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BC'S MENTAL HEALTH AND SUBSTANCE USE JOURNAL

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visions

why culture matters in mental health

the answers are within

visions

Published triannually, *Visions* is a national award-winning journal that provides a forum for the voices of people experiencing a mental health or substance use problem, their family and friends, and service providers in BC. It creates a place where many perspectives on mental health and substance use issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Substance Use Information and funded by BC Mental Health and Substance Use Services, a program of the Provincial Health Services Authority.

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visions

the big picture

4 Editor's Message
Bakht Anwar

5 The Answers are Within: Supporting those from collectivist backgrounds
Saira Sabzaali

7 Huckleberries, Moose Trails and Healing: Culture humility and the cultural foundations of mental wellness
Sheila Blackstock

10 Language That Helps Everyone Feel They Belong: Why cultural humility matters in counselling
Kara Ko

stories + strategies

12 Healing Within Group: Facilitating men's groups in Punjabi
Gary Thandi

15 Inside the Walls I Once Envied
Erfan Khaleghi

17 I Value my Heritage, but also my Individuality
Nupur M.

20 Delivering Culturally Competent Mental Health Care: Gaps, barriers and pathways forward
Tricia-Kay Williams

23 Schizophrenia Solutions
Paul Bhushan

26 Indigenous Mental Health Programming: How community input can lead to respectful help
Rebecca Watts, Jolan Farkas, Bonnie Spence-Vinge, and Robert Brooks

29 The Wrong Shade of Brown in a Small Town
Nirbhau Kaur

32 Ask for Help: Evolving in a new country while living with PSTD
José Guillermo Flores

looking ahead: community and social connection in substance use

34 Roshni, a New Light to Culturally Relevant Recovery
Bavenjit Kaur Cheema

37 Beyond Harm Reduction
Sharon Karsten and Christopher Hauschildt

40 resources

about *visions*

I've had the privilege to be involved in *Visions* in some capacity since 1999 and was its Editor-in-Chief from 2007-2020. I have seen so many positive impacts of sharing stories—for people with lived and living experience of mental health and substance use challenges, their families and supporters, policy-makers, researchers, and a host of service providers.

All our readers will know that we are, have been and will continue to be in tough economic times. We are each living it to different degrees and the ones whose wallets are hurting most are the ones who need more support, not less. Governments, including *Visions*' funder, are also impacted by the economy. The good news is that *Visions Journal* will continue in 2026 and into 2027. The bad news is we will only be producing 2 issues in 12 months after the issue you're reading now.

If you value Visions, tell us what helps the most or themes you want us to cover. We welcome your input at www.heretohelp.bc.ca/visions (Click on the "tell us" link on the right-hand side [desktop] or at the bottom [mobile]). Help us keep this amazing story- and strategy-sharing space going. When spaces for information and dialogue remain, we are reminded we are in this together.

Sarah Hamid-Balma

editor's message

Visions has always tried to be a trailblazer in elevating the voices of folks with lived experience in British Columbia. This issue that you are about to read, "Don't Erase Me: Why Culture Matters in Mental Health," focuses on integrating the experiences and stories of those who may not have been at the forefront of storytelling in the past, but who make up some of the rich diversity of our province. Belonging to a collectivist community (a term that appears often in this issue), my culture and heritage influence my view on health, and I always try to bring that perspective to my role as Managing Editor when shaping topics and selecting contributors. Rather than working in individual silos to support different groups, this issue hopes to inspire systemic change by ensuring culture is embedded in all aspects of care.

As the Guest Advisor for this issue, Dr. Saira Sabzaali, puts it, there is a delicate disconnect between colonial healthcare systems from the realities of people it serves. A common theme in this issue is that when people seek help, they rarely show up alone; their communities, heritage and traditional healing practices follow. So, culture shouldn't be an add-on but, rather, foundational to how healthcare systems are set up. Kara Ko in her article urges readers to move away from the notion that culture only belongs to certain groups and reaffirms that "no one is culture-less". So, by adding in cultural competency practices, healthcare systems are strengthened to the benefit of everyone.

Indigenous scholars have been at the forefront advocating for more holistic approaches to health, including integration of culture and cultural humility practices. Dr. Sheila Blackstock outlines three domains for this: *identity and belonging, safety and trust and systems transformation*. Articles in this issue can relate to these domains, from Roshni Clinic integrating elements of South Asian identity and language to the importance of institutional buy-in to support Black students at SFU, you'll read about how different programs, people and professionals define "culture." I hope this issue successfully showcases that when cultural-competency strategies, cultural-humility frameworks and culturally-responsive programs are included, no one is erased.

Bakht Anwar

Bakht Anwar

Bakht Anwar is one of Visions *Managing Editors and Leader of Health Promotion and Education at the Canadian Mental Health Association's BC Division.*

Below are definitions from HeretoHelp's Culture, Mental Health, and Substance Use:[1]

Culture: includes sharing a set of values, beliefs, traditions and sense of belonging.

Cultural Humility: the ongoing process of learning from others and reflecting on your own biases, assumptions, and privileges so you can build authentic partnerships and correct power imbalances.

Cultural Competency: the knowledge to interact effectively with people from different cultures and places and is generally achieved by learning about values, customs, beliefs, and other important factors.

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The Answers are Within

SUPPORTING THOSE FROM COLLECTIVIST BACKGROUNDS

SAIRA SABZAALI, PHD, RCC

As mental health clinicians, we don't always know the latest cultural references or understand the complexities and unspoken expectations of every person we meet. But if we have a general understanding of how people from collectivist backgrounds position the self (or the "I") and understand suffering, we can avoid some pitfalls.

Saira Sabzaali, photo credit: Sonny Thaker

Dr. Saira holds a PhD in transpersonal psychology. A longtime practitioner in her field, she is Clinical Director at The Expansion Project (theexpansionproject.com). Saira co-founded Advanced Consciousness Therapy, a modality that unites energy medicine and psychology, and has developed Counselling South Asian Clients, a course for therapists of all cultural backgrounds

Here's an example. A client looked at me with tears in her eyes: "No one's ever *got it* like this before." I had just shared a rough visual sketch on my whiteboard of the mother–son relationship in South Asian culture. I highlighted how filial bonds (children's loyalty to, and connection with, parents) have trumped romantic relationships for generations in her family system.

We moved on to reminisce about a scene in a well-known Bollywood movie from the 90s where the guy simply won't make the girl his bride unless every member of her family (even her old-fashioned, unreasonable, hard-to-please father) is fully supportive of the relationship.

We shifted to discuss her current experience living in a joint-family household with her in-laws and brother-in-law's family. She told me about how the advice from her last therapist had been to "Just move out." Phrases like "Set boundaries" or "Focus on your own peace" feel like rotting mangoes to my client. She swallows them to be polite, but she'd never choose them herself. It's not what she's

asking for, and she definitely doesn't share them with anyone else.

While this vignette is a composite symphony of a variety of encounters from many people who come to me for mental health support, moments like this play out in my practice month after month, and year after year. As a South Asian therapist working mostly with culturally diverse clients, I have had to navigate the delicate disconnect between the individualism and independence of Western psychology, and the group-focused, contextual nuances of my clients' day-to-day experiences.

Mental health care was not designed for collectivism

Many underlying assumptions in mainstream psychology don't fit with a collectivist worldview, where the greatest value is in the group, not the individual. The basic difference relates to identity. According to an important study by Markus and Kitayama,[1] in collectivist cultures, the "I" (what these researchers called the *interdependent self*) is embedded in a family and community context.

So when "I" look for mental health support, "I" am not a discrete entity separate from my context. When "I" come, my whole family (and sometimes my whole cultural community) is coming with me! That means how I talk about myself, my life, my dreams and my loved ones will happen through a filter. For the *interdependent self*, identity is relational, and interpretations and decisions about one person's life are not always made just by that person. This is different from the *independent self* that's part of European cultural values, and a core idea that modern psychology is based on.

Experts in our own lives

There have been countless moments when a client comes to a realization in a session, and then we explore what this new perspective could mean for their loved ones. We navigate how, or whether to, talk about these new insights with those in their social web. That's because, for them, well-being includes responsibility and belonging, not just personal growth. As Monique Peck, a founding member of The Expansion Project, writes, "Healing is never just personal."[2]

In her book *But What Will People Say?*, Sahaj Kaur Kohli talks about her dance with external validation versus internal knowing, and how her mental health journey with a culturally attuned practitioner helped her find a third way between "all about me" and "all about them."[3]

For example, many first- and second-generation immigrant children from Asian, South Asian and Middle Eastern cultures have been taught from a young age to defer to authority, especially for anything health-related. This can mean clients from those backgrounds will feel uncomfortable questioning or pushing back against mental health clinicians if they see us as "the expert."

To address this, during the first session, I let clients know that in my approach to mental health, I believe people have their answers already waiting inside them. My job is to help quiet some of the internal noise so they can reconnect to that inner wisdom.

Throughout sessions, if I notice they're starting to credit me with their progress, or pushing for me to give them advice, I gently remind them that they are the one doing the work between sessions, and they are the expert on their own life.

Fostering curiosity

My responses above would likely work with a client from any background. But this approach is especially empowering to someone who is culturally conditioned to dismiss what they are experiencing if someone more "qualified" is present.

In this way, the therapeutic relationship becomes the testing ground for showing up in a new way with a whole category of people. It means cultural assumptions can be looked at with curiosity and openness, without either of us having to convert the other into our way of seeing the world.

My hope for mental health professionals is you will continue to ask the questions about what assumptions underlie your approach, and for people seeking out support, that you will find a practitioner who really gets you, even if they're from a cultural background different than your own. V

related resources

Some of Dr. Saira's top tips for how to make mental health care friendly to people from collectivist backgrounds:

- Remind people they are the experts in their own lives
- Make room for the *interdependent self*—the part that's in an intricate web of relationships
- Remain curious and avoid cultural assumptions

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Huckleberries, Moose Trails and Healing

CULTURE HUMILITY AND THE CULTURAL FOUNDATIONS OF MENTAL WELLNESS

SHEILA BLACKSTOCK, RN, COHN, FNCEI, PHD

Cultural humility is a lifelong practice of self-reflection and self-critique that asks health professionals—and health systems—to recognize and address personal and structural biases, while humbly learning from the people and communities they serve.[1]

Sheila Blackstock

Sheila is a Gitxsan nursing scholar and associate professor at Thompson Rivers University. She has over 36 years' experience in acute, rural, Indigenous and occupational health. Sheila researches racialized incivility in nursing, develops Indigenous health curricula and advances cultural safety in BC health policy

In Canada, national guidance further clarifies that cultural humility and cultural safety exist on a continuum and are essential for equitable care for First Nations, Inuit and Métis Peoples, given the persistence of racism, discrimination and stigma in health systems.[2]

When practised earnestly, cultural humility improves mental health care because it creates spaces where Indigenous identities, knowledge systems and healing practices are respected and centred—conditions that have direct implications for safety, trust and well being.[1, 2]

A lifelong learning

Growing up in rural northern BC on a ranger station in wildfire season, we developed a deep respect for the interconnection of the bush to the climate and all living things. In our Gitxsan culture we realized the role of wholistic health (physical, mental, emotional, spiritual and environmental) and well-being; being interconnected with being on the land.

In my youth, I developed a deep understanding of how the land ethos is intricately balanced with my well-being—out in the bush picking huckleberries with my dog; cross-country

skiing on packed trails to cross paths with a cow moose and her calf seeking a reprieve from the deep snow. All these things and more brought serenity and balance to me.

These lessons of gathering from the bush are integral to our culture, and there are many more lessons to be learned. Cultural humility is much the same approach to "understanding what you do not understand," and seeking guidance to learn more. Ultimately, the goal is to create environments where First Nations feel safe and open to share stories.

Indigenous approaches to wellness

This lived experience resonates with Indigenous mental health scholarship in Canada, which shows wellness is relational and land-connected: identity, language, kinship and relationships with the land support resilience, meaning-making and healing.[3] In this view, culture is not an add on to care, but a foundational source of wellness that shapes how distress is expressed, how help is sought and which pathways to healing are most effective.[3]

Accordingly, cultural humility asks clinicians, educators and leaders to approach Indigenous knowledge systems as authoritative, and to co-create care grounded in local teachings. This approach aligns with the First Nations Health Authority's description of cultural safety as care that addresses power imbalances and results in environments free of racism and discrimination.[1]

More support for culture as wellness

Canadian policy frameworks reinforce the stance led by Indigenous scholars. The First Nations Mental Wellness Continuum, co-developed with First Nations leadership, defines mental wellness as a balance of the mental, physical, spiritual and emotional. Wellness is then supported by culture, language, Elders, families and Creation.[4,5] The framework's widely cited pillars—hope, belonging, meaning and purpose—underscore that culture and connection are not extra, but determining of wellness across the lifespan.[5]

For educators and practitioners, this implies that promoting specific activities are mental health interventions in their own right, including:

- Land-based programs
- language revitalization
- Elders-in-residence models[4,5]

Combating Indigenous racism

Research shows how Indigenous specific racism—from policy to interactions with the healthcare system—undermines mental health and access to services.[6] The resulting inequities affect everything from help-seeking to staying in treatment and outcomes, contributing to disproportionate burdens of distress and suicide in some communities.[3, 6]

BC's professional guidance emphasizes several core expectations for culturally safe and humility-informed health practices, including:

- Self-reflexive practice
- Anti-racism
- Person-led care[7]

Cultural humility responds by shifting responsibility from "fixing the patient" to transforming systems—confronting prejudice, changing policies and embedding accountability structures that protect the right to culturally safe care.[1,6]

National standards and regulatory guidance are converging around these expectations. The Health Standards Organization has put forward a national Cultural Safety and Humility standard (CAN/HSO 75001) that sets requirements for organizations to co-design, deliver and evaluate culturally safe services with First Nations, Inuit and Métis Peoples.[8]

The requirements also address Indigenous-specific racism across the full care pathway.[8] This work complements provincial and professional guidance in BC emphasizing self-reflexive practice, antiracism and person-led care as core to competent nursing and allied health practices.[7]

Humility and reconciliation

Cultural humility also aligns with the Truth and Reconciliation Commission of Canada's Calls to Action. These calls include expectations for:

- health equity
- cultural competence
- closing gaps in health outcomes[9]

For postsecondary programs and health organizations, this means shifting curricula, quality-improvement metrics and funding to uphold Indigenous self-determination in health. It also means supporting distinctions-based (tailored) approaches that reflect the unique priorities of First Nations, Inuit and Métis communities.[2,9]

From a research perspective, the mechanisms linking culture, humility

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and mental health can be thought of in three reinforcing domains:

Identity and belonging: When services affirm Indigenous identities, language and land relationships, they support *coherence of self* (feeling integrated) and *collective continuity* (feeling like your group endures)—key ingredients of resilience.[3,5]

Safety and trust: Humility-informed practice explicitly recognizes power differentials, addresses bias and fosters relational accountability, thereby improving engagement and therapeutic alliance.[1,8]

System transformation: Standards and policies that embed cultural safety shift structures (i.e., governance, workforce, measurement) so that equity and Indigenous leadership are built into how care is designed and evaluated.[4,8]

How we change

For educators and service leaders, several practical steps flow from this evidence. They should:

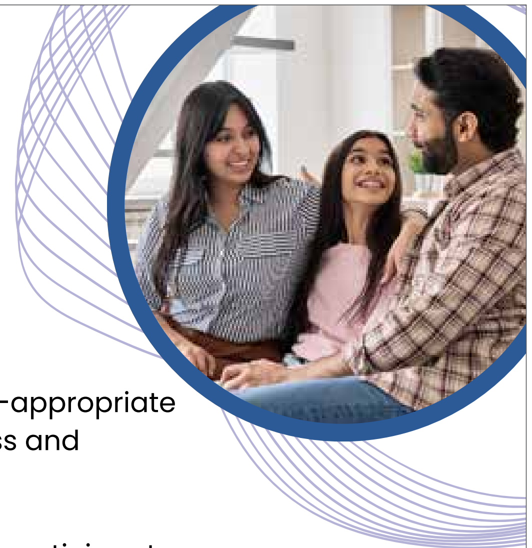
- **co-develop** curricula and services with local Nations, Elders and Knowledge Keepers, recognizing them as co-educators and co-researchers[1,4]
- **build** land-based, language-rich programming into mental health promotion and recovery pathways, including grief and trauma support[3,5]
- **implement** organizational standards that require antiracism training, distinctions-based approaches and evaluation metrics tied to safety and outcomes[2,8]
- **ensure** accountability through patient-reported experience measures that explicitly assess cultural safety and through governance structures that include Indigenous leadership[1, 8]

My Gitxsan reflection illustrates why these commitments are not abstract ideals, but *clinical and pedagogical necessities*. Experiences of harvesting, being on the land and encountering non-human relatives foster calm, meaning and balance—outcomes that the First Nations Mental Wellness Continuum Framework recognizes as integral to mental wellness and that are sustained by culture and relationships.[4,5]

Cultural humility provides the ethical and methodological stance to honour those knowledges while transforming health and education systems that have too often dismissed them, thereby advancing mental health and well being for Indigenous Peoples in ways that are safe, relational and just.[1,6] V

Living with mental illness in your family?

What would you like your child to know?



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Language That Helps Everyone Feel They Belong

WHY CULTURAL HUMILITY MATTERS IN COUNSELLING

KARA KO, RCC, MSC

When you meet someone—anyone—for the first time, what do you think you know about them, just based on how they look or sound? Now, if you're a mental health professional, think about meeting a client for the first time in counselling. What assumptions pop into your mind?

Kara (she/her/elle) holds a Master's in brain and cognitive sciences from MIT and is a Registered Clinical Counsellor in BC. She specializes in culturally responsive care and supporting neurodiverse adults and children. She writes, speaks and consults about cultural identity, neurocognitive diversity and emotion regulation in counselling, supervision and organizations

Kara Ko, photo credit: A. G. 2026

It's important to notice these moments, because this is where cultural awareness begins, and cultural awareness is the basis of cultural humility.

Peeling back assumptions

So, what is *cultural awareness*? It simply means being open, curious and aware that everyone, yourself included, has a story that shapes how they see the world. *Cultural humility* means that, rather than assuming you know about a person based on your first impression, you stay open and let them teach you what matters to them.

Humans want to fit in. In counselling, this desire is especially strong. Clients want to feel better, that they are not "other" and that they don't have to explain who they are or feel like they must educate the counsellor about their point of view. Having to defend their identity or explain their background can be tiring and even painful.

Research supports this. Psychologists Schmader and Sedikides have found people tend to move toward places where they feel they fit.[1] And UBC researchers Bedi and Moscovitz found clients feel more comfortable and understood when counsellors show respect for their cultural background and identity.

Noticing how we talk

Inclusive language can help everyone feel included. For example, Air Canada

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changed their greeting policy from welcoming passengers with "ladies and gentlemen" to more inclusive language, like "everybody" and "tout le monde."[3] Organizations are noticing that language matters.

Here's a common example of language that may result in someone feeling left out. Think of a counsellor asking a client who belongs to a visible minority group or has an accent, "Where are you from?" Even if the question is intended to show friendly curiosity, the effect can be alienating. If a counsellor feels they must ask about a client's background, they can consider the reason behind the asking and be sure it's not just a question directed at clients who look or sound "different."

Even small details matter. For example, having intake form options limited to Mr., Ms, or Mrs., or a limited list of genders can leave some clients feeling left out. A simple change to an open space for titles or pronouns can help people feel included. It lets clients fill in the blank.

Unpacking the questions we ask

When I ask a question in counselling, I think: "Is this a question I would ask any client?" This includes thinking about race, gender, orientation, whether someone comes from a *collectivist* (prioritizing group or family goals) or *individualist* (prioritizing individual goals) culture, and more. I ask myself: "Is this a question I would only ask a client of my own background or culture and needs a more culturally aware lens"?

Here's an example: If I ask a client why they don't just leave a program of study they don't enjoy, that question might be received differently based on their cultural background. Likewise if I ask the same client why they don't just work harder to stay in the program to make their family proud. A person raised in an individualist culture might focus on personal happiness, while a person raised in a collectivist culture may care deeply about family happiness, which they may see as inseparable from their own.

Instead of making any assumptions, using a cultural humility lens, I can simply ask the client open-ended questions about their reasons for doing what they're doing, and listen.

Refocusing the lens

Practising cultural awareness and humility is at the heart of the counselling process. This is because people may identify differently from how they present. It's a mistake to assume that someone identifies with, say, a collectivist or individualist culture based on their speech or appearance. This can be an easy trap to fall into.

I've observed counsellors assuming that culture only refers to people of colour or ethnic minorities, or people whose lived experience is not mainstream. But the truth is that everyone has culture, whoever we are. No one is culture-less.

This doesn't mean we should ignore a person's culture just to help them fit in.[2] Instead, cultural humility means accepting, with openness, whatever a client wants to share. Asking open questions when an issue might relate to someone's culture, gender, orientation, age or ability can help counselling move forward in a helpful way.

For example, if a client mentions that family expectations matter a lot in their decisions, I can ask, "Can you tell me more about what your family values mean to you?" Or, "Would you like to tell me more about that?" That way, they get to decide what feels right to share.

Taking concrete steps

Keep learning: Wendt and colleagues advocate for an engaged and informed approach to becoming culturally aware.[4] The goal isn't to learn about every culture, but rather, to engage in the lifelong process of awareness-building.

From there, you can build the humility that comes from understanding your own limitations. Remember: no client shares your exact background (and therefore your culture), so you must bring cultural awareness and humility to every interaction.

Know your limits: If you feel a client's needs are outside your area of expertise and you're not sure how to talk to them without them feeling othered, until you receive the appropriate training, the ethical choice is to refer them on to someone who can better support them.[5] Do not place the burden of educating you on the client.

Recognizing a client's worth as a human being, without judgment, is essential to providing unconditional *positive regard* (showing complete acceptance and valuing of a person).[6] Cultural humility and inclusive language are ways of offering unconditional positive regard to all clients. When clients feel understood, respected and included, healing can truly begin. V

Healing Within Group

FACILITATING MEN'S GROUPS IN PUNJABI

GARY THANDI, MSW, RSW

In my 25 years in the field of social services, I've had the opportunity to both study and facilitate groups with Punjabi-speaking men. This group includes men whose first language is Punjabi who immigrated to Canada from South Asian countries, such as India and Pakistan.

Gary Thandi has his Bachelors and Master's degrees in social work and 25 years' experience in the social services sector. He is Executive Director of the non-profit and registered charity Moving Forward Family Services, which provides low-barrier counselling and support services to residents across Canada

Gary Thandi

I've been involved in studies to address their mental health and substance use needs, with a focus on culturally responsive prevention and intervention. That means I approach all care with an eye to these men's specific cultural upbringing and social ways. I've also facilitated groups with these men on substance use, mental health and intimate partner violence.

I've had the chance to engage with many others in the field over the years, too; here I share some of our observations about facilitating groups with Punjabi-speaking men.

A chance to share

While Punjabi men come from a collectivist community, they may not discuss topics like social and emotional health openly within their family and extended family circles. That's because, as Dr. Nitasha Puri notes, the men may be "influenced by ideas of masculinity and the norms of patriarchy."

Dr. Puri, a medical doctor in addictions medicine and clinical professor, adds that Punjabi men are often "under intense pressure to be so many things to so many people—financial provider, emotional support partner, very involved fathers, caring sons and sons-in-law." Group therapy might be the first opportunity in their lives to explore topics like mental health, substance use, stress, the impact of patriarchy, trauma and self-care, she says.

Tejinder Gill is a certified addictions therapist with more than 25 years' experience working with diverse men and their families impacted by substance use. Gill uses talk therapy and what's called "motivational interviewing" with this group (where people find their own motivation to change). He says it's a special honour working with the Punjabi community. He says men often come to group with alcohol use and family conflict problems.

Working in Punjabi can open men up who struggle to express themselves, he adds. "The men are able to express their emotions for the first time openly and not feel judged by anyone. It's always special to work with the South Asian community in a group setting and see the changes made."

Keeping culture in the group

Therapist Gurmukh Aujla thinks a lot about culture in his work. Aujla facilitates substance use and mental health recovery retreats for men from diverse communities. "Working with South Asian men in group settings lets us take a culturally attuned approach," he explains, "and shifts us away from Western individualistic models towards a relationship-centred approach, aligning with many South Asian worldviews."

This approach validates cultural identity and creates a supportive environment where men can explore vulnerability and reconnect with cultural strengths that emphasize belonging, reciprocity and collective well-being," he adds.

Therapist Keerat Singh agrees. "I have often asked clients this simple question: 'who are you?' The simple answer has always been: 'I am a father, brother, mother, sister, friend or daughter.' When we connect, we find purpose, connection, shared goals and interests that lead to increased levels of belonging."

Moving past conflict

Often men are referred to a group program in Punjabi by the courts, social workers or probation officers after some involvement in the criminal justice system or the Ministry for Children and Families. These events do not happen in a vacuum. As Dr. Puri notes, "Structural factors of racism, vulnerable work conditions, immigration issues and legal issues are all adding to the men's stressors."

Therapist Sartaj Sandhu agrees. "I've noticed that their relationship with conflict and authority isn't random. It's shaped by histories of failed justice systems back home and the constant pressure to survive here." Sandhu says that once trust is built with Punjabi men in group therapy, "they stop trying to 'work away' their emotions and start naming the pain."

He adds, "What struck me most has been how emotional men became the moment their side of the story is finally heard. For many, it's the first time they aren't treated as the problem, but as human beings navigating trauma, stigma, migration and systems that rarely listen to them."

Building on faith

Sandhu makes an important observation by noting that, for Punjabi men, self-care has a unique flavour. He says this care "rarely involves bubble baths and journaling; it's deeply rooted in culture, such as temples, service to the community, responsibility and honour."

His conclusion? "We cannot support South Asian men by forcing Western templates onto their lives. We support them by understanding the culture that shaped their resilience and the systems that shaped their silence."

Faith may be a healing factor for Punjabi men. Aujla facilitates a faith-based retreat for Sikh men battling substance use. "The nature-based setting helps soften emotional defenses and mirrors core Sikh principles of humility, interconnectedness and alignment with the natural order."

Yet, as mental health practitioners, we all also look for what's universal in the struggles of Punjabi men. "The need to connect begins early in the mother's womb," says Singh. "This primal need continues throughout our lives, as we connect with parents, peers and our intimate partners."

Themes uniting Punjabi men

Dr. Puri, meanwhile, says groups with Punjabi men should foster several key themes. These include knowledge and understanding of the brain and mental health, but also connection to:

- family members through healthy communication and empathetic skills for compromise
- the self and spirituality via nature, religion and mindfulness
- community via seva (volunteering)
- others who know the suffering and struggle (peer supports)

Dominant systems of care, while effective, are slow to respond to the needs of diverse communities. My colleagues

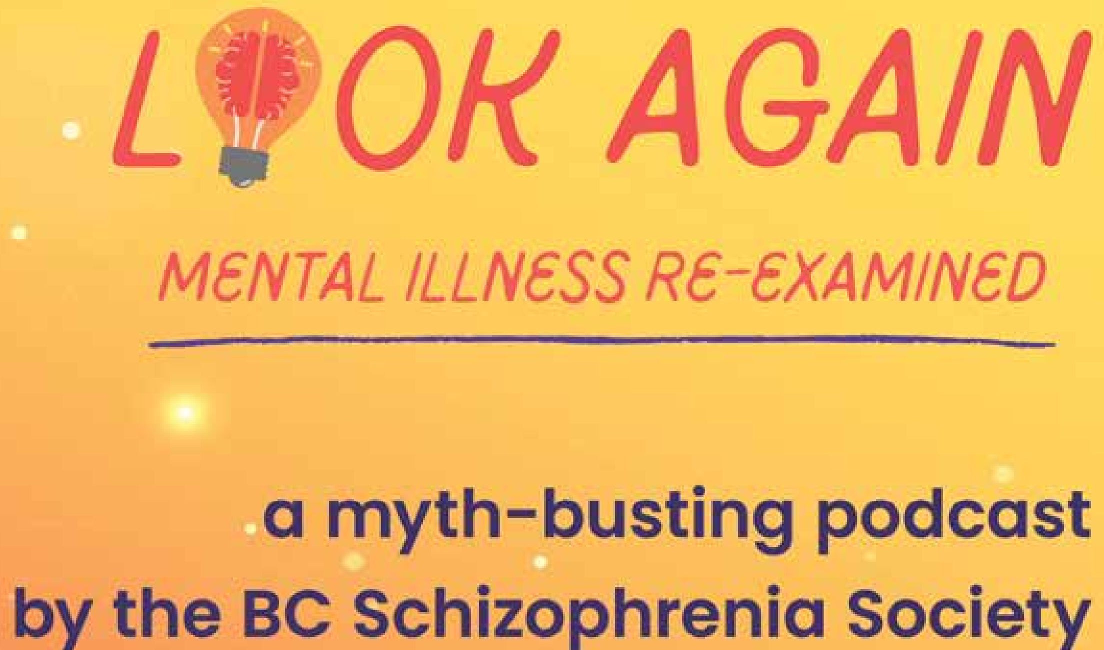
are at the forefront not just in delivering culturally responsive healthcare, but also advocating for a system that can better support Punjabi men and all diverse communities.

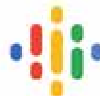
To Punjabi-speaking men and their families considering accessing group, family or individual services—or anyone interesting in exploring ways to support diverse communities—please reach out through our email address: hello@movingforward.help. V

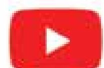
related resources

You can find out more about the work of the counsellors who've taken part in this article:

- Learn about Gary Thandi's non-profit at: movingforward.help
- Visit Keerat Gala's page at the BC Association of Clinical Counsellors, at: bcacc.ca/counsellors/harkeerat-gala
- Gurmukh Aujla works at Vaapsi Recovery House, a culturally responsive sober living house. Learn more at: vaapsi.org
- Nitasha Puri and Gary Thandi are part of a long-term research program called Rahi Research. Discover their work at: rahibc.com
- Read Sartaj Sandhu's profile at: linkedin.com/in/drsartaj







Inside the Walls I Once Envied

ERFAN KHALEGHI, BPSYCH

Growing up on the North Shore of Vancouver, it was always a dream of mine to attend a local international boarding school—up until I was employed by that same school.

Erfan Khaleghi

Erfan was born in Montreal in 1995 before moving to Iran at the age of 5. The move was intended to let him be flexible in both Iranian and Canadian cultures. Erfan holds a BA in psychology and has worked in advising and coaching youth

During my younger days, I walked by the school weekly with my friends. We were all jealous of the students attending there. "Look at this soccer field," we'd say, admiring their facilities. "I bet these kids play on it every day! I wish we had this at our school."

We were so preoccupied with the physical appearance of the school; we barely considered what went on within its walls.

From dream to reality

After graduating with a psychology degree, I wanted to gain some real-world experience. As it turned out, the same school I'd wanted to attend was hiring. Lucky me: I landed the job. Soon, I received a presentation by the school principal, introducing me to the student body. These young people came from many different parts of the world.

My smile and excitement turned into a somewhat clear frown as the principal explained how a significant portion of learners were from families whose parents, despite money and success, wanted their children far away so they could focus on work or other projects.

This wasn't the case for everyone. Some students were simply looking for a better education; however, in most cases, distance was part of the story. Many had become detached from their parents even before arriving in Canada.

Suffering behind a gilded wall

After about six months, I was promoted to Senior Youth Advisor, which meant I had 50-plus students under my direct supervision from 4:00 p.m. to midnight. This is when the realization hit me that I had had it great during my high school years.

The cultural tensions inside the school were magnified for me in moments when a student would cautiously knock on my office door, their voice lowered, eyes scanning the hallway to make sure they weren't seen by their peers before stepping inside my glass office.

My eyes were opened: I needed to ignore the book's cover! Because just like a book, the students' content was hidden from view. It consisted of culture, language and upbringing—all vital, considering what students were struggling with and how they handled stress and emotional stability.

In some cultures, mental disorders are often viewed as a sign of weakness. For others, these complex challenges are not even seen as real. This is ironic: some cultures are quick to label someone with a disorder or illness to justify ostracizing them, while others use the label to avoid responsibility for looking after the individual. It helps explain why some foreign kids in the Canadian international school system struggle to seek support and access youth mental and social services.

A host of fears

For many students, mental health struggles weren't simply a matter of "feeling sad" or "being stressed." They were a negotiation between identities; the one they carried from home, and the one they were expected to adopt in Canada.

For some, talking about their problems was like betraying family trust or expectations. To me, the thinking seemed to be: "If my parents find out I revealed my weaknesses to you, rather than checking in with them first, they'll be disappointed."

For others, discussing mental health at all was unfamiliar territory. They lacked communication skills for these new emotions, especially in English. And for many, the fear wasn't only about being judged by their peers, but being misunderstood by the adults meant to support and guide them. A recurring fear was that anything they shared with me might be relayed back to their parents.

This wasn't because they had something to hide. The consequences of disclosure were just unpredictable. "My mom will worry," one student told me. Another said, "My dad will think something is wrong with me. He'll think I can't make it here."

Sometimes, students feared their parents would misunderstand the problem entirely, interpreting anxiety as defiance, depression as laziness or social withdrawal as a personal insult. These were not bad parents, just people shaped by their own cultural frameworks and education about mental health and how to handle their children's new needs. They still loved their kids from afar.

Students were scared of being erased, or having their experiences rewritten through a cultural lens that didn't fit their new reality. It was only when they started reshaping that reality that they could step out of their comfort zone and feel secure sharing their emotions.

A youth mental health rethink

Working in this environment showed me that when we talk about mental health support for youth, culture cannot be an afterthought. Culture shapes:

- how emotions are expressed and viewed
- how vulnerability is understood
- what "help" looks like
- which approach will make young people feel safe enough to discuss their feelings

In my work, I would always start out with a vulnerable story about myself. Coming from an immigrant family, some of the challenges were familiar territory. Typically, this opened the door to deeper conversations. It was also important to let them know their experience was unique and their parents might struggle to understand, given their own upbringing.

In time, the school I once admired for its facilities became something entirely different: a place where culture, plus social and mental development, collided daily with vulnerability; where young people navigated not only academics, but identity, belonging and the complicated distance between themselves and the families who loved them, even if imperfectly.

I learned that true support begins with listening, cultural humility and the belief that every young person deserves to feel seen, no matter where they come from. It's so important for kids from diverse backgrounds to come forward without fear of being judged. It's also vital for counsellors and teachers to identify these individuals early and let them know it's good to seek help.

To young people, I encourage you to go, pave your own roads, instead of walking the same roads your parents took during their development. V

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I Value my Heritage, but also my Individuality

NUPUR M.

In many families, attitudes towards mental health are passed down through the generations. Expressions like “We faced real challenges back in our day, this is nothing” are usually meant to encourage strength. But they unintentionally minimize a person’s emotional struggles. Intergenerational views create a barrier to seeking support because individuals feel pressured to “toughen up.”

Photo credit: Deepak Sethi for ©iStockphoto.com

Nupur is a mother of two. Of South Asian descent and first generation in a Western country, Nupur is exploring ways to live up to her own ideals of motherhood. An aspiring professional, she is also striving to develop her personal identity while maintaining her cultural heritage

In my culture, people avoid talking about mental health. Those conversations are seen as signs of weakness. The belief is that such traits are not present “in our family” and “our genes are strong.” People must discover solutions alone.

I was left alone as a child to navigate my path. Besides other odds I faced, I was physically abused. Now, as a mother to my own child who struggles with his mental well-being, I can feel like protecting and supporting him puts me at war with my own people.

Silent victimization

I was beaten up brutally by a family member every day growing up, sometimes multiple times a day. It happened randomly—at home, at family gatherings, at my school—and I lived with constant fear. The shape of my day was at the mercy of this individual’s mood.

I was sad about why this seemed so normal. Why didn’t anybody stand up for me? Why didn’t anyone question the bully? Instead, I was asked not to make a big deal about it and cover up the act. Beatings were often compensated by gifts. “Cheer up, you’re a

Photo credit: Bhupi for ©iStockphoto.com

Our lives were balanced and refined from the outside, hurtful and dark inside... But for years I cried secretly in the washroom knowing there was no escape. This affected my mental health.

good girl," family members would say, patting me on the back. Not once did they ask how I felt, or if it hurt.

A socially acceptable exterior

Surprisingly, these people were highly educated with good social standing. Our lives were balanced and refined from the outside, hurtful and dark inside. Believing they couldn't be wrong, unable to defy societal norms, I too kept showing up like nothing ever happened. But for years I cried secretly in the washroom knowing there was no escape. This affected my mental health.

It was not easy to face peers at elementary and high school, cousins or guests at home who saw me getting beaten. I became a muted and lonely person.

I remember on the first day of college, I attended orientation day with a black eye. Instead of asking how I was feeling, my mother gave me her diamond earrings to match my dress. A guest speaker looked straight into my face, but I didn't flinch. I had become immune to such glares.

My abuse—severe enough that I once became catatonic, so emotionally disconnected I ended up in hospital—continued until I was 27. It only stopped because I got married. I was happy leaving that house, ready for my new beginnings, full of hope, love and companionship.

Struggling towards new patterns

My son is the first grandchild in my family and the only male child. He was recently diagnosed with mental health challenges including borderline personality disorder and generalized anxiety disorder. In my culture, aspirations get attached to future generations. I've heard things like: "You don't have to share this with anyone, he'll be fine when he mans up." For this reason, I haven't been able to share his diagnoses with our families.

I want to protect my son's image. He could easily be labelled as "mental"—the word widely used in my culture. So we cover up his distressing moments, explaining them as anxiety due to study pressures. This saves us from any shame attaching to the family name and replaces it with a moment of pride in his dedication to scholastics.

My son also experiences self-harm. Visible scars on his body speak loudly about his mental health struggles. He wears long-sleeved shirts to hide his arms, especially with friends or chosen families.

After seeing fresh marks on his neck recently, I was looped into the future. I may have been a strong mother holding his hand, but I also felt myself succumbing to cultural and societal fears, and stereotypes about mental health: Who will entrust their daughter to him? Will he find a partner who will understand him? As his parents, this is a big topic for us. But recognizing these cultural patterns is essential if we want to foster more compassionate conversations across generations.

Letting in some air

During a visit to the ER with my son, I scanned through brochures we received. One described an organization called FamilySmart. Feeling

Connect & Learn With Us!

Free Online Events for Families

FamilySmart supports parents who have children or youth with mental health and/or substance use challenges. Join us to connect and learn with other parents

LEARN MORE AND REGISTER:
familysmart.ca/events

CHECK OUT OUR FREE, ONLINE VIDEO LIBRARY:
familysmart.ca/videos

related resources

To learn more about FamilySmart, please visit familysmart.ca.

And find out more about the Help for the Hard Times workshop at: familysmart.ca/help-for-the-hard-times-workshop

directionless, I registered for one of their online workshops, called “Help for the Hard Times.” It was designed for parents whose child or youth has been a patient in a psychiatric unit or visited an ER visit due to their mental health.

I vividly remember my husband and I feeling overwhelmed after our first session. Meeting other families coping with similar challenges removed our feeling of isolation. We learned that this organization includes parents with lived or living experiences. They support other parents because they understand what it sounds like, feels like and looks like.

For example, my son was 17 during his first hospital visit. We received no guidance there, and I'll never forget how we ran between departments due confusion over his transitional age group. But FamilySmart came through with emotional support, without us having to fill out any forms. Their services were free, with no waitlist. It's a shame that we rarely feel this safe sharing our big feelings with our immediate or extended families.

Making room for feelings

Things would be so different if people were given a chance to voice their emotions without their words being twisted. I promised myself my children would have a life chosen by them. I wonder if I have succeeded. While we have open discussions at home, why didn't my son tell me sooner about being bullied at school, for example? What stopped him?

We all have to feel free—not judged—when sharing big feelings. Validating and acknowledging young people's feelings while teaching them how to survive and fight is an important step. To those suffering from hurt or abuse, please get help, before it's too late. V

Delivering Culturally Competent Mental Health Care

GAPS, BARRIERS AND PATHWAYS FORWARD

TRICIA-KAY WILLIAMS, MA, RCC

Culturally competent mental health care is a critical, yet inconsistently delivered, component of psychological mental health services across Canada. In my work as a clinical counsellor in private practice and at Simon Fraser University (SFU) I have witnessed how deeply culture, identity and systemic marginalization shape clients' mental health experiences.

Tricia-Kay is owner and Registered Clinical Counsellor of Metamorphose Counselling and Consultation (metacounselling.com). Skilled in treating trauma and anxiety, as well as career and relational issues, she is the Clinical Counsellor for Black students at SFU. Tricia-Kay is an active community and social services professional who serves as a board member at New Hope (Refugee) Community Services

Tricia-Kay Williams

These observations have clarified not only what is currently lacking in systems of care, but also what's possible when institutions and clinicians commit to meaningful change.

Gaps and barriers in culturally competent care

In my professional settings, the most significant gaps arise for clients who hold marginalized or intersecting identities. In private practice, I primarily serve individuals who identify as BIPOC (Black, Indigenous and People of Colour) as they navigate life, career and relationship transitions. Many are coping with grief and loss, racial discrimination, identity development and complex relational dynamics—whether with partners, siblings or parents.

Others present with mental health concerns rooted in past and present experiences, including:

- chronic anxiety
- functional depression
- isolation
- trauma responses

These concerns don't exist in a

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vacuum; they intersect with lived histories of marginalization and ongoing systemic stressors.

At SFU, I work mostly with Black-identified students who face similar challenges. These challenges often relate to being "the first" or "the only" in an academic space, and include intense expectations and uncertainty–all of that, plus academic pressures. These students are frequently navigating not just coursework but also:

- racialized isolation
- financial instability
- fear of failure in institutions not designed to support their cultural identities

Cost: One of the most persistent barriers I see is financial access. Many of my private practice clients struggle to afford therapy. This is even more pronounced among marginalized students from low-income or international backgrounds. Cost is one of the largest disruptors of continuity of care—especially for clients who require long-term, trauma-informed support.

The right fit: Another significant gap is access to clinicians with lived experience. Services such as the Vancouver Black Therapy & Advocacy Foundation offer low-cost counselling. But waitlists are long. There are too few Black clinicians to meet the high demand.

A shortage of culturally competent providers—particularly those trained in trauma-informed, anti-oppressive frameworks—means clients often wait months for care. Other times, they are forced to work with clinicians who may unintentionally perpetuate harm through microaggressions or cultural misunderstandings.

Institutional barriers: At SFU, Health and Counselling operates under a brief counselling model. That means it's designed to offer short-term interventions and referrals to community resources for additional support and longer-term care. While this model is effective for many students, it often can't address the complex needs of marginalized clients with high anxiety, trauma histories, housing or food insecurity, or ongoing experiences of discrimination.

These concerns do not resolve within a few sessions. And while counsellors may offer extended or more frequent sessions for at-risk or high-need students, sustainable healing requires consistency, continuity and systemic support that may extend beyond the constraints of brief care.

Reaching underserved populations

Underserved populations are best reached in their communities, where they already experience familiarity and safety. At SFU, partnering with Black student organizations, such as Students of Caribbean and African Descent, was a crucial pathway to connecting with students who might not otherwise seek counselling.

More broadly, underserved populations are often located where basic needs—food, housing, healthcare access—are unmet. By ensuring these needs are addressed through accessible, equitable and culturally sensitive programs, institutions and clinicians can significantly improve mental health outcomes. The Community Kitchens model exemplifies this approach, offering nourishment, practical skills and culturally affirming community spaces at no cost to students.

Institutional buy-in and reaching Black students at SFU

The creation of the role of Clinical Counsellor for Black Students at SFU emerged in direct response to Black student advocacy. Students had been calling for improved support and to confront the university about racial inequities on campus.

Their demands, grounded in lived experience and shaped by years of under-servicing, aligned with SFU's public commitment to equity through the Equity Compass and its signing of the Scarborough Charter, a national agreement to address anti-Black racism within post-secondary institutions.[2,3]

Before my role was formally established, I served Black students on a contract basis for two to three years, and demand for services was immediate. Students were already seeking therapy but lacked designated, culturally aligned support. Once the dedicated role was created, many of these students continued their care with me, and we worked to create accessible, lower-barrier pathways for booking sessions.

The Health and Counselling department and Student Services have been receptive to implementing changes that support Black student well-being, prioritize Black students and ensure timely access to services.[1] Student feedback has been central to shaping programming. For example, Black

students advocated for the creation of a Black Healing Space. This is a community-based therapeutic group that now operates four to six times per semester.

They also requested a dedicated hub for culturally relevant programming, leading to the university's commitment to build a Black Student Centre, scheduled to open in 2026.

Institutional support has also extended to Black joy–centred programming and community resources. At my recommendation, SFU expanded Community Kitchens featuring African and Caribbean cuisine—spaces where students gather to cook, share meals, develop basic culinary skills and build community.

These kitchens have become essential for students experiencing food insecurity or lacking meal plans. In 2026, a partnership with SFU Residence added three more community kitchens specifically for students without consistent access to meals.

In addition, Student Services has supported the delivery of trauma-informed training and workshops focused on identifying microaggressions in clinical practice. These initiatives represent important steps in creating a campus ecosystem where Black students feel seen, supported and empowered. V

Tips for mental health professionals working with BIPOC Clients

Delivering culturally competent care requires intentionality, humility and continuous learning. Several practices can help clinicians develop stronger therapeutic relationships with BIPOC clients.

1. Cultivate genuine curiosity.

Each client's cultural background shapes their experiences differently. Even clinicians who share identities with their clients must avoid assumptions. For those without lived experience, learning outside the session is essential, like researching cultural rituals, community norms or historical trauma.

2. Incorporate identity exploration early.

Make time to understand who the client is. This includes their identities, values and community contexts. Sharing aspects of your own identity, when appropriate, helps build connection and reduces power imbalances.

3. Make room for emotional processing.

Many BIPOC clients benefit from sessions where the goal is to be understood rather than problem-solved immediately. Warmth, presence and nonjudgmental support help clients feel seen and affirmed, particularly when they have experienced minimized or invalidated emotions elsewhere.

related resources

For more on developing specific tools to support Black people's mental health, check out the Canadian Mental Health and Well-being Handbook: An introduction to an Africentric Approach to Black Mental Health and racial trauma, by Tiffany Gordon, Shanique Edwards, and Anthony Q. Briggs (Black Mental Health Canada, 2023).

Learn more about the Black Student Support and Healing Space at SFU at: www.sfu.ca/students/health/support-resources/group-support/healingspace

Visit the Vancouver Black Therapy & Advocacy Foundation at: vancouverblacktherapyfoundation.com

Schizophrenia Solutions

PAUL BHUSHAN, BSC

My family came to Canada from India in 1967, when I was just two years old. Like many immigrant families, my young parents arrived with high hopes of building a better life in a new and prosperous country.

Paul Bhushan

Paul holds a Bachelor's of Science in management and systems science from SFU. He completed the Canadian Securities Course and has become an active investor in the equity markets. A Certified Mental Health Worker, he also holds a diploma in accounting. Paul's been a community inclusion worker for the past seven years

We settled in Vancouver, with my dad working as a mechanical engineer and my mom working for Vancouver General Hospital. The future seemed bright, full of optimism and dreams of new opportunities.

But life didn't unfold as expected. My dad struggled to maintain steady employment, often bouncing from job to job. At the time, my family believed this was due to the stigma he faced as an Indian man seeking work in a predominantly white country. This likely played a role, but the deeper issue emerged in 1972, when he was diagnosed with schizophrenia.

A parent's diagnosis

Back then and even now, that diagnosis was terrifying. It was the 1970s, and we weren't far away from the times when people with mental health struggles were treated with barbaric, dehumanizing methods. I vividly remember visiting my father at Riverview Hospital when I was nine years old, clutching my mother's hand and feeling so scared and overwhelmed.

The following 12 years were incredibly difficult. My dad lacked insight into his illness and often refused medication. Our home was in turmoil, and I lived in constant fear that others would discover his condition.

In 1985, my dad took his own life. I loved him deeply and think about him every day. He lives in my memory now, and I feel he is always with me.

But in the official statistics, he is just another life lost to a complex and challenging mental illness.

My own diagnosis

The first time someone suspected I might have schizophrenia I was 16. My dad took me to his psychiatrist, worried I was developing the same illness he had. The concern was dismissed, though in hindsight, there may have been early signs that could have been recognized with a greater societal understanding of the illness.

It took several years of emotional hardship and countless struggles, as well as numerous visits to psychologists, doctors and mental health professionals, before I received an official diagnosis of schizophrenia in the early 1990s. My interpretation of reality at the time was that people were out to do me harm, and it took being diagnosed twice before I began to accept the illness, and began my journey to recovery.

A process of recovery

Early on in my recovery, I tried to "make up for lost time," pushing myself too hard. I made no allowance for my illness and didn't give myself a chance to succeed.

Eventually, I realized it would take time to get back on my feet. Even when I was on the road to recovery, some days felt like a setback, and that was OK. Progress meant taking smaller steps and having compassion for myself. I found that the caregivers I worked with offered expert and caring advice. Since I grew up in Canada, I didn't feel a need for culturally competent care.

I like to use an analogy: a person facing severe mental health challenges is like a campfire whose coals have burnt down and are covered in ash, but still alive. With care and attention, those coals can reignite. But the fire needs ongoing monitoring and tending to keep burning. So all of us with a mental illness need support and assistance from family, friends and professional caregivers.

Where I am today

For me, several factors keep me stable today and keep my light bright. After my father's experiences, I saw the importance of medication and ongoing psychiatric care. I've built my own loving family. I have an incredible wife and two wonderful children. They, along with the rest of my family and friends, are my support network. My roles as a husband, father and son give me purpose and strength.

I work in community support helping people with disabilities live fuller, more independent lives. I've earned a Bachelor of Science in management and systems science and an accounting diploma, and I've completed extensive coursework focused on counselling, peer support and self-development.

I've shared my story widely and even facilitated my own support groups for people experiencing mental health challenges. I love the structure of my work, and I'm proud of my ability to help others.

some strategies for recovery

Paul's lived experience has shown him that strategies for living with schizophrenia go a long way to living a full life. These include:

1. **Acceptance:** The very first step before beginning recovery is to accept you have a mental illness and not be in denial. You have to accept a doctor's diagnosis.
1. **Medication:** In North America, medications are the proven and accepted way to treat schizophrenia. Most people can experience a healthy recovery if they take their medications.
2. **Insight:** Because of the nature of schizophrenia, many people never realize they have an illness. Developing insight is part of recovery.
3. **Support:** Developing a strong support network, where people can guide us and where we "check things out" with our understanding of reality, is critical. That means we can test our thoughts against those of others.
4. **Building towards a work life:** Most people want to work—for income, but also for more confidence, self-esteem and feelings of accomplishment. I've developed a work recovery model with steps to gain employment. Jump over steps that don't work for you, and stop where you feel comfortable:
   diagnosis → unpaid volunteer work → paid volunteer work → part-time work → four days per week → full-time work or self-employment → fully recovered

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In a world that can often feel harsh and unforgiving toward people with schizophrenia, I want others to know to be kind and patient with themselves along their journey. Understanding of this illness has improved since my father's diagnosis in the 1970s, but misconceptions and stigma persist, both within society and the medical field.

Accepting my illness wasn't easy and recovery still isn't. It's an ongoing process that will continue for the rest of my life. But today, I live a rich, complex and beautiful life. I wouldn't trade it for any other. The main thing I would like for you to take away from my story is that it is possible to successfully live with schizophrenia.

If my story resonates with you, I've written a book about my experiences and strategies to manage schizophrenia called Schizophrenia Solutions. If you or a loved one are struggling with schizophrenia, it is my sincere desire for the book to help you. Even if you take from it just one or two suggestions, my aim is for it to assist in your recovery. V

related resources

Read more about Paul's book, Schizophrenia Solutions, at Amazon.ca:

- amazon.ca/Schizophrenia-Solutions-Paul-Bhushan/dp/196445106X, or
- watch his YouTube video: youtube.com/watch?v=HPiCVvvhDPQ.

Paul also offers coaching sessions. Reach out at: paulbhushan2@gmail.com.

Indigenous Mental Health Programming

HOW COMMUNITY INPUT CAN LEAD TO RESPECTFUL HELP

REBECCA WATTS, JOLAN FARKAS, BONNIE SPENCE-VINGE, AND ROBERT BROOKS

Recently, the co-authors gathered for a series of discussions. Rebecca and Jolan shared insights from the program Big Worries, Strong Spirit (hereafter BWSS), and Bonnie and Robert discussed their work on Strengthening Families Together – Indigenous (hereafter SFT-I).[1]

Rebecca (she/her) is Inuk (a Nunatsiavut beneficiary) and white, originally from North West River, Labrador, now living on WSÁNEĆ and Lekwungen lands in Victoria, BC. She holds a master's degree in Indigenous Governance. Rebecca is acting Program Manager for the Big Worries Strong Spirit program at the Canadian Mental Health Association BC Division

Jolan (she/her) is from the Gitga'at First Nation, now living on WSÁNEĆ and Lekwungen lands in Victoria. She has over 25 years' combined education and work experience in the field. Jolan currently works with the Big Worries Strong Spirit program at the Canadian Mental Health Association, BC Division

Bonnie is Interior Regional Manager for the BC Schizophrenia Society. She's currently helping develop Strengthening Families Together – Indigenous at the BC Schizophrenia Society

Robert is Provincial Manager of the Strengthening Families Together (SFT) program at the BC Schizophrenia Society. His 30 years' experience in forensic psychiatric services and passion for helping people with lived experience and their families have informed his work to improve the SFT program and enhance the new, Indigenous-focused SFT-I program

Photo credit: CIRA Indigenous stock images

BWSS is a free program designed to support First Nations, Métis and Inuit families whose children, aged 3–12, are struggling with big worries—also known as anxiety. Since BWSS has been active for nearly two years, the idea was for Rebecca and Jolan to share learnings with Bonnie and Robert that may assist with SFT-I program development. SFT-I offers support to Indigenous families to better cope with a loved one with mental illness.

It became clear early in the discussions that the learnings were mutual and reciprocal. This article captures shared themes that came up in these conversations.

Non-Indigenous umbrella programs

Both BWSS and SFT-I were created from existing mental health programs. BWSS came about when an Indigenous advisory group,[2] a working group of Indigenous professionals and Elders used a blueprint from an existing program[3] to create new content with an Indigenous focus.

BWSS is now in Year 2 of its development, but work is still underway to make the program more culturally safe, with a stronger foundation in Indigenous theories of health and well-being. To enhance cultural safety, BWSS is:

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- collaborating with a program development team, including the resident Elder, an Indigenous clinician, a non-Indigenous clinician and the program lead and manager, with input from the early childhood interventions director at the Canadian Mental Health Association, BC Division
- conducting an environmental scan of intake assessment tools so all tools fit the program's needs, while steering away from pathologization of Indigenous people and families[4]
- enhancing program content to be relational, respectful and accountable

SFT-I development used learnings from a previous model of delivery called SFT-First Nations. That program was based on the Strengthening Families Together curriculum for families of loved ones living with mental illness, supported by the BC Schizophrenia Society. Significant information, editing suggestions and research were also gathered from the First Nations Health Authority.

Building relationships across Indigenous communities

The idea for delivery of SFT-I has now changed. The BC Schizophrenia Society is seeking to establish genuine collaborative relationships with individual First Nations, Metis and Inuit communities across the province. Each community should have the chance to:

- integrate its specific cultural practices and knowledge into program delivery
- decide on the best method of delivery that works for them

Likewise, the BWSS resident Elder and Indigenous clinician provide input on that program's content. BWSS hopes to bring in more Elders to offer virtual family support, like monthly drop-ins online with families, and spending intentional time with communities. This will allow the program to cultivate deeper connections and ensure the work is relevant to the Indigenous people it serves.

But relationships are not developed instantly. Both programs need dedicated time to build trusting, transparent relationships. Relationships are also the foundation for people's willingness to engage with programming.

Community dynamics also change. For example, the BC Schizophrenia Society has had to pause communications and discussions with a community about how SFT-I might be delivered with its input due to community priorities shifting.

Program delivery

BWSS is delivered online in one-on-one sessions between a parent coach and a caregiver. The program has expanded the definition of "caregiver" to include relationships beyond a parent (like aunties, uncles and grandparents). But learnings are still constrained to one appointed caregiver and one child, even though there may be other caregivers and children in the household or communities that shape lives.

For SFT-I, the ideal way to deliver programming would be to include community support by an Elder or knowledge keeper from a community. While a face-to-face program delivery method is aligned with Indigenous values, program staff also have to consider a unique challenge in maintaining confidentiality when community members are so deeply interconnected.

Approaches like online delivery may not be a good alternative, considering the value of relationship building and unstable internet. Regardless, program delivery has to be:

- appropriate
- useful for communities
- culturally sensitive

Colonial constraints in Canada

All the co-authors share a concern about bringing programs to First Nations communities that were created within the colonial context of the mental health care system in BC. For example, the BC Schizophrenia Society has had to consider how a medical model (describing diagnosis and mental illness treatments) might conflict with an Indigenous view of mental illness. How can programs truly include community values and cultural practices?

Preparing for program delivery for the non-Indigenous Strengthening Families Together program starts with putting up brochures and posters, letting other agencies know, then letting families reach out to sign up. Preparation for delivery of the SFT-I program is moving away from the ideas and processes of SFT delivery.

The goal now is for each community to have input into how the program would be delivered and how sessions will be presented. Program content could therefore incorporate different components across regions and communities in BC.

This open-ended delivery could pose challenges, as funders will likely be interested in how many sessions are completed and the number of communities SFT-I is delivered in. Similarly, BWSS is held to the same reporting framework of the earlier non-Indigenous program it used as a blueprint.

As well, the costs in time and funds to travel to remote communities, build relationships and start collaborative work isn't always considered by funders or during program evaluations.

Can a program include the best of Indigenous and non-Indigenous worldviews?

The key to making programs work better is involving everyone and respecting the journey more than the outcome. Instead of rigid checklists and frameworks rooted in mental health theory, it's vital to allow programs to be flexible enough to grow and morph according to the needs of Indigenous communities.

Indigenous communities across BC are diverse, so any delivery of a program needs to consider community-specific differences. Good intentions are not enough to ensure success. Programming for Indigenous well-being starts with intentionality rooted in Indigenous teachings. V

what counts as "success"?

The co-authors note that adapted Indigenous programs face challenges in the way success is measured from a colonial perspective versus an Indigenous way of measuring outcomes, including in:

- **Evaluation:** Colonial-based program evaluation tends to count sessions completed, numbers of clients and completion of evaluation reports.
- **Reporting:** Since both BWSS and SFT-I are primarily government funded, they're required to use what may be more quantitative (counting) criteria for reporting outcomes. Not capturing outcomes that are of a more qualitative nature (meanings and experiences) could result in incomplete measuring of success.
- **Moving beyond counting:** Transforming a program to have an Indigenous perspective should include changes to funding parameters so they are not exclusively quantitative to reflect some of the qualitative nature of Indigenous approaches to health.

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The Wrong Shade of Brown in a Small Town

NIRBHAU KAUR

For most of my life, I believed the systems in BC were fair. As long as you conducted yourself appropriately, followed the rules and advocated for yourself, doors would open. I truly believed that, until it was my turn to stand on the other side of the wall.

Photo credit: Beatriz Herrera for ©iStockphoto.com

Nirbhau Kaur means "fearless" and carries with it the principle of nirvair, meaning "without hate." These concepts are central to Sikhism's legacy of resilience. Nirbhau loves travel, connecting with friends and spending free time with her family. She uses her personal experiences to write and encourage others to fight for justice

My job makes me a mandated reporter. That means if I am aware of abuse, I'm obligated to report it. I've always been told to trust the process. But when I needed the services of local representatives of two government ministries related to a case of abuse, I had to navigate their prejudices and cultural stereotypes. It turned my once idyllic world upside down.

A shattered trust

I've lived in a small BC community for 35 years. It's my home. Starting in 2019, my family was lucky to become involved in the lives of two very young children who are related to us. Their parents were not able to take care of them on their own. So we stepped in, alongside other family members, to assist with the care needed in the children's early lives.

Custody issues arose two years later. This situation was complex. But when one of the children disclosed abuse by a family member (unrelated to my own family), we knew we had to act.

Of course, we turned to the authorities to report this suspected abuse, expecting support and action. I genuinely believed everything was in place to help us—and the children—equally, without prejudice or bias. Boy, was I wrong.

Suddenly, the colour of my skin became my identity. Local government representatives traded in racist stereotypes related to my cultural background, for example, that men in my culture are alcoholics and abusive. These stereotypes were used to dismiss our concerns. We're a minority in the region where we live.

Photo credit: nemke for ©iStockphoto.com

I know my cultural background wasn't the problem. It was the government officials' lack of understanding of it. If I was treated as if I was uneducated and lacked stability, insight and resources, it frightens me to think how someone without privilege, education or a strong network of support is treated. What happens to those who lack resources?

Maybe we would've been treated more respectfully elsewhere. As it was, this was just the beginning.

I, along with others in my family, was subject to months of harassment and false accusations on the part of government representatives as the custody case continued, and even as the fate of these children hung in the balance. I soon learned: cultural ignorance in small town systems is not passive, it is active harm.

Gone was any respect my family or I had meticulously fostered over the years. Gone was the person who'd volunteered, actively participating in my community. I was treated with suspicion, condescension and malice by members of those ministries.

After protracted, painful custody negotiations and an investigation, we were eventually vindicated in every respect. Slowly, a few officials understood we weren't calling in false reports or subjecting the child in our care to harmful stories about the other party. Quite the opposite. People who knew our family for over 50 years began to see cracks in the stories that had circulated about us.

But the damage was done. Our trust has been shattered. I doubt I will ever fully trust another agency to uphold their mandate and do their job without bias.

Family

What is a family? During this very difficult period, local government representatives told us, in no uncertain terms, that family is the biological woman and man who give birth to children. A genetic match. But these assumptions don't fit into many cultures, including my own.

Like BC's Indigenous nations, our culture sees the value of "extended" family—though for us, that term doesn't even apply. Family is those who raise us, who guide us and ensure we are safe. The narrow definition they insisted on was a punch to the gut. While caring for the children, we created bonds that didn't need labels, forged relationships that will last a lifetime and fully embraced the children into our lives.

I know my cultural background wasn't the problem. It was the government officials' lack of understanding of it. If I was treated as if I was uneducated and lacked stability, insight and resources, it frightens me to think how someone without privilege, education or a strong network of support is treated. What happens to those who lack resources?

A history of harm

My experience has opened my eyes to how little cultural sensitivity is given

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to those who exist outside the majority. For many years, there was no priority given to the Indigenous communities for any type of reconciliation, for example. Change was overdue. Cultural sensitivity and systems that work for their community should have been in place.

I believe these systems can be used as a guideline to foster cultural safety in other communities of colour. It seems as if there is no space for the nuances of South Asian, Middle Eastern, African or East Asian cultures. Yet Canada is made up of citizens from all these regions. We Canadians pride ourselves on inclusivity—a melting pot of people. But is that just when it's convenient?

Those of us who live these experiences can't just go home and wash off the feeling of being less than because of our skin or backgrounds. We need a framework agencies adhere to that includes diversity education, regardless of geographic location.

Real lives are at stake; families are still torn apart—all because of individuals who carry bias. Cultural sensitivity can't just be a box each minority group is jammed into, then ticked off. Society cannot allow children and those at risk to fall through the cracks.

Finding our way forward

Throughout the custody process and investigations into the abuse, I relied heavily on my network of lawyers, social workers and professionals who, like me, knew how to navigate the system. It was their support that saved me from fumbling, which would've had severe consequences.

We were also able to get counselling for one of the children involved in our case. It was free support, which was very welcome. Otherwise, we would have faced long waitlists and high costs. While we didn't ask the child to tell us what happened in those sessions, we could see they loved it. This made us feel such relief. Finally, there was support for this child. It's so important for kids to have a voice—not ours, the child's alone.

One of the children also attends an Indigenous-run preschool that prioritizes the whole network of family, not a narrow definition. This space mirrored our own way of life. We've raised the child in our care to understand that family doesn't mean blood ties, but the people you can depend on, who have your best interests in mind and love you unconditionally.

For the safety of our future and the most precious members of our society, government ministries and mental health systems must do better. Being the wrong shade of brown and outside of major centres should not determine the fairness or support available. V

dealing with cultural bias

I've had many people in my community reach out to share stories that did not end well when dealing with cultural bias. What I've told them is:

- documentation is critical (keep email and texts, for example)
- staying organized is non-negotiable
- find advocates committed to the safety of the children and your family
- stay the course and rise above the noise, because the truth always comes out

Ask for Help

EVOLVING IN A NEW COUNTRY WHILE LIVING WITH PSTD

JOSÉ GUILLERMO FLORES

I came to Canada as a refugee from El Salvador. There was a civil war going on there in the 1980s. The guerrillas were fighting the government, and I was caught in between. I was a union member in my work, and I was being persecuted, even though I wasn't part of the left wing or the right wing.

José arrived in Canada in 1986 from El Salvador. He worked as a fabricator for 25 years and a printing press operator for 15 years. Now retired, he lives in Victoria, where he enjoys spending time with his three children and six grandchildren

José Guillermo Flores

I eventually left for Costa Rica, but there, somehow, I was drugged and kidnapped. I don't remember the next three months of my life. I went back to El Salvador, but the situation was still very bad. I kept living, trying not to get involved in anything. I got married and had three young children, as well as one more child who died while I was still there. That loss was devastating.

Years of struggle

It was a dangerous time. I was feeling so insecure all the time that I was getting sick. I was paranoid. I felt I was in bondage, oppressed and so desperate. I didn't know anything more than violence and abuse.

I wanted to make my children safe. So I sold everything I could and left. I went to Mexico and applied for refugee status at the Canadian Embassy from Mexico City. They accepted my case. The process took about five months and used up all the savings I had—I spent everything. When I came to Canada in 1986, I had only $100.

The people at the embassy told us we were going to Ontario. Then a few months later, they said we were going to Vancouver. But the World Fair was happening and there was no room for us, so they sent us to Victoria.

A new life

It was really hard here at the beginning. We had nobody in Victoria. I had my wife and kids, but there was no link or support to practice my English—there just wasn't any support to learn the language. You had to do it by yourself.

So I studied as much as I could. I went to school and studied hard to survive and to work. There are many things you have to get used to in a new country.

I didn't really connect with other people from the Salvadoran community in Canada. I got a little skeptical about them. They were people with radical ideas, wanting change, still involved in the politics. I didn't want that. I went a different way.

After I was here, I was relaxing, but then I started having flashbacks to the things that had happened to me. With a flashback I would get so scared. I'd be stressed out. So I looked for help. I went to the hospital a couple of times. That's when I was diagnosed with PTSD.

I knew I was sick, so getting my diagnosis—having a word for it—made me feel validated: it wasn't a fault of my own. This had been inflicted on me. I felt relieved to be clear about it. There was something wrong, and it had to be fixed. I got treated.

Finding support

I was a member of the Mormon Church at that time, and they really helped me a lot. With the church, I was exposed to the environment, the culture. It was easier for us to get by. The Inter-Cultural Association of Victoria also helped us a lot.

Still, there were many times I found I was suffering on my own. I couldn't find anybody to share my situation with. It would have been nice if there'd been more awareness or support. But I tried to be independent as much as I could. Once I started learning the basics of the language, I went back to work and I kept working up until I retired.

We became citizens in 1991. My kids were so young when we got here, they had a different life. They grew up here, went to school and made a lot of friends. They're good people. They didn't suffer the trauma I did. They're the reason I did this—to save them from harm.

Gaining perspective

I'm divorced now. And sometimes, to this day, I need to talk to somebody. I have a therapist I see once a month for my issues. A therapist always finds a way to make you feel good, to find an answer for your situation.

Sometimes I feel overloaded with things in my head, and I unload them on my therapist. He makes me see a better way—an easier way out.

I think people shouldn't be afraid to get closer to other people and ask questions like "how are you feeling?" or "how are you doing?" A little more closeness. I couldn't find that for a long time.

I've been back to El Salvador, but it's never easy. I've had really bad nights there. Now the country is safe, but for me, it's still hard to believe. There's a fear behind everything in my head. I'm so grateful to this country, to the feeling of safety I've had here, and the life I've been able to build.

To others who struggle with PTSD, I encourage you to be open. Don't be shy to ask for help and look for the resources that are out there. V

related resources

Learn more about the Inter-Cultural Association of Greater Victoria at icavictoria.org

Find out about PTSD symptoms and help at: bc.cmha.ca/documents/post-traumatic-stress-disorder-2

Roshni, a New Light to Culturally Relevant Recovery

BAVENJIT KAUR CHEEMA, MD, CCFP, CISAM

People of South Asian descent are often raised in a culture of collectivism, especially first- and second-generation immigrants. They're taught to see themselves as part of a larger whole that includes their family, community and friends, rather than as isolated individuals. Understanding this, and the weight community carries in a person's life, can be a powerful tool when supporting members of these communities through substance use and recovery.

Bavenjit is the Medical Lead Physician at Roshni Clinic. She has worked in addiction medicine for the past two years, with a passion for improving culturally responsive care for the South Asian community. She also co-founded Asra, an organization supporting Punjabi families in navigating systems of care for alcohol use disorder

Bavenjit Kaur Cheema

In everyday life, a strong sense of community is reflected through South Asian places of prayer (e.g., Gurudwaras), extended families, neighbours who feel like family and friendships that grow into lifelong support systems. Communities can offer consistent care and belonging. At the same time, they can also bring judgement, shame and fear of being talked about.[1] The same community that can hold someone through healing can make it much harder to ask for help.

Recovery within the collective

For some people struggling with substance use, community becomes a circle of care that facilitates healing. For others, it becomes a barrier. Embarrassment and fear of losing respect can prevent them from discussing or accepting help for their substance use. This is where healthcare communities become pertinent to a patient's recovery.

Research supports what many of us see every day: social connection plays a major role in recovery from

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substance use. Strong social support is linked to:

- better treatment outcomes
- lower relapse rates
- improved mental health
- feelings of connection to others
- higher likelihood of staying in care and maintaining long-term recovery[2]

In contrast, social isolation increases the risk of substance use, relapse and early death.[3]

> **In BC, South Asian men have experienced increasing rates of drug toxicity deaths. International research also shows South Asian men are more likely to experience disability or death related to alcohol use disorders compared to other populations. Yet despite these greater health risks, South Asian communities access the least number of resources for help.**

Local community, local support

In BC, South Asian men have experienced increasing rates of drug toxicity deaths.[4] International research also shows South Asian men are more likely to experience disability or death related to alcohol use disorders compared to other populations.[5] Yet despite these greater health risks, South Asian communities access the least number of resources for help.[6]

What creates this hesitation? A key barrier is the lack of culturally tailored resources and programs that help patients feel understood.[6] When people seeking care are met with systems that misunderstand their lived realities, they may feel further isolated and withdraw from ongoing support.

The Roshni Clinic was created to close these gaps. Its goal is to provide culturally responsive addiction medicine care for South Asian people in BC. The clinic dates back to a needs-based assessment in the Fraser Health region that identified South Asian communities as underserved in mental health and substance use care. Thus, in 2017, the Fraser Health Authority created Roshni—meaning "light."

Today, Roshni operates four days a week and includes a team of professionals who all speak either Punjabi or Hindi, including:

- a physician
- nurses
- a social worker
- counsellors
- a peer support worker with lived experience

A warmer light

From the moment someone walks through the door at Roshni, the intention is to create an environment that feels like home, where patients don't have to overexplain the basic principles of their lives or fear judgment. Some features of Roshni's approach include:

Shared language: The sense of ease is immediately palpable when patients hear their mother tongue spoken in the examination room. When people can describe their struggles in their own words, the fear and anxiety of seeking help begins to soften, and even those hesitant to engage in care may approach with curiosity.

Cultural knowledge: Roshni provides a deep understanding of the cultural contexts of substance use. Many patients describe using substances such as afeem (opium) or kamini, an Ayurvedic preparation containing opioids.

These substances are uncommon in Western addiction medicine, but deeply rooted in some South Asian contexts. They are often used for energy during physically demanding labour jobs and may not be recognized as harmful at first. Over time, dependence develops, and people seek help.

Linking culture with clinical expertise: Because the team understands both the cultural meaning and clinical risks of these substances, treatment plans are both realistic and trusted by patients. This may include:

- adjusting medication schedules around work hours
- involving family members in treatment routines
- using culturally meaningful explanations to help families understand substance dependence and recovery

Healing is not seen as something that happens alone, but within relationships. Over time, a new kind of community begins to form, one that is trusted to remain consistent and non-judgmental throughout the recovery journey.

related resources

Learn more about the Roshni Clinic at: fraserhealth.ca/Service-Directory/Services/mental-health-and-substance-use/substance-use/roshni-clinic

Although Roshni is a self-referral clinic, many patients can initially be hesitant to engage in counselling and other psychosocial supports. The clinic's model includes creating long-term relationships with physicians who see patients regularly. As trust grows with providers who speak their language and understand their world, patients often become more open to counselling and peer support. Counselling at Roshni reflects this cultural lens: spouses, parents and adult children are frequently part of the conversation.

Healing is not seen as something that happens alone, but within relationships. Over time, a new kind of community begins to form, one that is trusted to remain consistent and non-judgmental throughout the recovery journey.

Substance use care is difficult for anyone to access. But when people feel ostracized from basic principles of connection and community, their opportunity for recovery decreases further. Sometimes we need to lean on people who aren't directly within our inner circle to find our own voice in our recovery journey.

Through creating micro-healthcare communities with a sense of belonging and acceptance, we shine a new Roshni (light) on the path of healing. V

MDA
MOOD DISORDERS ASSOCIATION
OF BRITISH COLUMBIA
A BRANCH OF Lookout
Free Peer-Led Support Groups
MDABC.NET/RESOURCES/MDABC-SUPPORT-GROUPS

Beyond Harm Reduction

SHARON KARSTEN, PHD AND CHRISTOPHER HAUSCHILDT

Walk With Me is a social justice and research initiative designed to spur system change in relation to the toxic drug crisis. Below, Sharon and Christopher share lessons from their work with the initiative.

Photo credit: georgeclerk for ©iStockphoto.com

Sharon has played leadership roles in non-profit arts contexts and has worked with a team to create the Walk With Me project. She now serves as a Michael Smith Health Research BC Scholar and faculty member at Vancouver Island University. Sharon is honoured to live on the territory of the K'ómoks First Nation

Christopher is a Peer Researcher with Walk With Me. He is a person with lived experience of polysubstance use and houselessness. Through mentorship, community engaged research skills and leadership development, he has found opportunity to pursue graduate studies in the Global Leadership Program at Royal Roads University

Sharon

I've been part of the harm reduction movement for nearly a decade. I've joined the fight to instill harm reduction principles in healthcare settings, where people who use substances face ongoing discrimination. I was also an instigator of Walk With Me, an initiative that started as a group on Vancouver Island, and now operates as a non-profit society working throughout BC.

The lessons from my work within the harm reduction movement have been nothing short of humbling. I've learned the importance of:

- meeting each individual where they're at
- honouring voices and stories of people with lived and living experience
- building leadership by people with lived and living experience into each initiative and project
- advocating for lifesaving interventions, such as a safe(r) supply, overdose prevention sites, naloxone distribution, witnessed consumption and decriminalization

Despite my commitment, I've struggled to reconcile the term *harm reduction* with the full range of interventions I've seen as characteristic of this movement. I've seen a component within this work that's both powerful and underacknowledged—even downplayed: the radical, utopian,

future-focused project of enabling wellness.

Is it possible that, in the focus on keeping people alive, something essential about harm reduction's commitment to forms of wellness is being suppressed? This includes physical forms of wellness, but also cultural, spiritual and social forms.

I believe a new term is needed that makes room for a life beyond subsistence.

Beyond reducing harm

Formed in 2019, the Walk With Me initiative consists of people with lived and living experience of the toxic drug crisis, Knowledge Keepers, community-engaged researchers and artists. The group's approaches include policy-based research, education, community and arts development initiatives, and more. Walk With Me aims to:

- raise awareness about the importance of harm reduction; and
- advocate for improvements in life-saving services and supports for people who use substances.

Our team has had the privilege to host art exhibitions featuring the work of people who use substances. The artwork is, in every case, compelling and starts dialogue about issues like safe supply, but also about the artists' visions for change.

For example, in our most recent exhibition at the Comox Valley Art Gallery, we set up couches in the middle of the gallery and hosted wide-ranging conversations with members of the public. People with lived and living experience who'd made the artwork held shifts. Some brought guitars. Others took on the role of docents (guides), providing insight into their art and creative practices.

These conversations were beautiful. They bridged previously unconnected worlds. People attending the exhibition asked the artists many questions—some about drug use, but also about how pinhole cameras work, how an artist chooses a particular shot or angle, and about the artists' messages. A beautiful alchemy happened, a blend of genuine curiosity with an honouring of creative practice and lived experience.

In another illustration, our team was invited by a participating community to witness a cultural tattooing ceremony and travel out on the ocean with the local community members. We engaged in a powerful connection with those whose land we were on, and with stories of place. We saw beaches that had become battlegrounds, and places where foods and medicines were gathered.

We bumped up against a rock full of sea lions and received cultural teachings about the power and role of this creature. In this space, I saw land, water and body-based practices as generators of meaning, belonging and purpose, and as ways to connect people in solidarity.

Experiences like these have made me question what the most important focus should be for this movement. I see something beyond survival. It's a quest for meaning, purpose, belonging and connection—the ingredients that

a history of lessening harm

Harm reduction has varied, contested roots. Some claim the movement began in the 1980s with distribution of clean needles for HIV prevention.[1] But instances can also be traced back to the 1960s, with the first methadone clinics, and to the 1966 US Black panther manifesto, which advocated for key principles like empowerment of Black and oppressed peoples in employment, housing, policing and healthcare.[2,3]

In spite of recent backtracking on harm reduction gains, like decriminalization and safe supply, British Columbia has been a leader in the movement. BC established the first safe injection site in North America (Insite) and has invested in prescribed safe supply alternatives.[4]

In the contemporary harm reduction movement, key commitments include:

- patient-centred, judgement-free care for people who use substances, and meeting patients "where they're at"
- understanding abstinence as only one of many pathways to stabilization
- acknowledgement of the lived experience and leadership of people who use drugs[5]
- practices that acknowledge public health as social justice and foster health and liberation by contesting inequality[3]

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SAFE Exhibition. Photo credit: Caresse Nadeau

cause human beings to thrive, not just survive. While these ingredients are woven into the harm reduction movement, they can be dampened by the movement's focus on survival.

From these observations I ask: is it enough to only help people get through another day? Can't we do more?

Christopher

My lived experience is rooted in a history of teen and adult suicide attempts, trauma, depression and polysubstance use disorder. For me, the question of finding meaning and purpose amidst the toxic drug crisis has profoundly shaped my journey of wellness and my search for more than just survival.

Keeping people alive is essential. But without cultivating purpose greater than staying alive, harm reduction feels limited in bringing about its aim of sustained harm mitigation (beyond service delivery). The question of why a person would want to continue on—in spite of the unfathomable pain of losing loved ones frequently across decades—feels important to consider.

My journey has been one of creating a life I don't need to escape from. I've found this life through honouring the memory of those I've lost, service to community and working to effect change surrounding the crisis.

The need for escape is a dire reality of the toxic drug crisis. There is a hopelessness amidst the sustained loss of loved ones due to poisoned substances, which people are also attempting to survive. I've needed purpose to do more than survive through a reliance on harm reduction, and I believe this is a necessary component for others to activate their own sustained wellness.

While the motives of meaning and purpose are unique to each individual, I've seen a common quest for these across many people who are entrenched in substance use but haven't had equitable opportunities to imagine what this purpose might be. While harm reduction may offer people the essential means to stay alive, it feels important to ask—and to imagine—how this concept provides the meaning and purpose needed to do more than just survive another day.

Perhaps one method for harm reduction to become a space of opportunity for making meaning and purpose lies in the expansion of mentorship, skills development and paid opportunities to engage in service to others; the co-imagination of meaningful and purposeful tools to spark self-empowerment begins with curiosity, reflection and dialogue.

As such, I pose these questions as a starting point for the reader to consider:

- How do we within the harm reduction movement give people more than just survival?
- How do we address the essential need for meaning and purpose as a means to thrive?
- What do meaningful opportunities look like to those deserving of equity?
- How do we leverage our positions of power and knowledge to encourage leadership and self-empowerment in those we serve?

resources

Moving Forward Family Services

movingforward.help

Moving Forward offers free short-term and affordable long-term counselling to British Columbia residents. Moving Forward Family Services has several programs, including counselling using diverse therapeutic interventions, trauma counselling, coaching programs, and community wellness sessions. Services are available in over 20 languages.

Culturally Connected

culturallyconnected.ca

Tools and resources for people working in health and related sectors to support cultural safety and cultural humility. Health literacy and cultural humility are connected through communication and shared understanding, and bringing these approaches together helps reduce barriers to care by building collaborative relationships between clients and care providers.

Creating a Climate for Change

fnha.ca/Documents/FNHA-Creating-a-Climate-For-Change-Cultural-Humility-Resource-Booklet.pdf

Culturally unsafe care continues to prevent Indigenous people and communities from accessing healthcare. This booklet from the First Nations Health Authority introduces the impacts of colonialism and systemic racism in healthcare and explores what's possible when everyone works together with humility.

- San'yas Indigenous-specific anti-racism learning courses for people who work in health, justice, child welfare, the foster system, and other sectors: sanyas.ca

How to provide anti-racist healthcare

formationmentalhealthforeveryone.ca/en

A free online course from the University of Ottawa's Vulnerability, Trauma, Resilience & Culture Laboratory.

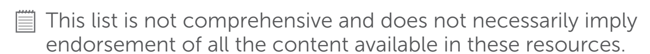
Learn more and find support

- Black Mental Health Canada: blackmentalhealth.ca
- Black Health Alliance: blackhealthalliance.ca
- Black Therapist List: blacktherapistlist.com
- Healing In Colour: healingincolour.com
- Black Youth Helpline: blackyouth.ca and 1-833-294-8650
- Vancouver Black Therapy & Advocacy Foundation: vancouverblacktherapyfoundation.com

South Asian Health Institute

fraserhealth.ca/health-topics-a-to-z/south-asian-health/south-asian-health-institute

Culturally appropriate and translated health information for South Asian communities, including mental health and substance use information and health system navigation.


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

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