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BC's Mental Health and Addictions Journal

visions

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opioids

what do trauma and gender have to do with opioid use

creating community in the middle of a crisis

visions

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background

experiences and perspectives

alternatives and approaches

letter to the editor

The issue released by *Visions* on the topic of self-injury brought up a lot of emotions and understanding for me.

As a young adult, I first practised self-harm when I was 18 and completely alone and unable to cope in my first year of college. I had an undiagnosed mental illness for years before this and had no support network or healthy coping skills. My attempts at self-harm landed me in the hospital for the night. I was not intending to hurt myself but how I was coping had alarmed the doctor and therapist I was seeing at the time; I'm not sure they knew how to approach it and feared I may act farther. At the time I was completely unprepared for the struggles I was going through and had no tools in my toolbox, so to speak.

This sparked a long battle over the years to recovery and my long journey to develop good coping techniques. What helped me recover the most was having hope that things would get better and finding someone who was trauma informed to validate my experiences and make me realize that I am not broken or weak but resilient for surviving all the things I have in my life. I'm so glad that *Visions* has touched upon this often misunderstood aspect of mental health.

—Ashley, Vancouver

editor's message

Late last fall, while working on this issue, my six-year-old daughter injured herself and we ended up at BC Children's ER. The doctor told us they were going to give her fentanyl for the pain. My chest tightened and I thought, 'My God, no. Not fentanyl!' Despite knowing that fentanyl is a good medicine when used appropriately, I had fallen into the trap, the trap of thinking in terms of 'demon drugs.' I momentarily forgot that how and why a drug is used—the context—must be the focus.

Coordinating this issue has been one of the most moving experiences I've ever had with *Visions*—and I've worked on well over 50 issues. Maybe it's partly because I interviewed a few people for it (something I don't normally do) to help some contributors share their voices. While I was listening, I remember thinking, 'People need to hear this.' There are lines that still echo for me, blowing apart preconceptions: Al Fowler's telling me that he had stopped using opioids on his own but went back on to get housing. Or Farren clarifying that she didn't lose her kids because she started using again; she used again because she lost her kids. Or John asking us why our society is so uncomfortable with discomfort and pain.

If you feel a bit removed from the opioid crisis, this *Visions* will turn what you think about cause and effect on its head (spoiler alert: there are no single causes or single effects). In fact, the reason this issue is a little bit longer is because we really wanted to ensure readers could see how people got from A to B (or Q!). And since some narratives get more play in the media, we wanted to showcase a real diversity of stories from different genders, ages, regions, incomes and backgrounds, each with a unique pathway and outcome, many tragic, most hopeful.

Let's keep up the dialogue. Maybe the dialogue needs to extend to similar causes. For example, consider how much the opioid/overdose crisis has in common with another tragedy in our communities: suicide. In both cases we have preventable deaths, stigma, silence, misconceptions, complex causes, trauma, loss, escape from pain… And public outcry not nearly loud enough.

If you never read *Visions* cover to cover, this is the time to start. If nothing else, to honour the thousands of lives cut short and hundreds of thousands of lives directly hurt by those losses, we need to listen and seek to understand.

Sarah Hamid-Balma

Sarah is Visions *Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division*

Humanizing Our Response to the Opioid Overdose Crisis

Dan Reist

Overdose deaths in British Columbia have been increasing since 2012. This fact led the Provincial Health Officer to declare a public health emergency in April 2016. Since then, much has been done to address the problem. But we still have a long way to go.

Photo credit: ©iStockphoto.com/juanmonino

Dan is Assistant Director (Knowledge Exchange) at the Canadian Institute for Substance Use Research at the University of Victoria. He has worked in substance use services in British Columbia for well over two decades. He believes our systems need to focus more on building capacity in individuals and communities to nurture themselves and take on responsibility for their own well-being

We know far more than we used to about the drugs being used. Many overdoses are caused by a set of drugs called opioids. These include traditional opiates, like heroin, which are derived from the opium poppy, as well as a range of similar, chemically derived drugs, such as fentanyl. We also now have much better up-to-date data to track what's happening on the street, and we have increased the number and type of services available to people who use opioids.

Yet the number of overdose deaths continues to increase. Why is this? What more can we do?

When I read the reports and look at the numbers, it is very difficult for me to see the human beings that the data represent. It's time to change how we think about drug use and problems like overdose: it's time to humanize our approach.

By humanizing our approach, I don't mean talking more about client-centred services or running more anti-stigma campaigns.

Humanizing the system means that we must stop focusing on drugs as the problem. We must stop making artificial distinctions between bad

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Humanizing the system also requires that we take an honest and critical look at how drugs have played a role in human power relationships throughout modern history.

drugs, less bad drugs and good drugs. We have to get over our hang-ups about drug use in general. The fact is that human beings have been using psychoactive substances for thousands of years—for both recreational and medicinal purposes. Our ancestors didn't distinguish between a drug that made them feel good and a drug that made them healthy and well.

Humanizing the system also requires that we take an honest and critical look at how drugs have played a role in human power relationships throughout modern history. Some (but not all) Indigenous cultures were destroyed when European explorers and settlers introduced them to alcohol. Prohibition—the government-sponsored, widescale ban of alcohol and other drugs in the early 20th century—and the promotion and sale of drugs in the modern world have been shaped by racial tensions, economic interests and patterns of social control in our communities.

For example, Canadian prohibitions against opium were introduced as a way to control the Chinese immigrants in cities like Vancouver in the context of racially motivated labour unrest. Similarly, the promotion of amphetamines to women after World War II was largely designed to find a market for the over-supply of a drug that had been used by the troops and to pacify women displaced from the workforce by the returning soldiers.

The control of drugs (by government and non-government figures) has supported long-term power imbalances and has contributed to cultural disintegration. Consider, for example, the impact of the intentional over-production of gin in 18th-century London, England, on the urban poor, or the introduction of whisky into Indigenous communities whose land and way of life was being systematically stripped from them.

Minority groups and disempowered populations paid the greatest price in overdoses and other drug-related problems in the past. It is hardly surprising that they continue to pay the greatest price today.

With some historical understanding and insight, we should be able to admit that the problem is not the drugs. But are we prepared for the alternative—that the problem lies in how we view drugs and the individuals who use them, and that our treatment systems often perpetuate the power imbalances already in place?

In our modern social services and health care systems, treatment and care plans are often based on a power and control model. We have "experts" (doctors, nurses, counsellors and other staff) who prescribe solutions to the "non-experts" (patients or individuals seeking help). Our treatment systems rely on medical "evidence" derived from carefully controlled studies that tell us what the "problem" is and what our best "fix" is likely to be. In this power structure, the expert gives the orders, and the non-expert follows them.

Even our prevention programs use this power and control model. We

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are constantly looking for new and better programs that will successfully prevent people from adopting behaviours that are harmful to their health. We focus on getting the "right" message to people so they can make the "right" choices. We use a range of social marketing techniques to persuade people to view drugs in the "right" way and to adopt the "right" behaviours when it comes to drug use. And it is always the authority figure who knows what is "right."

There is no doubt that almost all drugs can be dangerous, especially if they are used too often, in a concentrated form or without careful thought and intention. While there has been a lot of talk about legalizing drugs as a first step towards solving the "problem" of substance use in our communities, legalization alone is not going to solve all the problems we have created. Legalizing alcohol after the experiment with prohibition was an important step, but we still have significant problems with its use in our communities. We need to rebuild a healthier culture of substance use.

But how?

Oddly enough, we can find the beginnings of an answer to this contemporary question by looking at how the ancient Greek philosopher Aristotle and later thinkers in the humanist tradition have thought about knowledge.[1-4] Aristotle talked about two kinds of knowledge. The careful study of patterns of cause and effect leads to a very useful kind of knowledge—the kind of knowledge that allows us to expand our control of the world around us. Today, we might call this scientific knowledge.

But Aristotle also spoke of another kind of knowledge—the knowledge of practical reason. This knowledge comes to us from our interactions with other human beings and our environment as we explore ideas of what it means to live a good life.

Within the humanist tradition, which emphasizes self-knowledge over external authority, such exploration requires that we view others as having agency and the freedom and ability to make decisions about their own well-being. In this framework, practical reason involves a give-and-take process in which we seek to understand one another while at the same time finding a way to live together in society. While scientific knowledge is focused on achieving certain goals, practical reason is focused on the relationships between separate autonomous beings. It is about building bridges between individuals and within communities.

We've done a pretty good job of expanding our scientific knowledge about drugs and their potential benefits and harms. But has that expansion taken the place of, or come at the cost of, a more humanist approach? Scientific knowledge is expressed as fixed realities and exact measurements. It provides us with a means of control. Human emotions and social interactions, however, are not fully captured by scientific laws and numbers. Increased social understanding is possible only when we stop viewing and treating human beings as mere scientific objects. We need to see them as individuals whose subjective experiences are as important as the objective events that happen to them.

In order to solve the problems that we have created with our use and perception of drugs, we need to resolve the complex power dynamics in our society. This might mean easing our commitment to controlling drugs, controlling messages and controlling people. It might also mean investing more in building understanding, building connections and building capacities for self-care and self-healing within individuals and among our communities.

As more voices are heard and more perspectives understood through genuine, respectful dialogue, we are more likely to find real, long-term solutions to substance use issues in our communities. The social norms and rules we craft together will be less reflective of the desires of special-interest groups and be more responsive to the needs of everyone.

But engaging in this dialogue is far from simple. We are each limited by our own perspectives, and we are all influenced by special interests. We must constantly ask ourselves, *Whose voice has not been heard?* How might our cultural assumptions and social rules impact different individuals and groups? How do we create equitable, inclusive, engaged communities? v

Opioids and Opioid Use in Canada
A COMPLEX HISTORY

Gaëlle Nicolussi, MA

One hundred and ten years after opium was made illegal in Canada, we find ourselves in the midst of the worst opioid overdose crisis in our history. How did we get here?

Gaëlle is a research assistant for the Canadian Institute for Substance Use Research at the University of Victoria

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How has our historical relationship with opioids shaped the current situation? Why are some opioids illegal? What role do governments and drug companies play?

One might be excused for thinking that opioids were made illegal because we discovered they were dangerous. We might also believe that this class of drugs is so powerful that its users become immediately dependent and will do anything to acquire the drug. But neither is true, and the truth is not quite that simple.

The early days of opioids

Opioids have been used throughout the world for thousands of years—as medication and for other reasons. The earliest clear reference to opium poppy cultivation is more than 5000 years old. The ancient Sumerians of lower Mesopotamia referred to the opium poppy as *Hul Gil*—the "Joy Plant."[1,2] Since then, opium has been used in many cultures and praised for its healing effects. It has also been used for sacred and recreational purposes, though the boundaries between different types of use were never clear.

Laudanum (a mixture of opium and alcohol) was used as a common remedy for a variety of ailments in the 17th and 18th centuries.[3] Then, in 1804, German chemist Friedrich Wilhelm Adam Sertürner isolated morphine from opium.[4] Morphine became the preferred medical treatment for pain, anxiety and many other health issues, particularly after the invention of the hypodermic needle in 1853, which made the drug easier to administer. In 1874, heroin was derived from morphine and used primarily to treat pain.[5]

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what is morphine?

Morphine is one of many different chemicals present in raw opium. Heroin is morphine that has been even further refined via chemical reaction (it is simply morphine with an acetyl molecule attached). Heroin is roughly two to three times as potent as morphine.

Since then, an almost limitless number of related drugs (known collectively as opioids) have been derived from opium or synthesized in laboratories. These opioids have been promoted by their makers, prescribed by medical professionals and used by the general public. One famous opioid-containing product was Mrs. Winslow's Soothing Syrup, a morphine and alcohol mixture that was marketed at the end of the 19th century as a concoction to help fussy children sleep.[6]

The era of prohibition

As the opium trade between China and British India took off during the 16th and 17th centuries, the Chinese government banned importation of the drug in order to reduce opium consumption among its citizens. Not only was the Chinese Empire unsuccessful in regulating opium use among its citizens but its attempt to suppress the opium trade led to violent military retaliation by the British Empire.[7]

Throughout this period, trade and use of opium (and, later, heroin) increased in Europe and North America as well. In the West, the 20th century was characterized by prohibition. But these sorts of government policy changes were driven by trade and immigration concerns rather than a widescale perception of harm. In fact, it was only when the West's opium trade with China began to decline, around 1906, that the Chinese government was able to regulate importation and consumption of the drug.[8]

Canada was one of the first countries to ban opium for personal, non-medicinal use, starting with the *Opium Act* of 1908, which made it an offence to import, manufacture, possess or sell opium for non-medical reasons.[9] This legislation was passed in response to the public campaign for Chinese exclusion and the moral panic about drug use and its impact on race relations and gender roles. Anti-Asian sentiment led to labour riots against Chinese and Japanese workers in Vancouver in 1907.[10] The ban on opium was seen domestically as a response to the "Chinese problem" and internationally as leading the way on the "opium problem."[11]

After World War I, a string of amendments to existing legislation led to the *Opium and Narcotic Drug Act* of 1929. This would become Canada's main drug policy until the late 1960s, when other countries began to introduce similar legislation and we entered an era of international prohibition of non-regulated trade and consumption of narcotics.

The pharmaceutical promotion of opioids—and the court's response

At the same time that Western governments were prohibiting the non-medicinal trade and use of opioids, pharmaceutical companies and medical authorities were promoting and selling opioids for a range of medical and health purposes. For example, at the end of the 19th century, the German drug company Bayer began advertising heroin as a cough remedy that was more effective and less addictive than either morphine or codeine, setting the stage for other pharmaceutical companies to promote new opioids as both effective and non-addictive.

Synthetic opioids (such as oxycodone) were introduced in the 1950s; doctors quickly embraced them as a treatment for pain.[12] During the 1980s, physicians explored the use of prescription opioids to treat cases of chronic pain. The prescription opioid landscape changed again in the 1990s, as new, slow-release opioids entered the market, offering pain-treatment options that were supposed to be safer.

Pharmaceutical companies increased marketing efforts to health care providers, holding information symposia and offering coupons for some of their opioid medications. The market for those medications grew. In 1996, Purdue Pharma began to aggressively market and promote OxyContin, its synthesized opioid remedy, following the pattern originally set by Bayer: it exaggerated the drug's effectiveness and downplayed its addictive potential.[13]

In the late 2000s, the courts began to recognize the dangers inherent in the pharmaceutical promotion of opioids. In 2007, Purdue pleaded guilty to misleading regulators, doctors and patients about the risk of dependence associated with OxyContin and agreed to pay $600 million in fines.[14] More recently, Purdue Pharma (Canada)

agreed to pay $20 million—including $2 million to provincial health plans to help compensate for how the company had marketed and sold OxyContin.[15]

The way forward

Substances derived from the opium poppy (and similar, synthetic opioid concoctions) have been used throughout human history—for medicinal and sacred purposes, and for pleasure. Physical and ideological wars have been fought over the drugs—both in an effort to protect the opioid trade and in an effort to stamp it out. Many individuals and corporations have become rich because of opioids, but countless others have lost fortunes—even their lives and the lives of their loved ones.

Opioids have been praised, demonized, prohibited and promoted, all at the same time. They are certainly not going away; maybe it's time we learned, as individuals and as communities, to manage these substances in our midst. This will mean we need to change the way we talk about drugs. Rather than using a simple binary of good and bad, we will need to acknowledge the complex reasons people use drugs and the different impacts drug use can have in different contexts. Then we will need to help people develop the skills they need to make informed and positive choices. v

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Young, Bipolar and Addicted to OxyContin
AN INSIDER'S PERSPECTIVE

John Charles Hilderley

In 2000, when I was 18, I was prescribed OxyContin for two painful kidney problems. The drug was relatively new then. The first three and a half years, I took up to 240 mg a day (considered a high dose) plus Percocet, a drug that contains smaller doses of oxycodone, for what my doctor called "break-through pain."

Photo credit: ©iStockphoto.com/shadrin_andrey

John lives in Vancouver. He is a writer, tutor and recovering addict. He is also bipolar. His novel on addiction and recovery, titled The Time of the Plague, *is available on Amazon*

I hadn't used "oxy" before. I had taken morphine pills, recreationally, as a teenager, but was never addicted. (A friend had lifted them from his grandparents' medicine cabinet.) I also drank alcohol off and on, but I stopped when I had the kidney issues. Drinking made the kidney pain worse.

I had also been diagnosed with bipolar disorder. In the depression phase, I would lose my appetite and have little or no energy. I would fantasize about suicide. In the manic phase, I would feel like I could see and absorb hundreds of streams of ideas at once. I would hear voices. I felt I could do anything and everything, without needing to sleep or eat. At some point, of course, I would crash; existing on ideas and air can only sustain one for so long …

But I didn't want to admit I was bipolar because many people in my family had the illness and I saw what that meant. In my family, it meant extended stays at the psych ward and, in the worst cases, suicide.

Under the oxy—and off the oxy

To say that OxyContin helped with the kidney pain is an understatement. I don't think I could have functioned without it. I went from being curled up in a fetal position on the bathroom floor on some days, just waiting to pass a kidney stone, to being mobile and not debilitated by pain—in other words, *normal*.

In the beginning, oxy made me feel euphoric; later, it provided a calming, stabilizing high. In hindsight, I think I gravitated towards oxy because it regulated the way I felt. Rather than dealing with the rollercoaster of emotions that is bipolar, I felt a relieving flatness.

Eventually, surgery fixed the problem that had caused my kidney pain. But by that time, I was dependent, and my physician explained that I would have to be tapered off OxyContin slowly. That's how I got off the oxy: slowly and grudgingly. It took six or seven months.

A crash—literally

Less than a year later, I fell 12 metres off a roof, cracking my lumbar vertebrae. I was unable to walk for six months—and I was back on the oxy for another year and a half.

When my hospital prescription ran out, I followed up with my GP, who was not happy about prescribing me oxy again, but it was also clear that I was in regular, daily pain. At this point, I discussed going back on oxy with my mother, who had bipolar. My mother was familiar with addiction to pills (in her case, Ativan and clonazepam), even though she refused to admit that she was ever an addict.

At the end of a year and a half, I was blasting through my monthly prescription in the first week of each month; I had to buy opioids illegally for the rest of the month just to float my boat. Most of the time, I bought oxy, along with morphine and hydromorphone. But somewhere along the line, I started smoking heroin regularly, too.

At the end of my legal prescription period, I was warned by my physician (as well as fellow oxy addicts) that the original-formulation oxy was no longer available, and a new formulation was being introduced. OxyNEOs were supposedly resistant to tampering (with the time-release part of the drug).

But Purdue Pharmaceuticals (the company that promoted and sold OxyContin) had created a demand, and that demand was not going away. As a result, places in Ontario that had never had much heroin before were now inundated with the stuff. I personally watched waves of people switching to black-market hydromorphone (Dilly 8s) or to heroin.

Vancouver—West side

In 2006, I moved to Vancouver to do an undergraduate degree at UBC. Throughout my academic life, I straddled the line between being a nerdy high achiever (having the top grades in many classes) and being a total ne'er-do-well. I won spelling bees in Grade 6, and sold contraband cigarettes behind the baseball diamond. In Grade 9, I hung out with the matheletes—and sold acid.

I financed my undergraduate degree with bursaries, grants and scholarships. One can be addicted to opioids and still be entrepreneurial and proactive, particularly if one is in a state of maintenance. Maintenance is about regulating and staving off withdrawals: it is not about getting high; it is just about feeling not sick.

While I was at UBC, I found an addictions doctor nearby in Kitsilano, and he prescribed me both methadone and Suboxone (separately, of course). I vacillated from use to sobriety to methadone to Suboxone. Eventually, I managed to stay away from using for a number of years.

But as I neared the end of my undergrad, in 2010, my mother went missing. I flew back to Ontario to help look for her. She was supposed to be taking five different heavy-duty psych drugs a day, but she had quit cold turkey two weeks previously.

It turned out that she had taken her own life.

I'd been in bad shape when I had my kidney stones and then later when I injured my back, but this was nothing to how I felt when my mother killed herself.

I blamed myself. I got very angry with my father. Ach, it just tore my heart out. Even though I had been off illicit opioids for a few years by then, I relapsed in Ontario after my mother died. I used oxy and Ativan, which I found in my mother's prescription stash. By the time I returned to Vancouver, I had also got my hands on a hundred methadone pills from an old friend of mine.

In 2011, I started using heroin. Thankfully, I never overdosed. I did, however, have to revive a roommate with naloxone when I came home one night. He wasn't breathing, had no pulse and his lips were blue. This experience, along with the memory of my mother, pulled me out of the wasteland of heroin addiction and back into the land of the living.

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Setting myself free

I got off opioids in 2013. I decided to go back to a daily dose of methadone. I also went to Narcotics Anonymous (NA) meetings.

For exercise, I dragged my sorry hide to the local pool and swam laps every day. I also started running and going to the gym. During this time, I began to play and record music with a friend of mine from UBC. On the advice of my physician, I have continued to stay on a low dose of methadone.

I also finally got prescribed the right psych meds for my bipolar disorder because my girlfriend—bless her heart—made me go to the local emergency department with her. I needed to go. I was constantly talking with people who were not there. I was paranoid. I had messianic delusions. At one point, I was so removed from reality that I felt I might never return, which was deeply frightening for me.

On the bipolar meds, I have a degree of stability. I sleep regularly and I feel more even-keeled. It's ironic that while I was able to admit I was an addict many years ago, accepting my bipolar diagnosis took much longer.

Fear fed my addiction, and acceptance set me on a path of healing. I was afraid of the power of my addiction and the hold it had over me. But when I finally accepted that I was an addict and that I had bipolar 1, things starting getting better for me, slowly but surely. I realized I had been stuck in an ever-accelerating cycle, where I self-medicated to function in the world, which inevitably and reliably made things worse, again and again and again.

> When we stop demonizing our own pain, we can stop demonizing the pain of others—and we can stop ignoring the suffering we see around us.

Thoughts on the overdose crisis

You have probably heard this old chestnut: No one ever dreams of being a junkie when they grow up.

I used opioids so that I wouldn't have to face my mental health issues. Opioids provided me with a comfortable, impermeable blanket; they killed the pain, soothed the voices, calmed my racing mind. In the Western world, we have a sick relationship with pain. We think that we are entitled to live completely pain-free. We believe we deserve instant gratification and comfort. We unambiguously embrace pleasure and demonize pain.

I am not suggesting that we need to stop avoiding pain. But I do think that we need to re-imagine how we see and judge pain and physical discomfort. Is all pain so categorically harmful that we should imbibe everything from opiates to cough syrup to avoid it? Don't we learn from pain?

When we stop demonizing our own pain, we can stop demonizing the pain of others—and we can stop ignoring the suffering we see around us. Vancouver prides itself on being healthy, green, ethical, free-trade, organic, spiritual, open-minded and aware—but we aren't aware where it really counts: we don't show concern for the people of the city.

People who use substances are frequently systematically punished and discriminated against—or worse, forgotten. As a society we have become desensitized to suffering—we don't want to see it—so we walk past the panhandler on our way to work, we ignore the howling of the ambulances. *What can I do about it anyway? They do it to themselves. It's their fault. They have a choice. They deserve it.* These are all sentiments I have heard shared openly by fellow Vancouverites.

But we can save lives—if we can acknowledge and accept pain, and if we can challenge those who look at someone who uses drugs as anyone other than a brother, sister, daughter, son, parent, friend, colleague or peer. Those who use drugs are human, just like the rest of us. We all feel pain and we all feel fear. When we overcome our fear of pain, we can access great strength and grace. It is there, waiting for us.

And when we acknowledge that, we can begin to heal each other and ourselves. v

How Did We End Up Here?

HOLDING ON THROUGH A CLOSE FRIEND'S OPIOID ADDICTION

Astrid*

It was 4:00 on a Friday evening, about 24 hours since anyone had last seen Gwen. She had been given the opportunity to get help, but she chose instead to leave the hospital. No money. No cell phone. No car. No purse. Nothing. And no one had heard from her since.

Astrid lives in Vancouver, works for a non-profit mental health organization and volunteers with the Child and Youth Mental Health and Substance Use Collaborative

** pseudonym*

Photo credit: ©iStockphoto.com/juanmonino

Originally, Gwen was supposed to write this article. She wanted to write it as a way of chronicling her battle with opioids, in the hopes that her struggle would inspire others who faced the same challenges or who had to watch a loved one cope with similar issues.

But at 4:00 that Friday evening, with Gwen still missing, I sat down and began to write the article on her behalf.

It's hard to believe now that Gwen is someone with whom I used to spend a great deal of time. We met through mutual friends when we were young adults. I was giving her a ride home from a party when I got a flat tire. She spent the next several hours with me, waiting for roadside assistance; we've been friends ever since.

That was 25 years ago. Over the years, we stayed close. Even when we lived 2,000 kilometres apart from each other, we spoke to each other by phone almost every day.

When a friend has been in your life for so long, you just assume that you'll be friends forever. It never occurred to me that things would change so drastically that I would no longer recognize someone I had once been so close to. But 25 years into our friendship, I often don't recognize Gwen at all.

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Gwen grew up in a suburb of Vancouver. She graduated from high school, attended college and went on to do very well as a sales manager for a large company in the US. She had two children while living in the States, and although she went through a divorce, she had a very supportive family who would fly down at a moment's notice to lend a hand. She was living the dream and was extremely happy.

Then, at some point, Gwen was diagnosed with an autoimmune disease and was prescribed opioids to control her pain. Shortly after that, Gwen witnessed her good friend, mentor and boss shot and killed in front of her. Although she wasn't physically harmed, she suffered the emotional scars of witnessing the murder of a man she was close to.

Gwen decided that it was time to move home to Canada. When she returned home, she was still taking prescription opioids for her pain, but her doctor in Canada was reluctant to provide her with the dose that she had been prescribed while living in the US. Unbeknownst to most of us, she started purchasing opioids on her own. Once the painkillers became too expensive to purchase on the street, she opted for the less expensive street drugs.

Over the next year or so, I didn't see Gwen very much. At first, I thought it was because she was busy adjusting to her new life back home in Canada. She was working and living on her own with her children, but had her parents nearby to help. Although we didn't see each other often, we continued to talk frequently on the phone. But it's hard to gauge what's going on in someone's life over the telephone. She told me repeatedly that she was fine—and what reason did I have to doubt her? When we finally had a chance to connect in person, the change in Gwen's appearance was alarming: sunken eyes, pale skin, strange behaviour. She would disappear into the bathroom for long periods of time. I knew that something wasn't right.

> It never occurred to me that things would change so drastically that I would no longer recognize someone I had once been so close to. But 25 years into our friendship, I often don't recognize Gwen at all.

A mutual friend and I decided to stage an "intervention." We took Gwen out and tried to talk to her and discover what was going on. Gwen assured us that her appearance was a result of her autoimmune disease. We challenged her, but she insisted that everything was fine.

After that meeting, I heard from her less and less frequently. Occasionally she would resurface and call me every day for two weeks. Then she would disappear again. Whenever she called, she seemed okay—or she acted as if she wanted me to believe she was fine—but I wasn't convinced.

One day, her brother reached out to me and another friend to let us know that Gwen was spiralling out of control. She had been let go from her job and she and her children had moved back in with her parents. Apparently, she had started stealing money and possessions from them. Her brother had taken a photo of her basement bedroom to show us. It was strewn with drug paraphernalia and garbage: bits of tin foil, baggies and cigarette ash covered her bed. This was alarming for us to see.

We decided that we had to do something. With her parents' support, a few of her friends showed up at the house and surprised Gwen; we told her that we knew what was going on and that we were there to help her. She seemed willing to accept the help.

We helped her family arrange for her to enter a detox and rehabilitation program in the BC Interior. Although she kept telling us that she didn't need to leave Vancouver, that what she really needed was counselling instead, she reluctantly agreed to go into the rehab program for the sake of her children. The detox centre was close to where Gwen's extended family lived. I offered to take her to the airport and put her on a plane, and a family member agreed to meet her at the airport at the other end. Overall, Gwen seemed positive and optimistic about what was to come. She certainly knew all the right things to say.

Her friends were there to help her pack and provide words of encouragement. We armed her with some great books and inspirational cards. I drove her to the airport. I parked in the roundabout, walked her to the check-in. And then I left. I remember wondering as I said good-bye to her whether I should have walked with her to the security gates. But then I thought, "Naaaah!" She'd said all the right things. I was so sure she wouldn't do anything to jeopardize the plans we'd made to get her help.

Gwen never got on the plane that day.

Later, she blamed me, told her family that we had arrived at the airport late. Her family booked her on another flight and she eventually arrived at her location and spent a week in detox. After that, she was sent back to the Lower Mainland, where another friend picked her up at the airport and took her to the rehab centre for what was supposed to be a three-month stay.

One week later, I got a call from Gwen. My heart sank as soon as I saw the number on the call display. She had left the rehab centre. She had decided that what she needed after all was counselling and not drug rehab. I felt sad for her; I knew she needed more than counselling.

We found out later that she hadn't voluntarily left the rehab centre; she had been kicked out for using drugs.

This happened a year ago, and I'm sad to say the story has repeated itself more than once. Each time we intervene, she tells us that she can beat this addiction on her own. She tells us that she doesn't need help. She tells us whatever she thinks we want to hear so that we will leave her alone. Most of her friends do leave her alone, but I just can't. Although she is now someone I hardly recognize, I continue to hold on to all of the memories I have of a younger, healthier Gwen. I won't leave her alone because I'm hopeful that one day I'll have my friend back again.

Eventually the Ministry of Children and Family Development got involved. Gwen is now no longer allowed to enter her parents' house, or her children will be removed from the home. She hit rock bottom and was sleeping in her car. It was after she tried unsuccessfully to kill herself that she was admitted to the hospital—and it was that Friday afternoon that she walked out and disappeared without a trace. That was the Friday I started writing this article.

But as I finish this article a little more than two weeks after I began writing, I'm relieved to be able say that Gwen did go to detox that Friday afternoon. She stayed there for two weeks, and as I write this now, she is in a transition house waiting for a bed at a rehab facility.

When will a bed be available, and will she have the patience to wait for it? I don't know.

In the meantime, she keeps telling us everything we want to hear and assures us that this time it will be different. I really want to believe her, but I don't know if I do. Will things be any different this time around? I guess only time will tell.

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Living a Good Life—With or Without Opioids

IT ALL COMES DOWN TO DECENT, SAFE HOUSING

Al Fowler

I first started using heroin in the late 90s. I was in Matsqui Penitentiary, so it was just a way to get high and escape reality. I was 32 years old. I had started off young, sniffing gas and glue as a kid, and I smoke and drank. Everything was just another means to escape.

Al Fowler

Al does peer research for the BC Centre on Substance Use and also works for the Vancouver Area Network of Drug Users (VANDU) and the BC Association for People on Methadone (BCAPOM). He is one of the co-writers of the handbook Patients Helping Patients Understand Opioid Substitution Treatment

Based on an interview with Al Fowler by Sarah Hamid-Balma

Before I was sent to the penitentiary, I was living in Nelson—Procter, actually. I'm really a Procter boy, if you know Kootenay Lake at all.

I did my parole in Vernon. By that time, I wasn't using heroin. It wasn't difficult to stop; I hadn't been using every day, so I wasn't wired or dope-sick.

Then, in the late 1990s, I was in a few bad car accidents and one of my vertebrae was cracked. When I was released from the hospital, I was basically just told, "Well, go home and lay on the couch for a couple years."

A friend of mine in Vernon—it's funny, his name is Al, too—his dad was getting a big bottle of morphine every month. He sold them to us dirt cheap. That's when I started using again. This time, I was using to deal with the pain. Morphine definitely helped with the pain. We used every day. The funny thing is, my friend's dad tried to blame me for getting Al wired—even though Al's dad was the one selling us the pills!

I figured we were grown adults, so the only person I was harming was myself. I wasn't stealing money. If we had a bad day, all we'd have to scrape up was $10 (back then), and we could just split that one pill. It's not like we were taking 100 pills a day. We were just keeping our habit at bay.

Photo credit: ©iStockphoto.com/is_imagesource

That's part of the stigma of being a drug user and being on methadone: we're not listened to as individuals with something important to say.

Prince George, weed and sticker shock

Me and my wife were in Vernon a couple years and then we went up to Prince George. In Prince George, we had housing—a three-bedroom trailer and five acres. I had a different lifestyle, then, growing marijuana. No more daily morphine pills. The price of opioids in Prince George was just stupid. I wasn't gonna pay $50 for a pill that might be unsafe. Up there I just dabbled once in a while, and I wasn't dope-sick.

From methadone to methadose

We moved down to Vancouver in 2010. The housing was better in Prince George, but we weren't tempted to go back. Prince George is not a safe city. I feel safer walking downtown here in Vancouver than I do in Prince George, let's just put it that way.

So we come down here and we're staying at the First United Church. A friend of mine said he knew a hotel we could live in if one of us was on methadone.

We didn't have other housing options. That's why I went on the methadone program—to get us housing. That's the only reason. And that got me tied into the Palace Hotel and that whole story.[1] It all comes down to decent, safe housing.

With the methadone program, I went to the clinic every day, seven days a week. I'm kind of a late-afternoon guy, so I wouldn't go first thing. If you get the methadone at 9 am, come 5 or 6 o'clock the next morning, you're going to start flopping around. With my routine, I can have a good night's sleep and get up in the morning without feeling sick.

I started on methadone in 2010. Four years later, the program started using methadose. BCAPOM (British Columbia Association for People on Methadone) had two weeks' warning that it was coming. The province said it was safer, harder to take out of the pharmacies.

But it made a big difference to me. With methadone, I felt better. I could drink my dose and I could go 36 hours sometimes without needing another one. With methadose, I have no energy, no get-up-and-go to accomplish anything. And methadose reacts with the antidepressants I was on. It screws up your heart rhythm or something, so now I can't take any antidepressants.

The importance of lived experience: The patient handbook

With the opioid problem, doctors are now having this knee-jerk reaction: they've cut off everyone's pain meds, their valium, everything. For years, they prescribed these to their patients, and then all of a sudden, because some guy comes out with a study or some guidelines, it's started this whole friggin' crisis we're living in. Now, all these chronic-pain patients are going to the black market. But the black market isn't safe anymore.

Seeing a doctor every two weeks and walking into a pharmacy every day is belittling right from the word "go." I know that if I was, say, diabetic, and the medication my doctor is giving me is not working and I'm killing my body and stuff, the doctor would say, "Okay, let's discuss what's going on." But the methadone doctors? "You quit chipping [using once in a while], or you're cut off." How does that solve anything? So what if the guy wants to chip? That's his harm reduction, on really bad days. But the methadone doctors cut you off if you can't stay on the program.

Now the methadone program is run by BC Centre for Substance Use instead of the College of Pharmacists. I work for the centre as a peer research assistant. But a doctor who

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learned about methadone 25 years ago, they really get stuck in their ways and we can't tell them anything. "Oh no, it doesn't affect you that way." "Yeah, it does, we've actually lived through this." That's part of the stigma of being a drug user and being on methadone: we're not listened to as individuals with something important to say. We're mostly seen just as dirty ex-junkies who're now getting their dope for free.

That's why a group of us in the methadone program wrote *Patients Helping Patients Understand Opioid Substitution Treatment*, a handbook about methadone patients' rights.[2] The University of Victoria approached a group of us through BCAPOM. The handbook isn't written by the doctors or counsellors. It's by the patients, for the patients, in our language. We let other patients know what they're going to face. We tell them: this is what's gonna happen, this is the way you are going to be treated, this is how not to be treated that way.

The way forward: Safe housing and better access

I do a lot of work nowadays with VANDU [Vancouver Area Network of Drug Users], BCAPOM. We're on the decriminalize-and-regulate path. It's funny, up until the 1950s they used to sell laudanum over the counter. Morphine was in just about everything. Big Pharma, they took it over. It's just some cash grab by some pharmaceutical company is how I see it.

With methadose, a lot of people are relapsing because methadose just metabolizes faster. *I've* been using, because it [methadose] just don't last. But it's terrible; it just isn't working.

Last time Trudeau was in town we did some roundtables; I sat in there and I told him I used to grow my own poppies up in the Kootenays. Because they can grow here. I would take my poppies and bleed them, I'd get that and smoke that in a pipe like oil and then I'd take the rest of the plants, I'd chop them up and I'd make tea. And I'd just leave it in my fridge. It would be so simple: we could grow our own poppies, produce our own.

The funny thing was, January, February, when I ran out of that tea, I wasn't dope-sick at all because I was taking it naturally, basically just boiling it down and making a tea. No chemicals added to it. I never got sick. I'd drink a cup of that tea a day and I'd be fine. And when it would run out, it would run out; it was no big deal.

I wish I had access to that now. I probably could've kicked my habit. I stopped growing poppies because I moved here and lost everything.

Trying to get clean in downtown Vancouver is just ludicrous. The thing with the treatment places is in the majority of them you do the 90-day program and they're like, "Okay, you're better now, here's your welfare cheque, see ya!" You end up living at ground zero. You can't get out of it.

But we've been doing real good the past year, me and my wife. I still get hot flashes from the methadose, but my wife is always supportive. We've been together 16 years now. She doesn't use, never used. Though she doesn't come with me to the clinic or the pharmacy, she's involved with BCAPOM, and she comes to the meetings and the protests.

Life has its ups and downs, but our housing is stable (not like the Palace Hotel). We have a good apartment, and our rent is subsidized. It's nice, we're out by Commercial now. In this society, so many people are so close to being homeless—it's like the choice between turning the lights on or having lunch today.

The thing is, I had to go on methadone to get that first housing downtown. I don't have to use methadose anymore, but now I'm wired to it. And I have me and my wife to support. She's not in the best of health, we're both in our 50s. I can't afford to just quit and be sick for three months.

It's not like I'm going to treatment either, especially now that I'm on the methadose—most treatment centres don't accept you on methadose. And abstinence these days isn't the best idea. People come out of them recovery houses and they're using again and then they're dead because they're getting all this fentanyl.

During Prohibition in the 1920s, people still drank alcohol, they just did it more dangerously. Look how many deaths there were from bad alcohol, alcohol poisoning, blindness, all the violence. Now, it's exactly the same thing with drug use. There's all the stigma around using, but people still do it. It's just more dangerous now.

When I look back at it all, I know that if we could have got into housing without my entering the methadone program, then I would've just kicked my habit. Then I wouldn't be wired to methadose now. It all comes back down to housing again. v

It Takes a Recovery-Ready Community to Keep Loved Ones Connected and Healthy
AND TO REDUCE THE HARM FROM SUBSTANCE USE

Sherry Vaile Robinson

My son Tyler fatally overdosed on heroin laced with fentanyl in a friend's hotel room on January 27, 2016. He was 23 years old.

As a single parent, Sherry navigated a confusing health care system to find supports for her son, who lived with substance use challenges as a teen and young adult and pervasive mental health issues for eight years of his all-too-short life. Sherry is a member of Moms Stop the Harm (www.momsstoptheharm.com)

Sherry's son, Tyler

Like many parents who have lost a child to fentanyl overdose poisoning, I have searched for answers, and I struggle with feelings of remorse and guilt. There are so many "what ifs" to consider. I am sure that Tyler would have preferred to share his experiences from his own perspective rather than have his mother tell his story.

As a single mother on long-term disability—with some physical and mental health issues of my own—I felt powerless to be able to provide my son with the support he needed, especially when he began experiencing mental health challenges and became more aggressive as a young teen. It did not matter that I had always considered myself to be a competent and skilled parent; the highly charged emotions of a male teenager in a mature physical body, combined with the intense, drug-induced reactions that Tyler experienced once he began using substances, were too overwhelming for me to manage safely alone at home.

In Kamloops, as in many small communities in British Columbia, there were barriers to accessing the few mental health and support services available. The long wait for services prolonged the stress for our family. Matters went from being tolerable to requiring crisis intervention as Tyler's behaviour escalated once he entered puberty. By the early years of high school—after waiting more than a year and a half on a child and youth mental health waitlist—it was too late: there was no

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way Tyler would willingly enter an office to meet a counsellor.

By this time, after frequent use of ecstasy and LSD, Tyler had developed an addiction to crystal meth and heroin. His behaviour became aggressive when he was upset or angry and sometimes the police visited our home to mediate the tense situations.

There was a brief period in high school when things looked hopeful. Tyler met a male teacher whom he respected and felt connected to. He wanted to remain in that teacher's relatively small, specialized classroom, where his social anxiety was reduced and he felt especially connected to his peers. In such a huge high school, this teacher and this classroom made attending school tolerable.

But Tyler was soon expelled from school due to an incident of aggressive behaviour. This expulsion contributed to a downward spiral in which Tyler became even more disconnected from home and his school peers. He began to couch surf; he would live with friends until there was conflict and then return home.

I have a particularly painful memory of this period, one of the several times I had to call the police for assistance. Tyler was being held in the back of the police car, clearly in emotional distress. The officer told him, "Tyler, act like a man." Tyler retorted, "Show me, I don't know how."

On another occasion, Tyler was admitted to the hospital involuntarily because he was thought to be at risk for self-harming. It was a hopeful attempt, coached by a counsellor, to have Tyler assessed by a physician and connect him with services. But Tyler was released from the psychiatric facility 48 hours later. There was no face-to-face family meeting. I received a phone call that he had been released. I picked him up on the street outside the facility.

Tyler told me that the whole experience had been traumatizing. He'd been kept in seclusion and the psychiatric assessment had been brief. He had not been connected with any community supports. He'd been told that first he needed to address his addiction. It seemed as if Tyler had fallen through every crack in our fragmented and resource-lacking health services system.

During this time, I was told that Tyler would have to hit rock bottom before there would be a change, and that might even mean poor health, such as organ failure. No parent of a teen wants to wait for a decline rather than seeking prevention!

As the years went by, I realized that I was grieving the loss of time with my son, and the loss of opportunities for Tyler. His peers had graduated from high school. They had got their driver's licences and had secured jobs; they had the ability to travel. Tyler was unable to focus on tasks or hold down a job. He survived on a small disability income.

He tried attending a detox centre a couple times but would leave early due to his anxiety. There were even a few attempts at home to transition onto methadone and Suboxone, as well as a trial of medication for psychosis. But it was still not safe for me to have him at home; his intense and aggressive behaviours were now sometimes fueled by psychosis.

Without stable housing options or a treatment centre, Tyler's attempts at recovery would always fall apart. It is known that access to these supports needs to be available when the person is most motivated and willing.

In the months leading up to his death, Tyler had been struggling to fulfill his probation orders due to a shoplifting charge from earlier that year. The judge's ultimatum: either attend a recovery centre or return to jail.

Tyler booked into a nearby abstinence-based recovery centre on the last day of the deadline. Despite his optimistic plan to stay there for five months, he left the centre after only a two-week stay due to his anxiety and withdrawal symptoms.

In my opinion, an abstinence-based recovery model is unrealistic and medically dangerous. Withdrawal symptoms during the initial detox can be severe, and the individual who is dependent on opioids is very vulnerable at this time. Relapse happens frequently as people try to self-medicate to ease the physical and mental symptoms of withdrawal.

Had there been adequate support on site to provide medical and psychological assessment, monitoring and counselling, perhaps Tyler could have persevered with prescriptions and emotional support to manage the intense symptoms that accompany withdrawal from opioids. But Tyler left the centre and returned to Kamloops. He sent me a remorseful

Sherry and her son

message that he was sorry and wanted to return.

Throughout Tyler's life, whenever we said good-bye to one another, no matter what else was going on, we always told each other that we loved each other. Those good-byes made life feel so precious. You see, Tyler knew that fentanyl was out on the streets and that his drug use was life-threatening.

In May 2016, a few months after Tyler died and while I was still overwhelmed by my grief, I came across a report for the Legislative Assembly of British Columbia: *A Review of Youth Substance Use Services in B.C.*[1] The report was prepared by the Representative for Children and Youth, Mary Ellen Turpel-Lafond. She argued that yes, indeed, there were many cracks in our support systems for youth and families. The report validated my grief and frustration. No longer did I have to see Tyler's death as a personal failure or feel guilt and shame.

I have privately journaled for many years. But I found that after my son's death I did not feel satisfied to privately journal. I needed to channel my grief in a positive way. I did not want to be anonymous anymore.

I chose to go public on social media with my personal experiences. It has helped me to explore the grief that I went through before Tyler's death, and the grief that I continue to go through. I can channel that grief and feel empowered to make a difference, challenge stigma and hopefully prevent future fatal overdose poisonings. Although friends and followers say that my social media posts are heart-wrenching to read, they have helped them to better understand addictions and mental health concerns. My posts have made a difference. I would like to be an encouraging voice so that other families and individuals will practise courage and seek or advocate for supports as well.

Addiction is a health issue, not a moral issue. Community shame and stigma destroy human connections essential for health and wellness. As a community, we all need to listen to understand what it is like to live with an addiction and help build relationships that encourage the inclusion of all people. It is crucial that community frustrations are not projected onto struggling individuals and families, increasing shame and stigma, breaking down the desire to seek help. More young men die using opioids in seclusion instead of seeking supports to reduce the harm.[2] What is needed in order to recover is a community connection. After all, at the root of the word "community" is "unity."

Connection happens through a dialogue of shared understanding. Dialogue can only happen when we practise listening empathically to each other, connecting to others as they are, not as how we want or expect them to be.

When we respond by acknowledging the person's feelings rather than being defensive, we create an atmosphere of compassion, and compassion builds connections. People with addiction need compassionate boundaries and social supports, not rejection. With a sense of belonging, our loved ones may be less likely to relapse and self-medicate with substances.

The opioid crisis is everywhere. We can't avoid it and there is no point expecting that it will just go away. Our communities need to become "recovery-ready" communities. A recovery-ready community can provide preventative and supportive services when the person is most motivated and ready to seek help. It takes courage to seek and ask for help. When a society places stigma on addiction and mental health issues, it drives people into isolation.

Tyler was a forthright communicator and did not like to be silenced. He was a quick-witted, opinionated and intelligent young person. But his voice is now silent and missing from our conversations and our community dialogues.

Disconnection and isolation increase the chances of opioid poisoning. Our communities need to reduce the harm and the stigma of substance use. When our communities are recovery-ready, we create a sense of belonging. A sense of belonging in community is what keeps us healthy. v

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“It helped me forget”

A YOUNG MOTHER’S JOURNEY THROUGH LOSS—AND FINDING HOPE

Farren Whitford

Growing up, I lived with my mom until I was about 12 and then I moved in with my grandma (me and my stepdad just didn’t get along). I lived with Grandma for about a year. She was an awesome lady. Then I got taken away by MCFD [Ministry of Children and Family Development, child protection services].

Photo credit: ©iStockphoto.com/Halfpoint

Farren lives in Quesnel, BC, currently at Season’s House Shelter. She is looking to be reunited soon with her four children, who are in government care. She’s a member of Lake Babine Nation and was named after her mom’s favourite character on the television show The Young & The Restless

Based on an interview with Farren by Sarah Hamid-Balma

After that I was in foster care as a ward of the ministry. I’m 29 now.

Around the time the ministry took me away, I quit school. That’s when I started using drugs. I had smoked weed already, but somebody really close to me—one of my older friends—he introduced crack to me. I didn’t even know what it was at first. I thought he was smoking weed out of a pipe, but it was crack. So, when I started smoking crack, I didn’t even know what it was. I was also doing crystal meth, I was doing down* and Percocet and morphine. I was doing everything.

I thought I was having fun. It made me want to be with people. It helped me forget how fucked up my life is. I didn’t know any better. I was just a kid.

I finally moved in with Grace, my foster mom. She’s a wonderful lady; she never gave up on me. I stayed with her for about three or four years. We’re still close. I still call her Mom.

I still used drugs when I was at her place. But I quit for a year when I was 16. I was pregnant with my daughter and I went to juvie.** But then I quit and I could have kept my daughter.

** “Down” is western Canadian slang for synthetic oxycodone, an opioid.*

*** “Juvie” is slang for juvenile corrections.*

My grandma wanted me to keep my baby. But three days before I got out of juvie, my grandma passed away. I could have stayed in a foster home and had my daughter but I didn't know if when I turned 19 if she could come with me or she'd have to stay in care. I didn't want to chance it so I let my mom and dad raise her. I moved in with them and when my daughter was two or three months old, I got kicked out and then I couldn't see my kid for a while. So I started using drugs again.

It wasn't hard to stop (when I was pregnant). When a person is pregnant they should never ever do drugs. All my kids—I have four kids—I've never done drugs while I was pregnant, never drank. I never even took a Tylenol. Did labour all natural. My other three are in foster homes, separated. My oldest is 12, my son just turned 8, my daughter's 6 and my baby's 3.

I haven't seen my kids since last February. I'm working toward seeing my kids now. I need to talk to a psychologist and do drug and alcohol counselling. I don't think any of it will help. I just wish bad things would just stop happening. I use drugs so I can just stop thinking about everything.

When my kids were home with me, I was clean for many years. I quit when I was 19. They've never known me to do drugs; I never even drank. I despised drugs. I hated drugs. I did parenting classes and moms' groups. I did a whole bunch of programs. I had my day scheduled in my day planner.

They didn't get taken into care because I started using. I started using again because they got taken into care. So my kids get taken. My kids' dad ended up going to jail. I lost my house. My uncle died then, too (of ALS). I had to get an abortion around then. And then it was just me, alone. It was a brutal month.

The day they were taken, October 2014 … My kids weren't even home; they were at school. I was cleaning everything up. My baby, he had his own area, like half the living room. His area's all clean and he's nice and safe. The rest of the house I had everything pulled out; I was cleaning while my other kids were at school. I had a new social worker for like two or three months. That social worker, well, she came over while I was taking my kids to school and all she sees is a big mess.

And then I went to go get my kids, and my son and daughter weren't at school. I called my social worker and she tells me, "Come to the ministry," and then she took my baby from my hands. They never told me for like a whole month why my kids got taken. All she kept saying was that I was a bad mom.

Then she blamed me because my daughter lost her hair when she was 10 months old. But my daughter has an autoimmune disease. Her hair grows in and then falls out, grows in and falls out again. She just kept saying it was my fault. And then my daughter's hair started growing back in and they're like, "See, this is how you're supposed to look after your kids." I was like, "It's gonna fall back out," and they're like, "It looks like it's growing to me." And they're like, "You're just a bad mom and you can't even take care of them."

A few days later, my daughter's hair started falling back out, so I said, "So it's my fault it's falling out, I'm stressing her out and everything?" So I said, "You guys are stressing my kid out. It's your guys' fault now. So how does it feel? It's not my fault, it's nobody's fault." They wouldn't even apologize.

When they got taken away, I only got to see my kids like twice a week for an hour and a half. And then the social worker tells me I can only see my kids once a week—that was when they'd been there for like six months. I told them, I've been doing everything you guys want. You aren't even working with me. And my youngest, he's just a baby and you only let me see him once a week? Then I flipped out. I had been calm for like six months, I was doing everything she said. But I finally snapped and I got charged with uttering threats.

I finally have a good social worker now after two years. And I have an advocate helping me through the shelter, Seasons House. My advocate was a boss at the ministry for years. He helps talk for me and he makes sure everything's getting done. He's been around a long time. When I was a kid, I told my grandma that I was going to go to school and become a social worker one day and take his job.

I've been at Seasons House five or six months. I didn't have to be homeless; I chose to be. I didn't trust myself. I didn't want me to have a place where I'm just going to do drugs and OD myself. I can't do that. I can't abandon my kids.

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> I didn't have to be homeless; I chose to be. I didn't trust myself. I didn't want me to have a place where I'm just going to do drugs and OD myself. I can't do that. I can't abandon my kids.

When my kids got taken away, I used again. Mostly I do speed, but for the past year and a half, I've been doing heroin, too. It just helps me forget. The speed calms me down, I guess, because I have ADHD and that's what speed does for ADHD. Heroin is not a good drug to get into. People need to go get help and admit they have an addiction instead of hiding it. I kept trying to believe I didn't have an addiction, that I could just quit whenever. Of course, I have an addiction now but I've been trying to fix it.

I'm not on any medication right now. I really suggest going on Suboxone. I was on it for a while; I just got lazy to go get it. It was f$%*ing horrible when I quit heroin this last time … like really bad flu. But it wasn't like when I first quit heroin, when I just tried to do it cold turkey. Never doing that again! I'd never got sick because I'd always had it so I was always wondering what everyone was talking about. But now I know. You can get cold and hot at the same time, sweat and shiver, pain into your bones. I wouldn't wish withdrawal on my worst enemy. The sickness lasted like six or seven days but the sore bones took a couple of weeks.

But then I ended up doing heroin again and that's when I got Suboxone to help me quit. I decided to get help and finally admit that I have an addiction. I didn't feel sick from stopping Suboxone. I would really recommend it. It's really easy to come off of and you're not going to be on methadone the rest of your life.

But I've still been doing speed every day for the past two years. I was prescribed ADHD meds when I was a kid. My doctor is thinking of getting me back on it so I don't have to be doing speed to calm me down. My brain's just all over the place if I don't do it.

I have to keep going to counselling to see my kids again. And I have to get my own place. Winter's nearly here and I kinda need a place. But I only get like $375 subsidy for rent and rent's $750. I can't afford a place as a single with $375.

The past few months, me and George from Seasons House here, we've saved three people with the Narcan kit. The first time was two people by the river: they were practically dead and then everyone was just standing around watching them die and so I jumped in there and told people what to do.

There's fentanyl in the speed I take. I'm always alone when I use so I guess when I do it, I guess I just don't care. I do care but I don't. Just some days I get too depressed.

But I'm actually thinking of going back to school to be a drug and alcohol counsellor when I quit. And now I also want to learn my First Nations language (my grandma tried to teach me) so I can teach my kids; I think they would like it. My kids give me hope. They're the only reason why I'm still here.

The Chronic Pain of Pain Management

HOW THE NEW OPIOID PRESCRIBING GUIDELINES RISK PATIENT CARE

Kathryn Sutton

Since the College of Physicians and Surgeons of BC (CPSBC) announced changes to the opioid prescribing standards on June 1, 2016, health care providers and people living with pain have raised concerns about how the new policy may have a damaging impact on the treatment of chronic pain in this province.

Kathryn is the Communications Lead for Pain BC, a BC-based registered charity dedicated to improving the lives of the one in five British Columbians living with pain

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The new policy included legally binding standards as well as guidelines; since the policy was launched, new national guidelines for opioid prescribing have been issued and the CPSBC is in the process of revising its policy, limiting it to the BC legal standards used together with the national guidelines.

The CPSBC policy was intended to reduce the prescribing of opioids and other medications likely to be misused. By extension, it was hoped, the new policy would also reduce addiction, overdoses and other adverse outcomes. Yet since the CPSBC policy was introduced, the number of overdose deaths has continued to rise; there were 510 overdose deaths in BC in 2015, 981 in 2016 and 1,422 in 2017.[1]

The devastation of the overdose crisis in BC is undeniable. Every

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day, four people in the province die by overdose. But data from the BC Coroners Service show that while the opioid fentanyl is involved in roughly 80% of overdoses,[2] the number of overdoses from opioids prescribed to patients for pain has remained virtually constant for more than a decade.[3]

Poor access to non-pharmacological pain management is part of the problem. There is little public funding for physical therapy, psychological support and other pain management services.

Pain BC supports evidence-informed practice for doctors and adequate pain relief for patients. We strongly encourage non-pharmacological approaches to pain management, and we recognize the harms of unsafe prescribing. While we support efforts to curb the unsafe prescribing of medications, we have serious concerns about the implementation of the CPSBC's new prescription standards. Policies like this don't exist in a vacuum. They have an effect on, and are impacted by, the context of the broader health care and social system.

One in five British Columbians lives with chronic pain,[4] but only 8-12% of people taking opioids for chronic pain are also living with addiction challenges—a rate of addiction similar to that of the general population. The new standards make it very difficult for people who live with chronic pain to access pain management medication through legal channels and have driven some people in pain to access medication through the illicit drug market.

Many chronic-pain patients have told Pain BC that they are no longer able to access the pain medications they were once prescribed. They cannot find or afford effective non-pharmacological pain management options. Some physicians have told us they are reluctant to prescribe opioids for fear of sanction.

"This change in prescribing standards has presented significant challenges," says Terri Betts, a hospital pharmacist and parent of a young adult with chronic pain. "Our family doctor left her practice earlier this year, and a new physician implied my daughter's pain was all in her head, even though he had been forwarded a specialist's report with a clear explanation of the likely source of her pain. After a few months, my daughter's opioid medication ran out."

Terri's personal experiences are reflected in her work as a pharmacist: "Patients at the hospital now tell us how apprehensive they are about their doctor's upcoming retirement," she says. "They know that a new doctor won't prescribe opioids even if the medication has been helpful and the patient has used them carefully for years. It's a very difficult time to be a person in pain."

Poor access to non-pharmacological pain management is part of the problem. There is little public funding for physical therapy, psychological support and other pain management services. Patients who have funding through extended health benefits often can't find experts who have the knowledge and skills in pain management in their local communities, and many people in pain do not have employer-funded extended health coverage because their health problems limit their ability to work.

Additionally, doctors in BC typically are not able to devote enough time in a standard office visit to do a complete pain assessment (which should include a discussion of the patient's pain, sleep, mood and function). Nor is there time to review all the non-pharmacological and pharmacologic options for pain management or properly assess a patient's risk of addiction. BC currently has no complex care fee code for chronic pain, like it does for mental health, hypertension, diabetes and other complex conditions. This fee code recognizes the complexity of managing chronic disease and provides physicians with sufficient time to ensure patients receive optimal care.

We also hear often from people that their physician's confusion or apprehension about the CPSBC standards and national guidelines is affecting patient care. "The College of Physicians and Surgeons say these are just guidelines, but my GP took them as gospel, and immediately started to limit my opiate use with their guidelines

Photo credit: ©iStockphoto.com/juanmonino

Fears of overdose and fostering addiction are having a harmful impact on people in pain, including those who live with both pain and addiction.

as a ceiling for how much he can prescribe," says Andrew Koster, who has ankylosing spondylitis, a form of arthritis that can cause vertebrae in the spine to fuse. He is currently awaiting knee-replacement surgery.

"These diseases have robbed me of my ability to work, to be an active and present father, to be a husband who can share and contribute," Andrew says. "There are drugs that have been suggested by pain clinic clinicians, drugs that might help me manage my pain, that I won't get to access because my GP won't consider prescribing them in this current climate."

It's well understood that opioid prescribing has been used as a band-aid solution for an inadequate broader system of care for people with persistent pain. In the summer of 2017, the BC Centre for Disease Control recommended improving access to affordable multidisciplinary, non-opioid pain management strategies, including counselling and physical therapy, as part of its recommendations for reducing opioid use.[5]

In the absence of the necessary supports, patients and physicians have often relied solely on prescription medications to treat pain. Now, fears of overdose and fostering addiction are having a harmful impact on people in pain, including those who live with both pain and addiction.

Addiction is a complicating factor, and life circumstances such as poverty, trauma, mental illness, economic inequality and unmanaged pain can all contribute to an individual's reliance on addictive substances. But punitive prescribing standards do not adequately address these complex social dynamics. They will not end the crisis of overdose deaths or magically bring about an end to addiction. One of the root causes of addiction—untreated pain[6]—needs to be addressed with an accessible, multidisciplinary approach that includes both pharmacotherapy when it is needed and non-pharmacological supports.

Far from being helpful, the CPSBC's standards are having unintended negative consequences—potentially contributing to the overdose crisis rather than helping to relieve it. At Pain BC, we fear that the new policies will force chronic pain patients to take desperate measures in their search for adequate pain relief. Lacking accessible alternatives, some patients are turning to the illicit drug trade for their pain treatment options. The overdose crisis has made the illicit drug market a dangerous field indeed, but some people with chronic pain—both those with substance use issues and those without—feel they have no other choice.

One of the first principles of medicine is reflected in the Latin phrase *primum non nocere*—first, do no harm. The new prescribing guidelines do more harm than good. Physicians who treat the 20% of British Columbians who live with chronic pain need workable options that don't further stigmatize the patient or the condition. v

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Duncan's Overdose Prevention Site

DUNCAN'S OVERDOSE PREVENTION SITE SERVING THE COMMUNITY AND MAKING POSITIVE CHANGE

Melissa Middlemass

The overdose prevention site in the city of Duncan on Vancouver Island opened on September 12, 2017, as part of a program funded by VIHA (Island Health) and operated by Canadian Mental Health Association's Cowichan Valley branch.

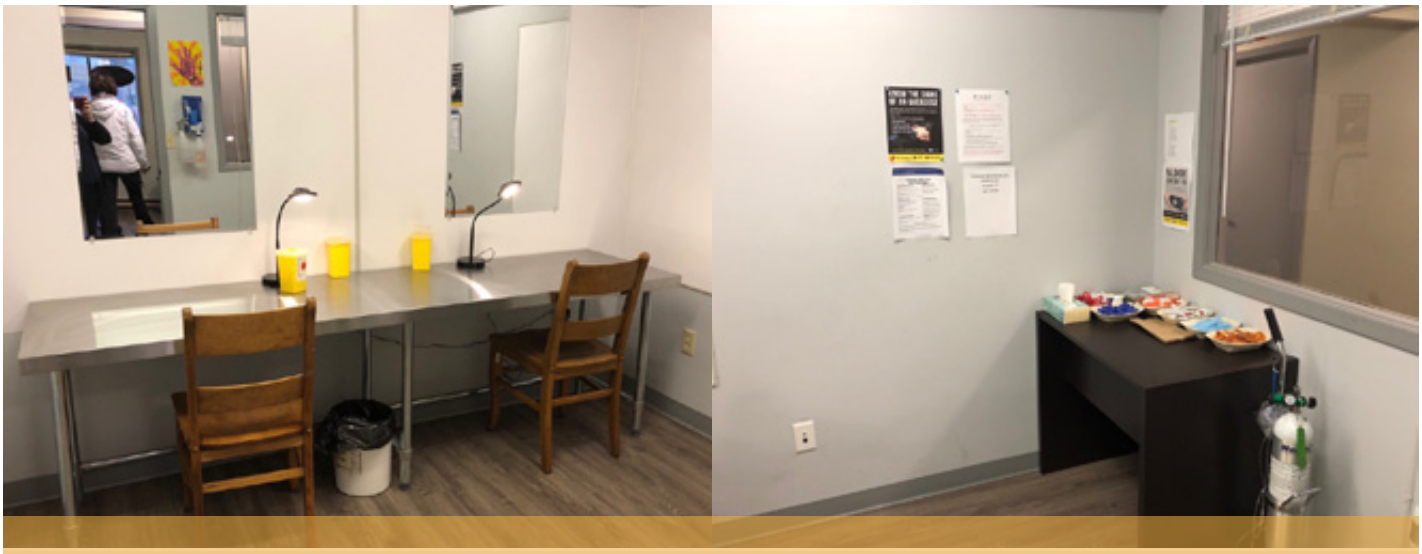
Photo credit: ©iStockphoto.com/monkeybusinessimages

Melissa is an overdose prevention site worker with the Canadian Mental Health Association's Cowichan Valley branch in Duncan. She joined CMHA last February, having previously worked at the sobering centre in Victoria

The decision to open the site was driven by the need to help address the growing number of overdoses in Duncan and the increasing concerns of local health care professionals and residents.

The overdose prevention site itself looks very much like a medical clinic—in fact, it used to be a doctor's office. Currently, the site is staffed for six hours a day (from 1:00 to 7:00 pm), and two staff members are on-site at all times. On average, the site sees about 13 people each day, but this number fluctuates—and we tend to get busier on the days when welfare and support cheques are delivered. Client numbers have also increased as we become a familiar presence in town. In Duncan, an overdose prevention site is a completely new amenity, and at first the residents (potential clients and non-clients alike) were unsure about our presence. Over time, however, we have begun to build relationships.

At the site, when clients first come in, we greet them and try to make them as comfortable as possible. A local food bank donates muffins, and we



The two spaces at the Duncan overdose prevention site

Over time, we've learned a lot about all of them, their likes and dislikes, and their past. And over time, we can see that the site has become a comfortable place for them.

offer snacks, juice and water. In fact, we try to have clients to drink water in front of us. Often, they come in very dehydrated, especially if they have been using heavily over the past several days.

Once clients are settled, we make sure they have the supplies they need (like sterile needles) to take the drugs they've brought with them. We don't have any cubicles. just one small room with a stainless-steel table and mirrors. We had thought initially to separate the space into compartments, but we're not sure now that we will. Many clients come in as couples or with friends, so they're using together—generally injecting, although the odd client will snort cocaine (at this point we don't allow smoking because we don't have adequate ventilation).

When we first opened our doors, most of the clientele were women, but over the past several weeks we've started seeing more men. Now that we've been here a few months, we're not only seeing people who live on the streets; we're also seeing people from the community who have housing. Many of those who have housing come in for supplies, but some of them come in to use as well.

We definitely have regular clients, but recently we've also seen a lot of new faces. And a lot of those faces are young—our youngest clients are in their mid-teens. Our oldest clients are over 40, although it is often difficult to discern exact ages. Generally, the younger clients are chattier, and the older ones are more reticent. Most of our clients are in their 20s or 30s.

It's especially distressing to see the younger people in here. To have access to shelter, you have to be 19, so these younger people have nowhere to go. I think that's what frustrates me the most.

So far at the site, we haven't had to use naloxone. We've had five or six overdoses, but we've actually been able to bring everyone back with oxygen. When we consulted with other site workers, we learned that the best approach is always to use oxygen first—and 90% of the time that's all that is needed. Oxygen works: it gets the client talking, keeps the client stimulated. Of course, we're right here with the client, so if something happens, we catch it immediately. We see what's happening, and we react quickly to ensure they get oxygen as soon as possible.

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One of the most satisfying aspects of working at the site is seeing the social connections that are slowly being made. One client used to hide in the corner; he would talk to us but he did not want us to see him using. Another asked if he could close the door, and we had to tell him that it was against our policy, so he would hunch over while he was injecting. He didn't want anyone to see him physically using. At the other extreme, another client chats with us continuously the entire time, without a care in the world.

Over time, we've learned a lot about all of them, their likes and dislikes, and their past. And over time, we can see that the site has become a comfortable place for them. One of our clients has even gone into rehab; we haven't seen him since. Another client has started asking about detox options. One couple comes in and gives us hugs and asks how we're doing. It's rewarding to help people, and it's rewarding to see how appreciative they are. We've started building trust; our clients know we don't judge them, and they've started opening up to us.

I think most people don't understand the trauma that many of our clients have gone through to get to this point. Perhaps they had a work accident and became addicted that way; perhaps they had a difficult home life and turned to substances to cope. Negative stories in the news and on social media don't help, and the community backlash at times has been difficult. While people might like the idea of a program that addresses the opioid crisis, they don't always like the idea that such a program might be in their own neighbourhood. The concept of NIMBYism is pretty well entrenched.*

I think most people don't understand the trauma that many of our clients have gone through to get to this point.

At the Duncan overdose prevention site, we've been lucky so far. We haven't experienced too much in the way of negative judgement. A few visitors early on expressed concern, but we went out of our way to be open with them and to show them around, and they left feeling good. Another gentleman came in and told us that while he wasn't initially happy to know we were in his neighbourhood, he has been pleasantly surprised: our presence is not as horrible as he thought it would be!

Bit by bit, I've even been able to convince a skeptical family member that the overdose prevention site is a positive presence in the community. As I tell him stories about our clients and their experiences, he's begun to see things differently. Recently, he even donated a tent!

No one wakes up one morning and decides to be a drug addict. Open, non-judgemental listening can make a difference in someone's life, and it can make a difference in our communities. My family member is finally listening. He's coming around. And that's huge. For me, that's the sort of positive change that the Duncan overdose prevention site symbolizes. v

** NIMBY is the acronym for the colloquialism "Not In My Backyard," the idea that while people might support positive social change in the abstract, they may not feel comfortable seeing concrete changes implemented in their own communities or neighbourhoods.*

What Do Trauma and Gender Have to Do with Opioid Use?

Natalie Hemsing, MA, Nancy Poole, PhD, and Lorraine Greaves, PhD

The majority of women and men with substance use problems report having experienced some form of trauma, and most have experienced multiple traumas.[1] People often report that they use substances to help cope with the stress or negative emotions that result from trauma. Our work at the Centre of Excellence for Women's Health (CEWH) suggests that a gendered and trauma-informed approach to responding to opioid use is essential to improving practice and policy to meet the needs of all opioid users.

Natalie is a research associate at the Centre of Excellence for Women's Health (CEWH), in Vancouver, BC, hosted by BC Women's Hospital and Health Centre, with an extensive background in sex- and gender-based analysis, research on women's substance use, and systematic reviews and knowledge syntheses on a range of girls' and women's health issues

Nancy is the Director of the CEWH, leading knowledge translation, network development and research related to improving policy and service provision for girls and women with a range of health issues, including substance use and trauma

Lorraine is the founding Executive Director and current Senior Investigator at the CEWH. She is an international expert on women's substance and tobacco use, gender and health promotion, and the integration of sex and gender in research, program and policy development

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Compared to other substance users, women and men who are addicted to prescription opioids are more likely to report a traumatic event.[2] They also tend to have first experienced trauma at a younger age and are more likely to report a childhood trauma, including childhood abuse or neglect, or to report having witnessed violence.[2] Women and men who have a history of trauma tend to report more severe addiction to opioids, and poorer physical health.[3] Depression, anxiety, self-harm and suicide are also common among women and men who are addicted to opioids (including prescription opioid misuse and illegal opioid use).[4]

Women and men who are addicted to opioids report different experiences. Among women, the greatest risk for opioid addiction is receiving a prescription for opioid medication.[5] In general, women tend to report experiencing more chronic physical pain, and are more likely to receive a prescription for an opioid painkiller.[6,7] The risk for chronic physical pain is even greater among women who have

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been victims of violence and abuse.[8] Women may also be more likely to use prescription opioids to manage the effects of trauma. There is some evidence that women are more likely than men to use prescription opioids to cope with negative emotions and pain.[9]

In contrast, men are more likely to use illegal sources of opioids, and engage in riskier drug use, including using the drug while alone, increasing the amount used and ingesting the opioid in a way other than the drug was intended to be ingested (for example, by crushing and snorting or injecting).[10-13] Men are also more likely to die from an opioid-related overdose (fentanyl in particular).[13] However, trauma is also a risk factor for prescription opioid abuse among men. For example, among young injection drug users, men with post-traumatic stress disorder (PTSD) are at the greatest risk for prescription opioid abuse and addiction.[14]

Both women and men addicted to opioids report complex needs, including the need for mental health, legal, financial and family supports.[15] While women are more likely to be victims of sexual violence, childhood abuse is linked with greater risk for prescription opioid abuse in both women and men.[16,17] Clearly, the evidence suggests that gendered and trauma-informed approaches to early intervention and support are needed to address opioid misuse for both women and men.

How can trauma-informed practice help?

Trauma-informed practice (TIP) is a set of ideas and ways of working with clients that recognizes how important it is to offer safe, non-judgemental services so that people with a history of trauma can access and benefit from available substance use supports and treatment. Trauma-informed approaches do not require that the service provider ask about or discuss the trauma. Instead, trauma-informed approaches are designed to ensure client safety, choice and control in the decisions that impact their substance use. They also provide opportunities for the client to build appropriate coping skills to manage trauma responses.

Trauma-informed approaches are designed to ensure client safety, choice and control in the decisions that impact their substance use.

There are four key principles of TIP:

1. **Trauma awareness.** TIP involves developing awareness (among both service providers and clients) regarding trauma, the effects and responses to trauma and the links with substance use and other health effects. Basic training of all staff and administrators is key to creating this awareness.

2. **Safety and trust**. Trauma can negatively impact client trust and safety, feelings of self-worth, emotional control and interpersonal relationships.[18] Creating an environment that considers the emotional, physical and cultural safety of clients is central to TIP. Such an environment will provide welcoming, friendly reception, calm waiting areas and posters with supportive messages.

3. **Choice, collaboration and connection.** Service providers use an open and non-judgemental communication style, work together with clients and provide options for change and growth. It's fundamental that clients have choice in how they seek treatment—choice based on safe and healthy relationships with service providers.

4. **Strengths and skills-building.** In TIP, clients are supported to identify and build on their strengths and use healthy coping skills. This may include identifying triggers and practising calming and grounding techniques (for example, breathing, mindfulness and meditation). It also means making change at a pace the client feels comfortable with.

Practical steps towards assessment and early intervention

Trauma-informed approaches involve all levels of staff. Dr. Sandra Bloom describes a trauma-informed agency as a "strong, resilient, structured, tolerant, caring, knowledge-seeking, creative, innovative, cohesive and nonviolent community where staff are thriving, people trust each other

to do the right thing, and clients are making progress in their own recovery within the context of a truly safe and connected community."[19]

Trauma-informed approaches to assessment and early intervention offer an opportunity to begin support on opioid use with a conversation with the client.

Here are some practical approaches to early intervention conversations:[20]

1. **Ensure the safety of the client in the conversation**—asking about trauma is not necessary to provide trauma-informed care.

2. **Let clients know that they do not need to provide details of any traumatic event** and they do not need to answer questions that make them feel uncomfortable. Let them know they can take a break from the conversation whenever they need to.

3. **Ensure that service providers are trained to recognize and respond to signs of re-traumatization**, and have the training and knowledge of resources and referrals to support clients who want specific support related to trauma.[21]

4. **Ensure the client's privacy and a safe physical environment**. For example, ask the client if he or she is comfortable with the door being closed, offer the client water and determine how to make the client most comfortable.

5. **Tell the client up front how information from the conversation will be used or shared.**

6. **Explain why you are asking questions, and regularly check in with the client**, listening closely to make sure the client is still comfortable with the pace and subject-matter of the conversation.

7. **Attend to signs of a trauma response** (e.g., sweating, shaking, a change in breathing) and offer calming or grounding support if it is needed.

8. **Ask about the client's strengths**, including the client's goals and interests, coping mechanisms and available supports.

Trauma, gender and equity issues that are central in determining and shaping opioid use need to be addressed in our conversations and in our support strategies for opioid-related treatment programs. At CEWH, we are working on integrating trauma- and gender-informed approaches into Canada's substance use response system. As one report on trauma-informed approaches sums up, "trauma informed care is as much about social justice as it is about healing."[22]

related resources

Visit bccewh.bc.ca/publications/reportsresources for information on

- women and prescription opioids
- trauma-informed practice
- gender-informed resources
- gender-transformative resources
- women, girls and prescription medication

For additional resources, see the following books and websites:

- Greaves, L., Poole, N. & Boyle, E. (2015). *Transforming addiction: Gender, trauma, transdisciplinarity*. New York: Routledge.
- Greaves, L., Pederson, A. & Poole, N. (Eds.). (2014). *Making it better: Gender transformative health promotion*. Toronto: Canadian Scholars' Press.
- Intersections of Mental Health Perspectives in Addictions Research Training (IMPART): www.addictionsresearchtraining.ca.
- Poole, N. & Greaves, L. (Eds.) (2012). *Becoming trauma informed.* Toronto: Centre for Addiction and Mental Health.
- Promoting Health in Women: www.promotinghealthinwomen.ca.

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More Tools in the Toolkit

EXPANDING MEDICAL TREATMENT OPTIONS FOR OPIOID ADDICTION

Cheyenne Johnson, MPH, and Emily Wagner, MSc

Every day in Canada, 16 people are hospitalized as a result of an overdose. Seven people in the country will die. That's every single day. More than 3,000 deaths due to overdose are anticipated in Canada in 2017 alone.

Photo credit: ©iStockphoto.com/juanmonino

Cheyenne is Director of Clinical Activities and Development at the BC Centre on Substance Use (BCCSU), a provincially networked organization with a mandate to develop, help implement and evaluate evidence-based approaches to substance use and addiction. She completed her bachelor of nursing science at Queen's University and her graduate degree at Simon Fraser University

Emily is Senior Medical Writer at the BCCSU. She completed her undergraduate and graduate degrees at Simon Fraser University. Prior to joining the BCCSU team, she worked and volunteered at a number of non-profit organizations in the areas of mental health, HIV/AIDS and women's health

Here in British Columbia, the staggering increase in the number of overdoses led to the province declaring a public health emergency in the spring of 2016. Despite the efforts of first responders, health care providers and peer groups working tirelessly to respond to overdoses when they happen, fatal overdoses continue in the province at an unfathomable rate. More than 1,000 people have died in the year and a half since the public health emergency was declared.

The introduction of fentanyl and other powerful opioids into the drug supply has been a major contributing factor to the overdose emergency. The death toll also exposes a reality that addiction medicine specialists, families affected by addiction and people who use drugs have known for some time: the system of care for substance use is ill-equipped to properly identify, treat and care for those with problematic substance use.

Opioid addiction is a major driver of the recent surge in overdose deaths in the province. It's also one of the most challenging forms of addiction facing the health care system in BC. Addiction may involve the use of illicitly manufactured opioids,

Opioid addiction is a major driver of the recent surge in overdose deaths. It's also one of the most challenging forms of addiction.

such as heroin or street fentanyl, or prescription opioid medications obtained illicitly. We don't have current estimates for opioid addiction rates among Canadians, but opioid addiction affects approximately 2.1% of Americans.[1]

Earlier this year, the team at the BC Centre on Substance Use (BCCSU) released guidelines to support physicians, nurse practitioners, nurses, allied health professionals and other care providers involved in the treatment of individuals with opioid addiction. The new guidelines address both the lack of awareness among care providers and the under-utilization of alternative treatment options. Developed in consultation with key health systems partners, community and family advocacy groups and international experts, the guidelines reflect the best available evidence and are informed by the lived experiences of people who use drugs and the families of people who use drugs. They also make recommendations for best treatment.

Buprenorphine/naloxone

The new guidelines recommend buprenorphine/naloxone, which has a brand name of Suboxone®, as the first-line treatment for opioid addiction. It's safer than methadone, with a lower likelihood of fatal overdose, a lower risk of adverse events and fewer side effects and interactions with other drugs. Treatment also requires fewer clinical visits and, in many cases, is more flexible when it comes to take-home dosing.

Methadone

For many years, methadone has been the most commonly prescribed treatment for opioid addiction in Canada. Studies have shown it to be significantly more effective than withdrawal or other non-pharmacological outpatient treatments, both in terms of retaining patients in treatment and suppressing opioid use.

However, there are regulatory challenges and potential negative individual and public health effects associated with methadone. Patients on methadone must visit their doctors frequently to receive their medication; most patients have to take their medication daily at a pharmacy, witnessed by a pharmacist. This can make accessing treatment difficult for some. The potential for interactions with alcohol and other substances increases the relative risk of toxicity. There is also an increased risk of medication being diverted to the illicit drug market, where methadone is bought and sold illegally. Recent reports have also highlighted the low number of methadone prescribers in British Columbia, particularly in rural regions, as well as the program's poor retention rates.

Slow-release morphine

Another treatment option recommended in the BCCSU guidelines for patients who have not benefited from either buprenorphine/naloxone or methadone is slow-release oral morphine. Kadian®, a slow-release 24-hour formulation, is approved in Canada for pain management; there is growing evidence to support its use in the treatment of opioid addiction.

Other treatment options

Unfortunately, these medications don't work for everyone. Side effects, intolerance, cravings and ongoing drug-related harms may mean that some individuals require other treatment options. Without treatment alternatives, these individuals face significant risks, including fatal overdose, due in large part to the unpredictable presence of fentanyl and other opioids in the illicit drug supply.

That's why the BCCSU guidelines also include recommendations for non-oral treatment, called injectable opioid agonist treatment. This treatment includes injectable hydromorphone and prescription heroin—and it is controversial. But the guidelines are grounded in extensive international and Canadian research, including the North American Opiate Medication Initiative (NAOMI)[2] and the Study to Assess Long-term Opioid Maintenance Effectiveness (SALOME),[3] studies conducted at Providence Health Care's Crosstown

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Let's Talk Opioids
STRENGTHENING COMMUNITY THROUGH DIALOGUE

Nicole Bodner, BA (Hon), and Kristina Jenei, BSN, RN

In British Columbia, rates of overdose-related death are out of control. Community attitudes bounce between compassion, fear and rejection. The situation continues to be seen as a problem of individuals. But substance-related harm is not only about the individuals who use drugs. It results from a breakdown in human connectedness.

Photo credit: ©iStockphoto.com/lorenzoantonucci

Nicole is a research assistant for the Canadian Institute for Substance Use Research (CISUR, formerly CARBC) and the coordinator for the province-wide Opioid Dialogues project, funded by the Ministry of Public Safety and Solicitor General

Kristina is a research assistant for the Canadian Institute for Substance Use Research and the coordinator for the Let's Talk Cannabis project, a national project funded by Health Canada on dialogue in view of upcoming changes to cannabis legislation

Addressing the overdose crisis—in BC and beyond—must therefore include healing and nourishing the bonds of community. Strong communities make for healthier citizens. When our communities nurture human connections, we are better able to face social challenges.

How can we build strength and resilience in communities, especially those already hit hard by overdose deaths?

Addressing complex issues such as problematic opioid use and overdose requires that we build a shared understanding. Different people hold different views about how to move forward. Yet even the best efforts of recognized experts in the medical research and health services fields have not been able to resolve the crisis or reduce the number of overdoses. No one has all the answers. Now is a good opportunity to begin having honest and open community dialogues about drugs and drug policy—dialogues that include input from a range of stakeholders, including those with lived experience around drug use.

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Ironically, dialogue is more about listening than talking. When people feel listened to, they also feel validated and respected.

What is dialogue?

Ironically, dialogue is more about listening than talking. The sort of listening that is important in dialogue demands our empathy and our genuine curiosity about the experiences of other people—including their assumptions, beliefs and values. When people feel listened to, they also feel validated and respected. The experience of being listened to empathically widens our minds and opens our hearts—and prepares us to listen appreciatively to others with the same kind of engagement and respect, even to people with radically different experiences and points of view.

Few of us ever take the opportunity to engage with people who hold different views. Our social networks are generally made up of people who share our beliefs. Yet when we engage with people who are different from us, we get to see another side of the human story. Even if we do not wholly agree with the new perspective, listening openly and empathically expands our understanding.

How can we engage in dialogue?

Unlike other forms of public communication (for example, debates or negotiations), dialogue is not meant to lead immediately to agreement or action. Instead, the hope is that we will come away from dialogue with a new understanding of the subject, of each other and of ourselves. This new understanding enables us to work together more effectively as community members. As a result, our communities become more flexible, and better able to respond to challenges. And as individuals and communities, we develop a greater sense of control over our own lives and well-being.

Dialogue is more than a process or methodology—it is a way of being. It is an art that requires reflective practice. It is the skill of connecting and building bridges between individuals with different views, especially in times of change.

But meaningful dialogue doesn't just happen. Genuine dialogue occurs only when enough of the necessary ingredients are present. We can do our best to provide those ingredients and maintain a certain flexibility and readiness for dialogue, but we cannot force it into being.

What are communities in BC currently doing to promote dialogue?

In the spring of 2017, 27 coalitions representing both rural and urban centres in the province's five health regions received support from the province-wide Opioid Dialogues project, a community-based dialogue initiative funded by the Ministry of Public Safety and Solicitor General and managed by the Canadian Institute for Substance Use Research (formerly CARBC). These community projects included informal gatherings such as coffee-shop dialogues and booths at community events; meal-sharing at grassroots-style community dinners and facilitated dinner programs; art-based ventures that used drawing, painting, poetry, plays and photography to inspire open-ended conversation; programs that incorporated Indigenous traditions such as talking circles and other ceremonies; and community forums and other public-storytelling opportunities (such as podcasts and TEDx-like events).

In October 2017, due to the continued interest in the Opioid Dialogues project, the Ministry provided a second, larger grant to the institute to support even more communities in their work to facilitate public dialogue. To date, dozens of coalitions from around the province have applied for funding and are working on enhancing their understanding of how to facilitate egalitarian, non-judgemental

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conversations with a range of community stakeholders.

Does dialogue really work?

Based on reports from participating communities, the practice of dialogue is already having some transformative effects on individuals and communities affected by the opioid crisis.

For example, Our Cowichan Communities Health Network, together with various partners, hosted an event at which people were separated into groups of 10 and encouraged to share their fears and concerns about the current opioid situation. Tables of service providers, members of the business community, parents and other stakeholders participated in a series of conversations before re-grouping to talk about what they had learned. At the end of the evening, the energy in the room of over 100 participants had shifted from "You need to do something about the needles" to "What role can I play?" and "I learned a lot because this problem belongs to our communities."

A member of the Surrey North Delta Local Action Team commented on how dialogue had increased a respectful understanding between community members: "I was pleasantly surprised at one table after hearing a mother talk about how badly the police officers had acted when she called 911 on her son who wanted to harm himself. A gentleman was sitting at the table who disclosed he is a police officer and then went on to apologize to the mother for what had happened. Both parties got to share their sides and then they both admitted to how hard it must be to be on the other side of things. Neither party defended their position or tried to make the other agree with them or change their mind."

Finally, a dialogue facilitator with the non-profit PHS Community Services Society in Vancouver pointed out, "Everyone is open about the struggle of using drugs, but there is fear [of] what life would look like without drugs. They asked me what recovery meant to me. I said it's about finding inner peace with who you are as a person. When our group was over, lots of participants stated that they are very grateful for having a place where they can use their voice. I believe everyone enjoys it because it's not a place of judgement, but a place to heal."

We can all contribute to the dialogue that needs to happen in our province. All it takes is the willingness to be curious about and connect with other community members holding different views. The more we devote ourselves to listening empathically and to caring about people who are different from ourselves, the healthier and stronger we will all be as we work towards freeing our communities from the opioid crisis and beginning the healing process. v

five principles for promoting meaningful dialogue

1. **Practice empathy**
   Create a space that encourages everyone to feel what it's like to wear someone else's shoes. Encourage personal stories and testimony.

2. **Celebrate diversity**
   Include a diverse range of perspectives through your program design and activities. Ensure that all voices can be heard, and embolden everyone to participate.

3. **Promote curiosity and learning**
   Pose thoughtful questions that encourage exploration and self-reflection. Model reflective listening and encourage participants to practise reflective listening techniques in order to increase learning and understanding.

4. **Expose assumptions and suspend judgement**
   Explore how our personal views are influenced by our assumptions and past experiences. Bring assumptions out into the open and meet them with respect and curiosity.

5. **Put power in its place**
   Focus on creating safe space, not controlling the discourse. Discuss openly the ways that power imbalances operate in your community, and invite people of power to participate in that conversation as fellow citizens.

Creating Community in the Middle of a Crisis

Katrina Jensen

At the end of 2016, I received an important email. The email had been forwarded to me by someone who had received it from someone else who had received it from someone else, and so on—until it landed in my inbox sometime in November, more than six months after the overdose crisis in BC had reached such epic proportions that it had been declared a public health emergency.

Katrina is the Executive Director of AIDS Vancouver Island (AVI). She has been working in the area of harm reduction for more than 20 years. She dedicates this article to the memory of all those who have been lost to overdose

Photo credit: ©iStockphoto.com/juanmonino

Our staff at AIDS Vancouver Island had just been called to an urgent meeting with Island Health's chief medical health officer—for the first time ever. "I can't tell you the exact numbers," he said, "but we know it's in the triple digits." As it turned out, 138 people had died from overdoses in BC that month, almost double the total of the previous month.[1] What was already an unimaginably bleak situation had suddenly gotten much worse.

As I read through the email chain in my inbox, three words jumped out at me: Community. Overdose. Coalition. And then one more all-important word, especially to anyone working in a non-profit agency: *Funding*.

The email was about a new funding project called the Overdose Prevention and Education Network (OPEN), and it couldn't have come at a more opportune time. As the largest harm reduction service provider on Vancouver Island, AVI had been on the front lines of the crisis, responding with limited resources to the needs of our clients. But we were doing it in isolation; OPEN promised the resources to enable us to reach out across Victoria to build a community-

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based response—exactly the sort of support that we and many others had been looking for since the crisis began in December 2015.

We immediately applied for funding and, by February 2017, eagerly began work on establishing a community-based overdose coalition to provide education and help build within the community the capacity to respond to the crisis. OPEN provided the tools for our organization to reach out to others whom we knew had been heavily impacted by the crisis.

Over the next three months, the AVI coordinator met with a diverse range of people and groups, including front-line organizations, Indigenous communities and people with lived experience of illicit drug use and their families. We were also able to work in new ways with our existing partners, including SOLID, the only peer-based agency for current and former drug users on Vancouver Island.

The people we connected with included many parents who had lost children to overdose; soon these parents were meeting regularly at AVI. Jenny Howard, who lost her only son, Robie, to a fentanyl overdose in May 2016, told us that her involvement in the OPEN project was both energizing and healing: "When we come together like that, it's that sense of committed energy and that feeling of connection. Hearing from the ground up how the crisis was impacting people was a moving experience that broke down barriers."

Our work culminated in a community activation event in May 2017, where we asked the important question

We keep *saying* that addiction is a health issue, but until we really start *seeing* it and *treating* it as a health issue, in the same way that we see and treat diabetes and heart disease as health issues, then we are not going to make progress.

Where to next? The symposium provided community members and service providers with an opportunity to reflect on the events of the previous year and a half in relation to the overdose crisis and to engage in dialogue about the short- and longer-term steps needed to reduce the number of our community members who were dying from overdose.

More than 100 people participated in the symposium, with the goal of honouring the work being done, caring for each other and finding a way through this crisis together. Community members came together to find healing and to find a path forward, articulating what they needed in order to be able to continue to address stigma and save lives. Discussion topics included access to treatment, supporting Indigenous peoples and communities, creating safety in housing, services for families, access to harm reduction and substance use services and supporting front-line workers.

What also emerged at the symposium was a sense of frustration on the part of those most central in this crisis—namely, the people who use drugs, their families and the front-line workers who care for both. This frustration stemmed from the common feeling that these individuals were not being considered in the decision-making processes that directly affected them. It was widely agreed that if community-level knowledge were included in decision-making, it would be clear why some approaches have fallen short.

We also heard about the need for greater accessibility: The need for treatment services to be available in the communities where people *are*, in harm reduction centres, in shelters, in housing. The need to look seriously at home-based detox programs, to expand access to opioid agonist treatment and provide people the support they need to maintain their treatment plans. The need to consider heroin-assisted treatment and other models that have been successful in stabilizing people's lives and improving their health. The need for an end to the criminalization of people who use drugs.

We keep *saying* that addiction is a health issue, but until we really start *seeing* it and *treating* it as a health issue, in the same way that we see and treat diabetes and heart disease as health issues, then we are not going to make progress.

Our efforts also need to focus on creating supportive communities and services. Symposium participants recognized that one of the most significant challenges they faced was addressing the stigma around drug use and overdose. Fear of being stigmatized prevents people who use illicit drugs from accessing services. Stigma within communities makes it difficult to find neighbourhoods where new services can be located. Stigma also impacts the families and friends of people who use drugs or who have died of overdose.

doing grants differently: activating BC's communities to respond to the overdose crisis

Community Action Initiative

What is OPEN?

Overdose Prevention and Education Network (OPEN) is coordinated by the Community Action Initiative (CAI), a provincially funded non-profit agency that has dedicated $750,000 in grants, training and other supports to community-based organizations across British Columbia. The goal of OPEN is to address BC's opioid overdose crisis by getting communities involved and increasing their capacity to serve those in need.

Each organization funded by OPEN receives a grant to build partnerships with other community members. Organizations are encouraged to explore new collaborative relationships, especially with those who have direct experience of substance use and overdose (like drug user groups and the families of people who have overdosed). The year-long process culminates in the development of an action plan to tackle the issue of overdose in the community. During the term of the grant, organizations also receive training in various support and response skills and have access to other resources, such as an online community of practice (a web portal that provides a virtual meeting space for overdose responders to share resources and ideas: www.openanswers.ca) and a conference to exchange information and insights.

Currently, OPEN funds 10 organizations. It aims to double that number by February 2018, at which time organizations already funded by OPEN can apply for additional money to put their action plan into motion.

How does CAI's OPEN project do grants differently?

CAI's mission is to increase the capacity of community-based mental health and substance use organizations and support community-led solutions to mental health and substance use issues. Since its establishment in 2008, CAI has invested over $12 million in capacity-building efforts for over 600 organizations across BC. OPEN provides a unique opportunity for organizations to gather their community members together, assess their needs, build new relationships and come up with innovative strategies and responses to the opioid overdose crisis—without asking organizations to demonstrate that they have met particular service-oriented goals.

Participants also agreed it was critical that public attention remain focused on the overdose crisis. We need to continue to build awareness and collectively express our outrage in order to build the community support and the political will necessary for change. We must continue to find ways to share our stories and our grief.

The symposium event spearheaded a number of important initiatives. A group of parents, peers, community activists and front-line workers started meeting weekly to organize activities to mark International Overdose Awareness Day on August 31. Dialogues with local First Nations communities and organizations and the First Nations Health Authority have continued. The symposium report with its recommendations was shared widely, and a copy was sent to the provincial Minister of Mental Health and Addictions.

Our coalition of OPEN partners also continues to meet regularly, promoting education and helping to raise awareness of addiction issues, safer drug use practices, overdose prevention and stigma reduction. We are advocating for an end to policies that criminalize drug use, and we are encouraging policy changes that enable swift access to life-saving treatments and interventions.

As I write this, we are nearing the end of the second year of the overdose crisis, and the number of drug-related deaths continues to increase. But I am constantly amazed by the compassion and resilience of those working on the front lines, and by the expertise of the harm reduction, housing and health care workers whose skills form

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the backbone of overdose prevention and response. I am humbled by the courage of family members who have found the inner strength and motivation to become community organizers. And I am continuously inspired by those who have experienced personal addiction and the loss of friends and loved ones but who still feel compelled to come to the table and share their wisdom and knowledge.

It has been a long road, and we have a long way to go. My hope is that our coalition will soon be one of many in the province, all with the aim of enabling our communities to better respond to the needs of all community members. Together we must prevail and bring an end to this crisis—because overdose deaths are preventable, and we must never, ever forget that.

MORE TOOLS IN THE TOOLKIT—CONTINUED FROM PAGE 36

Clinic in Vancouver. These studies show that hydromorphone and prescription heroin are both effective treatments for opioid addiction and can provide social stability and health benefits to those who have not benefited from other oral treatments.

In addition to these pharmaceutical treatments, evidence-based psychosocial interventions and supports, including counselling and programs that focus on individual circumstances like housing and employment needs, are also recommended to support recovery from opioid addiction. And it's important to strengthen the residential treatment system with a view to aiding individuals seeking long-term recovery from opioid addiction.

Care providers and patients need to have as many treatment options available to them as possible. Expanding access to treatments is critical to addressing the opioid overdose crisis and will aid the development of an addiction system of care for all British Columbians affected by substance use and addiction.

resources

Alcohol & Drug Information Referral Service
1-800-663-1441 or 604-660-9382 in the Lower Mainland
Free, multilingual and confidential help any time of day for any British Columbian seeking support, community resources, or treatment for any substance use concern.

Stop Overdose BC
www.stopoverdosebc.ca
Learn how to have conversations about substance use, where to go for help, and how to recognize and respond to an overdose. You can also find more from **Toward the Heart**, where you can learn how to use naloxone, learn more about the take-home naloxone program, find a supervised consumption or harm reduction site, and learn more about reducing harm.

Learn About Opioids
www.heretohelp.bc.ca/factsheet/learn-about-opioids
Learn more about opioids, why people use opioids, when use might be a problem, and how to find help if you or a loved one is concerned about opioid use.

Patients Helping Patients Understand Opioid Substitution Treatment
www.heretohelp.bc.ca/workbook/patients-helping-patients-understand-opioid-substitution-treatment
This workbook from the Canadian Institute for Substance Use Research, developed by people with experience using opioid substitution treatments, discusses different treatment options, how treatment works, what can help people achieve their goals in treatment, and more.

A Public Health Guide to Developing a Community Overdose Response Plan
www.uvic.ca/research/centres/cisur/assets/docs/resource-community-overdose-response-plan.pdf
A tool to help communities assess and strengthen their capacity to respond to and prevent overdoses, address stigma, adopt health promotion practices, and improve community substance use services.

Coping Kit
www.heretohelp.bc.ca/workbook/fgta-coping-kit
A toolkit by From Grief to Action for parents of adult children who experience substance use problems. Find advice and support from parents who have been there, including how to build healthier communication skills, how to take care of yourself, and where to go for help.

Self-Management BC: Chronic Pain Self-Management Program
www.selfmanagementbc.ca/chronicpainprogram
A free six-week workshop for British Columbians who experience chronic pain. Learn how to manage symptoms as well as the mental health impacts of pain, communicate effectively, use medications, live well, and make evidence-based care decisions.

OPEN Answers
www.openanswers.ca
Connect with others from around BC who are engaged in overdose response and prevention, share resources, and learn more about grant opportunities from the Community Action Initiative.

Understanding Addiction
www.understandingaddiction.ca
This online course from the Canadian Mental Health Association BC Division is designed for employees and volunteers who work directly or indirectly with people who use substances or experience an addiction. Learn more about how to work effectively and respectfully with people who experience addiction.

BC Centre on Substance Use
www.bccsu.ca
Find substance use research, training opportunities, guidance for care providers, and more.

This list is not comprehensive and does not necessarily imply endorsement of all the content available in these resources.

heretohelp
Mental health and substance use information you can trust

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