

visions

Vol. 12 No. 4 2017

families and crisis

plotting the
course ahead

breaking the
cycle of crisis



we're in full colour now!

We've made changes to how *Visions* is printed so that it's both more engaging and costs us less money to print. We were able to do both and hope you enjoy the new look. We welcome your feedback.

footnotes reminder

If you see a superscripted number in an article, that means there is a footnote attached to that point. In most cases, this is a bibliographic reference. For complete footnotes, see the online version of each article at www.heretohelp.bc.ca/visions.

we want your feedback!

If you have a comment about something you've read in *Visions* that you'd like to share, please email us at visions@heretohelp.bc.ca, or you can mail or fax us at the address to the right. Letters should be no longer than 200 words and may be edited for length and/or clarity. Please include your name and city of residence. All letters are read. Your likelihood of being published will depend on the number of submissions we receive. For full guidelines, please visit www.heretohelp.bc.ca/visions

visions

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

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bc partners and heretohelp

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I would like to first thank you for all your hard work in support of mental health! I am a recent past contributor to *Visions*. I'd like to introduce your readers to Spikes-on-Bikes! Phs (Portland Hotel Society) has launched a new initiative to address Vancouver's on-going fentanyl overdose crisis. Volunteer peer outreach riders on bicycles are now rolling around the back alleys, 7 days a week. I am one of the outreach riders. We answer questions and offer information and harm-reduction supplies. Every rider is trained in naloxone administration and overdose response, first aid/CPR, and non-violent conflict resolution. We've also been empowered to facilitate on-the-spot naloxone training to the public, an unprecedented approach to an unprecedented situation. The crisis has both gravely affected our local community and the global community, as well as brought about new strength and urgency to the causes of both harm reduction and responsible drug use.

— Nick Crier, Vancouver

I always appreciate receiving *Visions* magazine and usually pass it on to a neighbour. The Body Image issue was especially relevant and pertinent to me. It was heartening to read about how people had got over their eating disorders and moved on to better health and acceptance of their bodies. Wonderful success stories! When I was finally diagnosed with anorexia and bulimia in 1967, treatment was brutal. I had never been away from my family before, but psychiatric hospital was an education. I am now nearly 64 and it is very good to hear that people with eating disorders are now treated with dignity.

—C. Linley, Nelson

editor's message

We try to cover the full spectrum at *Visions*: from a focus on wellness and preventing problems, to a focus on supporting recovery for ongoing, episodic concerns. It may be tempting to put some of our themes firmly in one camp or the other, but don't be deceived. Case in point: this edition is very much a *prevention* issue. Although I cannot deny you will read stories of pain and distress, there is a strong theme of prevention as well because, let's be honest, no one likes to go through a crisis; it's traumatic and stressful. So you'll see that the stories all talk about some aspect of what helped (or would have helped) reduce the severity of the emergency or prevent a future one. You'll pick up some great wisdom from family and friends, from individuals experiencing a health issue who were supported by family and friends, from clinicians, and from other community partners and advocates.

The other theme that struck me was love. Profound love. (Sorry for getting mushy). I've worked at the Canadian Mental Health Association for a long time. I know too well the tensions between the needs and wishes of family members and the needs and wishes of people directly experiencing an illness or substance use problem. Maybe our system reinforces the tensions too much? Whatever the reason, I was expecting to receive submissions with a lot of, well, bitterness: "my family just doesn't get it...they belittle me" or "my brother says he hates me but can't he just see that I'm trying to help?" Not to minimize family conflicts—all families have them—but all the people who approached us to submit experiential pieces have written what are essentially love letters to their loved ones. It's incredibly moving to read the I-love-you's and the thank-you's. If you are a supporter and ever feel resentful or underappreciated, read this issue. The thank-you's are transferable. I'm going home to hug my family now.

A few closing notes:

- We have two distinct guest editorials for this issue: one about families of young people and one more about families of adults.
- Please enjoy the first-ever issue of *Visions* in full-colour! Believe it or not, it's now less expensive to produce—and, we hope, more inviting, too.
- Don't forget to vote in our subtheme poll (see p. 30) or in the provincial election. Happy Mental Health Week!



Sarah Hamid-Balma

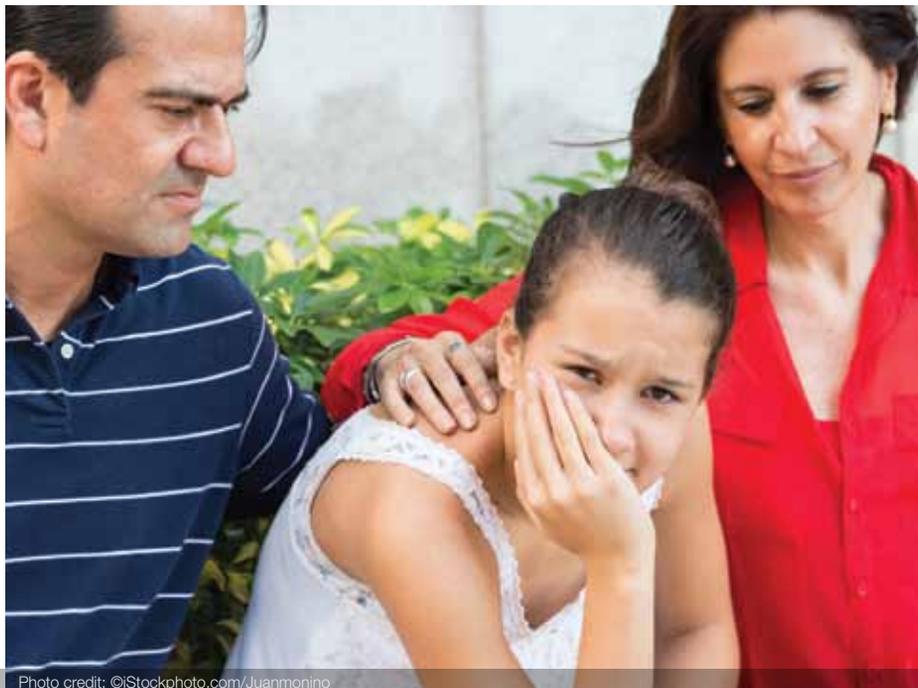
Sarah is Visions Editor and Director of Mental Health Promotion at the Canadian Mental Health Association's BC Division

Being Seen and Heard

IT MATTERS IN WELLNESS; IT MATTERS EVEN MORE IN CRISIS

Keli Anderson

How can we best support families of young people with mental health challenges when they're in crisis? We help prevent them from going into crisis in the first place—and when that isn't possible, we see them, we hear them and we treat them with kindness.



Keli has a 28-year-old son who was diagnosed at age 10 with bipolar disorder. For 17 years, Keli has promoted early intervention. She co-founded the FORCE Society for Kids' Mental Health in BC within a year of her son's diagnosis and was its Executive Director from 2000 to 2013. She co-founded the National Institute of Families for Child & Youth Mental Health in 2009 with Dr. Jana Davidson. In 2015, Keli became President and CEO of both organizations

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The irony of our current service systems is that they seem to be designed to *deal with* crisis once crisis is in progress rather than to *avert* crisis altogether. Our systems have a limited capacity to promote mental health, prevent mental illnesses or intervene early on. And there is no integrated system of care for child and youth mental health—just a loose patchwork of services. Because of this, we can pretty much guarantee that more young people and their families will be in crisis in the short and long term, not fewer.

Nearly 13% of children and youth in Canada and BC experience clinically important mental health symptoms and associated impairments at any given time. That means that roughly four students out of every classroom of 30 will struggle to learn, make friends, participate in activities and function in their families. Yet more than two-thirds (86%) of children and youth with mental disorders do not receive specialized mental health services.¹

With kids, it's easy to dismiss early warning signs of mental illness

When the health care community understands that the family of the person in crisis is **also** experiencing crisis, working well together is possible.

as developmental or parenting issues, or as just a “phase” they are going through. But we know that an estimated 70% of mental illnesses originate in childhood and adolescence.¹ Without timely intervention, there can be significant consequences for the individual as well as his or her family and community, across generations.²

Historically, expert-based systems have treated parents as part of the problem, not as part of the solution. This is particularly the case in child and youth mental health, where big investments are made in parenting programs that are designed to get children to “cooperate.” Systems approaches can leave families feeling blamed, judged, dismissed, invisible or ignored. This shuts down any opportunity for families to explore what they need to know or do for their kids, or for the family as a whole.

A parent once told me that when a service provider—the only one of all the professionals she had ever dealt with—said to her, “Your life sounds like hell,” it meant everything to her—she felt seen and heard for the first time, and she felt the kindness in his words.

Until very recently, the recognition and valuing of families as assets

in child and youth mental health, and the intentional involvement of families as partners in child and youth mental health care, has largely been absent in our systems. Yet family-centred approaches are considered best practice in early childhood development and in child and youth physical health care.³

Broadly speaking, “family” refers to an interactive group of one or more relatives, partners, close friends or supportive persons. In other words, “we are all family members, whether our family is natural or chosen, large or small, temporary or permanent, conventional or unconventional, resilient or fragile.”⁴ Our experiences with family shape us. Family-centred approaches to mental health care recognize this and the central importance of family in the lives of children and youth. Such approaches focus on the strengths, assets and capabilities of young people and families.

So why is it important to support *families* when their kids are in crisis?

When young people are in crisis, the caring people in their lives are also feeling that crisis. As human beings, our desire to be seen, heard and treated with kindness is amplified when we experience a mental health

crisis—just ask anyone who has been there. When the health care community understands that the family of the person in crisis is *also* experiencing crisis—and makes the extra effort to see and hear family members and to treat them with kindness—working well together is possible. This in turn makes a huge impact on how a young person and his or her family move through a crisis and bounce back. This sort of approach isn’t just a “nice to do”; it’s a “need to do.”

The focus of our work at the National Institute of Families for Child & Youth Mental Health is the transformative power of bringing youth, families and professionals together as partners in creating enhanced mental health for children and youth. We provide knowledge, tools, support and resources to develop the sort of caring, connected relationships among young people, families and service providers that make working well together a possibility.

FamilySmart™ equips youth, families and professionals with what they need to work together through what are often the very difficult challenges that children and youth face when their mental health is compromised. This practical knowledge is important at every stage of a mental health challenge, but it is especially important when young people are in crisis. Good working partnerships between health care professionals and primary care providers are fundamental to the mental health of children and youth: they can save lives.

I invite you to join us: learn more about the FamilySmart™ program at www.familysmart.ca. ▼

Families in Crisis and BC's *Mental Health Act*

Deborah Conner

In 2012, “approximately 11 million Canadians (38%) aged 15 and older reported having one or more immediate or extended family members with a mental health problem, that is, problems with their emotions, mental health, or use of alcohol or drugs.”¹



Deborah is Executive Director of BC Schizophrenia Society and has been a part of the organization for more than a decade in various roles. She is currently looking to further connect and expand with organizations nationally and internationally

In times of crisis, families experience a huge amount of stress—from dealing with their immediate emotions of fear and anxiety to dealing with the medical system and supporting their loved one as he or she is being hospitalized. Having provided support for families for more than 34 years, BC Schizophrenia Society (BCSS) understands the importance of family involvement in the treatment and care of people living with schizophrenia and other serious and enduring mental illnesses.

BCSS also understands the toll this takes on families. Families impacted by mental illness need support from a wide range of mental health professionals, as well as other families

with lived experience—before, during and after a crisis event.

In the most extreme incidences of psychosis, when an individual experiences visual or auditory hallucinations or beliefs that seem real, the individual may be of harm to him- or herself. In some extreme cases of untreated or treatment-resistant psychosis, the individual may cause harm to others (most often, family members). Fortunately, in these rare cases when a person is at risk of harming him- or herself or others *due to mental illness*, the individual can be involuntarily admitted to a hospital for psychiatric evaluation. While this process may be fraught with anxiety and fear for both the individual and

the family, it is often the first step to getting the help needed.

Under BC's *Mental Health Act*, a psychiatric evaluation consists of a physician explaining to the involuntarily admitted person the nature of his or her condition, options for treatment, and the likely benefits and risks of treatment. If the patient is deemed capable, he or she can sign for their own treatment. If the patient is found incapable by the attending physician or psychiatrist, the physician or psychiatrist then explains to the director of the psychiatric unit the nature of the patient's condition and the pros and cons of treating the patient. The final decision to accept or refuse treatment is then made by the director of the psychiatric unit.

This process is currently being challenged in the BC Supreme Court.² If this challenge is successful, there may be dire consequences for untreated involuntary patients, families, physicians, nurses and the medical service system. This challenge to BC's *Mental Health Act* wants decisions to treat or not treat to be made by a substitute decision maker, usually a family member.

Most family members want to be closely involved with the development of the treatment plan for their involuntarily admitted family member. However, many families do not know or understand the impacts of one medication or treatment over another, and many do not want to be the person who actually consents to a treatment that an involuntary patient may be actively resisting. Often, relationships

between family members and those living with schizophrenia and other enduring and serious mental illnesses are strained. One client who meets weekly with her son said, "If I had to consent to treatment he did not want, even though it was necessary, all hell would break loose and my relationship with my son [would] probably [be] destroyed."

Treatment legislation such as BC's *Mental Health Act* exists to help families and people with severe and persistent mental illnesses (like schizophrenia) in crisis situations. It helps ensure that people receive medical treatment as soon as possible in order to provide a better long-term outcome. Most importantly, it ensures that involuntarily admitted patients are not kept in hospitals for an indefinite period of time, trapped in their psychosis.

Supporting people living with schizophrenia and other severe and persistent mental illnesses means supporting their families. It means giving families the tools they need to assist in making decisions about the care of their loved ones, and it means advocating for systems that ensure accessible treatment through involuntary services. BCSS works with families and communities across the province to provide psychosocial education, health literacy, advocacy, research and direct emergency support.

From the experiences of its members and of families in other provinces, BCSS is convinced that the challenge to BC's *Mental Health Act* will not advance the treatment or the rights of people who live with schizophrenia and other severe and persistent mental illnesses.

The current *Mental Health Act* benefits those who are so ill that they cannot accept treatment voluntarily. It protects them—and their families—by ensuring that they have access to the treatment they need, when they need it. ▼

visions editor's note

The recent court challenge of BC's *Mental Health Act* is complex; there are many competing rights to consider and try and balance. The challenge argues that the *Act* ignores the principle of consent protected under the Charter of Rights and Freedoms and the United Nations Convention for the Rights of Persons with Disabilities. BC's *Mental Health Act* is different from similar legislation elsewhere in Canada because once someone is involuntarily admitted, they are deemed to have consented to any psychiatric treatment chosen by the treating physician. This authority does not just apply in hospital but also applies when the person is back in community on extended leave. Other jurisdictions in Canada have other legal steps or safeguards to try and first get consent or put more limits on treatment (substitute decision-makers are just one of these potential safeguards). It's clear that involuntary admissions are stressful and often traumatic for all involved. Yet, is there a way to protect a patient's rights while not increasing the distress or fear experienced by family members? For more context, see this editorial from the Canadian Mental Health Association's BC Division at www.cmha.bc.ca/charter-challenge

Writing My Own Lyrics

OVERCOMING DEPRESSION, ANXIETY AND COUNTRY MUSIC

Kim Wilson

You could walk past me on the street and never guess that I struggle with depression, anxiety and panic attacks on a daily basis. I have always been an upbeat person. But the truth is that appearances aren't everything. Sometimes an upbeat demeanour hides what's really going on inside.



Kim Wilson

Kim is a business consultant and devoted mother. She is passionate about writing, coaching and helping people. She would love to become more involved as an advocate and assist others who face similar issues

Both sides of my family have a strong history of depression, anxiety and bipolar disorder. In the past, mental illness has directly impacted some of my closest relationships. At the worst of times, I have had to make tough decisions and cut loved ones from my life completely.

Thirteen years ago, I was a happy-go-lucky 25-year-old. I got my dream job, bought my first new car (fully loaded), moved out on my own and was completely enamoured with my boyfriend. Life was going really

well for me, both personally and professionally.

Then, in a flash, it all came crashing down; I began living out the lyrics of a real-life country song instead.

It was the holiday season, and my beloved cat, Oliver, passed away of kidney disease. I barely had time to process that loss when my roommate told me he was moving out. The following week, my boss verbally abused me at our company Christmas party. I was humiliated and felt like

I had no choice but to quit the next morning. Two days after that, I was in a car accident and my new car was written off.

Losing my roommate, my job and my car in one month meant that I had to move back in with my parents. I needed support during this time, and I was glad I had them to rely on. Unfortunately, my boyfriend couldn't handle any of this: he broke up with me.

All of these compounding factors led to a downward spiral. I was devastated. I had no desire to be social at all. I barely left my home for the next four years.

For a long time, I allowed myself to wallow in sadness. I focused only on the past. I didn't allow myself to enjoy the present or think about the future.

My doctors seemed unable to communicate effectively about my health. All they wanted to do was prescribe medication. Unfortunately, the medication made me feel loopy. I failed to see its value, so I stopped taking it. Nobody (including me) seemed to recognize the seriousness of what was happening. I was not provided with any additional resources or support, and I began to flounder.

I had no idea that I might be depressed. That word was never mentioned around me, even by my medical practitioners. I just felt sad and craved isolation. I looked to my mother for guidance, as she was my biggest support, but she didn't know where to begin to help me. Mental

illness education was not widely available. Yes, my mother had dealt with her own depression over the years, but it was difficult for her to see my situation objectively.

While I was in crisis, my mom provided me with a calm stability and a stress-free place to live. She loved me unconditionally and did her best to keep me safe. It was comforting, but slightly enabling. I didn't have to address my mental health. I just floated along. Miserable. But still afloat. My mother's love and support buoyed me; she is an incredible person and my best friend.

It was a long, hard road to recognition, self-preservation and eventual healing. I finally woke up one morning and decided that I was not going to sit and watch life pass me by anymore. I knew I needed to do something or I would completely self-destruct. I could feel it. I got up that day and started making efforts to change.

Most of the knowledge I gained at this time I had to piece together for myself. I didn't receive a diagnosis of depression until I was in my thirties, so I had no idea what I was up against. My doctor's advice and prescriptions didn't work well for me. I stopped reaching out for professional help for a while and focused on doing anything and *everything* I could just to feel better.

I wrote down some firm goals. I got on the computer and researched tirelessly about how to improve my health. I quit smoking. I stopped drinking alcohol. I stopped ingesting caffeine (yes, even chocolate). I

became more active and lost 40 pounds of excess weight.

I created a digital collage of my goals to display as my computer background so I would see it every day and be inspired to keep going. I started practising the art of gratitude and positive thinking (thanks to an *Oprah* episode I watched). Somewhere along the way, I realized that planning something as simple as a day trip to the city, or a picnic at a local park, could provide me with a touch of joy and some much-needed relaxation. Finding positive thoughts to occupy my mind calmed me and kept me focused on my goals. Slowly, I began to pull myself out of the dark hole I'd been living in.

Life picked up again. I was looking better, feeling better. I started listening to music again and I had interest in socializing with people. I felt like me! But I had to be vigilant. It was only a matter of weeks before anxiety, depression and panic attacks started to creep back in. I eased up on myself; I realized that being positive is something I would have to work on every day. It would be a constant battle, but one I badly wanted to win.

And then, a few years ago, I fell into another crisis situation—another sad country song.

Once again, I lost my job and my car—and I discovered that I was pregnant—all within a few months' time. I was living in a tiny apartment; I had nowhere to go and no way to plan for my soon-to-arrive family.

This time it was my sister Amanda who came to my rescue. She opened

her home and invited me to live in her basement until I got back on my feet. She became my birthing coach and my rock. She was there for me while I struggled along after my son was born, and she gave me the space to enjoy the new experience of motherhood. She made me realize that no matter what, we would always be there for each other. *No matter what.* She is an amazing sister.

With my family's support and lessons learned from the past, there was no downward spiral this time. Things aren't perfect. I am still looking for flexible work as a single mother. And locating suitable, affordable housing has been a challenge. This time around, though, I'm ready to fight with everything I have to ensure a stable and healthy environment for my family. It has been tough at times raising a child on my own, but I wouldn't trade this experience for anything. My son means everything to me. He reminds me every day to take nothing for granted. Every moment counts.

So now, I challenge the negative voices in my head. I have a sense of compassion for myself and my struggles. I spend time stretching, breathing and walking, as these things bring me inner peace. I have realized that sometimes bad things happen for good reasons, and life will get better. I try not to hold onto pain.

I believe that practical guidance is key to successfully navigating the government's health care systems. In my experience, information and services in British Columbia are not easily available and the systems are too complicated for most people to



Photo credit: ©iStockphoto.com/AleksandarNakic

I have realized that sometimes bad things happen for good reasons, and life will get better. I try not to hold onto pain.

take advantage of. It is important to find an advocate who can assist with finding the right programs or services for you. For me, finding an advocate at the Disability Alliance of British Columbia was a step in the right direction.

Today I am in a much better place than I ever have been. I found a family-oriented place for my son and me to live, and I am focused on our future, which is looking pretty bright. My family continues to be there for me and for that I am very grateful. Good days and bad, I try to forge ahead with a positive outlook and make the best of what life throws at me. At this point, I feel truly blessed.

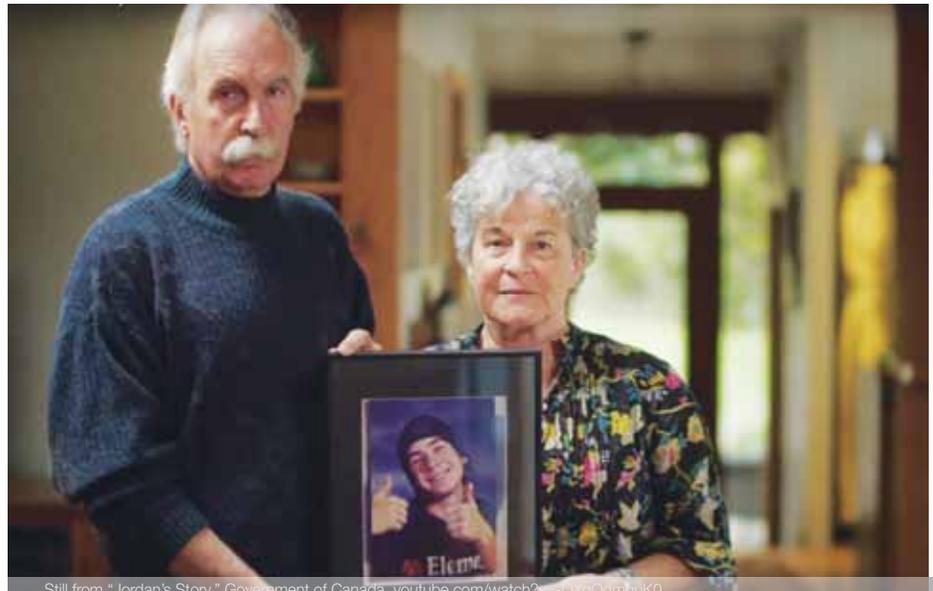
So that old country song can play as long as it likes, but it won't ever take me down again. I know I have the inner strength to survive any crisis. ▾

Hindsight—A Difficult but Valuable Gift

Leslie McBain

This is the short story of our only child, our son Jordan, his life and his death. It is also about hindsight. Hindsight can be a learning tool—for me and perhaps for you, too.

Leslie is co-founder of Moms Stop the Harm (www.momsstoptheharm.com), a network of parents who have lost children to drug harms. She advocates for drug policy reform to provide supports for people dependent on drugs. She lives on Pender Island, BC, with her husband, Carl. You can watch their story at youtube.com/watch?v=QXgQdmguK0, or you can Google “Jordan’s Story, Health Canada”



Still from “Jordan’s Story,” Government of Canada. youtube.com/watch?v=QXgQdmguK0

Carl, Leslie and a photo of their son, Jordan

Jordan was a happy baby, inquisitive and active. As a newborn, he slept only about 10 hours in 24. On the day he was eight months old, he walked for the first time, to the delight of all. He didn’t stop challenging himself physically all his life.

He never required a lot of sleep, which was tiring for mom and dad, but his young life was full of travel, adventure, joy, friendships and family. We felt blessed to have such smooth sailing. The part-time daycare and preschool Jordan attended from age two until public school suited his high energy.

We made an informed decision to keep Jordan in the Montessori

kindergarten an extra year as he was so rambunctious. His focus on tasks was not thought by his teachers to be at a Grade One level. But he was happy and sociable. He loved his teachers, and the varied structure suited him.

Jordan continued to be funny and popular and became a leader of his peers. This sounds lovely, but there was also a worrisome side. His antics disrupted the classroom, his reading skills were below average, and he was not a team player. By Grade 5, an older and wise teacher suggested we have him tested for ADHD (attention-deficit/hyperactivity disorder) and dyslexia. He had low levels of both. We employed a tutor, and his teachers

gave him the time to run around the school when he needed to release some energy. His report cards were just above average, so while we were concerned, we weren't overly worried.

Other quirks seemed small at the time—Jordan couldn't wear socks that had a seam in them, he couldn't eat an apple that wasn't quite the right texture, he would sit on the floor of the shower and let the warm water run over him until we intervened or the hot water ran out. There were smells that he couldn't tolerate. He had episodes of rapid blinking that he couldn't control. He had occasional brief rages at home that consisted of yelling in intense frustration over a seemingly insignificant thing. Again, while we were concerned, we didn't think professional help was needed.

And then, high school! We all know the pitfalls and perils of these years. Kids from our small southern Gulf Island in BC take a water taxi to attend the Gulf Islands Secondary School on one of the larger islands. This meant that I could not be as involved with the school, and sometimes Jordan had to stay overnight with another family. Up until this point, Jordan, his dad Carl and I had been close and happy. But now we began to see changes. Jordan started to party with his friends—typical except for the copious amounts of pot and alcohol that he and his friends consumed. He was open about this with us, and occasionally took us up on our offer of the no-questions-asked ride home.

But you can't keep a teenager locked up because you think he might get



drunk or smoke pot. You can't follow him around or text him every 15 minutes to find out what he is up to. I did what I could: I talked to him about how pot affects the developing brain, and about the dangers of alcohol addiction. I printed out articles and left them on his bed. We watched him closely, and we hoped that this was just a stage he was going through.

But it was not. By age 19, Jordan was an alcoholic and a cigarette smoker. He was also using cocaine. He soon asked us for help; we got him into a rehab facility for what was to be a three-month stay. He walked out after six weeks, declaring that six weeks was all he needed, that he was clean and sober and could stay that way.

He was wrong, as many of us are at the age when we think we know everything.

The next three years were torture for my husband and me. Jordan bounced around from our community to Vancouver to the Cayman Islands, to Ottawa, to Mexico and home again.

He was on an adventure laced with drugs and alcohol. He was dealing drugs. He loved the fast lifestyle, the cool clothes and being the life of the party. Miraculously, he was never arrested.

Throughout this period, we know, from anecdotes told by his friends after his death and from what we already knew about our son, that Jordan remained kind and connected. He championed the underdog, he helped those less fortunate than himself, and he loved children and animals. And he stayed connected to us, by phoning, texting, even bursting through the back door unexpectedly. But we saw the effects of drugs and alcohol—in his eyes, in his thin body, in the lies he told us about money or his whereabouts. He was constantly texting, and we now know that he was "conducting business"—dealing drugs.

Jordan returned to our small community in his twenty-second year with a steady girlfriend, and he started his own small business. We were hopeful, although we knew

substance abuse was still a problem. Then Jordan injured his back on a job, and our family doctor prescribed the highly addictive opioid oxycodone. A few weeks had passed before Jordan told me that the doctor had prescribed him a hundred pills. I was shocked; I made an appointment with the doctor and told him that Jordan was at risk of addiction. But because Jordan was over the age of consent, and because the doctor seemed not to consider my advice, I had no say in Jordan's care. This was the beginning of the end—and the first failure of the medical system in Jordan's case.

Over the next six months, the doctor prescribed oxycodone in higher and higher doses. Jordan became completely focused on obtaining and using this drug. We watched helplessly as his business declined, his girlfriend struggled, and he developed other health and sleep problems.

I spoke to the doctor again and told him that Jordan was now addicted to the drug. The doctor became angry and defensive. He decided to stop prescribing the drug, but he did not offer any support for withdrawal and recovery from addiction. Looking back, I believe he was simply ignorant in the matter. One cannot just "quit." Withdrawal is so painful that some find it impossible to go through. The physician's ignorance and oversight was the second failure of the medical system.

CONTINUED ON PAGE 39

talking about drugs with your child

Centre for Addictions Research of BC

It's never too early or too late to talk about substance use with your child. Recent fentanyl-related incidents are a reminder of just how important those conversations are. Talking openly about opioids and other drugs can help build a strong relationship with your child—a key way to protect them from substance-related harm. The exact words you use are less important than connecting and engaging in conversation.

One way to begin the conversation is to ask for your child's opinions about the current focus on fentanyl. What do they think about the crisis? Why might people be overdosing more often? How do they think they can address their own wellness and safety in the current environment? The goal is to get your child to talk and share their thoughts and feelings.

Responding to your child's drug use

If you discover that your child is using, the most helpful response is still open and honest conversation.

- **Think before you react.** Taking time to go over things (on your own or with someone else) can help you clarify what is going on. Maybe a particular event or interaction led to the current situation. Maybe your child is dealing with issues that you aren't fully aware of.
- **Wait for the right time.** A thoughtful conversation is probably not possible while your child is intoxicated or high. Address immediate safety needs and wait until later to have a talk.
- **Listen more than talk.** You could start by acknowledging your own concern and saying, "I'm worried because ..." or "I'm afraid because ..." Then give your child an opportunity to express their own feelings, making sure they know they are being listened to. You might say something like "I'd be really interested to hear more about ..."
- **Lower the risks.** A child who is using a substance may need help managing the risks and using the substance in the safest way possible. The Safer Use series (www.heretohelp.bc.ca/factsheet/safer-use-series) offers some ways to reduce substance-related harms.

"Parenting: The Drugs Question" (www.uvic.ca/research/centres/carbc/assets/docs/hs-parents-list.pdf) provides more tips on how to help address substance use with your child.

For information on treatment options and resources throughout BC, call the Alcohol and Drug Information and Referral Service at 1-800-663-1441. In Greater Vancouver, call 604-660-9382.

You Probably Don't Know What I Did Last Summer ...

A TEEN'S EXPERIENCE WITH A MENTAL HEALTH CRISIS

Jessica Wiechers

Ah, summer. For many people my age, summer vacation is a time to relax, hang out with friends and just let go. At least, that's what I always thought summer vacation *should* be.



Jess, 17, lives in Ladner, BC. She's in her last year of high school and hoping to go to Kwantlen Polytechnic University next year. She's bisexual and an aspiring artist and writer. She loves politics, dogs, Starbucks and Netflix. She hopes to one day become an activist, advocate and author

But it was never like that for me. I always hoped the next summer would be different. I'd think to myself that maybe next summer I would actually have friends to hang out with. Maybe next summer my sleep patterns would stay the same and I wouldn't get day/night reversal—or, at the very least, the nightmares would stop. Maybe next summer the absence of school and the loss of structure it had provided wouldn't

have a devastating impact on my mental health.

Unfortunately, this summer was no different from all the others. Actually, it was a bit different: it was one of the hardest summers I've ever experienced.

To start, I was still recovering from the explosive break-up of my first relationship. The relationship itself

hadn't lasted long—barely two months. And I don't regret that it ended. But I do regret the way it ended. I think I could have handled it better and maybe we would have left on amicable terms, like she had wanted to. Instead, it ended with both of us saying things that perhaps we shouldn't have, and I haven't heard from her since.

Then, school ended—something I've never taken well. I thrive when my physical environment is structured and routine, and I wilt when it's as chaotic as my mind. I tried to manage the chaos. I made a list of things to do and tried to stick to it. I caught up on all the reading I hadn't had time for during the year. I tried to make plans with friends. I wrote fan fiction¹ and watched an unhealthy amount of Netflix. I tried to relearn the piano. I enrolled in a social justice course that got my mind working and spoke to my political side, which I'm always trying to strengthen.

But it wasn't enough.

Sleep started to evade me, like it always does in the summer. When it did come, the nightmares came with it. I would stay awake as long as physically possible. As you can imagine, this did nothing to slow the steady decline in my mental health.

Not surprisingly, I soon fell back into my bittersweet habit of self-harm. I had started cutting when I was 13 years old, but I had managed to stop and had been "clean" for a year and a half.

Logically, I knew that cutting was an addicting, dangerous behaviour that would provide only short-lived relief from my emotional pain—not to

mention that cutting only ever gave me the *illusion* of control.

But that *feeling* of control was what I so desperately craved. I could control how deep I cut. I could control how often I did it. Finally, I could control how much pain I felt, instead of my mind deciding for me.

But I didn't *really* have control.

Soon, the cuts started getting deeper, and I started to cover a larger area of my body. I had started with the tops of my thighs, but eventually I moved to my right leg, which, now, is about as scarred as my forearms.

It continued like that, slowly getting worse, until one unfortunate, memorable day when I had a bad panic attack and, once again, attacked my right leg. After cleaning up, I left my room feeling shameful, guilty and scared. My dad was in the hallway when I came out of my room and noticed that I looked off. Both of my parents have known about my mental health struggles for many years, and my dad is pretty good at reading me. He asked me if I was okay, and I said no. Because, well, I really wasn't.

I sat down on his bed, and he asked me what was up. I just remember breaking down; all of a sudden I was shaking and couldn't sit still. I started crying, and he came and sat down beside me. He knows that I don't like physical contact, especially when I'm in an emotional state, so he just sat there with me while I cried.

To distract me, he asked if I wanted to watch an episode of *The Last Ship* (great show, by the way), and we

did. I was still coming down from the events of the day and ended up falling asleep. He put the show on pause, turned on the news, and let me sleep. It was soothing, and the nap was very much needed.

After that day, for the next few weeks (while my mother was away for a month at a summer French program), that became our thing. He was always up late working on his photography or finishing work, so he had no problem staying up with me to watch a couple of episodes of a show. We started with *The Last Ship* and eventually moved to *Battlestar Galactica* (another great show). After a few episodes, I would be tired enough to actually sleep. Plus, watching something distracted me from the dark thoughts that usually haunted me at night.

So, yes, last summer was really hard. But my dad really helped me through it. I hope he knows that all of those nights spent watching TV, or talking, and all of those dinners out when we'd get my favourite foods (sushi or Thai)—all of those things made me happy. They made that first month of the summer livable and I'm beyond grateful to him for that.

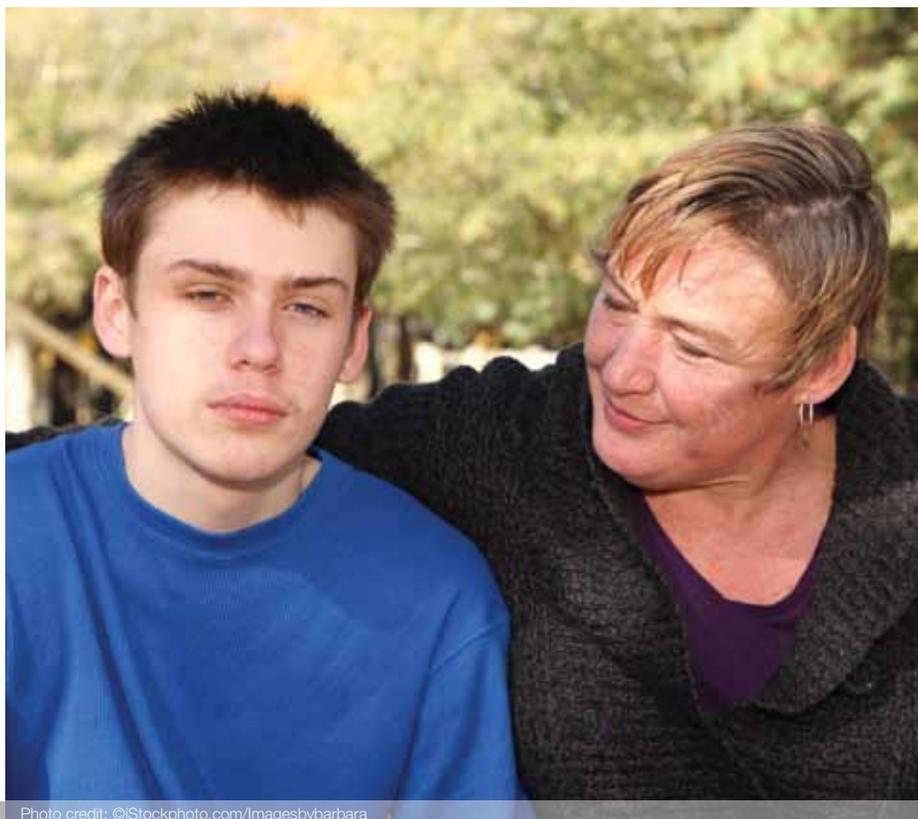
Living with mental illness makes life a little (okay, a lot) trickier. This upcoming summer (if it follows tradition) is probably not going to be all that easy to deal with, but I have two very strong and supportive parents who, I know, will be there to catch me when I fall. Trust me when I say that living with a mental illness is a little bit easier when you have a strong support system of people who actually *care*. ▼

The Long Road

A MOTHER'S PERSPECTIVE ON MENTAL ILLNESS, COMMUNITY AND RECOVERY

Lisa

People say that nothing changes you like becoming a parent. I was so excited to become a mom; when each child came along, they just fit right in like they had always been part of the family.



Lisa is the mother of four children, one of whom has a serious mental illness. Her son took part in the BC Psychosis Program at UBC Hospital and then spent time in a tertiary care facility. He currently resides with his family on Vancouver Island

When we have children, we have the highest hopes for them to grow up healthy, able to find their passion and live a full life. We all have these hopes, and it is devastating for the entire family when they don't play out the way we would like them to. But sometimes our children get sidelined for the short term, or perhaps even for a longer term, by a serious mental illness.

My eldest son was always a bright, happy child with plenty of friends. He participated fully in any and all adventures. But when he was about 16 years old, his dad and I started to notice subtle changes. He became quieter, participating less and less in the outside world.

Our son's first psychotic break and suicide attempt occurred in the spring

of 2014, when he was 18 years old. He had moved away from home and was not sleeping or eating well, smoking pot and drinking alcohol. After he tried to take his life, he returned home psychotic. We called emergency services. He spent the next two months in the hospital. After several weeks of antipsychotic medication, he was given a diagnosis and certified under the *Mental Health Act*.

We were completely devastated by the diagnosis of schizophrenia; when our son was finally discharged from hospital, we were told that we had to prepare for a long road ahead. We were referred to the British Columbia Schizophrenia Society (BCSS) and told to sign up for the Families First program. We were also given a list of support services.

The next two years were very challenging. Our son experienced several psychotic episodes and was admitted to the hospital several times. After 10 difficult months at home, he was moved to mental health housing. Shortly after he turned 20, two days before Christmas 2015, our son made his second serious attempt to end his life. Another hospitalization followed, and yet another medication change.

Mental illness strikes out of the blue, no matter your level of parenting skills, income, education or how much you love your children. Yet among the general population, there is remarkably little understanding about the nature of mental illness and the toll it takes on individuals and family members. There is a tendency on the part of relatives and

friends—even strangers—to directly or indirectly blame family members for the situation.

Our son's illness has had a huge impact on the entire family. We have lost touch with friends and acquaintances who just don't "get it." Some are afraid, some say, "Maybe it's time to walk away," and others say, "That's so surprising because you are such good parents." Over time, the family became increasingly isolated. I was exhausted, having to provide 24-hour care for our son. About 10 months after our son's first suicide attempt, soon after he moved to mental health housing, I was diagnosed with caregiver burnout.

I was told by my therapist that my son's risk of suicide was so high that I had to have a life in place—just in case. I began an exercise routine and started walking seven kilometres every day. I focused on healthy eating patterns, and I started night school courses to give my mind something else to focus on. Educating myself about mental illness and the effects of stress also helped to ease my anxieties about the family. As my family saw me regaining my "normal," they began to feel better too. Eventually my energy returned, and I had the emotional strength to refocus on all my children. I even began working part-time.

But as difficult as these years were for me, I cannot even begin to imagine how terrifying the past few years have been for my son. I can only liken it to having someone tie my hands behind my back and confuse the thoughts in my head.

In early 2016, it felt like a late Christmas gift when our son was accepted into UBC Hospital's BC Psychosis Program. He began the program in February of 2016. I was finally able to believe he was safe, getting the sort of long-term, intense and unrelenting treatment that he needs. This involved medication therapy, but it also included learning how to make healthy life choices. While our son's illness is not his choice, it is exacerbated by poor behaviour choices, which for him include choices about food, alcohol and drugs, exercise and sleep routines.

Psychotic illnesses are devastating for those experiencing them and for those who must watch their loved ones go through such an experience. My son's illness has changed me more than any other event in my life. It has been a long process to deal with my anger, frustration and disappointment in a system that is so hard to navigate. And for a long time, I felt guilty, as if my son's illness were my fault. Even my son has had to tell me, "Mom, it's not your fault." After a while, I began to accept the truth of this statement.

Education has been the key to easing my anxiety about my son's illness and to my understanding what he is going through. In the past few years, I have educated myself a great deal about mental illness and the mental health system in BC. I have read everything I can find and I have participated in as many educational programs as I can. It is an ongoing process.

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Family, Friends and Borderline Personality Disorder

HOW TO SUPPORT THE PEOPLE YOU LOVE

Laurie Edmundson, BA

I have had mental health problems my entire life. I was the kid who cried a lot and threw temper tantrums, then I was the kid who had unexplained stomach aches, then I was the kid with severe anger management problems.



As a young adult, Laurie uses her education in criminology and psychology as well as her lived experience to speak publicly about youth engagement and leadership, anxiety, borderline personality disorder, self-harm and harm to others, parenting and early intervention. She is the Project Lead of a Child and Youth Mental Health and Substance Use Collaborative Local Action Team

Photo credit: Bryan Jones

Laurie Edmundson

I would kick, hit, scream and blow up at people for no reason; I was just a nightmare when I was angry. Then I was the girl with anxiety: I couldn't go outside, talk on the phone or, basically, do anything that a "normal" person would be able to do.

Then my lashing out became even more dangerous: sometimes I would hurt those around me or harm myself. At the age of 19, after living through a never-ending cycle of one crisis after another, I received a diagnosis of borderline personality disorder.

Receiving a borderline personality disorder (BPD) diagnosis can be difficult: there is a lack of available and reliable information out there, and a lot of stigma associated with the disorder. I had heard for years from various counsellors and doctors that I had "borderline traits," but I refused to accept it: all of the negative portrayals and false information I read online made it seem like BPD was a life sentence, but it doesn't have to be. Only when I hit rock bottom and was lucky enough to connect with an amazing counsellor who explained



Photo credit: ©iStockphoto.com/kielerpix

I refused to accept it: all of the negative portrayals and false information I read online made it seem like BPD was a life sentence, but it doesn't have to be.

everything I needed to know about BPD and my treatment options was I really able to accept and appreciate the diagnosis.

Once I got to that place, I realized that getting diagnosed was the best thing to have ever happened to me. It meant that I, as well as my friends and family, could understand what was behind my behaviours and the emotions I was experiencing, and I could finally start my recovery. Beginning dialectical behaviour therapy, a type of cognitive-behavioural therapy especially effective in the treatment of BPD, was what turned it around for me. Throughout the seven-month program, I learned life-changing skills and met other people who faced the same challenges I did.

Support of family

It is an understatement to say that my family relationships were tested many times prior to my diagnosis. My poor emotion regulation caused difficulties

for family members; I had lashed out both physically and verbally, unable to cope with or understand my intense emotions.

It took them some time, but my parents are now incredibly informed about the disorder. Before I accepted treatment myself, my mom sought help at the Dialectical Behaviour Therapy Centre of Vancouver, where she learned about BPD and acquired the skills to help her as a parent of a child with the disorder. My father also became much more educated about mental health issues and is now the biggest supporter in my efforts to combat stigma and to teach the public about BPD. Sometimes when I am in crisis, it is still hard for my parents to know what to do. But if I say I need help—for example, if I need to get to the hospital emergency room—they do the best they can even if they do not fully understand what is going on.

Other family members affected by my disorder need longer to recover before

they are able to forgive what happened in the years prior to my treatment. It is not easy for family and friends to live in a seemingly constant state of crisis, in which apparently random outbursts of verbal and physical aggression, ups and downs in relationships with others and suicidality caused distress in those around me.

Those who have known me for a long time see the changes in my functioning and have been able to move on from the past. The skills I have learned in therapy have helped me to regulate my emotions, deal with stress in healthier ways and function more effectively in interpersonal relationships. This has brought me closer to family and friends. And by learning about the disorder, we all understand better where some of my behaviours and emotions are coming from, and we are better equipped to see potential problems coming.

Support of friends

For a while, I was ashamed of my diagnosis and kept it very private, sharing it only on a need-to-know basis. After I finished a course of dialectical behaviour therapy in January of 2015 and was feeling much healthier and more grounded on my own, I began to tell my friends what was going on. BPD is not a commonly discussed disorder; my friends didn't know what it was. But they were amazing about asking questions in a non-stigmatizing way and researching the disorder so they could better understand what was happening in my life.

I think of many of my friends as my family: they are my greatest support system. Not only do they keep me

laughing and entertained and make me feel loved on a daily basis but they have also learned how to deal with a crisis when one arises. Since completing the therapy course, I spend most of my time happy, busy and in control of my emotions. There are, however, times when I still experience crisis (although these crisis periods are few and far between, and much less intense than they used to be before treatment). I don't think I ever had a conversation with my friends about what to do if I was in crisis; they just somehow knew exactly how to help.

For example, in October of 2016, I experienced what was for me a very long crisis situation—brought on by a nasty combination of burnout, a medication change that didn't work for me and some social stressors. Usually my crises come and go within hours or days, but this time I experienced almost a month of near-constant suicidality, urges to self-harm and constant anxiety.

Within hours of noticing something was wrong (within 24 hours after I began pulling back from work, feeling hopeless and becoming increasingly suicidal), my friends jumped to my rescue. One of them called me up and told me that I needed to come over for the weekend because I sounded like I “needed a friend.” It was a non-negotiable request: I went over and we just watched TV, talked and grabbed food together. I honestly believe that this is the best way to keep your friends and family safe when they are in crisis. You don't have to talk about the problem, you just have to be there, keep them distracted and make sure they're safe.

My friends are exceptional at decreasing my anxiety. Throughout that month, they never abandoned me, they never let me cancel plans, and they never let me be unsafe. They checked up on me regularly, made sure I was getting out of the house and listened to what was going on in my head whenever I needed them to.

How to help when the people you love are in crisis

Living with untreated BPD may involve a lot of crisis—for the individual with BPD and for their families and friends. The disorder can also be characterized by difficulties with interpersonal relationships, which can make accepting the support of family and friends—and supporting someone with BPD during a crisis—challenging. What I've learned is this:

1. Understanding the underlying causes of the behaviours of someone with BPD is key to repairing relationships and keeping everyone safe in crisis. It is important to educate yourself and your friends and family members about BPD and any other mental health issues you or your loved one with BPD might face.
2. The best way to be supported by and to support your loved ones is to spend time with them. Keep the person in crisis distracted and

entertained while making sure they are physically safe by being in their presence. In the midst of a crisis, someone with BPD may be unable to express or even think about what might help them in the moment. It can be helpful to discuss what to do in the event of a crisis before the crisis occurs—when the individual with BPD is mentally well.

3. BPD is treatable. An individual with BPD may experience crisis situations from time to time, but you can learn the skills to help yourself or your loved one to live a totally normal life and be a happy, healthy person.

Because of the stigma associated with BPD, and the erroneous assumption that the disorder is untreatable, it is easy for those living with BPD to lose hope—especially when the individual with BPD falls into the dark cycle of negative thoughts that often accompanies a crisis.

The most important thing I have learned is that there is hope. We are all human, and as humans we all have dark times that come and go. As long as we make a point of being there for the people we love, not only will we help decrease the likelihood of crisis but we will also keep them safe while they are waiting for the crisis to pass. ♡

related resource

For those who want to learn more about BPD, I found Alexander Chapman and Kim Gratz's *Borderline Personality Disorder Survival Guide* (New Harbinger, 2007) very helpful.

A Bump in the Road

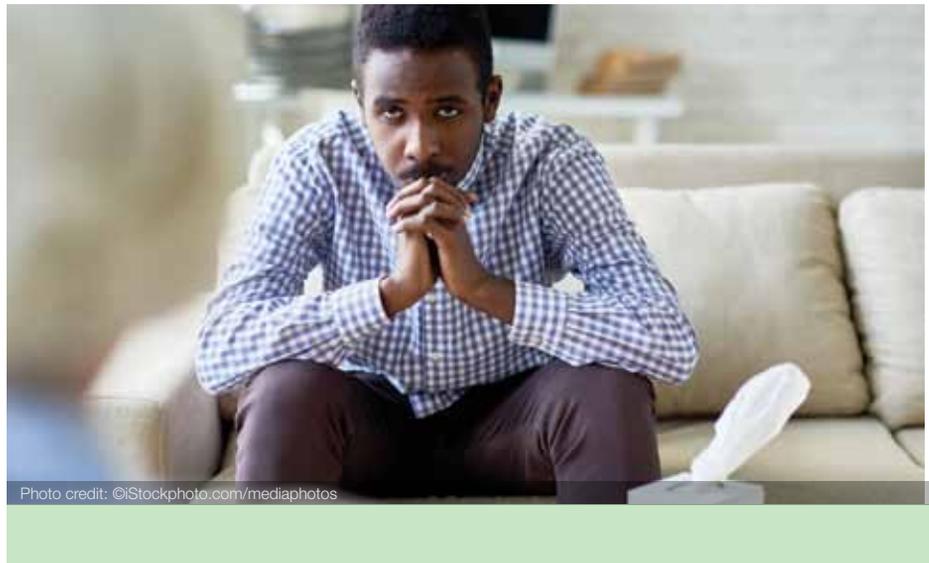
HOW AN INDIVIDUAL'S CRISIS AFFECTS THE FAMILY

Valentina Chichiniova, MA, RCC, CCC

Jay* was encouraged by his psychiatrist and his family to come see me as a counsellor. As soon as he came into my office for our first meeting, before we even had a chance to sit down, he rushed into an explanation of why he was “here,” in therapy.

Valentina is a Clinical Counsellor at the Mood Disorders Association of BC and a Practicum Supervisor at a graduate counselling psychology program. She serves on the executive council of the International Association for Counselling, has presented at a number of conferences and has co-facilitated workshops for counselling professionals

**pseudonym. This composite narrative incorporates the experiences of several clients in my practice. Names and certain facts have been changed to protect the identity of individuals, but the story and the interventions I discuss are an accurate reflection of clients' various experiences and my approach to working with clients and their families*



He told me that getting out of bed, making food, eating, showering, even undertaking simple tasks like checking phone messages or emails, had become difficult. He also said he was struggling to keep up with his coursework at university. He was not seeing much of his friends and did not feel like returning their calls. He was not talking much to his family either, even though they were “constantly on his case,” checking in with him and telling him they felt lost as to how to help him.

As he spoke, Jay sounded agitated and frustrated. He looked guarded, sitting as far away on the couch in my office as possible, barely lifting his gaze from the floor. His hair was

messy, and I suspected from their wrinkled appearance that his clothes had come out of the laundry hamper. Jay explained that he was feeling overwhelmed and depressed. His voice dropped in volume as he told me hesitantly that he was having thoughts about “wanting to die to stop the pain” and was occasionally purposefully hurting himself. He also blamed himself for the recent breakup of a romantic relationship, for worrying his family and for pretty much everything that he felt had gone wrong in his life. He said that he was feeling embarrassed about mistakes he had made in the past. He felt stuck, confused and helpless.

Jay was in crisis.

What is crisis?

The word “crisis” derives from the Greek *krisis* (decision) and *krinein* (decide). In English, the word crisis often carries with it the sense of a “decisive point.” Jay was going through an emotional crisis; he had reached an emotional tipping point—a point of decision.

When my clients are dealing with an emotional crisis, they frequently tell me that their usual way of dealing with life has become disordered. Often I see my clients in crisis confused about their obligations and social connections. Some scholars have suggested that during an emotional crisis, how we see reality and think about our environment changes. We lose sight of what is actually happening. We think about what *should* be rather than accepting what *is*.¹ Naturally, this affects our ability to work and upsets how we relate to colleagues, friends and loved ones. During an emotional crisis, we frequently remember other times of hardship or crisis. Like Jay, we mull over old anxieties and feelings of guilt, which makes it even harder to move forward. We may feel anxious, irritable, guilty, ashamed, hostile or depressed. Our appetite, sleep and overall energy may also be affected.

As Jay continued to talk, I learned that he had moved to British Columbia a few months previously to attend university. His two sisters were also going to university in the Lower Mainland. He spoke of a good relationship with his family.

I also learned that Jay saw himself as a “very sensitive, anxious” person: he did not remember a time when anxiety

was “not here.” He talked of how anxiety had affected his life—from his needing extra help with school work to his having trouble creating and maintaining friendships.

His low mood, though, was something new. Though he had been the one to end the romantic relationship, he felt sad and said that life had changed dramatically. He felt frustrated by constant calls from family, even though he knew they were trying to help. He was scared by his sense of helplessness but did not see how he could take control of his feelings.

After a few sessions with Jay, I received an email from his parents. They wanted to share with me their view of Jay’s struggles and to assure me that they were ready to do whatever was needed to help their son. They were worried about his well-being and were not sure how to support him in a helpful way. As Jay had given me his consent to share with them certain details, I was pleased to be able to do so and happy that the family wanted to become involved. From my conversations with Jay, it had become clear that his need for support and the aid offered by his family were not compatible; I hoped we could change that.

In my clinical experience, family can be an invaluable source of support when people are experiencing crisis. However, when a member of a family is in crisis, the crisis affects the family as well. Understanding how an individual’s crisis affects the family support network helps to ensure that the aid being offered is the right kind of aid.

Families are like complex systems. They work well when there is a balance between the internal and external forces that affect them. Internal adjustment processes—the family’s ability to cope with everyday stresses and life events—respond to external changes.¹

In Jay’s family, there was balance in knowing that Jay was succeeding in school and managing his anxiety well. When he suddenly experienced crisis, the family system became distressed. This in turn created more tension for the entire family. New internal dynamics began to emerge; although these were intended to restore the balance in the system, they weren’t very successful. When Jay ended his romantic relationship, his mood dropped, which affected his school and his other social relationships; consequently, his parents’ worry began to increase. They started calling more frequently, asking more questions, giving more advice, all with the aim of restoring the previous balance. They were likely also trying to manage their own fears—the less they knew, the more they *wanted to know* so that they could help.

Jay requested that I meet his parents without him present. He believed it would be more helpful if I could listen to his parents’ views without them worrying about how he may react or feel in the moment. I agreed to do as he requested. This situation was not atypical. In my experience, families often choose to work together with me in some capacity. Sometimes family members simply wish to share their perspective, sometimes they wish to take part in a session, with or without my client. How we proceed



Photo credit: ©iStockphoto.com/PeopleImages

Understanding how an individual's crisis affects the family support network helps to ensure that the aid being offered is the right kind of aid.

depends on many things, including the comfort level of my client, geographical distance and financial factors.

Jay's parents were thankful for the opportunity to meet with me. Although they knew that Jay had been dealing with anxiety for a long time, our discussion clarified that they did not know how his anxiety was affecting his life in the moment. I also learned that they did not know much about mood disorders, which was important because Jay's doctor had recently diagnosed him with depression. Finally, I heard more about Jay's interests, talents and strengths.

In my next meeting with Jay, we talked about the need for change in all parts

of the family system in order to bring back balance. We discussed how I could help with that process, and mom and dad subsequently joined us for a number of sessions. Jay was able to explain how anxiety and depression affected his life, and mom and dad heard what it was like for Jay to feel depressed and anxious. Jay was able to discover and talk about his biggest areas of struggle, and his parents learned how they could offer more help and support. Finally, they also learned how to talk about Jay's struggles in a way that was helpful and empowering, for him and for themselves.

In the course of our work together, Jay's mood began to improve and his anxiety decreased. He improved

his ways of managing anxiety and depression and made changes to promote a healthier lifestyle. His relationship with his parents improved as well.

Working with Jay and his family was a challenging and emotional experience. Much like other families, they struggled to accept the ways that depression and anxiety affected their child. In our sessions together, tempers sometimes flared and emotions were fragile. Blame was cast, and in the heat of the moment, people labelled each other and each other's behaviour—often in ugly and unkind ways.

At times, I felt stuck in my work with them because they felt stuck in their inability to see beyond their own needs. I felt frustrated with the rigid expectations they had. They felt frustrated that the process of change takes times to unfold.

And then there were times when we celebrated empathy, cooperation, team work and progress.

For me, working with clients who face chronic mental health challenges highlights the need to include the family in the process of change, even if for a limited time. The cycle of suffering and recovery so typical of chronic conditions places tremendous stress on the person who struggles with them, but it also places stress on their family. In my experience, the only way to ensure harmony even in difficult times is to empower the people involved—and that includes family, too. ▽

New Life Brings Hope to a Family Struggling with Mental Illness and Addiction

Linda Del Degan

I walk quietly into the room. My daughter-in law has a contented smile on her face. My grandson, all of four hours old, is snuggled in her arms. My son, eyes closed, his body enfolding his family, is also smiling gently.



Linda is an elementary-school teacher and a new grandmother. As the daughter of a concentration-camp survivor and the mother of children with mental health and addictions issues, Linda is familiar with the struggles faced by families with similar challenges. She hopes that soon there will be more support services for families in crisis

It has not always been like this and it may not always stay like this, but I savour this moment.

As a child, my son was challenging, impulsive, constantly not listening and getting into trouble. Before the age of 13, he had three depressive episodes, and then he experienced a psychosis. But there were limited services for youth his age, and it was only after he'd been in and out of several treatment centres that he received any diagnoses at all.

I had assumed his childhood depressive episodes were situational.

We had immigrated as a young family to Canada from Britain when our son was two years old. When we arrived, we established a group home for teenagers. Within a few years, our son was abused by two of the group home clients. We were horrified. We immediately involved Social Services,* and the abusers were removed from the home. But our son suffered severe trauma.

Then, when my son was seven years old, my children's father abandoned us and moved to Victoria. He saw his three children only sporadically and wasn't emotionally or financially

* the Child Protection office of the Ministry of Children and Family Development (MCFD)

supportive. He left our children feeling neglected, unloved and inadequate.

After their father left, the children and I lived a life of fear—fear about the present, fear about the future. My youngest daughter retreated to her room. My middle daughter grew up too quickly, taking over household tasks, compensating for her elder brother's emotional swings and erratic behaviour. I, too, struggled emotionally and relied on close friends for support. We asked ourselves desperately, "When will it end? When will we feel safe?"

I was fortunate even in this difficult period to meet the man who would become my new husband and stepfather to my children. I was hopeful that things would get better—but instead, they got worse.

It was during this time that my son's mental health really began to deteriorate. When he was 15, he had a particularly difficult visit with his father. He came home angry, disappointed and deeply hurt. Over the next few weeks, he started swearing, bullying his sisters, stealing money from his stepfather, and smoking cigarettes. And then, early one morning, he quietly informed me, "Last night I was planning how to kill you."

I still remember the fear that coursed through me in that moment. I realized that something needed to be done.

Together, he and I went to the hospital. There, he was taken to a different room and interviewed alone. At the end of the interview, the psychiatrist came out to the waiting room and told me, "Your

son is psychotic. He is a danger to you. He must not go home."

My life changed that night. From there, my son was moved to the psychiatric unit at Children's Hospital in Vancouver. Over the next several months, despite the safety protocols of the psychiatric ward, my son made several suicide attempts. The psychiatrist would quietly explain that these suicide attempts "weren't serious, they were just attention-seeking."

I was unconvinced. Seeing your son's arms in bandages due to self-inflicted injuries seems pretty serious to me! But I also felt completely unsupported. No one offered any advice, no one offered any support services to our family as we went through this crisis. During this period, I often went to the garden at the back of the hospital to sob on my own. I was desperate for answers, an end to this horrible nightmare.

When I had no more tears left, I would return to my son, trying to present a calm and soothing presence. I would tell him how much I loved him, how I would always be there for him. I've continued to use this approach over the years.

Much to my sadness, my son didn't come back to live at home after his hospital stay. We tried to have him home several times, but he had started using non-prescription drugs—he called it "self-medicating"—and this made him unpredictable, unsafe. After spending time in various treatment facilities, he was in foster care for the next several years.

As a mother, I was plagued by my feelings of failure and thoughts of "If only I had done this or that." And although I visited him regularly, I never found out until much later how difficult and demoralizing those years in foster care had been for him.

At the age of 23, while he was attending Vancouver Film School, my son was officially diagnosed with schizoaffective disorder, with adult ADHD and an anxiety disorder. The experimentation with medication began. Eventually he seemed to reach a certain stability. He got married, he was sober, he was able to work. But inevitably something would happen to destabilize him, and he would become psychotic. This happened over and over again, until eventually his wife had had enough and left.

If it had been difficult before, it became even more difficult at that point. My son's life became completely consumed by his drug addiction. I would only hear from him when he was in crisis, psychotic, or about to become homeless. We always took him in. For a while he would stabilize, and then he would disappear before he could get additional help.

Two years ago, when he met his current common-law partner, both tried to stay sober. But always at the six-week mark, they would give in to their cravings. Social Services got involved, and my daughter-in-law's two daughters from a previous relationship were removed from the home.

When my daughter-in-law found out she was pregnant again, I wept. I feared what would happen. Social

Services had been very clear: if they used drugs, their baby would be taken from the home. My son was determined to be a good dad, a loving and caring dad—all that he never had.

And so began their journey towards sobriety. My son sought help from Delta Mental Health, but the organization could offer only 10 minutes a month with the psychiatrist. And when he became psychotic and the ambulance was called, he would often refuse to go to the hospital. His previous experiences in the psych ward had terrified him. I think it's fair to say that my son has been traumatized by our own health care system.

But in the calm that always follows the storm, he has often quietly told me, "Mum, you saved my life!"

As I write this, my grandson is four months old, and he is thriving. When I look at my son with his own son, I can remember more easily the many kindnesses he has shown me over the years, the times when he has made me laugh until tears rolled down my cheeks. My son is a gentle, compassionate, intellectual soul, an artist, a musician, and a comedian, determined to thrive. He enjoys philosophical discussions, he is tender with his wife, he loves his stepdaughters and enjoys spending time with his niece and nephews. And he is proving himself to be a doting, loving father.

And how wonderful it feels when he holds me in his arms, hugs me, and tells me that he loves me!

But our family life has not been one of surviving one crisis and then moving



Photo credit: ©Stockphoto.com/Image Source

I hope that in the future a greater understanding of mental health issues and addictions will mean that there is more help available for families going through similar circumstances.

on. The nature of my son's mental health and addictions means that we are constantly anticipating and preparing for the next crisis. My son wants desperately to enjoy a life of equilibrium, but he needs guidance to manage his complex mental health challenges without succumbing to his addictions. When he does not receive the mental health support he needs, he runs the risk of "self-medicating" with unpredictable street drugs. Many addictions programs do not meet the needs of those with severe mental health challenges, and many mental health support programs are not set up to serve those with addictions.

Thankfully, we have recently discovered the Supported Independent Living (SIL) program, a provincially funded housing initiative for those with mental health issues and

addictions. My son is now on the wait list, looking forward to the possibility of moving out with his partner and their son, and regaining guardianship of her daughters.

I hope that in the future a greater understanding of mental health issues and addictions will mean that there is more help available for families going through similar circumstances. The wait lists for psychiatrists and counsellors are long, which is particularly difficult when emergency support services and housing options are limited. Ten minutes a month is not enough! More coordination among health support systems would serve families better.

But throughout all of this, I have only to look at my grandson's smile to feel hope for the future of our family. ▽

Plotting the Course Ahead

MENTAL HEALTH AND THE ULYSSES AGREEMENT

Mark Littlefield, MA, and Natasha L. Smith, BA

In ancient mythology, the gods told the hero Ulysses that if he wished to make it home safely with his men, he had to sail his ship between two islands inhabited by the Sirens, beautiful mythical creatures—half-woman, half-bird—whose song rendered sailors incapable of good thoughts or actions.

Mark works with the British Columbia Schizophrenia Society and the Ministry of Children and Family Development (MCFD) – Child and Youth Mental Health (CYMH) to help families and professionals build effective care plans for both parents and children dealing with mental health concerns

Natasha is a panromantic asexual, not only a proud single parent to a rare Phoenix bird but also a proud woman of Musqueam descent. She lives with bipolar 2 and borderline personality disorder. Her bachelor's degree is in political science and anthropology



Photo credit: ©iStockphoto.com/FatCamera

Ulysses knew that if he and his men heard the Sirens' song, their ship was likely to crash upon the shore, and everyone on board would be lost.

Ulysses devised a plan. He had the crew put wax in their ears so that they would not follow his directions at a time when he knew he might make poor decisions. He also ordered his men to tie him to the mast so that he could not jump into the sea—even if he were tempted by the Sirens' song. Finally, he ordered them to not change course under any circumstances, to keep their focus on home. With this plan, Ulysses and his men were able to

sail past the Sirens and return safely to the shores of Greece.

This tale of heroism is the inspiration behind the name of the Ulysses Agreement, a collaborative, non-legal document that outlines a plan to follow when a family member experiences a mental health crisis and is not able to take part in family life as usual. This co-authored article, from the perspectives of a clinician and of a parent, focuses particularly on how a Ulysses Agreement (UA) can benefit a family when it is the parent who has a mental health concern. But in fact, UAs can be helpful tools *regardless of*

who is facing mental health challenges.

Each UA can be tailored to suit a family's unique needs.

From the perspective of a clinical partner

Over the past eight years, I have had the honour to work with families in which a parent has a mental health concern. These parents often report that their number-one fear is losing their children to Child Protection Services.

Many parents tell me they experience judgement, ignorance and even bullying from extended family members and professionals about their capacity to parent. They also hear that they are incapable of parenting, a burden to their children and, in some cases, a threat to their children's safety.

In my experience, however, all parents parent in similar ways—whether they have a mental health concern or not. Like all parents, parents with mental health concerns love their kids, want the best for them, will do anything for them—and on occasion wish they'd been able to sleep a little longer, just for the peace and quiet. Like all parents, they manage the good times and the bad.

In my work, I have found that one of the best ways to address the fact that a parent has a mental health concern, and may require certain types of support at various times, is to create a plan that details how friends, family and professionals can work together to enable parents to focus on their recovery while letting their children know that they and their parent will be cared for. Both these things are

All parents parent in similar ways—whether they have a mental health concern or not. Like all parents, parents with mental health concerns love their kids, want the best for them, will do anything for them.

fundamentally important—otherwise, kids worry. The Ulysses Agreement is such a plan—a document that outlines a course of action that the parent has developed in partnership with his or her supportive community.

In addition to providing everyone with clear guidelines about how to work together, the UA helps manage parents' fears. Essentially, it tells the world, "I may happen to have a mental health concern but that does not interfere with my role as a parent. Here is my plan to care for my kids when I may not be able to do so myself."

When a UA addresses the needs of a family in which a parent has a mental health concern, it provides the following:

- A description of the daily wellness activities the parent undertakes to stay healthy and happy
- A brief explanation of the mental health concern and what symptoms can look like
- A description of early warning signs—when to enact the UA
- A description of early support activities
- A list of medications that work and others that don't
- A description of what care plans are in place for the children and the

parent should a hospitalization be required

- The children's daily care routines (from a child's perspective, predictability means safety)
- Guidelines for talking to the children about what is happening to their parent
- How contact between the parent and the children will be maintained

The UA should be revisited regularly and updated to reflect the unique and changing needs of the family over time. The UA should also be flexible enough that it can be adjusted to meet unforeseen circumstances, while still staying true to the parent's original intentions.

For a UA to work the way it is intended to work, the individual with the mental health concern must see the UA as a wellness plan rather than as a punishment for having a mental illness. When the UA works, children report, "I like knowing who to talk to if mom starts becoming unwell. I also like knowing what will happen to me and my mom if she goes to hospital again." Parents report, "I like knowing that my kids will have their needs met, I know what they will be told and that we will stay connected. I also like that I can focus on my recovery so I can get back to parenting

quicker.” Family members report, “I appreciated knowing what I can do to help, as well as what not to do.”

From the perspective of a parental partner

Having struggled most of my life with mental health concerns and addictions, my journey has been the uneven ebb and flow of bipolar and borderline personality disorder, which usually ends in crisis and a trip to the psychiatric hospital for a “stay-cation.” As the mother of a 12-year-old boy who struggles with his own mental health concerns, I now find myself with the strength and desire to provide more stability in our lives as a family.

The United Nations Convention of the Rights of the Child (UNCRC) states that children have the right to their own opinion, that their opinions matter, and that their views must be heard and considered when care decisions are made¹ I believe that the intentions of the UA and the UNCRC are related. Children should feel they are part of the process when plans are made to address mental health concerns in the family. As a parent working on my own state of recovery

and wellness, I believe the UA allows for my child to be comfortable sharing how my mental health concerns are affecting him; this in turn helps us work towards managing those concerns—what great parenting is all about!

Despite the seeming formality of the UA’s structure, developing a UA and sharing it—or something like it—with your own support network (family, friends and so on) can actually bring some comfort. And even though the UA is not legally binding, it gives everyone in the network the chance to communicate in a healthy, productive way, during times of wellness and recovery and during times of challenge. This removes the stresses of the unknown, as well as any links to feelings of obligation and confusion (which may be present when a family is dealing with Child Protection Services, for example, and feeling forced to do what they’re told so that

their children will not be removed from the family’s care).

For example, once when I came home from a lengthy stay in hospital, I was told that if I did not comply and take the medications I’d been prescribed—medications that made me very tired, and which consequently make parenting very difficult—then my son would be taken away from me. Developing a Ulysses Agreement together allowed my child and me to learn and acknowledge to ourselves and each other our strengths and our supports. It has also helped us identify new strengths and supports.

Now, with the UA agreement in my tool box, I know I can show my medical practitioners and others that I have a plan and a support network, and we can all begin the task of removing the shame and stigma around mental illness, addictions and more. ▾

related resource

You can find a blank UA form at www.bcscs.org/wp-content/uploads/Ulysses-Agreement-blank-adult.pdf.



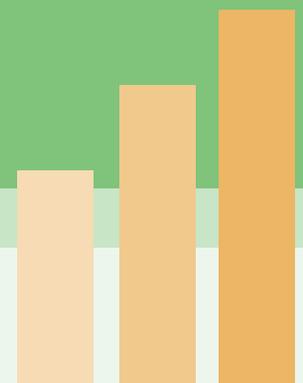
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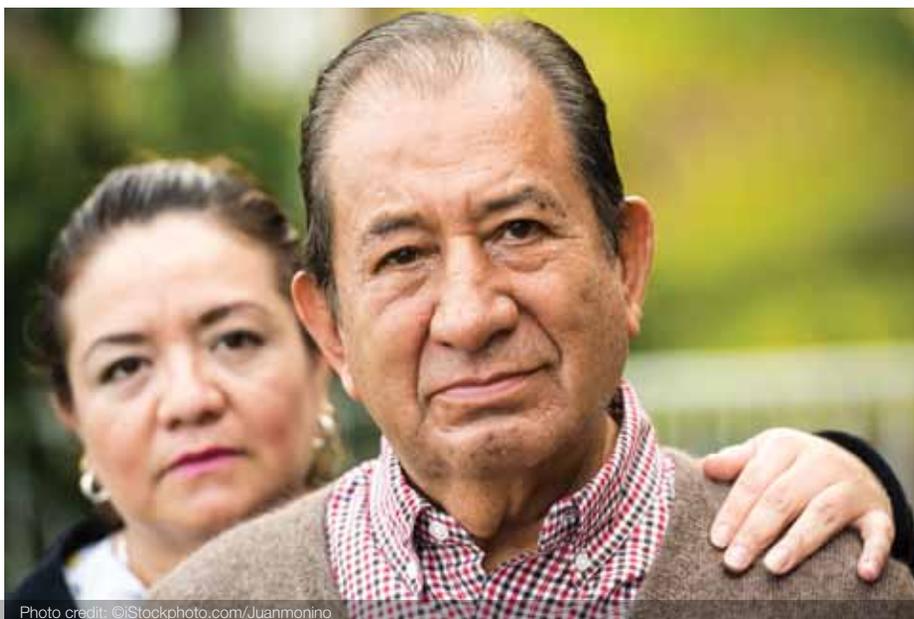


Connecting the Dots

PRIVACY, INFORMATION-SHARING AND FAMILY PARTICIPATION IN THE MENTAL HEALTH SYSTEM

Clara Sitar, BSW, MSW, RSW

The experiences of family members in the mental health system have touched my heart both personally and professionally. I have witnessed individuals I care about struggle in the system as they tried to help their loved ones, and I have overheard well-intentioned colleagues talk about family members in ways that lacked sensitivity.



Clara is a Social Worker and Clinical Case Manager with Fraser Health. She also practices as a counsellor. She has co-facilitated the Strengthening Families Together course and has contributed to Vancouver Coastal Health's Family Advisory Committee and Fraser Health's Family Support and Inclusion Steering Committee. She is passionate about challenging stigma and discrimination

This article is based on research for my master's degree in social work (2012).¹ I am honoured to share what I learned then and how I practise now. In preparing this article, I was excited to discover how much has changed since 2012, and how much hope there is now for families and their loved ones.²

In 2016, a coroner's inquest reviewed a cluster of suicides by people who had recently been patients on the psychiatry unit of Abbotsford Regional Hospital, and revealed compelling

issues related to family involvement and information-sharing. Information about the patients' suicidality had been withheld from family members who might have been able to advocate for them, because the patients had expressly denied the health care team permission to disclose the information. In fact, the team could still have done so, despite the patients' wishes.

These possibly preventable deaths are not the first of their kind; they

illustrate that legislation on privacy and information-sharing with families has been widely misunderstood, with tragic results. The inquest found that all health practitioners, including doctors, need education on *how to apply the existing legislation properly*.³

Appendix 13 of the *Guide to the Mental Health Act* tells us that “obtaining consent from the client is generally preferred when releasing any personal information to a third party.” But it also states that “[p]ublic bodies may release necessary personal information to third parties without the consent of the client where disclosure is required for continuity of care or for compelling reasons if someone’s health or safety is at risk.” It also states that “[t]he health care provider should consider whether the family’s ‘need to know’ outweighs the client’s wishes. If the provider believes it is in the best interests of the client to disclose personal information to the family so they can provide care to the client, the health care provider may do so.”⁴

“Continuity of care” is an important concept for clinicians. In my work setting, it means that when I take on new clients, I access their mental health records so that I can learn about the presentation and history of their mental illness, including any safety risks. This prepares me for the responsibility of becoming their social worker or case manager.

The *Guide to the Mental Health Act* extends the concept of “continuity of care” to include family members and friends who are direct caregivers—even if their ill loved one does not reside with them. Family

Family members who care for a loved one after a mental health crisis often feel terrified, especially at the beginning. This anxiety increases if they are told that information related to the care of their loved one is confidential.

members who care for a loved one after a mental health crisis often feel terrified, especially at the beginning. This anxiety increases if they are told that information related to the care of their loved one is confidential. Family members may not even know the diagnosis, the medications, or what to do if things get worse. In addition, the emotional distress of family members can be entirely overlooked by the health care team.

I consider the family to be my client, too, so I support them when I can. If I need information to do *my* job, then so do they.

A few ideas for family members and close friends

It is helpful to understand that clinicians may struggle during communications with family members for several reasons:

- They may genuinely want to share basic information but fear accidentally disclosing too much
- They highly value the relationship they have with the family’s loved one and fear that sharing information “behind the client’s back” might ruin that relationship
- They interpret that the family wants to know too much
- They have heard negative things

about the family (it can be hard for clinicians not to believe the client when they hear only the client’s perspective)

- The client is adamant that the family should not be involved

Recently, I was communicating with a family member without my client’s knowledge because it was necessary for my client’s care that I do so. It helped my discomfort when the family member said, “I don’t want to interfere with your relationship with my son because I know that relationship is important.”

It is also helpful when a family member says, “Don’t worry, I’m not asking for a lot of detail about my loved one because that’s private between you and her. I just need to know what to do when I’m concerned about her.”

Explanations of your involvement can make a difference, too: “When my son gets sick, he never wants professionals to share information with me. So I can see that it would be hard for you. When he’s well, we have a pretty good rapport. Even when he is unwell, he still relies on me to bring him food, drive him places, and so on.”

A clinician can even be told, “I know working with a client and the family is a balancing act. All I want to do is share some important things I’ve noticed lately because when she’s unwell she can be very secretive about it. Can I share why I’m worried?” Know your rights: clinicians must listen to your concerns.

If you see worrisome changes in your loved one, write them down in detail. Your observations can be vital in helping the doctor make care decisions.^{3,4} Some family members provide letters to clinicians so that they know the letter has been read and will be kept in the chart.

If you aren’t feeling heard, don’t give up. Ask to talk to the hospital social worker, or the manager of the mental health service or facility. Ask about a family involvement program. If you and your loved one are just entering the mental health system, or if you want to talk about mental health concerns, contact the BC Schizophrenia Society in your area. The society helps all families of people with mental illness, not just the families of people with schizophrenia. In addition to providing one-to-one support, support groups, online support, advocacy and opportunities for respite, the society offers the 10-week Strengthening Families Together course, a national education program for family members and friends of people with serious mental illness.

A few thoughts for clinicians

Some terminology commonly used to describe family relationships—such as “over-involved,” “enabling,” “enmeshed,” “co-dependent” and



Photo credit: ©iStockphoto.com/Juanmonino

“toxic” — does not belong in our professional vocabulary. These words stem from out-of-date theories that blame families; they do not help us to be better practitioners.

Perhaps you might try to imagine your own child, parent or partner becoming mentally ill or addicted. How far would you go to help your loved one? Which terms or approaches would you want the health care provider to use? A mother once told me that she knew she was enabling her adult child but she didn’t know how to be different. I said, “I don’t like the word ‘enabling’; you are a loving mother in a very difficult situation. But it’s true that sometimes our style of helping can hinder instead. Would you like to learn about other ways of being that could help your son?”

If I’m feeling pressured or unsure when I am talking to a family member, I take a break. If I need to, I check in with my coordinator. Sometimes just taking a moment of quiet will clear my head and help me to re-centre myself. Finally, I must remember that it is my professional responsibility to accept—and even

seek—collateral information from families.

Making connections

I have deep gratitude for the family members who help keep my clients safe, taking care of them in countless ways. I feel better knowing my clients are supported by their families and friends—a recovery-oriented approach.

The increasing inclusion of families in our mental health system will positively affect outcomes for people with mental illness and for those who love them. Yet policies and protocols alone will not necessarily create meaningful change—change in our values, beliefs and attitudes will. Everywhere I have practised, I have witnessed colleagues display incredible dedication to their clients. This tells me that if families have more opportunities to share their compelling stories, clinicians may find the stories influential in their own work. The more we can listen with our heads and our hearts, connecting the dots between family and clinician experiences, the more we will be able to embrace this challenging yet rewarding part of our practice. ▼

Family Support and Involvement at Vancouver Coastal Health

Isabella Mori, MEd, MPCC

Vancouver Coastal Health (VCH) has a Family Support and Involvement (FSI) team. This team assists families with resources, education, information and support, as well as with facilitating the inclusion of family in the care of their loved ones.

Isabella is a counsellor with over 25 years' experience in mental health, addiction and social services. She has helped strengthen the voice of clients and families since 2000, when she piloted a number of client-driven initiatives in Vancouver's Downtown Eastside, including a participatory action research project on volunteering



Photo credit: ©iStockphoto.com/monkeybusinessimages

The team also works on including families in important decisions taken by Vancouver Coastal Health, including, for example, the design and planning of the new VCH mental health hospital, the Joseph and Rosalie Segal Family Health Centre. We work in the community, alongside Vancouver mental health teams; in acute care, which includes shorter stays at Vancouver General Hospital or UBC Hospital; and in tertiary care, which involves longer stays in regional mental health facilities, from Richmond up to Whistler and the Sunshine Coast.

How does the FSI team help?

The FSI team assists families and individuals in various ways. We use

the acronym “IRIS” to explain how we work. IRIS grew out of the *VCH Policy for Family Involvement in Mental Health and Addiction*, which has been in place since 2013.

Involve family in the care team.

The FSI team encourages health care providers to include family as part of the decision-making care team. “Family” may include blood relatives, relatives by marriage or any other individuals whom the client views as “family.” Depending on the client’s wishes, and his or her clinical needs, families are involved as people who know about the client’s history and who can help make informed care decisions.

Family members are often a patient's main support, and their insight and information can be an invaluable resource. A nurse caring for an agitated client once told me about how she took the time to listen to the client's father's experiences. The client's father pointed out that the client had autism. He explained some of her idiosyncrasies and how to de-escalate problems. The nurse followed the father's recommendations and was able to help the client feel less agitated. The nurse felt that if she had not taken into account the father's insights, a stressful situation could have turned into a traumatic seclusion-room experience.

Recieve information from family.

Even though family members often know important information about the client, sometimes health care providers are reluctant to listen to it. The FSI team reminds health care providers that families are not bound by the *Freedom of Information and Privacy Protection Act (FIPPA)* in the way that providers are. Families can give as much information as they wish. It is up to providers to reflect on how much information is useful for the client's care, and what can be set aside.

In a crisis, listening to information from family can be vital, especially when a client is momentarily confused and does not remember details that may be important. Certain medical conditions can affect mental health episodes, treatment and outcomes (diabetes can worsen psychotic symptoms, for example). It is important that health information is not forgotten or overlooked.

Family members can help ensure that important information gets passed on to the care providers.

Inform families. Health care providers often need guidance on how to inform families appropriately. Often a provider's respect for the client's privacy can clash with the family's desire or need to know what is going on with the client's health care.¹

But families need other types of information as well, especially when they encounter the crisis of their loved one hospitalized for the first time. They have questions about the hospital (When and how often will my loved one see the doctor? Why can't my loved one listen to music on his cell phone? Why is he in a seclusion room?) and the system (Why is my loved one suddenly in a different ward? Will she get support after she leaves the hospital? What about housing?). Families may also have questions about mental health or substance use (When will my loved one be cured? Is there any hope? Can she go back to work?).

The FSI team works with health care staff to answer these questions. For example, we make sure that care staff has information and program pamphlets, and we remind staff members that we are available to answer the family's questions when

they don't have the time to answer them themselves.

Support family. We have observed that simply when an FSI team member is in the hospital as a family champion, health care staff members pay more attention to supporting families. Since the FSI team began providing support services, we have heard reports of more nurses, doctors and social workers incorporating a family's experiences into health care planning, listening to families and supporting families in times of crisis.

The FSI team is also always available generally to provide support to families. Our telephone numbers and email can be found on our website (see below). We make sure there is coverage when one of us is absent. We are available for short-term coaching and counselling, or just to listen when it all gets too overwhelming. We also facilitate support and educational groups.

The FSI team works to ensure that the voices of families are heard in all parts of the system, from staff education and hiring to policy writing and the building of VCH's new mental health facility. Of course, our efforts do not always achieve a perfect outcome. But we are grateful that VCH has opened up the opportunity for families to be involved, and to be supported in times of crisis. ▽

related resource

For more about the FSI team, see www.spotlightonmentalhealth.com/family-involvement/. The website includes all our contact information.

Breaking the Cycle of Crisis

THE ROLE OF POLICE IN A CRISIS INTERVENTION

Deborah Skaey, BA, MA (pending), APR

With the shift from institutional care to community-based mental health care, more people with mental illness are living in the community. By default, police officers are becoming the first point of access to mental health services for persons with mental illness.

Deborah Skaey is a Senior Communications Strategist for the RCMP and has managed multiple projects throughout BC RCMP. She also teaches media relations to future RCMP spokespeople and teaches the Internal Communications Workshop to senior leaders. Before working for the BC RCMP she ran her own communications consultancy and taught public relations at universities in Metro Vancouver



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Given that 20-30% of police contacts involve persons with mental illness,^{1,2} many communities are looking at different models of care. People with mental health issues or addictions are not criminals; they are ill.

When an individual is in crisis, family members may not know how to help their loved one. Often their first instinct is to call 911.

“Police officers play a small role on the path to care for those suffering from mental illness, but it is an important one,” says Corporal Ian Hastie of the Salt Spring Island Detachment. “We are often the first professionals to meet and identify people requiring help.”

* apprehend is not the same as arrest and will not generate a criminal record or appear on a police record check

The first role of the police, is to assess the situation, reduce any threats, and ensure the safety of all involved. When police attend the scene, they will make the initial assessment to identify what is needed to establish safety. They also will need to determine if the situation is a criminal investigation or a medical emergency. If necessary, they can use authorities granted under the provincial *Mental Health Act* to keep individuals and the public safe from harm. Under the *Act*, a police officer can apprehend* a person and take them to a doctor for immediate examination, when they are observed to have a mental disorder, or they are acting in a way which endangers themselves or others. If police take the individual to

the hospital, they must wait with them in the emergency room until the doctor examines them. This can take a great amount of time and can be a huge drain on police resources.

This is why it is critical that families provide as much information as possible when they call 911. It may seem invasive but police need to know all the facts before attending. Police need to know what the family is experiencing. Are they afraid? Is the person threatening them or others? Is the person threatening or causing themselves personal harm? What medications has the individual been prescribed? Have they taken the prescribed medications or any other substances? Does the person react to specific stimulus such as loud noises, fast movement, or the presence of more than one person at a time? How are they behaving—angry, paranoid, or agitated? Is the person hearing voices?

“We need the family to be honest with us,” says Staff Sergeant James McLaren, Detachment Commander for Kitimat. “Don’t minimize or downplay the situation. If we show up not prepared—without critical information—we react appropriately to the situation according to the information we have, but it may not be what the person in distress needs.”

Families should tell police what they are expecting. Do they want police to calm the situation down? Do they want the police to assist them in taking the individual to receive medical care? Do they want the police to apprehend the individual and take him or her to the hospital? “Families know what works and what doesn’t work,” says S/Sgt. McLaren. “If the person feels



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It is critical that families provide as much information as possible when they call 911. Police need to know what the family is experiencing.

ambushed if they see a lot of people at once, we’ll send one officer in and the other one remains out of sight but available if needed.”

Police recognize the value of taking the time to talk with the person in distress, to ask the right questions, and to listen.

“Officers must approach these situations with a high degree of patience, care and compassion,” says Cpl. Hastie. “We work towards building trust with the person to gain their cooperation.”

Police officers are often asked to respond to multiple calls about the same person in distress. It becomes a revolving door. Often a person in distress will call 911, and police will attend as first responders to assess the safety of the situation. The person may receive emergency services or extended hospital care, then be discharged only to repeat the process the next day, week or month. It becomes a “cycle of crisis.”

Surrey RCMP Detachment has had great success with the Car 67 Program, which is a partnership with Fraser Health Authority and the Surrey RCMP. Once police officers who initially arrived on scene responding to the 911 call have assessed that the individual may need additional emotional or psychological support, they can request that Car 67 attend.

Then, a specially trained uniform RCMP officer and a clinical psychiatric nurse—arriving in an unmarked police car—work together and respond to calls received involving emotional and mental health issues. Car 67 provides on-site mental health assessment, crisis intervention and referrals to appropriate services. In a single decade, Car 67 handled 12,000 files. Unfortunately, some of these calls were for the same individual.

While officers can bring at-risk patients to the hospital for immediate treatment following an intervention,

it is ultimately up to the patient and their health professionals to set a long-term strategy.

However, if the person has been assessed numerous times, or has been apprehended repeatedly, or is the subject of multiple 911 calls, there needs to be another level of crisis intervention that is long lasting. Corporal Taylor Quee took a lead role in standardizing a coordinated, multi-disciplinary team approach. In 2011, she created a new position, the Police Mental Health Liaison Officer (PMHL), whose role is to focus on the long-term case management of clients who have persistent or high-risk contact with police.

“I used to work in Whalley and I would see the same people in crisis over and over,” says Cpl. Quee. “Their risk behaviour would start to escalate, perhaps involving a weapon the next time.” She wondered, “Why couldn’t we resolve it at the first incidence of interaction and not wait until it escalated to criminal behaviour?”

Surrey’s approach to mental health clients involves a three-tiered approach. The first level of support for mentally ill individuals is the general duty officers responding to crisis situations as identified from 911 calls. The second level is the Car 67 program, which responds to mental health calls at the request of general duty officers. The third level is the Police Mental Health Officer who focuses on the long-term case management of clients who have persistent or high-risk contact with police.

Now manager of Surrey’s new Police Mental Health Intervention Unit, Cpl. Quee has five PMHL officers on the team. These officers are trained to liaise with hospitals, psychiatric professionals, and care workers who together will determine how best to approach each individual situation.

“The PMHL officer will explore interventions that would be beneficial to the individual in breaking the cycle of negative behaviour and manage the client before the risk behaviours escalate,” says Cpl. Quee.

The Car 67 team will bring a person to the attention of the PMHL who is high risk or has had multiple police contacts. The PMHL officer will work with the mental health care team to develop a collaborative strategy for support before the client’s behaviour deteriorates. If the client does not have a mental health care team, the PMHL officer will advocate for one and connect the client to the necessary services offered by the mental health system.

The mental health care team may include a psychiatrist, case manager, social worker, probation officer, family caregiver, and emergency room professionals who together will develop a response plan tailored specifically for each client. Typically, this team will meet monthly with the hospital and the client to problem-solve. This could include helping to find the person a home or a job.

Since these clients have been treated for their mental health disorders and have the appropriate care, there is no longer any need to dispatch police. Police can be back on the streets to respond to emergencies.

Recognizing the success of this model, other municipalities across BC have implemented a similar program with a mobile crisis intervention team.

“My role is to reach out, connect, obtain trust, and link those in need with the resources that will help them get better,” says Cpl. Quee.

Cpl. Quee is the former chair of the BC PMHL committee and there are now 25 officers around the province with designated police and mental health positions. She indicates that police in communities of any size can partner with the health care professionals and case workers to develop a plan for their shared client.

This model of collaborative problem solving for complex cases has many benefits, including reducing emergency room congestion, freeing up police resources, saving money, and potentially decreasing homelessness. It is also better for the quality of life of the client who is supported for several months after the initial intervention; and it’s better for the families. It’s better for everyone. ▽

visions recommends — related resource

Tips for Communicating with Police in a Mental Health Crisis. From the US, but relevant for any family member. See <http://bit.ly/communication-with-police>

HINDSIGHT—CONTINUED FROM PAGE 14

At this point, now firmly addicted to opioids, Jordan began buying “Oxy” on the street. He needed more and more money, and slid right back into the world of drug dealing.

Finally he realized that life had become untenable. He knew he needed to enter a detox facility, and we helped him get there. After 12 days, he emerged clean of opioids but still faced a very painful withdrawal. We could find no post-detox support, no physician willing to prescribe suboxone (a drug that Jordan had researched and which is now widely and successfully used in withdrawal and recovery), and no psychiatrist who could take on Jordan’s case. This lack of post-detox support was system failure number three.

Seven weeks after he left the detox facility, and in a bad state of

withdrawal, Jordan relapsed. On February 4, 2014, at the age of 25, our only child died alone of an accidental overdose.

In hindsight, we can now see that all the little things—the high energy, the quirkiness, the sensitivities, the risk-taking, the problems with focus and dyslexia, Jordan’s overcompensation for hidden anxiety—led our son to self-medicate. But we couldn’t put it all together at the time. And now he is gone.

As I now advocate for drug policy changes in government, I understand that the medical system was not ready for the recent sudden increase in addiction and overdose. Doctors have historically received almost no training in addictions and recovery, and that is now changing. Opioid prescription and management is

becoming an integral part of medical school.

Advice is a hard thing to hand out: every child is different. I can only say to other parents, Be aware, be non-judgemental, and give your children credit for being intelligent. Try to leave anger out of discussions. Your children need your wisdom, not your fear. And they need your love. They really need your love. They also need information on how to avoid dangerous drugs, and they need to know that if they *do* decide to use drugs and alcohol, they should never use them when they are on their own. Make sure your child’s school is including talks on drug safety in the curriculum.

Hindsight may be 20/20, but it can be a hard thing to live with. I hope that *our* hindsight can be *your* foresight. ▽

THE LONG ROAD—CONTINUED FROM PAGE 18

Throughout, BCSS has been very helpful. The organization holds an annual conference on a variety of mental health subjects, and the BCSS family support group provides the opportunity to meet other families. There is no replacement for meeting people who have lived through the same experience: it is gratifying to interact with others who “get it.” It has been a painful process for everyone involved—not only for our son and his parents, but for his siblings, our extended family and our friends.

When our son participated in his first group therapy session early in 2016,

we began to hope that he might eventually reach a place of peace. When that happens, the rest of our family will finally have peace as well. After all, he is expected to make a full recovery—it just may take him a while to get there.

At the end of 2016, 12 months after he entered the UBC Hospital program, our son began transitioning home. It *has* been a long road. We are so thankful that the attentive care from his health care providers (with a trial of clozapine) has resulted in a positive outcome for our family. Our son is adjusting nicely to home and

his family. He has started to reconnect with old friends. Things are definitely looking up.

I hope in time our son will accept his illness and get back to having happy, healthy adventures. We could not have come this far without significant help from the local Early Psychosis Intervention Program, the local chapter of BCSS, a host of caring health care providers and our family and friends. Recovering from a mental illness really does take a community. ▽

resources

BC Schizophrenia Society family resources

www.bcscs.org

An organization helping family members for any serious mental illness. Find the family support calendar for support groups around BC, Strengthening Families Together course, and more resources for families.

FamilySmart, Institute of Families for Child and Youth Mental Health

www.familysmart.ca

A BC organization that supports parents, caregivers, and other family members who support a young person with a mental illness. Find local and provincial Parents in Residence and Youth in Residence peers to help you navigate health systems, find the monthly 'in the know' webinar series, and more.

Child and Youth Mental Health Collaborative

www.collaborativetoolbox.ca

An initiative that brings together parents and caregivers, families, schools, health professionals, community partners, and everyone who supports child and youth mental health in BC. Learn how to join your Local Action Team, find local initiatives, and find resources.

How You Can Help: A Toolkit for Families

www.heretohelp.bc.ca/workbook/family-toolkit

Developed by the BC Schizophrenia Society and FORCE Society (now Institute of Families). Learn more about mental illnesses, how to support adults and young people through recovery, how to work well as a family and take care of yourself, and how to work with schools.

Family Self-Care and Recovery from Mental Illness

www.heretohelp.bc.ca/workbook/family-self-care-and-recovery-from-mental-illness

Developed by the Mood Disorders Association of BC. This toolkit helps caregivers care for themselves. Learn about caregiving planning tools like discharge planning and advance planning and find strategies to help you stay well.

FGTA's Coping Kit

www.heretohelp.bc.ca/workbook/fgta-coping-kit

Developed by From Grief to Action. Learn how families can cope with substance use, minimize harms, seek help, and manage difficult situations, thoughts, and feelings that come up when you're concerned about a family member's use of alcohol or other drugs.

Overcoming Borderline Personality Disorder: A Family Guide for Healing and Change

Valerie Porr, Oxford University Press

A hopeful guide for families learning to build relationships with a loved one diagnosed with borderline personality disorder, but it's useful for any mental illness that affects relationships. Learn skills based in dialectical behaviour therapy.

Guide to the Mental Health Act

www.health.gov.bc.ca/library/publications/year/2005/MentalHealthGuide.pdf

Information on voluntary and involuntary admissions under BC's *Mental Health Act*.

Quick resources for families:

- BC Mental Health Support Line at 310-6789 (no area code needed, available 24/7)
- Kelty Mental Health Resource Centre at www.keltymentalhealth.ca or 1-800-665-1822
- Interior Region Family Navigators from CMHA at www.bcfamilynavigator.com
- Support and navigation by email from HeretoHelp at bcpartners@heretohelp.bc.ca

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



heretohelp

Mental health and substance use
information you can trust

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