

visions

supporting parents

shame, blame
and stigma
towards families

becoming
the father
i never had



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 substance use issues can be heard. *Visions* is produced by the BC Partners for Mental Health and Substance Use Information and funded by BC Mental Health and Substance Use Services, a program of the Provincial Health Services Authority.

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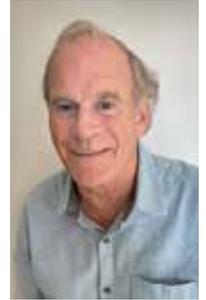


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editor's message

There's a popular Punjabi folk song I heard often growing up, called "Maavan thandiyan chaavan," which roughly translates to "Mothers provide cool shade." The sentimental song talks about the nurturing and care that mothers provide. As a child of immigrants, growing up I watched my parents work incessantly in order to provide for their three children. Before she left for her nursing shift, my mother used to wake up at 6:00 a.m and make that night's dinner so that we'd have something to eat when we came home from school. It wasn't until I grew older that I began to interrogate that song and some assumptions within it – such as the idea that mothers are the ones who nurture (as opposed to fathers or other caregivers or family members), that all mothers are nurturing, and that parenting should be about sacrifice. It also made me question, "If parents care for their children, who cares for the parents?"

This issue of Visions addresses many of these assumptions and questions. Our Guest Editor, Dr. Robert Lees, edited a previous version of Visions on parenting more than 15 years ago. Although support for parents, families and children has come a long way since then, we know that families – both parents and children – continue to face hurdles in the mental health system. A lack of preventative programs that emphasize family wellbeing, lengthy wait times, and a lack of affordable family-centered services such as counselling continue to be obstacles families must contend with. And, within the services that do exist for families, there are relatively few that address parental mental health.

As families shifted to new realities such as working and schooling from home due to the COVID-19 pandemic, with it came a growing awareness of the challenges of parenthood. Although I'm not a parent, I watched my siblings, friends and other family members adapt to these changes and juggle their parental, work and other life responsibilities while worrying about what the future holds. Although the pandemic might cause continued uncertainty, one thing is clear: the mental wellbeing of parents is important, and too often ignored.

Thinking back to my childhood days, I realize now that my parents had little formal support as they grappled with raising their children in a new culture and a foreign land. If you have loved ones that are parents in your life, I hope this issue inspires you to check in on them and ask, "How are you doing?" ▾



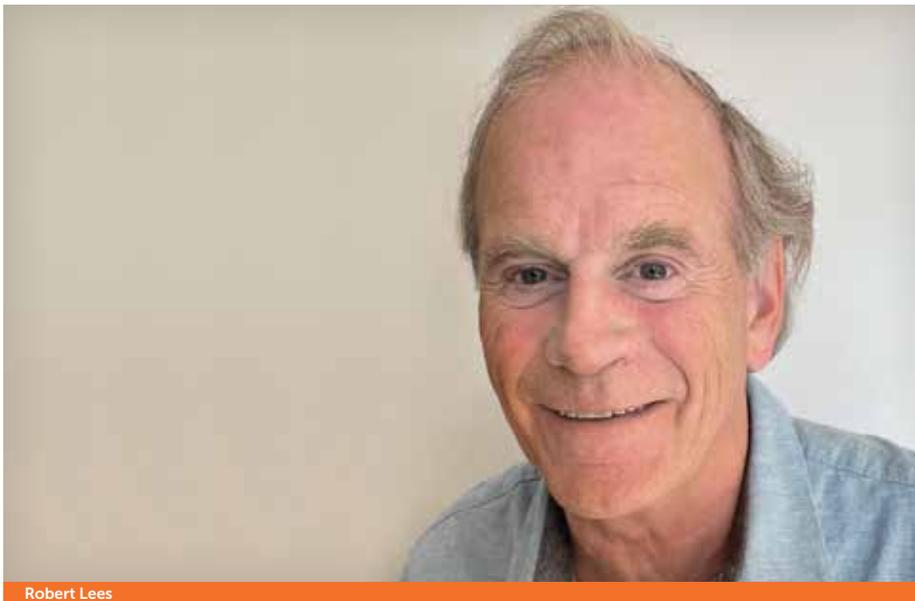
Kamal Arora, PhD

Kamal Arora is Visions Editor and Leader of Health Promotion and Education at the Canadian Mental Health Association's BC Division

Is it a Case of—the More Things Change, the More They Stay the Same?

ROBERT LEES, ED.D, R.PSYCH

Around 1997, a group of like-minded health and social service providers connected to form an organization we called the Provincial Working Group on Supporting Families with Parental Mental Illness. All group members had seen that the mental health system focused primarily on individuals, often neglecting the important role that families can play in treatment. For many of us, the interest was in ensuring that mental health professionals recognized and met the needs of children who had parents with mental illness.



Dr. Lees is director of counselling and training at the Chilliwack Youth Health Centre, a past president of the BC Council for Families and author of The Growth in Marriage Handbook and Prepared Companions

Now, almost 25 years later, I wonder if there has really been any advancement towards this objective. At the time, most studies suggested that one in five schoolchildren had a parent with mental illness. In the 1990s, we heard stories of parents admitted to psych wards and no one speaking to the children about what that meant. We heard of parents who died by suicide and no one speaking with the children about understanding mental illness or inquiring about their needs.

The working group spent considerable time, off the corners of desks,

developing resources and advocating. Our vision included developing what were known as the four Ps: protocols, practices, policies and programs. We foresaw the need for regular community training forums that would sensitize and build skills in family based practice. Eventually, we developed a community forum training manual.¹

Recently, a colleague who manages a mental health and addiction service said, “We do pretty good at patient-centred care but not so good at family-centred care.” A litmus test



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While patient-centred care should always be an important standard, in my view, the system is heavily imbalanced. We need incentives that lead to practices for family healing and support. ”

I use is whether, when adults are admitted to psychiatry, anyone asks about the functioning of the family and the welfare of the children—and then responds. Given my experience, I don't think we've come very far.

Family centred care is a complex topic and initiative, but at its core it means asking about family relations, including family members in treatment, and recognizing that the mental health needs of one have a ripple effect throughout the family system—generations up, and down.

The evidence base for this practice area is limited, which in itself suggests slow progress towards adopting a more family-centric practice model. A 2016 report of audits of

adult, child and adolescent mental health files found that “none of the services included in the authors' study appeared to have effective methods in place to detect the presence of parental mental illness and assess the children affected by it.”²

Including families in the response to the opioid crisis

The opioid crisis, which has taken a staggering number of lives, has not only affected individuals but whole family systems. While the interest is rightly in attempting to prevent overdose deaths, there is also an enormous need to work with these whole systems towards healing. The youth health clinic in Chilliwack, where I work, has seen a surprising number of teenagers and young adults

grappling with grief related to the loss of a parent to drug overdose. The shame associated with addiction often makes this a silent suffering for family members. While my colleagues in addiction services have worked harder than most to respond to the needs of those affected by the addiction of another, I have never heard of a post-intervention service for the hundreds of families affected by these complicated losses.

Understanding perverse incentives

Very often compensation systems for mental health professionals, including psychiatrists and physicians, are dedicated towards individual-focused care only. Of course, considerations related to privacy and autonomy are at play, but many readers will have had the experience of visiting their family doctor and being told to speak about one problem per visit. This is a perverse incentive against even a holistic individual perspective, never mind consideration of relationships and family functioning.

I work in a setting providing care to young people ages 12–26. I frequently need to remind training counsellors that it is preferable, if the young person will agree, to involve the family in counselling. What they find immediately is a multiplication of variables involved: take the “bio-psycho-social-spiritual” model of assessment, which is meant to be a platform for case conceptualization, capturing the breadth of human experience, and multiply it by the number of people in the room. This is difficult just in terms of office space and booking appointments. In other words, it is harder work and requires special preparations and skill. So there

are perverse incentives to only work one-on-one with youth.

Acknowledging adverse childhood experiences

There is growing awareness among medical and mental health professionals of the role played by so-called “ACEs,” or adverse childhood experiences, in creating trauma, and the role trauma plays in mental illness. The Adverse Childhood Experience Questionnaire³ comprises 10 questions, all of which relate to experiences in the family. Of course, biological factors implicated in serious and persistent mental illness are extremely important and are known to play a significant role in illnesses such as schizophrenia and bipolar disorder. However, they are only part of the story. It is easy to see how ACEs can create anxiety, depression, toxic stress and post-traumatic stress. If much of the origin of illness is based in family functioning, then it stands to reason that the path to healing is in supporting and healing families.

Advocating for family-centred care

Perhaps I am myopic, but from my lens as a provider, it is the not-for-profit organizations that advocate for family-centred care, including the BC Schizophrenia Society, FamilySmart, Canadian Mental Health Association and others like them. These are the least securely or well-funded parts of the whole mental health system. The future of these organizations is precarious, depending as it does on the favour of politicians and bureaucrats. Nevertheless, because they are so often directly bound to the lived experience of families, they see a more holistic picture that gets missed in only patient-centred care.



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For example, a partner agency I know, a women’s domestic violence shelter organization, includes couples and family counselling, thus expanding their mandate to address root causes of relationship dysfunction. Sadly, I believe they are a rarity.

Finding the balance

While patient-centred care should always be an important standard, in my view, the system is heavily imbalanced. We need incentives that lead to practices for family healing and support. We need incentives for psychiatry wards to employ family therapists, and payment schemes that reward family doctors and psychiatrists for spending office time with families. We need training for mental health and medical professionals to ensure they feel competent dealing with the increased complexity demanded by family work.

We also require massive investments in prevention work with families that

will ensure equal or greater return in dollars saved and lives spared the pain of psychological and mental distress. We need a long view. As one of my clients used to say, there are no shortcuts, just dumb cuts and smart cuts. Let’s make the smart cut—invest in family mental health in a big way. ▽

Shame, Blame and Stigma Towards Families

KELI ANDERSON

Parenting is hard even without mental health challenges in the family. But when a parent or their kids do face these or substance use challenges, what makes it ridiculously hard is the stigma families are subjected to.

Keli has devoted the last 21 years to giving voice to parents and families whose kids struggle with mental health. Two non-profits she started are now joined together as FamilySmart (familysmart.ca). There, over 40 young people and parents with lived experience work alongside her to enhance child and youth mental health and support families



Stigmatization of people with mental health or substance use challenges is a defining issue for society. Stigma not only harms people with mental illness and addiction, it injures their family members, who are often stigmatized by association.

The term “family stigma” refers to blame, shame and contamination that falls to family members based on some aspect of one member’s experience. Typically, parents are blamed for causing their child or youth’s mental health challenge or mental illness. Siblings and spouses are often blamed for not helping their family members or ensuring they adhere to treatment plans. And children or youth are fearful of being

contaminated by the mental illness of their parents.¹

Family stigma undermines the critical role that families play in caring for struggling relatives and creates pervasive barriers to help seeking, early detection, assessment and intervention.²⁻³ For example, a parent may not want to seek help for a child or youth struggling with anxiety for fear that others will judge them for being too anxious and for inflicting that on their child or youth.

But when has shaming or blaming people ever been appropriate or beneficial? I’d like to look at some issues related to two areas of family stigma.

Family stigma related to parental mental illness and substance use

If a parent has mental illness or a substance use disorder, they and other family members, including children, may experience stigma. Children and youth may feel embarrassed by the struggles of a parent and will sometimes be reluctant to make new friends or bring friends to the family home. This stigma might also look like:

- seeing the looks, glares and side-eyes of passersby, hearing snide comments
- receiving uninvited, non-stop “advice” and coping with the fatigue of wading through information people give you
- a youth or child recognizing their notoriety in a setting if, for example, a parent has a visible altercation with school personnel; these types of situations often result in judgement rather than empathy, and internal thoughts like, “they know my voice there” or “oh, they know all about us”

Family stigma related to child and youth mental health challenges and substance use

For much of the twentieth century, parents and parenting practices were held to be fundamentally responsible for child and youth mental health challenges or illness. Still today, while there is extensive and multi-faceted literature on stigma and the stigmatization of mental illness in adults, far less research has examined the stigma associated with child and youth mental illness.

Yet, for children and youth with mental health and/or substance use

challenges, these barriers to care can have dire consequences across the lifespan. For other family members, this stigma might show up as:

- a chorus of internal critical voices with messages like, “I’m a bad parent,” “he just needs more discipline” or “I should stop giving in to him”
- questions and judgements about yourself as a parent
- self-doubt
- internal debates about the impact of gossip, with thoughts like, “what will people think?” and “how will our family be treated?”

Parents of children using substances are perhaps hit hardest by family stigma. That’s because those challenges are often seen as a result of absent supervision or boundaries set by parents. Parents are blamed. This may result in thoughts like, “we should have been more strict” or “we must have done something wrong.”

Unfortunately, all of this blame, internalized stigma and shame can lead to a reluctance to ask sooner for support or help for a loved one. And if, when seeking help, parents encounter blame and shame related to a child or youth with mental health or substance use challenges, harms and negative impacts may follow for:

- parents’ sense of ability and empowerment
- parents’ experience with services, leading to an “us (parents) versus them (services)” attitude that negatively affects decision-making and future help seeking
- service providers’ engagement with parents

- the child or youth’s ability to get help
- parents’ engagement with the child/youth/young adult

Getting past judgement and stigma aimed at families

No matter who has a mental health or substance use challenge in a family, everyone is impacted, and families often can and do help with needed care; they may also need help as a result. It is imperative that health care providers, service providers and systems look beyond the person in front of them and think of the experiences or needs of others in a family.

Lastly, given how frequently parents or caregivers feel judged or blame themselves for possibly having done something wrong to cause the mental health or substance use challenges their kids are experiencing, they do not need others to make them feel worse.

My hope is that people will be inclusive and choose caring over judgement. Wrapping care and caring around a whole family not only makes the most sense, in my experience it can change everything for the better—for everyone. ▽

Becoming the Father I Never Had

BRUNO FELDEISEN

I once met a man I was told was my father. I must have been six years old at the time, and I have some glimmers of memories from that strange encounter. It happened in a hotel room on a sunny afternoon. I'm not sure how we ended up there. I just remember feeling the sun's warmth piercing through the kind of white lace curtains you typically find in southern Europe or France, where I was born and lived as a young person.

Chef Bruno is a judge for CBC TV's The Great Canadian Baking Show. He has worked at Patina Restaurant in Los Angeles and the Four Seasons Hotel in New York and Vancouver. He has also taught at the Pacific Institute of Culinary Arts. His first cookbook, Baking with Bruno, appeared last year. Outside the kitchen, Chef Bruno is an advisor to Anxiety Canada and loves spending time skiing, snowboarding and hiking with his son, Sergio



Bruno Feldeisen

I was sitting on the floor playing with my toy car. My mom and the man were discussing something that sounded serious. No argument, just firm, monotone talking. No hand holding, no hugs, no kisses and no soft voices either. Once, I think I felt the glance of the guy who was supposed to be my dad. That glance had no emotion in it—like he was checking out the price of an item on a store shelf. It was all a bit surreal. But somehow, I did not care for this person, never wanting to jump into his arms or feel the strength of my co-creator. I felt miles away.

Later, my Mom told me his name was Simon and that he was married and much older than her. For me, that was the end of any fatherhood story.

In hindsight, I never really suffered for not having a dad around when I was a kid. I never felt embarrassed about it and just got used to it. When needed, I invented an imaginary father. I think the only thing I missed was pronouncing the word Dad. I was always curious to know how it would feel to say it, how it would sound in my voice. Sometimes, I created an alternative world, allowing myself

to wander through a different reality where I had a father by my side, where I could pick up the phone and call my Dad to say “I love you” or tell him I would be late coming home after soccer practice, an imaginary world where I could be hugged and loved by a father...

My life took off on its own journey. I developed an interest in cooking and an insatiable curiosity about food, which would eventually lead to my future career. But I had no father by my side to guide me through the years I spent at home with a mentally and physically abusive mother who struggled with drug addiction and mental illness. From that, I did suffer a lot, developing anxiety and post-traumatic stress disorder (PTSD). At age 14, I became an orphan. Sadly, my mother passed away from a drug overdose when she was just 33.

So there I was, alone. I say “alone” because no one can replace a mother. No family, no mentor or friend. You are left with this huge sense of loneliness, an abysmal crater surrounding you. You don’t cry, you don’t suffer, you just feel empty. Only many years later, in my early 40s, did the cries and suffering appear in the form of PTSD and panic attacks. But at 14, all I knew was that I had never used the word *Dad*, and now I would never again use the word *Mom*.

Then, one day, the girl I was dating became pregnant. She wanted to keep the baby. I was scared but never once asked her to get an abortion. As the weeks passed, I got attracted to the idea of becoming a father. There was pure joy in the prospect and a huge sense of curiosity, but also a lot of

what ifs: what if I could not do it and walked away? What if I died and the baby never met her/his father? What if I could not feel any emotions about my child? What if not having that father’s love would condemn me as a cold-hearted man?

I was scared. Scared of not knowing how to become a father. My real father had abandoned me. Maybe in was in my DNA to do the same. How could I be a great man, mentor and father figure when I, Bruno, had never felt that tight fatherly hug or hand on my shoulder, had never been told bedtime stories. I was so lost in these emotions—right up to the moment I got into the delivery room, feeling dizzy and cold and somehow numb.

Then, there he was: my son, being born. I was becoming a father and the *what ifs* were gone. We looked at each other, our eyes locked in an intense moment and I felt something strange: my heartbeat slowing down, my mind at peace, like we had met somewhere in the past, in another life.

Life is magical. Life is powerful. Human beings are resilient. Human spirits can overcome any fear. Here I was, a grown man full of fears, learning on my own how to become a father.

Today my son is 14. He is a ski instructor, loves snowboarding and skateboarding, plays electric guitar, enjoys Metallica and is as tall as I am. He is full of dreams and, of course, fears. But I will be there, next to him, to ease his mind so that he can explore life to the fullest. I am so proud of him, but I am proud of myself, too.

I’ve earned this pride; learning to overcome the fears that ravaged my life has freed me to be his father.

My son often asks me how it was growing up without a dad or mom. I tell him it felt “normal.” Now I have a new normal: I’ve become the father I never had. ▾

related resource

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Thrive

A SUPPORTIVE NETWORK FOR FAMILY AND FRIEND CAREGIVERS OF OLDER ADULTS WHO USE SUBSTANCES OR ALCOHOL

MICHEE-ANA HAMILTON, MSC AND JAN KLIMAS, MSC, PHD, C.PSYCHOL., PS.S.I

Detecting problematic substance use in older adults is often hard because many symptoms of substance use are similar to the symptoms of other physical illnesses common in the aging population.^{1,2} The use of substances and alcohol also makes an elderly person's care needs more complex. Family caregivers are critical in helping to manage substance use and promoting successful aging. Caregiving requires many sacrifices, and often caregivers end up giving up their own well-being while providing care for their loved ones.

Michee-Ana (she/her) is a research analyst whose interests include quality of care for people affected by substance use, resilience in marginalized communities and health equity. She has had the privilege of collaborating with people with lived and living experience of substance use

Jan (Jano) (he/him) is a psychologist whose research has spotlighted the quality of social interactions among people who use drugs and who receive diverse addiction treatments. Currently, Dr. Klimas is investigating predictors of risk in developing prescription opioid use disorder



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Yet, the contributions of family and friend caregivers are often overlooked and undervalued in the care system. These family members and friends also frequently struggle to identify with the term “caregiver.” This is in part because helping financially or providing weekly emotional support through a phone call feels like a natural way to support an older family member who uses substances, whereas caregiving feels more formal and implies looking after all of the needs of a loved one.

The lack of recognition for the contribution of family and friend caregivers results in a shortage of programs, resources and supports to meet their needs. Caregivers are often at risk of experiencing depression, anxiety and burnout.³ When caring for an aging adult who uses substances or alcohol, the risk of caregiver burnout goes up. Not only are family and friend caregivers helping their loved ones deal with a stigmatized and misunderstood health condition, they also often help

coordinate other formal care and treatment for their loved ones and provide support for other important needs (like finding adequate housing).

Stigma and lack of understanding around substance use also affect these family members and friends; for example, caregivers often feel isolated and do not have a place to share their experiences. Additionally, children who care for an aging parent who uses substances sometimes feel pressure to provide a level of care and support for their parents that goes beyond their means or abilities.

The strain on caregivers will only grow over time. In Canada, the number of older adults with substance use disorders will rise significantly in the coming years. This is due to many factors, including:

- lifestyle changes (e.g., grief, social isolation) that may lead to increased substance use
- increased prescription medication use to manage illnesses as physical health weakens. This can lead to misuse of prescription medications and substance use disorders
- aging among people with substance use disorders, who experience huge barriers because of changes across many health domains

For all of these reasons, we created the “Thrive” program. Thrive works with caregivers to build a supportive network where family members and friends can connect with people who have similar experiences. We aim to help prevent caregiver burnout and protect caregiver well-being through our resources and support. We offer practical tools, helpful resources and

a stigma-free environment. In some cases, Thrive is the only space where caregivers can freely talk about their feelings and concerns about their loved ones’ substance use and circumstances.

When caregivers do not have enough support and knowledge about substance use in seniors, it is harder for them to notice when their loved ones experience problematic substance use. Through Thrive’s partnerships, we work to increase knowledge around substance use in older adults in various ways. This includes providing a workshop, in collaboration with the Canadian Deprescribing Network, on the potential harms of using multiple prescription medications in older adults. Right now, Thrive holds monthly remote support groups for family and friend caregivers throughout BC. We also offer our monthly support groups to those who care for an older adult who may be at risk of harms associated with prescription medication misuse.

Substance use in older adults is often neglected, which can lead to older adults falling through cracks in the care system.^{4,5} In the past year, 39% of people who died from illicit drug use in BC were over 50 years old;⁶ it is clear that this group of people and those in their support systems urgently require attention and care. Thrive’s services are open to caregivers of older adults 65 years old and above. We are also open to providing services to caregivers of older adults 55 years old and above.

In our monthly support groups we use practices to encourage mental well-being, such as heart breathing, which increases awareness of the breath and

helps people connect to feelings like gratitude, appreciation and compassion. We offer practical skills as well. These include knowledge about factors that affect decision-making (such as ambivalence, which is when someone has mixed feelings on a subject) and skills for empowering family and friend caregivers to make positive changes that improve their wellness as they care for others, such as using a decisional balance tool (a grid where people can consider the advantages and disadvantages of a choice from every angle).

These are resources a person can use when making positive changes in their life. Our approaches are founded in the principles of motivational interviewing (MI), a counselling approach that helps people deal with uncertainty around decisions. The principles of MI are compassion, acceptance, partnership and evocation (i.e., bringing a feeling to mind). We adapt Thrive’s programming to meet the needs of the caregivers we interact with. For example, we take their feedback into consideration as we plan our support-group program focus. We also provide ad hoc virtual workshops and refer family and friend caregivers to useful resources.

For more information about Thrive, please contact the program coordinator by email, at michee.hamilton@ubc.ca, or by phone, at 236-335-5793. The Thrive program is funded by the Government of BC, managed by the United Way and affiliated with UBC’s Department of Family Practice and the BC Centre on Substance Use. Thrive is also supported by Family Caregivers of BC. ▼

Navigating Motherhood: WHERE IS THE INSTRUCTION MANUAL?

MELISSA MEDJUCK, MSW, RSW

Before I gave birth to twins three years ago, my partner and I discussed a lot of topics: strollers, baby names, birth plan. We felt prepared... and we were. Just not in the areas that counted the most. As a new mom¹ I struggled. Despite my privilege and being well supported, I felt anxious and overwhelmed. I had an acute sense of loss of self. I wondered why no one had told me how hard it would be: did I miss out on some magical instruction manual others had read?

Melissa Medjuck (she/her) (melissamedjuck.com) is a registered social worker, certified birth doula, postpartum doula, yoga teacher and mom to twins. As a maternal mental health therapist, she offers video counselling services to BC residents. As a doula, she offers support to families living in Vancouver and surrounding areas



Melissa Medjuck

Parenthood can be a tough transition for many reasons. We have unrealistic expectations about what our experience will be like, and this can lead to feelings of shame and self-judgement. We internalize society's beliefs about motherhood as effortless and intuitive, while taboos against expressing negative feelings about motherhood lead to isolation. Mental health stigma reduces disclosure. Ultimately, our system does a poor job of supporting new parents.

In hindsight, I wish my partner and I had discussed issues related to parental mental health, like how to:

- assess and talk about my mental health as a mother
- budget for mental health and postpartum doula support
- define and support one another's ideas of self-care
- support me when my perfectionist tendencies might not best serve me

- identify words of affirmation for times of struggle
- list parental duties and determine how to share them

It's never too late to start these discussions—whether it's just before another baby arrives or months and years in.

In my case, early motherhood left me feeling like a failure. I know I am not alone. As a maternal mental health therapist, I speak to moms every day who feel like they are failing. All new parents worry. Sometimes this worry can escalate into anxiety, including scary and intrusive thoughts, which over half of new moms report having.² Many are experiencing what is called “perinatal” anxiety and depression, which often starts in pregnancy or begins any time during the first year postpartum and can last for years if untreated. Perinatal anxiety and mood disorders are influenced by a mix of genetics, biology, stress, environment, systemic inequalities and social determinants of health—not personality flaws.

Parents are not regularly screened for perinatal mental illness, a concerning reality given that a recent Canadian study revealed that levels of postpartum depression have almost doubled during the pandemic, with 35% of mothers reporting symptoms of depression compared to 19% pre-pandemic.³ Postpartum anxiety rates are even higher: over 72% of moms experience postpartum anxiety, and this number has almost tripled since the pandemic started.⁴ Fathers, non-birthing partners and adoptive parents are also at risk for perinatal anxiety and depression. One of the greatest predictors of fathers’ and non-birthing partners’ perinatal mental health

guides and resources

Current toxic cultural narratives around motherhood cause us to internalize unrealistic expectations about what our experience “should” be like. I wish I had examined my assumptions about motherhood because, in many cases, I discovered very different realities.

Assumption	Discovery
I will fall instantly in love with my baby.	I am still a good mom if it takes me time to connect with my baby.
Motherhood will make me feel whole and happy.	Other parts of my identity still matter, and moms undergo a challenging identity transformation; loneliness, anger and resentment are common feelings moms experience.
Having a baby will bring my partner and I closer together.	Partner conflict is common post-baby. Engaging in daily check-ins, expressing appreciation, responding to requests for connection and using assertive communication are useful.
My instincts will naturally tell me what to do.	Parenting involves learning a new skill set and managing a mental load; there isn't one “right” way to parent.
I will always want to put my child first.	My needs are important, my well-being affects my family and putting myself on my to-do list is essential.

Related resources:

Organizations

- Pacific Post Partum Support Society (postpartum.org) provides free or low-cost programs for mothers in BC experiencing a difficult pregnancy or postpartum adjustment, including telephone support, weekly support groups and support for partners
- Postpartum Support International (postpartum.net) provides a helpline and free online support groups. Visit postpartum.net/get-help/provider-directory for their Online Provider Directory

Tools

- For help with intense emotions, see the guide Coping with Depression in Pregnancy and Following Birth, at: heretohelp.bc.ca/workbook/coping-with-depression-in-pregnancy-and-following-birth
- For information on self-compassion, visit: self-compassion.org
- For a social network connecting women across fertility and motherhood, consider Peanut, available at: peanut-app.io
- For more on assertive communication, visit: psychologytools.com/resource/assertive-communication and gottman.com/blog/weekend-homework-assignment-tips-for-asserting-yourself
- For more on partner check-ins, visit: gottman.com/blog/how-to-have-a-state-of-the-union-meeting

How we support new parents needs to shift, as do the cultural narratives of parenthood being joyful and easy; our avoidance of sharing parenting challenges; and the stigma surrounding and devaluation of perinatal mental health. ”

is having a partner with perinatal depression and anxiety.⁵

Postpartum care should be an ongoing process, with holistic, affordable and accessible support tailored to each new parent’s needs, rather than a single encounter at a six-week checkup. This support should include programs for specific groups, such as Indigenous, immigrant and non-Indigenous Canadian-born people. Perinatal mental health counselling should be free and offered to all parents and parents-to-be.

And while we advocate for systemic change, here are some strategies to help you navigate motherhood:

- acknowledge and validate your feelings: “This is hard. It makes sense that I feel this way”
- engage in self-compassion; talk to yourself like you would to a friend
- examine perfectionist tendencies and consider where you can lower your expectations
- value your work as a mom, give yourself praise and notice what you’re doing well
- try relaxation and mindfulness practices to reduce anxiety (and limit your time on social media and Google if they’re not serving you!)
- develop realistic self-care goals, including activities you can do with your child present

- move your body, eat nutritious food and give yourself permission to rest
- connect with family, friends and moms who “get you”
- if you have a partner, discuss the invisible load that the default caregiver carries and try a weekly partner check-in
- explore supports groups and self-help programs
- talk to a maternal mental health therapist or your health care provider about how you’re feeling

How we support new parents needs to shift, as do the cultural narratives of parenthood being joyful and easy; our avoidance of sharing parenting challenges; and the stigma surrounding and devaluation of perinatal mental health. Venturing down this uncharted emotional road requires a village to march along with you. Isolation and lack of support are leading causes of perinatal mood disorders, which is why I believe that receiving support is essential. It certainly was for me—my decision to see a maternal mental health therapist was a turning point in my motherhood journey.

I hope if you are a new parent reading this, you know you are not alone in your struggles, you are not to blame and it’s okay to ask for help. ▾

Battling the Body Blues

PARENTS AND YOUTH

ELVIRA CHAN, BA COM AND JOANNA ZELICHOWSKA, MA, RCC

Even though body image and eating attitudes are complex, parents often navigate overly simplified myths about these issues. For example, you may believe that mothers are mainly responsible for modelling positive body image and eating behaviours, or that boys and men are not vulnerable to eating or body image concerns. If you struggle with body image or an eating disorder, you may worry that your child will inevitably have the same experience or that your own challenges will hinder your ability to be a good parent.



Photo credit: fizkes at ©iStockphoto.com

Elvira is the project coordinator for Jessie's Legacy Eating Disorders Prevention and Awareness Program in North Vancouver, BC. Currently, she is completing a post baccalaureate diploma in counselling and human development at SFU. Elvira is an active advocate and volunteer in the mental health community

Joanna is manager of Jessie's Legacy Eating Disorders Prevention and Awareness Program in North Vancouver, BC. She is passionate about raising awareness and reducing stigma about eating disorders

It is normal to have feelings of guilt, anxiety, fear, shame or embarrassment if you believe these myths to be true. But these are all blanket statements that do not take into consideration other influential factors, such as mainstream media, peers and the larger culture, that contribute to shaping a child's body image and eating attitudes.

In reality, we know that any parent or caregiver can model and encourage healthy body image and eating attitudes for their children. And while eating disorders impact more women and girls than men and boys, body

dissatisfaction and disordered eating are very common across all genders.¹

Further, we do not have to be "perfect," completely healed or free of our own body image or eating issues to help children develop healthy attitudes and support them with their own challenges in these areas. We can hold space for working on our own struggles while also encouraging critical thinking and thoughtful discussions within our families.

The good news is that parents can be influential in creating a supportive

environment that will help children combat harmful beliefs around weight, shape and body size. Our goal for this article is to encourage you to start these conversations, be compassionate and patient as parents, and develop awareness to any blind spots and biases that are not serving you or your family.

Unpacking harmful beliefs and attitudes

A good place to start is to give yourself time to reflect on your own ideas, beliefs and assumptions about weight, shape and size. For example, do you hold different assumptions about a person’s health status, values, personality characteristics or lifestyle based on whether they exist in a small or larger body? Take a moment to think about where you learned these associations. Do your friends and family hold the same beliefs? Or perhaps the media content you consume has shaped some of these attitudes. It can be challenging and uncomfortable to ask these questions, but it is a necessary first step in assessing whether these views are based on facts and our own values, or simply ideas we have adopted from various sources around us.

Our cultural environment shapes our views, which can in turn be communicated indirectly to children through comments, reactions and behaviours. We know that children often imitate what their parents do and say, and adopt the behaviours and attitudes of the people around them.² When parents and caregivers model or frequently talk about weight-conscious behaviours, such as dieting and restriction, their children are more likely to show signs of body dissatisfaction and engage in eating disorder behaviours.³

body image and eating attitudes check-in

The following questions are intended to help bring awareness to thoughts and attitudes that you may be holding onto consciously or unconsciously.



Do you make evaluative comments in front of your child about your own body and appearance or the appearance of others?



Do you identify as a perfectionist and have high standards for your appearance?



Do you monitor your child’s food choices or portions out of fear that they will gain weight?



Do you place a high value on your child’s appearance or athletic performance?



Are diet foods, strict exercise regimes and other weight-controlling behaviours commonly talked about or available in your home?



Do you have special “food rules” for yourself or eat different foods from other family members?



Is there a certain body shape or size that you believe is the healthiest or most desirable?



Do you compare your child’s body, weight, size or appearance with that of others?



Do you frequently praise your child for their appearance?

You can work towards adopting a more inclusive attitude and be thoughtful about what you communicate to your children by becoming conscious of assumptions you may unknowingly subscribe to.



Changing the conversation

You can work towards adopting a more inclusive attitude and be thoughtful about what you communicate to your children by becoming conscious of assumptions you may unknowingly subscribe to. Did you know, for example, that unhealthy eating behaviours and body image concerns can present themselves differently in boys, with more of a focus on leanness or a muscular physique, body comparisons in sports, strict exercise regimes and prioritizing athletic performance? An excessive focus on fitness or muscularity can be detrimental to mental and physical health, and it is important to be mindful about having these conversations with boys as well.

You have the capacity to shift your experience by being mindful about the amount of attention and focus you place on ideas of body image. This is not about being perfect. Rather, with increased awareness you can start to be more intentional about the messages you want to impart to your child and for yourself.

Some suggestions for parents who want to change the conversation with children about body image and eating attitudes in a positive direction include:

- be mindful of your child's media consumption, and teach them that images are almost always modified and promote a particular body ideal
- encourage traits and characteristics that are not appearance-based, such as kindness, ambition, empathy, curiosity or perseverance
- point out that body diversity is healthy and normal
- avoid making comparisons or negative comments about your own body or other people's bodies
- avoid judging your child for expressing concern about their body or appearance, and be open to listening with curiosity
- offer support to your child by being present and empathic. You don't have to "fix" their problems; validating their experiences can be very helpful

Remember that this is not about attaining perfection but cultivating awareness. Moving forward, we can make choices that reflect a more inclusive and compassionate attitude towards all bodies. ▽

Can We Cork the Wine Memes for Good?

KRISTYL CLARK

Can I confess something to you? I'm so tired of wine mom memes. You know the ones, where a static photo of a boozy mom gets the meme treatment with a text overlay saying "Mommy's Little Helper," or a woman holding a massive glass the size of her head quips: "Just one glass a day keeps the doctor away." As a society, I feel like these memes have set us back 50 years.

Kristyl is a former Black Press Media reporter and contributor, and founder of the award-winning family blog ValleyMom.ca. In addition to highlighting her family's adventures around the Fraser Valley, she writes candidly about mental health and addiction. Follow her on Facebook @ValleyMom.ca, on Instagram at @ValleyMom.ca and through her blog, valleymom.ca



Kristyl Clark

In the 1960s, Valium, a drug predominantly prescribed by men to manage women's anxiety, was the original Mother's Little Helper. Valium (generic name: diazepam) may be much less of a social phenomenon these days, but Mommy still has a special helper, and it can be just as addictive and harmful.

If you love your wine, this is by no means a judgement on you. You do you! But in my case, one glass usually leads to:

- drinking the entire bottle
- my husband having to hide alcohol from me in the basement (at first, I thought he was the one with the problem)

- making reckless decisions
- harming my mental and physical health, including horrendous hangovers
- being a crappy mom, human, wife or friend
- hating myself

I know I can't be the only one. Caring for your baby, toddler or child can be really stressful. Trust me, I know. I had two babies in under two years, so I was always feeling depleted and overwhelmed.

The truth is, I adored my wine, a.k.a. "mommy juice," a little more than I should have. I would gladly drink it from a box. I enjoyed it while wearing polka-dot socks. Pinot, Chard or

Merlot? It can be hard to say no. A glass of white pairs well with cheese, especially cheesy reality TV shows like the *Real Housewives of Orange County*, but also goes hand in hand with baby showers, girls' nights, date nights, camping, baseball games, picnics, playdates and Netflix. As you can see, this Valley Mom was in quite the fix.

It was shortly after I stopped nursing my youngest, Zoe, that wine went from recreational activity to alarming nightly habit. My husband Jason was working a string of late shifts while we rented the top floor of a house on a secluded street. It felt like I was on a deserted island with a baby and toddler. I'd finally get my girls to sleep around 7:00 p.m., then watch all the lights on our street go out like clockwork.

I felt so alone, so stuck and bored out of my mind. Wine offered a cheap, tasty solution. Once Zoe was sound asleep in her milk coma, out came mommy's own soothing bottle. All my worries and stress from the day—toddler meltdowns, a teething baby and mounding debt—dissipated with every delicious sip. Four years later and 10 pounds heavier, this occasional party for one began to blend into my own bedtime routine.

Pretending to be a "normal drinker" was a piece of cake, until it wasn't. It was just one day after returning from a couples' trip to an all-inclusive resort in Mexico that I keeled over in pain on our kitchen floor. The spasms started in my stomach and radiated in waves to my back like labour contractions. My doctor shook his head the next day when I admitted how much

alcohol I had consumed during our vacation. Alcoholic gastritis was his diagnosis.

"Does that mean I'm an alcoholic?" I asked, turning fifty shades of red, masking my nervousness with a forced laugh. He alleviated my concern by letting me know this was common after a week of overindulgence but to lay off the sauce and spicy food for a good 30+ days. Yet, that very night, I recklessly poured myself a generous glass of wine, wincing as each sip felt like hot lava burning a hole in my esophagus. For the first time, I started to feel scared.

Still...I had never driven drunk, had never been to jail and was able to run a thriving freelance side hustle. My family was intact. My resolve would slowly dissolve when I compared myself to people who seemed worse off than me, making me forget the lines I did cross, like being hungover every single damn weekend for four years straight, and my 5:00 p.m. glass of wine becoming a 4:00 p.m. glass, until I thought, eff it, 3:30 p.m. is just a half an hour earlier, right? I was constantly foggy-headed, irritable, restless, discontent, anxious and sad, but I didn't have an alcohol issue... right?

Oddly, nobody noticed my non-issue. Or if they did, they gave me a break. After all, us moms are encouraged to seek solace in wine. It's how friendships are formed at the playground. It's how moms can escape without having to leave their house. It's how many mothers claim to survive parenthood "just one sip at a time." Yet, it's also how families are destroyed, lives lost, souls crushed

and life's special little moments, like an extra snuggle or conversation, are forgotten or missed altogether.

I was a walking, talking wine mom meme.

It took me a while to recognize that I had a problem and reach out for help. Looking back, I was terrified of being viewed as a bad mom. Turns out, speaking up is how I found a tribe of incredibly inspiring, sober, badass women in a recovery program. I dreaded walking through the doors of that dimly lit church basement, which smelled of bad coffee, in case someone recognized and judged me. But I quickly discovered I had found my herd.

Turns out, the majority of the women I met there are also moms with a strikingly similar story to my own. Some hit harder bottoms and lost their homes, jobs, marriages, custody or more, but the feeling of helplessness, of being a bad mom, was the same. The opposite of addiction is connection, and these moms helped heal that hole in my soul that I had been trying to fill with Chardonnay.

We're constantly being told to "drink up," then to "shut up" when things get out of control. Well, I'm done staying silent. There's a good chance you have a mom or two on your friend list who is genuinely struggling to keep it together. So before you "like" or share that next wine meme, remember: with each re-post, you're actively supporting a reckless marketing tactic that trivializes women, moms, mental health and addiction. ▼

Connecting Families and Communities Through Conversation

MAHBOUBEH ASGARI, PHD

Dialogue is about expanding our capacity for attention, awareness and learning with and from each other. It is about exploring the frontiers of what it means to be human, in relationship to each other and our world.” (Glenna Gerard¹)

Mahboubeh is passionate about using dialogue to develop resources and materials for teachers, parents and others. She founded The School of Inquiry (schoolofinquiry.com) to empower children, youth and adults to think critically, creatively and caringly. Mahboubeh (asgarim@gmail.com) is available to provide consultations to communities, schools, parents and individuals to use dialogue in their practices



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“Dialogue cannot exist [...] in the absence of a profound love for the world and for people.” (Paulo Freire²)

When we are thinking about talking with our children, partner or someone else about a complex topic, such as drug use, mental distress or another issue, we may prepare by gathering information about some of the risks involved. We may be tempted to use facts and statistics to scare someone away from or change a behaviour we perceive as negative (leaving out possible benefits). We tend to think and decide for them. This is usually done with good intentions—we want to protect the people in our lives.

However, research shows that this is not the most effective way to help others navigate the world.

People need more than information. They need to be understood. Our goal is not to tell them what to think or which choices to make. Instead, we have to find ways to inspire the desire to communicate—about drugs or anything else—and achieve well-being. One method of communication that leads to meaningful engagement is dialogue.

Dialogue

Dialogue is a two-way conversation in which we seek to understand each

other. While talking is part of the conversation, listening and asking good questions are the more important skills. In dialogue, the goal is not to find the right answers, reach agreement and “get to yes.” Nor is it to prove our point or convince someone else of how wrong they are. Rather, in dialogue, we seek an understanding of someone else’s perspective and to accept each other for who we are so that we can communicate better and live better together.³

The following are some of the key elements that foster dialogue.

Start with a safe space: A safe space is a welcoming, respectful and non-judgemental space where everyone can express differing ideas and opinions. Safe spaces reduce feelings of anxiety or vulnerability. Sitting in a circle, approaching others with empathy and openness, seeking first to understand then to be understood, practising attentive listening and respecting confidentiality all foster safe spaces.

Build on your relationship: Positive relationships and open communication are the foundation for good dialogue. This involves understanding each other rather than focusing on truth or assessing the details of what others tell us (sometimes by jumping on them when we don’t like what they try to say!)

In dialogue, even when we disagree, or when there is something we don’t like, we need to recognize that another person’s position represents a new possibility to be explored. This requires us to reflect on our assumptions and become aware of how our way of seeing the world is influenced

by them. While this may not always be easy, it is worth the effort.

Listen: In dialogue, we avoid the temptation to shower our children, partner or others with wisdom; instead, we let them do at least half of the talking. Listening is not just about hearing words. It’s being ready to hear others’ ideas and positions, being open to new information regardless of the consequences to our own position and having the desire to understand new ideas and perspectives.

Suspending (not defending) our assumptions and judgements while listening to someone else (in other words, putting them on hold) is important, as is focusing only on what is being shared and trying to understand.

Be empathetic: Empathy is at the core of human relationships. It is the attempt to imagine ourselves in someone else’s shoes and to try to see and feel the world from their perspective. In dialogue, rather than being too quick to say, “I know how you feel,” we should empathetically take the time to explore how someone else feels about their own circumstances.

When we are empathetic, the intention is to know what another person is experiencing, and not necessarily to respond to that experience in any concrete way. Sometimes, we may tend to respond by distracting the person from their feelings and thoughts, or by getting logical and giving advice. It is important to keep in mind that being present, listening attentively, having an honest commitment to the pursuit of understanding and being willing to experience discomfort make empathy possible.

Be open and curious: In dialogue, everyone is open to new ideas and possibilities, and truly curious about how others think and why they see the world the way they do. Communicating perspectives and seeing the world through others’ eyes allows us to share ideas without demanding acceptance, and to challenge assumptions without passing judgement. To promote openness and curiosity, we can practise encountering difference with thoughtful questions rather than defensiveness.

Ask open-ended questions: Open questions are far more useful in dialogue than attempting to elicit ready-made answers. Open questions do not have simple factual answers. How and why questions tend to be more powerful in generating dialogue than what questions⁴ Here are some examples of open-ended vs. closed questions:

- “How do you feel about ...?” (Not: “Doesn’t that make you feel ...?”)
- “Why do you think ...?” (Not: “Don’t you realize that ...?”)
- “What worries you about ...?” (Not: “Don’t you think is a problem?”)

Moving dialogue forward

Dialogues are explorations without a specific destination. The path is open to be explored through conversation. Words and questions are the lanterns that light the way and illuminate new possibilities. We just need to follow along as explorers on an adventure. ▽

Our Two Biggest Fears

JEAN PATTERSON*

My son had his first psychotic episode in 1998 at age 15. He spent a month or so in the psychiatric ward at BC Children’s Hospital. Since we lived on the Sunshine Coast, where there were no specific resources for adolescents suffering from mental illness, Rick* moved in with his father after release from hospital so that he could remain in Vancouver. Once he turned 19, his father and I no longer had a say in whether he continued treatment. He was still plagued by delusions but was unable to understand that he had a mental illness and that not everything he believed was real.

Jean is a mother and grandmother who lives and writes in a small BC community. While she is long retired from both motherhood and paid work, she finds that concern for both her children—even the one who does not suffer from a serious mental illness—never ends

*pseudonym



Photo credit: pappamaart at ©iStockphoto.com

For the next 13 years Rick was tossed about in the world, abandoned by a system that is hesitant to deal with patients without their consent. I watched Rick self-medicate with illicit drugs, lose housing due to psychotic behaviour and take up with questionable companions (many of whom also suffered from mental illnesses and were involved in drug use and petty crime). He was unable to sustain relationships with women and lost custody of—and visitation rights to—his toddler daughter. I became convinced that this lifestyle would kill him. I longed to be able to facilitate compulsory treatment.

After a stay at New Westminster’s Sherbrooke Centre¹ in 2015, Rick was at last certified and placed on “extended leave.” This means he is legally required to take medication and see a psychiatrist. I thought this would lead to greater stability for him, but it hasn’t happened that way. The mental health system has no control over a patient’s drug use. Rick has become addicted to crystal meth. This drug seems to undo the effect of his anti-psychotic medication. It amplifies his paranoid delusions.

Lately there has been much discussion about how police shouldn’t be

handling mental health crises, that these events are better dealt with by people with psychiatric training. Rick came to stay with me at a point, several years ago, when his case manager at New Westminster Mental Health was unable to find housing for him. I was given two alternatives: take him in or let him be on the street. Shortly after arriving at my home, Rick became delusional and aggressive. I called the local mental health agency hoping for advice on how to defuse the situation without involving police. I just wanted tools to stop things from escalating, but the response I got was, "If you feel you are in danger call the police." It seems the mental health system thinks in terms of crisis management only, not prevention. I felt outraged.

Since then, Rick has stayed with me on and off. I have had to call the police about him many times. I now understand why it is no use calling a mental health agency. A person in full-blown psychosis is unreachable by logic or compassion. Mental health personnel aren't equipped to force an unwilling patient to go to hospital—they don't have the muscle. What usually happens: if the person does get to hospital and there is space in the psych ward, they are given an antipsychotic shot, kept overnight and released—regardless of whether they are stable or have a home to go to. If there is no bed, they are turned away on arrival. Sometimes they end up in jail.

Family members are not trained to deal with this, police are inadequately trained and mental health agencies seem powerless to help anyone who is uncooperative.

Rick was not given a firm diagnosis of schizophrenia until his stay at Sherbrooke Centre. I believe that if he'd been diagnosed earlier and received appropriate help during those lost years (voluntarily or not!) he would be doing better now. I know of people with schizophrenia who have jobs and relatively stable relationships. It is possible.

For a long time I blamed the people who work in the mental health system. As in every profession, some workers are more competent and sensitive than others. But even the most well-motivated professionals do not have the funding to support our loved ones. Recently, I was once again given the choice no mother should have to face: let your grown child live with you or he will be homeless. I am elderly and half Rick's size. He resents me for pressuring to have him certified and for helping the system to apprehend his child (an action any responsible grandparent would have taken, given the situation). It is not safe for me to live with him, so he is homeless once again.

People with severe mental illnesses need and deserve more individual attention than the mental health system provides. They need affordable housing—with real supports. The current version of "supportive housing" is inadequate. Housing physically disabled people and low-income seniors in the same building as those with mental illnesses, drug addictions or both while failing to provide suitable on-site treatment and supervision creates another kind of skid row hotel—funded by government this time!

I know that a return to institutions like Riverview is not a popular idea with

some. I also know we desperately need a place where those in acute psychosis can be sent, at least until they are stabilized. Right now, when Rick has an episode, there is usually no space available anywhere.

What with the housing crisis, the opioid crisis and the poorly resourced mental health care system, I don't yet see improvement for Rick on the horizon. Over the years I have felt anger and frustration with the system, as well as grief over my son's illness. I was offended by the suggestion that I get free counselling from provincial mental health services, as I saw their failings as the cause of my angst.

Lately, Rick has had a case manager who not only goes above and beyond to try to help him, but gives me emotional support as well. I suspect it is at a cost to her own free time. I have come to understand that Rick resists help from anyone. The knowledge that there's nothing more I can do has brought a degree of emotional detachment.

Despite this relative peace there is always the worry, at the back of my mind: what will become of Rick now? As one of my fellow BC Schizophrenia Society branch members said recently, "We have two fears. One is that we'll outlive our children. The other is that our children might outlive us." Who will look out for them then? ▽

Calling my Spirit Back (and Other Crimes)

HOW COLONIAL INSTITUTIONS CARRY ON THE LEGACY OF RESIDENTIAL SCHOOLS

TJ FELIX
(THEY/THEM)

“Never before has there been a time for our LGBTQ2S+ community to walk as freely as we do in North America and most of the western world. I believe we are in that moment now because of those LGBTQ2S+ Elders who literally died for all of us.” – Jeffrey McNeil-Seymour (Secwepemc/4th generation settler)¹

TJ Felix is a two-spirit artist and educator from Splantsin and a member of the Secwépemc Nation. They are currently working as the community educator at Pivot Legal Society and living on the stolen, ancestral lands of the x^wməθk^wəyám (Musqueam), Skwxwú7mesh (Squamish) and səlitwətaʔl (Tsleil-Waututh) Nations



TJ Felix

This morning I woke up to news of the ‘discovery’ of the remains of 215 children, some as young as three, found buried on-site at the former Kamloops Indian Residential School. This news must’ve come as a shock to anyone who subscribes to Canada’s revisionist history, but survivors and intergenerational survivors know far too well the suffering caused by the union of the Catholic Church and the government of Canada.

Many Indigenous people continue, unknowingly, to adopt values that

are not our own, but those of our oppressors. And our histories are intentionally obscured or co-opted by the Canadian government in order to continue to oppress us. Our languages, customs, laws, culture, and connection to the land were outlawed until the mid-20th century in an attempt to ‘kill the native and save the child.’ Our Ancestors, at a risk to their bodies and minds, kept our Indigenous ways of knowing alive. But Canada’s sexist, racist, assimilationist laws and policies still continue to divide and even remove us from our communities.

As I write this, mass graves found on the grounds of residential schools across so-called Canada continue to be exhumed, the number of bodies found has exceeded 1500, and that number is going to keep rising. We've mourned the loss of these children, felt their absence in our homes, and we've felt it across many generations. But as the number of children found rises, so too does the number of children who are currently lost in the system, lost in hostile cities, who may never realize the powerful visions for change they hold within their lived histories, who may never make it back home.

My experiences as an Indigenous two-spirit youth in and out of public schools, foster care, youth shelters, rehabilitation centres, welfare offices, holding cells and hospitals were largely what informed my suicidal ideation and gender dysphoria. I learned the hard way that I put myself very much at risk just by being myself. I had to compartmentalize, or outright suppress parts of my identity to survive in the heteronormative status quo of Canadian society. I had been conditioned to hate myself, and unironically referred to myself as a 'self-hating Indian' when asked about my background.

I believed every word that was said about us, that we were lazy, drunk, irresponsible and a liability, that there was no way we could help ourselves because we didn't know any better. I believed this in part because I saw it firsthand. I saw the way we hurt each other, I saw the suffering, but I had no context, no understanding of why our people were in so much pain. Aside from a paragraph or two about Louis Riel and the Red River

Rebellion, there was no representation of Indigenous peoples or our histories in any of the textbooks during my time in public school and, therefore, zero acknowledgement or understanding of the fact that, regardless of gender and/or sexual orientation, there was a role for everyone in each of our distinct nations prior to European contact. The shame, lack of self-confidence, and crisis of identity I developed were symptoms of the ongoing genocide that my Ancestors had to reckon with.

By 2009, I was 19 and living on the streets of Vancouver for the first time. I was completely uprooted, without culturally safe support, and lost in a city that was not my own. My social anxiety and shame around my substance use kept me from reaching out or accepting the help offered by those close to me, so I ended up homeless, then in a youth shelter in downtown Vancouver. None of the workers there were Indigenous, but many of the youth were. I struggled to fit in, didn't know or get along with anyone, and the services that were provided failed to address any of my needs.

It felt like the system was rigged against me, like I would never be able to call somewhere home again, like I was a moving target for some unseen force as I continued to fall through the cracks.

The youth shelter I was staying in, as well as many of the service providers I have relied on for survival, are faith-based organizations that uphold the values of the Christian religion. I remember having to sit through a prayer before meals more often than not. I know now that every "free"

service I accessed was actually paid for through compromising my spirit a little bit at a time until I was a shell of my true self. I was meant to be a vessel for the word of God but ended up carrying little more than misguided hate for myself and my people.

At the time, I didn't yet have the language to understand myself or my body, or have a voice to speak out against the homophobia, transphobia and racism I was subjected to on a daily basis in these institutions. I had no Elders, peers or positive role models to support me as I transitioned into my true selfhood, no safe space to freely express myself, and no way of acknowledging that I, as a queer, neurodivergent, two-spirited substance user, deserved love and community just as much as anyone else.

I didn't even know about residential schools and the impact they had on my community until I was arrested for theft and put through the alternative measures program for the second time. This program pairs Indigenous youth with an Indigenous cultural support worker as opposed to a probation officer. By the time I was arrested in 2016 my urine had tested positive for fentanyl and a number of people I knew had passed away. As my substance use increased, I found it harder to maintain work or relationships, and I didn't have the capacity to realize that I was essentially committing suicide by continuing to access the poisoned drug supply, let alone understand that it was the intention of colonialism to drive me towards it. Getting arrested and being illegally held in the basement of the store I stole from for two hours gave me time to reflect. It was time for

change, I just needed some guidance. I received this guidance from my support worker, who after learning of my past, only gave me one condition, I had to learn about residential schools. I thought I had gotten off easy, but this turned out to be harder work than any community service I'd ever done. Ultimately though, this was the guidance I needed to begin the long journey of reconnecting, of rooting myself, and of understanding the context for how and why my family hurt themselves and each other.

Unfortunately, my experience is not an isolated one, as many LGBTQ2S+ youth I know face similar hurt when accessing services and programs for homeless youth. Culturally enriched and trauma-informed resources for two-spirit

people by two-spirit people, especially outside of metropolitan cities, are few and far between. The resources that are available specifically for LGBTQ2S+ people are largely through the non-profit sector, chronically underfunded, and overall, incapable of truly holding space for the reciprocity, beauty, and complexity of our Indigeneity and interconnectedness.

Our bodies, our identities, and our land continue to be exotified and commodified without acknowledging our agency. We, as Indigenous peoples, carry our homelands. We are, each and every one of us, a sovereign body with strong bloodlines connecting us to each other and to the Earth. We hold ancestral knowledge that is waiting to be awoken by a

song, a story, the teachings of an Elder, a long walk out on the land, the unconditional love of and from our communities, and to suppress those connections, that knowledge, is an act of genocide.

Many LGBTQ2S+ people have experienced some level of intolerance in their home community and continue to migrate to urban areas for their own safety. Through this, as well as the child welfare system, resource extraction, systemic poverty, anti-homeless and anti-substance user stigma, Canada continues to dehumanize and uproot us with little to no accountability.

For Indigenous people, Canada is comparable to an apocalyptic wasteland where sacred sites are buried under condos; the bodies of our Ancestors gather dust in the basements of museums; women, girls, transgender, and two-spirit people continue to go missing or be found murdered; we are heavily monitored by, brutalized by, and overrepresented in the criminal justice system; we are disproportionately affected by homelessness and housing insecurity; and social workers are kidnapping our children with impunity with support from the police.

And yet we continue to survive.

So, what are you doing to ensure that we too are not buried? ▾



Photo credit: Srdjanns74 at @iStockphoto.com

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Supported Housing

A PROMISING INTERVENTION TO ADDRESS MENTAL HEALTH ISSUES

KAREN LOK YI WONG, MA, MSW, RSW

Many of you may have heard of what the media call Canada’s “mental health crisis.” This refers to challenges arising from meeting the needs of people with mental illness, including housing. Housing matters to people who experience mental illness. Coping with mental illness is hard, and having safe and stable housing helps.



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Unfortunately, the current housing system lacks affordable housing, leading to increased homelessness. Being on the street makes people who already have mental illness even more vulnerable. Many simultaneously experience substance use disorders and contact with the criminal justice system.

I want to take a closer look at one solution for ending the mental health crisis. It’s called “supported housing,” which refers to independent housing with outreach support and usually some tolerance of substance use. In general, supported housing consists of single-occupant apartments in medium-sized buildings. There are also apartments

for couples and families, and units reserved for women and youth.

As the name suggests, supported housing includes some support staff, either from outside or on site, and sometimes meals, laundry or house-keeping services. In BC, supported housing is run by a variety of non-profit organizations, with an application process that usually starts through case managers or housing clinicians at the regional health authorities.

Benefits of supported housing

Evidence shows that, after one year, people who enter supported housing usually remain stably housed, with no increase in substance use. Actually,



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Considering that supported housing is a long-term, effective solution to the mental health crisis, there should be an increase in subsidized supported housing and a larger supply to reduce wait-list times. ”

people generally experience a decrease in substance use, fewer mental health symptoms and fewer visits to hospital emergency rooms.¹ People in supported housing (who have mental illness, substance use problems or both) also receive fewer prison sentences.²

Many people with mental illness say they prefer supported housing over residential housing, such as group housing, room and board arrangements or shelters.¹ This is because supported housing respects their autonomy, while these other forms often place a lot of restrictions on residents. Further, the cost of providing supported housing for people with mental illness is lower than that of shelters and social,

criminal-justice and health services for this group.

Finally, studies show that supported housing is as effective in housing homeless people with mental illness as it is for people with simultaneous mental illness and substance use disorder.³

Limitations of supported housing

One problem with supported housing is that it may increase social isolation because people live independently in apartments, although this can be improved by better use of common spaces. Also, unlike residential housing, in supported housing health and mental health services are mostly available on an outreach basis instead of on site. The main implication of this

is that people need to manage their own medications, which can be a challenge. However, there are ways to improve self-management of medication, such as through the use of blister packs.

Another issue is that not all supported housing is subsidized. The rent can be too high for some people, who can end up being discharged back to the community, into shelters or onto the streets. Considering that supported housing is a long-term, effective solution to the mental health crisis, there should be an increase in subsidized supported housing and a larger supply to reduce wait-list times.

Connecting with voluntary integrated services

Homeless people with other disorders are often willing to go for treatment if services are tailored to their needs. Many people respond well if services integrate subsidized supported housing as well as health, mental health and social support, such as training in life and social skills, and occupational training. Evidence shows that use increases when these services are:

- voluntary⁴
- staffed by compassionate, non-judgemental personnel who are respectful of people's choices⁵
- equipped to provide concurrent mental health and substance use disorders with a harm reduction approach⁶
- diverse—for example, offering access to subsidized counselling and psychotherapy, as well as medication
- accessible, with low barriers (i.e., no requirement of abstinence from substance use)⁶

Unfortunately, voluntary integrated services currently have limited spaces, making them hard to find even when people want to use them. For example, in BC, wait list times are usually three weeks or more. These services should be more widely available.

Providing adequate income and reducing stigma

Mental illness, homelessness, substance use disorder and contact with the criminal justice system all share two root causes: poverty and stigma. Poverty comes out of income inequality. Therefore, fairer distribution of income would allow homeless people to have enough income for a good quality of life. This can be achieved through policy changes to provide more accessible benefits and a higher minimum wage. Of course, increased income support should go hand in hand with affordable housing. If the cost of housing is too high, even if people have better wages they will still be in poverty.

Meanwhile, reducing stigma is a vital step in ending the mental health crisis. Stigma refers to discrimination against a person because of their characteristics, such as their mental illness or substance use disorder. Educating the public on the root causes of the mental health crisis can reduce stigma. Supported housing reduces stigma too because it tells the society that people with mental illness, homelessness and substance use disorders should not be blamed. Instead, they need a stable, safe and supportive place to stay.

Linking up police and mental health and substance use disorder teams

Coordination among mental health teams, substance use outreach teams

and police can complement supported housing. Called “assertive community treatment” (ACT) teams, these groups can share information, work in mobile units and be available 24/7 for rapid response to mental health emergencies. Currently, there are five ACT teams in BC’s Lower Mainland consisting of interdisciplinary professionals like nurses, social workers and psychiatrists. The Vancouver Police Department joined ACT in 2012.

One challenge of this model is effective communication and collaboration among team members, as they come from diverse disciplines and backgrounds. Having a common goal to support people with mental illnesses and substance use problems is thus crucial. Ongoing and comprehensive police training for working with people who experience multiple disorders and regular team evaluations also help.

Through supported housing, people with mental illness get a safe home base. Then, it’s up to others to step up and reduce poverty and stigma, offer more integrated services and increase coordination among health services teams. Together, we can turn the mental health crisis into an opportunity for better health. ▽

resources

FamilySmart

familysmart.ca

FamilySmart supports families, caregivers, and young people and recognizes that everyone has a role to play in helping children, youth, and young adults manage their mental health and in helping families live well. FamilySmart offers:

- Parents and Youth in Residence, a program that connects parents and youth with people with lived experience who can provide systems navigation, peer support, information about accessing services, and education.
- In the Know events are an opportunity to meet other families in your community and listen to a presentation from an expert.
- FamilySmart Practice Program helps young people, families and service providers work together.

BC Schizophrenia Society

bcss.org

The BC Schizophrenia Society supports families and caregivers of people who experience a serious mental illness. The BC Schizophrenia Society offers:

- Regional Educators located across the province who help families and loved ones find and access local resources.
- Family Support Groups, monthly support and education events for adult loved ones, family members, and caregivers. Learn from an expert about a mental health-related topic and connect with other families in your area. Family Support Groups are located across the province.
- Strengthening Families Together and Strengthening Family Together—First Nations, multi-week education and support courses that teach family members and friends how to care for themselves and for a loved one who experiences a mental illness.

Family Caregivers of BC

familycaregiversbc.ca

Family Caregivers of BC supports all British Columbians that care for a family member, friend, or neighbour with information, education, and resources. Family Caregivers of BC offers:

- The BC Caregiver Support Line, a help line for caregivers who need to talk to someone who understands and can connect them to resources in their community.
- Caregiving Support Groups, confidential weekly groups where caregivers can connect with others, learn, and share their experiences.
- The Caregiver Learning Centre, a library of print resources, videos and webinars, the Caregivers Out Loud podcast, and free online courses to help caregivers take care of themselves, navigate health systems, set boundaries, navigate tricky situations, and more.

Raising Kids with a Healthy Body Image: A guide for parents of young children

jessieslegacy.com/resources-and-information

Raising Kids with a Healthy Body Image: A guide for parents of young children from Jessie's Legacy offers tips to help parents look at their own assumptions about body image and model healthy body image to young people.

Substance Use and Young People: A guide for families and their caring communities

heretohelp.bc.ca/workbook/substance-use-and-young-people

This workbook from the Canadian Institute for Substance Use Research helps parents and other important adults understand substance use and talk openly about substance use with young people.

Moms Stop The Harm

momsstoptheharm.com

Moms Stop The Harm advocates for harm reduction approaches and supports families of people who use substances. They offer education, Stronger Together BC support groups, and resources.

☰ 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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