

visions

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rural, remote and northern communities

up and
down in a
small town

catching those who
fall between the cracks



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We would like to acknowledge that the coordination and production of this issue of Visions Journal took place on traditional, unceded Coast Salish territory.

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“Youth Facing Health Inequities,”
Visions Journal, 15(3)

My friend is a peer support worker in a psychiatric hospital. She told me about your magazine which I now receive. For the recent issue on youth, I just want you to know that the stories shared really help people to understand each other better. I loved Anita Shen’s story and also Seren Friskie’s and Troy’s interview but I’m not done reading the full publication yet. At the time of writing this, I am personally in quarantine but not ill, am staying well. It’s really nice to see such open minded, progressive, outside-the-box, inclusive thinking. It makes me hopeful. Thank you.

—T. O’Donnell, Langley

“Workplace Bullying and Harassment,”
Visions Journal, 15(4)

Visions’ recent workplace discrimination issue reminded me about the need to highlight the needs of employees and put in place policies to protect those who suffer from mental illness. Countless times I have experienced discrimination in my role. I have been dismissed for my medical circumstances (depression, anxiety and PTSD), while others who have more sympathetic illnesses like diabetes, heart conditions, or physical injuries got more help, support and acceptance. I was forced to work through my mental injury, covering it up for fear of being judged. I went through extensive recovery and now speak about mental illness with family, friends, and in the workplace. We’re not broken people. We have a medical issue. I have a new perspective on mental illness and addictions. They are more than just forms of personal weakness. *Visions* is one platform that can shape the attitudes and change opinions about mental illness. Secrets make you sick. There is no battle won when you go it alone.

— Julia Wong, Vancouver

editor’s message

Where we live matters—it fundamentally shapes our experience. And not just our housing, but the community, neighbourhoods and land. This issue is actually a subtheme under “culture” because culture, considered broadly, is about groups of people with shared values, context and experience. As you’ll read in the pages ahead, there are definite shared realities of living in smaller, more isolated communities. Getting a regular window into that world is important instruction to all those in urban spaces who often make decisions about services and supports in rural regions. When many services were closed during the initial COVID-19 outbreak, urban- and suburban-dwellers got a peak into the feeling of disconnect many rural and northern citizens are, frankly, used to.

I am a settler writing this from a big city built on unceded Coast Salish territory, but my best friend is from a rural community. I distinctly remember her distress during the terrible 2018 wildfire season when her family had to evacuate. Her brother, who has schizophrenia, had a psychotic episode triggered by the stress and had to be hospitalized. His small local hospital has no psychiatric ward so he had to be transported three hours to the next largest city to wait for a bed there. Their parents could not visit him often. It was incredibly stressful for everyone that he couldn’t get care near home and that home was also being ravaged by an environmental disaster—sadly, both of those outcomes are far more likely for people living outside cities like Vancouver and Victoria.

I know that a lot of concerns raised in this volume are also not unique to rural and remote British Columbians. Deaths from a toxic drug supply are an issue everywhere. So is housing insecurity. So is suicide. And people in urban centres, despite more choice, still have lots of struggle accessing help and care in the publicly-funded system. Most subsidized services seem to have very particular criteria and if you don’t check all the right boxes (age, diagnosis, symptom severity, postal code) and get the right referrals, you can feel just as isolated, neglected and alone in the middle of a big city. There’s so much to love about life in a small town so let’s make sure our rural, remote and northern neighbours have extra support to get help when they need it and that we also commit to making changes that make the system more accessible for everyone. ▽

Sarah Hamid-Balma

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

Spotlight on Mental Health in Rural BC

Edward Staples, BSc, MA

I live about 12 kilometres northwest of Princeton, a typical small, rural BC town. We have a supermarket, two banks (one is a credit union), a hospital, a medical clinic, an arena, a golf course, a community centre and a range of small businesses that serve a population of about 5,000.



Edward is a retired teacher living in the Tulameen Valley, near Princeton. President of the BC Rural Health Network and Director with the BC Health Coalition Steering Committee, Edward believes in equitable access to health care services for rural BC residents. He and his wife, Nienke Klaver, formed the Support Our Health Care (SOHC) Society of Princeton, dedicated to improving Princeton's health care model. Edward was also instrumental in establishing the Princeton Health Care Steering Committee

Photo credit: Linda Raymond at ©iStockphoto.com

In my experience, mental health issues in rural BC are essentially the same as they are in urban BC. For example, Princeton is currently experiencing an opioid crisis similar to that being experienced in large urban centres, and like other regions of the world, we are also coping with the new realities of COVID-19.

But the primary difference between rural BC and urban BC is access. In Princeton, we have several “access issues,” including an insufficient number of mental health care professionals and a lack of information about how and where to get help.

Then there are travel barriers: mental health care practitioners and services are often located far from where people live, and transportation options are limited or non-existent.

When we consider mental health services in rural and remote BC, we have to take into account other factors as well—factors that also result in barriers to access. The value placed on self-reliance in rural and remote BC is high: “I don’t need anyone’s help.” The stigma faced by those seeking help is also significant: “I always knew he was nuts.” These and other factors contribute to access issues in small

One of the realities of “living rural” is that the further you get from urban centres, the fewer services there are—and less of each service is available. This results in increased suffering, for both rural patients who require mental health care and the community as a whole.

towns, and to the number of people who avoid seeking help.

Eight years ago, my wife and I, along with several other Princeton residents, formed the Support Our Health Care (SOHC) Society, a grassroots advocacy organization dedicated to the improvement of health care in Princeton and the surrounding areas. In September 2017, SOHC joined five other like-minded organizations to form the BC Rural Health Network (BCRHN). As President of the BCRHN, I am pleased to see the growth of the network to include 38 health care advocacy organizations and individuals across the province.

Early in its development, the BCRHN identified access to mental health services as a common concern among its members. Today, one of the goals of the network is to improve access to mental health services for all rural British Columbians.

One of the realities of “living rural” is that the further you get from urban centres, the fewer services there are—and less of each service is available. This results in increased suffering, for both rural patients who require mental health care and the community as a whole. Over the past several years, rural communities have

seen a gradual reduction in health care services due to regionalization, an organizational change in which health services are “centralized” in urban centres to reduce costs for the health authority of the region. Of course, the term is a misnomer from the point of view of rural residents: with centralization, many health care services are no longer “central” for rural BC. Instead, the organizational change has increased the personal costs of rural residents, who must now travel to urban centres for needed care.

At the same time, we have seen a decrease in transportation options, most notably the recent discontinuation of Greyhound bus services. These factors have had a huge impact on our communities. The most vulnerable populations—the infirm, the impoverished and the elderly—are impacted the most.

The difficulty in accessing mental health care services and transportation services means that mental health issues may not be dealt with in a timely manner. This can lead to or exacerbate addiction, family dysfunction, marital breakdown, chronic health problems and other personal and social challenges. Ultimately, this places an increased burden on other health care service areas, such

as primary care, social services, public health services and community services.

Princeton is fortunate to have an excellent team of mental health professionals providing a broad range of services, including a mental health and substance use clinician, a registered psychiatric nurse and two community rehabilitation support workers. Karen Fulton, our community’s registered psychiatric nurse, agrees that the main challenge in providing mental health services in a rural community is the issue of accessibility. As she pointed out in a personal email exchange, “In rural communities, we don’t tend to have access to [a high] level of specialized care. When treatment programs are available in a small town, we are presented with other challenges, such as stigma, which creates a barrier to successful outcomes, where a client refuses to engage in treatment based on feelings of shame and blame, and their own internal struggle.”

To deal with other issues, such as providing care over a very large geographic area, Fulton said that the clinician “must find creative ways to support clients with limited programming available.”

When asked what things might look like if there were unlimited funds for mental health care services, Fulton said she could envision a mental health centre with access to a variety of specialized programs: “I would see open doors, welcoming everyone who is willing to learn and engage in treatment.”

When we consider rural and remote populations in BC, it is particularly

important to look at the needs of Indigenous communities, since they constitute one of the largest isolated populations in Canada. The Canadian Collaborative Mental Health Initiative affirms that “Canada’s Aboriginal Peoples, who constitute a large proportion of those in isolated areas, are burdened with some of the highest rates of mental illness and often have the least access to appropriate care.”¹

The way forward must take a culturally safe approach that responds to specific needs of all rural residents. Cultural safety is “an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care.”²

I’ve identified several strategies that would improve mental health services in rural, remote and Indigenous communities. These include

- providing mental health access information through a variety of communication channels, including the Internet, the newspaper and pamphlets that would be available locally in key locations, such as primary care clinics, hospitals, town offices and grocery stores
- working with community stakeholders and Indigenous community members to develop education and self-help programs aimed at prevention
- improving access to transportation through increased private and public bus service, taxi vouchers for people with limited income and, where appropriate, a community-

organized volunteer driver program

- developing programs to enhance culturally safe and trauma-informed diagnosis and treatment of mental illness (which takes into account how an individual’s experience of trauma might adversely affect their ability to function and their mental, physical, social, emotional and spiritual well-being)
- using videoconferencing and other virtual care options to help overcome the challenges of distance and isolation

The COVID-19 pandemic has had significant impacts on mental health and mental health care in rural, remote and Indigenous communities. Some of these impacts have been negative and some have been positive. The negatives include things like a general increase in fear, frustration and anxiety. On the positive side, as a friend who has chosen to live in a remote location puts it, when it comes to socializing, “COVID has taken the pressure off.” This is an interesting observation: for many people who are dealing with mental health issues, including anxiety, self-isolation is a treatment of choice. For some, COVID-19 has increased their isolation, which has been helpful. Isolation for them does not mean complete lack of contact. It simply means they can choose their contacts to meet their needs.

The COVID-19 crisis has made me realize how easily mental health can become negatively affected. For my wife and me, the most significant change has been the loss of in-person contact with friends who are important sources of support in times of stress and anxiety. It has shone the spotlight

on the need to improve access to mental health services, developing preventative programs, removing stigma and working together collaboratively for the good of the community. As we emerge from these challenging times, the true test will be in how well we apply what we’ve learned in order to do what we do differently and better. ▼



rigorous evidence for rural health care planning: understanding outpatient substance use treatment for british columbia's rural and remote first nations

Jude Kornelsen, Christine Carthew, and Nicholas Lloyd-Kuzik, Centre for Rural Health Research, Department of Family Practice, University of British Columbia

Mental wellness and substance use are top-priority health concerns for British Columbia First Nations, particularly in rural settings, where access to mental health and substance use services may be limited due to a lack of local providers and financial, social and geographical challenges associated with travelling to services outside of the community.¹ Together, the Assembly of First Nations, the National Native Addictions Partnership Foundation and Health Canada have identified remoteness from health services as a barrier to addressing problematic substance use and associated mental health issues among BC First Nations.²

BC's First Nations Health Authority (FNHA) is committed to addressing and supporting mental wellness and problematic substance use among BC First Nations. This is reflected in their policy on mental health and wellness, where the FNHA describes its goal to "ensure that all First Nations people have access to a culturally safe, comprehensive and coordinated continuum of mental health and wellness approaches that affirms, facilitates and restores the mental health and wellness of our people, and which contributes to Reconciliation and Nation rebuilding."³

To move this vision forward, FNHA and the Centre for Rural Health Research are working in partnership to explore best practices for outpatient substance use care among rural and remote First Nations in BC. (Patients receiving outpatient care do not need to stay overnight at a hospital, clinic or doctor's office.) The Centre for Rural Health Research at the University of British Columbia is currently conducting a review of the international literature on this subject.

Our preliminary findings point to the importance of culturally embedded and community-based

treatment programs for substance use care among rural Indigenous populations.⁴⁻⁷ Community-based substance use programming can eliminate the need for those living in rural and remote areas to leave their communities to access care.^{7,8} Culturally embedded approaches to care are grounded in Indigenous spirituality, language and culture.⁴ They consider the impacts of colonization, displacement and continued racism on substance use among Indigenous peoples.⁴

Challenges to the delivery of substance use care in rural settings must also be considered for the development of successful treatment programs. These include, for example, recruiting and retaining qualified care practitioners and staff,^{5,9,10} geographic barriers (such as a community's remote location or an individual's isolation)^{9,11} and language and cultural differences.⁹

Finally, current research highlights the importance of providing supportive (or "wraparound") services,^{12,13} embedding treatment within a system of integrated care¹⁴ (for example, substance use care integrated and coordinated with physical and mental health services), and securing long-term, sustainable funding^{6,7,15} for substance use care among rural and remote Indigenous populations. Wraparound services are designed to improve an individual's access to care and to help them stay in care.¹³ They address barriers to receiving treatment, such as needs for adequate child care, transportation, housing, legal services and employment assistance.¹³

In the coming months, the results of our literature review will be available on the Centre for Rural Health Research website at crhr.med.ubc.ca. ▽

It /s Different in the North

Shamalla M.L., MA, RCC

They say most people move to the North to find a job, or to start a career and then transfer to a big city. I moved here after visiting and falling in love with the Northern way of living. I was attracted to the close-knit community, better work-life balance and a larger, more challenging caseload that inspired professional development—and, no traffic.



Masitsa Shamalla

Shamalla is a proud Canadian and a native of Kenya. She has been a registered clinical counsellor in Northern BC for six years, running a private practice and serving as a mental health and addictions clinician on First Nations reserves. Prior to this, she worked with immigrants and refugees in the Lower Mainland

On my first day, I was working at my desk at the end of the day when the lights went out. I walked out into the hallway, but it was dark and quiet. The next morning, I recounted this experience at the team meeting and my team laughingly asked why I was still sitting at my desk after 4:30. I quickly learned that, despite larger caseloads, most people prioritize spending their evenings on personal interests, family and social events.

The joys and challenges of Northern living

When I first moved here, I was elated that I could bank, make a payment at city hall, grocery shop, drop off my groceries at home and eat lunch—all

within my lunch hour! Trading an average of three hours of commuter traffic for a city where my home, office, gym, church, bank and most friends are all within 10 minutes of each other was certainly worthwhile.

Community is the mainstay of small-town living: we depend on each other, socially, spiritually and economically, and really pull together to support one another. Professionally, there is more collaboration between agencies. We are isolated so we tend to share and make good use of our limited resources.

I have run into people who sometimes erroneously characterize the North as the place to move to when life

isn't working out somewhere else, or a place populated by "uneducated rednecks" with "outdated values and opinions." That could not be further from the truth. I am living proof that educated, open-minded Canadians live here because we love living here and enjoying all the North has to offer.

Of course, living in a small Northern city has its disadvantages. However, while we lack four-star restaurants, large malls and 10-screen movie theatres, we enjoy living in a natural playground. We make the most of long summer days, and we indulge in hobbies and new interests to get us through the long, frigid winters. Life seems to unfold at a slower pace so relationships tend to be more meaningful and intentional, likely due to fewer competing interests.

Working in health care in the North has significant challenges. In the Lower Mainland, I had colleagues who specialized in anxiety, eating disorders and addictions. In the North, we are chronically short-staffed, so one individual fulfills all these roles, and much more. During my time here, I have served adults, children, geriatric and Indigenous populations. I have facilitated groups for addiction, anxiety and postpartum issues. I have also provided mental health support to a new birthing centre and to a new medical clinic with foreign-trained physicians, many working in a multidisciplinary team with colleagues in mental health for the first time. I also do corporate training, teach psychology at the local college and run a thriving private practice. I have enjoyed these roles, but not being able to specialize can mean being very good at many things but excellent at few.

Working with First Nations communities

My primary role has been providing mental health and addictions support to five local First Nations communities. The program was launched four years ago and is the first of its kind in Canada. It was created to reach clients who face significant barriers in accessing conventional mental health and addictions services.

As we know, stigma and racism directed towards First Nations continues to be a problem in Canada and is one of the main barriers to access to care. People have made derogatory comments about what I do and have asked why I choose to work with First Nations communities when I could be working anywhere else. I have also witnessed First Nations clients receiving poor treatment on many occasions because of their race. Other issues include lack of transportation, physical isolation, poor internet or phone connectivity, low literacy levels and poor understanding of the health care and social services systems, poverty and language barriers. Many clients have experienced trauma, which can be triggered in physically or culturally unsafe spaces.

Small collective communities often deal with dual relationships that lead to conflicts of interest. For example, the health liaison responsible for child protection calls may also be related to most young mothers in the community. The health care centre usually serves as the community's social hub, so it is almost impossible to ensure that confidentiality and healthy professional boundaries are maintained.

Accessing care can also be challenging for cultural reasons. For example, differences in our understanding of time and schedules can be a barrier for some clients. I often joke that the six people I see in a day are often never the ones I was scheduled to see, but always the ones I needed to see. We require that clients sign a consent form to access our services. Yet the practice of signing forms has a long, traumatic colonial history among many First Nations communities. Elders are revered in most First Nations communities, and their wishes are respected. However, sometimes those requests contravene client confidentiality or are in opposition to the requirements of licensing regulations.

There are scarce employment opportunities in the North; many work in the oil and gas industry, which primarily hires men and usually demands long hours or long stints away from home (sometimes up to 21 days), which isn't conducive to family life. Sports and music programs, prenatal and parenting classes, couples counselling, the library and cultural and higher education opportunities are all located in town. This typically means a one- to two-hour drive on a clear day, but inclement weather for six months of the year can make the drive longer and more treacherous.

However, the beauty of this program lies in our ability to meet clients where they are. My experiences here have certainly been some of the most challenging, yet most rewarding, in my career. Working on reserve effectively and efficiently means getting to know individuals and their families, how they are connected, and their unique and collective strengths and challenges.

This enables us to ensure that care is delivered in a culturally safe and sensitive manner. With time, we have been invited into sacred spaces and entrusted to share in birth experiences, diagnostic appointments that likely wouldn't have been scheduled otherwise, wakes and funerals. We have helped facilitate healing circles and we have been witness, support and advocates when children were removed from or reconciled with their families.

Being present has also enabled us to take advantage of spontaneous opportunities to engage, help and heal. We have done grief counselling in a smoke-filled shed as women skinned and smoked moose meat. We have done postpartum counselling while holding babies so moms could drink tea. We have counselled youth holding bannock on sticks over an open fire. Trauma is prevalent in the communities we work in. It is not unusual to hear "You're the first person I have ever told this" after a client recounts an experience of sexual abuse or the memory of being torn from their parents and home to attend residential school. In many communities, substance abuse, substance-induced psychosis and suicidal ideation have been normalized. And as in most communities, violence against women is a major issue; we continue to educate and empower women and men to stand up and speak out against violence.

Our greatest impact has been in building a bridge between reserves and mainstream programs. We have seen an increase in understanding of our clients and their needs, and increased access of services. We often liaise among communities,

hospitals, specialists, BC Housing, social services, child welfare, spiritual leaders, schools, police and probation programs. On request by the First Nations communities, we also offer training on issues that are pertinent to First Nations health.

The future of clinical work in the North

I am grateful to have attended two fine institutions of higher learning in Canada. Although I credit my master's degree in counselling psychology with giving me a solid framework for clinical practice, I was disconcerted by how ill prepared I was to counsel multicultural and Indigenous populations. This is a disgrace, and it definitely made my transition to the workplace more challenging, given the significance of First Nations history in Canada and the multicultural make-up of our population.

Fortunately, I grew up in a collective culture, and there are strong similarities between collective cultures. Some shared values—such as the emphasis on relationship building, the celebration of cultural activities and the mentoring of the next generation of leaders—made it easier for me to find my way. My grandparents were spiritual—avid farmers who were deeply connected to the land. This augmented my appreciation for First Nations' beliefs in the Creator, respect for the land and the therapeutic benefits of nature. I have also enjoyed learning and trying new skills such as archery, horse riding, berry picking, carving, hunting and food preservation.

My hope is that more First Nations history will be taught earlier in schools, and our curricula will be

modified to reflect the Canadian cultural make-up. This will better prepare future health care workers and communities to associate with and serve all Canadians in meaningful and culturally sensitive ways. We desperately need leaders with a vision for a collective and sustainable future that doesn't promote or sustain colonial ideology.

I also hope the BC government is able to establish programs that attract more skilled, knowledgeable and enthusiastic care providers to the North, and encourage them to stay. High staff turnover rates in our health care institutions are disheartening, particularly in First Nations communities that thrive on relationships built over time and are re-traumatized when staff leave.

Ultimately, the North is beautiful, in so many ways. We seem closer to the rhythm of the land and the seasons, maximizing our days without the noise and the traffic while we take care of each other. It is different in the North—in all the ways that count. ▼

Going Mental in a Small Town

Michael J.

Some people are raised in a small community. Others move to a small community for work, family or other reasons. Those who choose to stay appreciate the connection to nature and the freedom from city life, the beauty and quiet of it all. Sometimes the sweetest sounds are the ones you never hear. Most notable, though, is the sense of community. You know your neighbour, the folks at the store know your name, people know your dog and, for the most part, everyone helps each other out.

For the past 10 years, Michael has lived in a small community on the west coast of Vancouver Island. He operates his own business, loves where he lives and for the most part enjoys—or at least accepts—the challenges of living in a small town



Photo credit: Fug4s at ©iStockphoto.com

But life in a remote community can also be challenging. Isolation, income security and access to services can affect people's mental health. Everyone experiences challenge differently; the issues I faced became clear once I needed services and didn't have easy access to them.

Over the past six years, I have been seeking help to address some of the mental health issues I struggle with. Depression, anxiety, negative core beliefs—all began to be much more present; becoming much harder to manage.

While there are some resources available in my home community, finding

and accessing the right resources can be difficult.

Everything got harder to ignore; I would get angry and frustrated at nothing and not really know why. I started to withdraw. When I went out, I would feel self-conscious about being awkward, and then I would drink to manage my self-consciousness. It seemed the best solution was just to not socialize.

Asking for help is difficult when you live in a small community. You can't be anonymous. You can try to be, but people in a small community talk (at least that's what you tell yourself) and I felt embarrassed about needing

help. I didn't want my doctor knowing about it; I didn't want anyone knowing about it.

Eventually, I booked an appointment with a mental health clinic in "Town." ("Town" is what anyone from a small community calls the next largest community—it usually has a Wal-Mart.) I called the clinic but the soonest appointment I could book was a month away.

When you get to the point where you're so low that you call someone for help, you need help now, not a month from now. The delay can seem like an eternity when you're in the moment, the peak of your crisis. You also quickly find that life isn't going to wait for you to get your shit together. So you just have to figure it out.

When the appointment day arrived, I had already successfully employed all my usual survival techniques. I'd spent a month burying all those emotions—the mentally, physically draining ones, the ones that scared me enough to book the appointment—and the thought of having to dig everything up again seemed unnecessary now. But I knew that if I didn't, it was bound to repeat itself.

I kept the appointment, but it wasn't very reassuring. After a few appointments, I remember receiving a tentative diagnosis of bipolar disorder and depression. I requested therapy more than once but was made to feel that therapy was only available following a course of medication—if it was available at all. The doctor then prescribed medication I wasn't sure I wanted to take. Side-effects, and the absence of expected benefits, ultimately made my

mental state worse. I was on medications for some time, maybe a year or so, before I realized the negative effect it was having. I thought I was going crazy.

A few years later, my thirties would prove to be filled with challenge and heartache. My mother passed away suddenly. My dog passed that year as well. Toxic romantic relationships took their toll. My father had a sex change that neither he nor my family told me about beforehand (that needs its own story, I'm sure). I also quit my job and started a new business.

Needless to say, my plate was full. Overwhelmed, stressed, confused, angry, scared and scarred: suicide started to become a dominant thought.

I decided to ask for help again, though. It actually gets harder the more times you ask, but this time I was serious. I knew I needed to get better. I stayed closer to home—and friends—and told my family doctor what was going on. I got a referral to the mental health clinic and was able to meet with a psychiatrist eventually. After one meeting, he concluded, "there's nothing wrong with you." He would add, "You just need to change how you think."

"Oh?" I replied.

"You just have to learn to be present," the psychiatrist said.

It was just that simple.

I was offered appointments with a counsellor, taught about mindfulness, meditation and how to let go of things. These techniques didn't really answer why I felt the way I did. But I was

assured that the why wouldn't be important anymore. This frustrated me; I felt in my gut that I needed to know the why in order to understand and to heal.

But I tried. A few years of meditation, going overboard on motivational tapes and positivity seemed to help calm some anxiety and depression. But while these skills made me feel productive for a time, they didn't address the underlying issues in any comprehensive, healing way. In hindsight, I was like a lion tamer whose only tool was a toothpick.

I had effectively used up what mental health services were available to me. The mindfulness skills I learned are helpful, but you have to practise the skills to stay on top of it. As long as you practise the skills, then you can manage how you feel about your problems, even if they don't go away. But if you lapse in your mindfulness practice, then you start to struggle again. Stress and the demands of life can make mindfulness as a practice hard to maintain over time. In my experience, mindfulness skills were the first to go when things got rough again—which they did.

By the end of 2019, things had gotten steadily worse, and in the first day of the year, I made another serious suicide attempt. On January 2, I woke up in my truck, parked deep in the woods, wondering why the hell I was still alive. How was I going to ever feel normal again? I couldn't even kill myself properly. What help could there be when I'd already tried twice and was still in this position? Did I even have the energy to fight anymore? I was still alive, yes, but I

None of this has been easy, not even writing all of this, but I'm told that I have to "fight" to get the right treatment, "fight" to see the right doctor and "fight" to advocate for myself.

was too afraid to move forward and had nowhere to go back to. I felt stuck.

I somehow got myself to a nearby emergency room. I felt like I was floating like a ghost. When my name was called, I spoke very slowly, said that I was sorry and that I had tried to take my own life.

This gets you a minimum two-day stay in the hospital. With a new prescription and yet another new diagnosis—this time attention-deficit/hyperactivity disorder (ADHD) and major depressive disorder—I was told to "take it easy" for a few days, given the address of a walk-in counselling clinic, the number for a crisis line, some very kind good-byes. Then I was on my own again.

Surviving a suicide attempt doesn't provide you with any great moment of revelation; instead, you just feel worse. Before you make the attempt, you feel like you have an answer to your pain: a plan B—the plan you follow when everything gets to be too much. But when plan B fails...guilt, shame, confusion and fear are all you're left with—on top of all those other shitty feelings that made you come up with a plan B in the first place.

When you decide it's time for plan B, people close to you may go into crisis mode; you might even feel safe for a

short time. But when the immediate crisis has passed, you return to the real world and, well, so does everyone else. It is on you to fix it, but to acknowledge and talk about what really happened and why—that's hard. I felt guilty for not feeling better, people told me to keep trying or to try harder. I had a desire to bury it all over again.

I did manage to go to an appointment at the walk-in counselling clinic though. I sat in the waiting room for two hours before seeing someone, but this was my only goal for the day. I didn't find any deep answers—as soon as I sat down, the floodgates opened and everything poured out. But I felt I was finally being heard.

I made another appointment for three weeks later—the clinic is about 200 kilometres from where I live, so I have to plan ahead (another challenge of small-town living). On the day of my appointment, the only road washed out. We rescheduled for the following week, but then my counsellor went on medical leave. I had one meeting with a replacement counsellor, and then the COVID-19 pandemic began. Since then, appointments have been by phone, and I haven't found them particularly helpful yet.

Despite these setbacks, I have tried to move forward, but it's frustrating. I had hoped to be on track to a better

understanding of myself. I keep hoping things will get easier, but life has always seemed to be a little more difficult for me and I'm still no closer to understanding why I feel the way I do. Co-morbid symptoms (symptoms common to a variety of disorders), assessment after assessment, conflicting opinions and diagnoses, plus the waiting in between appointments! None of this has been easy, not even writing all of this, but I'm told that I have to "fight" to get the right treatment, "fight" to see the right doctor and "fight" to advocate for myself.

But I'm tired, and all this fighting is exhausting. I've been at this for a long time now. Not all of it has been bad over the years; it's the reoccurrence of things that has been so defeating. The year 2020 has been the hardest year of my life. I don't want to let down the people who care about me but I don't necessarily have faith that things will get better. I know I'm not alone; it just feels that way sometimes. ▼

Longing and Belonging

NAVIGATING CULTURAL EXPECTATIONS, STIGMA AND THE MENTAL HEALTH CARE SYSTEM IN A SMALL TOWN

Navjot K. Gill

Growing up as a second-generation immigrant in a small Okanagan town of 5,000, I often felt like I had my feet in two different worlds: one that was deeply rooted in my Punjabi culture and the other where I tried desperately to blend in to a mostly white community.



Navjot grew up in the Interior of British Columbia and now lives in Coquitlam, BC. She has a master's degree in public health and works in the field of mental health and community engagement. She explores the themes of identity, healing and community in creative forms on her Instagram @_navjotk

Navjot K. Gill

My first language was Punjabi and I lived in a multigenerational home with close ties to India. I was surrounded by community members whom I called aunties, uncles and grandparents, even though we weren't related. We practised the Sikh faith in our living rooms until the community built a Gurdwara (temple). I loved performing *shabads* (hymns) on traditional instruments at community gatherings. Yet at school, I felt like I had to hide my Punjabi culture to blend in. I was embarrassed of my accent and hated being pulled out of classes to attend ESL sessions. I skipped eating lunch when my mom

packed traditional foods and I was bullied for wearing Western clothing made out of Indian fabrics.

I knew I didn't fully belong in either world. I knew I would eventually rebel against the gendered expectations of my family and Punjabi community. I also knew I would never be able to completely let go of my culture, family and spiritual practices in order to assimilate.

As a child, I often felt alone, sad, unsafe, fearful and anxious. At school, I had no educators whom I felt

comfortable to confide in. At home, we never spoke openly about our feelings. Issues like sexual abuse, domestic violence, addiction and suicide were completely taboo, even though we saw these growing up. So many men in my family and Punjabi community struggled with alcoholism, and we lost family members in Canada and India to suicide. When we heard the words *“No one really knows what happened,”* we knew that we shouldn’t ask any more questions. The silence created a vicious cycle of stigma: somehow, mental health challenges were always the fault of the individual. Like so many others in my family and community, I suffered in silence.

I was 14 years old when I had my first drink of alcohol, which I stole from my uncle’s liquor cabinet. I drank alone at night in the orchard. It was taboo for women to drink, and I can’t imagine what would’ve happened if anyone in the family or the Punjabi community had found out. Reflecting back now, I see that drinking and using substances numbed the pain I felt from witnessing sexual abuse, alcoholism, racism and violence against women and not having anyone to confide in.

After a year of substance use, I attempted to take my own life and was immediately flooded by scattered support from a fragmented mental health care team that turned my life upside down. I missed a year and a half of school, stayed for months at children’s psychiatric units and spent much of my time being transported from one care space to another.

Living in a small town meant there were few mental health supports available locally. Either my care providers

drove to visit me or I was driven to visit them. Every visit to my psychiatrist was a five-hour drive; my social worker would take me. When I spent months at a time in psychiatric units, my family drove four hours every time they wanted to see me.

I travelled 10 hours each week to see a traditional healer who my mom insisted would cure me. The healer would perform prayers to remove a curse that someone had supposedly placed on me. I would have to do more prayers at home until our next appointment. It frustrated me that my family was more willing to accept that I was cursed than to consider the environmental factors that were affecting my mental health.

Once, my visit to a healer was two months long—in India. Until we arrived, I had no idea that the “family trip” with my grandparents was actually a healing trip for me. I was in a constant tug-of-war between what my Western doctors thought I needed and what my family thought I needed. To everyone, I was the problem that needed to be solved, with either Western medicine or Eastern prayers.

I felt the greatest stress when my social workers visited me in town. I had the option of having an appointment in my family’s living room or meeting with the social worker in a public park. Neither felt safe. I knew that my being seen day after day in public spaces with various white adults holding mysteriously thick binders would set off alarm bells for those members of the Punjabi community who saw me. I felt sick to my stomach every time I saw someone I once called “auntie” look at me, turn

to her group and then invite everyone to look back at me. Had they forgotten that I was the same girl who used to sing hymns with their children at community events?

My family kept my mental health a secret by staying silent. We never used the words “mental health” and my name in the same sentence. We let others make up their own stories. My extended family was told I had an undiagnosable physical condition, and my peers thought I had dropped out of school. I would hear my mom use the phrase *“No one knows what is wrong”* over and over. Rumours about me spread like wildfire. My friends told me their families thought I was pregnant and that my parents had taken me to India to get an abortion. The weight of this rumour—in a community where family honour is the fabric of society—was soul-shattering. My Punjabi boyfriend at the time was asked by his family to break up with me because they didn’t consider me a suitable life partner; eventually, he did.

I felt misunderstood: by mental health care professionals who lacked cultural competency; by my family, who did everything in their power to hide my mental health instead of listen to my concerns; and by my Punjabi community, which distanced itself so far from me that I felt shunned. I had nowhere to go.

I stopped talking to my friends and cousins. I stopped going to cultural spaces like the Gurdwara so that I could avoid running into people I knew. I picked appointment times with my family doctor during school hours so my peers wouldn’t see me

going to the office. I avoided sitting in waiting rooms. I refused care from any Punjabi provider because they all knew someone I knew, and I doubted that my privacy would be respected. When my social workers came to me for appointments, I met them in the most isolated parks. I even invested in a pair of oversized sunglasses thinking they would provide me with the anonymity I needed.

The longer I struggled and fought stigma and a fragmented mental health care system, the more I felt guilty and responsible for my mental health challenges. Why wasn't I getting better? Was it my fault? Did I do this to myself? I calculated the cost of each trip and wondered how my family afforded it. I often tried to just "get over it," somehow speed up the recovery process to reduce the burden I felt I was putting on my family. During this time, I lost a sense of home, belonging and identity.

The experience of being excluded in small communities—or feeling stigmatized by one's mental health challenges because *everyone knows everyone* and you have no privacy—is painful. I felt ashamed, silenced, numbed and forgotten. This is how I remember my life growing up in a small, tight-knit community. It often feels safer to stay silent than to find people to connect with again.

As time went on, however, I realized that staying silent just increased the weight I was carrying. As a young Punjabi woman, I also knew that rumour-fuelled community conversations about my sexuality were far more damaging than anything anyone could say about my mental health.

My well-being is connected to the process of reconnecting to my culture, participating in community and being present with my family.

I found ways to step out of the shadows, and I began to speak openly about my mental health. This didn't necessarily reduce the stigma I faced, but it empowered me to connect with my truth. My life trajectory shifted when I signed up for youth volunteer programs and found adults whom I could trust. They became my anchors in a stormy sea. When I shared my mental health struggles with them, they listened, validated my experiences and often told me their own stories. They saw me, heard me and created space for me to engage in community.

The day I graduated from high school, I packed everything I cared about in my car and drove out of that town. A part of me had needed to leave all along, but my guilt and shame had kept me there until it was socially acceptable to leave. I didn't stop speaking to my family. I just needed space to breathe.

I spent my early twenties exploring what became my life purpose: breaking the cycle of stigma and creating spaces for healing. I started off speaking about stigmatized topics and engaging youth to participate in community; eventually I began hosting cultural events where grandmothers, mothers and daughters could connect, share and celebrate. During this time, I also engaged in yoga, meditation, journaling and art; these provided

me with opportunities to connect my body, mind and soul.

The healing process continues. Understanding my relationship with substance use has been challenging, but by actively listening to my body, I have learned healthier coping mechanisms. I have an incredible counsellor who has supported me in managing my post-traumatic stress disorder (PTSD) through culturally safe therapy and has helped me explore my relationship to substances in a safe environment. I have become better at recognizing my early warning signs, which I monitor through meditation and other practices.

My well-being is connected to the process of reconnecting to my culture, participating in community and being present with my family. My family still lives in the Okanagan (in an even smaller community), and I visit them often. I continue to host community events, especially for the Punjabi community.

I often remind myself that I am resilient, that I did what I needed to do to survive and that there is strength in me to keep moving forward every day. I now know the space I inhabit—between two cultures—can be nurturing, fluid and empowering. ▽

Up and Down in a Small Town

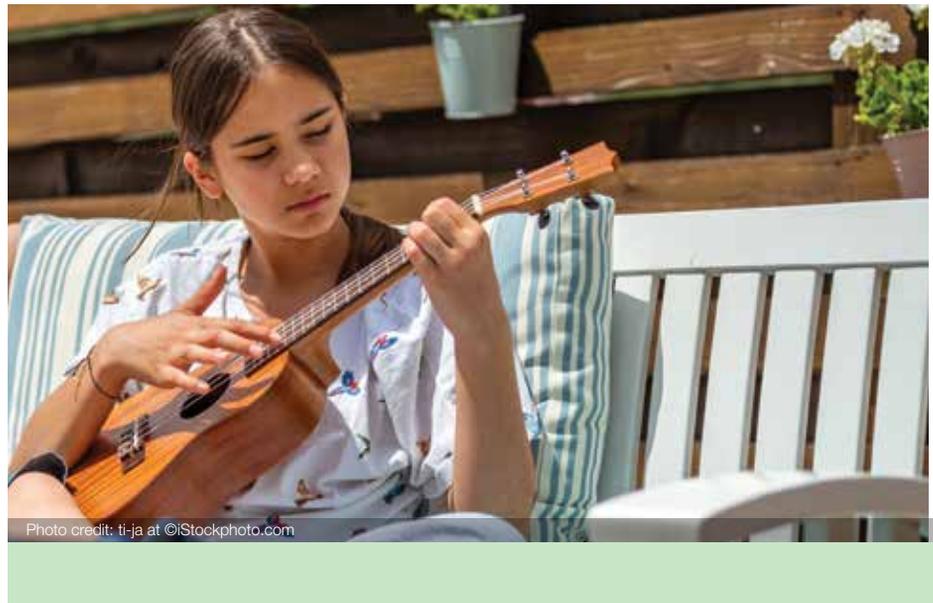
A YOUTH'S PERSPECTIVE ON LIVING IN A RURAL COMMUNITY

Bailee Lyons

I live in Smithers, BC. I've lived here since I was five so I consider it my hometown. I think Smithers is a beautiful place. I feel like I used to take the mountains here for granted but they're actually really beautiful. You're just able to step out into your backyard and see this beautiful view.

Bailee is 15 years old and lives in Smithers

Based on an interview with Sarah Hamid-Balma



At the same time, it's so small. There's limited stores and stuff because it's such a small town. There are also times where there's a lot of snow, really icy roads and cold weather. There's lots of homeless people and I'm sure they get affected by the cold weather. The most annoying thing is that everyone's news gets around to everyone else. It feels like everyone knows your business.

I always knew I was different. But I'd say probably Grade 6 is when I started to really struggle. It was obvious to me that my friends' lives were a lot less chaotic than mine. In Grade 6, I started to take out all the pain on myself and started to self-harm.

I was friends with the more popular kids. They were all really nice. The pain I was taking out on myself was less about school feeling rough and more about home. There's been family shakeup for almost forever—ever since I was little.

I moved away for the end of Grade 7. When I came back for Grade 8, it was like I was new. I didn't really have friends. The transition to high school wasn't rough but I got a bad reputation because I was considered a bad kid. I got in with the bad kids, too, I guess. We would just get high at school and stuff. I wasn't using drugs in elementary school; it just started in high school. The life that I took once I

got into high school—it was a different path that I didn't see myself taking.

I think using drugs and alcohol is a big part of people's lives in Smithers because it's such a small town and it's easy to fall into that stuff. It's probably stress and boredom. There's not too many opportunities for having fun here. If there is, it's really expensive—dance or skiing or sports. My family couldn't afford that—lots of other families can't really afford that. I feel like people turn to alcohol and drugs as a way to have fun and fit in with people. There's definitely a lot of overdoses, too. My close friends have struggled with that and [have] overcome it.

I'm in Grade 9 now. I didn't really start taking breaks from school until last year. I went through a really hard time, even ending up in the hospital for a while. When I returned to school, it just felt kind of weird. That happened twice last year. Then this year, I kind of lost all my friends—including those from elementary school—and also just lost my motivation for school. So I haven't really been going.

I've been in and out of foster care since I was four. When you go into care, you are connected with the Ministry and they're like your guardians. Even after people return home, their help and support will still be there, just for safety or if you need someone. They're really helpful. I don't know if my experience is true for everyone, but for me, it's been like that. They're the ones who got me my phone for safety in case I needed to call someone, like a hotline.

At one point, I was in this really bad foster home. They controlled

everything we did. I just wanted to control something myself and that thing was food: I developed an eating disorder pretty quickly and dropped a lot of weight. That was a couple years ago. I don't struggle with that so much anymore. I still have body image issues but I don't have eating issues anymore.

I also struggle with anxiety. It seems I can't get away from it. I'll be having a good time and it'll just hit me. It's all kinds of anxiety: panic in my body, shyness, worrying all the time and flashbacks. Sometimes I'll get flashbacks of messed-up stuff that's happened in my life. Sometimes I don't see the flashbacks, but I can still feel them. I don't know if that makes sense, but there's certain things that can trigger it—a song, a noise, a place or words. And then I'll just get the feelings of when bad things happened, and that is just not a good time.

I struggle with depression, too. It gets worse during the wintertime here because it gets really, really cold. And then I can't go outside and it's gray, foggy and dark—it will get pitch black by 5 o'clock in the winter.

Back in Grade 6 when it all started, there were people in my life that were looking out for me who suggested that I get help—mostly my nicer, supportive foster parents. (I had good experiences with foster parents and not-so-good ones.) The Ministry of Children and Family Development is also really good with counselling.

When they suggested I get help, at first I was all, *No, I don't really need that*. Then I did it for a while, and it went really good, so my counsellor would say, *I don't think you need this*

anymore. And I would think, Okay. There's been lots of ups and downs. But recently, I've come to terms with getting help. And my worker at the Ministry, Acasia, is super amazing and kind and gets me. I've been connected with Acasia since the wintertime.

I was in foster care not that long ago. I returned home a couple of months ago, but recently, I kind of got kicked out of my house. The reason I transitioned home is because I had fallen into a dark place again while I was in foster care. I OD'd and ended up in the hospital. They thought that it would be best for me to return to my mom instead of back to foster care. I thought the same thing. But my mom had just broken up with her partner, so we were living in a shelter. I knew that when we got a place of our own, things would go downhill. I tried to tell the Ministry that, but nothing happened. It was fine for a bit at the new house and then things went downhill with me and my mom and now I'm kicked out.

It wasn't the first time [I'd been] back with my mom. Usually we [my siblings and I] would go into foster care for a couple months or a year while she got better—from addiction mainly—then we would return home and things would be good for a while. Then things would flip and we'd go back into care.

I have an older sister and a younger sister. In fact, I will be moving in with my older sister soon. She is in her 20s and lives in another city. My little sister's still living with my mom. I think that's working okay because they have a better relationship.

Acasia and I meet once a week. Because of COVID-19, we can't meet at the office or go on drives like we used to. So we just go for walks. I don't just see her when I'm not doing good; I see her when I'm doing good, too. I'm ready to learn how to deal with all of the things that have happened in my life. And work on my body image and self-love. She's really helpful with that.

The things that have happened [in my life] have caused me to be sensitive. I've also learned bad patterns from my mom. One thing that helps me is knowing that it's not my fault that I am this way right now, that trauma actually physically changes your brain, the way you think and feel things—and that's okay. I can change that over time.

I really love art and music. It would be cool to share my music with other people locally. A dream I have is opening my own store, maybe a coffee shop or a clothing store. Maybe play my music in the background. I sing and play ukulele (I've tried to teach myself piano a couple times, but I gave up).

I would like to get into healthy living—eating and exercise—finding

balance. In the past, I tried to restrict food or exercise because I didn't like the way I looked and I wanted to change that. But I've changed my perception. I realize that if I am going to do something like that, [I have to do it] to be healthier.

It's kind of hard for me to describe my spirituality. I'm interested in energy—good energy, bad energy and how we're all connected. I also like to be connected to the earth and spend time in nature. I also like tarot cards and crystals and witchy stuff. Sadly, even though I'm Indigenous, I don't know anything about my culture. I was never taught about it. I hope one day I can be more connected with that.

I enjoy going for walks or just sitting in nature mindfully and really looking at everything and just listening to the noises and breathing.

I draw and paint. I like any sort of art: dance, makeup, fashion, cooking—taking something and creating, making art out of it—transforming it.

I think people see me as this person who's had a hard life and done bad

things. I wish they could be more open-minded and more accepting. Know that I'm not a bad person. I have a good heart. I'm really accepting of everyone, I don't judge anyone. I wish that people would feel the same way.

Through all this, I haven't needed to use telehealth or travel long distances. I think Smithers has basically everything we need.

A myth that city people have about us in small towns is that we're just all friendly and we don't really have a lot of the problems that people might have in the city. But we do. Sometimes I like where I live, but I do want to go farther than just here. ▼

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Our Journey

THE STORY OF A SINGLE FATHER OF A CHILD WITH SPECIAL NEEDS

Jim

When my youngest child, Joseph,* was born, I knew he was going to be unique and high-maintenance. He was a much higher-energy person than my other two children (Joseph's older brother and my eldest, a daughter from a previous relationship). Joseph would often have loud and violent, unpredictable outbursts. He didn't crawl; he just started walking. Even when he was sick, he was active; the only way we knew he was physically ill was when we took his temperature.



Jim now lives in Telkwa, just south of Smithers, BC. He has three wonderful children and three very cute granddaughters. As an adult, he has moved around for work, living in small towns throughout the province, including Terrace, Kamloops, Williams Lake, Fort Saint John and Dawson Creek, to name a few

**pseudonym*

We tried to bring up our concerns about his hyperactivity with our family doctor, but we repeatedly heard that Joseph's erratic behaviour was due to diet and insufficient discipline. In other words, we were told indirectly that there wasn't anything wrong with our son; the problem was with *us* as *parents*.

Over the course of several years, there were many medical visits and a few trips to the hospital. But the outbursts and the hyperactivity continued. Joseph was going to do what he liked, and he seemed to have no fear. We had countless arguments with medical

professionals as we tried to get someone to see and understand our son from our perspective.

The challenges of raising a child with special needs took their toll. After a few years, my wife and I split up. I didn't see the boys for two years after the split. I would speak to my older son on the phone, but Joseph didn't like talking on the phone. The boys lived in Williams Lake with their mother; I lived in Dawson Creek. It was a seven-hour drive, so visiting was difficult. Eventually, though, I began booking vacation time so I could pick

up both boys and they could spend some time with me.

But parenting Joseph continued to be a challenge. One morning, when Joseph was eight years old and both boys were living with their mother, I received a phone call from the Ministry of Children and Family Development (MCFD). I was asked if I would take on the full-time care of Joseph or sign a release to give him up for adoption. Of course I told them I would be there the next morning to pick him up. For the first seven years of my life, I was in foster homes before I was eventually adopted. Being in foster care was not a pleasant experience; my adoptive life was no picnic either. I was not going to have my child go through that.

At the time of the phone call, I was visiting my father in Smithers. So, the next morning, I made the six-and-a-half-hour drive to Williams Lake from Smithers. Then we drove home to Dawson Creek—another seven-hour drive—and Joseph came to live with me.

Within the first month of living with me, Joseph attempted suicide—and he was only eight years old. This was not good. I went to Child and Youth Mental Health (CYMH) and requested help. CYMH flew in a specialist from Children’s Hospital, and they worked with him for a while. The specialist diagnosed Joseph with attention deficit hyperactivity disorder (ADHD) and started him on medication.

At first, the meds made things worse for Joseph. For example, one morning I received a call from his school, where the administration had had to lock him in an empty room with an adult to keep him from running away or

harming himself. I went to the school and picked him up. I decided that the meds were wrong. We had another meeting with the specialist and various care providers (a counsellor, a Ministry representative, an anger-management team and an aide who worked with Joseph after school). As a group, we decided to try another medication. This time, it worked.

School started going well and we seemed to be in a good routine. We decided to move to Williams Lake so we could be closer to Joseph’s brother and his mother. I got a transfer through work. Things went okay for a bit. Joseph was able to get some of the services he’d been receiving in Dawson Creek through MCFD in Williams Lake, and through the Boys and Girls Club. But he didn’t spend much time with his mother; he always wanted to come home after a few hours. And the elementary school I enrolled him in didn’t provide enough support; things started to get out of hand. Joseph would leave the schoolground when no one was watching, and no one would contact me or the police to say that he’d left. I would show up to pick him up after school, and no one would know where he was. I would be running around town looking for a young child. Fortunately, he loved to play in the park; most of the time, that’s where I would find him.

Things got more and more challenging, and Joseph’s behaviour became harder to manage. He would smash toys and throw things when he became angry, or he would storm out of the classroom. And sometimes it was difficult for those who didn’t know him well to know if he had really lost control or was just being

mischievous. As his father, over time I had learned what his triggers were, and I had learned how to get him to refocus and calm himself down. At school, they didn’t try to work with him to refocus; they just removed him from the class.

Finally, when Joseph was 11, I quit my job to stay home with him and support him. We had some help at home, but many support workers left soon after they started, for one reason or another. In some cases, they had personal reasons for leaving; in other cases, I asked them to leave when it became clear they didn’t have a clue how to work with a child who has ADHD and they just made things worse.

During this period, my father became ill. Joseph and I moved up to Smithers to be closer to him. My elder son stayed with his mother, and by this time my daughter was busy raising her own family. In Smithers, I got a job in a dealership to support us financially. Joseph finished Grade 7, but since then has refused to go back. Homeschooling was never an option; he needs specialized one-on-one support and I just couldn’t afford that.

CYMH tried to work with him but never consistently over the long term. People would come and go as they took up new positions, or sessions would stop if the support worker saw improvement. I also heard there were funding issues. But whenever the appointments stopped, inevitably Joseph would get worse again.

Over time, Joseph became anxious and depressed. He was quiet and

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Life on an Island Doesn't Have to Mean Isolation

BUILDING NEW MODELS OF CARE IN THE SALT SPRING COMMUNITY

David Norget, MA, ABS, and William MacPherson

William's perspective

My trauma began at birth. I was born blue, unable to breathe. I have Asperger's syndrome, which places me on the autism spectrum. I was a gifted child, doing deductive reasoning with fractions at the age of 3 and Grade 8 math at the age of 5. But I had poor physical coordination and was unable to understand child social dynamics.



David Norget



William MacPherson

David is Co-Chair of the Salt Spring Health Advancement Network (SSHAN), father of two, a registered clinical counsellor and an emergency mental health clinician. He has been a member of the Salt Spring community since 1989. He is grateful to live on the traditional and unceded territory of the Hul'q'umi'num' and SENĆOTEN-speaking Coast Salish peoples

William is a resident of Salt Spring and enjoys practising "biohacking" (experimentation on the body with the hope of reaping physical and cognitive benefits). A board member of the Chu'an Society, a community arts organization, and part of the SSHAN Mental Health Initiative, William also works for hip-hop company King of the Dot Entertainment

I was also obsessive. I had numerous illnesses and was given antibiotics many times a year. I now understand how this devastated my gut microbiome and contributed to the issues that followed.

By 9, I had suffered significant violence at the hands of bullies, which made me fearful of people. Luckily, I am an autodidact, which means I learn primarily by teaching myself. The Age of the Internet is an ideal time for autodidacts. The bulk of my learning was done at home.

At 15, I experienced increasing anxiety. I began using substances to calm my feelings. I was prescribed Paxil to deal with anxiety, exhaustion and depression. One side-effect of the Paxil was hypomania. I interpreted this as an improvement, as it freed me from fear. But as my hypomania intensified, I received new diagnoses: bipolar 1 and borderline personality disorder, co-occurring with an addiction to cocaine and alcohol. Within two years I was having manic episodes. I was prescribed mood stabilizers and antipsychotics.

The next decade of my life was defined by my mental illness. During much of this period, I was living in Vancouver. Eventually, I realized I wasn't able to cope well living in a city. I moved to Salt Spring Island to live with my parents, who had retired there a few years earlier.

Escaping the people and places that reinforced my bad habits helped—but only for six months. I then found new people with whom to share old habits and create new patterns that contributed to my mental illness.

My mental well-being was always shifting, and my emotional experience was intense. Cocaine and alcohol gave me the illusion of control. Compared with periods of crippling anxiety and depression, my manic episodes felt liberating. My drug use and impaired judgement created a destructive feedback loop. The mental lows following an episode of drug use would leave me with thoughts of suicide. I had to fight to re-establish equilibrium.

The resulting sense of shame and lack of self-worth was suffocating. My doctor told me it wasn't my fault. I was a victim of an illness that runs in my family. This helped assuage my self-loathing. But nobody seriously discussed the possibility of healing; I was simply prescribed medication to alleviate symptoms. At the time, mental illness was largely viewed as a genetic disease acting through neurotransmitter pathways: a lifelong affliction. But I had a growing suspicion that a lifetime of prescription medications had worsened my health rather than improved it. I also began to suspect that healing was in fact possible.

My obsessive, autodidactic brain kicked into gear. While researching the term “neuroplasticity,” I found a book by Norman Doidge: *The Brain That Changes Itself*.¹ Doidge discusses the brain's capacity to heal through rewiring itself after traumatic brain injuries. People who have suffered traumatic brain injuries and lose speech and motor functions can create new neural maps to regain lost function. I felt sure that if a person with a brain injury can relearn how to speak and move, then my brain could heal from its mental illnesses.

Many of the ideas I pursued—such as the principles of orthomolecular psychiatry (the use of high-dose vitamins to address mental illness) or eating a raw food diet—seemed to help temporarily. My doctor figured these ideas were placebos, valuable only in that they increased my feeling of personal agency. I know now he was right—but placebos can be powerful medicine. I was building an internal locus of control, foundational for mental wellness. I forgave myself for my afflictions, which were not my fault, while stepping into the driver's seat of my recovery, which was my responsibility.

Understanding the distinction between fault and responsibility saved my life. I felt I was painted into a corner, and I identified the few good choices I could make. But those choices opened up new possibilities. A small change in initial trajectory can result in a vastly different destination over time.

I also found health practices that were game-changing for my mental and physical health. These include the Wim Hof method of breathing and cold training, periodic fasting, a ketogenic

diet, yoga and—perhaps most personally important for me—the responsible use of psychedelics, the single most powerful tool I have found for healing trauma and rewiring the brain.

Today, my mood no longer cycles unpredictably. I no longer have a personality disorder. I don't abuse drugs or alcohol. I haven't taken psychiatric medication in years, and I now realize how medication had a negative impact on my well-being.* I continue to address the underlying causes of my mental health issues, the interaction of my trauma and biology—going into my own darkness while bringing my light. The greatest gift I ever gave myself was allowing my story to be one of redemption.

David's perspective

William's story is not an uncommon one; Salt Spring Island presents many of the same challenges to mental well-being that we see in larger urban centres.

Salt Spring has a population of roughly 11,000 residents, with an influx of visitors during the warmer months. We have a high per capita rate of homeless residents compared with the rest of BC^{2,3} and, from my experience, a correspondingly high number of mental health and substance use issues. Poverty and domestic and sexualized violence rates are also comparable.⁴

Health care and community research since 2012 identifies similar issues year after year. For example, a 2019 Community Health Needs Assessment³ found that:

- Not everyone has access to care, especially people experiencing multiple barriers (for example,

racism, homo- or trans-phobia, domestic violence and fear of domestic violence and the affordability, accessibility and availability of care)

- Residents of the Southern Gulf Islands (including Salt Spring) score lower in important health measurements than residents in the catchment of Island Health (serving Vancouver Island) and across BC
- About 50% of people needing mental health services on Salt Spring found services unavailable—25% found the wait lists too long and 25% were not able to find the services they needed at the time they needed them
- Services for people with disabilities, chronic illness and substance use issues and for those experiencing violence were available over 50% of the time—but not always when they were needed
- In 2018, 131 individuals on Salt Spring were homeless, a 58% increase from 2016
- In 2015, all of the 3000-plus RCMP callouts were described as having a mental health component. First responders note that mental health is a primary issue, among first responders themselves and the clients they are serving

The 2019 assessment also identified:

- A lack of information and coordination among providers on and off the island (some residents must travel off-island for care)
- A need to better serve those using the system, in terms of the range of services offered and the quality of services provided
- A challenge for clients in knowing where to go and for service providers in knowing where to refer a client

Because the island lacks a cohesive vision for a healthy and well community, Salt Spring's efforts to provide adequate service and care are ad hoc.

- A lack of information-sharing (organizations focus on fully serving their own clients rather than sharing information with each other)
- A need for greater learning through collaboration among service providers
- Burnout among staff members
- A challenge of interagency confidentiality
- A sense of feeling isolated and overwhelmed on the part of both service users and providers

Because the island lacks a cohesive vision for a healthy and well community, Salt Spring's efforts to provide adequate service and care are ad hoc. Over the years, needs have increased within an already challenged care system. Individuals and organizations have not felt able to stop what they are doing to take stock, connect with each other and with clients, identify what is needed, and then together enter into the learning required to provide service more effectively.

The challenges have become more apparent in the context of COVID-19, which has meant additional tasks to ensure health safety directives and additional coordination among providers (for example, to ensure COVID-19 testing for the insecurely housed and client access to showers and food). It has also highlighted disparities in the community—in terms of poverty, access to technology, domestic violence and racism, among other things.

Moving forward: Salt Spring Health Advancement Network's Mental Health Initiative

Salt Spring is a caring community with many skilled individuals. It includes a number of community-focused organizations, health and care-service professionals and volunteers, such as Island Health, Salt Spring Community Services, School District #64, Salt Spring Literacy Society, Restorative Justice and Copper Kettle (supporting vulnerable community members).

Examples of people and organizations coming together and involving clients to improve services include a collaborative practices table for children, youth and their families, the Salt Spring Health Advancement Network (a community health organization involving multiple agencies and community members) and a Local Action Team (involving agencies and community members). There is increased readiness among individuals and organizations to work together more effectively.

Research studies have shown the importance of social connectedness in maintaining mental health and personal life satisfaction.⁵ In January 2020, the Salt Spring Health Advancement Network initiated a one-year Mental Health and Well-being Initiative. As part of a five-year initiative for mental health and well-being in the community, the collaborative project includes the development of

a local mental health and well-being stewardship committee and a mental health symposium. The symposium was planned for spring 2021, but as the pandemic continues, the timeline is being adjusted.

The stewardship committee, composed of decision makers, clients and providers from the community, will lead the planning of a survey to clarify needs and issues, design the two-day symposium and work towards a mental health framework for the Salt Spring community. The symposium will bring a larger group together to discuss what is being done well and what could be improved or enhanced.

Better service for those in need and better support for providers is key. Stewardship will be integral in the next phases of this initiative. The participation of those with lived experience means a reality check is in place. Community mental health and well-being means ensuring all voices are heard. ▼

**Editor's note: As in all issues of Visions, William's story is not meant to replace professional advice. You should never stop taking medications, for example, without first talking to your doctor. Also, talk to your doctor and pharmacist before trying new treatments to make sure there are no interactions.*

OUR JOURNEY—CONTINUED FROM PAGE 22

slept a lot. He didn't like to leave his room. One day, the parent of a friend called me and asked about him; apparently Joseph had been posting dark thoughts on social media while I was at work. When I got home that night, I convinced him to see a doctor. Eventually he was prescribed antidepressants.

But the cycle repeated itself many times over the years. One February, when he was 17, he reached a very low point. He was suicidal. But the hospital was not an option as it would have put him in an even worse state. I was forced to quit my job again so that I could support him at home. In July of that year, he finally got to see a specialist.

Throughout those long months, I had pleaded to get him more sustained and consistent services. At first I was turned down because he was too young for the adult programs; our family doctor was finally able to get him accepted into adult treatment. But it was almost six months—February to July—before anyone in the treatment program was able to see him.

The specialist proposed to increase Joseph's antidepressant dosage over time. But we had to slow down the increases; it pushed him over the edge when the dosage got too high, too fast. Higher doses made him angry and hyper, and he had less control of his emotions. For example, if his shoe came untied and he found it difficult to re-tie, he would throw the shoe across the room and stomp out. We have also tried to find him another counsellor, but so far, we haven't been successful.

I have had to go back to work to support us financially. Joseph still lives with me, but now that he is an adult, I am no longer able to advocate for him as a parent within our health care system. Unfortunately, though, he doesn't know how to advocate for himself, either. Although I work with him as best I can, I am not able to give him all the help he needs.

It's still hit and miss when it comes to finding the right supports for him, but his depression and overall mood are great now. He is still on antidepressants, but he's no longer on medication for ADHD. His appetite is better; he grew three sizes the first year he was off the ADHD meds.

I believe that as long as he's with me and we do things together, like going on bike rides or travelling, he is content. I'm a pretty calm and reserved person, and I don't get excited or stressed out by change. I think this has been good for him; he has become more like me. But I feel he still needs support for his ADHD, which stops him from excelling in life.

I support Joseph in his decisions and will always be there for him. When I think back on our life together, I am so thankful for the experience as it has made me a better parent. I would never change my decision to raise my child and I would do it all over again in a heartbeat. And I still have hope that together we will find the supports Joseph needs to live a fulfilling life. ▼

Small Town, Big Heart

HOW OUR CANADIAN MENTAL HEALTH ASSOCIATION OFFICE CAME TO BE

Stephanie Aaslie and Kirsten Balaski

In small-town BC, it is tradition to look out for one another. From lending an egg to a neighbour when they realize mid-baking that they are out to organizing a fundraiser for a family who is having a hard time, people come together, forging a strong sense of community.



Photo credit: eyecrave at ©Stockphoto.com

The past few years have been tough on small towns in the Cariboo region of British Columbia. Devastating forest fires in 2017 and 2018 dealt a major blow to our primary industry, contributing to the recent closures of local sawmills and curtailments of shifts and production at other sawmills due to damaged wood lots. The opioid crisis continues to impact many in our region, and a lack of local mental health resources causes further struggle. Landslides, floods and the COVID-19 pandemic have added to these challenges.

And yet the people of Quesnel persevere with compassion. Paper hearts symbolizing encouragement and unity brighten the windows of homes and businesses, helping to combat disconnection as we all do our part to physi-

cally distance from one another. Soup kitchens have quickly adapted their services to safely continue to provide food to those in need. Volunteers and peers (people with lived experience of mental health or addiction challenges who have formed a strong network of support) shop and deliver supplies to others, putting their own health at risk. Community partners gather (virtually) to brainstorm how we can best continue to support the community. This is the spirit of compassionate collaboration that created the programs that we now offer at the Canadian Mental Health Association (CMHA) office in Quesnel.

With the recent hardships facing our little town, community members and supporting organizations saw

Stephanie was born and raised in Quesnel. She has worked in the social services for 20 years, the last six of which have been in the field of mental health at a low-barrier shelter and a community mental health and substance use office. She is currently the Clinical Program Coordinator with Quesnel's CMHA office

Kirsten grew up in the Cariboo region of BC and returned there in 2010. She has worked in community mental health for the past 11 years, at a low-barrier shelter and a community mental health and substance use office and in private-practice counselling. Currently she is the Community Food Coordinator with Quesnel's CMHA office

an increasing need for mental health supports and food resources; they came together to brainstorm solutions. This heartfelt action spearheaded the creation of meaningful programs, inspired directly by the needs of the community. These strong advocates forged a partnership with CMHA Prince George to create a satellite office in Quesnel. As a result of this dedication, the CMHA Quesnel office is now offering mental health and food coordination services.

In October of 2019, our CMHA Quesnel office officially opened, receiving a warm welcome from the community. Starting something new is daunting. Having strong co-workers and the support of CMHA Prince George, the Red Cross and our community partners and peers gives us the strength to persevere.

Quesnel is a unique community. Though it has faced multiple challenges and devastating losses over the

past few years, its heart is strong. The ripple effects of the wildfires are still felt. The Clinical Program Coordinator supports those in the community impacted by the fires, providing mental health services such as one-on-one counselling support, crisis intervention, advocacy and psychoeducation (both individual and group), as well as informational presentations. Topics include mindfulness, emotion regulation, coping with anxiety and depression, goal setting, communication and relax-



first nations virtual doctor of the day program

Kelsey Louie, MD, First Nations Health Authority (FNHA) Medical Officer

I'm pleased to be one of the First Nations doctors participating in the First Nations Health Authority's First Nations Virtual Doctor of the Day program, which serves First Nations people in BC who don't have a doctor or who may have limited access to their health care provider.

What it is: The program is open to First Nations people and their family members in BC, even if they are non-status. I am one of many doctors in the program who have Indigenous ancestry. All doctors in the program have lived experience or training in the practice of cultural safety and humility. This helps us to understand some of the environments and situations of the people calling in.

Why it was created: The COVID-19 pandemic highlighted the urgent need for alternative ways to deliver health care to First Nations people in BC, some of whom live in rural and remote communities where access to health care can be challenging even under normal circumstances. During the pandemic, many community

health centres and clinics where people would usually access their primary care services were temporarily closed. The First Nations Virtual Doctor of the Day program continues to be an option for people to access the care that they need, even as community health centres and clinics reopen.

How it works: Any First Nations person or family member in BC can **call 1-855-344-3800** to book a doctor's appointment. Appointments can be over the phone or through a computer, smartphone or tablet. Doctors with the program can offer counselling, review signs and symptoms or concerns, write prescriptions or order lab work or imaging if required—all within the context of a virtual environment. Appointments are not rushed, particularly if a medical need is complex.

Coming soon: The FNHA is developing a Virtual Addictions Medicine and Psychiatry service that will complement the Virtual Doctor of the Day program. ▾

ation. Other services offered include Mental Health First Aid training and critical incident stress debriefing.

Having the ability to adapt as needed, based on feedback from the public and community partners, is an important component of the Clinical Program Coordinator position. It is critical that people have access to services when they need them, in the moment where they are at, in a non-judgemental way. Because people may require flexible

access to services, we adjust our scheduling by meeting people after hours and on weekends if necessary. We are able to meet people in the community or at a destination where they feel comfortable. The office has only three employees, and resources in the community are not always readily available, so it is imperative that we work as a cohesive unit and think outside the box. Finding ways to assist people can demand both creativity and persistence.

The food coordination program also grew out of community collaboration. This program aims to identify the food needs in Quesnel and work with partnering organizations to create food resources to meet those needs. We are still in the beginning stages of this process. The COVID-19 pandemic has created unforeseen challenges. However, we are continuing to move towards streamlining the process of “food rescue,” allowing an increased amount of edible but unsold goods from local grocery stores to make their way to community members in need. With the guidance of our Community Food Coordinator, we are working towards creating more space for community kitchens, food skills training and the sharing of traditional food practices—with an emphasis on peer-led programming, low-cost food solutions and empowerment. We have been inspired by the ingenuity and passion displayed by dedicated community members working hard to feed those in need. We are incredibly fortunate that so many organizations and individuals are not only willing to collaborate with each other but excited about the opportunity.

Living in a small town provides us with unique opportunities to draw on our individual strengths to find creative solutions, working together alongside the people we support in the community we call home. Whatever challenges we face, we are determined to do what we can to give back to the community and support the individuals and community partners who have supported and believed in us. ▾

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Home Away from Home

HOW MOSAIC AND ITS PARTNER ORGANIZATIONS SUPPORT MIGRANT WORKERS IN BC

Dennis Juarez

Migrant workers are considered essential workers in British Columbia by Emergency Management BC. In 2018, migrant workers held 54,734 jobs on 3,846 farms across the country. There were temporary foreign workers from almost 100 countries working in agriculture in Canada. Nearly 90% of these temporary foreign workers came from just three countries: Mexico, Guatemala and Jamaica.¹

Dennis is the manager of MOSAIC's Migrant Workers Program and has experience working with refugees, refugee claimants and migrant workers. Previously, Dennis worked at Options as the refugee claimants specialist and employment specialist. Dennis has a Career Development Practice Certificate from Douglas College. For more information on MOSAIC's programs, visit www.mosaicbc.org/mwp



Photo credit: Juanmonino at ©iStockphoto.com

Some migrant workers have been coming to Canada for more than 20 years, for eight months of the year. Others have a one- or two-year contract with their employer. Many individuals work in rural and remote areas, with limited access to transportation and resources. During their stay, they are unable to see their family and friends in their home countries. They are often preoccupied with the safety of their loved ones and the need to send some or all the income they earn in Canada to their home countries. Migrant workers in some industries, like construction and hospitality, are often able to bring their families with

them to Canada. But these individuals then encounter other challenges, such as finding adequate housing, enrolling their children in school and finding employment for their spouse.

All of this causes stress among migrant workers. Many find themselves dealing with anxiety, depression, a sense of isolation, substance use issues and suicidal thoughts.

MOSAIC's support for migrant workers in rural areas

MOSAIC, with its Community Capacity Building Project (funded by the Government of Canada's

Migrant Worker Support Network), has collaborated with 23 agencies across BC to provide social services support to migrant workers. We provide education about migrants' rights and accessible services and resources, help improve migrants' work experiences in Canada and act as a trusted advocate in issues and allegations of abuse or wrongdoing. We also support employers, helping to improve their understanding of program requirements. We serve other support organizations as well, better equipping them to meet the needs of migrant workers and employers in their communities.

One of the key access points for the project is MOSAIC's Migrant Workers Hub in Surrey, which provides services and support to clients in person, by telephone and online. Many migrant workers find it difficult to share their experiences or ask for help, particularly to resolve issues with employers, because they fear there will be negative repercussions. The Hub provides a safe space for workers to share their stories and offers a hands-on approach to resolving workers' issues and concerns. Workers are supported on a one-on-one basis: an individual's needs are assessed, and appropriate resources and referrals are provided. Often, workers with mental health challenges are referred to group or private counselling sessions.

In some cases, however, cultural biases and stigma can affect how our clients receive our suggestions. For example, many workers in the Latin community refuse to attend counselling because of the cultural perceptions of mental health care. Some Latin Americans believe that expressing the need for

counselling is a sign of weakness, poor self-esteem and a lack of confidence. The prospect of reaching out for mental health support makes them question their manhood and raises fears that others may view them as ill or "crazy."

To help us better tailor our resources to serve migrant-worker populations in rural BC, MOSAIC reached out to our collaborators in the Okanagan—the Dignidad Migrante Society, Kamloops Immigrant Service and Kelowna Community Resources—for their insight into how we can best support migrant workers in rural areas.²

Mental health and substance use challenges for migrant workers

Living and working in a foreign cultural environment can be difficult,

taking a toll on an individual's mental well-being. For migrant workers in BC, cultural difference is one of the key challenges.

Consider the cultural role of alcohol, for example. Drinking is part of Latin American culture and is often not seen as a problem in Latin American communities. But while an individual's alcohol consumption may not be viewed as a problem in their home community, it may be interpreted as a problem in cultures that view drinking differently. In Canada, this cultural bias helps target migrant workers as "alcoholic." The fact that some migrant workers don't drink alcohol compounds the discomfort that many migrant workers feel when they are all painted with the same brush.



Photo credit: pixelfusion3d at ©iStockphoto.com

Migrant agricultural workers face mental health and substance use challenges such as culture shock, isolation from their new community of work and family and friends back home, and feelings of not belonging due to cultural and language differences. Many opt to self-medicate with alcohol and drugs.

The bias against drinking alcohol is not the only challenge that migrant workers face. As Natalia of Dignidad Migrante Society points out, “Migrant agricultural workers face a number of challenges in maintaining their mental health. Many feel invisible to their Canadian neighbours; some are even made to feel unwelcome. Migrant workers experience stress associated with long working hours, crowded living conditions and lack of privacy. They must also deal with the pain of lengthy separation from their families: their desire to give their children a better life means that they often do not get to watch them grow up.”³

Liza, from Kamloops Immigrant Services, says, “Migrant agricultural workers face mental health and substance use challenges such as culture shock, isolation from their new community of work and family and friends back home, [and] feelings of not belonging due to cultural and language differences. Many opt to self-medicate with alcohol and drugs.”⁴

In the experience of Javier from Kelowna Community Resources, most migrant-worker clients in the Okanagan area say that they are “under stress” and “need someone to talk to.” While he has not encountered instances where clients have used drugs, he notes that some workers will socialize at the pub when stressed about work and family.⁵

The challenges that migrant workers face are compounded by the fact that migrant workers’ medical insurance does not cover mental health care. Few mental health resources are free, yet many individuals cannot afford to pay the fees associated with them.

The pandemic has also limited socializing opportunities. Pubs and other social environments are not options. Opportunities to build community are also limited.

And there are few Spanish-language supports.

Addressing challenges with creative solutions

The Dignidad Migrante Society has been building community among migrant workers through celebration and interactive learning and games: “One of Dignidad’s core values is celebration,” Natalia points out. “We recognize that joyfulness, laughter and affection are tools of resistance and resilience.”³

Two staff members of the Kamloops Immigrant Services “make regular visits to the communities in the Thompson-Nicola region to meet with community service providers, farm owners and migrant workers. We find that in-person visits are a more effective way in rural communities,” notes Liza. “People like to put a face to the name, and we have very friendly faces!” During outreach worksite visits, says Liza, “We also take the opportunity to introduce ourselves and our services to increase the level of awareness about what KIS [Kamloops Immigrant Services] offers within the region and gain word-of-mouth exposure. When members of the communities know who we are and what we do, it is easier for them to refer a migrant worker in need of help.”⁴

Kelowna Community Resources has created a WhatsApp group that has

grown by word of mouth to include over 150 migrant workers. Group members share information and resources and stay connected with each other online. Javier also provided the names of various agencies in the Kelowna region that are able to offer additional mental health support: the BC Crisis Line, the Boys & Girls Club, the Canadian Mental Health Association, Counselling BC and the Elizabeth Fry Society.⁵

Many agencies host events on Mother’s Day, Father’s Day and the various Independence Days of migrant workers’ home countries. The agencies provide food for the gatherings and music. Other collaborating agencies offer cooking classes and English classes. These events and celebrations are intended to bring joy into workers’ lives and encourage personal interaction that might provide opportunities to share experiences and address problematic issues. To this end, MOSAIC also offers educational workshops about labour rights, workplace culture and taxes and organizes open discussions with government officials.

Providing support to migrant workers in a pandemic

The COVID-19 pandemic has affected how MOSAIC and collaborating

CONTINUED ON PAGE 35

Catching Those Who Fall between the Cracks

THE ROLE OF THE COMMUNITY OUTREACH WORKER IN RURAL HEALTH CARE

Jenny Pedwell

Many people fall between the cracks of the health care system in rural and remote communities. Many individuals do not meet the criteria to be considered “sick enough” to need a professional mental health care practitioner or provider. What happens to these people? How do they navigate the resources available in their community? Where do they turn?



Jenny has lived in Princeton, BC, for three years. She, her husband and their two children made the move from northern Ontario and have never regretted the decision. Jenny has a diploma in social services and significant experience counselling children and youth. She has been the community outreach worker for Princeton Family Services Society for two years

In Princeton, help is available through a community outreach program that is the result of many organizations working in collaboration to sustain and deliver important health and social care. The organizations include the South Okanagan Similkameen Division of Family Practice, OneSky Community Resources, Princeton Family Services Society and Interior Health. An integral part of Princeton’s community outreach program is the program’s community outreach worker, who, as a member of the primary care team, acts as a liaison between the program’s services and the program’s clients. The

community outreach worker’s primary role is as an advocate, helping clients to organize and coordinate life tasks, in whatever way best addresses the individual’s needs.

The community outreach program began in March 2015, with the initiative “A GP for Me.” Princeton had experienced a change in available medical care practitioners; many people found they no longer had a primary care provider. “A GP for Me” was intended to connect community members with primary care providers and to help primary care practitioners

provide effective support for their patients, many of whom were living with mental health challenges such as depression, anxiety and other psychosocial issues.

Over the past few years, the community outreach program has grown in scope, as organizations noted that the original initiative, aside from connecting individuals with primary care providers, also reduced the frequency of clients' emergency room visits and increased the likelihood that clients would be able to attend appointments with their care provider. A physician doesn't always have time to fill out forms during appointments, and a medical appointment can't always be rescheduled quickly. A thoughtfully organized community outreach program provides supports so that the relationship between an individual and their health care provider is as smooth and efficient as possible.

Within this framework, the community outreach worker is part of an integrated team that includes home care providers, social workers, mental health care providers and substance use and addictions specialists. In Princeton, we serve about 140 clients each year. Because the program's client base is diverse and client needs vary widely, some cases require only a one-time phone call while other cases involve years of ongoing care. The team meets on a weekly basis to strategize care approaches. Many of our clients are elders who need support with medical appointments or grocery shopping, or who desire social contact. About 12% of the program's clientele are individuals with mental health or substance use challenges. By

the time these individuals are referred to the community outreach worker by the doctor, they are already frustrated trying to navigate different government assistance programs.

Over time, it became clear that most of the people referred to the community outreach worker were living in poor socio-economic circumstances, sometimes alone, often with a low level of formal education. Many of these clients do not meet the criteria for a social or mental health worker but likely have an undiagnosed or unassessed mental illness or learning disability. Yet because they may be unable to organize themselves to navigate complex health care systems or find appropriate community resources, they are unable to access adequate assessment and care. This frequently leads to frustration, and the individual may give up looking for resources.

The community outreach worker might help an individual fill out applications for housing, income assistance, employment insurance or disability benefits. Frequently these forms are online, and the application process can be difficult to navigate. The community outreach worker might also help an individual on the phone or in person to organize funding, housing, transportation and other activities in the community.

In addition to helping an individual complete forms and submit applications to Service BC agencies and other support programs, the community outreach worker helps clients coordinate life events such as transitioning from a personal home into an extended care environment and might attend medical or other

care appointments with the client. The community outreach worker helps people connect with primary care providers and access community resources and programs that provide housing, financial and employment assistance. Support can also include help with transportation. Outreach varies depending on the individual's needs.

Sometimes clients just want a friendly ear. A community outreach worker often receives phone calls from clients who want to talk about their pets or how their garden is doing. Sometimes the phone call is a request to pick up some milk. In these cases, the community outreach worker will often take the time to visit in person, have a cup of coffee and chat about life in general. In Princeton, we have found that once an individual becomes a client of the community outreach program, the frequency of their visits to the emergency room decreases, and the frequency of their visits with their family doctor increases as there are fewer "no show" appointments. Appointments with a medical practitioner can now focus on the individual's physical and mental health rather than on navigating social systems—a task that is now supported by the community outreach program. As a result, the client's overall well-being also increases. They become more confident in themselves and know that they can call the community outreach worker anytime for help when they are feeling overwhelmed with everyday life events.

The people who would normally fall between the cracks in the health care system in other rural communities are generally not falling so far in

Princeton. This is due in large part to the community outreach program, its outreach worker and its other dedicated practitioners and staff. Our clients and our community are benefiting from the results of a well-thought-out and responsive community care approach.

To ensure that this valuable program endures, the Ministry of Health is currently being asked to include community outreach workers in an exciting team-based primary care funding initiative called the Primary Care Network. We hope that soon, many other communities will be able to include community outreach workers as members of their primary health care teams. ▾

HOME AWAY FROM HOME—CONTINUED FROM PAGE 32

organizations offer support to migrant workers—and the type of support that migrant workers need. Through my outreach work in Metro Vancouver and the Fraser Valley, I have learned that workers have felt more isolated during the pandemic; as a measure to help prevent outbreaks, some have been instructed to not leave their house or farm. In addition, employers saw a shortage of migrant workers just prior to high season. Employers, the Government of Canada and various consulates discussed how they could bring migrant workers to BC. Now, the provincial government and Vancouver Coastal Health are supporting the workers by putting them up in hotels while they complete their 14-day isolation period after they arrive in Canada. It is not easy to be laid off when you're far from home, especially if you are a migrant worker whose network is limited to your Latin American contacts. Although the federal government's Canada Emergency Response Benefit (CERB) is available to migrant workers, some workers are afraid to apply because they fear it might affect their immigration status. MOSAIC has been helping to provide more information about how the CERB supports migrant workers. When many workers in the Lower Mainland were recently laid off by a cannabis farm, our collaborating agencies provided food, transportation, emotional support, guidance in filling out work permit and CERB applications and help finding alternative employment.

The pandemic has also limited socializing opportunities. Pubs and other social environments are not options.

Opportunities to build community are also limited. Most of our collaborating agencies have closed their offices to the public. Natalia points out that migrant workers "are increasingly anxious about their own and their families' health."³ Liza says that clients of Kamloops Immigrant Services are more concerned about "understanding and applying for federal and provincial benefits and supplements."⁴

As a group, MOSAIC and our collaborating agencies have started offering services through online platforms such as YouTube, Facebook, WhatsApp, text and Zoom. MOSAIC's Migrant Workers Program is now offering online education sessions, and we share information through WhatsApp and Facebook, which enables us to distribute information about migrant workers' rights, COVID-19 guidelines and precautions and information about personal protective equipment and food handling and care during the pandemic. Kamloops Immigrant Services now provides one-on-one client sessions and follow-ups in various languages by phone, e-mail and web conferencing. Its Conversation Circle program takes place through Zoom; its Food Safe training is now online.

In many ways, providing support during the COVID-19 pandemic is more complex. But it has also forced us to find alternative ways to support migrant workers. We have had to rethink how we provide support and we have developed tools to provide that support more flexibly. ▾

BC Rural Health Network

bcrhn.ca

The BC Rural Health Network is an advocacy organization that works towards improving health care in rural BC communities. Find resources on mental health access, virtual health delivery, and connect with other health care providers, and find learning events.

UNBC Health Research Institute

unbc.ca/health-research-institute

The University of Northern BC Health Research Institute brings together diverse health researchers in northern BC. Learn more about their research and initiatives, find reports and publications, and take part in conferences, seminars, and other events.

National Collaborating Centre for Indigenous Health

nccih.ca/en/

The National Collaborating Centre for Indigenous Health at the University of Northern British Columbia supports Indigenous health across Canada. Learn more about geographic and other barriers to health and mental health care, culturally safe care, health initiatives around the country, and more.

Centre for Rural Health Research

crhr.med.ubc.ca

The Centre for Rural Health Research at the University of BC brings together health researchers, health care providers, planners, and policymakers to support evidence-based rural health planning. Find journal articles, reports, community toolkits, past presentations, and the CRHR podcast Innovation from the Edges.

First Nations Health Authority: eHealth & Virtual Health

fnha.ca/what-we-do/ehealth

The First Nations Health Authority offers virtual health and mental health services to members who live in isolated communities, have to travel long distances for health care, or can't access services as a result of COVID-19. Learn more about virtual substance use and psychiatry, virtual counselling services, Virtual Doctor of the Day, and other telehealth services.

Rural Coordinating Centre for BC

rccbc.ca

The Rural Coordinating Centre for BC supports health care providers in rural communities and develops frameworks and education to help rural communities thrive. Their June 2020 Summit co-created with the First Nations Health Authority discussed topics like addiction and overdose, cultural safety and humility, virtual care, transportation barrier, and other issues. You can find Summit proceedings and a summary report at rccbc.ca/summit/.

BC Emergency Services Community Paramedical Program

bcehs.ca/our-services/programs-services/community-paramedicine

Through the Community Paramedical Program, paramedics expand their services to non-emergency supports like wellness clinics, medical check-ins, wellness checks, and health system navigation. People who live in isolated communities who experience mental illnesses, substance use problems, and other health conditions can check in with a paramedic and stay connected when their usual care providers are located in another town or city. The program is available in 76 northern, rural and remote communities in BC.

BC Rural Centre

bcruralcentre.org

The BC Rural Centre explores innovative ways to support rural communities, share information, and develop research. Visit www.bcruralcentre.org/focus/health/ for health initiatives, success stories, presentations, reports, and other resources.

Centre for Rural and Northern Health

cranhr.ca

Ontario's Centre for Rural and Northern Health has a focus on virtual care like telehealth and ehealth. Learn more about initiatives like warm lines for peer support in northern communities, telehealth-delivered opioid agonist treatment, potential barriers and solutions to telehealth-delivered mental health care, and other topics.

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



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