitals
   - Hospitals are important access points and opportunities for intervention, but many won't keep at-risk patients in their care unless the case is extremely severe (i.e. suicidal).

     ("They discharged him at 3am with nothing but a bus ticket. There were no buses so he had to walk back, and he got severely beat up along the way.")
   - In response to the above, a participant shared that even those who present for suicidality can be discharged after an inadequate assessment.

     ("My sister called an ambulance after I tried to kill myself. It was not hard for me to convince the nurse [at the hospital] that I learned from my "mistake" and was not going to do it again. At the time, I just wanted to get out of there, but in hindsight, I know that I was in no state to be discharged.")

3) Gaps in accessing recovery
   - Lack of individualized services for people seeking recovery. Not enough recovery pathways for people who don't fit in with traditional recovery communities, such as AA and NA.
   - People are losing their lives on waitlists.
   - Lack of regulation of poor quality, dangerous, fraudulent recovery homes. Reports of flop houses being sites of sexual assault by the owners.

     ("Anyone can put up a shingle and call themselves a recovery house, but they are not keeping them safe and not giving any support. Families are going broke because they are so desperate."

     "There needs to be regular drop-ins to recovery homes by health authority officials.")

4) Lack of options for mental health
   - Very few treatment centres will care for people with multiple diagnoses.

     ("As soon as PTSD comes up, they say 'we can't deal with mental health, sorry'.")

5) Lack of options for non-opioid addictions

   ("The doctor kept prescribing him Xanax. You don't just get off of those. Yet, there's nothing being said about the Xanax problem.")

6) Stigma deters patients from seeking care
   - Health care professionals who use stigmatizing language.

     ("They told me that he had a 'defective character'.")
   - "Othering within the system": Addiction is treated differently from other illnesses.

7) More grief supports needed for bereaved families
   - Challenging to find counsellors specializing in bereavement from substance use.
   - People who are grieving need a connection, a supportive relationship. Not a phone number, a pamphlet.
   - Bereavement services severely underfunded, in particular, for youth.

     ("Every time I called the suicide crisis line, I was directed to the answering machine."
     "Our health authorities should be funding the hospices, not private donors.")

Summary of Positives

Guided by the questions, "What's working well? What gave you the most comfort in the days, weeks, months after your loved one died?", participants identified several positives in their lives:

1) Opportunities to gather in mutual support with other families
   - Hearing, "it's not your fault". Talking with someone who's been there about feeling relieved, and feeling guilty for feeling relieved.

2) Counselling and psychotherapy
   - Some found that they needed counselling before they could join a support group. One-to-one support is required before they were able to hear another's pain.
   - Therapy, including CBT.

3) Engaging in social change and activism

   ("What keeps me going is not letting my son's death go in vain."
   "Grieving families are an incredible, incredible force."
   "I'll always be outraged, and outrage drives change.")

4) Other things that have helped
   - Keeping an item that reminds you of them close.
   - Hearing the question, "what does your happy place look like?"
   - Meditation.
   - Helplines.

Highest Hopes and Biggest Dreams

To close, participants engaged in a solutions-focused brainstorm and offered suggestions for change and future steps.

1) Greater investment into prevention
    - Learn from Iceland's model: Governments provide life skills training to youth, instead of drug education in classrooms. Protective factors go up, risk factors go down, substance use goes down.
    - More supports for children and at-risk youth grieving the loss of their parents.
2) Addiction specialization in every sector
    - Separate emergency department for substance use in every hospital.
    - Alternatively, adding addiction medicine consults to all emergency services.
    - More training programs for those who want to specialize in addiction within their field.
3) Funding for bereavement services
    - Grief is a health issue. Health authorities should fund bereavement support.
4) Eliminate stigma and embrace compassionate responses in care
    - Drug use needs to be normalized. Stigma is killing people; forcing people to use alone in their homes.
    - Appropriate, individualized care for every addictions patient. No more premature discharges from care.
5) Meet families where they are at
    - Reduce barriers for grieving families to seek supports. Many people won't have the courage to call for help early on.
    - Innovate on ways to support families in the early days, beyond resource sharing.
6) More supports for poly-substance and multiple diagnoses
    - Treat concurrent disorders.

"The more I cried, the bigger my smile became." – session participant

Dialogue Session: Indigenous families impacted by substance use

Date: Thursday, November 29, 2018

Unfortunately, due to marketing issues, no participants attended this session. Moving forward, we are working with the local Indigenous community (organizations, First Nations) to ensure adequate time for invitations.

Dialogue Session: Service providers supporting families

Date: Friday, November 30, 2018

Summary of Key Issues

Guided by the question, "What's not working well?", participants identified eight main issues they experience in their practice:

1) Limited access to essential health care services for patients
    - Long waitlists for detox and mental health services. Unrealistic expectations for marginalized populations to stay on the waitlist (i.e. call back every day).
    - Detox capacity is very low; incidents include:
        i. Families and caregivers needing to help their loved ones detox while they wait for access. More outreach to support these families is needed.
        ii. Clients being denied access to services because their pee didn't test hot.
    - Limited access to opioid agonist treatment (OAT); incidents include:
        i. Clients detoxing on their own and presenting at the hospital for Suboxone, but were denied and treated horribly.
        ii. Caregivers having to follow up and push "higher-ups" constantly to get access to medication for their loved ones. Not enough trained prescribers and empathetic providers.

2) Lack of flexibility in service delivery
    - More services delivered outside of the 9-5 weekday schedule. Many people cannot afford to miss work.
    - More child-friendly services needed. Many parents cannot leave their young kids in order to seek detox or other health services.
    - More home visits needed – meet families and caregivers where they are at, and at times that are feasible for them.

3) Lack of a whole-person model of care
    - Silos between mental health and substance use
        i. Clients seeking mental health services are being funneled through detox instead.
        ii. Likewise, patients are being referred to mental health services without treating the addiction (i.e. client had substance use-induced psychosis, was only treated for psychosis without addressing the root cause).
    - Provide patients substance-specific care (not all addiction is the same). For example, those who are addicted to depressants often have high anxiety; those who are addicted to stimulants are often depressed. Address the root causes of the substance use.
    - More focus on safety planning in health care.

- More strength-based and community-based healing options needed. Our treatment system separates individuals from their communities; focuses on "fixing people", rather than working with people's strengths.

4) Service provider burnout and compassion fatigue
   - Providers are burning out over time: there is an initial burst of support and empathy, but it decreases.
     i. Most people with addiction will relapse during recovery several times, however, empathy from staff decreases over time, despite relapse being common.
     ii. Overall, a lack of public and staff understanding that recovery takes years, and most people will relapse 7-8 times, if they don't die.

     ("Whether it's week 1 or year 4, it's just as shitty, and they need just the same support.")

5) Observed barriers for caregivers and family members
   - Caregivers have no capacity for self-care.
     i. Common to get sick when immune system is compromised for so long (i.e. unable to take showers in fear of missing important phone calls).

     ("It's like we're grieving while we're still alive; grieving a life that just isn't happening anymore.")
   - Fear of child apprehension is a barrier to caregivers seeking help for their addiction.
   - Support for families should be engrained into the culture of addictions care, rather than be an individual's prerogative.
     i. Too often, it's one outstanding individual who goes beyond to provide support to the family. Providers are not supported to do this across the board.
     ii. More investment in training and supporting providers.
     iii. Many youth programs in Victoria, but a lack of support for families at the same time.

6) Stigma in health care
   - There is a "you need to take responsibility for yourself" attitude; incidents include:
     i. Emergency doctors turning down requests from families and patients to stay overnight, despite high risks of them overdosing that night.
   - Common misconception by providers that people who use drugs are single and street-entrenched. Many have families, children, and jobs – they are the ones dying due to entrenched stigma.

7) Private services
   - More enforcement needed to ban illegitimate private services (i.e. flop houses).
   - At the same time, more support is needed for legitimate private services. These services face a stigma around their for-profit status. There needs to be more integration of the private system with primary care and other health services. For example:

i. Sole providers should be able to access MHSU resources, but can't.

8) Address the social determinants of health
   - Lack of supports for children impacted by intergenerational addiction and/or trauma to prevent future drug use.
   - Lack of gender- and culturally-specific care: big access barrier for many.
   - Need to address poverty as prevention.

Summary of Positives

Guided by the question, "What's working well?", participants identified three positives they would like to see more of:

1) Community-based healing
   - Whether for staff and front-line providers, or families and caregivers, having a safe space where people can share stories and offer mutual support has been integral.
   - Online support groups and other websites also allow access to support without needing to sit around others, which can be daunting. One example seen as best practice is the "She Recovers" program, an online platform for women with the guiding principle, "we are all recovering from something": https://sherecovers.co/.

2) Meeting patients and caregivers where they are at
   - There are services where people can accompany you to get your daily dose of OAT. This service allows time for the primary caregiver (often, the family) to relax and practice self-care.
   - Nurses who visit people's homes, for example, when parents are needing to detox their kids on their own, are one way to meet families where they are at when bed-based treatment services are all full.
   - Community programs that are upheld as best practice include:
     - AIDS Vancouver Island: Provides wrap-around support to patients and families, from replacing ID, to supporting with plan G, to outreaching to families in the waiting room.
     - Tsow-Tun Le Lum: Indigenous addictions-focused program that offers cultural healing to families experiencing grief and loss.
     - Ministry of Children & Family Development: Many parents and caregivers do not seek treatment when they want it in fear of being "outed" and having their children taken away. The Voluntary Care Agreement under the Children Family Community Services Act allows parents and caregivers to go to treatment without risk of child apprehension. Instead, in the event the parent doesn't have a safe alternative for their children (i.e. grandparent, friend), they will be matched with a temporary caregiver by the MCFD. MCFD also supports parents with contingency planning.

- Umbrella Society.

3) Providers who take the time to understand and change the system
   - While it should not be up to the individual provider to go above and beyond in order for the patient and family to receive quality, compassionate care, participants expressed gratitude for those who do.
   - For example, one ER doctor held a focus group outside of their regular working hours to better understand with experience of going to ER after an overdose. The findings resulted in quicker access to Suboxone at Royal Jubilee Hospital.

Highest Hopes and Biggest Dreams

To close, participants engaged in a solutions-focused brainstorm and offered suggestions for change and future steps.

1) Paradigm shift in ideologies
   - The health care system is in need of a uphaul. Providers need to be more innovative and compassionate. The safety and care of each individual patient must be prioritized in every situation.
     - Until policies are designed to be more person-centred, providers need to be flexible with the rules, i.e. around discharging.
   - There needs to be a landscape of understandings of substance use and addiction. Only then, can we design holistic, community-based options for treatment and recovery that are rooted in a diverse understanding of what healing looks like for different people.
   - Decriminalization of people who use drugs.

2) Expand services that meet families where they are at
   - In-home counselling must be made available, especially for parents with young children who are working 9-5 and not able to leave their homes.
   - Expand services that are philosophically aligned with those of families, i.e. more culturally-relevant and –safe services.
   - Services must be more flexible and less silo'd, i.e. services that treat both mental health and addictions, including counselling and other social services; services that allow children.
   - Government-subsidized child care (i.e. $5/day) specifically for parents who need to go to treatment.

3) Greater investment into prevention
   - Improve drug literacy in children and youth. Mandate evidence-based curricula on drugs that build the capacity of our children and adolescents to make healthy decisions.

- Early intervention for children and youth who experience trauma, i.e. disrupt the intergenerational cycle of trauma and addiction if there is substance use in the family, without apprehending children.
- Expanded services and no wait times for youth seeking treatment for their addiction.

4) Greater supports for staff and front-line providers
   - Build capacity of organizations to host regular self-care initiatives and routine "maintenance" for all staff entrenched in the overdose crisis.
   - Support groups for caregivers and front-line providers focused on building resilience.

5) Build a continuum of care
   - Bridge the gap between private practices and public health and social services.
   - More resources needed for those making big changes in their lives, i.e. transitioning from income assistance to disability.