NFTF INTERVIEWS Project

- "Peer Equity and Healthcare Equity in the West Kootenays"

- A collaboration with the Nelson Fentanyl Task Force/ANKORS and the Rural Empowered Drug Users Network/REDUN.
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Nelson Fentanyl Task Force: NFTF INTERVIEWS project
"Peer Equity and Healthcare Equity in the West Kootenays"

Nelson British Columbia
September 2021

A collaborative project by
Amanda Erickson and Amber Streukens

Amanda Erickson MA RCC is the Nelson Fentanyl Task Force (NFTF) Facilitator and interviewer for the Healthcare Equity portion of this project. These are interviews with allies and service providers in the West Kootenay region in British Columbia. Amanda's work is in Section Two of the project.

This is collaborative narrative project with Amber Streukens.
Amber Streukens is the interviewer for the Peer Equity portion and the interviews with peers. Amber is a Street College Program Coordinator/Peer Navigator at ANKORS in Nelson. Amber's work is in Section One of the project.

This is an OPEN project for Community Action Initiative (CAI). The OPEN group includes the first 16 community action teams formed to address the declaration of the overdose crisis in British Columbia in 2016.

NFTF INTERVIEWS PROJECT
Section One
Peer Interviews
by Amber L. Streukens

Peer Health Equity: Barriers to Access for People Who Use Drugs in the Kootenay Boundary Region

Amber L. Streukens
September 2021

INTRODUCTION

The Kootenay Boundary Health Service Delivery Area (KBHSDA) covers approximately 28,000 square kilometers in the Interior Health Region of British Columbia. Located on the traditional unceded territories of the Secwépemc, Ktunaxa, Syilx, and Sinixt peoples, this region is home to roughly 80,000 residents (Statistics Canada, 2016). Like all regions in the province, the KBHSDA is experiencing unprecedented rates of illicit drug poisoning fatalities. Despite 5 years since the provincial declaration of a public health emergency, people with lived and living experience of illicit substance use (PWLLE) continue to struggle to have their basic and specific health care needs met (Soroush, 2020).

Canadian citizens hold equal rights to health care, but not equitable access. Concerns about health care access are relevant to all Canadians, and to specific groups more urgently. Though gaps in healthcare are seen to exist throughout the network of care, additional gaps are experienced by marginalized groups, including people who use drugs. Since social determinants of health are experienced as intersectional, not independent, individuals experiencing multiple forms of oppression face inequitable barriers to accessing safe and appropriate health care.

The health care needs of PWLLE must be considered a public health care priority to reduce the harms associated with illicit substance use and protect the equal rights of all citizens. Public health is strongest when all individuals have access to the care they need to be well. If PWLLE are unable to receive safe and appropriate health care, there are wide reaching impacts on public health, specifically seen in rising overdose rates and transmission of blood borne infections, but also more generally in the slow erosion of physical and mental health.

Whereas much of the provincial overdose response and services to support PWLLE have been traditionally concentrated in Vancouver and other urban centres, overdose rates in rural BC remain high and service access remains low (BC Coroners Service, 2021; McKinney, 2020). According to McKinney (2020) “overdose rates in rural B.C. are often *above* the provincial average and at levels

comparable to urban centres. The response to the crisis in rural municipalities is often hindered by limited healthcare infrastructure, geographical constraints, dispersed populations, and a lack of addiction medicine specialists." The barriers to rural access are substantial and pose a significant equity issue for PWLLE. Additionally, though stigma is an issue that impacts substance-using and other marginalized populations broadly, limitations to privacy, anonymity, and confidentiality raise additional challenges in small communities such as those in the KBHSDA. According to McKinney (2020), this has serious implications for the safety of PWLLE in an ongoing overdose crisis:

> "While stigma is a barrier for people who use substances everywhere, the lack of anonymity characteristic of rural communities may compound the issue and further impede a person's access to treatment. In the current fentanyl-environment, this results in a situation where a person who uses drugs in a rural setting is at a higher risk of overdose than their urban counterpart."

Recognizing the importance of equitable access to health care as an essential component of a comprehensive overdose response and prevention strategy, the following study aims to explore the experiences of PWLLE accessing health care within the KBHSDA. There are 3 active Community Action Tables (CATs) in the KBHSDA where multiple community stakeholders collaborate to respond to the ongoing overdose crisis. PWLLE are essential members of the CATs, bringing expertise and direction. As a PWLLE and harm reduction worker at ANKORS, I have participated with the CATs for 2 years and in this time have supported other PWLLE to become involved. In my role at ANKORS, and within my own personal lived experience, I have observed systemic and individual barriers to care and am invested in improving the quality of life for people who use drugs, including equitable access to appropriate and safe health care. This positionality inevitably informs the following reporting, and simultaneously made it possible to gather this data to share with provincial and regional networks.

METHODS

Acknowledging the depth of this field, and the limits of this project, the spirit of participatory action research (see Baum et al, 2006), specifically attention to dialogue and praxis (Freire, 1972), gently informed this process throughout. PWLLE were engaged to review all interview materials, including consent forms and interview guides, before recruitment. Participants had opportunities to review and provide feedback on this report prior to submission, and those interested are invited to engage in a follow-up project focused on peer dissemination of these findings and potentially other actions. As this project will

be guided by the needs and interests of participants, the outcome is still yet to be determined, but will likely include an educational tool.

Interviews were more conversational than scripted and ranged from 20-60 minutes in length. Participants were asked about barriers and challenges accessing health care, as well as positive experiences and potential solutions to improve access and patient experiences. Interviews were conducted in person and over the phone and Zoom. Challenges with communication technology and patchy reception were barriers that prevented some interviews from being included in this reporting.

Selection criteria and demographics

Participants were invited to this project through snowball sampling within existing networks and working relationships with PWLLE. The process was selective due to the limited scope of the study. Acknowledging that all stories are important, and that sharing stories is sensitive, attention to participant safety and potential benefits was taken into consideration. Attention to demographic criteria also informed selection, with efforts made to be as representative as possible within a small sample.

Qualitative interviews were conducted, in-person and virtually, with 8 participants between February and May 2021. The majority of participants resided in Nelson(4), Castlegar(1), and Trail(2) (other=1). Of 8 participants; 4 identify as female (including one transwoman), 1 participant identifies as First Nations (all others white), all are adults (30 to 65), with a range of employment status and income levels and sources, all experience concurrent mental or physical health concerns, 5 participants are independently housed, and 3 participants are unstably sheltered or living rough. Participant substance use patterns covered a wide range, including historic/abstinent, prescribed daily use, recreational illicit use, and daily illicit use. Likewise, participant drug of choice was highly variable in this sample.

Interviews were recorded, transcribed, and thematically coded. All personal identifiers, including contextual details and citations, were removed in reporting to ensure participant confidentiality and safety in small communities.

RESULTS & DISCUSSION

Most participants eagerly and generously shared quite personal and vulnerable stories, sometimes before being asked any questions. Participants readily identified numerous challenges they had experienced accessing health care and were usually equally prepared to offer solutions to meet their needs. For ease of analysis, results have been coded into categories of challenges and potential solutions.

Challenges

All participants expressed having experienced challenges within the health care system. Common experiences (shared by 2 or more participants) included: being labelled and experiencing differential (punitive) treatment as a drug user; having valid concerns dismissed or being denied treatment; avoiding medical care even when need is serious out of fear of mistreatment or unintended consequences; issues with trust and transparency; and issues with communication.

Labelling and stigma

The impact of stigma against PWLLE is still prevalent in health care settings. According to Chan (2019), stigma from health care providers commonly prevents PWLLE from accessing care, obtaining needed treatments, and often results in patients leaving care early. Among service providers, Lang et al (2013) found that major self-identified "barriers included stigma and discrimination, inefficient use of resources, and inadequate education".

Participants in this study shared their experiences and the consequences of being labelled as a substance user, which for some included mistreatment by health care staff and avoidance or denial of needed care.

> "When I hear a nurse say 'oh she's a frequent flyer' or 'drug seeker', when I hear that I want to scream, I want to pull my hair out. Don't do that. Don't label me. Because that is not me. The only time I come in is if I'm having a problem... Even at that point, there are times that I know I should be at the hospital...but I don't want to go to the hospital because of the way I get treated."

> "Once I was labelled as a 'frequent flyer' or 'she's just here for drugs', none of the nurses or doctors, none of them were nice. It was like everybody had their guard up because I was a 'user', and that was it, bottom-line."

Much (but not all) of the stigmatizing language experienced by participants was indirect, shared between health care providers. While perhaps less aggressive than overt discrimination, exclusionary and stigmatizing attitudes and toxic communication patterns are still experienced as quite harmful.

> "I really wish we were treated better in the hospital. It's disgusting the amount of ... talking outside the room, smiles and happy in the room, leave the room talking about you to co-workers."

Numerous participants shared an awareness that labelling, in addition to risking mistreatment, may have undesirable effects on their ability to receive appropriate care in the future. This parallels findings from a study conducted in Vancouver on the topic of substance use disclosure, which found that disclosure was associated with lower self-reported quality of care (Pearce et al, 2020).

> "I know that if I am marked as a drug user then I will not be able to access opiates if I have chronic pain, and that I will just receive systematically poorer treatment."

Ahern et al. (2006) conducted interviews with over 1000 PWLLE in the United States and found that, "as a barrier to care, stigma and discrimination may adversely affect both mental health and physical health by impeding entry into the health care system, reducing accurate reporting of health issues, and lowering the quality of care received." Stigma causes direct and indirect harm to PWLLE, a population with complex health care needs.

> "I didn't get care that I honestly needed because I was labelled. They see me coming into emerg, you can hear them "oh frequent flyer" and then they'll close the door. It's very frustrating for me because I have been clean for so long, I don't do anything like that"

For PWLLE in recovery, who are working hard to maintain their wellness while managing concurrent health conditions, being labelled as a drug user is an extremely disempowering experience. According to recommendations set forth by the Provincial Health Services Authority and the BC Centre for Disease Control (2017),

> "Recovery-orientated language refers to using language that conveys hope, optimism and supports recovery, and should be the standard for all healthcare professionals working with patients with addiction issues. There are multiple guides how to use recovery-oriented language, but the core principles are to respect the person's individuality and autonomy, emphasise their skills and strengths, and avoid reinforcing paternalistic models of healthcare"

Participant experiences recorded in this study indicate a failure to meet the recommendations set out in this report (PHSA/BCCDC, 2017), and reiterate our findings that

> "Stigma has been identified as a significant barrier towards accessing healthcare and this has direct detrimental consequences for PWUDs... negative

> attitudes can lead to poor patient care and, in turn, decreased the use of appropriate healthcare services. “

Neglect

Participants reported many experiences of neglect, abandonment, mistreatment, and rejection in the health care system. One participant’s words succinctly sum up many experiences, “they just minimalize everything and send me on my way”. The overall response from participants was that “drug addicts get put to the side…and they push you out early”. Across a variety of health care settings and individual life experiences, this theme of neglect was universal in all interviews. Whether perceived or real, the abandonment of PWLLE within health care results in feelings of exclusion and unworthiness.

> “I know when I’m being forgotten about, pushed to the side, because we have these people over here who are better, they’re not drug addicts”

> “No, I think they just didn’t care… I was upset and the doctor knew that and he just didn’t care, he didn’t care that I was waiting there for that long in pain”

Once labelled as a drug user, it can be difficult to access the appropriate care if practitioners become fixated on a patient’s substance use to the neglect of the primary presenting concern.

> “[the Doctor] wasn’t even treating me for what I was there for, he was more interested to see if I had narcotics or whatever in my system, that’s how I felt.”

PWLLE are individuals with valid and sometimes complex health concerns. Experiences of neglect took place across a spectrum of care, including general urgent and long-term care needs, and specifically relating to pain management. Numerous participants shared stories of having medications for chronic conditions drastically reduced or unexpectedly denied, often with serious consequences to the individual.

> “I never used any drugs or anything. But after [pain medication was cut off], I did. I had to. I had no choice. I had no quality of life. I was in bed 2 weeks out of every month, screaming, contorting twisting…I was in so much pain. It was either illegal drugs and the street, or staying on the farm and having no quality of life to enjoy the beach, the water, the chickens, the farmyard, the

> acreage... To know that I am now the old man on the street, and have been on the street solidly for 9, 10 years now, has affected a lot of people in my life... But with the street drugs, the fentanyl, I'm up 7 days a week, I'm walking and talking and active, whereas before I was not active at all."

Pain can serve as its own barrier to accessing care (Voon et al, 2021) and is a common concern for PWLLE. Chronic pain is more common among PWLLE than the general population (Voon, 2017), and for many is a significant pathway into illicit substance use. Restrictive guidelines imposed in reaction to a period of opioid overprescribing has contributed to the scope of the overdose crisis by forcing pharmaceutical pain patients to seek illicit substitutions (McKinney, 2020). While individual prescriber reluctance is understandable, the systemic abandonment of pain patients puts PWLLE at high risk of overdose.

Harm and avoidance

The unintended costs of disclosure, including child apprehension, changes in provider attitude, or a reduction in quality of care, lead PWLLE to avoid seeking health care services. Due to fear of harm or past experiences of harm, all participants reported avoiding seeking care, even when medically necessary.

> "Because of the treatment that I've had in the hospital and the way that the doctors talk to me or the nurses talk to me, that is one place I do not want to go ever."

Aware of the impacts of stigma on quality of care, some participants avoided care to avoid disclosing their substance use behaviour.

> "Ever since I became an iv user when I was 30, you just don't receive healthcare and you make sure to dodge the places where you do have to receive health care"

When disclosure risks unintended negative consequences to the individual or family, this prevents people from accessing necessary health care services, thus increasing the likelihood of harm to the individual.

> "When I had a substantial coke habit, I never had pressing physical needs addressed, or just general concerns about arrhythmias or how my heart was doing. I just would not disclose that to the doctor, so I never went, even at points when my nose was acutely bad and I should have received care"

In a study conducted in Vancouver focused on the topic of substance use disclosure, Pearce et al (2020) found that the majority of PWLLE do not disclose their substance use to health care providers, and that disclosure was associated with lower self-reported quality of care. The reasons for non-disclosure are wise and cautionary, but the consequence is a general lack of health care service.

> "I don't actively experience [stigma] because I do not disclose information that would cause me to be discriminated against. So it's more like there's a lack of care than there is discrimination, because I just do not access the services that I need."

This avoidance of care has broad implications in all health care settings, raising concerns about the cultural safety of existing substance use services within the health care system. Even within services designed to support PWLLE, inherent barriers continue to prevent engagement with appropriate care pathways.

> "There's no way for people to be able to receive any sort of help without losing who they are as a person. We have a friend, a worker in the construction industry who's losing jobs because [local OAT prescriber] won't prescribe him anything beyond a day"

One participant shared an experience where, upon requesting support from their doctor to access treatment for an alcohol use disorder, they were abruptly cut off a stable 10-year prescription of an anti-anxiety medication *and* denied support to access detox and treatment. When the cost of disclosure of substance use is so punitive and destabilizing, the consequences can be serious.

> "I was going for my wellness. God forbid I went out and got so fucked up and passed away because he cut me off"

Despite awareness of the risk of the toxic drug supply during an overdose epidemic, and institutional commitments to Trauma Informed Care, PWLLE continue to experience harm and trauma within the services designed to support them, which serves to deepen internalized stigma and reinforce barriers to care.

Trust and communication

Working relationships in health care, like elsewhere, depend upon mutual trust and respectful communication. As discussed previously, non-disclosure of substance use is highly common, and carries significant risks. As one participant highlighted "a doctor can't do his job properly, can't diagnose properly unless he

knows everything". Yet honesty is not always rewarded and sometimes has detrimental effects to the care one receives.

> "Yes, a lot of times I tell them about drug use and they will keep me pretty much away from a whole spectrum of drugs or basically they'll stop treating me or they'll stop dealing with me because I don't fit a certain pattern or I do fit a certain pattern."

> "But he just didn't believe a thing I said, and he kept pushing at me to find out what drugs I had done. And that really bothered me. I have been working my butt off to be clean, to have a good life. And I don't want anyone in my life that does that"

Provider attitudes towards PWLLE can be damaging to the therapeutic relationship and patient wellbeing, especially when patient expertise or honesty is refuted. According to the BC Ministry of Health (2015) "Patient-centered care puts patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families, and health care services providers." Though policy states that patients should be at the centre of the care team, multiple participants expressed feeling excluded from decisions or conversations about their care, and that this negatively impacts safety and trust.

> "I didn't like how they were like talking amongst each other and whispering to each other and stuff, it seemed weird... While I'm standing right there, or sitting right there, they were just talking amongst each other and about me, but very quietly. It kind of freaked me out a little bit."

There is an inherent and obvious power imbalance in any patient-provider relationship, which may be reinforced by provider attitudes and behaviour.

> "When he's proven wrong, he doesn't backtrack and say 'ok I made a mistake'. He knows everything. But he doesn't because he's never experienced what I'm going through. How can he tell me that I am not having this pain, or that I don't have another break in my back. He made me very frustrated, but I went along with everything he said, I remained calm the whole time because I didn't want any problems"

Whereas patient-centred care places a priority on patient inclusion and expertise, participants in this study shared concerns about providers failing to

believe in their experiences, providers failing to acknowledge or address power imbalances and their own inexperience, and providers failing to centre patient needs or treatment plans.

Inadequate pain treatment was an issue raised by numerous participants, with consistent reports that patient expertise was disregarded by professionals without lived experience of severe or chronic pain – to the detriment of the patient receiving care. Having one's experience believed and validated by one's care team is essential to building trust and rapport (Clarke, 2005). Though major issues of suspicion and distrust exist in the relationships between PWLLE and physicians, particularly around opiate prescriptions for pain or withdrawal (Merril, 2002), this barrier may cause substantial harm

> "Delay in treating pain or withdrawal, whether due to the fear of deception or inexperience, may lead to in-hospital illicit drug use or reduce patients' willingness to remain in the hospital.[43] It may also hinder the establishment of a therapeutic relationship that might more effectively address a patient's primary addiction problem."

Though practitioners are understandably bound by regulatory requirements that may limit the care they are able to provide, an emphasis on client expertise and power sharing has the potential to support more engaged and productive working relationships, and thus improve patient care for PWLLE.

Issues relating to trust and communication were also central to participant experiences of trauma within health care, such as being restrained or placed in isolation without any explanation when they awoke in a panicked state. For people living with complex and standard PTSD and underlying anxiety disorders, this is a deeply traumatizing communication failure.

> "All it would have taken was somebody calm, with a calm demeanor, to just say "look, this is what you came in like, this is why we're holding you the way we are". As soon as the mental health worker was there, it took her an hour to get me released"

Inclusive, clear, respectful communication can be an effective remedy to repair damaged working relationships and make health care more accessible to PWLLE. While most participants have considered filing a patient complaint, only two had done so to completion. The majority expressed that they felt it would be pointless.

> "It's like why bother when it's so endemic. I mean, are you going to file an administration complaint so that this burnt-out nurse gets a reprimand?"

Some didn't want to "make waves", seeing a complaint as potentially harmful to the quality of care they would receive in future. Another participant internalized the blame and stigma, assuming responsibility for their own mistreatment. Of those who had filed a complaint, both experienced unintended consequences, "in retaliation".

Solutions

When participants reflected upon experiences accessing care in which they felt respected and cared-for, participants shared moments with individual health care providers where they felt their concerns and needs were heard and they were seen as a whole person by perceptive, compassionate, and comprehensive practitioners. For many, there was an emphasis on being seen as an expert on their own experience, especially regarding pain. Overall, most participants spoke of a need for increased kindness and care within health care.

Invited to give suggestions on how to make health care safe and accessible to people who use drugs, participants offered small and large ideas to improve access. Most solutions presented focused on supports, systems, and relationships.

Supports

Almost all participants identified that they would use a trained peer advocate or support if one were available.

> "I think it should be offered immediately if they see someone in distress like that, not on the assumption that they use drugs or are substance users, but I think it should be offered to everyone. Everyone has trauma. And the advocacy should be there for that."

Front-line advocates or support workers must be made more accessible to PWLLE accessing health care in all settings, but especially so within the emergency department.

> "Someone on site immediately, not someone who needs to be called in. A peer on site, just like they have the candy-stripers or the volunteers. Hire a peer. Not dressed like hospital staff, just in their own. I think that would change the course of many visits. They'd be knowledgeable in certain things, all kinds of areas. Just so they could be there for you."

Though hospital social workers were seen as a safe and supportive role by some participants, the historical relationship that some PWLLE have with the social work profession triggers past trauma and does not satisfy needs for support.

> "as soon as you say that fucking word, bam, you're done. No, you're not on my side...Adoption foster removal. Your children. ... That word is a bad word...that word does not bring up safe space"

Culturally appropriate care is an important component for patient-centred care. If the available support models are found to be culturally unsafe for PWLLE, we must seek alternative approaches that respect the unique cultural needs of this population.

Systems

Findings from Urbanowski et al (2020) "highlight the importance placed on non-judgmental care that acknowledges peoples' past experiences of stigma in health care settings, as well as socioeconomic and structural disadvantages and how these can affect health care experiences and outcomes." While institutional commitments to reducing stigma or operating from a Trauma Informed Practice approach are important, some of the systemic solutions identified by participants focused on basic structural issues, such as provider burn-out, excessive workloads, inadequate pay, and poor working conditions. One participant highlighted the higher quality care received from student nurses, noting that "they weren't burnt out yet" – a statement which raises larger questions about the structure and staffing of the health care system.

Alongside trauma-informed approaches, a systemic commitment to cultural safety is necessary to reduce harm and enhance equitable access. According to First Nations Health Authority (2021) "Cultural safety is an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care." Whereas the framework developed by FNHA emphasizes safety for Indigenous patients, PWLLE also experience discrimination and entrenched power imbalances in health care. Participatory research additionally identifying a need for "culturally safe primary care" specific to PWLLE (Urbanowski et al, 2020), makes the following recommendations:

> (1) high level physician knowledge of substance use disorder as a health issue, and of current best practice treatment options; (2) respect, dignity, sensitivity, empathy, and understanding – not stigma or judgment; (3) equal access to compassionate care, regardless of

> substance use; (4) informed and collaborative decision making; (5) working relationships characterized by trust and rapport, consistency and continuity; (6) welcoming, comfortable, non-institutional, spacious, private and safe clinic environments; (7) an approach to care that recognizes social determinants of health and accommodates individual access needs; (8) patient supports to feel safe and to reduce anxiety, including practitioner and clinic competencies and characteristics, but also environmental supports such as an advocate, the environment outside the clinic and system supports such as adequate insurance coverage. Many of these requirements parallel the findings from this study and may serve as a framework on which to build a more equitable and accessible model of health care delivery.
>
> (Urbanowski et al, 2020)

In addition to considering the larger systemic factors influencing health care, some participants offered small creative solutions to restructure the delivery of care. One participant suggested modifications to the spatial configuration of waiting rooms to allow for improved privacy. Another participant recurrently mentioned the need for more low-barrier access points to care – such as outreach nursing, or simplified access to antibiotics and wound care. While there is a great need to reduce barriers within hospitals and other existing health care settings, the implementation of community-based health care models may enhance engagement for PWLLE by removing the care from the structures that have caused harm.

One participant suggested improvements to the intake process, to enhance support and choice for vulnerable individuals accessing emergency care.

> "'Is there someone I can call?' right there you're given an option, that means you're given a say, that means you're given a choice. If you choose to say no, that's fine, but now you can say yes... I think that would make a world of difference for people, especially when they're feeling helpless and lost, and don't have anyone."

These small and large system-level solutions seek to address the broad underlying issues, but without attention to supports and relationships, may not be adequate on their own.

Relationships

As identified in the above discussion of challenges, PWLLE enter the health care system with a history of harm stemming from poor working relationships. To improve accessibility, there must be a focus on the interpersonal. Attention to informed consent can have resoundingly positive impacts on repairing broken relationships in health care. Patients, especially those who have experienced trauma or abuse, appreciate communication, information, and consent.

> "He talked to me about everything he was going to do and that made a big difference. He told me what he was going to do as well, before he touched me. And that's a big one with women"

Though systemic solutions were identified as important, much of the challenges experienced by PWLLE in health care settings focus on the interpersonal and the solution to this is somewhat more complex than structural change.

> "I think that the missing piece is that our own prejudices and idealism is an ideological blockage to treating people like human beings, so there needs to be a fundamental shift in peoples thinking because people are treated with at-best dismissal or contempt or disgust, or a model of care that doesn't actually address what they need and that's what needs to shift so that your micro interactions on a day to day basis can be more based on love in reality."

PWLLE enter the health care system with complicated histories, often involving intergenerational oppression, systemic violence, and intersectional marginalization. For health care to be a site of *healing* (rather than harm), perhaps the missing ingredient to improving patient access, care, and equity is Radical Love. Drawing on the work of Freire (1972), hooks (2000), and others – a concept of Radical Love offers a vision of true solidarity and a commitment to anti-oppressive, liberating, and decolonizing ways of being and doing justice work.

CONCLUSION

Health care equity is a complex intersectional issue. While PWLLE experience significant barriers to access, diversity amongst substance users raises additional equity issues. The usual variables apply (such as income, education, housing, etc.) but other more specific intersections also impact the equity of access. Some PWLLE may have the privilege of "passing" or non-

disclosure, whereas others may not. Depending on one's drug of choice, access to appropriate treatment options varies extensively. For PWLLE in rural locations, such issues of vertical and horizontal equity remain significant (McKinney, 2020).

The findings from this small study confirm an abundance of research on the topic of barriers to health care for PWLLE and highlight a need for culturally safe health care for PWLLE. Institutional efforts to address stigma and trauma may improve accessibility and equity systemically. However, there is an additional need for improvements in interpersonal working relationships. To this end, there may be an additional need for grassroots, peer-driven advocacy for health equity for PWLLE.

In the coming months, there will be opportunities for PWLLE in the KBHSDA to review this study, discuss health equity in our region, and develop an action plan to address barriers. With an attention to praxis (Freire, 1972), this process must remain iterative and open to emergent needs faced by PWLLE.

Over 5 years of public health emergency response to the overdose crisis has failed to curb fatality rates. With abundant research pointing to unmet health needs, experiences of stigma and discrimination, and barriers faced by PWLLE, our collective energy must focus now on action. At a local health delivery level, we can advocate for better treatment of PWLLE, for enhanced service and treatment access, for peer-driven decision making. Though, beyond the details of how and where and what services are accessible to PWLLE, perhaps what is absent from discussions of health equity is an emphasis on healing and reducing the harms associated with illicit substance use.

The concept of Radical Love encourages another approach, one that strives for transformation and not simply inclusion into a deeply flawed system. Recognizing the diversity of this population, the data shows disproportionate rates of poverty, trauma, abuse, and mental health challenges among PWLLE (McKinney, 2020). Over 22,000 Canadians have lost their lives to illicit drug overdose since 2016 (Public Health Agency of Canada, June 2021). The voices PWLLE shared in this study identify persistent challenges to accessing care. For a population with complex unmet health needs experiencing significant isolation and stigma in an ongoing public health emergency, these barriers are unacceptable and pose significant risk to health and safety. The solutions, however, are multi-faceted and complex, and to some degree will require a reorientation of attitudes within health care – away from punishment and control, towards solidarity and love.

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NFTF INTERVIEWS PROJECT
Healthcare Equity Interviews
Section Two

Released in September 2021
Interviews conducted in April 2021

Written by Amanda Erickson MA RCC, ANKORS consultant.

My role with Nelson Fentanyl Task Force:

I work as a private practice Registered Clinical Counsellor (RCC) and a Community Action Team Facilitator in Nelson, Castlegar, and Grand Forks. I am supported by ANKORS West in Nelson to do community engagement and education in the region. We work in collaboration with local peers and with Interior Health.

I am grateful to live and work in the traditional unceded territory of the Sinixt, Syilx, and Ktunaxa Nations here in the West Kootenays. I grew up in Nelson and I am committed to the welfare of our populations here. I have worked for over 22 years in the field of social services. As a therapist I have focused on high-risk youth, parenting, and counselling issues such as depression, anxiety, and relationship issues.

My work with the Nelson Fentanyl Task Force (NFTF) and the local community action teams in Castlegar and Grand Forks has shown me the value of collaboration with peers and community stakeholders over the years. We discuss how to educate our local populations, how to reduce stigma, and how to take action to mitigate the effects of the overdose crisis in our region. The NFTF group was able to help support a local Overdose Prevention Site to start at ANKORS West in Nelson several years ago, when ANKORS won the provincial Innovation Grant. I have been honoured to work alongside skilled harm reduction workers and peers in the facilitation of the local community action groups in my region. Additionally, I write grants for ANKORS and consult with groups interested in our local work. I am providing an educational series for the region as well called NFTF CONVERSATIONS that started in 2020.

For the NFTF INTERVIEWS project, I am interviewing allies, service providers, harm reduction workers, healthcare workers, and Indigenous workers, who support PWLLE/people with lived and living experience of substance use/peers in our region. This is an effort to identify work that has been done with Nelson Fentanyl Task Force and associated members and to identify the needs for peers in our local region of the West Kootenays including: Nelson, Castlegar, Trail, and Grand Forks. Allies and healthcare workers who support peers in our region will speak to the ongoing needs for our rural and remote populations. We will explore the needs identified to stabilize our populations in the face of two intersecting emergency health crises: the overdose crisis and the COVID-19 pandemic. I have interviewed several workers with a narrative style interviewing process.

Interview Focus:

Interviews with allies and service providers for peers in the West Kootenays.
This is the Healthcare Equity portion of project. It is focused on "Creating a Space for Peers" and "Rural Inclusion in Community".

NFTF has examined what I call 'Rural Inclusion Practices' for peers in the local West Kootenay region over the last five years. This will be a brief synopsis of the work done in our region with ongoing monthly meetings and conversations between health and social service providers, emergency responders, government leaders, and peers to figure out how to best respond together to the overdose crisis in our communities over the last five years in the West Kootenays.

The way we have conversations in community engagement work is very important. NFTF meeting conversations reflect our respect for the experience of peers, as well as our respect for the experience of workers. Healthcare services on a community level will reflect the understanding around rural inclusion practices and equity development within organizations. Our ability as service providers to make space at the table for peers to speak and share stories is based on the personal development of inclusion practices and skill sets. This includes an understanding of oppression and marginalization for peers within healthcare and within our greater society. There must be an understanding of colonization and systemic discrimination against Indigenous peoples in Canada. We must develop an intersectional diversity lens that gives space for people and peers who are LGBTQ. We must develop our understanding of the experiences of Black, Indigenous, and people of colour who may face even more barriers in B.C. trying to access healthcare.

I have found that a deeper understanding around some of the roots of mental health and substance use concerns can help members to facilitate greater compassion for local peers and can reduce stigma. This development of understanding in our region has partly come from our monthly meetings across three communities for the last several years. Our conversations with service providers and peers and peer advocates have helped to develop more understanding of the needs of peers and the inequity within current healthcare and organizational systems. We have made some headway in our region in terms of our response, but there will be ongoing work to do.

As the facilitator for these community action teams, I have focused on 'Creating a Space for Peers' and what I call, 'Rural Inclusion Practices'. My background in social services for over 22 years has informed my practice as a facilitator for these meetings. I have aimed to collaborate with peers and peer advocates through ANKORS and the peer groups REDUN-Rural Empowered Drug Users Network and HOPE-Helping Our People Evolve. Over the years we have consulted together each month to learn together, to promote education and advocacy work, to solve problems, to identify gaps in the system, to grieve those we have lost to overdose, and to work to truly collaborate. Our communities still have a lot of developing to do in terms of being more educated about harm reduction, reducing stigma against peers, including marginalized peers, and reducing racism, but we have made a start.

All the work has been supported by ANKORS under the leadership of Cheryl Dowden, Executive Director. The standard has been set by ANKORS in local practices of equity for peers in our community. ANKORS works to partner and collaborate with other local organizations to improve conditions for peers here. Nelson is in a continued position to lead the way in terms of delivery of competent services for people here and we need to continue to work to advance this throughout the region.

NFTF was founded in 2016 as one of the first Community Action Teams in the province as a result of the declaration of the overdose crisis in BC. We have done three large community conferences and provide ongoing virtual education and workshops for our local community action team members. Membership is 300 people in our region with a wide range of stakeholder representatives.

NFTF was instrumental in ANKORS West beginning an onsite Overdose Prevention Site (OPS) several years ago in Nelson. NFTF members wrote letters to support the submission of the Innovation Grant and won the grant for ANKORS. There is now another central EOPS in Nelson, as an expansion of the ANKORS OPS service. ANKORS also provides onsite drug checking, an onsite OAT clinic, and all associated harm reduction/social services supports including referral to mental health, services, housing, food, treatment, and Indigenous services.

Interviewer for allies and service providers:
Amanda Erickson MA RCC Facilitator
Nelson Fentanyl Task Force
Castlegar Fentanyl Opioid Working Group
Grand Forks Community Action Team

Note this is a collaborative project:
Peer interviews and research for the NFTF INTERVIEWS Project submitted by **Amber Streukens, ANKORS.** This is Section One of the Project.

Funders: Community Action Initiative

Interview Questions for Allies and Service Providers:
Regarding Local Healthcare Equity for Peers/People with Lived and Living Experience of Substance Use/PWLLE.

For the Healthcare Equity portion:
The Interviewees are all members of a local community action team (CAT) and are service providers, allies to peers, support workers, and first responders local to the West Kootenay region in British Columbia. All workers are responding to the overdose crisis in BC.

Needs Identified by NFTF for the West Kootenays include:

Housing, more access to OAT (opioid agonist therapy), youth detox, youth treatment, access to safer supply, adult treatment centre, access to doctors and nurse practitioners, pharmacy delivery, long term trauma therapy, ongoing anti-stigma work, to expand access to low barrier services like overdose prevention sites (OPS) and EOPS, need for

ongoing education on harm reduction practices, need for more youth services, need for more Indigenous social services, outreach peer teams, outreach healthcare teams.

Interview Questions:

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Please introduce yourself and tell me a bit about the work you do in the community, in public healthcare or in frontline healthcare? Name, title, role, time in role, clients, service area.

Can you share a bit about how you have worked within your organization or in your role to support the healthcare equity, social equity, or harm reduction efforts, and the well-being and safety of local peers?

What is your background in working in response to the overdose crisis in BC, or in the harm reduction field or healthcare field? Why do you stay involved in the kind of work? What motivates you?

What priority needs are identified by peers you work with in terms of: local healthcare, mental healthcare, low barrier harm reduction care, housing, or other essential services?

Over the last 5 years, what changes have you seem in terms of health care equity for peers? Have there been any changes in community stigma and views towards for peers over the last five years?

What do you feel is needed going forward to support peers locally? What would advance wellness and stabilization for local peers and further healthcare equity for peers?

As a member of NFTF, what changes have you seen in our local community over the last five years? In terms of: harm reduction efforts, access to education and public awareness, advocacy work, healthcare equity for local peers, stigma against marginalized groups, stigma against peers, access to education about substances, harm reduction, housing, and the overdose crisis?

As a worker in our region what are the healthcare gaps that still need attention in terms of: peer access to local healthcare, mental healthcare, substance use, harm reduction supports, or safe supply?

Do you feel that there is healthcare equity for peers in our region? Are peer needs being met? How about for marginalized peers, including: LGBT peers, youth, Indigenous peers?

Is there healthcare equity for people here in terms of: community access to education about substances and addiction, mental wellness/mental healthcare services, substance use care services here?

What are some of your ideas about what can help to mitigate the overdose crisis here in BC, especially as we go through these dual crises with the COVID-19 pandemic?

What are peers/clients/patients asking for in terms of most needed local supports and services?

Do you have a comment on substance use/trauma/mental wellness and how to best support people to stabilize? What is helping to mitigate risk of overdose for our populations? What is working?

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021

"The more connectivity a person has, the more opportunity a person has and it's those moments I see success…When we have regular contact, regular relationships, regular opportunities for engagement and growth, that's when I see people start to stretch to take a little bit more wellness.

You have got to stabilize that core safety of staying alive then build out from there."

Amber Streukens, Peer Navigator, Street College, ANKORS

Photo credit: Tyler Harper

Nelson Fentanyl Task Force

NFTF INTERVIEWS

Amber Streukens
Street College Program Coordinator
Peer Navigator
ANKORS

By Amanda Erickson
September 2021

Amanda Erickson: My first question is if you could just introduce yourself and tell me a bit about the work you do in the community. Your name, title, your role, the time in your role, your service area and the clients that you serve?

Amber Streukens: My name's Amber Streukens and I currently work with ANKORS as the Street College program coordinator. I work in peer navigation as well, so that involves a lot of supporting people to access health care. I've been with ANKORS for over two years now. Mostly I work in Nelson, but I do work with folks throughout the West Kootenay Boundary region, I travel to Trail pretty frequently and periodically through Castlegar and Grand Forks liaising remotely with people in all of our little pockets throughout the Kootenays. I predominately work with folks who have substance concerns. The majority of the folks I work with are in an active use pattern. Some housed, some unhoused. I work with a few folks into recovery and I do a bit of support to their support team. I liaise with service providers and families, and I just try to keep an open door, to help link people in where they need to be.

Amanda Erickson: Could you share a bit about how you've worked within your organization or in your role to support the health care equity, social equity, harm reduction efforts, and the wellbeing and safety of local peers?

Amber Streukens: Well, I would say that a big portion of the role involves supporting people accessing healthcare. And that's across a pretty wide continuum. Whether it's healthcare that everyone needs like to go to, like the dentist or to get antibiotics from the walk-in. All the way through to the highly specific health care needs of people who use drugs, accessing detox, treatment, OAT, safer supply, hepatitis C treatment. In the smaller landscape of equity, I feel that the navigational role is really important. My observation is that people who use drugs just have a real hard time accessing all the healthcare, whether it's the dentist or the walk-in or detox treatment.

There are so many barriers that prevent people from getting care or getting through their care. But then in terms of bigger picture equity questions I have some opportunities to do some higher-level advocacy and to talk with service providers, the hospital, Interior Health, the OERC about what people who use drugs need in order to properly access healthcare. Then, in terms of social equity, we do a bit of support around accessing housing or work on those social determinants as well.

Amanda Erickson: And then the other part is around the wellbeing and safety of local peers. Do you want to talk more specifically about safety or violence?

Amber Streukens: Yeah, absolutely. We do a lot of harm reduction support which I definitely consider a wellness safety factor for people. Additionally, we do some crisis support. People will often call in that moment and just need to be held and maybe given some direction or referral or help to problem solve. I've made safety plans with lots of the folks we work with. I appreciate the flexibility in the role because it allows me to respond adaptively to what people need. A lot of that is just a supportive psychosocial checkpoint role which I think definitely enhances our wellness and safety. Yesterday, REDUN's outreach went and spent a whole ton of money just on stuff to keep people physically well and safe in homelessness. Both in the psychological social departments and the material we try to fill in the gaps.

Amanda Erickson: What is your background in working in response to the overdose crisis or in the harm reduction field? Why do you stay involved in this kind of work? What motivates you?

Amber Streukens: My background working in harm reduction and overdose response is limited to my time with ANKORS professionally. But what keeps me in it is substantially more personal then professional. I come to this role with lived experience of substance use and homelessness and poverty and grief and all the stuff that we all bring having our complex lives. The people keep me in the work, to be honest. And I'm a change driven person. I am dissatisfied with broken policy. I feel strongly compelled to continue to push forward for better big picture solutions. But the "what keeps me in it" is definitely the people, I care about my community. I've always loved people who use drugs and expect I always will. I want them all to be safe and well.

Amanda Erickson: It's great to hear you talk about your background and I just really honor that. What priority needs are identified by peers you work with here in terms of local health care, mental health care, low barrier, harm reduction, care, housing, or other essential services?

Amber Streukens: Housing is a serious issue. We have a serious lack of housing across the spectrum in the Kootenays. We have a lack of market housing. We have a lack of supportive housing. We have a lack of harm reduction housing, low barrier housing, family housing, low-income housing, like the entire ballpark of housing is a serious issue.

More specific to healthcare access, we have a serious deficit of primary care practitioners. I can think of literally a handful of folks I work with who have a doctor or nurse practitioner who is theirs. In terms of more specific healthcare access for people who use drugs, it's variable throughout the Kootenays our access to OAT and safer supply. There are certain communities, Nelson and Trail specifically, where we have incredible prescribers, like really compassionate, adaptable, responsive, creative people who are highly committed to making this work for folks. I feel very grateful to work alongside these professionals and to see their flexibility and their openness, all of that super inspiring. But there are communities in the Kootenays where people are still fighting to get methadone. And that **absolutely** makes no sense to me. We have very few days where you have contact and there's never enough boots on the ground to be honest.

And then detox and treatment is a similar equity nightmare. If you're on the Downtown Eastside and you want to go to detox, your pathway there is a lot faster than your pathway here. We have one space in which to detox in the Kootenays. I hear mixed reviews of people's experiences there. And the continuity of care; it's abysmal. You can go to detox, but then good luck getting into a treatment bed. And there's no such treatment bed within your community.

And then when you get out of treatment, Kootenay Boundary Supported Recovery provides an amazing opportunity for people in Nelson and people throughout the region who use it. But it's just much more challenging in our rural spaces than it is in urban spaces to get a referral together. I don't think people understand the multiple hoops and gaps and barriers and closed doors that are involved in trying to get to treatment.

Amanda Erickson: And that's just the system. That's not even just all the stuff...

Amber Streukens: That's not even the personal stuff, the readiness, and the motivation and the individual barriers of like, "Who's gonna watch my kids and will I lose my housing?" And that's just the best-case scenario. That's real hard.

Amanda Erickson: That's assuming we can advocate for ourselves.

Amber Streukens: Yeah, exactly. For the best-case scenario, when folks are super eager and ready and have a ton of support and are extremely capable of advocating and dealing with bureaucratic stuff, it's still really hard.

Amanda Erickson: Yeah. So, there's more work to be done. The next question is what do you feel is needed to support peers locally? What would advance wellness and stabilization for local peers?

Amber Streukens: I feel universally, in all of these issues, a helpful piece would be more supportive outreach teams. And I mean **collaborative outreach teams**, plausibly a nurse and a peer. And this is the thing that I've been raising all over the place. Whatever door of healthcare people are accessing, the barriers to even get to that door are so humongous. Then when things go slightly sideways, they derail very quickly. That's

institutional stigma, that's individual stigma, that's personal trauma. There's a lot of variables behind why the situation so precarious.

Maybe a “team of teams”, a team of peer-driven, peer-supported, peer-involved outreach teams could fill in a lot of those gaps, right? When somebody shows up at hospital and they have nobody to sit with and they have to wait four hours to get seen. And everybody in there is treating them like they're disposable. Having somebody who's recognizable and relatable and trustworthy and trained and skilled and knowledgeable, somebody that you can feel safe and understood by makes all the difference. It's the same at all the doors, when you leave the hospital. I have been involved in this conversation lately about Suboxone starts at emerge <emergency> and again, peer support follow-up, you know?

Peers can provide reminders to make it to your appointment next week. Peers support check-in’s, “Did you remember to pick up on the pharmacy at the pharmacy on Saturday? Cause I know they're closed on Sunday.” Peers are willing to do those flexible things, like text someone Saturday and say, “Go to the pharmacy.” Because they're not bound within the sticky criteria of certain other professions. We need more flexible roles to fill in the gaps because the issues that people who use drugs face don't happen between 9:30 and 4:30 Monday to Thursday. It's not the way our lives work. And if we're going to be really harm reduction oriented, we need to actually be meeting people where they're at.

Amanda Erickson: Yeah. I so agree with that. There are those five new integrated teams, so that's kind of a start for Interior Health.

Amber Streukens: It's a really useful model.

Amanda Erickson: And so that would be good here in the West Kootenays. One little team for a start would be running all around the region!

Amber Streukens: Yeah, totally. Like it takes a little time to build a rapport, but once you've got rapport that little team would be spread so thin! Like it would be such a useful service for people.

Amanda Erickson: Yeah. I guess the plan was ultimately for local nurses to get some safer supply training.

Amber Streukens: Yeah, I haven't seen that play out yet. I'm getting so many mixed messages about who's going to be Suboxone prescribing or OAT prescribing, or safer supply prescribing. We have not dialed in the scope of what we could be accomplishing with safer supply regionally or provincially. And I think our numbers estimate like 3% of those qualified are actually receiving safer supply prescriptions. It's just not hitting the mark. Which is really no local prescriber's fault, but more a guideline issue.

Amanda Erickson: I believe that in terms of the prescriptions, the nurse prescribers are allowed to write for Suboxone initially?

Amber Streukens: Yeah, that is what I remember as well, because I remember feeling **highly** disappointed by it. I just feel like we have this tool belt. It doesn't have all the right tools in it, but it suddenly has a lot more tools than it did a year ago. And yet we're still using the hammer and only the hammer! It feels like a huge miss to me to not be trying to stretch to a greater scope of prescribing when we have the opportunity.

Amanda Erickson: I guess we're lucky we have these few prescribers here creating access to some of the listed safer supply options. There's no perfect answer, although we do know some things that are working. We have some models like from Europe and even from the Downtown Eastside where we know something.

Amber Streukens: Well, this is absolutely it! There are good precedents out there and there are bigger instructions from peers on what it is that people need to get us out of this spot. But this is having regulatory and public image issues. My personal belief is we absolutely cannot wait to have public support for safe supply before we implement it properly. But politically, I can see how that's delaying things.

Amanda Erickson: It's tricky, isn't it? Because someone's public image is going to look pretty good when people start stabilizing and doing good.

Amber Streukens: Nobody wants to take risks with their career and their reputation. And simultaneously, most of the success that I have seen in this work has been because people took risks, because people stepped outside of the boundaries of their professional designate, because people took illegal unsanctioned actions to keep people alive. You know, those were the gains.

Amanda Erickson: I agree. That's the only way to push change forward. When you see the studies where they're stabilizing people, like in Britain and Sweden, and you have the added benefit for society of the huge reduction of crime. I imagine there's a huge pushback within the doctor community around safe supply?

Amber Streukens: That's just it. There's a huge pushback in the medical community. And the reality is that we don't have the same sort of data that we normally like to work with. We don't have decades of peer reviewed studies saying that giving people Ritalin will help them get off crystal meth, like that just doesn't exist. But we're also in a moment of unprecedented healthcare crisis. In the same way that we issued like carcinogenic and geno type studies on COVID vaccines, because we needed to have them **now**, we need to look past that research requirement around safer supply, because we need people to stay alive **now**. Give people the drugs and monitor how it goes. It's better than the nothing that we were doing before.

Amanda Erickson: How are needs being met in your perspective for more marginalized peers; women, LGBT peers, youth, Indigenous peers?

Amber Streukens: This question is heartbreaking. Like if I'm being really honest, the most marginalized of the marginalized are **struggling** and we're in a time of incredible isolation. You know what some of our most marginalized community members, I believe, need is very directed individualized peer outreach support. They need a person who they can rely upon to keep in contact and make sure that their needs are getting met and they're getting the services they require in safe and dignified ways. I believe that works best on a one-on-one outreach case management or peer support model. Our services are so few and far between and the needs of each individual are so unique to that individual, that there really is no way to, with a broad-brush, fix everybody's problems.

Amanda Erickson: Yeah. Do you have a comment on substance use, trauma, mental wellness, and how to best support people to stabilize? What's helping to mitigate risk of overdose for our populations?

Amber Streukens: The thing that I see to be most effective at reducing the risk of overdose, it's connectivity. Like people die using alone. You know, people typically don't die when they're using around other people. We take really good care of each other when we can. The isolation's a big thing.

But the more connectivity a person has, the more opportunity they have, and it's those moments when I see success. When I see the most wellness for people is when we have regular contacts, regular relationships, regular opportunities for engagement and growth. That's when I see people start to stretch to take a little bit more wellness. You have got to stabilize that core safety of staying alive and then build out from there. Sometimes "building out from there" that spirals into off-ramps, into treatment, into employment. People are really inspiring. I see people making great changes in their lives all the time, but it always starts with being really well held and supported in dignified, respectful ways.

Amanda Erickson: I just love how you describe this work and just so admire your passion and dedication to making change.

Amber Streukens: This work is great. We all give each other a lot in this work. I'm really grateful for the heart expanding opportunity that it brings my life.

This interview has been shortened and condensed.

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021

"We did this through the Nelson Fentanyl Task Force, where we changed our policy about attending overdoses.

We decided we weren't going to do that anymore because we felt that people might not phone to get help, and people might die because of that. And then months after that the provincial policy came out for that."

Paul Burkart

Former Nelson Police Chief
One of the founders of NFTF

Nelson Fentanyl Task Force

NFTF INTERVIEWS

Paul Burkart
former Chief of Police
Nelson, British Columbia.

September 2021
By Amanda Erickson

Amanda Erickson: Basically, the Nelson Fentanyl Task Force INTERVIEWS project is around how we're doing inclusion of peers in our communities and to try to reflect the work. Where are we going? How far have we come here in terms of rural inclusion and community for peers and what's that looking like within different organizations? Where have things changed and where do things kind of need to change? So, my first question is just to please introduce yourself and tell me a bit about the work you do in the community or have done? That'd be your name, your title, your role, your time in your role, and who you serve and your service area?

Paul Burkart: My name is Paul Burkart. I am the retired Chief Constable of the Nelson Police Department. Our department is a municipal department, and we serve the city of Nelson. I was the Chief Constable here for five years. I was Deputy Chief for three years, and then I worked as a Sergeant, Detective, and Constable for the 13 years prior to that and filled every type of role in the police department. When I first arrived here, within a month, I was a beat officer downtown. I got to know many of the business owners, as well as our street culture. I was quite heavily involved in various community projects and the Nelson Fentanyl Task Force was one of those that I initiated with a couple of the community partners, ANKORS, as well as Nelson Mental Health and Substance Use. So that was a big project, but I've been on a number of other committees as well, looking at everything from homelessness to poverty to substance use.

Amanda Erickson: Thank you. My next question is can you share a bit about how you've worked within your organization or in your role? To support the healthcare

equity, social equity, or harm reduction efforts, and the wellbeing and safety of local peers.

Paul Burkart: I think one of the biggest things I learned in policing in general over the last 26 years, it was pretty obvious to me as I grew from a rookie officer up until I became a senior guy, that in policing, although we had a role in dealing with these issues, we weren't going to solve them on our own. And neither were any other group that we were dealing with, no matter how good hearted and well-intentioned other groups such as ANKORS, and Nelson Cares are they're not going to do it on their own either.

Even when I was a Sergeant I was quite heavily involved with community, but as I worked myself into my Deputy position, and then finally as Chief, I made it a focus of mine to make sure that the police were heavily involved in these different work groups, in the committees. That involved the creation of the Nelson Fentanyl Task Force. I was the chair of the Vulnerable Populations Committee. And the Street Culture Collaborative started with a Chief Constable Diversity Advisory Committee meeting, and then Rona Parks just sort of took that and ran with it and did a fabulous job.

But it was certainly clear to all of us, and we see this most recently with the Vulnerable Populations Group, is that we cannot be trying to solve this on our own where there's so many different facets and different tasks that need to be completed. And none of us specialized in all of them. So, we have Nelson Cares who is good at housing. And we have Nelson Community Services, and they have the outreach workers. And then we have the Salvation Army. And then policing, where we have a lot of contact with people on the streets. And it's important that we're involved with that to make sure that our officers understand what's needed out there.

And giving an example of that is something we've changed, and we did this through the Nelson Fentanyl Task Force, is where we changed our policy about attending overdoses, where we decided we weren't going to do that anymore because we felt that people might not phone to get help and people might die because of that. And then, you know, months after that the provincial policy came out for that. We were thinking those kinds of things before it even became mandated for our department.

So, we looked at this and a big part of that collaborative approach is involving peers of course. It's a little bit difficult as a police department because a lot of our contacts are let's say a little bit more negative than contacts ANKORS would have. ANKORS is trying to support somebody, while we are getting a call about somebody and we're going down and dealing with them. But I think you saw a different approach by a lot of our officers, someone like Shawn Zukowski for example, our beat officer, where I think we've seen a change in the way we've done it when it's not all about enforcement anymore. It's more about people getting people help. And so, we're not just picking people up and taking them up to the hospital. When we know we're going to a call, we'll phone Mental Health first and maybe get them involved before we get them up to the hospital. And we might

not even take them, we might get Mental Health to do that and try to help with that thing that 'mental health is a criminal thing'. It's not, right? It's a mental health thing.

And that's the same approach we've taken with the drugs as well. I know one of the advocates from ANKORS and I, in one of the meetings we were talking about the decriminalization of hard drugs. And that was something that the National Police Chief put forward in supporting, because we feel that although we will continue to try to enforce the importation and the trafficking of hard drugs, we don't feel that simple possession is a criminal matter. It's more of a community health matter. So, we support decriminalization and in one of the meetings we had with the Nelson Fentanyl Task Force, one of the drug user support staff said in that meeting that we have already started to see less charges.

Something we've done locally is say, "You know, there's no use us charging these people that are using drugs. It just doesn't make sense. Right?" If they have got their pockets full of meth and they're breaking into places, you might charge them with the meth possession, but we're not out there purposely going after the individual users and we made that clear. And we made that clear that we supported the overdose prevention site. It was, “We're supporting people to be going to that site, so we could save some lives, and get it off the street as well.”

We're trying to guess sometimes what people need. And that shouldn't be our job. Our job should be asking those people what they need and getting the input from the peers and from groups like REDUN and different groups that know what they need, right? It was something as a police leader I learned too, because I wouldn't necessarily have thought of that ten or fifteen years ago, I would have been one at the front telling people what they needed and that wasn't right. That wasn't as effective as we find now where we do bring people in. And we saw that at various meetings. Certainly, with the Nelson Fentanyl Task Force there were a few people I didn't know that well and now I see them on the street and it's easy for me to walk up or for them to walk up to me and we have a conversation. So, it's that connection, right?

Especially in a small city, you might get lost in a larger center, but in a small city like this, where we're running into people every day it's important, we have those relationships from the various groups. Not only with myself and the peers, but myself and the Salvation, Army, myself and Nelson Cares, myself and Nelson Community Services, myself and ANKORS. You know I got a lovely card here the other day from a variety of people from ANKORS and it was really heartwarming for me to see what they said and about the relationship we've had since I've been chief. That to me sort of reinforces that I was doing some of the right things. Like I said, a big part of that is that peer support. And we were going down and building platforms at the homeless camp that we helped set up. That was a big part of the municipal mandate and I was a forefront on that, but it was important that we got peer input into that as well. Anytime we can get the input of the people we're serving; it just makes it better.

Amanda Erickson: You've touched on so much really important stuff and just thinking back it's amazing to hear all that you've done and that forging of relationships, right? That's huge. In many ways it goes against the grain of the hierarchical structure within your organization to create space at the table. Even some of those first meetings we had down at the police department, for me it's a little intimidating to go up into the police department, and then appreciating so much seeing the RCMP showing up for those meetings as well. You really set a standard with your actions and a kind of new way of doing things, because it does move away from those hierarchical structures.

Paul Burkart: Yeah. Which it has to, right? We also have to have a presence as police. We want to show up on a scene. But it can't be just about the uniform and the marked cars and everything. It also has to be you got to step out of the car and the person you're about to deal with says, “Hey, Paul!”, you know, because they know you at that level as well.

I taught DARE here for 11 years, in the schools. That was the first 11 years I worked here. So, some of those kids would be 30 years old. I used to show up at a house party and I'd have to shut it down and they'd open the door, and you know, you're going to get in a little confrontation. They'd go, “Oh, Detective Burkart!” And I hadn't been a Detective for, you know, six years. But they knew me and you know what? It had just worked so much better because we had that contact. So, yeah, it's hugely important for us to be more than just a uniform in a marked car showing up, we have to be part of the community and it's so imperative here. That's important for us to do our job, but it's super important for the peers. That they can trust the person that they're dealing with is huge.

Amanda Erickson: For sure. It's so interesting how things are happening here in Nelson, in just kind of a slightly different way. If you don't help to move things along towards more social change, social equity type stuff, then things kind of remain the same, kind of more of the old school. What do you think locally would help to advance wellness and stabilization for local peers and further health care equity for peers in our area? What's your sense about that?

Paul Burkart: Well, I think you certainly have to have advocates in all the different agencies for that. Like in Interior Health, for example, there should be somebody up at the hospital that is designated to do that, or that's part of their position. So, they can advocate on behalf <of peers>. That might mean reaching out to Mental Health directly. I know Mental Health, I think, has a worker up there quite often now.

I also think we are so active here and we have such great supports, and we have such great wrap-around services available. The way we sort of tried to get that Car 87 here is we said, “You got it in the bigger centers. Why don't we try it here and do that?” So, let's get a clean drug supply in here and really hammer it here and we'd see if that really can make a difference. I think we're doing quite well in that area, but let's put a ton of

resources in here and just see if it really makes a difference. And if they work here, let's move them out to other different parts of the province. When we supported the homeless camp last year, they'd be staying there and then we could get them on these programs to support them and get them a clean drug supply. We're still killing 1700 people a year, right? It's supposed to be better and we're not better, we're worse.

Amanda Erickson: It always comes down to how much a particular mental health worker or social worker is advocating and pushing for their client. And when we're in civil service of course, we have that pride of being a civil servant and trying to do the best for our clients. But that can be difficult for workers to maintain year in year out when they're faced with so many difficult situations coming up. Of course, in the role of law enforcement that can be very challenging at times I'm sure for workers. We work to hopefully remain well in our work and to advocate, but like you say it's down to the individual workers, how much they're going to push for equity for their people.

Paul Burkart: Yeah, absolutely. And so, they come with different views and different backgrounds and if you dealt with that same person for the 13th time this week, your willingness to support, rather than just throw them in jail, becomes a lot less. It's like, "I gave you a break the first 12 times and you're going to go to jail now", and maybe that's what needs to be done at that point too. But hopefully that's not after the first time or the second time.

I remember one circumstance where with one of the regulars <peers>, we were finally able to work with outreach and we got them in treatment. And so, he was supposed to catch the bus on Saturday morning, and he made the great effort of sleeping outside the mall in the wooded area right there to make sure he didn't miss his bus. And he missed his bus. The guys went down there and I'm in the office working a Saturday morning and they said, "Oh, he just missed his bus, but the bus is going to stop in Castlegar." And I said, "Get him over here. I'm going to jump in a police car and I'm going to drive him to Castlegar." And that's what we ended up doing. He phoned and left a message here for me about three weeks ago. And that was probably five or six years ago that I took him out there to do that. And here he is. We don't give up on people very easily.

Amanda Erickson: For sure, which is awesome. What's your sense about any changes in stigma against peers against marginalized groups in our local region over the last five years, do you think there's been much of a change in terms of the public discourse or public perception?

Paul Burkart: I think it's a little bit better, but we as police get a lot of those complaints. Let's say we took away needles, is that going to stop people from doing drugs? No, it's not. Are we going to give them a safe supply of needles? Is that going to make them do more drugs? Well, no. That's as silly, as saying that giving a 20-year-old a condom is going to make them more sexually active, right? It's not, it's going to protect them.

Amanda Erickson: It's an abstinence mentality.

Paul Burkart: I think in general that was certainly one of the pushes of the Nelson Fentanyl Task Force, was to try to reduce that stigma. I see my officers deciding on their own really, there are conversations all the time, but they're the ones out there not arresting people for the drugs, right? They're the ones that are making that judgment call. I can't tell them not to arrest somebody for simple possession. That's not my job as chief. My job is to encourage them, give them reasons why they wouldn't do that. But they're going to decide that on their own, I'm not going to give an order, not to charge anybody like that. A lot of that decision making was by our officers. They saw the importance of that, and they saw it as not being a criminal matter as much.

I see an improvement in the stigma, I believe so. Even when we set up that homeless camp, the complaints we had at the beginning were many. And when we worked with some of those people, I met with some of the shop owners that were really concerned about that. And it just seemed to get better, and they became more tolerant because they saw the value in it as well. And even my own officers, some of them were wondering why the police were so heavily involved in setting up this homeless camp. And later in the project were going, “That maybe had some value.” And that was good because we all need to be educated. That's not what we get trained to do in a police academy, right?

Amanda Erickson: For sure. It's that long-range thinking though, isn't it? Like, what's going to make things sustainable for our social stabilization down the road. And just like with access to clean supply. I mean, there have been studies now in Britain, right? Like where they're giving out the clean heroin and they're just seeing criminality decrease like crazy. It's simple, people are not breaking and entering and stealing to keep up their habit. Then we start to stabilize people and then guess what, a little less work for the police officers. And so that helps stabilize all around, right?

Paul Burkart: No, absolutely. It’s less work for the police officers, but also less work for mental health, and less work for everybody, when you're doing that. Because once people are stabilized a little bit, it just changes everything.

Amanda Erickson: Do you have a general comment from your perspective on substance use, trauma, mental wellness and how to best support people to stabilize? What's helping to mitigate risk of overdose for our populations. What's working?

Paul Burkart: Look at 1700 <deaths>! Nothing’s working really! Everything we've done has helped. I would say that number would be five times larger if we didn't do the stuff we’re doing. If we didn't have an overdose prevention site, if we didn't have camps, we didn't have the motel across the way, if we didn’t have supporting people, if we didn’t have Stepping Stones, if we didn’t have ANKORS doing what they do. If we didn’t have the Nelson Fentanyl Task Force changing policies for first responders, and doing

education, and doing the harm reduction work that we do. And then expanding it from the Nelson Fentanyl Task Force to the Castlegar group and the Grand Forks group.

It's not one group doing one thing. It's not the police arresting everybody with drugs in their pocket or arresting all the traffickers. It's more everybody doing a little bit of their part. And helping the other groups do their part. And there is our notification system for bad drugs. It's so hard to measure, how do you measure prevention?

I think we can do better treatment. Treatment on demand, that would be massive, right? You only have a small window when somebody decides that they don't want to do drugs anymore. And if you miss that window sometimes, they're back in the lifestyle for a year or two more until they decide again. Or maybe they're dead by the time that comes around again. And is it enough? No, it's not. I think we can still improve. We can do better clean drugs. We can do better support. A bit more housing and more of a regional approach. It's not only about a community approach, but it's about a regional approach.

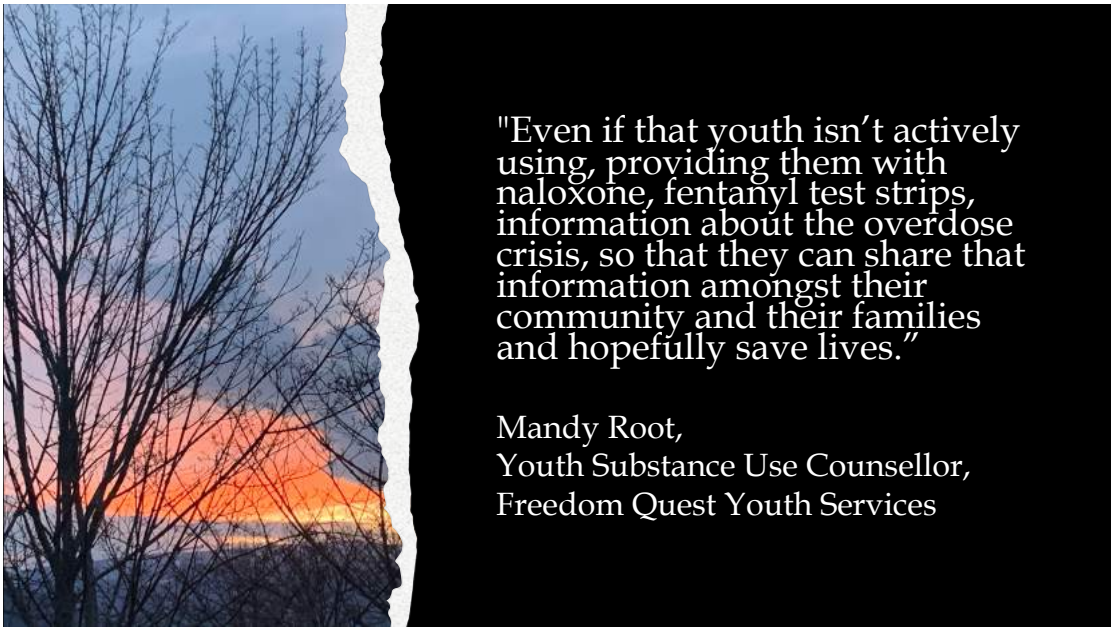
Amanda Erickson: We do kind of have a sense now of what works. We've had the setback now with the pandemic and the escalation of mental health stuff, substance use stuff. And, of course, more violence, and domestic violence, all these things that have cropped up since the pandemic. But, realistically on the world scale, what British Columbia is doing to address that our overdose crisis is very progressive. And part of that has been this ability to collaborate across agencies in such a harmonious way. I'm just so grateful to have worked alongside you and all those years.

Paul Burkart: It's been great. Thanks for your work on the Task Force. It was great when you stepped in and you've done a great job, expanding it and making this more accessible to more communities and everything else.

This interview has been shortened and condensed.

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021



Nelson Fentanyl Task Force

NFTF INTERVIEWS

Mandy Root
Substance Use Outreach Youth Counsellor
Regional Prevention Coordinator
Freedom Quest Youth Services

By Amanda Erickson
September 2021

Amanda Erickson: Could you please introduce yourself and tell me a bit about the work you do in the community in public health care, frontline health care? Your name, title, role, your time in your role, your clients, and your service area?

Mandy Root: My name is Mandy Root. I work for Freedom Quest Youth Services Society. My official titles are Nelson and Area Youth Substance Use Outreach Counsellor and I am also the Regional Prevention Coordinator. My job is to support youth ages 12 to 19 with whatever they need support with. But our little area of expertise is substance use, harm reduction and mental health. Our services are voluntary and we often go outside of our mandate because we're a rural service and there are not all the services that we need in our communities. I've been doing this job since 2016. I'm a social worker. Freedom Quest services all of the West Kootenays. Salmo is one of the Eastern boundaries, Kaslo up to the North. We go down to Trail, Castlegar, Nelson, all of the Slocan Valley, Grand Forks, out to Rock Creek.

Amanda Erickson: Can you share a bit about how you've worked to support the health care equity, social equity, or harm reduction efforts and the wellbeing and safety of local youth peers?

Mandy Root: So, with Freedom Quest our little special flavor is that we meet youth where they're at. I can meet youth anywhere that they would like me to meet them, whether it's in their home, their schools, outside in their communities. Wherever it works. That's very different than most youth service agencies because agencies like C.Y.M.H. <Child and Youth Mental Health> and others you have to go to their office. So that's what makes us a bit special. We are client-centered, we're non-judgmental, and we support youth to follow whatever path they identify as their priorities. The kids lead in what the priorities are. A lot of the time I'm trying very hard to hit some messages home, but if a kid doesn't identify maybe their problematic substance use as their main

priority, they'd rather figure out how to live independently or get a job or pass school, then that's what we work on.

Amanda Erickson: And what about in terms of the harm reduction access for youth through Freedom Quest?

Mandy Root: I was trained by Toward the Heart to "Train the Trainers" and to train the public. And I provide Naloxone training in schools and in my office and in community for youth. I also have fentanyl test strips and I put out many as I can. And then I've taken lots of kids to ANKORS to have their drugs tested because teenagers often are a little bit hesitant and nervous to access adult services, just because adults are scary when you're a kid. I go with kids to the hospital. I go with kids to hormone replacement therapy appointments. If they want, we provide transport where we can to things like the Waneta Plaza health clinic, or to public health here in town. But that's one thing I've noticed lately is neither of the nurse practitioners are accepting new patients at this point. So that's a real gap. There's a lot of youth that want to talk about their gender identity with a healthcare professional and there is just not that ability at this point, because they're so overworked. Even their waitlists are full at this point.

Amanda Erickson: Is there provision of care by telehealth? I guess only if you go through CYMH and then you get assigned a psychiatrist ?

Mandy Root: Yeah, exactly. And it has to be pretty dire straits to get to the level to get in. Do you want to say the question one more time? Just so that then I can make sure I covered all of it.

Amanda Erickson: Yeah, for sure. Can you share a bit about how you've worked to support the health care equity, social equity, or harm reduction efforts and wellbeing and safety of local peers?

Mandy Root: I take part in many different community groups, such as the Nelson Fentanyl Task Force, the Nelson Youth Action Network, then also the Nelson Youth Action Oversight Committee, NCOH <Nelson Committee on Homelessness>, pretty much anything that we can be a part of to help push youth focused agendas when it comes to harm reduction. And reducing some of the other things that contribute to substance misuse, such as homelessness, poverty, violence, all of that kind of stuff. I take part in their climate action groups to help with that. And I also run a couple of the LGBTQI+ groups in town from a prevention lens, as marginalized and stigmatized populations have higher risk of substance misuse. And when it's not pandemic time, I run harm reduction groups at the schools on Fridays. They're lunch groups to talk about safety and substance use and other harm reduction priorities. Drug alerts that come through NFTF are shared widely when I'm allowed to do those groups. And then I go into classrooms all over the region doing presentations for high school aged students. I'm really trying to hammer the message home that if you do in pills or powders, you better get them tested.

Amanda Erickson: What is your background in working in response to the overdose crisis in BC? Why do you stay involved in this kind of work? What motivates you?

Mandy Root: My background is in social work. I am motivated by decolonization and looking at ways to improve everybody's lives to be better. Substance misuse is not only a problem for youth. It's a problem for people who take care of youth. And if I can help equip youth with knowledge and skills to manage themselves, even if they aren't using substances, even if they're just substance use affected, I'm hopefully breaking some patterns and providing information that may be even adults don't have.

Lots of times when teenagers are talking to me about substance use, they say things like, “I'm not using pills or powders, but my older sister does, or my dad does, or my uncle does”. And it's really great then to empower that youth to have some skills and tools to possibly save a loved one's life as well. So, even if that youth isn't actively using, providing them with Naloxone, fentanyl test strips, information about the overdose crisis, so that they can share that information amongst their community and their families and hopefully save lives.

The overdose crisis has touched my life personally in many different ways. I've lost friends, I've lost family members. And so, this is an issue that is very near and dear to my heart. I don't believe that because you're a substance user that should be a death sentence. And I think that decriminalization is an incredibly powerful and important consideration that our government and our country and our communities need to consider.

Amanda Erickson: Yeah. I'm just sorry to hear about people you've lost and thanks for sharing that. What priority needs are identified by the peers that you work with in terms of local health care, mental health care, low barrier, harm reduction, care, housing, or other essential services?

Mandy Root: What teens tell me is that they would like to see is local detox, local residential treatment, more opportunities for different types of treatments, more opportunities for different types of mental health treatments for PTSD and trauma response, like EMDR, somatic therapy. Just like more of a variety, because especially for teenagers with their cognitive development, talk therapy sometimes isn't the most effective avenue for them to pursue things. We're really lucky to have the Art Therapy Institute in our town, so that teens in Nelson have access to art therapy, whereas kids in other towns don’t. That's a real perk of being in Nelson. Access to a psychiatric support, like an adolescent psychiatric unit <APU> is needed. The APU in Kelowna is better than having it in Vancouver, but it would be great if we could have one in Trail. Access to psychiatrists, through Child and Youth Mental Health being more readily available and having more than one psychiatrist to choose from. Here it's historically been a male, and female survivors of sexual violence often have put off receiving support based on discomfort with gender.

Nelson is not an affordable community to live in. And youth, who are typically the most restricted in wage earnings, are really feeling the brunt of this. Cicada place, which we're so lucky to have in our town, it's fantastic, but the waitlist for Cicada place is extensive, lengthy and long. I typically take at least a couple of youth a month to do intakes at Cicada place. There just isn't enough space at Cicada place though. It's incredibly wonderful but has pretty strict rules about substance use. And that can be a real barrier for some teens. I would love to see second stage housing and more bridging services for folks from youth services into adult services.

Amanda Erickson: And so, bridging to get into adult services is still a tricky part of things?

Mandy Root: Especially in our small town, because often those teenagers' parents are accessing the same services. It's quite uncomfortable to consider seeing the same counselor as your parent or your caregiver. The amount of affordable private counseling in Nelson on the list is pretty short as well.

Amanda Erickson: My next question is over the last five years, what changes have you seen in terms of health care equity for peers? Have there been any changes in community stigma and views towards peers over the last five years?

Mandy Root: I feel like a lot of the times when we have events and information sessions and community awareness initiatives we preach to the choir. We have a lot of peers. We have a lot of frontline workers. We have a lot of folks who are already aware. I would say that I haven't seen a lot of stigma change in our community. In fact, in a lot of ways I've seen it increase as the wage gap widens and we see more impoverished folks that are street entrenched and more visible. The stigma towards anybody who's kind of struggling I see it getting worse. And with this pandemic that only magnifies that.

How do we get those people out there with the bootstrap beliefs and the like, "Get a job, just stop using, just quit" beliefs? I wish we could reach those folks more. When I have the presentations in classes, I present some of our really like cool resources that talk about substance use in a more gentle and accepting way. I have parents call and email complaining about glorification of substance use when that is in **no way** what we're saying.

Amanda Erickson: We have got to keep pushing education forward as a community.

Mandy Root: Yeah. I was presenting in a grade nine class recently and one of the students was just so upset at the fact that if you go to take your drugs to get tested at ANKORS that they're not going to confiscate your drugs and vilify and punish you for using. Just like trying to get that one young person to wrap their mind around how that isn't going to help anybody. I don't know if I was successful or not, but that's where I'm having maybe the most effect, because they're seeing another perspective maybe that they're not ever going to get at home.

Amanda Erickson: Yeah, for sure. And it's difficult for people to understand that harm reduction ideology is not about promoting substance use. The frontline work like drug checking and the OPS <Overdose Prevention Site> is more about saving people's lives in the short term, rather than anything else, at least that's my understanding.

Mandy Root: Yeah. It's a reactive service, based on a system that isn't preventative. We have to be reactive when our systems aren't preventative.

Amanda Erickson: What would advance wellness and stabilization and further healthcare equity for youth peers locally?

Mandy Root: I would say my top three priorities would be local detox, local residential treatment, local APU, and more access to like those higher-level mental health supports, such as psychiatrists.

Amanda Erickson: Are peer needs being met for marginalized peers, including LGBT peers, youth, or Indigenous peers?

Mandy Root: I would say that we do a pretty good job, but we need things like way more parent support. We need way more parenting and family counseling. We don't live in Kelowna or in Vancouver, we just don't have the population to support, I guess, some of those more expensive things like detox and APU. It's like months waiting lists for the APU, right? They are so restricted for capacity.

Amanda Erickson: I'm so sorry to hear that.

Mandy Root: And the poverty, especially since the pandemic, with how many parents are service industry employees, employees at the lodges, employees at restaurants. It's like the poverty I'm seeing right now is out of control and kids are hungry.

Amanda Erickson: Yeah. I'm just so sorry to hear that. What is helping to mitigate risk of overdose for our populations? What is working?

Mandy Root: Okay. I would say harm reduction services are working. I would say de-stigmatization is working. I would say that the youth give me more hope than ever because they are open and aware. More than the adult population. I see kids caring about climate. I see kids caring about poverty and basic needs being met in a way that seems a lot more genuine and heartfelt than adults.

Amanda Erickson: They're still maintaining their heart center against all odds.

Mandy Root: They haven't been calloused yet by life. They still have so much hope. And it feeds me as a worker too their hope.

Amanda Erickson: As adults we can get caught in our ruts and ways of being and it's very difficult to change sometimes, but the children and youth have this capacity for change and for hopefulness. I mean the youth have evolved, hey?

Mandy Root: Yeah, big time, especially with LGBTQI+ plus stuff. Like seeing CIS/HET kids protecting and supporting the LGBTQ+ kids and respecting gender pronouns and respecting gender identity and sexualities. It's so much healthier than our generation.

Amanda Erickson: Do you have any final comments on need for services or services for Indigenous youth?

Mandy Root: I think we do a pretty good job in the Kootenays. COINS <Circle of Indigenous Nations> is really awesome. The Metis association is really awesome. I think that visibility in the Kootenays is a hard thing. On CBC today I heard there's going to be some sort of announcement from the government on their verdict on whether the Sinixt people exist or not. That dismissal of the existence of Indigenous communities locally. That population of Indigenous folks that you see in other communities in British Columbia is not super visible here. I think that's probably a barrier in itself. I love that I see frontline service providers doing land acknowledgements and having land acknowledgements in their email signatures and decolonization being talked about within agencies. I know it's talked about quite frequently in our agency. And COINS having access to Elders is super helpful.

Amanda Erickson: Well, it's super nice talk to you. Thanks.

Mandy Root: Thanks, you too.

This interview has been shortened and condensed.

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021

"..the approach of trying to support, empower, care for, love people is a much more effective approach than trying to incarcerate, police, push out. And so, I think that recognition of that, is really starting to roll at least as far as I can see."

Ryall Giuliano

Nelson Street Outreach, Nelson Community Services

Nelson Fentanyl Task Force

NFTF INTERVIEWS

Ryall Giuliano
Street Outreach
Support Recovery
Community Liaison

By Amanda Erickson
September 2021

Amanda Erickson: We're looking at rural peer inclusion practices in the West Kootenay region. Please introduce yourself and tell me a bit about the work you do in community, in public health care, or in frontline health care, your name, title, role, your time in the role, your clients, and your service area?

Ryall Giuliano: My name is Ryall Giuliano and I work in a program called Nelson Street Outreach which is part of Nelson Community Services. I also work in the Kootenay Boundary Support Recovery Program, which is a residential addictions treatment program. That's with ANKORS. And then I also work for Selkirk College as a Community Liaison. The first two positions are both based in Nelson. I do outreach and support recovery in Nelson. And the community liaison position, it involves research in Nelson, Castlegar, and Trail. It's sort of like an applied research project. We had Selkirk nursing students doing the actual interviews with people who use services.

Amanda Erickson: And so, you serve clients within Nelson in your outreach role?

Ryall Giuliano: Yes, Nelson for outreach and that's been about five years. And then the Support Recovery program is actually the whole West Kootenays. So people come from different places to access that service. But then with Selkirk, I've been going to Trail and Castlegar a bit more and getting to know people in those communities more which is really cool.

Amanda Erickson: Right? That's the applied research?

Ryall Giuliano: Yeah. And there's some good things happening in Castlegar and Trail in the past year and coming now. So that's kind of exciting to see. And it's nice to be able to bring knowledge over to other communities based on what we've learned here from different things that we've done in Nelson.

Amanda Erickson: Yeah, fantastic. Do you want to share a little bit more about that? Like what you're bringing through to the region these days?

Ryall Giuliano: Sure. I mean with Selkirk College, the project is called "Rural Homelessness and COVID-19". So, the idea was to figure out how Selkirk College could support vulnerable populations, specifically people experiencing homelessness, addiction, and poverty. We ramped up the street nursing program. We also participated in setting up a vaccination clinic for peers at the warming center in Nelson. That was a good success, and we hosted an information session prior to that.

I've also just been trying to get to Castlegar and Trail whenever I can just to get a better pulse. I went out with Deb McIntosh a couple of weeks ago in Castlegar and did some outreach in the evening. Been over at the Flamingo Motel there, which has become this really cool thing where it's kind of a shelter and sort of longer-term housing for a few people.

And then in Trail it's been exciting seeing REDUN <Rural Empowered Drug Users Network> grow over there. So going there and interacting with peers over there and hearing what's going on for them. They're becoming more active and trying to get some programs going in Trail that will support people through the summer.

Amanda Erickson: I'm just glad things are progressing over there and that things are reaching out more towards Trail community.

Ryall Giuliano: A big part of it is human resources, like having people in that community who are motivated to make things happen and kind of take charge in that way.

One thing I've seen happen in Nelson, is that people are really starting to realize that a harm reduction approach, or an approach that tries to take care of people rather than oppress them, is actually a lot easier and nicer and less expensive in the long run. Even just seeing that change in approaches in Nelson city council, how the city wants to participate, and how law enforcement wants to participate. That communication has really opened up possibilities that maybe weren't possible before, because things were so siloed. And in a funny way, COVID was almost a catalyst because it kind of forced us to work together in a way that we never had before and figure out novel solutions for things. There was also a lot of new funding opportunities to make some of these things that we've been talking about forever actually come to fruition.

Amanda Erickson: So great. I mean, it's kind of like that hidden gem within COVID-19. There are good things coming out of it, like it's moving along some social change.

Ryall Giuliano: It is totally. And there's an irony in the whole thing for me, which is, I think when COVID hit, it was like, “What do the people who are most vulnerable in our community need? What do the people who are experiencing homelessness or addiction need?” We're in a pandemic and they need exactly what they needed before! They need housing and food and healthcare and advocacy and support and to be treated like a human.

And so there's all this new money because we're in a pandemic, but really what it has enabled us to do is to address those other systemic issues that have been going on for decades and decades and well beyond my time. It just seems like there's so much motivation. And it feels like we broken through the ice on some things. Like we've had that sanctioned encampment at the Civic Centre for instance. And the idea of that ever happening in downtown Nelson prior to the pandemic was there was no way that would ever be a possibility. Because everything was shut down and the city was like, “Okay we want to do something.” And then the police got involved and the city got involved and all these different organizations got involved and then it happened. And now we've seen that it is a very realistic, helpful thing that we can do that doesn't, you know, make the city implode.

Amanda Erickson: Yeah, for sure. It breaks the mold, doesn't it? And sets a precedent. I'm just always so impressed by the collaboration in our town and the generosity of different workers to figure out ways to make things happen.

Ryall Giuliano: I’ve got to say that I really think a huge part of it is the incredible leadership that we have in so many different places. I'm just thinking about Cheryl Dowden and Jenny Robinson and Rona <Parks> when she was still at Nelson community services. Everyone's been so open to taking on projects and trying new things and giving workers the freedom and flexibility in order to make those things happen in a really hard time. And there's like a passion and motivation around it. And incredible things come out of that when it's not an environment of stifled and exhausted workers where everyone's stuck just in their role trying to do the bare minimum and just waiting to go home.

Amanda Erickson: I'm happy to hear that you're staying inspired in your role. It seems like it creates a kind of resiliency.

Ryall Giuliano: That's just so important to remain resilient in this kind of work. It's like instead of punching timecards or having really strict guidelines about roles or who's allowed to do what. Instead by having more of a culture and community that's based on, "I trust you to do an incredible job. I trust you to do your best. I trust you to make this happen, and we're all here to support you." It just really changes things.

Amanda Erickson: Awesome. That's like that unconditional support. In terms of local health care, mental health care, low barrier harm reduction care, housing, or

other essential services, what priority needs are identified by the peers that you work with?

Ryall Giuliano: Housing is really the thing here. It's really about having a variety of housing options for people, because one model won't fit everyone. I really think that we need some 24-hour supported living type housing for people with complex needs where there's mental health staff. It needs to be low barrier, where someone's not going to lose their housing for smoking weed in the stairwell or something, right? Something like the North Shore Inn that is more like apartments that have 24-hour staff. It's just made it so much easier for mental health workers to find people and connect with them, and for nurses to go to these places and connect with people. Like if someone needs wound care or has an infection they want checked out or isn't feeling great, it's just so much easier than someone in a tent out in the woods.

People maybe they don't have a cell phone, but they have a phone in their room if they need help or they need to call a doctor or they're waiting for a call. And the nurses are highly appreciated. And we do have incredible healthcare workers here. Dr. James Kitch, for instance, when we had the sanctioned encampment going on, I would just call him on his phone and he would come within 15 minutes often and check on someone and follow up and he could do referrals right there out in the open.

It was really ideal because that's a major barrier for people to take that time out of their day to go to a walk-in clinic. It's really unrealistic for people who have to hustle all day to get there, to get their basic needs met. If you take six hours away from someone who depends on panhandling or a meeting for a grocery card, when you're living that close to the line you can't miss those things. And mobility is also an issue.

Amanda Erickson: They've created those five new Integrated Outreach Teams in Interior Health region, but none here yet, but I believe those are like a social worker, a peer, and a nurse. And I think the nurses would have prescribing powers. It would be good if something like that could happen in the Kootenays.

Ryall Giuliano: What I see a lot of the time are people going into the OAT <Opioid Agonist Therapy> clinic to talk to their doctor about their medication, and oftentimes people accessing that clinic have a lot of other complex medical needs, but because of the way the system is right now there isn't room. There isn't time. There aren’t resources for that OAT doctor to be that person's family doctor. I mean for liver problems or hepatitis or something. It would just make so much sense to me if a person who was on OAT could access their OAT doctor as their family physician.

Amanda Erickson: Down in Surrey, there's kind of a side-by-side emergency center, where they just have everyone there that's needed. So it is not a regular emergency department. But it's kind of a center, like the Foundry, where everyone who's needed is waiting for people.

Ryall Giuliano: Right. If someone's going to make it to a doctor and they're doing their medication, it feels like it would make sense if people were able to access all their healthcare while they're doing that.

Amanda Erickson: Yeah. That would be amazing. Like you say, there's often lots of concurrent health issues going on, those need to be addressed.

So, in the last five years what are some of the main changes that you've seen in terms of harm reduction efforts, access to education and public awareness, advocacy, work, healthcare equity for local peers, stigma against marginalized groups, stigma against peers, access to education?

Ryall Giuliano: There are definitely some positive changes that I have witnessed and been a part of. In the past five years, the Street Outreach program was established, and the Support Recovery program was established. So, both of those programs are first of their kind in the community. I think the issues have become more present in mainstream media and thinking. Like even the word “stigma” is a word that most people would have a general idea of what that means, and people know about the overdose crisis. It's impacted so many people. People know the word “Naloxone” and way more people know how to use Naloxone.

I have heard from many peers that they are still experiencing concerningly high levels of stigma in our community. When there were people camping at the Government Road camp this summer, there were a couple of instances of violence, of people throwing like bear bangers at the tents and screaming at the people camping there. And so, the problem isn't solved, I definitely don't mean to insinuate that, but I do think that there's been a lot of progressive change.

The other thing I have seen in the last year is the willingness of the police to engage with social services and be involved. I've had a lot of conversations with police officers about harm reduction and it feels like we are getting on the same page a little bit more. With the city too, people just sort of understanding that the approach of trying to support, empower, care for, love people is a much more effective approach than trying to incarcerate, police, push out. And so I think that recognition of that is really starting to roll at least as far as I can see, and that's really cool. There's still lots of work to be done.

Amanda Erickson: I just love what you said about that. That people are starting to understand how to support people with less of a punitive approach.

Ryall Giuliano: For a long time, addiction, even in social services, was very much viewed as a character flaw or, “There's something wrong with that person.” And now we're really starting to understand things like intergenerational trauma or like the corruption of big pharma. And now that things have happened like massive lawsuits over Oxycontin. And there is more understanding especially regarding First Nations populations, and things like intergenerational trauma. When we know people had a very difficult childhood, and their parents may have had a very difficult childhood, and we are

showing empathy for that and finding ways to support positive growth, rather than just punishing people and locking them up or chasing them around because they aren't sure how to fit or exist (or the way that they want to exist doesn't suit everyone else). That approach of empathy and understanding that's what I root everything I do at a base level.

Amanda Erickson: Awesome. Well, people are lucky to have you in this community, right? Like for real, I really admire the work that you're doing on the ground. And so what do you think about the decriminalization push that's happening now?

Ryall Giuliano: I mean, anything that reduces the criminalization of drugs, I could probably safely say that I would be in support of because that's what a lot of this is rooted in. I think the way that people view people who use drugs and certain drugs, right? The bias towards certain drugs is based on arbitrary legal assignments that were made in order to oppress certain groups of people, like mainly newer immigrant populations, because they were perceived as a threat at some point.

It's like, "The government said alcohol is legal. I'm drinking a case of beer every night, I'm not doing anything wrong, there's nothing weird about me." But that person who's injecting heroin because they got a workplace injury 10 years ago on a construction site, there's something wrong with them. It's absurd really when you break it down.

Amanda Erickson: **I have some vague understanding of how that went down, like in the United States in urban Black communities and the demonization of people around crack cocaine.**

Ryall Giuliano: It started with opium in Canada. So, opium gangs that were predominantly people who had immigrated from different places in Asia and they were demonized, as like drawing white women in and getting them high and using them for whatever they wanted. And so they just sort of decided to target that.

Amanda Erickson: From my perspective, we're all going through this pandemic and it's so brutal, but we also have this time of transformational social change. And I am hopeful because I am seeing the way the money's flowing now. And the slow paradigm shift towards more awareness.

Ryall Giuliano: It's so critical that we acknowledge that the stigma around drug use is one of those "chicken and the egg" situations. We attribute this negative perception to a particular substance in order to oppress a group of people. An oppressed group of people reacts to that oppression and engages in behaviors that according to most informal social agreements are deemed inappropriate, like theft or lying in order to get needs met, because they're being treated as "other".

You're creating a situation where it's reinforcing that belief in the public eye, because they see this person who uses crack cocaine and that person is also a thief. Then those two things get melded together and become this permanent association when really that

person isn't a thief because of crack cocaine or crystal meth or whatever it is, they're a thief, because they're not getting their needs met, because they're being stigmatized and oppressed. And so that's really the essential piece that we need to break down. Because we're reinforcing this arbitrary assignment of judgment on a substance by continuing to stigmatize and leaving people in these situations where they're so disadvantaged that they have no other option to get what they need to live.

And there's a lot of people who are living rough and using substances who do things that aren't out of love and care. I don't want to kind of idealize what their role in this. It's very real. That's more about recognizing the underlying factors.

If you can think about what you're doing and say like, "Okay, why I doing this? Because I'm trying to do good and show love." You know, putting spikes on benches so people can't sleep. That is probably not a good way to direct a social movement. Right? Because what if it's you trying to sleep on that bench?

Amanda Erickson: Yeah, for sure. Totally. I wish you a good day. Thank you so much.

Ryall Giuliano: No problem.

This interview has been shortened and condensed.

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021

Nelson Fentanyl Task Force

NFTF INTERVIEWS

Alex Sherstobitoff
Rise Up Community Engagement Project Coordinator
ANKORS

By Amanda Erickson
September 2021

This interview was submitted as written answers to the questions.

Amanda Erickson: Please introduce yourself and tell me a bit about the work you do in the community, in public healthcare or in frontline healthcare? Name, title, role, time in role, clients, service area?

Alex Sherstobitoff: My name is Alex Sherstobitoff. I am the Rise Up Community Engagement Project Coordinator. My catchment area is the West Kootenay/Boundary area. The goal of my project is to: "Reduce barriers to accessing Health Care and Social Services for people who use drugs, people living with Hepatitis C and/or HIV/AIDS and people at risk of overdose and/or acquiring blood borne infections."

Amanda Erickson: Can you share a bit about how you have worked within your organization or in your role to support the healthcare equity, social equity, or harm reduction efforts, and the well-being and safety of local peers?

Alex Sherstobitoff: I work with the help of four peer leaders and the ANKORS Street College Coordinator to help facilitate the Grand Forks HOPE peer group and REDUN peer groups in Nelson and Trail. I travel twice a month to Trail and twice a month to Grand Forks. I also work with Nelson Fentanyl Task Force, Castlegar Fentanyl Opioid Working Group, Grand Forks Community Action Team (CAT), and the CRISM Centre for Research of Substance Misuse.

The peer groups consist of street entrenched people and community allies, and the CAT groups and CRISM groups consist of an array of Community stakeholders, front line workers, policy workers, and peers from Nelson & Trail REDUN (Rural Empowered Drug Users Network) & HOPE (Helping Our People Evolve) representing their communities. We meet about once a month to discuss and plan around mostly community issues revolving around the Opioid crisis and how we can mitigate any harms associated with the Opioid crisis.

Amanda Erickson: What is your background in working in response to the overdose crisis in BC, or in the harm reduction field or healthcare field? Why do you stay involved in the kind of work? What motivates you?

Alex Sherstobitoff: I've lived in the region most of my life and worked in this field for over the past 20 years. I have experiential expertise from drug use. I helped set up and initiate Harm Reduction initiatives in the West Kootenay/Boundary area communities since 1999. These include providing Harm Reduction supplies referrals and support to people who use drugs and to stakeholders willing to provide Harm Reduction supplies to folks who may need them. I've also provided presentations to community stakeholders, provincial and national entities. I've also worked with community and initiated Harm Reduction conferences regionally and provincially and involved people who use drugs in all initiatives I've participated in. People who use drugs provided their expertise on how they see the gaps in services, what works and what doesn't work.

I stay involved in this work because I feel I have a lot to offer communities whether it's Municipal, Regional, Provincial, National or International work. I am finding in the last couple years the hard part is keeping Hope alive. Many of the people I've worked with over the years have passed on due to poisoned drug supply. I see many good intentioned people coming into this work (Mental Health & Outreach workers, Shelter workers) but they have little to no expertise out in this field. There is a great deal of anger and confusion, whether it's folks that use services, or the folks that provide services, especially the community at large. I am seeing street folks accosted and abused physically and mentally daily by community that don't want street entrenched people to be in their community.

There was a time that Hope was blatantly alive and well especially when we felt there was a chance to have a safer supply of pharmaceutical Opioids for people who have become addicted to Fentanyl and/or Crystal Meth or that homes and shelters will be built to house our street entrenched folks. Today we see physicians not following COVID Prescribing safer supply options and the physicians who originally did begin to prescribe safer supply are cutting back on Safer Supply prescriptions and trying to bridge people onto Opioid Agonist Treatment.

I understand there are far more options for people who use drugs in Urban areas verses Rural areas. Most Rural areas have no option for safer supply initiatives or best practices identified by entities such as BCCSU (BC Centre for Substance Use) or BCCDC (BC Centre for Disease Control). People are dying at an accelerated rate and death rates continue to rise from poisoned drug supply. The other part is that benzo's <benzodiazepines> are in the poisoned drug supply to make it even more addictive and more toxic.

As of last week, Trail REDUN has asked the PIVOT Legal Society to help REDUN attend to matters that police seem to be overlooking. There are community people in Trail physically assaulting street people, throwing rocks and shooting bear bangers at the homeless encampment and accosting them. Police have come to some of the assaults but leave the interrogation to only a stern talking to on at least two occasions. This has left a dangerous precedent to the Trail community that it is ok to assault homeless people without any repercussions from legal system.

Amanda Erickson: What priority needs are identified by peers you work with in terms of: local healthcare, mental healthcare, low barrier harm reduction care, housing, or other essential services?

Alex Sherstobitoff:
*Low Barrier Housing is a number one need in each community of the West Kootenay/Boundary Region.
*Low Barrier access to a Safer Supply.
*Low Barrier access to health care and a non-judgemental Physician or Nurse Practitioner.
*Low Barrier O.A.T.
*OPS/Inhalation tent with expanded hours into the late evening.

Amanda Erickson: Over the last 5 years, what changes have you seem in terms of health care equity for peers? Have there been any changes in community stigma and views towards for peers over the last five years?

Alex Sherstobitoff: I have seen easier access to safer supply in Nelson and Trail but no access to safer supply in Castlegar and none in Grand Forks area. I understand that several folks are being bridged to OAT, rather than staying on safer supply options.
I feel we have a long way to go regarding health equity for peers. People who use drugs have trouble keeping appointments. This is a problem that can aggravate Health Care service providers and results in more difficulty for people who use drugs to access services. It would be helpful to have a place where street entrenched can gather with social distancing and have access to services. In many cases people who live rough are dispersed in the spring/summer/fall over a wide area in their communities making it difficult for service providers to reach the most vulnerable.

Amanda Erickson: What do you feel is needed going forward to support peers locally? What would advance wellness and stabilization for local peers and further healthcare equity for peers?

Alex Sherstobitoff: We need to get Municipal governments on side with Harm Reduction and housing initiatives for our most vulnerable populations. It would be helpful to have a place where folks can gather where there is access to Safer supply, community health care, social services, an OPS, an OD prevention inhalation tent, access to housing and food, access to detox, treatment and help when needed.

Amanda Erickson: As a member of NFTF, what changes have you seen in our local community over the last five years? In terms of: harm reduction efforts, access to education and public awareness, advocacy work, healthcare equity for local peers, stigma against marginalized groups, stigma against peers, access to education about substances, harm reduction, housing, and the overdose crisis?

Alex Sherstobitoff:
*Nelson has initiated an Overdose Prevention Site at ANKORS. Although there are barriers regarding times we are open, limiting access to working hours, and closed on Fridays and weekends.

*Access to drug checking has been initiated in Nelson a lifesaving tool to help combat overdose crisis.
*I've witnessed better access to Safer Supply in Nelson in comparison to other rural communities.
*Better access to OAT.
*Better access to shelter over the winter months but feel this is more in line with COVID protocols
*Stigma is alive and well but at this point Nelson seems to be quieter than other WKB <West Kootenay Boundary> cities like Trail or Grand Forks.

Amanda Erickson: As a worker in our region what are the healthcare gaps that still need attention in terms of: peer access to local healthcare, mental healthcare, substance use, harm reduction supports, or safe supply?

Alex Sherstobitoff: Many of our street folks fear stigma and are not always willing to access health care in particular if it has anything to do with negative side effects to using street drugs. Mental Health in an emergency has quick access, but for setting up an appointment may take more time than people are willing to wait. Sometimes an advocate can change the timeline of accessing Mental Health Services. There is option to access Safer Supply in Nelson, but providers are more apt to bridging one to OAT.

Amanda Erickson: Do you feel that there is healthcare equity for peers in our region? Are peer needs being met? How about for marginalized peers, including: LGBT peers, youth, Indigenous peers?

Alex Sherstobitoff: No. What some people have access to in one community does not happen in another. For example: COVID prescribing, OPS/Inhalation tent, housing, detox and treatment access to a health clinic for NP/Physician.

Amanda Erickson: Is there healthcare equity for people here in terms of: community access to education about substances and addiction, mental wellness/mental healthcare services, substance use care services here?

Alex Sherstobitoff: I do believe we have access to education to the general public but could ramp it up a bit to maybe open up opportunity to a quarterly zoom event for community folks to listen, watch presentations, engage about current issues and initiatives about OD crisis.

Amanda Erickson: What are some of your ideas about what can help to mitigate the overdose crisis here in BC, especially as we go through these dual crises with the COVID-19 pandemic? What are peers/clients/patients asking for in terms of most needed local supports and services?

Alex Sherstobitoff: Low barrier housing for street folks, Safer supply, Low barrier OAT, OPS & Safer Inhalation, Street Health Clinic daily availability and access to NP/Physician, low barrier detox and in-house treatment facility. The highest need is generally low barrier housing with harm reduction supports built in.

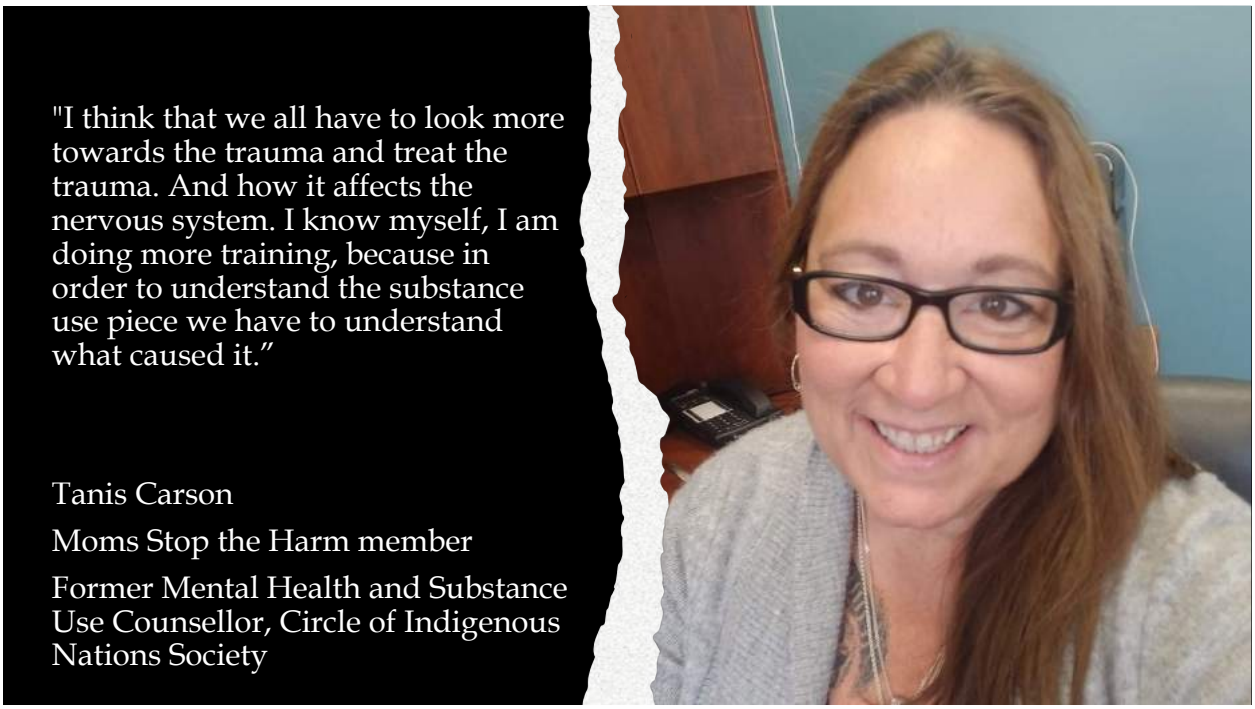
Amanda Erickson: Do you have a comment on substance use/trauma/mental wellness and how to best support people to stabilize? What is helping to mitigate risk of overdose for our populations? What is working?

We need low barrier housing and daily access to Safer Supply and supports such as OPS & Safer Inhalation and access to advocates, health navigators and peers involved in aspects of such programming. I see the peer encampments tend to watch over each other, although these days it's not just fear of OD, it's also fear from being accosted by community people because of stigma due to drug use and being homeless.

This interview has been shortened and condensed.

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021



Nelson Fentanyl Task Force

NFTF INTERVIEWS

Tanis Carson
Moms Stop the Harm Member
Grand Forks Community Action Team Member
Former Mental Health and Substance Use Counsellor
Circle of Indigenous Nations Society

By Amanda Erickson
September 2021

Since this interview was recorded, Tanis no longer works with COINS, but contributes in other ways in the Grand Forks community.

Amanda Erickson: The focus of this interview is healthcare equity for peers in our region. Please introduce yourself, tell me a bit about the work you do in the community in frontline social services. Your name, title, role, your time in the role, your clients, and your service area?

Tanis Carson: My name's Tanis Carson and I work in the Mental Health and Substance Use Program with Circle of Indigenous Nation Society (COINS). I work with clients with substance use disorders mainly and marginalized people. A large portion of my clientele are unhoused. As well, your everyday middle-class, working mother, father, and teenagers. I've been with COINS almost eight years, but I've been doing this kind of work for close to 20 years.

Amanda Erickson: Can you share a bit about how you've worked within your organization or in your role to support the health care equity, social equity, or harm reduction efforts, and the wellbeing and safety of local peers?

Tanis Carson: I've always worked towards that, but I think that it really started with joining the Community Action Team and joining the Social Services Advisory Group and working on strategies to support local unhoused populations. Like finding a place here to have a shelter, doing a harm reduction work with the ANKORS team, and being part of the HOPE <Helping our People Evolve> group.

I also work up at the shelter and I'll fill in shifts on the floor, if need be, but mostly I go up there and cook on the weekends. I was also on their harm reduction team a couple of days a week, and in the camps, doing harm reduction. I also do harm reduction out of my office here. Right now, I'm standing in for the Aboriginal Health Coordinator Position. I help connect Indigenous people to trauma informed healthcare practitioners and I do harm reduction in that role as well.

Amanda Erickson: What is your background in working in response to the overdose crisis in BC or in the harm reduction field or healthcare field? Why do you stay involved in this kind of work and what motivates you?

Tanis Carson: My training is in substance use and throughout the last several years, I have watched this crisis grow. I've always been dedicated to my work, and I lost a son to an opioid accidental overdose. I became part of Moms Stop the Harm. I joined the CAT group and I just really want to be part of positive change and see a safer supply and decriminalization. Just seeing that people are safe is my motivation. I also lost a stepson to drug harms, and he suffered from mental health struggles, as well as addiction. This especially drives me to work towards change in the health system. To see better services, more services.

Amanda Erickson: That leads right into my next question of what are the priority needs identified by peers you work with in terms of local health care, mental health care, low barrier harm reduction care, housing or other essential services?

Tanis Carson: Every one of them! I think that for my clients low-income housing and housing with wraparound services is a priority. I think for anybody to even begin to heal their traumas and addictions, having roots is the priority and then mental health services. That's really lacking here. We don't have enough mental health services for my clients. If they access an adult mental health worker in town, if they don't see that mental health worker within two months, their file gets closed. I think that people need access when they need access, without restrictions. I think that we're doing pretty good with access to harm reduction supplies, I think that we've come a long way. As far as safe prescribing, Grand Forks needs to get on board. That's a very difficult one and we don't have safe prescribing.

We do have the OAT clinic which several of my clients have struggled with. For example, I had one client who isn't mobile due to past injuries and disease and gets around on a bike and lives several kilometers from the clinic. His bike broke down and he couldn't get it fixed for a couple of days. When he finally made it in, they put his dose of methadone way down. Which brings us to another barrier. There is no local transit. There's no transportation here in Grand Forks for anybody to get to a pharmacy. So, if they're living up the North Fork or living rurally, where a lot of the camps are, it's really hard for them to get into town.

Our downtown business association and others don't want any substance users, homeless people being in the downtown core. So, they don't want them close to services. It makes it very difficult for those people to get to their medication. We need less barriers when it comes to people accessing their medication, so they don't get kicked off the program and so their doses don't get reduced so drastically. I know that it's dangerous if

they've missed a few days, cause there's a risk of overdose, but sometimes their doses are being reduced drastically.

I know that in other cities they have delivery for methadone and other medication. So, if we could have delivery for those that are shut in or have disabilities, because we don't have local transportation or local transit.

Amanda Erickson: Such a great point and so needed in our rural areas.

Tanis Carson: I feel we need a detox and treatment center in Grand Forks. The talk of having wraparound services here is great, because it is a much-needed service. I feel that Grand Forks has the population of people with substance use disorders to support that kind of service.

Amanda Erickson: Over the last five years, what changes have you seen in terms of healthcare equity for peers? Have there been any changes in community stigma and views towards peers over the last five years?

Tanis Carson: I have seen some positive changes particularly with a couple of doctors. They've taken training to work in the OAT clinic. I still, however, see stigma there. I think that we've come a long way, but we've got a long way to go as far as reducing stigma and equality. I think that people want to change, but I think that they get so stuck in their stigma. It's like a learned behavior. If you've grown up in a different lifestyle or in a more fortunate lifestyle, to be critical of others, and it's hard to unlearn those critical thinking behaviors.

I have seen some positive changes in the last five years, but I think that we have a long way to go, and I think that there needs to be a lot more education around substance use disorders. Housing and harm reduction can reduce deaths and crime and it can encourage people to access help. How are we going to get past that mental block that some people have? There's going to have to be creative ways to get to some of these people that have that stigma way of thinking. I think we're moving forward and with strong activists like Moms Stop the Harm that's making a huge difference. Leslie McBain is one of my heroes. The strength that she has and that work on a government level for change in policy.

Amanda Erickson: So great. Do you feel that there is healthcare equity for peers in your region and are peer needs being met? How about for marginalized peers, including LGBT peers, youth, and Indigenous peers? There is the new provincial study "In Plain Sight" that came out and showed that like 83% of Indigenous people who access the health care system had experienced racism. Do you want to speak to that for your community?

Tanis Carson: I feel that there still is some racism going on. I feel that there is a lack of trauma informed education, more than there is racism. It's a lack of understanding and a lack of compassion towards the trauma of our people. It's an unwillingness to learn or accept how our people were treated and why doctors should be more compassionate, or trauma informed.

Amanda Erickson: It's like people are holding that expert status, so they can't be taught.

Tanis Carson: Yeah. I think that you come up against that with a lot of people. It's that difference in power that you deal with. I think that that's what we're dealing with when we try and educate medical personnel on Indigenous needs.

Amanda Erickson: It is so important to bring trauma informed and cultural language forward and more into the common rhetoric of our everyday thinking and talking and ways of being.

Tanis Carson: The cultural piece is big. I think that doctors feel everybody can have trauma and they're going to treat everybody the same. So maybe it's that unwillingness to learn each culture and how to treat people according to their culture.

Amanda Erickson: Do you have a comment on substance use, trauma, or mental wellness and how to best support people to stabilize? What is helping to mitigate risk of overdose for our populations?

Tanis Carson: I really feel that we need more trauma informed counselors. Somebody on our teams that is more specialized in trauma, because I feel that trauma is always the underlying issue. I've always said that substance use disorders are secondary to something much larger. I think that we all have to look more towards the trauma and treat the trauma and how it affects the nervous system. I'm doing more training on that, because in order to understand the substance use piece, we have to understand what caused it. I think that that's a piece that's missing.

We can't just treat the addiction because that's just putting a band aid on a wound that's going to keep festering. I would like to see within our healthcare specific counselors that are trained in trauma and practices for healing. It would be really nice to have access to some of this knowledge around ways to heal the brain.

Amanda Erickson: Emotional regulation strategies, coping strategies.

Tanis Carson: Even just a simple one-hour class video that we could show for people on how the nervous system works and how trauma affects the nervous system. Because if you can understand it a little bit, then you can understand what's going on within yourself. It's like a sigh of relief. You know, it just takes a little bit of understanding for people to understand why they're behaving the way they are and why they've chosen substances.

Amanda Erickson: Well, I'm so glad that we have the time to chat today. It's really nice to hear about your perspective and how you work.

Tanis Carson: Yeah, it was nice.

This interview has been shortened and condensed.

Nelson Fentanyl Task Force (NFTF)

NFTF INTERVIEWS PROJECT: September 2021

"I think the most important thing is human connection…The most important thing that we do in that program is just be with people in their lives and provide unconditional love and support…

Where is the richness of life? And for me so much of that richness comes in community and human connection and that's where that healing happens as well."

Jasmin McMechan Former Program Manager
Kootenay Boundary Support Recovery, ANKORS

Nelson Fentanyl Task Force

NFTF INTERVIEWS

Jasmin McMechan
Counsellor
former Program Manager at
Kootenay Boundary Supported Recovery Program

By Amanda Erickson
September 2021

Amanda Erickson: So, my first question is if you could just introduce yourself and tell me a bit about the work you have done in the community. What was your title, role, your time in the role, your clients, and your service area when you were with the Kootenay Boundary Supported Recovery Program?

Jasmin McMechan: My name is Jasmin and I was in the role of manager and life skills worker at the Kootenay Boundary Supported Recovery Program for just over four years. The supportive recovery bed program, the best way to describe it is it's kind of bordering on second stage, almost third stage addictions treatment. It's kind of a tier down from residential treatment. Folks would live with us for up to six months in one of our eight beds in scattered units around Nelson. And during that time, we would be providing people with counseling support, life skills support, and safe housing. And in my mind, the primary objective of that program is kind of a community bridging program. People are coming there with some knowledge about themselves, about their process of recovery. They have some skills and they're just looking for some support and a safe place to land as they figure out what comes next. Our role is really in supporting them to figure out what comes next and take that next step into a little bit more independence. And the catchment area for that program is a West Kootenay Boundary.

Amanda Erickson: For sure. The next question is could you share a bit about how you've worked within the organization or in your role to support healthcare, equity, social equity, or harm reduction efforts and the wellbeing and safety of local people?

Jasmin McMechan: Yeah. I think that one really important thing that we decided to do early on in our program was that we wanted to have a harm reduction policy. A lot of programs that are residential don't really have a harm reduction policy and so if someone has a slip or uses in the time that they're there they are asked to leave the program. And we decided early on that we did not want to do that. And that's because we recognized that slips and relapses are really part of the process. And that's when people are incredibly vulnerable.

So instead of withdrawing services at that time, to be able to really wrap around someone and provide support felt really important to us. Instead of like, "Okay, now this has happened and now I'm a failure and I might as well just give up." To be able to be like, "No, there's some learning to happen here. And I have people that care about me and who want to help me get to where I want to be."

A policy that that can support harm reduction also needs to support the safety of everybody in the home because it is congregate living largely. So, there is a certain point at which we're not actually a harm reduction program. We don't have the staffing capacity for that. If someone was not at a place of actually being in the place that fits with the program goals, we have asked people to leave (for ongoing substance use).

A huge piece of the program and working within the program is really being in people's lives and having an opportunity to work with them and either help them in terms of advocacy or help them to advocate for themselves in the health system. And being in people's lives in that way allows you to know what's happening and what's going on and to be a lot more involved than if you just see someone once every two weeks or whatever.

And then the peer component, I feel like that's an important part of supporting people and having people feel supported. One of the peer volunteers is a person who came through the program before. And so being able to have people who have had experiences in the program come back and be able to kind of mentor people through and provide some extra support to me that feels really important.

Amanda Erickson: That's great. It's just so nice for people to see like, "Oh, here's someone who made it through the program and they're doing relatively well now." It must be motivating.

Jasmin McMechan: Yeah, it's great! And we had another peer volunteer who came to us not having gone through the program but came to us as a volunteer who's now a student with us. And I think having that peer component, that knowledge, just brings such an incredible richness and value to what it's offered.

Amanda Erickson: Yeah, I bet that it does. What are the priority needs identified by the peers that you worked with there? I'm thinking in terms of local health care needs, mental health care needs harm reduction, care, housing, or other essential services. What do you see around the Kootenays in terms of the priority needs for our region?

Jasmin McMechan: So, in my mind with the folks that I've worked with in this program, there are two major needs. The first is housing, which I'm sure everyone's going to say. But I can't stress enough how important that is and how often that would come up doing feedback interviews with people in the program. People being like, "The fact that I don't have to worry about where I'm going to be tonight, that I have a place where I am." And then, on the flip side of that it's only for six months. And the amount of stress that people experience knowing that they're safe for now, but not for always. It's not knowing if they're going to be able to find something, it's devastating for people. I don't think that we could ever underestimate just how important housing is in terms of someone's wellbeing.

On a personal level, the house that we were supposed to move into up here is being renovated. And it probably won't be ready for several months. We are staying in a room in someone's house. Kind of like couch surfing. There's no housing up here <Northern BC>. And it's been very interesting for me as someone with an incredible amount of privilege and stability and support in my life to recognize just how destabilizing it's been for me. I'm not homeless. I have a roof over my head. I'm not sleeping outside, but it's just that feeling of not having a place to put your feet, to unpack your stuff, to like land and feel like you have a sanctuary and somewhere you can go is so hard. So, number one is housing

The second thing that I would also identify as a huge gap in our services is trauma counselling services and trauma specific services. The population that we're working with at the supportive recovery bed program are generally transitioning away from being kind of involved in the street community and focusing more on recovery. And so, a lot of people are in a place where they're feeling like they're ready to do that work. They **want** to do that work. They want to figure out some of those deeper levels and try to work through that. And there just isn't anything available for them. And so, to me, for the folks that I've seen come through our program, who are really in that place that's a huge loss.

Amanda Erickson: I guess MHSU can be more CBT, DBT oriented, and there's no room for more long-term trauma focused work. Is that what you mean?

Jasmin McMechan: Yeah. There are people at mental health who are trained in EMDR, who are trained in trauma specific therapies, but they're not allowed to use those modalities. The clinician within the program is a counselor who is more focused towards counseling and providing that.

Amanda Erickson: We know a lot about the influence of trauma, but in terms of the provision of services we're just still getting there it seems like.

Jasmin McMechan: Yeah, there's so much of a focus on services being trauma informed, which is so important, but the next layer is that we have to also offer trauma specific services. And we're not giving people the tools to really move forward. People's readiness and ability to do that really intense work is going to come in and out, and we have to be able to offer that over the course of a lifetime. There's no quick fix, you know.

Amanda Erickson: For sure. It's kind of like with grief, trauma can tend to show up again different times if we're under stress or whatever.

Jasmin McMechan: Yeah. Maybe the one other thing that I would add is just around education. And I know this is something Nelson Fentanyl Task Force works on all the time, but just around education for people within the healthcare system. Like just doctors and nurses having the correct information, even just about medications, but also about addiction.

It's a huge barrier for people to go to the hospital because of the way that they're treated most of the time. I understand why people don't get the care that they need because they're dealing with this wall of stigma. And it's not everybody obviously. A lot of people do really good work, but the overarching feeling is that people aren't respected as humans when they have a history of substance use, and they go into the hospital or the walk-in clinic or wherever.

Amanda Erickson: That's a big barrier. It's such an important part of the work and peers getting more organized around the province. And that exposure that healthcare workers can have with peers to deepen their understanding.

Jasmin McMechan: Yeah, absolutely. And the service providers, we could do a better job of creating connections, between the different silos of service. It's kind of like, the hospital staff are in their own zone, and Mental Health and Substance Use are in their own zone. And then the community organizations work pretty well together. And we do work together, but there has to be like a really concerted effort to make that happen. Like I know that the Fentanyl Task Force does a good job of this, because having everybody at the same table is super important. I think that's something I could have done better in my role, is to get to know people in the hospital a bit better to find ways to create more of those personal connections, because especially in a small town, that is how things happen. I can think of so many situations in which having that personal connection would have made all the difference.

Amanda Erickson: For sure.

Jasmin McMechan: Yeah, it's complex, but it’s certainly important to keep building those bridges.

Amanda Erickson: Yeah, I totally agree. The coordination of care and those kinds of wrap around services and making referrals go through. That can just take everything just to make one referral go through! It helps if there's some personal connection or rapport that's been built up between workers, hey?

Jasmin McMechan: Yeah, absolutely. So much more support can be offered to folks who are maybe having a harder time if everybody can work together. Then there's a whole team that's there that can kind of wrap around and help someone through that. It makes a difference. To me, it's like the difference. between writing someone off and not. How committed are we to standing with people as they go through their process?

Amanda Erickson: Yeah, for sure. What's your focus when you're working with people to help them to stabilize. What have you seen that's been working?

Jasmin McMechan: I think the most important thing is human connection. It's not that the life skills component of things isn't important. The most important thing that we do in that program is just be with people in their life and provide unconditional love and support to the best of our ability.

I feel like the more I've done this work and the more I've spent time with people the more it's like, “How do we measure success?” I don't know that we really can. Like for me, success in this work is not that somebody stopped using substances. There's this thing that happens where people are like clinging to sobriety and the white knuckling it and that's not life. That might be what needs to happen for now.

But for me, it's like, “What does the rest of life look like? And how do we support people to find things that bring them joy and connect them to parts of themselves that they might feel like they've lost at some point, or maybe even never knew they had? Where is the richness of life?” And for me so much of that richness comes in relationship, in community, and in human connection. And that's where that healing happens as well. There's been some sort of success when people feel more connected and even if they're still using substances that it doesn't have the same kind of devastating impact on their life. And they have hopefully connected with some part of life that feels like something that just brings joy. Joy to me is something that is important.

Amanda Erickson: I just agree with you on so many levels, with what you're saying about experiencing joy and relationship.

Jasmin McMechan: There's a large portion of the people that have come through the program that we've had to ask them to leave for some reason or another. And maybe there's like a moment where it’s really hard in our relationship, but 90% of those people, if I see them downtown, we're going to say “Hi” and pre-COVID, give each other a hug and check in and I'm so happy to see them. Even if things felt super rocky for a second there, when we had to ask them to leave, like they say, “Thanks for everything that you did.” It feels like we have provided at least a little bit of that community and connection. Even though people are getting kicked out, they're being seen as humans and being seen as

important. We're all just humans. And we're just trying to figure this out together. And nobody has the right answer.

Amanda Erickson: Yeah. Sounds like recovery can look a lot of different ways.

Jasmin McMechan: Exactly. Like we all go through periods where we don't feel well for whatever reason, right? There isn't anybody in this world who won't go through, at some point in their life, a period where they feel unstable or unbalanced or whatever. If people would just understand that addiction and substance use is just another facet of that. Everybody is different and wellness looks different for everybody.

Amanda Erickson: Yeah, for sure. For some people you know, the closest thing to them is fentanyl, then that might be what they're picking up instead of some other coping skill.

Jasmin McMechan: Most people are using substances. Not everybody has this kind of catastrophic chain of events attached, but that's for a bunch of different reasons. That's because of the support system that they have around them and other coping mechanisms they have and all that. But people are using some substance to cope with their day, even if it's just coffee in the morning.

Amanda Erickson: I'm so grateful that you could take time to do this with me.

Jasmin McMechan: Yeah. Well, thank you so much for including me.

This interview has been shortened and condensed.

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